The Secretary's Advisory Committee on

Infant Mortality,

US Department of Health and Human Services

Data and Research to Action

Workgroup Meeting

4:42 p.m. – 6:05 p.m.

January 25, 2021

Attended Via Webinar

Reported by Gary Euell

1 **WORKGROUP MEMBERS**

2 **Alison Cernich, Ph.D., ABPP-Cn**

3 *SACIM Ex-Officio Member*

4 Deputy Director

5 Eunice Kennedy Shriver National Institute of Child

6 Health and Human Development

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8 **Jeanne A. Conry, M.D., Ph.D.**

9 *Workgroup Co-Chari, SACIM Member*

10 President

11 Environmental Health Leadership Foundation

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13 **Danielle Ely, Ph.D.**

14 *SACIM Ex-Officio Member*

15 Health Statistician, Division of Vital Statistics

16 Centers for Disease Control and Prevention

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18 **Rosemary Fournier**

19 Fetal Infant Mortality Review Director

20 National Center for Fatality Review and Prevention

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1 **WORKGROUP MEMBERS - continued**

2 **CHARLAND D. KROELINGER, PH.D.**

3 Acting Director

4 Division of Reproductive Health

5 Centers for Disease Control and Prevention

6

7 **Magda G. Peck, Sc.D.**

8 *Workgroup Chair, SACIM Member*

9 Founder/Principal, MP3 Health Group

10 Adjunct Professor of Pediatrics & Public Health

11 University of Nebraska Medical Center

12

13 **Paul H. Wise, M.D., M.P.H.**

14 *Workgroup Co-Chair, SACIM Member*

15 Richard E. Behrman Professor of Child Health

16 Policy and Society

17 Stanford University

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1 **WORKGROUP MEMBERS - continued**

2 **ALSO PRESENT:**

3 Gina Obiakor

4 Gary Euell

5 Tina

6 Emma

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1 P R O C E E D I N G S
2 **DR. MAGDA PECK:** There we go. How's
3 that?
4 Is that a little better?
5 **DR. JEANNE CONRY:** And I'll take notes.
6 **DR. MAGDA PECK:** Okay. I'm sorry, you're
7 going to take notes? Who said that?
8 **DR. JEANNE CONRY:** Jeanne.
9 **DR. MAGDA PECK:** Jeanne, actually you --
10 please do that and I think Gina, can you take
11 yourself off mute and let us see you for a second?
12 **MS. GINA OBIAKOR:** Hi, everyone. Let me
13 turn on my camera.
14 **DR. MAGDA PECK:** All right. So, I want
15 to do just a little bit of housekeeping here for
16 folks to be able to do what you need to do. We
17 have about seventy-five minutes of extraordinary
18 exhale after having inhaled for five hours. I
19 want to see if there's -- do a quick once-around
20 for introductions, but so toward that end, if
21 everybody would themselves on video so we can get
22 a visual of you, that would be great as we go once

1 around. And I have just a slide or two to put up
2 so that people can sort of have a guidance for how
3 we're going to move our time.
4 So, we're going to start in gallery, then
5 I'm going to do a quick switchover into a share
6 screen from my side if I can do that -- if you
7 would give me permission to do that, I'd be very
8 grateful, whoever is in charge of that, maybe
9 Emma. You're the one that's going to make that
10 happen that I, as your host, can make that happen.
11 And then we're going to have a fast and furious
12 one hour to try to render out what we can do and
13 seize this moment.
14 While I'm doing the once-around, let's
15 see -- Emma made that happen. Good. Emma, you're
16 going to give me -- and what I would like to do if
17 the people do have a chat, if there's one or two
18 kind of aha, something that you heard, this is
19 your first thing. I mean, some people like to
20 multitask. If there some -- something you said I
21 didn't know that, something that I discovered,
22 something that is just like extraordinary,

1 something really urgent, what is one aha you want
2 to make sure you ante up with? That's what you're
3 going to put in the chat box. So, that's the
4 multitask as we go around.
5 Jeanne, we're going to start with you,
6 and I'm just going to do a rapid-fire quick intro,
7 your name, where you're from, and one thing people
8 need to know because we have a couple of people
9 who don't know each other here. If you would do
10 us there.
11 **DR. JEANNE CONRY:** Okay. Jeanne Conry.
12 I'm retired from Kaiser Permanente, past president
13 of ACOG, incoming president for FIGO, the
14 International OB/GYN Society, and my -- I don't
15 know, the aha is just Paul's entire presentation
16 and the summary about the refugee status and how
17 serious it is when we compare Latin America to the
18 rest of the world. I just don't think anybody
19 appreciates it.
20 **DR. MAGDA PECK:** Thank you for that.
21 Rosemary, you are next.
22 **MS. ROSEMARY FOURNIER:** Thank you, Magda.

1 Rosemary Fournier. I work at the
2 National Center for Fatality Review and
3 Prevention. My role there is FIMR support, Fetal
4 and Infant Mortality Review, to our 160-some local
5 programs. And my aha, like Jeanne, was the
6 stories that we heard from the nurse midwife who
7 explained, you know, the stories of the families
8 at the border. Those, I will never forget. They
9 are going to stay with me.
10 **DR. MAGDA PECK:** Thank you for that. I
11 appreciate it.
12 Danielle, let me hear you and see you.
13 **DR. DANIELLE ELY:** Hi, I'm Danielle Ely.
14 I work at the National Center for Health
15 Statistics and I manage the Linked Infant
16 Mortality File. I think, I don't know if it was
17 so much as an aha moment for me, but I was glad to
18 see that the data that we're collecting matching
19 the maternal COVID with outcomes seems to be
20 matching what other sources are finding. So,
21 that's a very good feeling to see that
22 consistency, I suppose.

1 **DR. MAGDA PECK:** Thank you for that.
2 Paul Wise. Good to see you, Paul. Brilliant this
3 afternoon.
4 **DR. PAUL WISE:** Thanks. I'm Paul Wise,
5 Professor of Pediatrics of Policy and
6 International Studies at Stanford.
7 **DR. MAGDA PECK:** Any aha you want to ante
8 up with?
9 **DR. PAUL WISE:** I was aha'd by the scale
10 and diversity of programs that are relevant to
11 this committee and the requirement and the
12 inherent difficulty of trying to coordinate all of
13 them in some manner that's both effective and
14 efficient.
15 **DR. MAGDA PECK:** Aha. Allison, you found
16 your way in. Quick introduction, where you're
17 from in case folks are just coming in now and one
18 thing -- that aha that you heard today that really
19 stuck with you.
20 Can you hear me, Alison?
21 Okay. So, can you give us a quick intro?
22 You're on mute.

1 **DR. ALISON CERNICH:** Sorry about that.
2 Alison Cernich, Deputy Director of NICHD.
3 **DR. MAGDA PECK:** And is there one thing
4 that you heard over the last five hours that is an
5 aha or has stuck with you?
6 **DR. ALISON CERNICH:** I think just the --
7 some of the data from NCHS, I think, just
8 resonated with me as we start to look at our
9 pregnancy data. They're not representative. I
10 think it really highlighted what we need to
11 concentrate on with respect to pregnancy.
12 **DR. MAGDA PECK:** Thank you very much for
13 that.
14 Charlan, welcome to our group. We are
15 happy to have you here from CDC. Quick intro and
16 any aha that you want us to hear from you.
17 **DR. CHARLAN KROELINGER:** Hi, everybody.
18 Charlan Kroelinger.
19 I'm the Acting Director of the Division
20 of Reproductive Health at CDC. I'm happy to be
21 here and Paul, I really liked your policy slide
22 where you showed the impact in numbers of the

1 changes in policy over the last four years on
2 immigration. Very interesting, thank you.
3 **DR. MAGDA PECK:** Thank you for that.
4 **DR. PAUL WISE:** I should just mention
5 that I trained with Wanda Barfield and Diana
6 Bianchi, so you're Deputy to all my training
7 buddies. This is quite remarkable. It makes me
8 feel very old.
9 **DR. MAGDA PECK:** Just very seasoned,
10 absolutely.
11 Gina, you've been our note-taker, but as
12 a DRPH student at Loma Linda, this is the second
13 time you've been with us, anything you want to
14 tell us about you and a quick aha?
15 And you're on mute, go ahead.
16 **MS. GINA OBIAKOR:** Hi, everyone. It's
17 just a pleasure to be here, and I'm currently a
18 doctoral candidate at Loma Linda University, and I
19 think that the biggest aha moment for me was the
20 stories at the border. I thought that those were
21 super profound and as I continue in my studies
22 right now, specifically on perinatal depression

1 and things like that, it really struck me, some of
2 these stressful life situations that have, you
3 know, been highly correlated with those health
4 outcomes that we were able to witness.
5 So, it was great for me to see that and
6 it's a pleasure to be here. Thank you for having
7 me.
8 **DR. MAGDA PECK:** Thanks so much for that.
9 We appreciate it.
10 Ada Determan, good to see you back. We'd
11 love to see you. Got something you want to ante
12 up with?
13 You're on mute.
14 **MS. ADA DETERMAN:** Yes, hi.
15 Hi, everyone. Yeah, it's good to be
16 here. Thank you. I agree with most that, you
17 know, the stories that were told in the last few
18 session were the most powerful and, you know,
19 really struck me, like all the work that's been
20 done and what they focus on just to get, you know,
21 the feeling of -- sense her feeling and passion
22 and just -- it was just really something to hear.

