**December 6, 2023**

**Preconception/Interconception Workgroup Transcript**

DR. SHARPS: Good morning to everyone. I'm Phyllis Sharps, and as Vanessa said, Joy Neyhart, we are co-chairs. And I will tell you this is the first time I've done this on a federal advisory committee and workgroup, so I am going to think that maybe we start with introductions and then I believe we are supposed to begin our discussion about what the workgroup might help to accomplish in terms of reviewing materials and our deliverable, our recommendations from this group to the Secretary.

So, I will start and then I'm going to shut up. My name is Phyllis Sharps. I'm a nurse doctorate-prepared and formally Associate Dean for Community Programs at Johns Hopkins University School of Nursing where I ran and oversaw three community centers, one of which was in a shelter for abused women and children. We also had one for senior health, which was in a residential, independent living facility, and a third center was in a public school in Baltimore City, K through 8.

For my background, I am a maternal and perinatal maternal child health clinical nurse specialist and I have spent my whole career, which is now more than 50 years, focusing on women's health primarily in community settings.

And one interesting thing about me, and maybe everyone may add something, is I started my career as an active-duty nurse in labor and delivery. And as I heard the presentations about rural health, which I never really had thought about, my hospital, the Military hospital at Fort Leonard, Missouri would probably be considered a rural health hospital, and we had a very small delivery unit and nursery. And so, as a Military nurse, I got to do it all.

By the time I would tire of labor and delivery, it was time to rotate to postpartum and after a few weeks I'd be in newborn nursery, so it was a neat way to start one's career. So, I will turn it over to Joy.

DR. NEYHART: Good morning or good afternoon, if you're on the East Coast. I am a pediatrician who's been practicing in Juneau, Alaska, which is not quite rural and not quite urban. It's the smallest, I think, state capitol, 30,000 people, and we have no roads in or out, so it's remote, yet, we serve a lot of legislators and policymakers. Also, there's a Tribal Health entity there which is Southeast Alaska Regional Health Consortium, which I joined about a year and a half ago after 20 something years in a small, independent practice, so I've done the gamut.

I still attend deliveries and provide neonatal resuscitation when necessary. I stabilize critically ill neonates and critically ill children, readying them for

transfer to tertiary care facilities either in Anchorage or down in Seattle. And then, over the past eight years or so, I've been providing some low-income tenant coverage in small rural hospital in Montana and Wyoming, and I very much see the difficulty of maintaining a well-run and well-staffed delivery unit in these smaller communities, yet they're really needed.

So, I am hoping that we will get the information. When we had our meeting in November, we had asked for some information and I don't know if it's been able to be compiled or not, we asked for some information about what has been done so far and what's working in terms of improvement and where we can build upon what's already been happening.

Do you know, Vanessa, if that information was pulled for us to work from?

MS. LEE: I think we felt that perhaps the -- article that we put in that gave sort of a history of preconception and where things stand now might help to fill some of that info.

DR. NEYHART: Well, there was a question requesting the data about the existing HRSA programs, what's the evidence that these programs are being effective.

MS. LEE: Yes. And I can answer it, Sarah, pretty sure there's no dedicated preconception funding right now, either at CDC or through MCHB. We have things like the well

woman visit through Title V, which is why we asked for Keriann to present on some of the measures that at least states are collecting around postpartum now mostly, rather than general women's health. But I think she spoke to this lack of data and I don't know if others want to chime in because we could have experts on the call, but I think it was her call to us that there isn't a lot of data to know how many do get the well woman visit, how effective is that, what's the quality of their care, things like that. So, that's what I understood to be a big issue.

And it depends if you want to, as a group, hone in more on postpartum because there's a whole different set of issues that come with that. And as you saw, we are tracking postpartum care more, again, through other programs versus a standalone. So, based on postpartum, we have measures interwoven into Healthy Start and Title V block grants. Obviously, I think home visiting tracks that as a measure as well. So, it's very piecemeal right now I would say.

DR. SHARPS: Maybe we should finish the introductions and then maybe we can move into the discussion, and I could share a few highlights. We actually did have a meeting with Dr. Verbiest before this meeting and I had fielded several questions to her about things perhaps we could think about, but I think we did hear about what also some of the agencies are currently doing if there are things

that were different and maybe also request from our HRSA staff the kinds of materials we might need for further deliberation and discussion.

So, I'm going to go on how I see my screen, so Vanessa, I think you're next if you wanted to introduce yourself.

MS. LEE: Sure, Joy, and thank you, Phyllis, so much for co-leading this workgroup. I'm Vanessa Lee. I'm with HRSA's Maternal Child Health Bureau in the Division of Healthy Start and Perinatal Services and I'm the designated federal official for the Advisory Committee and also a project officer right now mostly with grants related to improving maternal and women's health. Glad to be here.

DR. SHARPS: And I'm going to take a stab at it, but I think I'm going to mispronounce, but I see Iseoluwa Gamu from HRSA.

