The Secretary's Advisory Committee on

Infant and Maternal Mortality

U.S. Department of Health and Human Services

Virtual Meeting

Day 1

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Attended Via Webinar

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Marie-Elizabeth Ramas, M.D., F.A.A.F.P, Family Physician, President-Elect, New Hampshire Academy of Family Physicians, Founder, Medrise and Consulting

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ShaRhonda Thompson

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Charlan Day Kroelinger, Ph.D., M.A., Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention

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

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

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

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C O N T E N T S

P R O C E E D I N G S

WELCOME AND CALL TO ORDER

LEE WILSON: All right, good morning, folks. This is Lee Wilson. I'm the Director of the Division of Healthy Start and Prenatal Services in the Health Resources and Services Administration at the Department of Health and Human Services. I am acting as the designated Federal official for this Advisory Committee on the Infant and Maternal Mortality, Tuesday, March 15, 2021.

I'd like to welcome both our longstanding members to the Advisory Committee meeting and the new eight Committee members who are joining with their first meeting today. Welcome to all. We look forward to a rich and full discussion on infant and maternal health and morbidity and mortality today.

This is a two-day meeting beginning at noon on March 15 and running through 4:00 o'clock on the 15th, and on the 16th, beginning at 12:00 o'clock and running until approximately 4:00 or thereafter.

We will be covering a review and approval of the minutes from the previous meeting, and we will be hearing

a series of presentations today with some open discussion. At this point we have no planned votes for recommendations to the Secretary today, so for those of you who are joining or linking as a public participate, we welcome you, we're glad that you're here and there will be no votes.

We will provide an opportunity at the end of the first day of the meeting on day two for public comment, and so if you -- there was a call in the Federal register for individuals to lodge any interest in making a public or a written comment. We have received one written comment, and I believe we received requests for two public comments. So, anyone who is interested in making a public comment, please let that be known and if we have the available time, we'll put you in there.

So let me turn it over to our Chair, Dr. Ed Ehlinger, to give his welcomes and open the meeting.

ED EHLINGER: Thank you, Lee. Good morning or good afternoon. You know, those people on the east coast, I assume everybody is on Eastern Standard or Eastern Daylight-Saving time, but we know that we have people all the way from Alaska to Washington D.C. and all points in

between. So welcome to you on this beautiful day here in the twin cities of Minneapolis, Minnesota where I am. It's about freezing, and the sun is shining. So welcome, as Lee mentioned, to the returning members and to the new members of SACIM, all of our ex-officios and also to the people who are on board from the public.

So, welcome on this, the Ides of March and on World Social Work Day. You know, like I said, I'm coming to you from Minnesota, in Minneapolis, the ancestral land of the Dakota and Ojibwe people, and I'm hoping, if everything turns out, that I will be able to actually welcome you in person in June when we have our meeting at, I'm hoping at the Shakopee Mdewakanton Sioux Community tribal land. I'm a little nervous seeing what's happening to COVID in Asia and Europe, so let's keep our fingers crossed and that that is a blip there and we don't have a blip here.

So welcome, welcome. And I know later on in the agenda, we are going to be having more prolonged or more in-depth introductions, but I do just want to make sure that we know who's in the room, who's in this virtual room. So, I would like to have -- I will call your name

and have you just very briefly say who you are, where you're from and sort of your professional position, and we'll come back later to a more in-depth introduction. So, just your name, where you're from and your position. And I'll do it in alphabetical order. So, Sherri Alderman.

SHERRI ALDERMAN: Good morning. Good morning, my name is Sherri Alderman. I am at the moment in Portland, Oregon. I live in Oregon in a rural area and in the metropolitan area. I have time each. I am a developmental behavioral pediatrician with infant mental health expertise, and I am faculty at Portland State University. Thank you.

ED EHLINGER: Great. Steve Calvin.

STEVE CALVIN: Hi. Steve Calvin. I'm a maternal fetal medicine specialist also in Minneapolis, and I work with midwife colleagues at the Minnesota Birth Center.

ED EHLINGER: Charlene Collier. I don't see her on the list quite yet.

EMMA KELLY: We're having issues getting her onto Zoom but she is present.

ED EHLINGER: All right. Jeanne Conry.

JEANNE CONRY: Hi, Jeanne Conry, retired from thirty years of practice with Kaiser Permanente, past President of the American College of Obstetricians and Gynecologists and current President of the International Federation of Gynecology and Obstetrics, part-time in California and currently in Paris.

ED EHLINGER: All right, good. Tara Sandra Lee. I hope you can -- she has a sick child and I'm hoping she can make it.

TARA SANDRA LEE: I am. Can you see me? Can you hear me?

ED EHLINGER: Yes.

TARA SANDAA LEE: Okay, good. Hi. My name is Tara Sandra Lee. A PhD in biochemistry, training at Harvard Medical School in fetal development and continue those efforts, faculty member as well in research and clinical medicine, again, with experience in fetal development. Currently, the Senior Fellow and Director of Life Sciences at the Charlotte Lozier Institute in Arlington, Virginia. Today I am in sunny Wisconsin just outside Milwaukee.

ED EHLINGER: Great. Colleen Malloy. I don't see Colleen. All right, Katherine Menard.

KATHERINE MENARD: Kate Menard. I am a Maternal Fetal Medical Specialist. I'm based at the University of North Carolina in Chapel Hill.

ED EHLINGER: Great, thank you. Joy Neyhart. I know Joy is on call so she may be called away from the meeting.

JOY NEYHART: Okay, I'm here. I don't know if you can see me or not.

ED EHLINGER: Yes, we can.

JOY NEYHART: I am Joy Neyhart. I've been a private care pediatrician in Juneau, Alaska for the past 21, almost 22 years, and I am coming to you today from the ancestral lands of the Tlingit and Haida people of what is now considered Southeast Alaska, and as of April 4th, I will be serving those tribes as a hired pediatrician for the Southeast Alaska Regional Health Consortium, and so my demographics will change on the member list. I'm pleased to be here and thank you for having me.

ED EHLINGER: Thank you. Janelle Palacios.

JANELLE PALACIOS: Good morning, I'm Janelle

Palacios. I'm Salish and Kootenai originally from the Flathead Indian Reservation of Montana. I'm coming to you today from Northern California on the ancestral lands of the Coast Miwok people. I am a clinician, a nurse midwife in the Bay area, a researcher, a storyteller and a mother with three sick children here at home. So, I will be on and off camera. Good to meet everyone.

ED EHLINGER: You're -- it sounds like you're not alone in having sick children, so welcome to the club. Magda Peck.

MADGA PECK: Good morning. This is Magda Peck. I come to you now visiting my grandchild and one to come on the ancestral lands of the Winnebago Potawatomi and Omaha Tribes in Omaha, Nebraska. I usually awake in Richmond, California where I head an independent consulting group called MP3 Health that focuses on leadership and storytelling or maternal and child health and public health. I'm an adjunct professor of pediatrics and public health at the University of Nebraska Medical Center, and I'm founder and senior advisor of CityMatCH, the national organization dedicated to racial equity and urban maternal and child health leadership. It's a

delight to be here with you again today and welcome to the new members.

ED EHLINGER: Thank you. Belinda Pettiford.

BELINEA PETTIFORD: Hello, everyone. I am Belinda Pettiford. I am head of the Women, Infant and Community Health Section here in the Division of Public Health in the State of North Carolina. So, good to see everyone and as Magda said, welcome to the new members and everyone that's able to join us today.

ED EHLINGER: Marie-Elizabeth Ramas.

MARIE-ELIZABETH RAMAS: Good morning, everyone. My name is Marie Ramas. I'm a family physician and have been practicing full scope family medicine including surgical obstetrics and hospital work for the last 13 years. I am located in Hollis, New Hampshire and am part of the commission of health for the public and sciences for the American Academy of Family Physicians and president-elect of the New Hampshire Academy of Family Physicians. I'm very passionate about health equity, particularly in our BIPOC communities and lead charges and advocacy work surrounding that. I'm also a founder of Medrise and Consulting, which is a consulting organization

that supports relational coordination and relational transformation within organizations to help improve health equity and equity within organizations themselves. So, I'm very happy to be here in my first meeting.

ED EHLINGER: Great. Well, we're glad you're here. Phyllis Sharps.

PHYLLIS SHARPS: Good afternoon, everyone. I am Phyllis Sharps, formerly, after 20 years of faculty and associate dean at John Hopkins School of Nursing for community programs and initiatives. I've retired and now professor emerita. I reside in Columbia, Maryland, which is about 20 miles south of Baltimore, and my focus of research and practice has been on violence against pregnant women and testing nurse home visitation initiatives.

ED EHLINGER: Great, welcome. ShaRhonda Thompson.

SHARHONDA THOMPSON: Hello. My name is ShaRhonda Thompson. I am from St. Louis, Missouri. My day-to-day job is in the freight transportation world, but I'm here because of my advocacy for infants and mothers in the community.

ED EHLINGER: Great. We're really glad you're with us, ShaRhonda. Jacob Warren.

JACOB WARREN: Hello, my name is Jacob Warren. I'm a health equity epidemiologist. I'm the Director of the Center for Rural Health and Health Disparities in the Mercer School of Medicine where I work on health equity issues in intersectional rural communities.

ED EHLINGER: Great, welcome. And Paul Wise cannot be with us today. He has been called to Poland, actually, to work with some of the kids with cancer coming out Ukraine. So, he is actively involved doing maternal and child health work, but he is in Poland at this time.

Let's go back, I think now, Charlene Collier is on -- is connected.

CHARLENE COLLIER: Thank you so much. I'm sorry for the technical difficulties. I'm Charlene Collier. I am an OB/GYN at the University of Mississippi Medical Center, where I also hold a joint position with the Mississippi State Department of Health, and I direct the Maternal Mortality Review Committee as well as the Mississippi Perinatal Quality Collaborative, and I'm very passionate about health equity and addressing social

determinates of health and improving maternal quality of care. And this is my first meeting and I'm very glad to be here. Thank you so much.

ED EHLINGER: We're glad you're here, too. And Colleen Malloy I think is now connected.

COLLEEN MALLOY: Hello everyone. My name is Colleen Malloy. I am a neonatologist and pediatrician, and I work for Northwestern University in Chicago in Lurie Children's Hospital, a pediatric hospital. And I also have a degree in health informatics, so I have a vent in that arena as well, and I appreciate the ability to come together today, this morning, to talk about these important issues.

ED EHLINGER: Great. So, we have a good turnout for appointed members of SACIM. I will continue to say SACIM, it just comes second nature. I haven't gotten to the ACIMM yet, ACIMM, yet so I'll say SACIM. And I'm going to go down the list. I'm not going to list all of the ex-officio members but I'm going to see who's on, and I think have them unmute. So, Allison, Allison Cernich.

ALISON CERNICH: Hi, Allison Cernich, Deputy Director of the Eunice Kennedy Shriver National Institute

of Child Health and Homan Development at the National Institutes of Health. Great to be here today.

ED EHLINGER: Danielle Ely.

DANIELLE ELY: Hi. Danielle Ely. I work at the National Center for Health Statistics at the Division of Vital Statistics in the Reproductive Statistics Branch, and I manage the linked birth and infant death file. It's great to be here, thanks.

ED EHLINGER: Good, glad you're here. Karen Remley.

AMANDA COHN: Dr. Ehlinger, Karen Remley is on the phone right now, but she is also on the COVID Response, so may not be able to participate at this moment.

ED EHLINGER: All right.

AMANDA COHN: I am Amanda Cohn. I am with the Division of Birth Defects and Infant Disorders in the National Center for Birth Defects and Developmental Disabilities.

ED EHLINGER: Great. Thanks. Anybody else, ex-officio that I haven't mentioned?

MICHAEL WARREN: Good morning or good afternoon.

Michael Warren. I'm the Associate Administrator for the Maternal and Child Health Bureau here at HRSA.

ED EHLINGER: Okay, good. And Anne.

ANNE LEITCH: Good morning, everyone. I am Anne Leitch. I am with the Maternal and Child Health Bureau and I'm a management analyst who is supporting this committee while Vanessa Lee is on maternity leave. Thank you.

ED EHLINGER: All right. And Michelle Loh, behind the scenes person for all of this.

MICHELLE LOH: Good morning, everyone. I'm Michelle Loh. I'm the management analyst for the ACIMM team.

ED EHLINGER: Great. So, we've got a good group of folks. So, thank you for making time to be with us today. And those of you who know me, you know, know that I always sort of kind of set a historical context for some of our work because I think we need to learn from our history, and particularly as we're thinking about historical trauma, we also think about some of the historical things that have gotten us to the positive places we are today.

And so, as I look back on this day in history in 1964, Lyndon Baines Johnson asked for a war on poverty. Exactly one year later he went to Congress and said we need to pass a voting rights bill. And those two things that led to major policy changes related to sort of a health and all policies approach with the war on poverty and getting the people the right to vote, which influenced public policy. We had a rapid decline in infant mortality during that period of time and had an unprecedented ten-year trend where we actually reduced disparities, black and white disparities in infant mortality form around 1965 to 1974.

When some of those policies started to change, our rate of improvement in infant mortality slowed and our disparities started to increase and have continued to increase since that time. So, it just tells me that public policies, health and all policies approach can actually make a difference.

The other thing that happened on this day, as you're well aware, on the Ides of March, Julius Caesar was assassinated, but you know, the soothsayer said beware the Ides of March and Gaius Cassius had this favorite line, he

said the fault, dear Brutus, is not in our stars but in ourselves that we are underlings. He was pointing out the fact that we can't blame others for lack of action. We can't blame others, or our stars, or our fate for some of the things that happen, but we have to take ownership ourselves. And he said that if people consider themselves underlings, if they consider themselves without power, they're not going to make much change, pointing out the fact that we should take things into our hands. We do have power, a lot of particularly collective power to make a difference.

So, I'm telling you, we are not underlings on this committee, we actually have some power. We have a way to advance recommendations to the HRSA Administrator and to the Secretary of HHS. So, take advantage of that during our time over the next couple of days, and certainly for all of the members of this committee for the length of time that you're on this committee, use the power that you have, the power of your experience, the power of your knowledge, the power of your connections to actually make a difference to moms and babies.

All right, a couple of things. We have a little

bit of change in our agenda from what we published because the presenter from the Indian Health Service had to back out. So we're not going to have that Indian Health Service prospective being presented today. And because of the rules that we can't add new things without going through the public record, I'm not adding any new items to the agenda, but we're expanding some of the topics that we have. And I do want to make sure that Lee knows that we are going to be talking about race concordant care and we may be talking some bullets on those recommendations. So, I just want to make sure that we're in sync, Lee, with what's going on.

WELCOME FROM THE HRSA ADMINISTRATOR, CAROLE JOHNSON

ED EHLINGER: So, with that, we're going to move on with our agenda, and I am really pleased -- I am really pleased that we have Carole Johnson with us, the recently appointed Administrator of the Health Resources and Services Administration. And HRSA is the group that sort of – you know where SACIM resides within the organization. So, Ms. Johnson, thank you for being with us and we really look forward to your comments, this morning.

CAROLE JOHNSON: Thank you so much, Dr. Ehlinger, and thank you to everyone on the Committee. Welcome to the new Committee members. Just listening to the introductions and bios, I know how much the critical experience that you all bring to the table is going to pay dividends for me in this role to have the benefit of your expertise and your input as we work going forward to combat the infant mortality and maternal mortality challenges that we all face together.

I'm just really honored to have the chance to be with you today. I am the new HRSA Administrator. I come here most recently, having worked for the White House COVID Response Team, but prior to that, having been the Commissioner of the New Jersey Department of Human Services where we work through our Medicaid Program to expand post-partum Medicaid services for a year after birth. And I will tell you that we were very excited to do that. We were the second state in the country that got that approved through CMS, and I -- and thinking about this Committee, it was this Committee's recommendations, I believe in your 2013 report that were one of the first places I ever saw that recommendation made. And so it

took a little while, but I am someone who in my policy role has always benefited from the work of this Committee.

And so I'm really delighted to now be in a position where I can work directly with you on the critical challenges that are in front of us. And some of those are well known to all of you. You know, we obviously are all living with -- living with now where we are with COVID and the effects of COVID, not only on the physical health of so many individuals in our country, but also the mental health and the needs of women and children across our population.

And so, you know, it's a priority for me, a priority for the Secretary, a priority for the President that we're focused on mental health, and that we're pulling all the levers we can to ensure that we're focused on mental health or children who have experienced so much loss, whether it's learning loss or whether it's direct grief and family loss, or whether it's just the loss of having the connectiveness with their friends and family over the last two years, but also the maternal health issues associated with mental health, and that we are thinking about and building the capacity to reach and get

mental health services to pregnant people and that we build networks that can support that. You know, Michael and his team here at HRSA have been doing some really terrific work about building -- using our resources to be able to build regional telehealth, teleconsultation support to primary care and maternal health providers, and we're just -- we're really excited about how we can learn from what we've done thus far and really take it a step further to continue to build that capacity and support.

But in addition, we have so much more work to do to ensure that women's voices are heard, and seen, and experienced as we build out our healthcare system, services and supports. We know that they're unacceptable disparities between black and white maternal health outcomes. We know there are unacceptable disparities between black and white infant health outcomes, and that it's going to take all of us working together to really think through and identify the steps and strategies that can reverse the course on that front and address the systemic race issues, address the workforce challenges, address the range and host of issues that we have in this space that we need to work on together.

In addition, I will note that we are very focused on the workforce challenges at large. It is a moment in time right now, as you all know, because you're experiencing this in your practices, where the -- we can have very good policy and we can invest in good policies, but if the workforce isn't supported and feel supported to be able to deliver on those policies, then we will not have accomplished our goals. And so it's critical that we continue to invest in growing the workforce, diversifying the workforce, ensuring that the workforce is serving the communities that need them most and that is reflective of communities, but also that individuals who are in the workforce now feel supported and cared for, and recognized for the incredible contributions they've made over the last two years, but you know, it shouldn't take a pandemic for us to recognize and support the workforce.

So, we have actually, through the American Rescue Plan, been able to make some -- to create new programs really focused on the healthcare workforce mental health and resiliency, and we're going to continue to focus on this issue going forward because, you know, it is -- for a long time we've invested in training and doing

the work to create new healthcare -- new employees in the healthcare workforce. We need to be focused not only on training but also on retention and also on, you know, creating healthy workplace environments.

And so all that is to say that this Committee is so important to us here at HRSA and your input and expertise are going to be really valuable as we work to tackle some critical issues that are front and center on the Secretary's agenda, front and center on the President's agenda, including mental health and reducing the unacceptable racial disparities in maternal health and infant health outcomes.

So much of what we've done in this based so far is built on the work that you all have done, and we're just really excited to be able to work with you on the steps going forward.

So, thank you, again, for the chance to be here with you today and for the work that you will do in the weeks and months ahead. Back to you, Dr. Ehlinger.

ED EHLINGER: Do you have a few minutes for some questions.

CAROLE JOHNSON: Absolutely.