1 But the one thing that I really want to
2 follow up on after the meeting though, Magda, is
3 your Health Equity Data Tracker that you talked
4 about. I was hoping that maybe I'd find out more
5 about that as well as some of the -- I think
6 someone presented on measures of discrimination,
7 racism, et cetera. I don't remember who spoke
8 about that, I was kind of half-listening at that
9 point because I was working on something. And I'm
10 also just for -- if you don't know, I'm with the
11 Division of Health Start and Prenatal Services.
12 I'm the Data Evaluation Team Lead. Thanks.
13 **DR. MAGDA PECK:** Thank you so much for
14 that introduction.
15 I have captioner Tina 1 and 2 and Gary,
16 our transcriptionist, and Emma with LRG.
17 Is there anything you want to say us as
18 the backbone to this?
19 **UNIDENTIFIED FEMALE SPEAKER:** I want to
20 just welcome you being here.
21 **DR. MAGDA PECK:** Okay. Thank you for
22 that, making sure that works.

1 **UNIDENTIFIED FEMALE SPEAKER:** I've really
2 been enjoying the work in kind of the back end of
3 SACIM for a long time now. So, I've been enjoying
4 being a little bit more involved this year and
5 I'll just be here in case anything goes wrong.
6 But you all are ready to lead the meeting.
7 **DR. MAGDA PECK:** Okay. Thanks so much.
8 We appreciate that.
9 Tina, I think you're the only one we
10 haven't heard from. Is that true? And she can
11 continue to caption us. Okay.
12 With that, we welcome you all. Is there
13 anybody that I missed that might have not been
14 visible on the screen? I think I caught
15 everybody. Inclusion is one of my core qualities
16 that I try to or at least values that I try to
17 aspire to.
18 My name is Magda Peck. I'm an
19 independent consultant around women, children,
20 families, fathers, storyteller, and academically
21 affiliated as a Professor of Pediatrics and Public
22 Health at the University of Nebraska Medical

1 Center, and I am the designated lead for the Data
2 and Research to Action Workgroup. And Charlan,
3 you'll just have to catch up quickly because I
4 think everybody else has sort of been here.
5 So, just hold on tight, and here we go.
6 One of the things that we have on our
7 docket today, there are essentially three or four
8 possibilities and I'm going to just pull up, if I
9 can, or be talking about as I try to pull it up, a
10 set of actions for us to be taking today and make
11 the most of our time in a pragmatic way. So, let
12 me pull this down.
13 The first is the notion of responding to
14 COVID-19 and I'll bring that up quickly. Let me
15 just pull this over for you to take a quick look
16 at, and I'll pull this up like this.
17 By background, I didn't know how many
18 people would be here today, so we know who we are,
19 who we have background.
20 We sent a letter on COVID-19 back in June
21 with some very specific and very, very broad
22 recommendations about expanding investments and

1 robust data and surveillance systems, ensure the
2 uniform standardized collection and full reporting
3 of race and ethnicity data, supporting strategic
4 research and evaluation efforts -- let me go back
5 here one more -- and then to have a particular
6 focus on approaches for protecting mothers and
7 women and infants amidst the COVID pandemic.
8 And then uniform data standards, greater
9 data sharing, interoperability of data and systems
10 across sectors, addressing social and
11 environmental factors, driving racial disparities
12 amidst the pandemic and beyond. This is what was
13 the language that came out of our June meeting and
14 was submitted to the former Secretary of Health
15 and Human Services that is part of the repertoire
16 of recommendations for SACIM.
17 We had done some consultation last time
18 and had given some recommendations about what we
19 thought should happen since that time in
20 September, and I'm just going to put them up for
21 your quick review about underlying social,
22 political, economic, and environmental

1 determinants, and we've been acting a bit upon
2 that. Linkage of data systems and hence medical
3 record, birth registries, and specific to racism
4 to be able to listen to community and individual
5 lived experiences and community voice and
6 innovation and metrics and frameworks, data
7 systems, and research methods. And the shift from
8 individual behaviors to systemic racism from race
9 to racism.
10 So, just to remind you, in addition to
11 other things we'd like to look at around
12 environmental exposures, we are now five months
13 later after putting some recommendations out about
14 what should be some resources to look at, and we
15 come to this moment for us about what we want to
16 be able to act upon at this extraordinary moment.
17 So, I already started our conversation
18 around both the Maternal Health Initiative, around
19 Title V's update, around COVID and pandemic, and
20 more broadly about health and racial equity,
21 knowing that tomorrow, we will also have more on
22 environmental health and climate change.

1 I wanted to know if we could start the
2 conversation today specific to COVID, because that
3 has an immediate opportunity for urgency and then
4 going to what we heard around the Maternal Health
5 Initiative or Title V and then throughout that,
6 talking about health and racial equity. But I'd
7 like to know -- and I did not put in here, which
8 should have also been in here -- which is
9 immigration. My apologies. I'll come to that on
10 the next slide. My apologies. I did this quickly
11 while I was multitasking.
12 So, I was wondering if you could start
13 thinking about an opportunity to draw kind of this
14 kind of map for yourself on a piece of paper, you
15 know, the columns of what we heard about today,
16 add another column please for -- for the work
17 around immigration that needs to be added here,
18 and I will add that in just a minute, and I will
19 appreciate if you can begin to tell me about
20 specifically what did we discover and learn, and
21 I'm going to start with the COVID column, and what
22 are unanswered questions for today. And that's

1 where I want to go back to our full -- I'm going
2 to take us off screen share for a second.
3 But I wanted you to know that's how I'm
4 going to organize us today, which is going through
5 different columns at a time, starting with COVID,
6 next going to government -- all government --
7 Maternal Health Initiative and Title V, then going
8 to our immigration and border health that we heard
9 about, and just open it up for discovery and
10 unanswered questions that we have with the
11 understanding that we will then be looking through
12 the lens of gaps in data and research and what are
13 our opportunities of our workgroup.
14 So, that's what I thought might be
15 helpful for today, just so we have a way of
16 putting some pieces together and thinking in sort
17 of a framework, if you will, and I would like to
18 start with COVID and what we heard and open it for
19 things that you heard around the COVID
20 presentations, anything that was extraordinary in
21 your learning, questions that were unanswered, and
22 then gaps or opportunities.

