1 The Secretary's Advisory Committee on
2 Infant Mortality,
3 US Department of Health and Human Services
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7 Health Equity
8 Workgroup Meeting
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12 4:30 p.m. – 6:00 p.m.
13 January 25, 2021
14
15 Attended Via Webinar
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20
21
22 Reported by Mitchell Gibson
23

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1 **WORKGROUP MEMBERS - continued**

2 **Milton Kotelchuck, Ph.D., M.P.H.**

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8 Chair, Midwives of Color Committee

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12 **Belinda D. Pettiford, M.P.H., B.S., B.A.**

13 *Workgroup Co-Chair, SACIM Member*

14 Women's Health Branch, Head

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17 **Rachel Tetlow**

18 Federal Affairs Director

19 American College of Obstetricians and

20 Gynecologists

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1 **WORKGROUP MEMBERS - continued**

2 **Michal D. Warren, M.D., M.P.H., F.A.A.P**

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6

7 **ALSO PRESENT:**

8 Vincent Levin

9 Mitchell Gibson

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1 **P R O C E E D I N G S**

2 **MS. BELINDA PETTIFORD:** We'll give
3 everybody just another quick minute to get on --
4 into the meeting.
5 I sent out an agenda last night, so if
6 you're already on the committee, you would have
7 received the agenda. If you're not, you don't
8 have it. But I'll share my screen because it's
9 pretty brief.
10 But I want to give people another 40
11 seconds to join us, just in case another few
12 others are coming in.
13 The meeting is being recorded, so if you
14 don't want to be recorded, this is your time.
15 Okay. Maybe, we've got 20. We got a
16 great group. Excellent.
17 And Janell is not going to be able to
18 join us today. She does send her regrets, but she
19 had already scheduled this time to do something
20 with her family. And by all means, we do not want
21 her to change that. And that's very important.
22 And so, she does send her regrets. But just know

1 that she is here in spirit.
2 So, thanks so much, everyone. Again,
3 some of you received the agenda, some of you have
4 not. If you can just type your name in the chat
5 box, I think that's going to save us some time,
6 because I am sure at 6:00 eastern time, you all
7 will be strutting out.
8 So, you might leave before then.
9 Hopefully you can hang out as long as possible.
10 If you've been participating in the full SACIM
11 meeting much of the day, you probably heard kind
12 of the message that Ed, our interim Chair, just
13 provided for us.
14 He really needs us to focus on this
15 meeting, and because we are the Health Equity --
16 we've come up with some recommendations for the
17 specific areas that we've been focused on today.
18 And those specific areas are COVID 19. And I know
19 we've come up with some recommendations earlier,
20 so maybe we can just update those unless we think
21 of something new. And we're going to have -- and
22 so if you just heard the presentation by Paul and

1 -- oh, my gosh, I just forgot her name already.
2 The midwife from that area, the -- you already
3 know some of the things that you may want to think
4 about as recommendations there.
5 We have talked about in this group of
6 before, racism. I want to make sure we're
7 including that as well as environmental health.
8 Which we're going to talk more about it tomorrow.
9 But if you have any recommendations or suggestions
10 there.
11 And in the morning, we're going to have
12 to do a presentation to share with the group what
13 we talked about today. So, if someone wants to
14 take notes, that's great. If not, I'm going to
15 pull up my other computer screen and try to
16 facilitate and take notes at the same time.
17 That's the one great thing about being in the
18 office today, where normally I'm working from home
19 is that I do have three computer monitors. So, I
20 can take multiple notes different places.
21 So again, if you could put your name, if
22 your representing someone other than yourself in