MS. GAMU: Hi, it's Iseoluwa. Hi, everyone. I am a health equity fellow at HRSA currently. I am working in the Division of Home Visiting and Early Childhood Services, and I'm hear really to just listen in and learn some more about what's going on because I have been looking at certain ACIMM recommendations and categorizing them from the ones for the IAIM population, so that's a project that I'm working on.

DR. SHARPS: Welcome. I see Emma next -- I'm sorry. Let me go back, but let's start, Gayle Goldin, from

the Women's Bureau of the Department of Labor.

MS. GOLDIN: Gayle Goldin, I'm Deputy Director of Women's Bureau at the Department of Labor. Happy to be in this group. There's so much, as you know, that -- your reproductive health with workforce labor, not the other kind of labor, that enables people to be able to make decisions about their reproductive health and their economic security, so I thought it would be a really interesting workgroup for me to join.

DR. SHARPS: Emma.

MS. ALLEN: Hello, everyone. I'm Emma Allen and I'm the logistics contractor. I'll be assisting, taking some notes today.

DR. SHARPS: Thank you, Emma, for getting us sorted out and in the right rooms. Veronica?

MS. GUTIERREZ: Hi, I'm Veronica.

DR. SHARPS: Your sound is a challenge.

MS. GUTIERREZ: So, I work for Early HeadStart. I am a maternal child health specialist and I work in helping the families, making sure they're keeping up with their health stuff, dentals, vaccinations, all that stuff. I'm going to start working with pregnant women soon.

DR. SHARPS: Thank you. Sarah?

MS. WRIGHT: Hi, all. I'm Sarah Wright. I am also in the Maternal and Child Health Bureau at HRSA in the

Division of Health Start and Perinatal Services. I'm a project officer on a couple of maternal health focused programs and I'm just joining today to listen in on the discussion. Preconception health is very near and dear to my heart, so I look forward to hearing what everyone contributes.

DR. SHARPS: I think we lost someone. Anna Lipton was on, but I don't see her now. So, did I miss anyone that's not showing up on my screen?

(No response)

DR. SHARPS: Vanessa and I had a chance to meet with Sarah, the presenter from yesterday, before, and if anyone hasn't gotten the article that she wrote, it was published just recently, September of 2023. I thought it provided an excellent background of where the field has been, where it has gone, who has funded it, and I think what's also interesting is the last part of the article which talks about the challenge.

I mean, traditionally, from what I understand, and folks certainly can jump in, is that preconceptual healthcare and interconceptual care has primarily focused on women and around reproductive issues, having healthy pregnancies, having healthy outcomes, but there has been also now looking at just how do we keep women healthy, either around pregnancy, before pregnancy, after pregnancy, and I know in

my own background when I think about interconceptual care now when is that? Is it when you're a teenager or is it in between pregnancies and what about after pregnancy, and the article alludes to that, that the whole notion of trying to determine what this is, is very nebulous.

But I think there has been certainly a shift to looking at more of Well Woman care and that if women are healthy, regardless of where they are in their life course when pregnancy comes or happens or they're thinking about it, their health would be in a better state.

I think we talked a little bit about some of it, the issues that still haven't been addressed and I think she talked a little bit about that in the slides and being more inclusive in our, I guess, care as we think about women and that there are perhaps some priority groups around women with chronic conditions and chronic illnesses and/or diseases that may be contemplating pregnancy.

We also know that there are many more women being incarcerated now and how do we manage their preconception care and interconception care, as well as the whole issue around some of the mental health issues that women maybe or birthing people. My last doctoral student told me I needed to be more inclusive in my language, so the pregnant people and/or birthing people and the overlap between mental health and substance use and the impact upon just health, in

general, but certainly pregnancy health.

So, I think one of the things that Sarah and I talk about is what's next, what hasn't been done, and as Joy mentioned, what are the things that are working and are they things that need to be brought to scale? Are there voices that should be in this discussion as we move forward and what are the areas that we ought to be thinking about and that could be recommendations to HRSA that would be something perhaps that they could take actions on, or the Secretary might be able to be proactive on.

I think we will just have a general discussion. I will say that this workgroup already did set its meeting times. And I think, Vanessa, towards the end of our time, you might be able to remind us. I know it's a Wednesday and I can't remember. It's on my calendar, but I can't remember whether it's the second or the third or the fourth, but we hope that you will continue to join.

And if there are people that you also think that are not here for whatever reasons today, but you'd like us to reach out to, to include in this workgroup, please let us know too. So, Joy, perhaps your vision or discussion around what the group should be thinking about or working towards?

DR. NEYHART: At the detailed level, I'm not real good at that, but from sort of the very high, altitude view, improvement won't necessarily happen without more of a

foundation in how we treat mothers and children in the country and so I'm going to not be very good at specific programming and specific recommendations, but backing up toward how can we convince policymakers and where other funding goes in terms of shoring up things like early childhood education where the foundation for healthy people and healthy women begins that's broken much further down the line. Does that make sense?

DR. SHARPS: One of things too that Sarah and I discussed when we met previously is that messaging is often a challenge too. How do we, I think, in this heightened time too when words matter and it's very easy to be offensive, even though your intent is good, but how do we develop messages around preconception health or interconception health that was sometimes perhaps maybe related to family planning without being offensive, but also honoring the autonomy of women to participate in decision-making about how they manage their reproductive health and/or fertility or those kinds of things.