1 So, I'm just going to put COVID on the
2 table first. Jeanne, come first and help us out.
3 **DR. JEANNE CONRY:** So, I mean, I -- to
4 me, the first thing is the safety of the vaccine,
5 and I -- we're -- we're working on it. But I
6 think there are some -- do you want us to answer
7 part of the answer ourselves or just --
8 **DR. MAGDA PECK:** Absolutely. Go for it.
9 Go across.
10 **DR. JEANNE CONRY:** So, the safety of the
11 vaccine. There are a number of physicians and
12 health care providers who are pregnant and getting
13 the vaccine. Have we done anything to somehow get
14 that into one database? I see it in my
15 physician's mom groups. I see every mom who is
16 pregnant and getting the vaccine. So, it seems
17 like there's -- it would be the ideal way to
18 capture a database, and I don't know whether we've
19 done it. So, I would say that.
20 And then, I would say the same thing for
21 children, but I'll let a pediatrician address
22 that. But to me, that's probably the first --

1 first spot. The safety of the vaccine so that we
2 will be able to answer some questions by the end
3 of the year.
4 **DR. MAGDA PECK:** Thanks so much for that.
5 Anybody want to echo on that or take it
6 further or in terms of wanting to expand on
7 another opportunity around COVID-19?
8 **DR. JEANNE CONRY:** I'll say one more
9 thing.
10 So, I -- and this I -- this is indirect
11 information. I was speaking with Elliott in Main
12 who oversees the California Maternal Quality Care
13 Collaborative, and Elliott had shared how some of
14 the data that CDC is relying on is based only on
15 three hospitals in the Bay area for all of
16 California, and I'm not sure what -- and somebody
17 from CDC would know more than me -- but it's not
18 reflective of California. I mean, you look at
19 what's happening in the Southern California area,
20 it was only three hospitals in all the Bay area
21 that are being used for assessment of California.
22 And so, somehow at least picking a Los

1 Angeles hospital would seem like a reasonable
2 spot, or as I keep saying, getting into the Kaiser
3 Permanente database simply because we've got
4 electronic and at least throughout Los Angeles and
5 throughout large parts of Northern California.
6 **DR. MAGDA PECK:** You know, I was
7 wondering, Paul, can you think about crossing over
8 into -- no pun intended -- onto the border health,
9 migrant health, and COVID-19? Is there any
10 specifics that you'd like to be able to -- I mean,
11 these are not silos.
12 So, can we -- the recommendations that
13 you would like to put forth or get us thinking
14 about or questions around data and research,
15 COVID-19, both diagnosis and treatment and the
16 border policy issues?
17 **DR. PAUL WISE:** Well, there are two
18 components.
19 One is COVID policy within the detention
20 facilities themselves. There are Health and Human
21 Services, there's Border Patrol, there's ICE, and
22 it would be extremely helpful to ensure that the

1 best thinking come out of CDC and HHS are provided
2 comprehensively in a coordinated fashion to all
3 three agencies.
4 The second is what happens when people
5 leave the detention facilities into interior
6 United States, and then you're basically talking
7 about not so much the risks to pregnant women of
8 the vaccine, but they fall into a group that may
9 be the least likely to know how to access the
10 vaccine or have appropriate information regarding
11 the utility or safety of the vaccine. So, again,
12 it elevates the role of these migrant clinician
13 networks that can coordinate care from the border
14 to whatever part of the country they ultimately go
15 to to ensure that care is appropriate.
16 Both, I think, are relevant to SACIM. We
17 need to make sure that these -- that basically
18 Homeland Security agencies have good coordinated,
19 very fast-changing guidelines coming out of the
20 CDC and other arenas of public health and second
21 that migrant groups, particularly if there is an
22 increase in released into the US migrant groups,

1 have appropriate access to vaccines and other
2 preventive measures.
3 **DR. MAGDA PECK:** Thank you. Any other
4 comments about COVID and/or crosswalk with border
5 and migrant health that you heard?
6 **DR. JEANNE CONRY:** Yeah, just carrying on
7 from what Paul just said, I think this is the
8 ideal opportunity for science to guide the other
9 organizations.
10 So, you've got HRSA input, you've got CDC
11 input. They're the scientists, they're the
12 clinicians, they're the physicians, they're --
13 they're guidance on what's the best behavior, the
14 best treatment, the best in terms of health care
15 policy for everybody on the border is where it
16 should be.
17 So, you know, it's kind of like the --
18 the problems we run into when a woman is arrested
19 and put in jail and we, as the physicians, try and
20 say exactly how she should be treated. She should
21 not be -- she should not be restrained. So, there
22 are a lot of issues that come up where the

1 restraints or the conflict about how somebody is
2 going to be handled because they're in a detention
3 facility comes in direct conflict with how
4 somebody should be given care, and we should be
5 the ones who are speaking on behalf of care and
6 health and healthcare policy. And that should be
7 the overriding factor there.
8 **DR. PAUL WISE:** Could I -- could I just
9 offer one other potential issue, not border-
10 related per se? But I think we should be, as best
11 as we can, anticipatory of where the conversations
12 are likely to be in a few months.
13 Currently, well, over the past couple of
14 months, the vaccine policies have targeted health
15 care workers, for the most part, which is a pretty
16 well-defined group where there is structure for
17 the distribution for keeping track and they're
18 probably the most knowledgeable about the vaccine
19 of any group you could possibly think of.
20 In three months, we're going to be
21 talking about the general public, our people over
22 65, and I think it's important that we advocate

1 for tracking mechanisms to identify social
2 inequalities in provision of the vaccine two or
3 three months down the road.
4 Even today, when you move to 65 and
5 older, you're seeing an explosion of
6 diversification in who's getting it and who's not,
7 and I think it's only going to be that much more
8 profound as the numbers of people who should be
9 eligible grow enormously and the amount of vaccine
10 will not be able to keep up. And scarcity and
11 inequalities is a really bad mix in the United
12 States, and as a group, we should be anticipating
13 the data requirements to ensure we at least know
14 that these inequalities are emerging.
15 **DR. JEANNE CONRY:** Yeah, and along the
16 same line --
17 **DR. MAGDA PECK:** Go ahead.
18 **DR. JEANNE CONRY:** I was just on a phone
19 call this morning with Israel about some other
20 issues, and the first thing that's come out is how
21 broad the vaccination is there, but they've
22 selected not to vaccinate the refugee population

1 and somewhere -- I haven't seen the article,
2 they're supposed to send it to me -- they've
3 already seen drops in hospitalizations and
4 somebody said mortality -- although it seems
5 pretty fast -- but they've seen a marked decrease
6 in hospitalization and mortality in Israel just
7 after the vaccine push.
8 So, Paul, I think that's a great issue
9 that is going to be coming -- how we vaccinate.
10 **DR. MAGDA PECK:** I want to mention that,
11 you know, as I've been serving on the Health
12 Equity Task Force with Satcher Health Leadership
13 Institute that someone asked me to tell them more
14 about, it was announced today that Google, which
15 is one of the funders -- Google, Gilead, and the
16 CDC Foundation -- Google has pledged to expand
17 equitable vaccine access and work on vaccination
18 data that will help assure greater equity and
19 vaccine distribution and supply.
20 So, I just think that as -- as private
21 investors are getting involved in supply chain
22 just by efficiency, the fact that they are -- I

1 will learn more about it -- there is some
2 cognizance of to bake in the equity up front. I
3 say so with a certain amount of healthy doubt, but
4 I will keep you posted. And if that's being baked
5 into a product that will be ready in the next
6 couple of months, it's like being ahead of the
7 curve, Paul. We'll be anticipating that, so we're
8 not trying to catch up later after it's already
9 baked in, who will get, who won't, who is
10 protected, who isn't, and further institutionalize
11 the egregious disparities. So, putting it in the
12 design upfront.
13 Other thoughts about opportunities in
14 COVID-19?
15 I wanted to acknowledge the
16 extraordinary, you know, shift before the change
17 of administration towards racial inequity and
18 racism being acknowledged and now a political will
19 opportunity for it to become further
20 institutionalized and elevated given the advancing
21 health equity and executive order from the 20th
22 about how this should play out in federal

1 programs.
2 So, other populations -- are there issues
3 that you heard today that could further drill down
4 our COVID-19 work?
5 Well then, let me ask you. You know, one
6 of the things I was just -- I talked about sort of
7 a cognizance of dissidence today about the -- as
8 Ed called it -- the warp speed in which the
9 maternal health interconnectivity has happened
10 where we had people from the FDA today present in
11 addition to -- and first time that she or they had
12 presented, at least to my knowledge, in SACIM --
13 of the current iteration with this whole in
14 government approach to preventing maternal deaths
15 and how that has gotten traction across agencies.
16 Do you have any in that particular arena?
17 Is there anything that stood out for you that you
18 said boy that's -- that's something or Charlan and
19 others who have been participating in this or
20 Danielle, is there anything that you're seeing
21 that you really want us to pay attention to? And
22 is there any opportunity to further that

1 initiative?