ED EHLINGER: All right. So, if people could raise their hand, there's a little button on the bottom, you know, if you have questions. While we're waiting for others, I was just made aware of the fact that, you know, and I think Dr. Warren is going to be talking about this sometime, because he just recently had an article in Pediatrics about, you know, looking at -- reducing disparities as part of the healthy people 2030 goal, and so my guess is that in 2025, which is halfway through, you'll be looking at the way that those things are going. But that also happens to be the 40th anniversary of the Heckler Report, which was in 1985, identified racial disparities as one of the things that we really needed to address and identify the fact that, you know, 60,000 people died because of racial disparities.

Have you thought about maybe revisiting the Heckler Report along with looking at the healthy people 2030 goals at the same time, at that 40th anniversary of the Heckler Report?

CAROLE JOHNSON: What an interesting suggestion. Thank you so much for raising that. Why don't I take that back and have some conversations with my colleagues about

that? I appreciate you suggesting it.

ED EHLINGER: All right, good. Steve Calvin.

STEVE CALVIN: Great. Well, thank you very much, Ms. Johnson, it's great to hear your commitment to a lot of these things, and particularly the workforce issue. I would put in my two cents worth as well. As a maternal fetal medicine physician working with midwives and just kind of having a broad overview of what happens in the U.S., we are woefully lacking in midwives, and I think we also know from studies that ACOG has done, that the obstetrical workforce is not enough from the physician end to take care of all of the mothers having babies, and I would think, too, even going with the Strong Start Study that came out of the Affordable Care Act, it pretty well demonstrated the value of midwifery care that's integrated with the safety net of physicians and hospitals. So, I just am putting in my two cents worth as saying I totally agree.

CAROLE JOHNSON: And I so appreciate you raising that. I feel like we're singing from the same song book. Midwives and doulas feel to me like just critical part of the work we need building that workforce and identifying

ways, and I'd love to hear your thoughts and suggestions as the Committee goes forward on how to expand the model it sounds like you have built in terms of best integration of midwives and doulas into the -- your larger work. And I think that's just critical and I'm so excited to hear you raise that because it's really a priority for me as well.

ED EHLINGER: We did make some recommendations to the Secretary last summer related to those and we'll make sure that you get reminded of those. Magda Peck.

MAGDA PECK: Welcome. We're delighted to have your leadership, so thank you. Here's my question. Thank you for referring back to the 2013 blueprint under a previous iteration of SACIM. One of the things that was recommended was greater intra-agency and intersectoral collaboration to get stuff done. And I was listening at the last SACIM meeting to the first lady of New Jersey give us a briefing of how quality of care, and access to care and policy has been transformed in your former state of New Jersey.

As you step into your HRSA role, where do you see the possibilities and collaboration with other parts

of Federal Government? In particular, you'll hear later, or you'll hear about our push to try to get housing and urban development, and HRSA and Health and Human Services to work more closely on security of housing and the prevention of eviction, especially in the critical lives of women and children.

So, now that you're at a federal level from a state level, can you talk about that intra-agency collaboration, a little bit about your vision for the kind of partnerships and working together that will be essential to address complex issues that drive infant and maternal mortality. Thank you.

CAROLE JOHNSON: Thank you so much for the question. I can hear the words in my head. I think of what First Lady Murphy may have said to you, which was, we started with a small table. That was my human services department, my colleagues in the Department of Health and the First Lady's office, and we grew it to a table that included our Agriculture Department, our Transportation Department, our Housing and Community Development folks because we had to. Our corrections facilities, because we had to, because as soon as we started, you know, building

out what we wanted to do, it required a whole of government response.

And so, we are committed here at HRSA. I'm committed to building out those kind of connections as well. I think most immediately, you know, here in the Department, the Secretary has really charged us with doing everything we can and bringing together our colleagues at CMS, at CDC, at NIH to really work collaboratively to tackle this challenge. But we would not be able to accomplish our goals if we weren't talking to and working with HUD and Ag and Transportation and really thinking holistically about those social determinants of health that are going to be critical for us to really make progress.

MAGDA PECK: That's terrific to hear. I want to thank you for that ability to know that it worked in Jersey – I'm a Philly girl – and worked in Jersey, and that the fact that you can then try to encourage that beyond what was written in the 2013 report, which calls for within HHS, at this point for what we now about factors, it's got to be across for all of Federal Government, and we'll look forward to working with you to

show how that can be done with recommendations, specifically in the area of housing. Thank you.

CAROLE JOHNSON: I appreciate that and I would say, I would echo, just echo something Dr. Ehlinger said earlier, your voice on these issues helps to make that happen. So you all being able to sort of chart a path to say, you know, here's what we know works and here's who should be at the table, that's always helpful to us as we, as a Department, try to bring others to the table and help them see their role in the solution.

MAGDA PECK: Thank you.

ED EHLINGER: ShaRhonda Thompson.

SHARHONDA THOMPSON: I wanted to go back to the midwife and doula conversation. So I know most women are more comfortable when their midwife or doula looks like them or similar to them, and I do understand that, you know there's training involved and there's cost involved with that training for a midwife or a doula, but do we have something in the works that will help with the funding of that, because the majority of the – I wouldn't say majority, but there are a lot of women of color that would love to participate as a midwife or a doula but just

do not have the funds available to get the training that's needed to do those things. So, is that something that we're looking into as well?

CAROLE JOHNSON: Thank you so much for the question, ShaRhonda. That is very much a part of our focus here at HRSA. We have the benefit in our agency of running both the maternal and child health block grant and maternal and child health services, but also, a number of the health professions workforce training programs in the Federal Government. And so, our teams across HRSA have been working with the President's team on the provisions of his Build Back Better agenda, which are really about how we transform our social services so that they best meet the health and wellbeing needs of all Americans. And as part of that conversation, we have talked to everyone about the importance of having midwives and doulas and what it's going to take to make that a viable career path for folks. Like that's going to take resources and training and it's going to take really figuring out then how to pay those individuals well through our Medicaid program, how to make it a viable career choice and opportunity for folks so that we can actually do what we

want to do, which is, as you say, have women and men who reflect the communities they serve be the ones providing these services.

And so that is a huge priority for us. You are exactly right that it takes money and resources. The President has been focused on that in the Build Back Better plan. There's lots of work to do with Congress on this but we also have lots of champions for these issues in Congress. And so, we're anxious to work with them on being able to do exactly what you said. Thanks for the question.

ED EHLINGER: Marie Ramas.

MARIE-ELIZABETH RAMAS: Thank you for joining us today. I wanted to follow on what Ms. Thompson suggested about pipeline and access. And I wanted to share an alternative perspective as far as access is concerned, which is, as you have alluded to, was compensation, and how these services are paid for our primary care safety net. I would like to remind and encourage you as you're developing these plans and talking about these plans to remember that family physicians are integral in the provision of care for both mothers and pediatric patients

and birthing people within the United States. And so, it is unfortunately, right now we have primary care family physicians that still own independent practices serving underserved communities and who serve within our community health center settings that -- and other services that are suffering right now, particularly in the midst of COVID.

So, we need to consider not only having access, you know, pipelining both primary care workforce, but also creating a compensation model that is going to be sustainable. And I would suggest that part of that that I have seen that is still practicing within a community setting is to continue parody within a telehealth and tele video services for our patients. I have many patients that their only way of communication with me is through their phone. And luckily, since I speak multiple languages, I can communicate with them in their primary and native languages, which is another barrier to access.

So, I would suggest that as you're considering how do we consider those social determinates, think about the informative, informatics determinates of health as well to help bridge the gap. The only other think I would suggest, and I'm so excited that you're -- that the

concept of mental health care is so high on the President's agenda. I had the opportunity to speak with both him and his wife regarding mental health and how it's just very close to their hearts.

We are in, in New Hampshire, we are in dire straits as one of the states that have the highest rate per capita of opioid related deaths, particularly in our state. And the children that are affected by those adults who have died is – it's stark, and it really grasps us. We've had children since the COVID pandemic that we have lost contact with completely due to lack of access to them, both in the rural areas as well as our more densely populated. Unfortunately, they are disproportionately representative of the BIPOC, Black, Indigenous and Person of Color community.

So, although we are a smaller number, finite number, the statistics still reflect that of our national statistics as far as access is concerned for mental health services.

So, with that being said, I'm interested to hear any community partnerships as you're looking at ways to address social determinates of health for our historically

under resourced communities such as Boys and Girls Club of America, Salvation Army, United Way. Those services that are integrated within the community that provide services and access in unique ways, meeting the patients where they are as opposed to having to create yet another barrier of coming to physical locations.

So, lots of what I said, but I would love for you to, if you can, pick at something that may have resonated, Ms. Johnson.

CAROLE JOHNSON: Thank you for all of those comments. They all resonate with me. I will say I -- your point on young children who have lost their parents to the opioid epidemic is such an -- it's so poignant, and it's so challenging. And supporting them as well as whomever their caregiver is going forward are the kinds of things that we need to do as a nation to be able to help those children to thrive. There's just too much grief and we are all very focused on the grief associated with COVID, but so much more is happening to young children right now as well.

Just to your larger point about community-based organizations, that's increasingly what I hope to be one

of my focused areas going forward at HRSA. Now, we are, as you probably know as a government agency, we get Federal appropriations that sort of are directive in terms of where – what we can do with those resources, but you know, we fund community health centers. We support rural health clinics. We have a – we sort of have a sense of how challenging it can be on the ground to make sure that you're supporting communities in the way that you just – the way to connect people to care is to have community support as you've just talked about.

We are fortunate to have the Ryan White Program at HRSA, because the Ryan White Program has decades of experience in building the kind of community partnerships that you're talking about and we're going to learn those lessons across our lines of work, and as we get, hopefully, new resources to support maternal and infant health, which we think we will, given the President's focus and agenda here, you know, part of that is about building partnerships at the community level so that they're trusted messengers. They are people who can actually help connect people to care and help people get retained in care. Because they are of the community they

serve, they are able to reach out and make those kinds of connections.

So, we are doing more and more work with community-based organizations, but we – there's much more work to do.

MARIE-ELIZABETH RAMAS: I appreciate that and that's exciting to hear. One of the things that I'm working with on the New Hampshire Governor's State Health Assessment and Improvement Advisory Council is creating a geo mapping opportunity with particular social resources for our patients that's integrated in multidisciplinary so that clinicians can work on it. I'd be interested to see how that develops as well.

CAROLE JOHNSON: I will very much be interested in seeing how you -- what that looks like for you and what kind of -- what we can learn from that for others as well. And my colleague just reminded me, too, about all of the work that we do with our Healthy Start grantees, that that is just, you know, it's sort of foundational for us to be able to have those kinds of partnerships at the community level.

ED EHLINGER: We have time for one more

question. So, Charlene Collier, you get to ask the last question of Administrator Johnson.

CHARLENE COLLIER: Okay, thank you. I appreciate your time. And I'll make it short. Yesterday was, as I think about the workforce, an employee supportive and encouraging that we absolutely need more midwifery care, particularly Black midwives and Indigenous midwives that yesterday was Match Day, which is a big day for physicians where senior medical students are able to find out if they get into a residency program. A very large number did not match simply because there are not enough residency spots. And I saw many Black, Indigenous, first generation medical students who did not match into spots, and we all know now it's not because of just qualifications, it's simply there aren't enough and as we're facing a physician shortage in many areas of the country, and to see unmatched OB-GYNs, psychiatrists, pediatricians, particularly from under represented communities, and knowing the cost of going to medical school and getting through that match process, I'm very interested in knowing what the Administration and HHS's response will be to addressing the residency number going

forward, because I think this is a critical issue as well. Thank you.

CAROLE JOHNSON: Thanks so much for your question. I am -- it reminds me of my -- my first round, I worked at HRSA several years ago, soon after the Affordable Care Act passed, and in the Affordable Care Act, we were able to create residency slots above the cap. And so, you know, continuing to look for ways to expand the base here is important to us. At HRSA, we -- fortunately, the American Rescue Plan provided significant new resources to allow us to expand our teaching health center graduate medical education program, where we're able to support residency training in the community. And so, we are actually out on the street now with solicitations for funding to expand that program. But I take your larger point. We are all committed to growing the workforce and growing the workforce for exactly the individuals who you just talked about. So, you know, the idea that it's distressing to me to hear the outcomes that you're reporting from what you saw yesterday. We are going to continue to use the resources available to us to try to grow those slots within the ways that we can. But

at a minimum, to continue -- what Congress has given us resources for now is to grow the training programs, or the pipeline programs, to grow our National Health Service Corp, to provide loan repayment and scholarships for serving in underserved communities.

So, I think that that's really, you know, an important part of what we're doing as well. But the critical issue of how many slots there are and what the caps are, that sort of lives in a broader political context with them, with some of our friends on the Hill, but I think that, you know, your point about how we diversity the healthcare workforce and how we actually don't just say that but actually deliver that on the ground is the challenge for all of us.

ED EHLINGER: Thank you. Let me just add a little comment to that. Here in Minnesota, we have about 250 physicians who are trained in foreign countries, who are qualified, have passed all their boards but can't get a residency slot. So that, again, adds to the -- would add to the diversity if we could do the more residency positions.

So, Administrator Johnson, thank you very much.

I really appreciate your comments. I really appreciate your scope and your thinking and how you are really connecting with the broader vision that the Administration has put out in terms of racial equity and pipeline and workforce development, and mental health. All of that is really, I mean, good to hear and it gives me hope that we can come up with some recommendations to you and to the Secretary about how we can work collectively with you to advance the health of moms and babies. So, thank you for being with us.

CAROLE JOHNSON: Thank you. Thank you for the time on your agenda. This conversation really has made my day. I feel so energized by having the chance to talk with all of you. So, thank you for everything.

ED EHLINGER: Great. Thanks. And Dr. Collier, I have to tell you that I didn't match, and it was the best thing that ever happened to me. I ended up going places I never thought I would go. So, matching is not everything, but it's certainly important. So, thank you.

All right, let's now move on to Dr. Michael Warren with your update. Michael, I'm looking forward to your words and also, I appreciate the article that you got

published in Pediatrics Perspective, and as I mentioned it, you know, its relationship to the Heckler Report, I'm looking forward to your comments related to that. So, take it away.

MCHB UPDATES

MICHAEL WARREN: Thank you, Dr. Ehlinger and Committee. First, thanks for acknowledging that article. I wanted to give a shout out to Dr. Art James and Dr. Zea Malawa who really inspired us at the Bureau to think differently and to challenge us to thinking about even the framing of disparities and survival lag, and really to underscore the urgency of the work that we all do. So, really appreciate their guidance and wisdom there.

I also want to thank Carole for being a part of the presentation today. We are so lucky to have her at HRSA, to have someone who has such a deep understanding of help and public health at a variety of levels. Having worked at HRSA before and in the Obama White House just before joining here, the Biden White House, but also her time in New Jersey and before that on the Hill. She just really brings important prospective. She, already in the short time here, we've seen she's a huge champion for

maternal and child health, so really glad she can join you all today.

I'm going to move quickly through some updates and certainly happy to entertain questions as they come up. I want to talk about the various ACIMM recommendations that have been made in 2013 and most recently in 2021, and just share some highlights for things that we are doing. I think it relates back to what Carole was saying about why your work is so important to us and your counsel is so important to us. It influences our programming and our response in a number of ways and I'm going to walk through those today.

On the next slide I will just -- I always start with our strategic plan. First of all, thank you to those of you who helped provide input into this revised strategic plan we launched last year with four key goals, those being access, equity, capacity and impact. We're currently in the process of developing specific strategies, activities and measures for each of those four goals and weaving that into all of our programs across MCHB, recognizing that the work of these four goals lies across the Bureau's programs and will be done in

partnership with stakeholders across the Federal Government, across states and across communities. And so that really is what grounds us.

The next slide just by way of background, as you all know, the Advisory Committee for Infant Mortality in 2013, and then the Advisory Committee for Infant and Maternal Mortality in 2021 made recommendations to the Secretary on strategies for reducing infant mortality rates and disparities. We have incorporated those recommendations into our work in a variety of ways and I want to touch on those today.

Just to refresh you on the 2013 set of recommendations, they were framed as strategic directions, so those involved the health of women across the life course, continuum of safe, high quality and patient centered care, a focus on preventive interventions, a focus on increasing health equity and reducing disparities, investing in data monitoring and surveillance and then collaboration as we heard Dr. Peck mention earlier.

There were some themes that were similar in the 2021 recommendations. Broadly those were categorized

around care systems and financing, workforce environmental conditions, migrant and border health and data and research for action.

So broadly, before I get into specific examples, I just wanted to sort of share with you generally how we utilize these recommendations. Not surprisingly, we incorporate these recommendations into program planning and implementation. I'm going to give you some very concrete examples over the next few minutes of how we have done that. We also utilize your recommendations to help advise the technical assistance that we provide to our grantees and to the field.

So, for example, the work around data monitoring and surveillance, we fund a fair bit of public health infrastructure related to maternal and child health data capacity, and I'll mention some of those later. But your recommendations help shape those investments and help us think about where we need to provide support to the field.

And then finally, we're frequently called on to respond to legislative inquiries. Those may be draft pieces of legislation. Those may be testimonies before various committees, and it is helpful to have your

recommendations to refer back to as an advisory committee to the Agency and to the Secretary. And so that's another way that your recommendations come to life.

So, I'm going to frame the next set of slides just to give you an overview of the kinds of activities we've done. This is going to feel a little bit like a whirlwind. It was exciting putting this together with a group. There has been a lot that has been done based on your recommendations, and we absolutely know that work is not done and much remains to be done. But I just wanted to give you a sample.

In that recommendation around improving health across the life course, I want to flag the work that's being done in preventive services. Long before the ACA, the Bureau was funding Bright Futures, which was a blueprint for pediatric care. That got a shot in the arm with the ACA when HRSA was tasked with approving preventive services in three buckets. Those are the recommended uniform screening panel, which relates to newborn screening. Bright Futures, which relates to child and adolescent health and the Women's Preventive Services Initiative.

Guidelines for preventive care in all of those buckets, once they are approved by HRSA, are required to be covered without cost sharing to most individuals. And so this really is a game changer as we think about that notion of prevention across the life course and standard setting and having those services available.

You heard Carole talk about mental health. We absolutely know we can't improve overall health without specifically thinking about mental health. Again, we take a life course approach to that. We've got our pediatric mental healthcare access program, which was first started in 2018. That got additional support in the American Rescue Plan, and so just in the last year, we've expanded from 21 states to now be able to cover 40 states, the District of Columbia, the Virgin Islands, Palaw, the Red Lake Band of the Chippawa Indians and the Chickasaw Nation.

We've actually got a funding opportunity that's out on the street currently that will allow us to expand to additional states using American Rescue Plan funds, but this assures that wherever a child presents to a primary care provider, that provider has access to specialized

consultation and resources related to mental health.

There's an analogous program on the maternal side, so screening and treatment for maternal depression and related behavioral disorders, and that is currently funded to be in seven states, and provides similar services, again, in terms of teleconsultation and being able to meet patients and providers where they are.

We also support content for stopbullying.gov, and we think about mental health and wellbeing, particularly for children and youth. We know that addressing bullying is important, so we work with colleagues across the Federal Government to develop content and make that available.