I see that we have someone that just joined, Deepika, we introduced ourselves, so would you like to take a few minutes, and welcome, to introduce yourself?

MS. MATHUR: Thank you. Hi, my name is Deepika Mathur and I am working at NCAH at the California Department of Public Health and my role there is an epidemiologist

and -- scientist and I have pretty broad background and I'm interesting in listening to you all because -- sorry I came in late -- prior to what Joy was saying and I believe what you're talking about is how to get those messages across, like you said, Phyllis, in a non-offensive way when you're talking about their health and I'm sure you've all probably already touched upon it, but obviously educating and informing communities and people, women before they get pregnant I think is a difficult task because until they're pregnant they may not be focusing on that, but I think that is something that I think the Public Health Department is trying to continue strategies and come up with other different methods to go ahead and try to reach those communities and people, who if they know about the difficulty aspects of pregnancy, the risk factors, the challenges that they might be facing, if they're more in tune with it, then it might prevent some of those problems down the road.

So, without having a good context of what you were all you talking about.

DR. SHARPS: I think we're just having a free, open discussion about where we would like to go and what needs to be addressed, where there are potential gaps. And I do see that Anna was able to join us again. So, Anna, we were introducing ourselves if you would like to say a few

words.

MS. LIPTON GALBRAITH: Hi, good afternoon, and I apologize. I've been having some internet issues this morning and keep getting kicked off of Zoom. It's so nice to see everyone. My name is Anna Lipton Galbraith and I'm with the National Academy for State Health Policy. I focus on our maternal health portfolio of work and excited to be with everyone today.

DR. SHARPS: Thank you. I love to hear from everyone and if people didn't get the article from Sarah, the speaker from yesterday, if you maybe could put that in the chat, we'll be sure that everyone gets it. I think was a very good piece and, I think, helps lay some of the groundwork for what this workgroup begins to focus on.

The one thing that I though was very interesting is, and the good news is that there's going to be funding for postpartum visits in a number of programs, which is part of, I think, of the preventative aspect is whether it would be reasonable to think about universal Well Woman visits and supporting that and where might that fit.

One of the things that I think that probably is some of the lack of evidence we have is we don't have any real evidence or research that would support -- I think we all know what the benefits of the well woman visit would be, at least annually, for most women, but I don't know that

there's a lot of research or data about why that's important.

MS. MATHUR: If I could quickly share, it's a very good point that you're bringing up, and well woman care I'd just like to share right now that we're actually doing research and we're going to be having a paper come out specifically on that topic about sharing some of the evidence that we have on postpartum results and what's needed, and part of what you said is crucial, which is that women do need postpartum care and it's for a particular time that was previously supposed of when they were at higher risks.

So, even though it has been known by the commissions, et cetera, for some time there are strategies underway that we will be addressing that, and I think it's a really crucial point because women after their deliveries there's not so much focus on them six months down the line, eight months down the line, even up to a year. It kind of shifts to the babies and so they actually don't get that much care, so that is something that I think you will be seeing more in the future and we are working towards that now to at least try to publicize this and make known that this is actually a big problem and we actually connect with the Well Woman visits as well because you do get that prior to pregnancy, but it is crucial, after delivery there's a lot of physiological changes that occur to the pregnant person and those need to be monitored for a longer term than they have

been. So, really great point there. Thank you.

DR. SHARPS: I think some of the research might need to be what's the value added of both the postpartum visit, which is what you've addressed, the changes and that kind of thing. And then, in the well woman visit, which I believe is different than the postpartum visit, but that there needs to be both, and that women's health is important even after they are on the context for the pregnancy.

I always used to joke that I thought they should put child and maternal health that way because really sometimes I think people are only interested in women because they're more focused on that the baby comes out healthy and once that happens, you know, you're kind of on your own kind of thing.

The issue also too is that we do have women who are living longer with chronic health conditions that reach the childbearing age and so they are managed very well if they're able to get into care and have good quality care. They manage very well during the pregnancy and up to postpartum, but there may be some long-term changes to their underlying chronic condition as a result of the pregnancy that probably also still need to be managed.

And there was another kind of population group that may be neglected or may need to be addressed in this preconception, interconception care, and that is that

transition of youth from 18 or so when they age out of pediatric care, but that 18 to 22 where they're pretty healthy, but maybe not ready to go to the family practice or the internal medicine kind of care and again having those medical professionals prepared to talk about issues around preconception, interconception for that particular age group. Some developmentals call that the emerging adulthood stage.

We have over a year or so to work on the issue and come up with our recommendations, I believe, and Vanessa can correct me. I believe Belinda said it would be towards the end of 2024 or early 2025 that we would be presenting recommendations.