2 So, I want to shift to what's happening
3 around this Office of Women's Health coordinated
4 (indiscernible) for policy and evaluation-driven
5 Surgeon General-supported, how that has rolled out
6 in the last six to nine months and what, from a
7 data and research perspective, is more needed now.

8 So, Charlan, is there anything you want
9 to add to that given you've been somewhat involved
10 in that?

11 **DR. CHARLAN KROELINGER:** You know, I
12 think you described it aptly, Magda.

13 It is -- it's really nice to see more
14 than just CDC and MCHB working together in this
15 area. It's great to have the Office of Women's
16 Health, the Office of Minority Health in DC join
17 together to work on the maternal and infant health
18 population. So, I think that's exciting. I think
19 some of the products that have come out are
20 helpful, but there's still more work to be done in
21 this area. And as you mentioned, we're very
22 focused in DRH, at least, on the issues of

1 structural and institutional racism and implicit
2 bias and other inequities. We've talked about
3 measuring in the past, but we really need to do a
4 better job of measuring now.
5 **DR. MAGDA PECK:** Jeanne.
6 **DR. JEANNE CONRY:** I think what we heard
7 was a tremendous collaboration, a tremendous
8 amount of data that's coming out, and I guess what
9 I'd love to come out of our group is just a
10 statement is it shouldn't be that much work.
11 If we had a fully electronic database
12 with access to birth records linked to children's
13 health outcomes, you'd have the Danish database
14 and Denmark can just query their database and
15 answer some big questions. We should be able to
16 do the same. So, eventually if ever we could get
17 a fully electronic record that's linked across the
18 country -- you can do it with an ATM card, why
19 can't we do it with our health records? And I
20 think it's where we have to go.
21 **DR. MAGDA PECK:** So, Jeanne, can you just
22 --

1 **DR. JEANNE CONRY:** It's really hard to
2 get great data.
3 **DR. MAGDA PECK:** It shouldn't be this
4 hard.
5 That said, one of the things when I -- I
6 heard Wanda say and others, you know, when I
7 brought up the disconnect or the distance between
8 the meteoric speed given historical glacial pace
9 of at least collaboration, perhaps some
10 conversation, and perhaps some co-creativity
11 across multiple parts of government around
12 maternal health and preventing maternal deaths.
13 Just getting at the data around dyads, how do we
14 connect the before pregnancy with pregnancy and
15 how do we connect, you know, a pregnant person and
16 baby over time.
17 So, just trying to figure out -- Charlan,
18 can you say anything about in your experience
19 where -- where are the children in this
20 conversation at all? Is it more like well, we're
21 going to get our own act together first and then
22 we'll come back to you? Like, I'm trying to

1 figure out how -- how we can at least encourage
2 greater integration between maternal and infant
3 health.
4 **DR. CHARLAN KROELINGER:** I think, again,
5 that's a great question.
6 I think what we're thinking about in DRH
7 is risk-appropriate care and how to align the
8 services offered to pregnant and postpartum women
9 with infants and what does that look like. Where
10 are women delivering? What facilities are they
11 delivering at or birth centers and, you know, what
12 kind of care is also afforded the infant there?
13 So, I think traditionally, the two groups have
14 been considered separately. We're very interested
15 in aligning those in terms of labor, delivery, and
16 birth, and I think that's the beginning of that
17 mother/infant dyad connection.
18 Then, of course, you can walk backwards
19 to preconception and forward to, you know, 1 years
20 of age or more for infants. But I think that's a
21 good place to start, and that's what we've been
22 considering.

1 **DR. MAGDA PECK:** Okay. So, I'm going to
2 come back to you, Paul, and others who were
3 biggest on what was happening on the border.
4 How do we connect this all -- all
5 government -- at least all HHS within government
6 emphasis on maternal health and preventing
7 maternal deaths with perhaps, which is one set of
8 collaborations, with the other set of
9 collaborations that are essential at the border
10 around Homeland Security and ICE and, in this
11 case, CDC through the Policy 42. You know, is
12 there a way -- is there an opportunity to elevate
13 -- that SACIM can make to elevate to the maternal
14 health working folks to consider how to
15 specifically address the population of pregnant
16 women and babies at the border? How -- how could
17 we make that -- connect that to the other?
18 **DR. PAUL WISE:** Right.
19 Well, the agencies have pretty strict
20 boundaries -- jurisdictional boundaries. Health
21 and Human Services is in charge of unaccompanied
22 kids once they get out of Border Patrol custody,

1 which, because of Flores, they need to get out
2 within 72 hours. They go to ORR. And maternal
3 health there isn't crucial or it isn't a huge
4 problem because they tend not to show up there.
5 But where it is, I think, intensely
6 relevant to Health and Human Services, are
7 pregnant woman and kids -- particularly kids with
8 special health care needs -- once they are
9 released into the United States because that falls
10 within the MCHB jurisdiction since the Children's
11 Bureau, and it is -- I can use the word appalling
12 that there's been so little support or attention
13 that has been given to the care -- the follow-up
14 care and referral systems for kids in this
15 situation.
16 And I do think that this should be viewed
17 urgently by MCHB and sister organizations within
18 HRSA because both guidance and funding would be
19 extremely useful and there's just a remarkable
20 opportunity staring us in the face.
21 **DR. MAGDA PECK:** So noted and, you know,
22 the idea of having some language that we might put

1 forth for that in the extra hour today that you
2 don't have might be -- I'm going to be at the end
3 -- just head's up, this is a really good example
4 of if I'm going to be doing a report out tomorrow
5 of some possible pieces of things to bring in the
6 afternoon, what are the opportunities we do not
7 want to miss right now because -- and a way to
8 elevate SACIM in doing it?
9 So, I would support that 1,000 percent,
10 Paul, and I think what you've been able to do,
11 which was a big aha for me, was to differentiate
12 between the caring piece and the capture piece, if
13 you will. I mean, the notion of detention versus
14 care. That plays out on both sides of the border.
15 One happens to be in terms of prison systems and
16 that -- that division is there all along. And
17 just and this -- being able to say our opportunity
18 for impact is post-release. Therefore, they are
19 here.
20 So, they're already here and integration
21 into and heightened risk and therefore opportunity
22 to know everyone -- and that was the other piece I

1 want to come back to see if you want to say
2 something about 700 or what proportion of the 700
3 children who still are separated and does SACIM
4 want to make a statement about future data and
5 monitoring and surveillance systems around the
6 well-being of children and mothers -- must always
7 be able to account. First, account for the 700
8 and of that proportion and never again.
9 So, I think it's a concrete number to
10 hold onto and to be able to hold ourselves
11 accountable to that number never being there again
12 and knowing within that, you know, who falls
13 within our purview of at least teens of
14 reproductive age, pregnant people, and infants in
15 the first year of life.
16 So, I'm wondering if that's another hot
17 one that you think we have an opportunity. Is
18 that expedient or not?
19 **DR. PAUL WISE:** Well, the separated kids
20 as a program -- the Zero Tolerance Program --
21 lasted about three weeks before it politically
22 became nonviable and they rescinded it.

1 The 700 kids are from two years ago that
2 can't reunite. Homeland Security and ORR have
3 been beat up by Department of Justice Inspector
4 General, Health and Human Services Inspector
5 General, congressional committees, Homeland
6 Security Inspector General, and three books that
7 have come out all clobbering them about the
8 incompetence and the cruelty of this policy. I
9 don't think we have a lot to offer. I think that
10 data systems need to be greatly improved.
11 But the broader issue is to lend our
12 support to rethinking the system of care beyond
13 Health and Human Services or ORR. You know,
14 basically, there could be a system for children
15 and families that don't rely on law enforcement
16 officers to feed a 6-month-old. It's just a crazy
17 kind of system and it's -- it's a vestige of the
18 fact that the system was built for adult Mexican
19 men and its sort of being backfilled to handle
20 tens of thousands of families and kids.
21 It's a heavy lift because Homeland
22 Security is going to have to deal with it and --

1 but this is a new administration and they may want
2 to say look, let's create a new pathway for
3 families and kids so they're not coming through
4 the same systems. There still needs to be a
5 detention because that's the only way to know
6 whether they're trafficked or not.
7 But within 72 hours or while they're
8 being processed by Border Patrol, they're in
9 child-friendly environments and not Border Patrol
10 processing stations by people in uniform and
11 bulletproof vests. There's no reason they should
12 be doing this. They want to catch bad guys on the
13 border not take care of 4-year-olds. We may have
14 something we could say.
15 **DR. MAGDA PECK:** Okay. Any thoughts
16 about that for others who are listening and our
17 collaborators?
18 The other crosswalk -- I'm going back
19 between border and COVID and maternal health,
20 while we're back on, I feel like it's a jeopardy
21 game across the top. Paul, it is jeopardy and
22 there's a lot of double jeopardy.