And then I'm excited to share that later this year we will be launching the Maternal Mental Health Hotline. This was something that was passed in the fiscal year '21 appropriations. HRSA received three million dollars to send up a 24/7 national hotline to be staffed by licensed or qualified professionals, who will be answering those calls. The plans for that are under way and we'll be excited to share with the Committee later this year when that line goes live.

The last thing I'll say on this slide about improving health across the life course, of course, we think about improving the quality of care. One of the things that has been a real bright spot is the AIM initiative, the Alliance for Innovation for Maternal Health. This notion that there are safety bundles or tool kits with these practices what when they are replicated, can improve maternal health outcomes. Those initially started as being implemented in birthing facilities, hospitals, community birthing facilities. In the last couple of years, there's been a move to think about communities' bundles. And so, recognizing that if you think about maternal deaths or pregnancy related deaths about a third happen in that window of labor delivery and up to one-week post-partum, but about a third happen during pregnancy and about a third happen in that time from a week post-partum to a year out. And so if we just focus on birthing centers and hospitals, we will have missed a significant opportunity. And so our AIM community care initiative works to get outside of that labor and delivery setting and think about supporting this work in communities.

The goal is to get to all 50 states. Right now we're in 44 states plus the District of Columbia, and we have over 1,700 birthing facilities that are participating in AIM.

On the next slide, again, continuing with this theme of life course, we have a number of investments in adolescent health, so our Leadership Education in Adolescent Health, our LEAH program, provides interdisciplinary training for providers who will serve adolescents and young adults.

We also have a national technical assistance center, our Capacity Building Program for Adolescent Young Adult Health that is designed to support states and communities as they respond to the specific needs of adolescents and young adults.

And then we fund a variety of research networks that are focused on improving infant and maternal health. We've got a practice-based network called the Pregnancy Related Care Research Network with OB's across the country, and then we fund two academic networks, one focused on life course and one focused on adolescent and young adult health that engage researchers from

institutions who, in turn, engage community partners to advance and answer important questions around life course and adolescent and young adult health.

The next set of recommendations was around improving the quality of care and making sure care was patient centered. And so you will see on the next slide a mention of the CoIIN, the Collaborative Improvement and Innovation Network. These really sort of took off in the 2013, 2014 time frame with the focus on infant mortality, a lot of collaboration with ASTO and other national organizations at the time thinking about reducing early elective delivery and this notion of CoIIN was how do we apply the principles of rapid cycle quality improvement using PDSA cycles, gathering our data, engaging stakeholders, how do we use that approach, like an IHI kind of a model in a public health setting. And so, early elective deliveries was a topic that folks tackled early on, but later that was expanded to include smoking cession during pregnancy and social determinates of health and safe sleep. And so that really has been a mode that has been helpful.

If we look at the impact of that, thinking about

early elective deliveries, for example, when we look at Region 4 and Region 6, so the sort of south and the mid-southwest, we were able to see a reduction during the time of the CoIIN by 22 percent in early elective deliveries among those states that were participating in the CoIIN.

We also recognize that the Bureau doesn't do this alone. Our footprint from a dollar standpoint is relatively small compared to some of our other Federal partners, so we really want to leverage relationships, particularly with Medicaid. There is a strong push to encourage and support states in their interagency agreement. So, by law, states are required to have an interagency agreement between Title 5, which is their MCH block grant program and the state Medicaid program. Those are in a sort of varying set of -- or varying status across states. Some states have ones that are more robust than others, and so we're constantly looking at ways that we can one, partner with Medicaid at the Federal level on supporting this, or CMS at the Federal level, and two, how we support states to do this work at their level.

We also fund something called the PIP, the Policy Innovations Program, which engages partners NASHP,

for example, is one of the partners we fund and engage through this work at the National Academy of State Health Policy. They do a lot of Medicaid work. They, for example, have done a deep dive just as recently as this January into how are states leveraging Medicaid and other funding sources to fund doula services, what does that look like, what's the landscape, what are the opportunities, what are the barriers? And so we rely on those partners as well to help us advance this work.

Of course, you all are familiar, I think, with the MIECHV Program, the Maternal Infant and Early Childhood Visiting Program, voluntary evidence based on visiting. The reason we tacked it under Medicaid partnerships is there has been a push to make sure that states are aware about the opportunities to be able to work with Medicaid to publicly finance evidence-based home visiting. So, a number of states have worked on this, New Jersey and Maryland in particular. New Jersey's Medicaid Home Visiting Pilot Program, for example, will pay for evidence-based home visiting. Maryland has an 1115 waiver that allows them to support this work.

And I mentioned Bright Futures on a previous

slide in terms of the preventive activities. One of the things that's important to note is when these guidelines are set out, how they are incorporated into payment models. So the periodicity schedule, which is the blueprint for what happens at every well child visit has actually be adopted as the periodicity schedule for EPSDT and Medicaid in 32 states. So, this is a great example of how these investments connect with each other and improve the quality of care overall.

At the time when we developed these slides and put them through clearance, we didn't have a final budget yet. As you all know, the House and the Senate passed the budget last week. Included in the President's 22 budget, the proposed budget was funding for medical home demonstrations. That was not ultimately funded in the final budget that passed Congress. However, it is important to note there were a number of legislative authorizations that accompanied those appropriations, where programs were authorized and listed as being authorized to have future appropriations, and this integrated approach with pregnancy medical home was included there. So, we are optimistic about the

possibility of that moving forward in the future.

On the next slide, and I realize I'm moving fast because I don't want to delay you all too much on your schedule, but certainly happy to follow up with any questions at the end of this or at any point during the meeting.

The 2013 recommendations called for thinking about how we promote evidence-based prevention activities, and specifically how we do that to a new generation. They cited five prevention activities, breastfeeding, family planning, immunization, smoking cessation and safe sleep, and I just wanted to acknowledge the various ways that we do that work. Some examples with breastfeeding, Healthy Start provides an immense amount of breastfeeding support and communities. They support lactation counselors, whether those are CLC's or IBCLC's in communities to really support initiation and continuation of breastfeeding.

Also, those Women's Preventive Services or WPSI guidelines that I mentioned earlier include guidelines for breastfeeding services and support. Those were updated just this past December. Once those are approved after

one-year insurers are required to start paying for those, and one of the most exciting elements of the latest round of WPSI recommendations in my opinion was that the recommendations required coverage in terms of the services and supplies, and to include a double electric breast pump. And so, starting in January of 2023, that will be a required covered service by most insurers across the country.

WPSI also includes recommendations around contraceptive care and counseling in the family planning category. And the space of immunizations, I mentioned Bright Futures and the work of the periodicity schedule, which outlines those recommended immunizations. We also adapt over time to respond to new challenges. So, at the beginning of the COVID pandemic, we know that the messaging was unless you're really, really sick, stay home, don't go to clinical settings. People took that to heart, especially people with young children, and that meant lots of kids didn't get well child visits and immunizations. We saw precipitous drops across the country.

And so, we launched a prize challenge. This was

a million-dollar prize purse that was available to support community-based projects to increase immunizations and well visits. We have done a number of these prize competitions, including around things like remote pregnancy monitoring or care for pregnant women and new moms with substance use disorder. These challenges are a fun way to engage folks in communities to get new ideas. Most of the people who apply for challenges have not applied for Federal grants before, and so it's a new way to tap into ideas from spaces where we've not heard. We also really set a low bar for in terms of a barrier for application. So instead of a typical 60, 80-page grant application, the challenge applications are no more than five pages. So it's a really easy way for folks to submit bright ideas. We typically get about 70 applications per challenge. We got 240 applications for this, which I think denotes the amount of interest across the country.

And over the course of the challenges -- or this challenge, we awarded a million dollars in prizes across the country. We also saw 23,000 immunizations and nearly 52,000 well child checks that were given as a result of this challenge. So, a great way to promote primary care

across the country and to promote partnerships in the communities to address issues moving forward.

Just to round out these prevention activities, I mentioned earlier the CoIIN worked. There was a CoIIN around tobacco cessation, and similarly with the early elective delivery work where we saw improvements, we saw improvements of about 11 percent in terms of smoking cessation during pregnancy among states that participated in the CoIIN over a three-year period.

The last thing I will say on the slide is safe sleep, we recognize the SID/SUID continues to be an important driver of infant deaths across the country, and so we support a national center, a national action partnership to promote safe sleep, to support states and communities in advancing this work in culturally competent and congruent ways.

On the next slide I'll touch a bit about the work to address equity and reduce disparities. This has long been a focus of the Bureau. Certainly, now there's a renewed emphasis with our new strategic plan with a push form the Biden/Harris Administration, the Department and the Administrator as you've heard. A big part of that

involves that interagency and partner collaboration. Dr. Peck mentioned this earlier, so the Bureau convenes Federal partners, specifically looking at ways we might collaborate around infant mortality and reduction efforts, and specifically disparity elimination efforts.

That has broadened from just HHS partners to also include non-HHS partners. For example, the Department of Housing and Urban Development or HUD, as you mentioned. We also participate in the March of Dimes Mother Baby Action Network, an important national collaborative that's advancing this work.

In the space of equity, we've also tried to make sure that we take an equity lens in terms of the strategies we're deploying, our program design, the most recent redesign of the Healthy Start Program was designed to support communities in advancing equity in birth outcomes.

We also are currently engaged in some work with an external contractor to look at specific strategies to getting to equity and infant mortality. We've shared with this Committee before our idea for the infant mortality initiative recognizing there are about 3,700 excess infant

deaths, those excess infant deaths mean the gap that we would need to close to be able to get to equity for the first time in this country. We've mapped those at the state and county level. We know, for example, that three states account for one-quarter of all those excess infant deaths. Three counties account for ten percent of all of those, so we have an opportunity to really focus our efforts, and we've engaged a contractor to help us look at what those strategies should be, were we to get new funding or if we don't get new funding and we've got to use existing resources and bully pulpit.

We also, through the Healthy Start Program, have really tried to support expansions over the years to advance equity. In the last few years there's been increased funding for clinical services to help further reduce barriers to access the clinical care. In the last year we've provided additional support to Healthy Start through supplemental funds to expand doula care services. That's not only to provide reimbursement services for the care, but also to support training and certification, as you heard about earlier to help reduce barriers there.

We recently have supported funds for Infant

Health Equity Planning, looking at how we might go beyond the traditional clinical approaches to think about addressing social and structural determinates of health and getting to equity and advancing toward those healthy people 2030 goals.

We've done that through some place spaced efforts, so some of you may know about the work we've done in Region 5. The reason we chose Region 5 for this work is that if we look at those excess infant deaths, Region 5 accounts for 20 percent of those across the entire country. And so, there is a great need there. Also, the States in Region 5 were very well poised for this. Many of them had maternal and infant health disparity elimination as priorities through their Title 5 block grants. So, we've worked with them over the past year on pulling together state and community partners to advance this work, and we're currently exploring how we can continue to support them through technical assistance as they implement plans to be able to get to equity.

We also have forecasted the availability of what we're calling our Infant Health Equity Catalyst Grant. So, this is moving beyond plans to action, and so these

grants won't fund more planning, they will actually fund communities and jurisdictions that have developed plans to be able to move that work forward.

We also recognize that we have to think about broadly social and structural determinates, and I just wanted to flag a couple of ways that our work addresses poverty. As an example, we've done work to promote the earned income tax credit and the child tax credit through our programs like a home visiting program, Healthy Start, and the block has ways to reach populations to address poverty and to help improve economic sufficiency. Next slide, please.

In the recommendation around data monitoring and surveillance, there's been a lot of work over the past decade or so since those 2013 recommendations to redesign our measures and data collection systems. So the Title 5 block grant underwent a complete overhaul to really think about the alignment of national outcome measures with performance measures and how state measures relate to those. And a new requirement that states developed evidence based or evidence informed strategy measures that they report on in their block grant application.

Similarly, the MIECHV program, it started in 2010. In the halfway point of the last decade there was an overhaul of those performance measures so that states are collecting those consistently across states and in the same way across states so that we can have national comparisons. We have had a number of evaluations of the Healthy Start Program that have influenced that data collection, and currently we are engaged with a contractor that's looking across our MCHB Program, specifically to understand how we are measuring health equity. We're starting with our programs in MCHB internally, but also looking at opportunities to develop measures that can be used broadly in the field.

In addition to the redesign work, we support some really critical state and national infrastructure. So annually, we conduct the National Survey of Children's Health. This is the only annual state and national level survey of children's halt and wellbeing that reports on a number of factors, the prevalence of a variety of conditions, issues around access, family and neighborhood characteristics that give us an idea of how children in the country are doing. If you didn't see, we just

published a piece in JAMA Pediatrics yesterday, looking at five-year trends from the national survey of children's health, and a couple that really jumped out over the five year period of 2016 to 2020, a 29 percent increase in anxiety and a 27 percent increase in depression among children under age 17, a decrease in parent's report of ability to cope with the demands of caring with children.

And I mentioned the mental health diagnoses stats earlier. Despite that, 20 percent of families still report that their children can't get the mental health help or counseling that they need. So, it's an important opportunity to be able to use those data to drive our programming.

We also support the National Fetal Infant and Child Death Review Center, supporting FIMR, the Fetal Infant Mortality Review and child death or child fatality review across the country. We support the State Maternal Health Innovation Program, which supports states to be able to gather their data around maternal health from a variety of sources that might be Maternal Mortality Review Committees, it might be vital statistics, payor data, hospital discharge data, to pull those data together, to

pull an interdisciplinary team together and identify strategies, innovative strategies to be able to address state specific concerns.

And then lastly, we fund the State System's Development Initiative or SSDI, which is sort of core infrastructure money for states to fund, in many cases the State MCH Epidemiologist to be able to have the data they need to advance MCH programming.

On the next slide, a few more examples of data monitoring and surveillance work, in the workforce space we support the Graduate Student Epidemiology Program. This is a paid summer internship for students. The goal of that is to increase and diversity the pipeline of early career professionals who are going into MCH epidemiology. It's a great way for folks to dive in and get that rally important practical experience in public health settings.

We also partner very closely with our colleagues at CDC on the MCH Epidemiology Assignee Program. That's a program that's administered through CDC's Divisions of Reproductive Health. We know that many states pay their state portion of that assignee through their Title 5 MCH Block Grant, and that's been a partnership with CDC that's

really helped to build some important capacity in MCH across the country.

We've got an emerging partnership with a group of historically black colleges and universities, and also minority serving institutions. There is a group of 11 that has formed an HVCU MCH alliance team. We've been working with that group since last summer to think about ways that MCHB can partner with HVCU's and minority serving institutions to build MCH capacity in those institutions and to further develop a diverse MCH workforce. There's the summit that they are hosting on April 7th. We're excited to be a part of that, as are a number of other Federal partners to think about how we advance this work moving forward.

If we can move to the next slide, please, we're getting close to the end. In terms of collaboration, we've got, of course, the ongoing Federal state partnership through the Block Grant. This is our biggest lever in the Bureau in terms of flexible funding and support to states to advance their MCHB needs I mentioned the State Maternal Health Innovation Awards. Right now, those are in nine states. And the prize challenge

competitions I mentioned earlier are partnerships with community innovators, and again, we've done those around remote pregnancy monitoring and addressing opioid use disorder in pregnant women and new moms.

Just to touch on workforce briefly before we wrap up, Carole mentioned HRSA's Bureau of Health Workforce. That Bureau has a number of programs aimed at increasing the capacity of the workforce, the National Health Service Corp and the Nurse Corp Scholarship Programs, for example, support providers across the country. The National Health Service Corp has its largest field strength in history right now with a recent 1.5-billion-dollar investment, a billion dollars of that from the American Rescue Plan, and it supports merely 23,000 primary care clinicians across the country, about 20,000 folks in the National Health Service Corp and about 2,500 in the Nurse Corp.

They will also have an announcement coming in the future about funding available to support community health workers and they've been actively working on maternity care health professional target areas. These help to identify areas where outcomes are poor and where

there are opportunities for placement. So this eventually will be used by maternity care providers who participate in the National Health Service Corp to help really think about the distribution and alignment of providers in areas of need.

That's the Bureau of Health Workforce in the Maternal and Child Health Bureau. I mentioned earlier our doula supplements, and as funding allows, we'd certainly like to continue to expand those. I mentioned the work that NASBE has done for us on doula financing, and just an example of how we're trying to support the state public health workforce in advancing equity, we partnered with the MCH Workforce Development Center at UNC Chapel Hill to create a series of learning communities for how folks can accelerate equity within their spheres. We recognize that ever state and jurisdiction is different. The support for this work is different. The political landscape, the resource environment. And so, the Workforce Development Center is meeting states where they are to help them move forward with this work.

That's a whirlwind. I see a couple of questions in the chat that I can answer in the chat if that's okay,

I'm happy to do that. But certainly, if other questions are there, I'm happy to answer as well.

ED EHLINGER: Thank you, Dr. Warren. That was a whirlwind, let me tell you. Nice job. Will you be with us through the remainder of the meeting both today and tomorrow?

MICHAEL WARREN: I will.

ED EHLINGER: Okay. Because there are some times in our agenda where we might be able to have some questions, but I think we have time for a couple of questions if anybody has any questions at this point in time, just raise your hand using the button on the bottom.

Michael, the one thing I'm just curious about is just your relationship with CDC and with all your programmatic stuff and then what CDC does relate to the maternal and child health, how does that relationship work, how can that be leveraged even more than it already is?

MICHAEL WARREN: Yeah. I will say we've got a fantastic relationship with CDC. Several of those partners are on the call today, the Division of Reproductive Health. Folks know Dr. Barfield and Dr.

Kroelinger, who is joining the Committee now as the ex-officio. We talk regularly. Wanda and I have calls about once a month just to talk about what our respective divisions are doing and where there's opportunities to connect. We talk more regularly than that on a variety of meetings. We see each other several times a week, usually, and try to think about how we align our work.

We recognize that in many cases our grantees are similar or the same, and so how do we align and best use our resources so that we're supporting the state and jurisdictional grantees in particular as best we can.

We also work very closely with the National Center for Birth Defects and Developmental Disabilities. Dr. Karen Remley is on the call or will be joining. We do a lot of work in conjunction with them around sickle cell and around newborn screening. So particularly germane to this Committee, those are the two groups we work most closely with. But as you all know, MCH work lives in multiple places across CDC. So the National Center for Chronic Disease Prevention and Health Promotion that's led by Dr. Karen Hacker, we work closely with them. The Division of Reproductive Health falls under them, but we

also work with other divisions there. So, for example, the Division of Nutrition Physical Activity and Obesity, we work very closely with colleagues at the National Center for Health Statistics. So, it – MCH kind of touches all of that and we engage them regularly.

When the pandemic hit and we really had to figure out what to do about those pediatric immunizations, we started a new engagement with the Immunization Services Division at CDC. So really appreciate their partnership and certainly look forward to that continuing moving forward.

ED EHLINGER: Great. Thank you, Dr. Warren. I don't see any questions, so let's put you on hold for a while and have you come back during the meeting for other questions that may arise. And if anybody has questions, put them in the chat and Dr. Warren can respond in that way. So, thank you.

APPROVAL OF MINUTES

ED EHLINGER: Next on the agenda is approval of the minutes. So, you know, I'm sure all of you have read the multiple pages of minutes in the briefing book. If somebody could make a motion to approve the minutes, we

can then discuss those.