MS. LEE: Yes, that is what I remembered as well, Phyllis, that we want to put forward the recommendations to HHS around early 2025, so hoping for a draft maybe by the end of next year 2024. And I think, too, in trying to narrow in your focus, I think Belinda had suggested two to three recommendations from each workgroup so that it didn't get too large, like the former report for AIAN was 59 and she wanted something a bit more succinct, I think, fewer recommendations, but obviously very actionable, so less is more this go around.

But the other piece, Phyllis, I just want to emphasize that Belinda has been saying in all three, and for those that are new to the workgroup, the overarching

recommendations that are being made are to improve Black or African American maternal and infant health specifically and to hone in on that population.

So, then my question to Phyllis and Joy and the group, and maybe this is something we need to explore if it's not known within the group currently, are there any unique challenges to Black or African American women or birthing individuals that would help to narrow in the recommendations?

DR. SHARPS: Let me pause. We have someone else that just joined, and I don't want to butcher her name. I need to hear it one time and thank you for joining us.

DR. CHAKHTOURA: My name is Nahida Chakhtoura. Nahida is easier than my last name. I am an OB/GYN by training. I am the Pregnancy and Perinatology Branch Chief at NICHD, so I'm the federal partner. And I am new to the group, even though I participated briefly in the initial introduction meeting, so I'm new to the working group, so happy to be here and happy to weigh in on anything that you need, any potential research that needs to be done or publications to look through, I'm happy to do that from our end.

DR. SHARPS: Thank you. So, I do think that the issues that come to my mind for the African American population, and we may also want to think about if pulling out recommendations from the most recent reported challenges

with the American Indian, Native Alaska population, but certainly access to care is a big issue. And I think also issues around sexually transmitted diseases and the prevention messages that come with using appropriate protective measures that not only protect from pregnancy, but also those diseases.

And I think we heard yesterday that syphilis is really increasing. I think Baltimore City is the chlamydia town. That's one of the ones that we struggle with tremendously. So, certainly, the issues around social determinants of health, I think, are challenges for this population of women.

Don't shoot the messenger, but my work is domestic violence and pregnant women. There are a lot of issues around reproductive coercion in terms of either being forced into sexual acts or being prevented from using safety protection kinds of things and/or if you happen to be using pills or any of those kinds of things are often a challenge for this population.

DR. CHAKHTOURA: Can I also add to things, if at all possible, from research that's been done at NIH? One is intimate partner violence leading to homicide, especially in areas like Louisiana and access to care in rural settings. It's also individuals who live in rural areas have increased risk of morbidity and mortality.

DR. SHARPS: I'm just finishing a book chapter on IPV and infant mortality and maternal mortality and severe maternal mortality. And we know that homicide females during that pregnancy period, pregnancy associated are on the rise, are very complicated and that also further complicates decisions that women are able to make about using or participating in preconceptual care.

MS. MATHUR: I also wanted to add to what Vanessa was saying earlier about focusing on African Americans, other minorities, and the access of care, so as this is a topic of interconception and post-conception, I would say that there is also research coming out and we're doing some of it now, focusing on what I was talking about earlier is that we have to have strategies to focus on young adults who may not yet be pregnant.

And then again, also make the connection between that longer postpartum care and then the well woman because once you have that postpartum care for the woman in the longer term, let's say for a year instead of just the current 42 days, once that's done they will be monitored and then they will continue to be monitored if risk factors arise or if they're dealing with other conditions due to the pregnancy itself. And when they're being monitored, obviously, if there are other conditions they also could be seen and then managed appropriately.

The other thing I just wanted to also mention was that I think one of our speakers spoke about it in family practice, but that's also something that research is showing is that there are a multitude of specialists and other clinicians who can play a role in taking care of women who are about to become pregnant or will become pregnant and those have been. And so, that's also something that we are currently looking at and will be sharing our results, but that's actually an important part of it because it has to be on everyone's mind what the complications can be down the line or before they even get there, so a lot of things can be prevented just by making sure that they're optimized medically and that includes mental health, a lot of other aspects of the whole person.

DR. NEYHART: I have a question for the group. Have any states actually or are any states actually providing Medicaid coverage 12 months postpartum or even more than six weeks postpartum yet? Does anybody know that answer?

DR. CHAKHTOURA: Yes, I think that there are about 26 states, but I can look it up.

DR. NEYHART: Okay. So, in the period of time that they've expanded that coverage, how has that improved the health of these women? Because if we could use that as a recommendation because I don't know that Medicaid can mandate that kind of thing for every state, but as a suggestion. I

don't know. What do you think if we could get data. If we can get data on improvement of outcomes and even perhaps decreased subsequent pregnancies just because the healthcare is provided and maintained, I don't know, that seems like a place to start from.

DR. CHAKHTOURA: So, I can say this, that California is again looking very closely. We've done the research, and we will be coming out with a paper that will share what we found in terms of monitoring these women a year out. It's a little bit different than currently what some of the other states do in terms of postpartum care, which may only be up to 42 days.

So, we have looked at that longer timeline of a year and the results do show that there are many more women who do become I'll just general terms, and again, because we haven't really released the data yet, but they do have more conditions due to pregnancy even a year out and so that group might be some kind of data that you could use to support the recommendations that you might be making. And I'm happy to speak to somebody afterward, if you'd like some more information on that and some more details.