1 Paul, I'm curious about the presentation
2 made about the separation of individuals from
3 their medical record and Jeanne, you're talking
4 and advocating for another electronic health
5 record. And so, I'm wondering how -- how we might
6 marry those and how the electronic health record
7 can potentially be the bridge and the dyad between
8 mother and baby. And so, I'm wondering what we
9 may want to say, if anything, about the importance
10 of assuring the possession and integrity of one's
11 medical record as essential to inform future
12 health care once in the caring part of the
13 systems.
14 So, I'd be really curious. It seems like
15 it's such a specific piece, but if not standing
16 alone, but connected to the other improvements
17 being made about electronic health records and the
18 essential -- particularly as people have a
19 destination that may be far from the border in
20 terms of where they ultimately are settled by ORR
21 -- having that -- just some of the agricultural
22 stream, that record is essential. We have -- it's

1 not 40 years ago, it's now.
2 So, how do we take the technology and
3 combine it with this opportunity.
4 **DR. PAUL WISE:** I'm constrained in what I
5 can say because it's under court seal, things I've
6 seen in working with CPB.
7 But ORR is pretty good at keeping track
8 of the records, medication, and transferring sort
9 of discharge summary information once the child is
10 released to a sponsor. It's been more problematic
11 with a verified throughput at CBP, where things
12 are moving very fast and in very large numbers and
13 it's been a transition. The issue of electronic
14 medical records within CBP issues around issuing a
15 medical record summary of any medical care that's
16 been provided while in Border Patrol facilities.
17 Those are all being worked on and
18 medicine tends to be confiscated if it's unlabeled
19 or unlicensed because a lot of people will come
20 through after going through Mexico and they have a
21 little baggie with a bunch of meds, and it looks
22 like Skittles. And basically, the medical people

1 at CBP are responsible for figuring out what
2 medication the person needs, getting it filled
3 within 24 hours, and making sure that any chronic
4 meds are provided.
5 But it's an ongoing issue that I think is
6 being worked on appropriately.
7 **DR. MAGDA PECK:** So, best not to touch
8 it?
9 **DR. PAUL WISE:** Well, primarily --
10 **DR. JEANNE CONRY:** I mean, I think we can
11 come up with statements, don't you?
12 **DR. PAUL WISE:** Yeah, you can -- you
13 could say -- especially after Annie's stories --
14 what Annie has experienced and just say that good
15 medical care requires communication and -- but
16 that is not an ORR issue particularly; it's more a
17 Homeland Security issue.
18 But, you know, we are -- we could say
19 whatever we want and we could issue a statement
20 that we support all efforts to create electronic
21 medical records, that the medical information be
22 conveyed appropriately, and that all appropriate

1 medications continue to be provided throughout the
2 whole system. I think that would be fine. The
3 response is likely, yeah, thank you, we're working
4 on it.
5 **DR. JEANNE CONRY:** Okay.
6 **DR. PAUL WISE:** But it's a good reminder.
7 **DR. JEANNE CONRY:** Yeah, okay. I mean,
8 it's not like we don't have the examples where
9 you've got Department of Defense and everybody in
10 the military with an electronic record that's
11 transferable. So, we've got examples of big data
12 systems. They'd have to say they want to do it
13 this way.
14 So, I think we can make a recommendation.
15 **DR. MAGDA PECK:** Okay. Thank you.
16 With that, is there -- let me go back to
17 -- so, I didn't hear anything further around
18 COVID.
19 **MS. ROSEMARY FOURNIER:** I just have one
20 other comment before we leave COVID.
21 **DR. MAGDA PECK:** Please do, Rosemary.
22 **MS. ROSEMARY FOURNIER:** Certainly. One

1 of the issues that struck me so profoundly this
2 afternoon with all of the presentations is how --
3 how very little transmission there is of COVID
4 from mother to child but the much more important
5 or salient features are the women who have chronic
6 health conditions that are exacerbated if they
7 have a COVID infection.
8 And the other thing I haven't heard too
9 much about that I think we may want to be
10 gathering more data on is the mental health issues
11 of pregnant women during the pandemic. You know,
12 how does that impact their pregnancy outcome,
13 their pregnancies, and we're not just talking
14 about women losing their lives and possibly losing
15 their babies, but the long-term implications of
16 the mental health issue.
17 So, I just wanted to elevate that piece.
18 **DR. MAGDA PECK:** Thank you for that.
19 **DR. JEANNE CONRY:** And I understand
20 there's an article that going to be coming out
21 from CMQCC based on the COVID outcomes in
22 California. Leslie would know more about it, but

1 I heard that's coming out in a month or so, and I
2 think they are seeing more of an impact than any
3 of the other studies.
4 **DR. MAGDA PECK:** Right. Rosemary, would
5 you be willing to send Leslie a quick note to that
6 effect and see if you can sleuth it out? I know
7 she wasn't able to join us this afternoon.
8 **MS. ROSEMARY FOURNIER:** Sure. I'd be
9 happy to.
10 **DR. MAGDA PECK:** That would be great,
11 just so we can follow up on that thread. I don't
12 want to lose that.
13 One of the things around data that we
14 heard from Michael Warren as he presented the
15 information -- now, I'm going to switch over to
16 what's happening in Title V and Block Grant, and I
17 thought it was, you know, interesting to get --
18 for those of us who have known the Block Grant
19 since before it was -- it's always interesting to
20 see how it has morphed and changed over decades.
21 I think what I heard Michael Warren say -
22 - given that he talked about at least the special

1 initiatives around racial disparities and around
2 maternal mortality and infant mortality -- were a
3 limited number in terms of that were being opted
4 into. I mean, everybody was doing something, but
5 that they would put it up into a level
6 accountability. I heard him say well, you know,
7 you can always influence by the guidance that gets
8 put out for the Block Grant.
9 And so, I was just wondering in that
10 domain of Block Grant guidance, which directs --
11 especially with the increases that likely will
12 continue to -- at least currently are coming -- is
13 there anything about the data and research
14 monitoring and surveillance around racial and
15 ethnic disparities and being able to measure
16 metrics around racism and discrimination that we
17 would like to encourage become baked into the
18 Block Grant guidance?
19 Any thoughts about that? Anybody hear
20 that? Maybe I was off on my own.
21 **DR. JEANNE CONRY:** I didn't understand
22 it.

1 **DR. MAGDA PECK:** Okay. Thank you for
2 saying that.
3 So, things happen because sometimes
4 they're mandated, right? So, in the MCHB guidance
5 that is when the states make their application for
6 that part of the Title V dollars, and they have to
7 therefore have a reporting back about how they --
8 about their populations.
9 And I'm just wondering if there's
10 anything that we heard from Michael or that you
11 heard today that might want to encourage even
12 better data collection -- required data collection
13 monitoring surveillance within Block Grant dollars
14 so that we have better metrics on racial
15 disparities either in maternal or infant
16 mortality.
17 Did anybody hear anything about that?
18 It's a little -- a little note to myself to ask us
19 and I just wasn't sure if there's anything there.
20 **DR. JEANNE CONRY:** Not that I know.
21 **DR. MAGDA PECK:** Okay. Is there anything
22 that -- yeah, go ahead, Ada.