MAGDA PECK: I actually did read them, Ed. And this is Magda Peck. I would like to make a motion for approval of the minutes as is, with a comment that says hats off to the folks who distill two days or four hours online into something that can be intelligible and useful.

ED EHLINGER: All right. Is there a second to that motion?

BELINDA PETTIFORD: Yeah, this is Belinda, I second the motion.

ED EHLINGER: All right. Any -- we're open for discussion. Any comments about the minutes?

MAGDA PECK: I just think it would be helpful, and I just would like to get 30 seconds from our newest members. When you read through this, was it helpful to you, and just to say if there's any way that you have input about how it has been useful to you to onboard, that's great feedback to get in addition to accolades for those who do good work.

ED EHLINGER: All right. And anybody can always give me feedback or to Anne or Lee, feedback on the minutes, so it's always a good thing because we want them

to be as useful as possible.

CHARLENE COLLIER: It definitely was helpful to understand the type of dialogue and what types of thought should be brought to the table and the discourse that's had between the two – between people, especially, because I think voicing everyone's perspective and the conflicts that even come up about how we work through those disagreements, I think was evident in the minutes, so that was helpful. So thank you.

MAGDA PECK: Thank you, Dr. Collier.

PHYLLIS SHARPS: Yeah, I would agree it provided a really good background on the scope of topics addressed and the conversation and the collegiality of the question and answers, I thought that was very helpful.

ED EHLINGER: Great. All right, hearing no edits that need to be made, all in favor either signify by, you know, doing a little thumbs up on your reactions or just give your virtual thumbs up.

All right, anybody opposed. The minutes are approved. So, thank you, thank you.

HEALTH OF INDIGENOUS MOTHERS AND INFANTS

ED EHLINGER: Next on the agenda we're going to

be talking about the health of Indigenous mothers and infants and I think the people who have been on the Committee for the last four years know that over the last year that we've been really focusing on the status of Indigenous moms and babies, trying to come up with some recommendations that we hope to put forward in June.

And for new members, that's sort of an update on where we are. We've had several meetings where we've had presentations related to Indigenous mothers and infants. We had planned on having the Indian Health Service do a session focusing on what they've been doing during this meeting. They were unable to be able to put somebody forward to talk about it at this point in time, but I still think we really need to continue to have this conversation because the hope is that we meet in June on a reservation here in Minnesota, where we finalize some recommendations related to the health of Indigenous mothers and infants, and we need that input from IHS. So, the plan is to have a meeting in the near future with at least the members of the Health Equity Workgroup, but with anybody else who may want to join us in that meeting with IHS to get some additional information.

But in the meantime, in leading up to that, I really would like to have Janelle Palacios, who's been leading some of our work on this, you know, make some comments about how we need to move forward and be thinking about coming up with a recommendation. So, Janelle, please, thank you. I look forward to your words.

JANELLE PALACIOS: Thank you. Oh, goodness. Thank you, Ed, for allowing this precious virtual space to share concerns regarding Indigenous health issues, and thank you, Lee Wilson and Dr. Warren, HRSA staff, ex-officio members and ACIMM Committee members for being here.

So, I'm speaking to you today as a frustrated Indigenous woman, as a researcher, a clinician, a mother, a nurse midwife, a daughter from the Flathead Indian Reservation as your Committee member colleague. I will be expressing my frustration and disappointment that representation from Indian Health Service is not here today.

So, we're dying. We die fast or we die slow, but we are dying. Our Indigenous mothers, our infants, our children, our partners and family members, we know

something is wrong and for the longest time we were told the problem was us, our race as Native Americans. Now we have data to support our knowledge and experience, and we can no longer be gas lit, but still help does not come. Indian Health Service is not here today.

Since September 2021, the Committee has heard from a few experts on Indigenous maternal health concerns. I shared with the Committee a few key historical events and Federal policies that had and continue to have far reaching intergenerational effects, including loss of land, relocation to reservations through treaty making, allotment of lands to heads of households through the Dawes Act, legal measures outlawing traditional meet of religions and cultural practices, which was reversed only 43 years ago, forced boarding school systematic institutionalization on the youth that spans over 100 years. And when boarding schools fell out of favor for assimilation, pass of laws that facilitated assimilation of Indigenous children through foster care and adoption policies, where today Indian children are still overrepresented in the foster care system.

The Indian Relocation Act in the 1950's ended

assimilating Native people and abolishing tribes, which relocated rural Native people to cities, promising secure jobs and housing, but often left families struggling and without a way back home to their reservation.

Federally funded targeted sterilization campaign among women of color, including Indigenous woman at service sites they were supposed to be safe at, such as Indian Health Service clinics and hospital facilities. Missing and murdered Indigenous women and girls that was not fully revealed through grassroots organizations and family members seeking to be heard but has made headway through across Canada and the U.S. to today, an open invitation to Indian Health Service from since January to share what has been happening in Indian Country, but IHS is not here today.

In the near future, I look forward to IHS sharing their responses on some key issues such as what are the pros and cons of healthcare funded and provided by Compact 638 Tribes versus Indian Health Service. We have yet to even share with the Committee what a Compact 638 Tribe is, and I would like IHS to share that.

It’s well established that IHS funding does not

meet the needs of our populations and I would like to understand what IHS does in light of such large shortcomings, especially when addressing MCH concerns.

Finding MCH data for this population is very challenging. Our small population prohibits many studies from including our numbers, but IHS has a source for MCH data, and given that IHS has access to their own data, what do we know? In the past when IHS published MCH data, it was already five to ten years old.

Today we lack basic maternal infant data, especially from HIS, and whether or not this data varies regionally. Does this MCH data vary regionally? That's a very key question. We learned from Dr. Susan Stemler, who shared her observations as an invited clinician to help annually evaluate IHS through the ACOG IHS contract relationship, that IHS lacks providers and staff. They are underfunded and there is a need to recruit Indigenous people into healthcare, and IHS could improve the relationship with tribal communities.

Recently ACOG and IHS celebrated their 50-year contract partnership with ACOG as a recognized expert to improve Indigenous maternal infant outcomes. But what has

happened as a result of this 50-year partnership? I have yet to see and report, and aside from obscure citation found on a separate report published by the National Indian Health Board, as of September 1st, 2021, the only recommendation to come from ACOG/IHS partnership was to recommend widespread drug testing among childbearing Native women. 50 years. That spans about three generations of my family and friends of childbearing age. And you may recall from my presentation in September, those women, women in my family and friends have experienced numerous losses, a number of demises, most of the labors and deliveries, live deliveries, were pre-term, and still this was in context of IHS and ACOG having a partnership. So, what has been done in Indian Country for Native women and children?

All of the invited experts on Indigenous MCH advocated for appropriate funding to IHS. Dr. Susan England, IHS ex-officio shared that in 2019 – this is 2019 now – the IHS expenditure per person was about $4,000, $4,078. That was in 2019. And for comparison, 2017 U.S. National Health Expenditure per person was $9,726. Again, in 2017, over $9,000 was spent per person versus $4,000

for Indigenous people receiving care at IHS in 2019.

We absolutely need funding. We need timely surveillance. We need to strengthen the Indigenous workforce, which we're trying to work on. We need to include the community and tribal organizations into structuring programs. We also need continued representation from Indigenous people and tribal organizations on oversight and advisement boards such as ACIMM.

Minimal attention has been given to our disparities. And usually, it's given in small bolus focused attention with short programming and funding that does not provide for sustainability. Still our childbearing women die two to three times higher than white women. Still our people go missing and murdered. Still our babies die in highest proportions than in most other groups in our developed country. And still our women, men, children are incarcerated at high rates. Still, we are not counted. We continue to be erased in data and in census counting.

Our problems are minimized and left for another day, another time, another ten years, another IHS

director, another president. No one is held accountable. IHS is not here today. We are dying. We die fast or we die slow, but we're dying.

I invite all of you Committee members to join me in raising concerns and questions to have answers so that we can be guided in our recommendations. Thank you.

ED EHLINGER: Thank you, Janelle. Comments from anyone. Jeanne Conry.

JEANNE CONRY: Janelle, I just want to thank you for everything you just said. It was an impassioned eloquent plea for attention that is sorely lacking. So, I just wanted to commend you for bringing that to all of us.

ED EHLINGER: Sherri Alderman.

SHERRI ALDERMAN: I chime in as well, Dr. Palacio. Thank you so much for your courage and your words and your passion. Please know that it's – I hear it, I feel it and I completely agree. And what I would like to add to your very eloquent words is that I challenge all of us to consider what dominate culture values are raised as a barrier to addressing these issues and how do we address that in order to get to the heart and the soul of what Dr. Palacios is bringing forth here.

Thank you.

ED EHLINGER: The urgency that the American Indian and Alaskan Native Community has been there for a long time, and it just has not been addressed. The data, and I think this is where -- you know, oh, they're small numbers, we can't do it. We have to find ways to look at the data, and different ways of looking at it so that the needs of American Indians, Alaska Natives, Indigenous moms and babies really get brought to the forefront. So that urgency is there.

Also, there is some urgency just for this Committee. We will be losing -- not losing. Half of this group that's here today will be moving off of the membership of SACIM, and so this wisdom, this understanding of the issues related to the American Indians/Alaska Natives needs to – I believe, needs to come forward with some recommendations in June. So, we have some urgency to come up with actionable recommendations, because I think this is a time where we have an opportunity to actually make a difference.

And so we're going to have to do a lot of work between now and June so we can get some recommendations

drafted, that we can get them vetted among every member of the Committee, that people can understand it, we can have the right kind of supporting information so that come June when we meet in person, we can finalize those so that we can all vote on them and move them forward. So, there's some urgency on our part. So that's why, I think we will be working with MCHB to try to – and IHS to try to set up a meeting in the near future as soon as possible to certainly have members of the health equity workgroup, but anybody else on this Committee who would like to be part of that meeting, to come and join us and have that conversation with IHS to then start to move forward on drafting some of those recommendations. Dr. Peck.

MAGDA PECK: Janelle, you're always my teacher and I hear you with my full heart, and we walk this path together. So first, thank you.

I noticed the disconnect in Dr. Michael Warren's presentation and Dr. Janelle Palacios' presentation and giving a -- here's what the recommendations have said. We have had general comments about funding the Indian Health Service. This is something we have brought up since day one, and so I was curious, Dr. Warren, if you're still on,

why you didn't mention in any of the six lenses from health equity to collaboration across HHS or within government or in community engagement. I think I was listening but maybe I missed it, you know, I have a hearing loss, that you didn't highlight or elevate Indigenous health and that focus specifically about collaboration with the Indian Health Service.

So, is there a way that this is an opportunity for you to respond immediately to the disability that has once again been spotlighted by Dr. Palacios? Yes, I know, Dr. Warren, I'm going to put you on the spot, but I -- can you give us some tangible -- and the last about that is that Dr. Ehlinger said, we want to shape recommendations, but we can't shape recommendations without having context, without having a baseline, without having some sense of what is the current status within the Indian Health Service. We have submitted a series of questions, and nothing has been forthcoming. So how can we, as SACIM, ACIMM be strategic without having the context and the background and the bottom-line information to put that recommendation sharply and strategically in place?

So, I share your frustration that we have a no

show today. I understand that there are powers in structures and politics beyond this, but this urgency means at least within our world of HRSA, of MCHB, at least we can recognize in MCH what the connection with HSH and not remain silent or omit it. So, Dr. Warren, I'm going to put you on the spot if you're here.

MICHAEL WARREN: Absolutely. Thank you, Dr. Peck and thank you, Dr. Palacios. I completely agree, and we've got tremendous opportunity in HRSA and MCHB specifically to do more and do better. There are a number of things that are currently under way, and I say that fully recognizing that we need to do more. So, I don't say that as an excuse, but I do -- and I do want to make sure that we do highlight some of the work.

I mentioned earlier the Region 5 summit, where in engaging with the states, many of the states in that region were very focused not only on black excess infant deaths, but American Indian/Alaska Native deaths, and so that was a focus of that work that is -- or is a focus of that work that's ongoing. One of the things to Dr. Ehlinger's point, that we're working with our epidemiology staff to do is to better understand some of the data

issues and to think about what some of the solutions are. Some of that has to do -- there is this notion of small numbers that gets brought up a lot, but there's also issues with coding and how can we think about different coding strategies that get around some of those small number issues to be able to look at that. So, that's one example of that work.

We're partnering with AIM to engage in the Indian Health Service on thinking about implementation of AIM bundles in IHS facilities. That is work that is relatively new, but I hope has some promise.

I would say the other thing that comes to mind immediately, two things that I would say, in some of our program areas, there is a focus on reaching American Indian/Alaska Native Populations, the MIECHV, the Home Visiting Program and Healthy Start. Both have tribal grantees.

And then safe sleep was the other area I was going to mention where we recognize that we can't have one safe sleep message at a national level. We need to think about messages that make sense for individuals and communities. And so, partnering with folks to get that

messaging right, particularly for American Indian/Alaska Native populations is important to us.

The last thing I will say, HRSA, last year, stood up a tribal advisory council that meets several times a year with tribal leaders from across the country, where agency leadership hears directly from tribal leadership around issues that are important and where there is intersection with HRSA Programs.

So, I share those as examples, not as excuses and recognize there is much more that needs to be done, and I so appreciate your comments and look forward to continuing to think with you and this Committee how that work can be advanced.

ED EHLINGER: Thank you, Michael. Here in Minnesota, when we think of AIM, we think of Clyde Bellecourt and the American Indian Movement. That's first what comes to mind and that's what we need, an American Indian Movement.

Lee, I know you had some conversations with IHS, the question in the chat about why aren't they here? Maybe you can give us some background of what happened.

LEE WILSON: Sure. And I'm going to try to walk

a very balanced path here as a sister agency to Indian Health Services. We have made numerous attempts to communicate with IHS and we do have regular communication with IHS. As you know, IHS is represented as an ex-officio member and the representatives have presented to the Committee in the past. We are aware that IHS has had a number of difficulties of late, whether that be with lay absences, transitions of staff, with COVID and other complications, and those are not intended to be an argument for or against whether or not it was appropriate or not appropriate for them to be here.

I am encouraged by the fact that they have a new Chief Medical Officer, Loretta Christensen, who she and I spoke at length last week. She has committed to being engaged with us now that she is in this new role and told us that they've hired a new maternal and infant health consultant. That's the term that they use for this position, who will be coming on shortly and will be charged with this sort of role.

Dr. Christensen did tell me that the agency is heavily engaged in activities at the Department administration level around strategies that are being

generated on the maternal and infant morbidity and mortality lane to establish priorities to address those particular issues. I am not at liberty and not fully informed in a way to speak of what those are, and she has also committed and agreed that staff from IHS will make themselves available to be working with Committee as an ad hoc working group or something to assist in developing background information and potential recommendations for you as you move forward with decision making in preparation for the meeting in June.

I do also want to, just a couple additional points. I want to point out for all of you as Committee members that in many of our grant announcements you will see when we are discussing need, especially in the maternal and infant health space, we call out the numbers to articulate what the disparities are. You will always see that the American Indian/Alaska Native numbers are highlighted along with the African American numbers because they are shockingly bad.

And that we are working on, as a funding agency to make it possible to address those needs in innovative and creative ways that might not be the typical solutions.

We often make grants to states and communities, and sometimes those are not the easiest route for us to be providing resources to tribal entities. And so, we are trying to find creative solutions to that and to allocate resources in those dollars.

Finally, I would like to thank Dr. Palacios because I think just her very articulate, clear, direct, passionate and measured comments today, and as always, they are – the embody those traits. She has articulated some of the very key and important points that need to be addressed in recommendations to the Committee and I want to thank her for that and thank you for continuing to push. It is this pushing on the Administration that helps, and the bureaucracy that helps the bureaucracy move forward.

So, thank you. We welcome it, we encourage it, and we will continue doing what we can to bring that engagement forward.

ED EHLINGER: Thank you, Lee. Thank you, Janelle. Thanks for everybody else. Charlene, did you have some comment that you wanted to make?

CHARLENE COLLIER: I just wanted to thank Dr.

Palacios for everything that you said. As someone who works within a state, and I sit on many committees where there's no representation from Indigenous. Our maternal mortality review committees state fetal infant mortality reviews, even national committees within ACOG and I think this is something we have to address immediately, that the small numbers excuse really is a reflection of genocide that's happening to Indigenous people. So, it's not small by virtue of small number of the people that are coming to this country, but their numbers are small because of being eliminated over time, and that is part of the problem. So particularly for Indigenous communities, that should no longer hold us back from reporting, particularly what we need to.

Also, in terms of Title 5 and block grant planning and MMRC's, which are both being funded from HRSA, having representation and having that be a specific objective, like what have you done to bring representation to these committees, and that's something I hold myself accountable to for our on state MMRC, but wanted to put that out there as a potential objective that if there are not Indigenous representation on our currently funded

committees that address maternal infant mortality, that they are sought out and prioritized. Thank you.

ED EHLINGER: Thank you, Charlene. Janelle, you get the last word before we take a break.

JANELLE PALACIOS: Thank you. Thank you, everyone, for your support. I'm almost tearful just with the messages that people are sharing with me, and thank you very much, Lee, for just demonstrating with your own words as well that it's the pushing that is needed. So, I am very privileged to be living in this time where I am able to push more and with the experience that I have and the life experiences that I've come with to be in this position. And it was such a short little moment for me that it's difficult to encapsulate everything that is so important and like which was just shared that our small numbers is based on genocide, but it was, you know, a systematic removal of people and extermination of people, but -- so the whole issue with Dr. Warren talking about trying to be innovative in how we're going to capture this population, it has to do with the roots that the Federal policies of who is counted as Indigenous and not.

But aside from that, I think the larger issue is

that is -- feeling -- making me feel less frustrated is that all of you who have shared with me your words of encouragement show me that we have people in powerful places that can help make things happen. We just cannot forget to continue these causes and cannot forget to be partners with people.

And in addition to that, it is a failure of our American culture because of its history that not everyone is well versed in our nation's history. And so, you know, there was a comment about like the popularity possibly of having to do with funding, you know, for example, of Indigenous -- of IHS. It might get more -- we might receive more funding or more air on time if it was popular, or if people knew what was going on. So I think that just being in a space where people are aware of it and recognizing it, that this needs to continue, just like all the work that is done to understand disparities among Black, Indigenous, people of color, it's not just on our level, it has to happen pervasively, throughout our culture for us to rise as one because we can't do that yet. So, thank you very much.

ED EHLINGER: Thank you, Janelle. Thank you all

for your comments.

BREAK

ED EHLINGER: I'm taking the Chair's prerogative and we're going to take a break now. I don't think we should just go into introductions right after this. We need a little time to take a break and process this a little bit, and we will come back at 2:00 o'clock Eastern Standard Time, 1:00 o'clock Central Time and take it from there. So, we'll see you back in about ten minutes.

(A break was taken.)

RACE CONCORDANT CARE RECOMMENDATIONS

ED EHLINGER: All right, welcome back everyone. We'll wait another minute.

All right, welcome back. I hope you took care of whatever physical and mental needs you needed to take care of and are now back for another couple of hours of good work with this Committee.