DR. SHARPS: Along those lines, is there any evidence, and I'm thinking about the impact on having the postpartum visits and workplace participation and/or. I mean one would assume that if women had that visit and were given

conditions that were well managed that they would be able to be a workplace at the appropriate time when they're cleared to come back, but also not missing a lot of time or their work performance or something would improve because of having this. I mean, I think, those are the kind of issues, certainly the health issues, but then, I guess, the impact on overall quality of life or being able to assume their activities of daily living or that kind of thing.

I think about when the work that was done around breastfeeding and making workplaces more friendly to and accepting to breastfeeding and having pumping rooms and that kind of thing, and part of the discussion was that women would be able to participate more in the workplace and they didn't have to miss time or have to make decisions on -- so there was an economic impact that was also described as a part of the value of doing that and I wonder if there was research related to that or antidotal evidence.

While people are thinking, Sarah Henry just joined us. Would you like to say hello, Sarah?

MS. HENRY: Hello. I'm sorry for joining late. I'm just really looking forward to listening to this conversation and learning from you all of the work that's happening to the communities and what can be done moving forward.

MS. ALLEN: I just put the PDF of Sarah's paper in

the in chat. Please let me know if anyone isn't able to access that.

(No response)

DR. GOLDIN: So, I just wanted to go back a little bit and touch on the labor force participation issue. I mean, I think, there's not only a lack of access to care as in the ability to reach a physician or healthcare professional, generally, but there's also the lack of access to time off from work to be able to seek that care and so Women's Bureau we have data about who has access to FMLA and how that's used and then who has access to the state paid leave programs or paid leave, generally. And it's no surprise that employer-based benefit for paid leave is largely for higher-wage earning jobs, so that's leaving out a large portion of the labor force. And if you slice that for race and ethnicity, it's unsurprising that we would see that Black women have difficulty accessing paid leave and paid sick time, generally, to seek that medical care.

So, I think it's important to have that as part of the conversation as well so it's not just about the medical recommendations, but actually that that's tied to the ability to access those medical recommendations. And I think that there's a real opportunity, frankly, for data on -- I mean there's a lot of data on research on health outcomes of having access to paid leave and I don't know how much of that

has been done through a race and ethnicity lens, but has been done through maternal and infant health outcome, looking at that in California is usually the state because it is the biggest and also has the longest standing law on paid leave. There's more research based in California, but I think research that shows the benefit of health outcome always is important. But there has been less research on how that benefits in the preconception stage and then long-term afterwards as the birthing parent and child are aging.

DR. SHARPS: Thank you. I mean, it's been my experience that very often some of the work we did around trying to promote breastfeeding in African American women they often are in jobs that have no health benefits and/or they're hourly paid workers. Even though maybe there is a breastfeeding support theme that's clinic or something that's free, but if you have to take time off from work to be able to do it, then it really isn't free.

So, in trying to make the choice of do I work, or do I seek healthcare, you know what most people are going to pick, I think, we need the funding and that kind of thing. One of things that we've seen in these downturns in the economy women that are in the labor force sometimes are in the service fields, hostess fields that tend to not be as impacted, so there's a pressure for them to continue to work, whereas, if they have a male partner they maybe in a job or

industry that was very much affected, so now we have kind of the tables turned. She becomes the sole breadwinner or the only breadwinner and so working can be really challenging.

MS. GOLDIN: Right. And I do think that the PUMP Act and the Pregnant Workers Fairness Act went into law in December 2022, so if a research recommendation is happening in '25, it would be interesting to see if the data trends that people, both their health and their labor force attachment is impacted by the implementation of those laws.

PUMP basically expanded the group of people that are covered under the Fair Labor Standards Act. I mean they didn't cover them under the Fair Labor Standards Act. Do not quote me because I'm not doing the good Wage and Hour description of it, but basically more people now have protections for pumping in the workplace and Pregnant Workers Fairness Act provides for robust accommodations in the workplace for pregnancy and the ability to take that time off, although not requiring it to be paid to be able to seek care.

So, being able to look at whether that impacted health and people's attachment to the labor force during that time period would be useful information.

DR. SHARPS: I mean, I think, that also looking at, I guess, some of the models or how they were able to come -- I mean, if there's something that we can learn from

that in terms of best practices or to move into recommendations around the care that we're talking about we may give some consideration to.

DR. CHAKHTOURA: I did a quick public search. There are seven articles and I just put them in the chat so that everybody has them, or if you'd like to send me somebody's email address so I can send them that's another option.

DR. SHARPS: I hope Vanessa and Emma are catching everything in the chat.

MS. ALLEN: Yes. The chat will be saved.

MS. LEE: Yes, the chat will be saved, along with the transcript.

DR. SHARPS: Okay, thank you. So, I guess, from everybody's perspective or the agencies that you work with or the patient population that you work with, where do you see or what are glancing gaps, I guess, from your own perspective you think in the world of preconception, interconception care?