1 the chat box, we would appreciate that. Or I
2 guess I should say, I would appreciate that.
3 So, thanks, everyone.
4 So why don't we start, just talking
5 **DR. WENDY DECOURCEY:** I just -- I'm sorry
6 to interrupt but I noticed that after Mitchell
7 Gibson name, it says transcriber. So, I wasn't
8 sure about notes needing to be taken, if it was
9 being transcribed. I don't know if you're out
10 there, Mitchell. I don't know if it's just a
11 tile, or -- that's reality?
12 **MS. BELINDA PETTIFORD:** We have a note
13 taker? Excellent.
14 **DR. WENDY DECOURCEY:** I'm not sure.
15 Mitchell, if you want to confirm that.
16 **MR. VINCENT LEVINE:** This is Vincent
17 Levin with the meeting contractor. We have a
18 transcriber and a note taker in the meeting, so we
19 are well covered on all fronts.
20 **MS. BELINDA PETTIFORD:** Thank you,
21 Vincent.
22 So, we have a note taker. Am I going to

1 be able to get the notes that quickly? Because I
2 got --
3 **MR. VINCENT LEVINE:** Yes, they will be
4 sent to you tonight.
5 **DR. WENDY DECOURCEY:** All right, great.
6 **MS. BELINDA PETTIFORD:** Thank you, Wendy.
7 That's a big help. So, I don't have to try to
8 triple task.
9 **DR. WENDY DECOURCEY:** Exactly.
10 **MS. BELINDA PETTIFORD:** So, we have --
11 since we've had our last meeting, and I sent to
12 several of you all last night the letter, the
13 draft letter that Ed had mentioned that we're
14 trying to have prepared to go to President Biden.
15 So, I don't know if people have had a chance to
16 see that letter, input they want to share. I can
17 try to share my screen, if you have not seen it
18 for folks that want to see it.
19 Give me a moment and I will share my
20 screen. I pulled it up on the wrong computer.
21 Because we do want to get some feedback
22 on this letter. It is opening now. I want to

1 make it larger so everybody can see it. Not 400
2 percent larger, but larger.
3 Okay. Let me see if I have access to
4 share my screen.
5 (Computer Voice: Recording Stopped.)
6 **MS. BELINDA PETTIFORD:** Okay. Can you
7 all see my screen?
8 **DR. WENDY DECOURCEY:** Yes.
9 **MS. BELINDA PETTIFORD:** Okay. Did the
10 recording stop on its own?
11 (Computer voice: Recording in Progress.)
12 **MS. BELINDA PETTIFORD:** Okay. Or did I
13 do something when I opened that up.
14 Okay. So, I wanted people to get a
15 chance to see the letter here. And I'll just be
16 quiet for a moment and give you all a chance to
17 review it briefly. And I'm going to go up and try
18 not to make you dizzy.
19 Okay. Do people have any thoughts or
20 concerns about the letter? Anything you think is
21 missing? Think it is on point, with a starting
22 place?

1 I'm going to stop sharing so I can see
2 you.
3 Thoughts, concerns about the letter? Did
4 everyone get to see it?
5 **MS. RACHEL TETLOW:** This is Rachel. I'm
6 -- I'm happy to speak up. So nice to see you,
7 Belinda.
8 I am curious about the thought process
9 behind the executive orders as kind of the framing
10 -- as opposed to like a blog or -- I'm just
11 curious, is that just what --
12 **MS. BELINDA PETTIFORD:** Yeah, I think one
13 of the reasons is we were working on a letter
14 earlier where we had had concerns about the
15 executive order. And President Biden eliminated
16 the executive order on his first day. I think
17 that it just connected it that way.
18 I mean, if you're feeling like it should
19 have a broader focus, we can definitely share
20 that. But initially, our focus was on explaining
21 why we thought the executive order was
22 inappropriate and needed to be removed. And so

1 now that we don't have to do that, it was just
2 showing that -- and I don't know, Paul, if you
3 have other thoughts on that as a --
4 **DR. PAUL JARRIS:** I think that --
5 symbolic and substantial statement that this was
6 made. I think we were on a course consistent with
7 the lower branches of the --
8 **MS. BELINDA PETTIFORD:** You're breaking
9 up, Paul.
10 **DR. PAUL JARRIS:** That we will not
11 receive -- that -- I'm sorry. That's all we can
12 do about it, so --
13 **MS. BELINDA PETTIFORD:** It's getting
14 better the more you talk.
15 **DR. PAUL JARRIS:** That's the opposite of
16 what I'm usually told.
17 In any case, I'm guess I'm saying that
18 it's a very symbolic and substantial statement the
19 president made on his first day in office, very
20 consistent with the delivery and the thought that
21 we'll never achieve what we need to in infant
22 mortality and in maternal health in this country.