In planning this meeting, knowing that we had eight new members coming on, this is sort of the beginning of the transition to the next cohort of SACIM members. I thought we'd take a little bit extra time to get to know both the new members and the current members, so expanding

our introductory time a little bit.

So, I'm going to take the next however long it takes to have the newest members -- and initially, I had planned on having all of the introductions on the second day, that the first day of our meeting we'd be talking about what we've been doing over the last four years, sort of a retrospective of current work, and then day two, really focusing on what lies ahead. But given the change with the Indian Health Service, had to readjust it.

So, I'm moving the introductions for the new members to now, so we get to know the new members. And I've had the opportunity and the privilege to do one on one interviews with all of the new members, just like I did with the members who have been on for a while, and I've learned so much, that we have really a great group of folks with lots of good experience, lots of interesting perspectives, lots of good ideas, lots of creativity, all really well qualified people.

And all of those qualifications are put down on your bios, which are in the briefing book, so we can read all of those things. And as important as those are, we can get that by reading that. What really struck me is

the stories that came forward about how you got into this work in the first place. So, I would like to take for the new members, and I'll call out your names, and I know Sherri Alderman said that she's used to going first because A is her name, and I'm going to go reverse order in terms of the alphabet.

But I would like to have each of the new members take two to two-and-a-half minutes to share your personal story about what stimulated or encourage to pursue the work that you are doing in your current setting, wherever that is, and what made you want to become a member of SACIM, what was that story, what was it that really brought you into this field, brought you into this work in the first place? So, let's start with that, and I look forward to Dr. Warren, Dr. Jacob Warren, to start us off. Tell us your story.

JACOB WARREN: You switched it up. Us W's, we never go first. I'm not used to going first. I just want to thank you for the opportunity to have this non-traditional introduction. I think it's great, instead of rattling off about who we are, what motivated us here, so thank you for that, Ed. And again, I'm just really

honored to have the opportunity to be here.

My path toward maternal child health is indirect, but it sort of underpins my whole existence, actually. I spoke with my mother before I shared this story, I wanted to be sure it was okay with her. My mother was a labor and delivery nurse, and she had a miscarriage one day when she was at work and hemorrhaged. And the only reason that I exist is that she hemorrhaged in a hospital. And that sort of highlighted to me from my entire existence the fragility of this entire process, and the distinct roles that power and privilege play in that dynamic.

It's been very real for my whole existence that the only reason I exist is because of that privilege that my other had of being a labor and delivery nurse at a hospital at the time when she had an encounter. So, that’s something that really drives that.

I’m also a member of a marginalized community that’s not always visible, and so my own personal experiences as a part of that really drives my passion for health equity work. And working in maternal child health particularly in rural communities, we’ve had a couple

mentions earlier today about small numbers, and that's something that really gets me going, because when we talk about rural issues is why we very often ignore our rural communities as well, because it's easy to segment off when we need to combine states. We're looking across ten years, but we can't really look at that number because it's so small, and we lose so many stories of women and children that don't get told because of that perspective.

And so that's what really is driving my passion for being a part of this community to hopefully raise those voices and assure that we continue to think about rural communities, whether they are racial ethic minority, majority, LTGTQ, whatever it is that we have diversity within rural areas that deserves just as much attention as we see devoted sometimes to more urban areas. So, I'm just really excited to help represent that in the Committee and I'm looking forward to being a part of this. Thank you all.

ED EHLINGER: You did a nice job of modeling how to start off. Thank you. ShaRhonda Thompson, let's hear your story.

SHARHONDA THOMPSON: Well, I, myself, am a

rainbow baby. I did not understand the significance of that growing up, how much my successful birth meant to my mother because she lost a child, until I reached childbearing age, and I was like, okay, now I understand what the loss of a child does to a person.

But what really got me into this was my personal experience. My two children are 13 and a half years apart. My son was born, labor, delivery, quick, fast, everything was great. Fast forward to 13 and a half years later, I ended up having fibroids and so they told me that I would end up having her prematurely.

Well, during that time I had Healthy Start actually came to my home and she would discuss things with me that actually brought me at ease as far as my results and what the doctor was saying, breaking things down so I could understand it more and have less stress about the outcome of my child's birth. And so I realized how important that was for me, and how there are so many women who don't get that opportunity to have someone come to them and explain things to them to help them understand what's going on with their bodies, because not everyone is, you know, educated in the medical field, or have that

knowledge of what questions they need to ask, or how to advocate for themselves.

So, going through that process, I ended up having her six-and-a-half weeks early, two weeks before then, I was in the hospital. They were able to stop her from coming and give me the shots that I needed so her lungs arones could develop. But I did end up having her six-and-a-half weeks early. She did spend time in the NIC unit, but the experience with my Healthy Start nurse and the education that I received from that, and to know that there are so many other women who don't have that opportunity, that don't see that okay, there is a possibility that it can be okay, but then also, the women who don't have an okay outcome, that they need mentally and emotionally after that, it's a lot.

So, my charge is to hey, let's advocate so these women can get what they need emotionally and education wise while they're pregnant and after the pregnancy.

ED EHLINGER: You certainly are doing that well, even in your first meeting. Thank you. Thank you for that. Dr. Phyllis Sharps.

PHYLLIS SHARPS: Hello. So mine is a story with

many turns. I am a perinatal clinical nurse specialist by profession, and it really started, I can remember as a little girl reading my -- I don't even know if they still make this magazine, but Ladies Home Journal, and there was always stories about can we save this marriage, and there was often kids involved and it just -- I really became interested in mothers and babies. So, I went on to nursing school, and my first after nursing school was as an active-duty Army Nurse Corp officer in the labor and delivery area, and I loved it. We had much more independence in the Army. I actually caught a few babies.

But one of the things I noticed early on is the African/American and Hispanic women, whether they were enlisted, whether they were officers, whether they were dependent wives, they just had bad outcomes, always bad outcomes, and I kept thinking well, why is that, because everybody has access to healthcare in the military.

And when I came off of active duty and started working in the civilian sector, it was even more pronounced of the differences among different racial groups. And I thought I was going to be a midwife, but one day as I was contemplating my future, I thought well,

as much as I love labor and delivery, healthy babies start in the community. They start long before they get to the hospital. And so I slowly shifted my focus on doing community-based practice.

And I started looking at things like maternal mental health, depression, and often substance abuse and violence against the women. As a part of that I had the good fortune of meeting a lifelong mentor, at that time, Dr. Campbell, who we will hear from tomorrow, and she said to me, we need people like you because there are not many women of color researchers doing pregnancy work.

And so, I spent the rest of my career just looking at testing interventions for violence against pregnant women, working in community-based care and advocating for women and children, and I just – I think I have something to add to the discussion. As clearly, you've heard from many of the workforce in other presentations, women of color are underrepresented in practice, in research, in policy committees, and so I think I'm very privileged to have the opportunity to speak. Thank you.

ED EHLINGER: Thank you. Thank you for your

story, thank you for being here. Dr. Ramas.

MARIE-ELIZABETH RAMAS: Hello, hello. I'm just so humbled to be part of this distinguished group of colleagues across the virtual table. My story. I appreciate having some time to share that story. I am a first generation Haitian American and the first physician in my family. And the reason why I decided to become a physician, particularly a family physician, is because I, from a very young age, understood the immense importance of the fundamental structure of what I feel society is, which is family, however we define family.

I've had the distinguished pleasure of serving in both rural settings and urban settings across the country as a family physician and providing maternity care and pediatric care in both medical underserved areas and in urban areas. And what's interesting, although I was born and raised in a very urban setting, but I recognize that need is need, regardless of whether you are in a rural community in the mountains of California that I've practiced in, or in the suburbs of Boston. Need is need and social economic differences matter. Race and ethnicity matter.

And so to be one of few, and to typically be a unique representative for those under resourced communities, wherever I am is both a privilege and it's an immense responsibility. Part of the reason why I work so hard in advocacy in multiple levels, both from a structural level, to physicians in practice, to local and state government, and not Federal is my passion and drive to assure that the stories of my patients, the communities and frankly my own personal story as a black woman who delivered three children in the United States health system, it is paramount.

My goal is to share in why metrics are important to understand why and how we can translate data to create a store that is both palpable and undeniably and unquestionably necessary for our legislators and our decision makers, and now the secretary to make sure that the health of our citizens and those who live in the United States are taken care of, and how that affects the grand scheme of things as far as health, wellness and productivity from even economic standpoint. But it starts at home. It starts in the womb. It starts in the pre- and anti-partum relationship, and to be part of that

continuity of care as a family physician, particularly has been an immense joy and I am privileged. So, I hope to do honor by the patients and communities that I have dedicated my professional career to as I serve on this committee here, and I'm looking forward to learning as well with and alongside all of you.

ED EHLINGER: You and all the other new members honor us by your presence here. Thank you. Dr. Neyhart, I hope you're here and not – oh, good, you are here.

JOY NEYHART: I am here. I'm trying to find my video. Okay, now I'm here. Hi, and thank you for having me, again, coming to you from the Indigenous lands of the Tlingit and Haida people in Southeast Alaska.

I am a fourth-generation Italian American woman who has wanted to be a pediatrician since she was five years old, and I am the first in my family to attend college and then going to medical school and to become a board-certified pediatrician.

Like I said earlier, I've been practicing in Southeast Alaska for the last 21½ years, and it's been a privilege to serve the families that I serve. My stories, I have a few different stories, but I'll keep it to two.

They have to do with pregnant women and substance misuse.

One of the stories that motivated me to want to serve on this Committee is being on call and being called in to attend the delivery of a baby whose mother had her last shot of heroin within an hour, and the events that surrounded what should we do with this baby? Well, the baby turned out to be a term, healthy baby even though she didn't have prenatal care, and what do we do with this baby. And my job was to make sure this baby and this mother did not get separated and to send them to a place where they would both receive the safe care that they needed.

So, that's one of the motivating stories. The other story is a little fatter, but still a good outcome for the child, and that a mother who was unable to overcome her substance misuse was still able to have a say about where her child would most safely and appropriately be reared, and being able to help that situation, and now this child is almost five and doing really, really well.

So, those are just two of the stories that I have but experienced with mothers who have substance use experiences. I also care for a broad range of children in

Southeast Alaska and want to see fewer of them not succeed. So whatever it takes in terms of improving healthcare, but also improving the determinates that they need to deal with and overcome so they can get to kindergarten and then graduate high school and move on.

ED EHLINGER: Thank you, Dr. Neyhart, I appreciate that. Dr. Kate Menard.

KATHRYN MENARD: So, it's kind of hard to follow these passionate folks in telling your story, but I guess the thing that brought me what – the reason I was very excited to be invited to be part of this group is because I strongly believe in the power of collaboration. And you know, in the -- it has been -- and my career has been most rewarding to be able to work in the sort of intersection between public health, you know, clinical medicine, public health and public health policy and academic medicine. So, this just fits for me.

Folks have spoken about their mothers. You know, I think I learned everything about leadership from my mom. I'm one of six and she worked full-time, taught school, raised six kids, you know, put dinner on the table every night and was amazing in that role, and you know,

worked, as I told Ed, she worked as a special education teacher, and I think that's kind of where I got my, you know, grounded love for child health, it grew from there.

But in my career, you know, I've had so many individuals, family members and other things that said that, as gratifying it is to work as a physician one on one, I always looked to the bigger systems issues as the place to really make a difference, and that's why I was drawn to study public health, you know, right out of residency and took that training and pursued the academic career path.

I've had the opportunity, given opportunity, really, by mentors and colleagues along the way to work in the public health arena, working in -- you know, it was Michael Lou that tapped me to be part of the first – co-chair the first CoIIN initiative on regionalization. And you know, and that set into helping to develop the locate took and the levels of maternal care document that I had opportunity to work on as my time as President of the Society for Maternal Fetal Medicine when I had the opportunity to work with HRSA and find a home for the safety bundles that we wanted to deliver on, and AIM

initiative. All of these things just kind of lead me down the path to kind of think to where I am today, where I can really – I feel like I can contribute something to an organization like this.

The experiences that I -- I want to -- you know, again, my mother taught me, you know, the gifts we're given were given to share and I've had wonderful experiences along the way that I think I can share back with the group and inform the group between AIM, between levels of maternal care, between the pregnancy and medical home program that I had the privilege of working on in North Carolina, all of these things, you know, together, I think and each of us, every single one of us is going to bring a different perspective to this group, and I deeply respect the perspectives that these folks in front of me will bring that I could never bring. And I just hope that I can contribute in an -- at least in a helpful way. Thank you.

ED EHLINGER: Thanks. And it's nice to have another Tar Heel here, you know, particularly since Belinda is going to be leaving this group after another meeting or so, so nice to have that North Carolina

connection. Dr. Collier.

CHARLENE COLLIER: Hello everyone. Thank you so much. Kate, my mom was also a special education teacher. I don't know if there's a common theme there but what -- some things about my path here started long ago. I also wanted to be a doctor since I was a very small child, but a big part of my influence was growing up in the segregated north in the 90's, and that surprises people. I'm from Englewood, New Jersey, in a community that was over 50 percent white, but my high school and the public school system was over 90 percent Black, and you know, and that difference was very palpable all throughout my childhood education, and then when it became in high school, teen pregnancy became a very obvious problem in my community that was not shared in surrounding communities. And although I wanted to be a doctor, wanted to be a surgeon at the time, I immediately became very impassionate about solving these problems and realized that it was not a biological or medical issue, that it was something that it was grounded in social inequities, and I wanted to become a physician that could address these social challenges that led to medical problems that we

see, and I didn't have the words to call it health disparities or inequities at the time, but I knew I needed a background in education that would afford me the ability to work in those spaces.

And then when learning about Black infant mortality and then Black maternal mortality, I immediately knew those were not biologically driven, that they were from social inequities and justice and racism and knowing that as a physician, just learning about medicine would not be the tool that would be needed to undo those inequities.

So, it really just started then, and as young as high school, and then I was very fortunate that a recruiter from Brown University came to my public high school where many students did not go off to the Ivy League, I was very fortunate to be able to go to Brown and have the program in liberal medical education that ultimately brought my connections to Mississippi.

So, after finishing at Brown, Brown has a partnership with Tupelo, which is a historically Black college in Jackson, Mississippi, and that's where my roommate med school was from and that really started a

connection to bring me here to Mississippi and begin my work here with the State Department of Health.

And all along, it's been my mission to really connect these various paths between medicine, public health and really integrating and recognizing that these medical issues that we see are not biologically driven, but we have to address the social inequities, the racism that really caused these problems, and that it really takes leadership to open the eyes, both within medicine, policy, public health of how we have to break down these silos to solve these problems.

So, that's what I've been trying to do throughout my career and have been very blessed and fortunate to be able to enter these spaces, so I'm very grateful to be here and thank you for the opportunity.

I'm also a mom of two boys and I suffered a severe obstetric hemorrhage and I work in perinatal quality and improvement, so I bring that experience as well about the importance of safety for mothers and how we can -- and the work that it's going to really take to ensure quality care for mothers in our country, so I'm really glad to be here. Thank you.

ED EHLINGER: Thank you. Thank you for those stories. Thanks for being here. Dr. Alderman, finally, the last as opposed to the first.

SHERRI ALDERMAN: Yeah, thank you very much. And Dr. Warren and I will have to compare notes afterwards to see what that experience was like flipping that around. So I – yeah, thank you so much for opening up this opportunity to share personal aspects of our lives because it does so much influence the paths that I have been on for sure.

I went into medicine when -- in midlife. Maybe it was my midlife crisis. I was 42 years old when I graduated from medical school, and all of those experiences that I had before I went into medicine, I fully see over and over again, every day, how enriching those were at helping me to be the very best physician and advocate that I can possibly be. So, I'm really grateful for that rather convoluted path that got me to medicine and the privilege that I now work to leverage in an ethical way to assure that every child has an opportunity to have a fulfilled life and realize their goals.

My family roots go back very deeply into New

Mexico, at least until the -- back as far as the 1600's, so I was very pleased to be able to do my residency and continue for a few years as a general pediatrician in New Mexico and just experience that culture, the multiple cultures there.

I'm also fast forwarding from the 1600's, I am a first generation to graduate from high school. And so I carry inside me all of those lived experiences that inform and create the emotional experiences that I Have moving now in a social culture, a professional culture that is very much a privileged culture.

I've lived multiple places, both within this country and around the world, and it was really during those times that I saw the importance that other countries placed in terms of public health initiatives focusing on children and pregnant women, and it was that influence that gave me the motivation to come back to this country and pursue a career in medicine, and I have no regrets about that decision that I made.

I also have strong feelings about child rights, and I use the convention on the rights of the child as my guide on where our efforts should be and how we can

improve lives in an equitable way for all children in our country and around the world. So, those are kind of the spirit with which I come very humbly to this Committee, and I am very excited to be at the same table with these very remarkable professionals with very touching personal stories, and I look forward to contributing and to learning. So, thank you very much.

ED EHLINGER: Thank you. Thank you, Sherri. And thanks, all of you. It just really reminds me that a lot of times our degrees and our professional positions are sort of like our masks, they're the upward facing things that we all see and respond to. But behind that are lots of stories, and lots of feelings, and lots of emotion, and that's where the passion comes from. That's where the energy comes from.

I'm just curious, any other thoughts that in listening to these stories that other members of SACIM, just sort of responses to some of those more personal stories? Just unmute and speak up if you have just some thoughts.

MAGDA PECK: Well, this is Magda Peck. I just -- first I wanted to explain that when you see me without a

picture is because I have a profound hearing loss and so I call in twice and so, thank you for spotting me there. Thank you. I profoundly believe in the power of story and live the quote that the shortest distances between two people is a story. And I believe the stories are the catalyst that will allow us to go from data to action.

I want to extend my profound gratitude to our storytellers today. Everybody is a story and when we are not invited to tell the stories inside us that need to be told, we are not using our power to change the way we do business so that there are more first birthdays and healthy women from generations to generation. So thank you. And as a lead for the Data and Research to Action Workgroup, stories are data and I will look forward as I pass the mantle on to whoever will co-lead the Data to Action work, that we follow our own recommendation, that data be blended with story and stories be elevated to hear the lived experiences. So more on that on the data report, but I am just thrilled to hear your stories. Thank you so much for that sacred currency that you have offered us.

STEVEN CALVIN: I'd also add, too, that the

experience and policy fire power that's being brought to the Committee is pretty overwhelming, so I'm grateful for all of that.

ED EHLINGER: Thanks.

BELINDA PETTIFORD: And I would add, Ed, this is Belinda. You know, we all bring wonderful experiences to the table and so excited about all of the new members and the work of the existing members that's continuing, but I'm especially excited to have ShaRhonda join us because I think the more we can focus on individuals with more immediate lived experience, and specifically with utilizing the systems that we have within this country, I think it just brings a unique perspective and we need to see more and more of that. So thank you, ShaRhonda, but thanks to everyone, but specifically ShaRhonda for at least coming to the table and being willing to represent their perspective.

ED EHLINGER: You highlight the fact that the point that Janelle made, that the stories that get told about the United States are geared in one direction and there are much broader stories, the stories are much richer and ShaRhonda's presence highlights the fact that

we need those multiple stories, multiple perspectives. Thanks.

Thanks to our new members for their stories and I look forward to actually -- the continuing members with your stories tomorrow. We will do the same thing, because I think it's those stories that are really important that really move us forward.