DR. NEYHART: Gaps seem to be access, but also education for young kids, and I'm not sure, can we target that as well. In the places where I work, the care is available. Alaska is a state that has a pretty generous Medicaid Program, and its eligibility is easier than maybe in some other states and then there's also the Tribal Health

Program, which is very differently and much better funded than lower 48 IHS.

So, from my perspective, it's not that the care isn't available. It's making sure the connections get made, but I can't speak to other communities.

MS. MATHUR: I would agree with that, Joy, that I think that in many instances, the care is there, the options are available, but the gaps seem to be in letting those communities and individuals basically know about it, that they can do this, and this is available to them. That still seems something that I think we can try to emphasize more or publicize more.

DR. CHAKHTOURA: I agree also with the education component because most women come into care when they are pregnant as opposed to understanding, especially if they have any high-risk conditions or they have hypertension or diabetes or anything else, to discuss care and improving their health before they become pregnant. I think there's a dearth of that.

MS. GAMU: From my experience, there's been a lot of talk about what we can do better to reach people before pregnancy like what's happening in the working groups, but there hasn't been anything actionable that's been made because we talk a lot about postpartum, but we don't really talk about reaching people before they even get pregnant,

which is why I joined this conversation today to learn what more can be done and get that information to the groups that I'm in.

MS. MATHUR: That's an important point and thanks for making that point. I would say that our state actually, and I would imagine most every state, has programs where they have perinatal programs where they are trying to reach out to communities. And in California, we are aware of and really try to stress communities that are vulnerable and that there are communities that show disparities of healthcare access, so there are programs that actually make this their mission. And so, I would say that is being done, but again, there is room for improvement, and I think that as more of this comes about and we discuss this and perhaps we can strategize.

Like I think part of this workgroup could be that all of here have different interactions and we can think about what types of programs might help and maybe to publicize that, like what would help your particular community or the ones that you're linked with or know about. What would help those individuals. And then make sure that you get that information to a jurisdiction or an agency or what have you who do those programs to let them know about and then they can take it from there since they are set up to do that work.

MS. LEE: And as I've been listening, I'm trying

to also remember and think what federal investments or programs either previously existed or currently exist related to all of this and I don't know if anyone remembers the Office of Minority Health used to have a preconception healthcare educator program and I just Googled it to see. I don't think it exists any longer, but I'm wondering if we could have someone from OMH, Office of Minority Health, just talk a little bit about that program, maybe what came out of it, and if this is something that the Committee would recommend bringing back or adopting. It would be interesting to hear some of the lessons learned from that, but it was specifically to address the persistent disparities in infant mortality by again reaching people younger or earlier before they actually got pregnant. And I know it worked a lot with colleges, so there is a paper. It looks old now. It's from 2019, but I'll put it in the link, and there was a group that, I guess, adopted OMH's program to increase preconception health knowledge among African American women at risk for at-risk birth outcomes. I don't know if anyone else on the call remembers that Office of Minority Health Program.

DR. SHARPS: I don't remember that program, but I do remember that there were in late, like you said, 2019, 2020, a lot of peer education for that for college campuses around that, taking care of your health. Some of them were

kind of issues around protecting yourself from sexual harassment and that kind of thing, but the idea was promoting health and what resources.

Someone mentioned that other healthcare providers or members on the health team could be involved in preconceptual counselling, so it may be also -- I think best practices are there. Also, scripts or quick trainings on how to incorporate that kind of message in any kind of visit when you see your physician or your family physician or your primary care or something. Is there a brief message or couple of questions that could be asked to access that and maybe connecting people with resources or community kind of things might be something maybe in a toolkit around how a variety of providers could message or connect people to services.

MS. LEE: I'm going to put that in chat, like that was part of the work of the preconception COIIN Sarah Verbiest led. They did have just provider tools and I think it was scripts or the actual screening tool and then what to do if you got positive screens on certain factors, so I think they did have a heavy emphasis on provider training and tools, so I'll look for that.

DR. SHARPS: Well, I guess if there's any publications around that or research or anything about -- I like the idea and I've said this in our other meetings of the

Advisory Committee is that it seems that many programs are funded and on a variety of different topics, but if we could identify some of the best practices that maybe being done in small communities or just around and we view them and if there's any evidence and then either making it available as well as thinking about how they might be scaled up to reach larger communities or larger groups of more people.

I think there's a lot of good work that goes on in the many communities in the United States, but I don't know that people are always aware of those things.

MS. GOLDIN: In thinking about yesterday's presentation, I'm also just wondering are there other data gaps that would be good for this workgroup to identify and put into recommendations. There was some talk yesterday about changes to reproductive health laws and their impact for long-term health. And also, as you were talking right then about education of providers, that makes me wonder as those laws are changing in the state level if that is something that's affecting long-term -- you know, you're not learning how to access care or what your care should look like younger and so then that's having long-term effects. Is there a way to capture that.

And from the Department of Labor standpoint, we know that access to birth control, in particular, is a way in which we ensure that women stay active and engaged in the

labor force and what will the long-term trends of that be as state laws change that might limit them access.