1 He very explicitly addressed issues around equity
2 and the underlying systemic and historical racism
3 driving the outcomes that we have. So, I think
4 that's the reason this committee put this forward
5 really to take advantage of -- what I think is
6 potentially and hopefully a historic opportunity.
7 I hope you got some of that.
8 **MS. BELINDA PETTIFORD:** We did, Paul.
9 Thank you.
10 You were just breaking up at the very
11 beginning.
12 Did that answer your question, Rachel?
13 **MS. RACHEL TETLOW:** Yeah, I think so. I
14 mean, I -- my thinking was more that I think there
15 -- there's a lot to be done, like, that -- that
16 the executive order is definitely a beginning but
17 also that there's going to be more to do beyond
18 that. And so, I -- but I think that the way that
19 the letter is written kind of uses that -- here's
20 our in, and you've demonstrated on day one your
21 commitment, and here's how we can build that out.
22 So, I think it does a good job of that.

1 I was just curious about the thought process
2 behind it. So, thank you.
3 **MS. BELINDA PETTIFORD:** Thanks for your
4 feedback.
5 Others? Yes, Pat? And then Milt.
6 **MS. PATRICIA LOFTMAN:** Yeah.
7 My assessment of this letter is that it
8 is just a beginning as a framework as a place to
9 start and not the end all and be all and that
10 certainly there will be more recommendations
11 forthcoming. But I think -- at least I don't want
12 to put words in people's mouth. I'm hoping that
13 this was just a signal to the new administration
14 that we are support and appreciative of this
15 initial action, which really would have -- which
16 really will give us some freedom with -- I think
17 we're going to feel like Dr. Fauci, you know,
18 we've been liberated. And will give us, you know,
19 an opportunity to do the work that we have to do.
20 So that's my take on it. That's my
21 interpretation.
22 **DR. PAUL JARRIS:** Yeah, I think that's

1 exactly right. Because there was a question over
2 the past four years about how much we could delve
3 into some of these years. There are clearly is
4 some opportunity around rural versus urban. But
5 there seems to be a diminished opportunity in
6 terms of racial and ethnic.
7 So, this is really saying, yeah, we're
8 with you. We need to move on this.
9 **MS. BELINDA PETTIFORD:** Thanks Paul.
10 Milton? Milt?
11 **DR. MILTON KOTELCHUCK:** Yeah, so this is
12 -- it's a fine letter. I agree with everybody
13 else. It's a -- it's just signaling to the new
14 administration.
15 But I do think that -- it didn't use the
16 word social determinants. It makes -- it makes
17 structural racism -- it didn't use the word
18 historical. It makes it like it's its own topic,
19 where it is its own topic. But I do think we
20 should say something -- use the word social
21 determinants of health, a little bit --
22 particularly when we -- the letter is an

1 unbalanced letter between health and health
2 access. And all the other factors, which involve
3 the housing, nutrition, those other factors are
4 actually the dominant factors. And those have
5 really -- even more profound structural racism
6 built into them. But I just would -- I would
7 strengthen that aspect of the letter. There's
8 like a sentence or two where if you just use the
9 word -- many of your other activities that you're
10 supporting are going to build up, you know, the --
11 the funds for families that are being proposed,
12 you know, COVID relief. Those are also addressed.
13 You don't need to say that, but there's a
14 place somewhere -- this is the first time reading
15 the letter, but I would use the word social
16 determinant -- right in this paragraph, we also
17 note racial disparities
18 That's -- that's where I would say we
19 also note that racial disparities are directly
20 impacted by social determinants of health, in food
21 security, education, which your administration is
22 also working on.