So now we're going to move on to the discussion of race concordant care and the recommendations. And we had a presentation, we had a session last fall where we looked at race concordant care and had multiple presentations on that, and it became obvious that the Committee would like to forward some recommendations on how to advance race concordant care because of its importance. So, the health equity workgroup has been working on that and has developed some recommendations that we will be discussing. So, I turn it over to Belinda, who will sort of moderate the session and Patricia Lofton, who has been a member of the Health Equity Workgroup who has been working on these for the last five or six months. So, Belinda, it's yours.

BELINDA PETTIFORD: Thank you, Ed, and thanks to

everyone. Yes, as Ed has stated, the recommendations and presentation today are coming on behalf of the Health Equity Workgroup that I am fortunate to co-chair with Janelle Palacio. So just know that these are recommendations that have come through the workgroup. As Ed mentioned, this past September, we actually had a presentation on race concordant care. We were fortunate to have Patricia Loftman with us, who's joining us again today along with Dr. William McDade. He's the Chief Diversity Equity Inclusion Officer with the Accreditation Council for Graduate Medical Education. And both of them share with us some opportunities, as well as some challenges. I think from the perspective of the Committee as we look at race concordant care, one of the key areas is we know that there have been factors in potentially reducing disparities and birth outcomes when we have been able to utilize this as a factor. We are very specific as a Committee more recently, and that it is connected to our recommendation, the larger recommendation from the workforce being more diverse and reflective of the communities being served. So that is another area of why we are really looking at race concordant care.

And our focus is really on race concordant care as based on relationship building that impacts access to services, but also utilization. So that is another reason we wanted to make sure that race concordant care. And then, I guess most importantly, we want to make sure that all communities have options to providers of choice. And you know, to us, race concordant care is not segregation. We have to constantly remind individuals of that. It is really about providing individuals options so that they feel the most comfortable in their care setting. So, to us, again, it's diversifying our workforce to make sure that individuals have options when they are getting the care that they are seeking to utilize.

So, today I am excited to have with us, who will be leading our presentation is Patricia Loftman. Again, Patricia was with us in September. She's been an extremely active member of our Health Equity Workgroup. Patricia comes to us as – she chairs the BIPOC Committee with the New York Midwives, and she's also a member of the Maternal Mortality Review Committee with New York City's Department of Health and Mental Hygiene. And she, herself, again, is a midwife.

So, Patricia, I'm going to share my screen so you can see the slides and I will let you take it from there.

PATRICIA LOFTMAN: Thank you so much, Belinda, and thank Dr. Ehlinger and the SACIM leadership.

So, I, too, will start with a story. I graduated from midwifery school in 1981 and began my first employment as a midwife in 1982. Now, in 1984, I'm still a relative neophyte as a midwife, however, we were inundated in New York City -- I'm located in New York City, in Harlem, New York -- and that was the first time that we addressed the issue of pregnant women and chemical dependency. Those of you who are of a specific generation will remember the crack epidemic that hit the east and west parts of the United States around the mid 80's and extended into the 90's. And we were very fortunate at that time to have a visionary MFN who recognized that chemical dependency is actually a mental health issue with medical consequences. And so, she -- I wish I could say that I entered into this willingly, however, she coerced us. She coerced myself and another midwife to be the provider for women who were primarily at that time Black

women in Central Harlem, to be their provider because she recognized that in order for women to come into care, that they had to be in an environment that was supportive, in which women felt trust and safety.

And so, while we took care of these women for ten years, I understood at the end of those ten years the value of race concordant care. So, the remainder of my 30 years as a midwife was really in clinical care, but I'm now at the point where I am – where I recognize that from a policy standpoint, race concordant care is literally critical in terms of positively impacting maternal mortality and morbidity. Next.

BELINDA PETTIFORD: Are you seeing my screen?

PATRICIA LOFTMAN: If you could just -- not really. I think the slide just needs to come down a little bit.

BELINDA PETTIFORD: Give me one minute.

PATRICIA LOFTMAN: Absolutely.

EMMA KELLY: If you stop sharing your screen and then re-share it, it should give an option. It looks like you're using two monitors to share the full screen size presentation.

BELINDA PETTIFORD: Thank you, Emma. I am using two monitors.

PATRICIA LOFTMAN: Great. That looks good. That looks really good. Thank you, Belinda.

So, what I would like to do today, because we seldom interface with women and allow them and permit them an opportunity to share their perinatal experiences with us. The women are the ones who utilize the systems that we develop, but we rarely, I believe, to have an opportunity to essentially get a report card from them as to what the perinatal system afforded them the ability to do. Next.

So, this was a national survey that was written in the – it comes out of the Birth Lab, which is located in British Columbia of primarily midwifes and they actually do extremely a lot of work regarding racial and ethnic women, their experiences in prenatal care, childbirth and post-partum, and most of the work that I have seen, most of the literature that I have seen comes out of the Birth Lab.

So, this was a national multi-racial and multi-ethnic survey with about one-third of the women, however,

resided in the State of New York. The majority were Caucasian, English speakers with post-secondary education and a moderate income. However, there were woman of color who were represented in this survey. Next.

The majority of the women received their care from midwives and obstetricians with a smaller percentage from family physicians. Although women of color received care by midwives, both out of hospital and hospital birth was equal, fewer women of color had an out of hospital birth, however, since COVID the rate of out of hospital birth among women of color has dramatically increased. As a matter of fact, I think COVID was an opportunity for women of color to explore out of hospital birth and their experiences with out of hospital birth reportedly has been very, very positive.

When you look at Cesarean birth, Cesarean birth for women of color was greater for women of color than Caucasian women, and for most women, private insurance was the primary payer of care. Next.

So, the surveyors asked women what was important to them during their maternity and newborn care. Well, having a trusting relationship with their care provider

was paramount. Having a provider who was a good match for what they valued and wanted in pregnancy and birth care. Not being separated from their baby after birth. Having enough time to ask questions. Options for their care, having the support people that they wanted present, and this was certainly an issue during COVID. Know that your provider, whether it was a midwife or an obstetrician or even a family practice physician who cared for them during their prenatal care would be there for them during their birth, and then having the option to have the choice of their birth was extremely important. Next.

When we look at equitable access to healthcare, you know, as I stated earlier, women of color were least likely to be able to access midwifery care. They were less likely to experience continuity of care, less likely to have the midwife or obstetrician who cared for them during prenatally, or attend their birth, although women reported that continuity of care was very important to them. Next.

Black women reported the lowest scores for autonomy and decision making and had the least access to models of care that support decision making. Black women

said it was very important, it was important or very important to have enough time to ask questions and options, but they were the most likely to have very short prenatal appointments, on average, about 15 minutes. Next.

Forty-six percent of Black women, 25 percent of Indigenous women, 25 percent of Latina women, 13 percent of Asian women and nine percent of White women agreed or strongly agree that finding a midwife or doctor who shared my heritage, race, ethnic or cultural background was important to them. Next.

Out of the women who said it was important to them to find a healthcare provider from their heritage, race, ethnic or cultural background, 69 percent of Black women, 49 percent of Latino women and four percent of White women reported having difficulty locating a provider, a doctor or a midwife from their race, heritage or cultural background.

Women who chose out of hospital birth were very deliberate in their decision. 90 percent of women said they wanted control over their childbirth experience, they wanted the ability to feel comfortable in the environment.

They wanted fewer intervention options. They wanted to avoid disturbance in their labor. They were concerned about having a Caesarean birth. They wanted safety and confidence to avoid separation from their baby and to avoid hospital policies and procedures that they felt were time limiting. Next.

Women of color predominately reported mistreatment by healthcare providers, which included being shouted at or scolded. Women of color were twice as likely as Caucasian to report that a healthcare provider ignored them, refused their request for help or failed to respond to requests for help in a reasonable time. Next.

Black women were twice as likely to report that their care providers performed procedures against their will, or the women were not consulted at all regarding whether they wanted a procedure done. Caucasian women were more likely to report that their care provider accepted their decision to decline a procedure or a specific care. Next.

Care in community settings and by midwives was associated with greater respect, privacy and dignity. Women of color reported lower overall rates of respect,

privacy and dignity compared to Caucasian women. And Indigenous women were most likely to report poor respect, dignity, and privacy. Next.

So, if finding a midwife or doctor who shared my heritage, race, ethnic or cultural background was so important, how can that achieved or can it be achieved. And when we at -- I think when we look at all health professions across the board, the ability to provide a workforce that is racially, culturally, linguistically congruent with the population and the community that they serve, I think we recognize that that is not an area in which we have been successful. But since my expertise is midwifery, I just wanted to share with you some of the data around midwifery.

So, there are approximately 13,500 midwifes, you know, more or less. 90 percent are white and female. Midwives of color, and that includes Black, Latinx, Asian and Indigenous represent 10 percent, which means nationally, you have less than 2,000 midwives of color nationally. So, the ability of a woman, in spite of what it is they desire and believe that they deserve, nationally the ability of women of color to ever interface

with a midwife of color is remote. Next.

When you look at the education programs, 87 percent of the education program directors are Caucasian. We have three programs that are directed by midwives of color. 75 percent of the faculty are all white. And the new education programs are in predominately white institutions.

There is an understanding that in order for institutions and education programs, and not necessarily in midwifery, but across the board, across all health professions, a lot of equity work and a lot of anti-racism work surely needs to be infused into the curriculum. Next.

And when you look at the diversity of midwifery students, the challenge to be able to produce a workforce that is racially, ethnically, and linguistically congruent with the population being serve, I think you can glean from this slide that when you look at the diversity in the United States population, we certainly see that Asian students, Latinx students, and actually this slide is about three years old. If we look at the latest census data report that actually came out last week, I read that

there are concerns that the 2020 census overrepresented Caucasians and Asian communities, but Black, Latinx and Indigenous communities were underreported. So, this even further exacerbates the ability to increase the workforce in terms. Of its diversity by race and ethnicity.

We spoke earlier about the Indigenous community, and as you can see, the American Indian/Alaska Native population of midwives does not even represent one percent of the midwifery community.

And in terms of the Latinx percentage, approximately 20 percent of the U.S. population, approximately 20 percent, yet still, when you look at the Latinx students who were admitted, and this is back in 2019, they are very underrepresented, whereas, when you look at the representation of Caucasian students in the population but their admittance into education programs, they're overrepresented.

So, you have an under representation of students of color and an over representation of Caucasian students. So, the ability to diversify the workforce, as you can see, is very problematic and definitely needs a lot of work. Next.

So, just to summarize the preceding slides, Black, Brown and Indigenous women reported that the perinatal care system available to them does not provide them access to care, by the provider of their choice. For them, the ideal perinatal system would have more access to midwives, a doctor or midwife who shared their heritage, race, ethnic or cultural background, a provider with whom they could develop a trusting relationship, a provider who is a good match for what they value and want in pregnancy and birth care, continuity of care throughout pregnancy and birth, shared decision making, a pregnancy and birth free of mistreatment, a pregnancy and birth characterized by respect, privacy and dignity, a pregnancy free of pressure to accept interventions and procedures. Next.

BELINDA PETTIFORD: I think that's the end of the slides. I think now, does anyone have any questions before we move into the recommendations?

I don't see any hands up. I can't see the chat. Yes, Jeanne.

JEANNE CONRY: I was just going to say this was incredibly valuable. It certainly -- the message that we've heard from the White Ribbon Alliance about the

importance of respectful care, and this just really, I think, focuses and brings out so many of the elements that we need to be striving for. So, thank you very much.

BELINDA PETTIFORD: No, thank you for the feedback. Anyone else?

ED EHLINGER: Thank you, Patricia, too, for pointing out that during the COVID crisis a lot of BIPOC women were looking for alternatives, because the situation had gotten even worse.

BELINDA PETTIFORD: Colleen, I see your hand?

COLLEEN MALLORY: Yeah. No, I didn't write down exactly the figures from the presentation but it's interesting to so much what we heard in the past, but I think that one side they talked about how women really want a doctor or a provider who shares their values and what they want out of pregnancy. I think it's important that the percentage for that was much higher than I think when you took that survey, the people that said that they wanted a doctor that shared their like specific race or ethnicity, the majority of people didn't say that. I think it was like 47 percent for African/American mothers and then it went down from there. I think Hispanic was in

the 20's and Caucasians were – yeah, I don't know if that -- if you can go back. I think – maybe one more. Just one more, I think. Maybe one more. Sorry.

Belinda Pettiford: No problem.

COLLEEN MALLORY: I think it's one more before this one. Yeah, okay, yeah, this one. So, I thought that was interesting, because it was actually less than half of Black women and 25 percent Indigenous women, 25 percent of Latino women -- well, you can read it yourself. Like that they didn't -- so like the majority thought it was more important to find someone who agreed with their ideas for pregnancy and birth more than specific to heritage, which I thought was interesting, because like the concluding side made it, I think, some more definitive, where it's like in this slide, at least, like only 25 percent of Indigenous women said that that was important to them. So, I just didn't know if you had like a reason why the status then became -- I feel a little bit more strongly worded that it was more of a universal thing, because it's like these stats at least kind of say that sharing the prospective of pregnancy and birth was more important than specific heritage and race, but I don't know how you --

this is just one survey and there's other data that's out there probably or --

BELINDA PETTIFORD: Pat, you are muted. I think you responded, but you're muted.

PATRICIA LOFTMAN: Oh, sorry about that. Yeah, so all of this data came from the study, and I think I would go back to the researchers to see how they ask those questions.

BELINDA PETTIFORD: Thank you, Colleen, and I'm following what you're saying, because you're saying those in the specific populations either agreed or strongly agreed with the following statement. So you were looking at it from the reverse, those -- it really just depends on what the other options were, I think, in the response.

COLLEEN MALLORY: Well, I was really surprised that it's only 46 percent for Black women to be honest with you, because that tells me that the majority did not agree with that statement. So, I was just surprised that it was only 46 percent, so I didn't know if that is something that you found surprising also, or --

PATRICIA LOFTMAN: But it's not an in sequential percentage.

COLLEEN MALLORY: Sure.

PATRICIA LOFTMAN: Okay.

BELINDA PETTIFORD: And I also think the next one connects to it, having difficulty locating one. So, all of that is connected. But no, you make an excellent point, Colleen, so thank you. Any other questions from anyone?

No other questions, we're going to move to the recommendations coming forth on the Healthy Equity Workgroup. So we are now coming forward with three specific recommendations for the Secretary. As you can see here, recommendation one, the Secretary should encourage and support the licensure and Federal recognition of certified professional midwives and certified midwives who graduate from accredited midwifery education program in all 50 states, the territories and D.C. We now this currently is not in effect everywhere, but it is trying to strengthen this and ask the Secretary to encourage it, realizing that the Secretary cannot make this happen by themselves, because these – you're dealing with State rules, State laws and things of that nature, but we think a word of encouragement could go a long way

in supporting this.

So, we'll start with recommendation one to see any thoughts, concerns, questions. I don't know, Pat, anything else you want to add to it?

PATRICIA LOFTMAN: Well, I think there's a recognition that there is currently a shortage of women's healthcare providers, including obstetrical care providers, most notably in rural and suburban areas, and that clearly negatively impacts access to reproductive care amongst reproductive healthcare, including maternal and infant care.

And while we have, you know, three nationally certified midwifery credentials, the certified professional midwife, the certified nurse midwife and the certified midwives, and many -- all certified midwives and certified midwives, and some certified professional midwives graduate from accredited -- formal accredited midwifery education, they are limited in their ability to practice in all 50 states. And so, this recommendation speaks to that.

BELINDA PETTIFORD: Thank you. I see Charlene's hand up.

CHARLENE COLLIER: Thank you. I saw that -- I mean, I was taken aback by the only 10 percent of the -- I believe it was CNM's are women of color in total. Is there any evidence at this point there already is more diversity among CPM's and CM's in terms of those in existence right now and how would this recommendation, as it's worded, directly ensure that these groups are also going to have diversity within them as opposed to, again, having 90 percent, you know, white women making up these numbers, too?

PATRICIA LOFTMAN: Yeah. The organization that represents CPM's, the National Association of Certified Professional Midwives, their data is not readily available. But what we do know, certainly antidotally, is that the percentage of CPM's who are women of color pretty much mirror certified nurse midwives and certified midwives. So, the population of women of color who are CPMs are consistent with certified nurse midwives and certified midwives.

And so the ability to have -- but the issue is that for those CPM's who hail from accredited midwifery education, those who are women of color are limited in the

space that they can practice. And so this recommendation would support the expansion of their ability to practice in all of the states.

BELINDA PETTIFORD: So, this actually increases access?

PATRICIA LOFTMAN: It would increase access, but it would -- it would increase access, and at the same time not only increase access to CPMs of color, but keep in mind these recommendations hopefully are aspirational in terms of what happens in the future.

BELINDA PETTIFORD: Thank you. Charlene, did that help you?

CHARLENE COLLIER: Yes, I think so. I think the recommendation is good across for our committee as a whole as we see improvement of -- we need more midwives, more access, so I think it cost cuts beyond the diverse workforce, but it may not specifically solve the diversity issue without that explicit pathway, like I don't even know much about the training programs, how accessible they are in communities of color. People have to travel.

I know midwives, for example, in Mississippi have a very hard time finding places to practice to get

their clinical hours. I don't know the inequities as it relates to being trained. Right now, even our -- you know, all of our midwives have a very hard time finding clinical hours. I don't know how those inequities differ -- you know, may impact the training of midwives as well and maybe we just need to consider that. So, but I think that the recommendation is very important across the board for our mission.

BELINDA PETTIFORD: Thank you. I think recommendation two and three will help get to that a little more. I'm sorry, Pat, didn't mean to cut you off.

PATRICIA LOFTMAN: I was just going to respond to Dr. Collier. It's really interesting, we used to have an education program, midwife education program in Mississippi, actually, that is no longer there. There are many, many issues specifically for students of color, not separate and apart from their education program, just clinical sites, faculty preceptors. It's really multi-pronged when it comes to students of color.

But the second recommendation would be Federal grant applications for health care professions, and that would include medical, midwifery, nursing. Must include

accountability metrics in the application to –

BELINDA PETTIFORD: Can you hold off on that one until we get the questions on recommendation one, I'm sorry.

PATRICIA LOFTMAN: Oh, certainly.

BELINDA PETTIFORD: We've got four other hands up.

PATRICIA LOFTMAN: Okay.

BELINDA PETTIFORD: Jacob, I see your hand.

JACOB WARREN: Yes, thank you. One question I had, and this might be gotten into later in the other recommendations, but I didn't see it. I don't know, again, the full scope of this Committee to hear recommendations in this area, but I know the issue we face here in Georgia is that nurse midwifes practice under APR incentives in Georgia with very limited scope of practice, and we're a state that could do a lot in terms of diversifying the workforce. A lot of the states we see here in the deep south sort of face a similar issue, that if we work to increase certified nurse midwives or other NPPA's, it's in states that don't have full practice authority. So, I didn't know if there's any consideration

to that sort of intersection that the states that could most contribute to diversity sometimes have the most restrictive scope of practice that might create a challenge for that as an entry point into the profession.