DR. SHARPS: One of the things that Sarah and I talked about is just the eroding of the whole notion around reproductive justice framework and the eroding of some laws or things that were available to women that in some places being dismantled or done away with and what is the long-term impact. And I think one of the things too even to think about is even the workforce issues in terms of providers limiting some of the services that they provided before because of changes in state laws about abortion care and that kind of thing and making decisions about what they need to do to maintain their practices or not and then are there certain things in maybe counseling that they would've done that they're not doing now, that kind of thing. I see Belinda has joined us. Would you like to say a few words to the group?

MS. PETTIFORD: No, I'm actually listening, Phyllis and Joy. I just want to make sure I get a chance to listen in to all of them, so thank you all. Appreciate everybody that's interested in this work.

DR. SHARPS: Thank you.

MS. PETTIFORD: Thanks.

DR. SHARPS: We have about maybe 15, 20 more minutes before we wrap up, but I would like to continue the discussion a little bit longer on either gaps or things that

we should look into because I think that after this meeting, Joy and I will probably talk to Vanessa about what we might need for our next meeting. I think the next meeting is in January.

Would we be able to have, if they were available, a speaker or someone to come in to talk with the workgroup at some point?

MS. LEE: Yes. That can be definitely an area that we could support and offer assistance in, any future speakers.

DR. SHARPS: I think we might also put together a reading list of the references that people are putting in the chat so it's all in one place and maybe links to them, so if people want to do even more background reading before we meet again in January.

And I think you'll have my email and Joy's email, and if you're anything like me, after the meeting is over, you'll say I should've said this or what about this. So, if other things come to your mind, just shoot an email and we'll be happy to add that discussion is in January.

So, so far, what I've heard in terms of potential gaps around access how to create a more seamless way -- in many areas the services are available, but perhaps people don't know what they are or what they are entitled to and how to make communities more aware.

Education was spoken to a number of times in terms of young people, as well as focusing on education and increasing awareness before pregnancy and not only just during the pregnancy or after the pregnancy. Maybe taking a look at best practices and best programs and if there is any evidence around those and I think especially if any of them have been funded by HRSA or any of our partners. That would be interesting to look at.

We talked about the Office of Minority Health who had a peer counseling program at one point for young people and Vanessa is going to do a little bit more research to see if that's available.

I would love to hear more about the provider toolkit from COIIN that Sarah talked about yesterday, if there's any information for that and potential data gaps or where we might address some of those issues.

So, anything else that we should be either in our discussion or are there other people or agencies that we should reach to out specifically to include in our workgroup? What voices aren't here that should be here?

MS. PETTIFORD: Phyllis, I wonder do we want to also reach out to some of our other national partners who have been working in the area of preconception, interconception care to see if any of them want to have a representative here. Several of them that have presented

over time have shared some of that information, so this might be an opportunity to reengage them. You and I can talk offline, you, me, and Joy.

DR. SHARPS: I know Sarah is attending a conference, but she said that she would be interested, so I would reach out to her again. I know we had a presentation from a family planning association, but I wonder also if National Planned Parenthood should be here or have any interest in joining or a representative. They've been doing this work for a long time, I think.

MS. GOLDIN: And they have a new initiative for Black women, focused on Black women in the past year.

MS. MATHUR: I'm sorry to ask this question, but since I missed the beginning, would you mind just summarizing what specifically this workgroup, what its aims are and also at the next workgroup who are you requesting to attend?

DR. SHARPS: We have kind of a nebulous charge and that is our general goal is that we are to come up with two to three, maybe four recommendations to go forward from this Committee to the Secretary around preconception, interconception health with a focus particularly on African American women. And I also thought we should look at the last report we put out on American Indian, Alaskan Native women to see if any recommendation was in there that we may also pull forward because these are two very high-risk

groups, and they need to be actionable. Things that HRSA would be able to follow up on or take some action on.

I suppose Joy and I, after this discussion, may maybe develop a charge and maybe a couple of goals and we could certainly circulate that before our next meeting and have a discussion on that. What I would not like to see is that we get so bogged down on that that we don't -- I've seen workgroups do that.

So, I think that we could have a working charge and goal, but keeping in mind that our deliverables would be the recommendations that would come forth from this workgroup to the Committee and then from the Committee to the Secretary.

MS. MATHUR: This workgroup is rather broad, so it's not constricted to certain agencies or anything from what I can gather, right?

DR. SHARPS: I think any agency that would have a voice or that may be a part -- I know there's an initiative on housing and health. Whether or not there would be a role to have a toolkit or information or messaging for that group, but we do know that homeless women or women who are unstably housed has lots of health issues and it does impact pregnancy and pregnancy outcome. So, it's something to think about. So, if you think about who's missing that might help us as we begin to craft, and I would think too, and I could be wrong,

and Vanessa and Belinda will tell me, but I think we want to have recommendations that would build upon what has already been done, but are the next steps and maybe in some way address persistent or existing gaps.

DR. NEYHART: The two things I jotted down from this discussion are there recommendations that need to be made regarding Medicaid coverage for women for at least 12 months after giving birth and can that be crafted into some sort of recommendation, given that only a few states it or not all the states are doing it, and is there data that we can use about improved health of this population once that care has been provided.