1 **MS. ADA DETERMAN:** I don't really have
2 any answers for that, but I just know, at least
3 within Healthy Start, and obviously I'm program,
4 so I can't make recommendations or I don't want to
5 say -- I can't say too much here, but you know, it
6 is something that we're very aware of and that
7 we're hoping we can move in that direction of
8 embedding these things within some of the programs
9 as we move forward within, you know, the funding
10 opportunities and trying to get things to focus.
11 We're kicking off an evaluation project,
12 but we do have, you know, health equity and
13 transformative evaluation as part of that. We try
14 to make sure that we always embed that within.
15 Like, that's why I mentioned earlier about the
16 measures talking about the discrimination,
17 structural racism, and try to figure out like what
18 I would like to know more about, what are the, I
19 guess, maybe the most useful or most credible,
20 like, you know, which have the strength behind
21 them that we can actually apply and start
22 investigating those as we look at some of these

1 MCHB programs, in particular the Healthy Start,
2 for my purposes.
3 **DR. MAGDA PECK:** Thanks. Okay. So,
4 those are our -- we have not gotten to the
5 environmental health piece.
6 So, we have gone through the Title V and
7 was happening on the Block Grant, and we've gotten
8 to the maternal health systems transformation, and
9 we've talked a little bit about the border and
10 immigrant health, we've talked about COVID and
11 then implicit in all this, the next thing I want
12 to get to is the notion about more in the area of
13 racial and ethnic disparity and a letter that was
14 sent out in draft. So, I'm going to leave that
15 for our last chunk.
16 And so, noted, Rosemary about coming out
17 of the outcome's registry. We'll take a look at
18 how registries are putting that forth.
19 I want to do a once-around if there's one
20 thing you'd really like us to be able to push as
21 an agenda. Everything you've heard before I get
22 to this letter piece -- COVID, border immigrant

1 health, Maternal Health Initiative, COVID-19, or
2 just MCH Block Grant, and what's happening within
3 the Bureau. What is -- if you had a wish list,
4 like you had a want, what is absolutely one thing
5 you would want SACIM to stand for, stand by, speak
6 out on for tomorrow?
7 That's -- I just want to know what's at
8 the top of your list of everything. And it could
9 be something you've said already, but I just want
10 to make sure that we all heard what's most
11 important and what's the opportunity. Jeanne.
12 **DR. JEANNE CONRY:** So, I -- I would want
13 to amplify what Michael Warren said about AIM
14 because if I were going to look at the single most
15 important project taking place across the United
16 States in terms of maternal morbidity and
17 mortality and impacting them whether their child
18 is going to live or die because, you know, of mom
19 living or dying, it's the systematic approach of
20 the AIM project.
21 And he gave, I think, three different
22 examples of how AIM has impacted outcomes, but

1 there are going to be a lot more, and it is
2 systemic, it's data-driven, and it's -- the goal
3 is to engage every single hospital in the state.
4 And when it's engaged and when it happens, you can
5 decrease, you know, like we've seen with CMQCC,
6 maternal mortality by 55 to 60 percent.
7 So, following AIM program, I was
8 delighted to see that they put more money into it
9 because then the goal would be to get every single
10 state in the United States in AIM, following all
11 the care bundles and implementing all the steps
12 that we know save lives.
13 **DR. MAGDA PECK:** Okay. Thanks for that,
14 Jeanne.
15 Who else has a here's my one or two?
16 Danielle? I know you've always had a --
17 you tend to sit back. I mean, here you are and I
18 know you're listening in from MCHS, within the
19 boundaries of what you can say of what you've been
20 involved in, what would you really hope SACIM
21 would speak more to?
22 **DR. DANIELLE ELY:** You know, I -- I

1 always go back to this idea of the electronic
2 health records like Jeanne brought up just
3 recently because, you know, that's one thing that
4 states struggle with having already, let alone
5 linked health records.
6 We're just talking have electronic health
7 records. There are still a handful of states,
8 like one or two, that send in paper copies or are
9 just getting their systems set up, which you would
10 think would not be an issue, especially with
11 territories. The US territories are -- so, with
12 the EHRs, I know some of the states can get some
13 funding, but it's very limited funding that we
14 can, you know, the federal government can offer to
15 update systems or put new systems in place that
16 might improve.
17 There is not, at least on birth side,
18 there is not one single birth registration
19 electronic system that is used, which can make it
20 more complicated for states to update their
21 systems, especially when you're talking about
22 adding a new item, like for COVID. For some

1 states, it has been like pulling teeth for them to
2 get these new items onto their certificate or to
3 even be allowed to give us the data.
4 So, I guess I would really just say if we
5 could push for funding for electronic health
6 records or for states to update their systems, if
7 there was a way to get a single system in place
8 that states could opt into. That way, they don't
9 have to put their own funds out into creating a
10 new registration or using a vendor that's going to
11 charge them for something they've pretty much
12 already done for another state. I don't know how
13 many of them would take advantage of it. These
14 are just things that I can think of, especially
15 where I'm based, and it's all data.
16 That's all I do, all data, all the time.
17 I think with those electronic systems in place, it
18 might help me be able to get data out faster to
19 people, which is always the goal.
20 **DR. JEANNE CONRY:** And Danielle, I think
21 that's a -- if you don't mind me interrupting --
22 Danielle, I think --

1 **DR. DANIELLE ELY:** Oh, no. I was done.
2 **DR. JEANNE CONRY:** No, no, I love it.
3 Because I think that's what we heard from Ed that
4 we had this Operation Warp Speed and then we can't
5 figure out how to get this vaccine out to people.
6 You know, if you had an electronic
7 database -- if we're going to prepare for the next
8 pandemic or the next problem, you've got to have a
9 fully electronic record or at least a certain
10 amount of it, and you can then take care of
11 people's needs easily based on that record. But
12 we've been just constrained from the very start
13 because of our lack of information and lack of
14 integration.
15 **DR. DANIELLE ELY:** Yeah, absolutely. No,
16 I absolutely agree.
17 But I know that we've talked about it
18 before, so sometimes I feel like a broken record
19 if I just say, no, really, we just try to get some
20 funding for states to update their systems.
21 **DR. MAGDA PECK:** No, that's -- the former
22 -- a former Surgeon General once told me --

1 Jocelyn Elders -- you say, you know, twenty times
2 -- you have to repeat it twenty times for a policy
3 to finally stick.
4 So, I wanted to just say keep on bringing
5 it out as it were.
6 Rosemary, what would you like to put up
7 on the docket?
8 **MS. ROSEMARY FOURNIER:** Well, first of
9 all, I'm putting into the chat that I completely
10 support Danielle's recommendation. I think one of
11 the priorities that I really, I mean, I just know
12 that this is a DRAW priority, but improving data
13 collection and oversight. Collecting and
14 disseminating reliable consistent data on both
15 maternal and infant mortality is just critical to
16 developing the solutions.
17 And Magda, you had that on one of your
18 first slides -- listening to and believing and
19 learning from community voices. So, this data
20 that we're going to be using can't just be, you
21 know, the usual vital statistics and population-
22 based data. It has to include voices of families,

1 voices of women, voices of those who have lost
2 infants and even family members to maternal
3 mortality.
4 So, that would be my -- my big aha to
5 make sure we're including the qualitative data as
6 well.
7 **DR. MAGDA PECK:** Excellent.
8 Who would like to -- Paul, would you like
9 to ante up here?
10 Maybe, maybe not?
11 **DR. PAUL WISE:** I agree with everything
12 that everybody has said.
13 **DR. MAGDA PECK:** Okay. I would like to
14 put forth that to the degree that there has been
15 extraordinary advancement in working across
16 agencies to address maternal health that being
17 able to go back and connect the mother and the
18 baby as a dyad for integrated systems as families
19 is essential.
20 So, I am happy that the catalyst has been
21 maternal mortality and I find that there's no
22 mention of fetal mortality. You know, there is

1 the disconnect between fetal and infant mortality
2 and maternal, infant, and fetal mortality.
3 So, the idea of somehow in our data
4 systems connecting them back as we move forward
5 and making that investment would be something that
6 I'd like to see added to our world.
7 Anybody else hear something that they
8 want to make sure that we emphasize? Then, I've
9 got one more thing to take of today with you all.
10 I don't know about you, but I'm exhausted and it's
11 only, you know, quarter to three where I am, so
12 you must be like, you know, tanking elsewhere in
13 the country.
14 So, towards that end, I would like to
15 share a screen, if I could.
16 Let's see what I can do here to bring up
17 and see if that works. I'm thinking this is it --
18 share. I'm hoping -- we'll see if this works.
19 Let me see if I can pull it up, and
20 that's not it.
21 I'm looking for this one here. Let me
22 try this one more time again.