PATRICIA LOFTMAN: And you know, you cite one of the barriers. There is no universal national policy regarding jurisdictional -- jurisdiction over midwifery. So, all midwives, every midwife in every state has a different accrediting body, reports to a different agency, and that is certainly a barrier. Certainly, something universal similar to physicians would certainly assist midwives in practicing nationally. But at the moment, as you cite, in Georgia midwifes are ALPN's, where in the State of New York midwives in New York come under a state board of midwifery and we are licensed independent practice nurse. So, it's literally different in all 50 states.

BELINDA PETTIFORD: And I think the other thing you've acknowledged, Jacob, because we deal with this in my own state of North Carolina next to you, you know, we have certified nurse midwives that can't practice under their, you know, full practice authority.

So, I know we discussed this in the Health Equity Workgroup, I just don't know if Janelle is on, if anyone else can remember why we didn't include it as part of this recommendation around the full practice authority. So, we'll put a note by that one and come back to it because I do think it's an excellent point.

LEE WILSON: Folks, this is Lee Wilson. If I can just jump in here as the designated Federal Official, I just want to point out that on the discussion for this Committee meeting is a discussion between the people who are invited to make a presentation to the Committee and the Committee members. I know that with the technology, we now have the ability for observes in the Committee to raise questions. You are free to raise those questions in the chat, but those questions are a sideline conversation that are going on. If we have the opportunity as individual Committee members or as this staff working with us to follow up with questions that may be raised, we can do that after the fact. However, this Committee is intended to be a discussion for the Committee members, and we do not want to encourage one voice to sound louder than another because they continue to – because they may be

asking questions of the Committee.

So, just to lay down some of the ground rules, please feel free to continue to add your chat, but please, do not expect that it will be addressed by the Committee or by the speakers of the Committee. Thank you.

BELINDA PETTIFORD: Thank you, Lee. And I see Jeanne's hand is up.

JEANNE CONRY: Thank you. I wanted to speak to very strongly about this midwifery discussion. I'm absolutely -- I spent my entire career working with midwives. I believe that we need to look at an international designation, International Confederation of Midwives has had for over a decade the minimum education training requirement for midwives in all countries, and they have that recommendation for everybody. So the requirement for a nurse – a midwife in Bangladesh and the United States, it a universal implementation of ICM standards and it ensures that women are going to receive the recommendations of what globally is recommended for midwifery standards.

In the United States it is -- I describe it almost as obfuscation. A midwife is not a midwife. So,

it gets very confusing for patients. You've got certified nurse midwives, certified midwives and certified professional midwives and they're different levels of education and training, and patients don't understand how distinct those levels of training and requirements are.

So, I am very supportive of the international confederation of midwives. If you are a midwife in Bangladesh, you know what your training is going to be. That's not the same in the United States. Bangladesh has a higher requirement for somebody who's called a midwife than we would here. I would strongly speak to following the ICM standards here.

PATRICIA LOFTMAN: Can I just respond to that? I think that if you look at recommendation number one, it is a U.S. mirror and ICM aligned. We talk about midwives who graduate from accredited midwifery education programs, which is U.S. mirror alignment.

BELINDA PETTIFORD: Okay, you actually dropped in the chat, Jeanne, what the International Confederation of Midwives –

JEANNE CONRY: Yeah.

BELINDA PETTIFORD: So, it's to make sure we all

are understanding it I know we have – I now Pat is a midwife and others are but many of us are not.

JEANE CONRYU: Yeah, 60 percent of midwives, CPM's, do not meet the ICM requirements. And I think ICM is a fabulous organization, and I know our own college of -- I'm blanking on how we call our college of midwifery -- follows ICM recommendations. But I would -- but I'll get the ICM statement.

PATRICIA LOFTMAN: Yeah, I'm just going to say again, I think you will see that ICM says that midwives should graduate from accredited midwifery education programs, and those are the CPMs that we're talking about. We're not talking about CPMs who do not have accredited education. We're talking about CPMs with accredited education, and that would be in alignment with ICM and U.S. mirror.

BELINDA PETTIFORD: Thank you both. So, I see Kate, your hand is up?

KATHRYN MENARD: Thanks, Belinda. Maybe my -- I applaud the work of promotion of, you know, increasing the workforce among midwives wholeheartedly, but my question, Belinda, is from your Committee, why really the focus on

midwives? I think this is a path that we need to follow, but to me it seems like there's so many other opportunities beyond this that are broader, you know, developing the doula workforce, for example, increasing the use of race concordant community health workers, certainly increasing, in addition to the midwifery professional workforce, the physician diversity and the physician workforce. And I just wonder if our recommendations can be more encompassing, and that's potentially -- I mean, focus is good, but maybe a broader reach would be more effective.

BELINDA PETTIFORD: Thank you, Kate. Now, we do have recommendations that have already moved to the Secretary around supporting community health worker doula services, so it's not that the Committee didn't consider it, these are recommendations that have already moved forward. This specific group of recommendations is really around diversifying the workforce, but specifically around race concordant care and starting with the population of midwives.

So, we are, again, open to additional feedback on it, but this is the conversation that did occur at the

Health Equity Workgroup.

PATRICIA LOFTMAN: Can I just make a little comment though. I think it's really important, the reason I started with the slides was I wanted to center and contextualize the voices of the women. And so if you remember the one slide where I talked about what it was that the women wanted, those were not my words, those were their words. And so I think we, at some point, if we're talking about centering the voices of women, I think we have to listen to them, you know, listening to what it is that they said that they wanted.

BELINDA PETTIFORD: Thank you, Pat. Other comments about recommendation one before we move on to one of the other recommendations? And thank you, Jeanne, for dropping that in the chat.

Okay, we're going to move --

CHARLENE COLLIER: Yeah, one last quick question, I'm sorry. Are there any HPCUs affiliated with midwifery training programs?

PATRICIA LOFTMAN: Not currently. We had one back in the 1980's. There was a midwifery education program in the Harry (phonetic), but that program no

longer exists. I know in the past that there have been overtures to the HBCUs. I, myself, have approached some of them in the past. In the past, they have not been overly, I would say interested for various reasons. Maybe the time has come to, you know, go back to see if there is now developed interest or not.

CHARLENE COLLIER: Yeah, I would encourage that. Thank you.

BELINDA PETTIFORD: Thanks everyone. Let's move to recommendation two, Federal grant applications for healthcare professionals which would include midwives, medical physicians, all healthcare professions must include accountability metrics in the applications to monitor efforts to improve diversity of the workforce that reflects the diversity of the population being served.

So, this one is more general. It is not specific to nurse midwives or midwives in general, it is specific to healthcare professions.

PATRICIA LOFTMAN: So, let me just speak a little bit to that before we go into questions. Healthcare profession education programs have multiple Federal funding grants available for them to access. And

many of those grants are designed to address maternal mortality and workforce diversity. However, the issue here is that those funding streams lack accountability metrics that contributes to system barriers that prevent Black, Brown and Indigenous students from achieving success in their education programs compared to their white counterparts.

So, for example, how many BIPOC students are enrolled? How many graduated. The students dropped out. When did they drop out? What is the attendance rate? How many passed the certification are licensing exam? What is the first-time pass rate? What was the retake rate for the exam? How long did it take healthcare professionals to find employment, and for graduate BIPOC midwives, that's critical because the information that we receive from BIPOC graduates is that it takes them twice as long to find employment as compared to their white counterpart. What is the racial and ethnic makeup of faculty in the healthcare profession education programs? What is the faculty recruitment process, and what does the curriculum look like? Does it infuse equity? Does it infuse anti-racism? Does it include policies – so, for example,

policies around institutional racism such as redlining that resulted in residential segregation.

These metrics do not seem to be currently present in these grants, and so in terms of expanding the requirements for grants, this is a recommendation that the Committee is proposing.

BELINDA PETTIFORD: Thank you, Pat, for clarifying that for everyone. Any questions? I see hands up, but I don't know if they're hands from before, so Charlene, do you have a question? Okay, so previous hand. Kate, do you have a question or is it a previous hand? Your hands are down, so I guess it was previous. Okay. Any questions, thoughts, concerns or comments about recommendation two? And Pat did a really good job of laying out some potential metrics to look at. Yes, Magda.

MAGDA PECK: Thank you so much. I'm looking for -- I understand the explanation coming from Pat, thank you, because I couldn't quite understand what this was. So first of all, thank you for giving that clarity. So, I'm going to just encourage that the intent of this is what we're considering, not necessarily the language in it specific. Because I think it needs to be much more

specific that it is inclusive of all healthcare related professions, and that would be very interesting to define what do we mean by that, physicians, nurses, nurse practitioners, physician's assistant, in the clinical side, social workers, dentists, nutritionist. So that if we think about who we are training, folks in the mental health workforce, if you are -- if you are in your intent to look at race concordant care, wanted to look at the constellation of providers through many different doors. I think this is an opportunity for us to define what that constellation is when we're trying to give greater choice, particularly will bring in more comprehensive care and mental health care, and potentially even dentistry and nutrition, and other domains of healthcare that relate to the perinatal experience in women's health. So, that's one thing I would really push to be as clear as we can so that the Secretary and the Department can act on these in alignment with development of the workforce.

And I also think the language improved diversity of the workforce that reflects the diversity of the population being served. I appreciate the language and you might want to have some specifics about what that

means so that it is -- there's a nomenclature that educates and we don't take for granted what that language means.

And then the third is from a data perspective. In terms of accountability metrics, I would like there to be both process measures, if you will, that are required, but I'd like to know how they're connected to the strategies. What are people going to do? What are the actions they get, the results that you want to get? I'm worried about single metrics that are process measurements without necessarily connecting them with their aims, with their strategies, with the impact and results. So, a little bit of expansion of that language so that we're not missing an opportunity not just to count people but to count impact. Thank you.

BELINDA PETTIFORD: Thank you, Magda, and yes, we probably could spend more time in listing out the health professions. That's why we put, you know, i.e., and et cetera, because we did not include everyone. We just listed a few here for the recommendation. So, I definitely understand the request there as well as the language clarifying, I guess, the language at that very

end around improve the diversity of workforce that reflects the diversity served.

And I mean, the metrics that we were looking at included a combination of process and outcome, but we would welcome feedback, I'm sure from the data group in trying to strengthen those if that will be helpful.

MAGDA PECK: Thank you so much for that consideration.

BELINDA PETTIFORD: Ed, I see your hand is up.

ED EHLINGER: Yes. I think we have to put this into context. We came -- you know, our Committee early on really said we are going to focus on health equity. That's going to be our north star and identify the fact that racial disparities were part of the background for the inequities that we had, and so that all of our work has been focused on inequities, particularly among racial inequities, among others. And then so from that last year in June when we put forth our recommendations, we had identified workforce as one of those things that was getting us to that area, and we made some recommendations. And our recommendations were, you know, HHS should expand and strengthen the public health workforce dedicated to

women's and infant's health through policy financing commitment to community-based providers, and we listed public health nurses, midwives, social workers, physicians, doulas, community health workers, that should be racially, culturally and linguistically diverse, reflective of communities.

And now I think we can say, and midwives are pulled out as part of that. Now we can say all right, we're going to have some recommendations related to that previous recommendation, give you a little bit more specific guidance. Similarly, I would like to find some way to package this, and we're going to have some letter or something to the Secretary that our work on Indigenous health actually also springs from that, relates from the equity and racial exclusion that has happened. And so that our letter will say, you know, we're following up on the equity piece that we've been working on for four years, particularly racial equity, and we're going to have some recommendations related to the American Indians, because they've been excluded so long, and we're going to make some recommendations related to the race concordant care, particularly around midwives because they are a

major provider of care in the area that we're responsible for, maternal health.

So, that's sort of the context when I'm thinking about how to move this forward.

MAGDA PECK: That's helpful.

BELINDA PETTIFORD: Thank you, Ed. I don't see any other hands up for number two, so we're going to move to recommendation three. Wait a minute, Charlene, I see your hand.

CHARLENE COLLIER: Sorry, sorry, I'm probably talking too much --

BELINDA PETTIFORD: No problem.

CHARLENE COLLIER: -- but I was just wondering if -- it focuses on metrics, but within the same recommendation, could you say when there is a Federal grant application that it includes resources, best practices and accountability metrics so that when you're creating a grant, embedded within it are the tools and resources applicants should go to in order to address diversity, meaning do they know where to start, do they know what to do, and rather than having them go find it, can the grant application, itself, embed within it the

resources like use this, here's the best practices and here are your metrics in the same recommendation?

BELINDA PETTIFORD: No, that's a very good point, Charlene, and I think MCHB does a good job with that now in putting tools and resources -- I don't know, Lee, if you're still on -- and links within the notice of funding opportunity that can take you to those specific areas.

LEE WILSON: Yes, I'm still on.

BELINDA PETTIFORD: Thank you. I just wanted to make sure you heard that part of the recommendation.

LEE WILSON: Yes, I did. Thank you. It just took me a while to get my speaker on.

BELINDA PETTIFORD: Okay. Thank you, Charlene. Moving to recommendation three then, develop and implement an external evaluation report on the life stand training, recruitment through initial employment for Black, Brown and Indigenous students in the various health professions that support MCH to develop and/or identify best practice guidelines for training institutions.

PATRICIA LOFTMAN: So, let me just say a few words about that, and I'm actually going to piggyback on

Dr. Collier, because what she just stated really was what this was getting to. All health profession health profession education programs are accredited by an accrediting body, and they have the rubrics that they use to accredit programs. But what is needed is within that accreditation process. Clearly, if we're able to tease out those institutions that are having -- that are achieving success with their BIPOC students, we want to be able to see what is it that they're doing? What resources do they have that they're bringing to bear into their program so that they're successful? What are the best practices and then share those resources and beet practices with other programs that may be having challenges.

BELINDA PETTIFORD: Thank you, Pat. Questions. I see Jacob's hand went up.

JACOB WARREN: Yeah, it might be premature because I'm new to the process. I'm not sure when things get to nest out at a more detailed level. I'm curious what the sort of mechanism of action for this evaluation would be, if it's going to be coordinated through the accrediting bodies that were just mentioned or straight to

each agency and what's going to actually get them to participate in this process.

PATRICIA LOFTMAN: Well clearly, this will be a request, and hopefully it would be one that would be entertained. Hopefully, the goal is once they are able to identify either resource, best practices for both, that this becomes part of the accrediting process that institutions, that programs would have to – would have to respond to. So, rather than have it be separate, it would be part of the process. I think it's difficult for education programs to evaluate themselves. There's just inherent bias. And so the idea of having an external body provide information resource on how they can improve a specific outcome and the outcome would be success with their BIPOC students would be part of that process. So hopefully, they would feel that this is significant and important enough to include in the process going forward.

BELINDA PETTIFORD: Jacob, did that answer your question?

JACOB WARREN: It did, thank you.

BELINDA PETTIFORD: Thank you. Magda.

MAGDA PECK: Thank you for this recommendation.

I was curious if you could speak more to lifespan training and clearly you talk about recruitment through initial employment. Putting on my hat as being a former dean of a school of public health in a previous life, I'm aware that the lifespan could be defined more broadly prior to recruitment and certainly beyond initial employment. I think we already heard the concerns about retention, and particularly retention of our practitioners of color and our students of color, especially in predominately white institutions. And so I'm curious if you could speak more or bring greater clarity to either the pipeline prior to recruitment or at least getting it past initial employment but perhaps throughout the first five years of practice, something that allows us to stick with it, so folks don't fall off a cliff. Thanks.

PATRICIA LOFTMAN: Yeah. One of the concerns that I have is that we have situations where if a hundred people or say a hundred people were to apply, 95 would be accepted. And the question is, as we know, health education is extremely rigorous. I remember telling someone if I had known starting my midwifery education program what it would entail, I probably would have never

gotten started.

So, the question is, when one – when a student is admitted, are they admitted knowing that the likelihood of their success is minimal? Are they admitted knowing that they will be able to complete the program? From the point of evaluating the application, the appropriateness of the application, the acceptance of the application throughout the education process. I am concerned that some students that are accepted might not have been the correct student to be accepted. And as a result, we are almost placing them in a situation where the attrition rate becomes extremely high.

So, part of me says if I'm in an education program and I accept say four BIPOC students in the first year and by the second year, three are gone, something happened, and what happened? And we need to be able to look at that and evaluate what happened.

MAGDA PECK: I concur, I just would like to encourage that in strengthening this application, that be reflected so that it's about retention of the student and support of the student and to initial employment. And the other underbelly of this is the student who is enrolled,

the student who does study but incurs debt but does not complete the program. So, there's a financial cost as well that is inferred here, and I was wondering if you wanted to elevate it.

BELINDA PETTIFORD: Pat, you are muted if you are speaking.

PATRICIA LOFTMAN: I think what we're here from the students, Magda, is exactly what you're saying. When they're admitted, they're admitted with the expectation that they will complete the program and then halfway through they are no longer there and the financial burden for them becomes great. So, the question is, from the point of evaluation of the appropriateness of the application to the point of admission, the point of support for the entire program, and to exit, we want to look at the entire spectrum.

BELINDA PETTIFORD: So, does that help you, Magda, with explaining what the definition of the lifespan is?

MAGDA PECK: Yeah, that gives me greater clarity, yes.

BELINDA PETTIFORD: Okay.

MAGDA PECK: I just think it would be helpful if it's unclear to -- my bottom line is, I now the intent, we'll work on language later, but if it's not clear to us, then it's certainly not going to be clear to the secretary. So, we want to make sure these are as crystal clear as can be and that can happen before June.

PATRICIA LOFTMAN: And I concur, Magda. My mantra is always if someone asked a question, that means it wasn't explained well.

BELINDA PETTIFORD: Thank you. I see another hand, Marie-Elizabeth.

MARIE-ELIZABETH RAMAS: Yes, thank you. I was going to mention something similar, particularly for recommendation number two.

BELINDA PETTIFORD: Okay.

MARIE-ELIZABETH RAMAS: Not only having accountability metrics in applications and improving diversity, but also improving sustained diversity of the workforce. And when it comes to training purposes in recommendation number three, I think we need -- it would strengthen the wording if we specifically mention that the expectation is not only to bring in BIPOC students and

training, but also to maintain and sustain their success within the programs. And what I'm finding particularly in New Hampshire, that is not as diverse, that that distinction is not always connected in a way that's straightforward. So, developing and implementing external evaluation report on the lifespan of training, and not only recruitment, but also supporting and sustaining success, I think that is important to make mention.

BELINDA PETTIFORD: So, the support and the retention components as well?

MARIE-ELIZABETH RAMAS: I do think that would strengthen the recommendation, because I certainly took that from the wording, but if I did not have my particular lens, I am not sure if a general audience would take that from the wording.

BELINDA PETTIFORD: Thank you so much. Thank you, Magda, is your hand back up or was it still up? No, it's down now.

Any other comments? I know there are tons of things in the chat, I'm sure, but I can't see the chat while I'm sharing my screen. Yes, Ed.

ED EHLINGER: I think what I would suggest is

that we all take a look at these recommendations in light of the recommendations that we made under workforce in our July 2021 report to the Secretary, because I want to name it in those recommendations. So, look at those recommendations. It's the number two in the recommendations, and I think that's in your packet, in your board book. So, look at that and look at these recommendations and try to figure out, I want this subgroup to sort of been tailored to them to sort of saying following up on those, this is what we're proposing.