And then the second thing, of course, is working on the recommendation around including lower-wage employment for paid maternity leave. So, those are the two that I jotted down that we've discussed.

MS. MATHUR: Thank you.

DR. SHARPS: And that last point that Joy made we thought was particularly pertinent to many African American women that are in low-wage, hourly-type jobs and may impact their access and even maybe their ability to pay for care and the recommended therapy based on the care.

And I think underlying all of these recommendations would be, being sure that we are sensitive to the needs of African American women, who, across the board,

whether they're low wage, whether they have insurance, whether they're well educated, are still challenged with poor birth outcomes for interconception era.

I think that that might be reflected in the sensitivity to culture and the messaging and the words we use and the framing that we hear yesterday too.

DR. NEYHART: I was reading something yesterday morning before the meeting, and I didn't write the reference down, but it's basically what our goal is to help guide policies that will simultaneously improve the life trajectory of two generations, which means translation to improvements for the entire population. So, I guess framing things in the benefit for the whole country rather than we want to just benefit this group. It translates to better abilities to maintain jobs. I'm not being very articulate, but I think you understand where I'm going.

DR. SHARPS: I think what was salient to me about Dr. Sweetland's presentation about framing is how you are able to make a recommendation that doesn't blame the person that we're focusing on, but also doesn't make the other people that we want to change feel guilty or feel that it's their responsibility or why should I care kind of thing. So, I think that that's one of the challenges around messaging around some of the preconception issues.

Sometimes when you talk to particularly Black

women about using contraception or birth control, I have had women become offended because now you're telling me how many children I can have or that kind of thing. And so, how do you give a message that really just talking about your health and how you manage your health.

Well, we are about five minutes from closing down. I think this probably is going to be the only break we have before we start at 2:00. I don't know if there are any more parting words before we go. I think we are ending at 1:30 and then we restart at 2:00, is that the way the agenda goes today?

MS. LEE: Yes. We break at 1:30 and then return back to the full Committee meeting Zoom link, which is that main Zoom link that everyone was in yesterday at 2 o'clock.

Phyllis and Joy, you mentioned sharing the cadence of further meetings or our frequency. It's the third Wednesdays of every month from 2:00 to 3:00 p.m., Eastern Time, starting in January. So, that's January 17th, from 2:00 to 3:00 p.m., Eastern Time, and after the January meeting, it'll be every third Wednesday. And these are meetings between the full Committee meetings. We anticipate the next full Committee meeting being in April, which we'll talk about later with Belinda.

I did put in the chat if you're not an AICMM member or ex officio member and you would like to stay

engaged with this workgroup or continue participating in the workgroup meetings, if you could just shoot me an email at CMM@HRSA.gov.

We can pull together a little list and also make sure you get the emails with all these resources or anything that the co-leads want to send out and then we can also put you on the meeting invites. I'm just not sure we have everyone's email address that is on the workgroup right now, so if folks could email me, I would just make sure we have your name and email contact information.

Phyllis and Joy, I was also monitoring the chat. We did get another suggestion for an entity to possibly engage the Office of Adolescent Health at the federal level. Thank you. And then we will Save the Date invite for our meeting schedules. If we have your email address, again, we'll be sure to include you on the meeting invites or Save the Dates.

Phyllis and Joy, I noted some other federal groups you could invite to the meetings in the future or just to present on what they know of what's going on or has been done. That would be the Office of Minority Health we talked about. We also have an HHS-level Office of Women's Health. WE also have Offices of Women's Health was in all of the different agencies. Like CDC has their own Office of Women's Health. HRSA has their own Office of Women's Health. And

then, CDC, I feel like it's missing from this group, as well as the Office of Population Affairs, OPA. They're the ones who manage Title X and all the Title X clinics in that program. They might be a good entity to have in our conversations going forward.

DR. SHARPS: I know also NIH has an office or a Division of Women's Health.

MS. LEE: True. Right.

DR. SHARPS: I'm on that Advisory Committee too, but we just finished our strategic plan, but it might be at some point interesting just to have them talk about their research portfolio related to this issue, if there's any.

Joy and I will attempt to also develop an agenda, but I think this meeting was good to have the free discussion. And if there are items that you would like us to discuss or think about that should be included on the agenda, maybe if you could send around January 10th or so, so we'd have a few days to get the agenda together.

You may come across a paper or something that you would like for us to be aware of or read before the meeting, if you would send those, we will send all of that out with the agenda also.

Okay, it is now 1:27, and I don't have anything else to say. I would like to thank everyone for attending and their participation and sharing your ideas, concerns, and

suggestions with us. That's been very helpful, and I hope in the next meeting I won't be talking as much.

Okay, if there is nothing else, I think we can just adjourn this meeting and I'll see everyone again at 2 o'clock.

MS. LEE: Thank you. Thank you, Joy, and Phyllis, for your leadership.

DR. NEYHART: Thank you, Phyllis.

MS. PETTIFORD: Thanks, everyone.

(Whereupon, the meeting was adjourned)