1 If not, if you could pull it up on your
2 own screens as well -- the ability to have the
3 President's letter in front of us.
4 I would like to dedicate a little bit of
5 time to this, and I'm going to stop share and ask
6 to share it one more time and see if I can pull it
7 up this time. It should be this one. I'm going
8 to try again. All right.
9 Is that showing on your screen now? Is
10 that a yes?
11 Dear President Biden -- okay, thanks.
12 **DR. JEANNE CONRY:** Yes, yeah.
13 **DR. MAGDA PECK:** So, towards that end,
14 this is something that came out of our workgroup
15 in part because we were focused back in -- not
16 knowing the outcome of the election and where
17 policy would head because of that election -- this
18 is not a partisan activity but rather a policy
19 question to be raised about whether -- whether or
20 not at this time given that the executive order to
21 which we had drafted a potential response, which
22 has now been rescinded, the sentiment therein

1 could be flipped to the affirmative and position
2 SACIM with our hyper focus on women of
3 reproductive age, pregnant women, lactating women,
4 babies in the first year of life and their
5 extended families.
6 What is the -- what about this strategy
7 of taking this kind of letter and then being able
8 to particularly embed a call for how SACIM can
9 help elevate the need for "more equitable data to
10 inform policies and programs" as taken straight
11 from the new executive order from January 20th.
12 So, I wanted to bring this to your
13 attention if you didn't get a chance to see it
14 before. I sent it out last night. I have it
15 available if, in fact, you want to take a look at
16 it and have it on screen, but that's what I'm
17 referring to, having forwarded it last night after
18 Ed sent it to SACIM members.
19 And so, from the workgroup perspective,
20 what do you think? Helpful? Not helpful? I'm
21 just wondering what your thoughts are about this
22 strategy and this content at this time.

1 And Jeanne, you're the one who responded
2 to me last night, and so, I'm going to pick on you
3 first.
4 **DR. JEANNE CONRY:** So, a couple different
5 views on it. I actually think this is what we
6 should be doing. I'm completely supportive of the
7 statement of the letter.
8 One of the things that I've had to do in
9 the last couple of years is regarding a lot of
10 different things. We've created a statement form
11 because this isn't going to be the first. If we
12 decide to go this route, we're going to have many
13 more statements along the same lines coming from
14 this group.
15 So, I'd rather see a standardized format.
16 This is kind of a free-flowing letter. I'd almost
17 rather see a standardized format that we have one
18 section that explains what SACIM is, we've got a
19 section that explains what the problem is, and
20 then we've got a section that says these are our
21 recommendations 1, 2, 3, and 4, because we're
22 going to have exactly the same issue and, you

1 know, President Biden, I mean, this is going to
2 tell him this is what SACIM is or somebody else
3 will do it, but we can write a letter, but I would
4 love to have it more organized in a fashion that's
5 going to be replicated every time we come up with
6 something. I can show you what I -- we've been
7 doing it for FIGO for, you know, a host of
8 different things.
9 But we finally got to the point where we
10 described to people what FIGO is. You want to
11 describe what SACIM is and let people know what
12 our goals are, but then you also want to say what
13 the main topic is and then your points 1 through 5
14 on how we think this topic should be handled. But
15 I like the content. I'd just organize it
16 differently.
17 **DR. MAGDA PECK:** Okay.
18 **DR. PAUL WISE:** Can I just ask sort of
19 strategically; we are an advisory committee to the
20 Secretary.
21 **DR. MAGDA PECK:** Correct.
22 **DR. PAUL WISE:** And we're writing a

1 letter to the President with a list of good ideas.
2 My question is I could see writing a
3 letter to the President if we had one urgent big
4 issue that deserves the President's attention --
5 something urgently impending that's going to be
6 catastrophic. Sending something to the
7 President's office that's going to be routed
8 immediately to HHS to the Secretary when I think
9 we're supposed to be writing letters to the
10 Secretary, I just question what the logic is here
11 and what the --
12 **DR. JEANNE CONRY:** That's a good point.
13 **DR. PAUL WISE:** -- what the utility is
14 and even the potential for counterproductive kinds
15 of outcomes.
16 **DR. JEANNE CONRY:** I think that's a very
17 good point. I hadn't thought of it that way.
18 **DR. MAGDA PECK:** I raised that to Ed.
19 This was, again, our interim chair or acting chair
20 has put this forth as a strategy. I have not
21 taken a stance on how I feel about the strategy.
22 My job is to facilitate and bring it to you, so,

1 to see what comes here.
2 So, that's why I want to make sure that
3 I'm not advocating for that strategy; I'm
4 presenting the strategy.
5 **DR. JEANNE CONRY:** That came about
6 backwards, don't you think? Not in -- I don't
7 mean that in a bad way. It came about because we
8 had this important discussion that these areas
9 should be sent on and lo and behold, we get a
10 President who adopted what we said should happen,
11 so it was a way of thanking him for doing what
12 we'd already recommended.
13 I mean, if you think of where we came --
14 how we came at it.
15 **DR. MAGDA PECK:** Right. A caveat here I
16 want to put in is that I have also recognized that
17 we have some federal employees who are part of our
18 DRAW committee, and I recognize and respect that
19 they will need to -- they may need to recuse
20 themselves from the conversation and there are
21 boundaries there in the generic form.
22 So, Ada and Danielle, I just want to

1 honor those boundaries and recognize that you will
2 be listening in. I had the same conversation with
3 Alison previously. So, I didn't say that upfront,
4 and I want to make sure that you are here and
5 present but not participating in the current time.
6 The second thing is that taking Paul's
7 point about under what circumstances and what's
8 the strategy, and I'm going to convey what I heard
9 from Ed to the group. The idea of wanting to
10 raise the visibility of SACIM and in particular
11 continue to champion the advancement of racial
12 equity and to position SACIM to be recognized and
13 a partner in that work specific to our charge.
14 And I think Ed had said he thought going to the
15 President because it was the President's executive
16 order, so it was a response to that, and because
17 there is not yet a confirmed new Secretary.
18 And so, I think, however, Paul, if -- so,
19 I'm hearing there is a process piece of
20 formatting, there is a content piece of message,
21 and there is a strategy piece relative why this,
22 to whom, with what intended outcome without

1 getting bit in the butt.
2 **DR. PAUL WISE:** Right.
3 And I would reverse the order because
4 let's think strategically what our contribution
5 ought to be and then figure out the best way to
6 achieve that goal. You know, anybody could write
7 a letter to the President, you know. I have
8 potholes in my street, write a letter to the
9 President.
10 The question here is, what's really the
11 incremental utility of doing this at this moment
12 when there are so many other things on the
13 President's plate and in public deliberation. I
14 just think we ought to be thoughtful and
15 pragmatic.
16 **DR. MAGDA PECK:** Good thoughts.
17 **DR. JEANNE CONRY:** Do you say you don't
18 think we should -- you see, I agree with what
19 you're saying, Paul.
20 To me, because the way this letter came
21 about, the timing of it seemed actually perfect
22 for me because we'd already had this long -- I

1 don't even know what happened to the letter, if
2 nothing came of it when we put it all together.
3 But it's more a thank you for making a decision
4 that's consistent with what we had already
5 recommended as a group.
6 But going forward strategically, I do
7 think we go to the Secretary first with a
8 statement in a specific way on any number of areas
9 if that's how we're going to be, I mean, I don't
10 know how we're going to be approaching it. But if
11 we've got like the four or five statements, we
12 might, or actually probably fifteen or twenty
13 statements that come out today, that should go to
14 the Secretary because we are his committee and we
15 want to make sure that it's raised on how we
16 develop those statements. But I kind of looked at
17 this letter as being different. Maybe I'm way off
18 there.
19 **MS. ROSEMARY FOURNIER:** This is Rosemary.
20 I think we pivoted, Jeanne, and the three
21 of us that put our heads together and wrote that
22 original letter -- it was Ellen Tilden, myself,