And then we can come back in June, and I hope we finalize it prior to that with some new wording that we can send out to the Committee, but then when we come together in June when we're in person, we can finalize that in the context of the new recommendations that were going to come in overall.

BELINDA PETTIFORD: Thank you, Ed, I agree with that suggestion that if people can look at these three recommendations an send your feedback back to Janelle and myself, and then we can pull Pat into that discussion as well and other members that are interested in it. But if

you can send your recommendations back to us, I guess what is a reasonable time frame, because if it's too long you will forget about it, and we still won't hear from you. And so is April 1st -- I know it's April Fool's Day, so is April 4th working for people?

ED EHLINGER: I think that would be a good thing. But again, do it in the context of those workforce recommendations.

BELINDA PETTIFORD: And Pat, anything else you want to add? Thank you so very much for your presentation today and all of the work you've done on these recommendations. I was taking notes throughout the whole time so I've got tons of notes from the feedback we received, but if you all can, as a full committee, send your recommendations back to Janelle and myself and I'll drop our emails into the chat for those that don't have it readily.

Pat, any closing remarks?

PATRICIA LOFTMAN: I would just like to thank the Committee for considering these recommendations, and we look forward to final recommendations for the June meeting.

ED EHLINGER: Great. Well, thank you, Patricia and Belinda. This has been very helpful. And thanks to all Committee members who had some input on this. This is great when I have to lower my hand here.

REVIEW OF COMMITTEE'S WORK AND UPDATES FROM COMMITTEE MEMBERS ON ACIMM ISSUES

ED EHLINGER: So for the last part of this meeting, I thought it would be good for the Committee members who have been on for the last four years, but also for the new members to sort of get a very brief update on some of the things that we've been working on, and I had asked Paul Wise, since in our recommendations last summer, we had some recommendations related to immigrants and border health, and he was going to, you know, give us an update on that, but since he's not on a different border dealing with other issues in Poland and Ukraine, he can't do that. So, we're not going to do that. But one of the issues that we certainly have been dealing with and wanted to just give a brief update, Steve Calvin, who has been chairing the Quality and Access Committee and some of the work we did around COVID and some of the recommendations came out from that.

Maybe Steve, maybe you can give us, you know, an update on some of the -- what we've known -- what we've come to learn over the last couple of years related to COVID and its impact on moms and babies.

STEVE CALVIN: Sure. Well, thanks, Ed. Yeah, and that's also why I'm really grateful for new members of the Committee, too, and I also should say ShaRhonda, I did my medical school training in St. Louis, and I think that's where you're from, and during the time I was there, I -- there was actually segregated hospitals. Homer G. Phillips and City Number One. So, your prospective is going to be really valuable.

In any case, COVID, obviously, uncovered a lot of issues and brought a lot of things to the floor, all kinds of levels, telehealth and the drive to have mothers who are looking at situations where they were going to basically sometimes be told they were going to be unaccompanied in labor surrounded by people in hazmat suits and so that was kind of the early days. But over time there's been significant information that has been gathered about COVID, and it's certainly true that COVID in pregnancy, and I'm sure Kate and my other obstetrical

colleagues and midwives' colleagues as well have had personal experience with the care of some mothers. In general, pregnant women are generally healthy but a lot of them have comorbidities, and there were women who died of COVID during their pregnancies, and those were certainly tragedies.

While pregnant, getting a respiratory illness like that could certainly be a major risk and, you know, presented a lot of challenges.

I think that there have been a number of articles recently that have looked at some of the morbidity and some of the other things, including an increased risk for pregnancy induced hypertension, preeclampsia, some preterm birth. There's probably a slight increase in the stillbirth rate. A lot of this has to be sorted out over time. Looking at the Health E states, the thing that came out, Donna Hoyer and the Division of Vital Statistics, that was quite interesting last month, just the fact that the maternal mortality rate in the country has gone up by a significant amount. Some of that is COVID related.

There are other issues, and there's the

continued basically acknowledgement that the risk of dying, if you are not Hispanic, you know, non-Hispanic, Black women is at least three times higher. It's certainly also higher among women who are over age 40 in pregnancy. So anyway, there's a lot of health information that is coming out. There have also been – there's some information now of outcomes with asymptomatic COVID during pregnancy, the whole issue of vaccination. Many of us have been part of recommending and offering vaccination during pregnancy, and there have been – there's been some significant resistance, and there also should be support for the women who choose not to be vaccinated, given the information as well.

So, I think a lot of this is just going to be sorted out over time, and I'm looking forward to working with these new colleagues on the Committee to identify things that are, you know, that are going, I think, to be helpful as we sort things out.

ED EHLINGER: Any comments from anybody else about what we've learned about COVID over the last couple of years related to moms and babies?

MAGDA PECK: This is Magda. I would just say

one of the other dimensions that was revealed was that early on, the tone deafness, if you will, of not looking at this aggregate of the data by race, and I'm just mindful that there is both and uninvited gift of COVID that it may have strengthened some of our data and surveillance systems. Not necessarily specific to women and children or pregnancy early on, but certainly elevating racial equity and inequity through a series of dashboards, through the Satcher Health Leadership Institute's dashboard, itself, in terms of the tracker.

So, you know, always I can think in times of vulnerability, what are the times of greatest opportunity, an old adage in maternal and child health. COVID showed us just how terrible the data were, how disempowered and how weak the local health departments were to be able to collect data and gave an opportunity to strengthen data and research for action. We should build on that as our opportunity now before we forget, and it unravels again.

ED EHLINGER: Thank you, Magda. Jeanne.

JEANNE CONRY: Thanks. Good summary, and certainly it improves our awareness. I would say this is one of the times where the global perspective has helped.

We've had a registry of births from around the world where every two weeks since COVID began, we've had OB/GYNs from around the world combining all of their information, putting it together and sharing it just so everyone would learn. You know, first Italy and then what happened in India, and it's been an incredible resource for it. I think some of that is going to be published in the next month or so.

One early -- I mean one tidbit that's coming out is this Plus and Titus. I've shared it with ACOG. But there are some very unusual looks at placentas. I was at a conference in Ireland last weekend and the placental biologists there is looking at what's happening, and it's not what we would expect at all. So, I think this really is one of those times where we are learning as we go along, and listening as things come out, and trying to know what we should be recommending, and how much is enough, and how much is not enough information.

ED EHLINGER: Thank you, Jeanne. COVID also highlights the fact that everything is connected. COVID has impacted housing, has impacted transportation, has impacted economic development, and they all impact

populations of color and the American Indians markedly more than the white population, which then springs down to the impact on pregnant individuals and their babies. So, it's all connected. So, we'll continue to follow.

Jeanne, why don't you -- one of the other issues we brought up, that Jeanne Conry brought up was the impact of environmental contaminants on health. And so we had a session on that, a great session, and we came up with some recommendations for that, and I'm curious, Jeanne, any follow up on those recommendations that you had, and also while you're at it, you also brought up the women's preventative -- or the Women's Action -- World Patient Safety.

JEANNE CONRY: Oh gosh, that's been so long ago. That was September. Oh my gosh, I forgot about that one.

ED ELHINGER: Yeah.

JEANNE CONRY: Well, first of all, just thank you for a fabulous job leading and maternal newborn and child health, and always keeping our perspective and a respectful discussion going. It's been marvelous to be a part of this. And then Magda, with your energy on our dated action committee, you've always been great.

You know, when I started -- when I was asked, it was as the OB/GYN looking at infant mortality and knew that I was bringing a perspective about women's health, and before, between and beyond pregnancy. But hearing Dr. Warren talk about the Women's Preventive Services Initiative and how much it's done, and the AIM Project. We heard during this last year from the California Maternal Quality Care Collaborative and know that not only have they focused on post-partum hemorrhage and hypertension, but they're also bringing in birth equity, and racism and social injustice. So, I think all of those topics have been extremely important. And for my own satisfaction, watching the AIM Program be adopted in Malawi, Africa, and show that maternal mortality in the hospitals that adopted the AIM Program that Dr. Warren described, their maternal mortality decreased. So, it's been incredible just to watch this year.

And then you're right, World Patient Safety Day was in September, it's every September. But this one really was a focus on safe and respectful care. And I think we've heard today a number of comments about how important respectful care is and how we all need to work

together to make it both safe and respectful care.

But you're right, we also talked about environment and whether we're talking about climate change or environmental exposures, they're endocrine disruptors that impact health in the United States. There was a large review article, 33 million births, and we saw that there was significant association between heat, ozone, fire particulate matter and adverse pregnancy outcomes. I'm from -- I might be in Paris right now, but I'm from the fire region of California, so every -- now it's into June, July and August when we're seeing the fires, we worry about what's happening to women.

I just wanted – from the perspective that we've had recently about the risks to our Black, Latino population, just last week the Environmental Science and Technology report compared white Americans with Black and Latinos and said whether you're looking at smog, particulate matter, industrial resources, there's a risk to – a disproportionate risk to our underserved populations in the United States. Pollutants, whether it's triggering asthma or heart disease and strokes, or as we've seen, pre-term delivery, low birth weight infants,

we see that there's racial and ethnic air pollution and exposure disparities persist. We've heard about the red lining. I'd never heard that term before you introduced it, Ed, and that still explains now not just the housing markets but explains the disproportionate findings we're seeing with environmental exposures.

And then we've also seen about the lead in pipes and impact on children's health. I was heartened to see one of the first statements coming out of the EPA is that we need to go back to our zero tolerance for lead and make that an important decision.

And we also heard about the endocrine disruptors. Whether we're talking about the air we breathe, the water we drink, the food we consume or the products that we use, there are chemicals that are impacting our health, the impact of children's health and certainly the impact of a fetus, our ability to reproduce.

So, I look forward to the new members taking on these topics and being a very strong voice advocating for maternal newborn health outcomes. Thank you.

ED EHLINGER: And Jeanne, thank you for your word here. Good example of two things, you know, one is

that somebody needs to push the environmental issues, because they often get said, oh, that's EPA's job, that's not MCHB's job, or it's you know, HUD's job, it's not MCHB's job. It is our job. So, we need somebody, I hope, to kind of push that out.

The other point that I make is that Jeanne had this issue, she brought it forward, we had a session on it, we got briefed on it, we came up with some recommendations on it. So, if you have some issues that you really wanted to work on, and you know, willing to lead on, this is a good place to do that. We have the ability as a committee to move those things forward.

So, Jeanne, you're a good example for both of those. Thank you.

JEANNE CONRY: Thank you, Ed.

ED EHLINGER: Comments from what Jeanne had to say. All right. And then Magda, you had also, you know, you raised a couple of issues and certainly have been the advocate for data and research to action, and also some of the housing issues. Any updates on any of the things that you've worked on over the last several years?

MAGDA PECK: Well, I just want to highlight for

our new members the opportunity to go upstream and be very specific about some of the issues that I raised all throughout today, which is going outside of health and human services, working across the department, and in this particular case with Housing and Urban Development, there is a new Secretary of Housing and Urban Development, Marcia Fudge. There is interest and an opportunity now to have greater interoperability, if you will, and connection between housing and health with that greater awareness.

So, the context for our last briefing that we had was look at housing insecurity as an upstream driver of adverse outcomes for moms and babies, and it had lasting impact across the life course. And this, as mentioned, was exacerbated by the pandemic and you see the CDC getting involved in they put a moratorium on eviction, something that had not happened before in terms of the different sectors working together.

I've come to understand eviction as a sentinel health event as elevated by Matthew Desmond now with the Eviction Lab at Princeton. He did his earliest work in Wisconsin when I was there as dean, and so I got to see through the lens and the stories of the extraordinary

exacerbation of stress for a woman who is pregnant and early parenting and breastfeeding to deal with one of the most excruciating adverse traumas which is to be not just homeless but thrown out on the street.

And so, we ask for a briefing, the summation of which is in your briefing books. And I'm directing this quick report out to our newest members. It's like passed over. You also speak to the youngest person in the room to be able to pass on the best story.

I just want to encourage you to have a chance to go back and read what happened in that part of our last meeting and even look at the materials that Dr. Richard Cho presented first to his senior advisor, to Secretary Fudge, and he had this sense that now is the time, having looked at the data and looked at studies such as the Ohio healthy beginnings home study that showed when you combine rental vouchers and maternal health services, you get more babies born at full term and fewer babies admitted to the NICU.

Another study he cited looked at housing vouchers to homeless families, looking at fewer child separations, decreased maternal stress. This is not

necessarily rocket science, but it's not necessarily given enough of our attention, given the silos between housing security and health outcomes. And the experience of pregnant and newly parenting people is one who we have an opportunity to intervene.

We came away hearing from Dr. Cho and from Dr. Gracie Himmelstein, who works with Dr. Desmond at the Eviction Lab at Princeton, based upon a new study that was published last spring, about a year ago in Georgia, looking specifically at eviction and adverse perinatal outcomes to say we can encourage -- it comes to us at SACIM to now push -- and we talked about that with Dr. Palacios -- push this moment in which there is some political will and interest in strengthening the relationship between HRSA and HHS, and housing and urban development.

That conversation is happening. We're being looked to try to give some specific recommendations that can be helpful. And Lee Wilson said a couple months ago at this last meeting that MCHB has been engaging with HUD to try and bridge some services and maybe, as Dr. Cho spoke about a the Healthy Start meeting there's the

potential for a housing report for all Healthy Start grantees. These are examples of not just talking about it but making specific recommendations that can augment and potentiate the power of Healthy Start and other programs that are in the field, in the communities for folks how know what is needed for the wellbeing of pregnant people.

So, we're going to be looking and we invite you as new members -- this will be the first of my pitch, the second will come tomorrow more broadly. But for now, we need your help as we and the Data and Research and Action Workgroup work with the Health Equity Workgroup to come up with specific recommendations for June that can catalyze – Allison Cernich, she was on earlier from NICHD said we're waiting to hear what you might recommend because she would love to invest with more money, more research in this area. So, three areas to look for and then I'll end.

The first is to continue to strengthen the linkages specifically between Health and Human Services and Housing and Urban Development, that we can be very specific about that, but this is the moment for us to encourage that kind of cooperation and leveraging each other and each other's resources and investments.

Two, that can be manifested also as greater data sharing, better shared surveillance and better research that build on the specific studies that are coming out, and the surveillance systems we have.

We know, for example, that FEMA and Case Fatality Review does look at some housing stability issues, but not necessarily about eviction. So we have opportunities to elevate based on data getting the two different departments to work together.

And third, there are a growing number of extraordinary innovations that we've been cataloging around, yes, in Ohio, but Boston Healthy Start and Housing in San Francisco in Homeless Perinatal Program and many others. They should not be pilot projects, a beginning, a middle and an end. We can make the recommendation to try to have more universal investments in housing security for every pregnant person, and that there should be zero evictions of pregnant women.

We have the opportunity to go from data to action, and so in my final months here serving with SACIM, please help us shape some very specific recommendations that can be strategic at this moment, and we hope to have

them concluded in time for the June letters to go to the Secretary.

With that, I invite my colleagues who have been listening in, I know, Belinda, you had early passed around this, and Janelle, and you've brought it to the Health Equity Workgroup. Rosemary, you may still be on from FEMA about how you're collecting data that we can go from small to more broad, but that's the update that I can give you that no passion lost, opportunity presents and it's time for us to get as specific as we can by June, and we have some specific ideas to grow. Thanks a lot.

ED EHLINGER: Thank you, Magda. You always have unique updates. Now, we're going to go just a couple minutes over the 4:00 o'clock, because normally -- well, in the past Wanda Barfield, as ex-officio member from CDC has usually given us some updates. And she, after 11 years as ex-officio member, she's stepping away from that and is handing it off to Charlan Kroelinger. If Charlan is still on, could you introduce yourself if you're still on with us? You're not coming through.

MAGDA PECK: I don't see her on the list.

ED EHLINGER: I see her picture. Technical

issues. But anyway, welcome, welcome on board. Glad you're with us. We'll look forward to some comments later on.

And thank you all. We have reached the end -- oh, ShaRhonda, you had a question.

SHARHONDA THOMPSON: Yes, a quick one. I know we just discussed housing, which I also think is a great help when it comes to infant mortality and maternal health. I just wanted to ask if in the past if any previous committees, have we tackled transportation at all as an issue for maternal and infant health?

ED EHLINGER: It has been brought up in our conversations, but it's not really been focused on. You know, as one of those social determinates of health, it came on. When we were talking about housing, it was related to housing, but again, it's an issue that -- like I would say wherever there's interest and energy and opportunity, when the come together we can move it.

So, if somebody has some interest and we have an opportunity, and some passion and energy to move it, it has an impact on moms and babies. Lee?

LEE WILSON: Yes, I have two comments before we

close out, so if this is a good time, Ed, I will just make them. First, I wanted to let you know that as I stated earlier today, there will be a public comment period towards the end of the meeting tomorrow. We did receive one public comment in writing. That came in to us after we had sent out the minutes for the briefing book for the Committee. So, I would like to encourage each of the Committee members to check your emails as Michelle will be sending the scanned copy of that correspondence to you in preparation for the public comment. It's rather lengthy and our general policy is not to read the public comment just in case inflection is not as intended.

So, I wanted to highlight that for you. We do make all public comments available, and they will be posted on the website as well so that when we are up and ready to do that, we can make that possible.

The second is just in response to, Magda, your comment earlier today about the minutes. I do want to call out in particular Abigail Duchatelier-Jeudy, and Anne Leitch, as well as the LRG staff for their hard work on this. This has been a difficult exercise for us over the years, trying to capture the more scientific and esoteric

discussions as well as some of the community-based discussions, also, in an era of equity and changing terms and norms and expectations, we sometimes have to make assumptions about sometimes gender or making an objective statement about an individual or something.

If we get that wrong, please let us know, we'll try to not make that decision in the future. But our point is to try to be as open and inclusive as possible without alienating others, and that is sometimes a difficult juggling match. We try and sometimes we might not get it right, but if we can correct, please do give us that input. So, thank you.

ED EHLINGER: Thank you, Lee. And thanks to everybody who participated, whether your voice was brought forward or not, you were here listening and paying attention and moving things forward.

For the new members, one of the things that I -- when I started out as Chair of this Committee, said we really need to change the narrative about moms and babies, change the narrative about what creates health, that it is not just about medical care and personal choices, as important as they are, but it really is about the social,

environmental and cultural, and societal issues that impact it.

And I think over the course of the last four years, we really have changed how we talk about moms and babies and birth outcomes in a much broader, much more holistic, much more inclusive way. And just from the conversations I've heard today, I think that narrative is catching hold. And I get a sense from our new members that we embrace that narrative, that it is really about the social conditions, about the economic conditions, about the environmental conditions. It's about the conditions in which we all live and pray and work and go to school that we really have to deal with.

It doesn't mean that medical care and personal truths are not important, they are important, but in the context of our environment. So, thank you for helping us change that narrative and advance a narrative about what really creates help for moms and babies.

ADJOURNMENT

ED EHLINGER: With that, we are adjourned until tomorrow at noon Eastern Daylight-Saving Time. See you then.

(Meeting concluded at 4:00 o’clock p.m.)