1 and Jeanne -- and I'm just your humble Ex-Facto
2 member here, so I don't have a lot of history with
3 the committee. But it was a direct response and
4 we felt that SACIM really needed to be on record
5 as saying we can't work like this. You cannot tie
6 our hands with that executive order that says we
7 can't educate our providers on implicit bias.
8 So, it was very specifically aimed at our
9 recommendations for you to rescind that executive
10 order, which, of course, did happen on January
11 20th. So, pivoting to this letter was kind of a
12 response from us -- from SACIM -- to say yes,
13 we're on record of saying you can't ever let that
14 happen again no matter who the administration is.
15 But yes, we applaud your efforts and we want to
16 know how we can best serve you.
17 **DR. MAGDA PECK:** So, going to the present
18 moment around strategy, and yes, Paul, the order
19 is exactly as you put it. I just articulated it
20 in terms of the order in which it was discussed
21 here.
22 But putting strategy first and the

1 content and then process. This sounds -- I am not
2 -- I am hearing some very helpful questions about
3 should a standalone letter specific to advancing
4 racial equity as the North Star, as Ed calls it,
5 for SACIM be in and of itself important enough
6 message without specific actions to introduce
7 either the new Secretary or the President,
8 depending on what audience, to how -- what our
9 singular lens is and affirming that particular
10 executive order.
11 Is that a smart strategy or is another
12 strategy to take the content of the letter, which
13 still is an affirmation, to the new Secretary,
14 introduce ourselves to the new Secretary, and meld
15 a condensed version of this particular advancing
16 racial equity response with other specific
17 recommendations that are action-oriented that come
18 out of this meeting and have one letter
19 transmitted to Secretary Becerra as the designee
20 so that it is on record, which would be a way to
21 potentially alter the strategy with sustained
22 intent.

1 The third is don't do anything on racial
2 equity right now because it's a moot point for
3 what our original intent was and just go straight
4 with what we would be doing, which is a letter to
5 the Secretary incoming, in this case a designee,
6 Becerra, and not make specific mention other than
7 in context about the new executive order and
8 advancing racial equity.
9 So, you know, keep as is, fold it
10 together, or new and have it be a piece of it
11 seems to be three potential strategies that we
12 could move forward. And I know we're in our last
13 minute or two, but I'd be curious if any of those
14 resonate.
15 **DR. PAUL WISE:** Not really.
16 And again, it's not because I'm grumpy at
17 the end of the day. Whenever there's a new
18 administration, one of the things that gets
19 examined very quickly is what are all these
20 advisory committees doing and can we get rid of
21 some of them. So, the subtext for anything we
22 transmit is not going on record for some statement

1 on justice but going on record of how we're
2 relevant to the new Secretary.
3 So, I think it's fine to write a letter
4 to the new Secretary outlining what we think are
5 the essential maternal and infant health --
6 basically making the case of why SACIM should
7 exist as opposed to some new assistant deputy
8 associate something or other decides, when they
9 look at the twenty advisory committees, that this
10 one seems irrelevant because the other ones deal
11 with the elderly and constituencies that actually
12 vote. Ours don't.
13 And I think we should be very thoughtful
14 about what we convey soon to the new Secretary to
15 outline what we feel our mandate is and how
16 crucial this is, particularly maternal mortality
17 and equity and continuing racial disparities in
18 infant outcomes and that this is the group that's
19 going to help you solve this. And that to me is
20 where we ought to be focused is making the case
21 for our mandate and not going on record that we
22 believe in the beginning of this superman intro

1 about social justice and wonderful American
2 values.
3 That's just me.
4 **DR. MAGDA PECK:** Thank you, Paul. Just
5 you and well-articulated.
6 I'd like to just check in with Jeanne and
7 Rosemary to see if you have any thoughts about
8 this.
9 **DR. JEANNE CONRY:** I see it differently.
10 So, I would look at this letter as a
11 response and you could reformat it or change it as
12 a congratulations, thank you for signing this,
13 this was an issue last year, we're so glad to be
14 on board, and look at it as a simple,
15 straightforward letter saying you recognized and
16 already addressed a problem that we had raised
17 last year, and I look at that as pretty
18 straightforward.
19 In terms of us justifying why we exist, I
20 thought we did that last year, and that's how we
21 are in existence. But I do agree that assuming
22 Xavier Becerra gets appointed, it would be a great

1 idea to summarize what we -- what our vision is
2 and where we should be going.
3 Fortunately for us, Xavier Becerra has a
4 long history with what we're doing because his
5 wife led the efforts here in California on
6 maternal mortality. And so, we're in a -- I don't
7 want to take anything for granted -- but I think
8 we're finally speaking to receptive ears about
9 what we're doing. So, calling that out
10 strategically, to me is fine.
11 But I kind of look at that as I don't
12 even know what our product -- are we supposed to
13 have a product every three months, do we have a
14 product every year? I don't even know what our
15 products are supposed to be for this committee or
16 yeah. But I look at the letter that came out as
17 something different because it had a specific
18 purpose in mind.
19 **MS. ROSEMARY FOURNIER:** And I would
20 certainly just defer to the members who have a lot
21 more experience than I do. But I do take all of
22 your comments, Paul, as strong and wise. And I

1 think I would go the direction of communicating
2 with the Secretary, not the President.
3 **DR. MAGDA PECK:** Well, I think that we've
4 heard your views. I want to open it generally for
5 any other final comments, and I will do my best
6 tonight to try to synthesize.
7 We do not have consensus around this
8 letter. We have issues to raise and there will be
9 discussion about it.
10 So, there's no recommendation.
11 I just wanted you to have the opportunity
12 -- particularly Jeanne, Paul, and me -- as we
13 participate in the conversation tomorrow knowing
14 that there will be pushback, as seen, as a letter
15 to the President would be congratulatory and
16 therefore a highly political move by some other
17 members of SACIM. And so, how to navigate what
18 has already been expressed as pushback and with a
19 diversity of views, which is healthy for us to
20 have, in our Secretary's advisory committee.
21 Parting -- any other advise before we cut
22 bait at about three after the hour?

1 And let me just start with Ada and
2 Danielle. Anything further that you want to make
3 sure we get to hear?
4 **MS. ADA DETERMAN:** Nothing further.
5 I was, you know, I was interested in the
6 conversation about the county approach that Dr.
7 Warren had mentioned where they focused on, you
8 know, the areas that had the greatest disparity.
9 I didn't know what this group would be doing with
10 that, but that's all that's on my mind right now.
11 Thank you.
12 **DR. MAGDA PECK:** Thank you.
13 Danielle, anything to add?
14 **DR. DANIELLE ELY:** I don't think I do at
15 this point. My brain is done.
16 **DR. MAGDA PECK:** We look forward to
17 having it be revived overnight.
18 Jeanne and Rosemary, any final thoughts?
19 **MS. ROSEMARY FOURNIER:** Not from me.
20 Thank you.
21 **DR. MAGDA PECK:** Jeanne, you seem to have
22 frozen. It must be the time of day. So, noted.

1 Paul, any other advice?
2 I want to thank you all. Thank you to
3 Tina and to Gary and to Emma and to Gina for
4 backing us up. I'll look forward to getting notes
5 eventually and figuring out what the heck I'm
6 going to do. Gina, if you want to stay on for
7 just a minute about cleaning up things, I'd love
8 to have a minute with you to know what's expected.
9 Jeanne, if you do have notes, if you do get back
10 on, please send them to me.
11 Strategy, focus, intention, this is to be
12 opportunistic, to be science-driven, and to be
13 highly collaborative and strategic and scientific
14 in our work.
15 Thank you all for your time today. I
16 look forward to seeing many of you tomorrow.
17 With that, we are adjourned.
18 (Whereupon, the Data and Research to
19 Action Workgroup meeting was adjourned at 6:05
20 p.m.)
21
22
23

1 R E P O R T E R C E R T I F I C A T E

2

3 I, GARY EUELL, Court Reporter and the

4 officer before whom the foregoing portion of the

5 proceedings was taken, hereby certify that the

6 foregoing transcript is a true and accurate record

7 of the proceedings; that the said proceedings were

8 taken electronically by me and transcribed.

9

10 I further certify that I am not kin to

11 any of the parties to this proceeding; nor am I

12 directly or indirectly invested in the outcome of

13 this proceedings, and I am not in the employ of

14 any of the parties involved in it.

15

16 IN WITNESS WHEREOF, I have hereunto set

17 my hand, this 10th day of February 2021.

18

19

20 ____________/S/_______________

21 Gary Euell

22 Notary Public