1 And last but not least, this is just as a
2 former member of the SACIM -- I would just say the
3 person -- it's great to send this to the
4 President. He'll see the letter, but it will go
5 somewhere.
6 But really, you want to address this
7 ultimately to the head of the Health and Human
8 Services. You've got to a really interesting
9 person who is the head of that, and his wife is a
10 long-time person who works in our field.
11 **MS. BELINDA PETTIFORD:** What were you
12 saying, Milt? Was somebody else speaking at the
13 same time?
14 **DR. MILTON KOTELCHUCK:** Yeah, someone
15 else did.
16 **MS. BELINDA PETTIFORD:** Okay.
17 **DR. MILTON KOTELCHUCK:** But I just said
18 you want this letter, also -- you want to think as
19 this is your first letter moving up the chain, as
20 the previous speaker just said. It's your first
21 stab at it, it's fine. But it also really -- as a
22 -- as a SACIM, your direct person who can do

1 things is the head of Health and Human Services.
2 Even if, in fact, her areas of need are greater
3 than Health and Human Services. But that's who
4 you're really writing the letter to over time.
5 **MS. BELINDA PETTIFORD:** You --
6 **DR. MILTON KOTELCHUCK:** It's hard -- it's
7 hard to get that Health and Human Service
8 Secretary to show up at one of your meetings
9 someday. That's what I would also be asking for.
10 You know, could you come speak to us? The
11 President is not going to do that, but the head of
12 Health and Human Services will, and that's who you
13 want to talk to because that allows you to speak
14 to a wide range of topics.
15 Past advice. I'll get off. I'll let
16 others talk.
17 **MS. BELINDA PETTIFORD:** Thanks, Milton.
18 I'm wondering if people are good with the
19 letter still going to the President based on the
20 way it was worded, but it will definitely copied
21 to the Secretary of Health and Human Services.
22 **DR. MILTON KOTELCHUCK:** Yeah, yeah.

1 **MS. BELINDA PETTIFORD:** And include in
2 the letter a request of the Secretary of Health
3 and Human Services to meet with the group, attend
4 one of our meetings.
5 **DR. MILTON KOTELCHUCK:** Yep.
6 **MS. BELINDA PETTIFORD:** And you said his
7 wife is an MCA chair?
8 **DR. MILTON KOTELCHUCK:** His wife is an
9 obstetrician.
10 **MS. BELINDA PETTIFORD:** Oh, okay.
11 **DR. MILTON KOTELCHUCK:** She's a -- she's
12 a longtime activist. So, there's more to him than
13 one realizes, okay?
14 **MS. BELINDA PETTIFORD:** Obviously. Okay.
15 Thank you.
16 Anyone else before we switch over to the
17 recommendations? These are great. Thank you all
18 for your feedback on those.
19 Why don't we switch over now to COVID-19?
20 So, we know we've come up with recommendations
21 before around COVID 19. I think we have them in -
22 - we've come up with them in other recommendation

1 areas.

2 But anything that you all think based on
3 the presentation today that we should move up and
4 include as a recommendation from our committee?
5 We've heard a lot today about pregnancy and COVID,
6 infants and COVID, information about whether
7 pregnant women should be included in clinical
8 trials. We talked -- heard about individuals of
9 reproductive age and COVID. So, anything that you
10 think we should be making as a recommendation that
11 we can send back to the full SACIM?

12 You can't all be quiet at once? I see
13 you waving.

14 **MS. PATRICIA LOFTMAN:** I find myself
15 conflicted because I think before we should make
16 recommendations, we really have to have an
17 understanding of why people behave the way they
18 do.

19 So, for example, I could actually combine
20 COVID and -- and racism, because a lot of what --
21 a lot of what we're experiencing in terms of the
22 reluctance of African Americans to accept the

1 vaccine has its roots and its history in racism.
2 So, for example -- so, for example, you
3 know, if we really wanted to improve many areas --
4 many individuals don't have a universal access.
5 So, we'll say maybe one recommendation would be
6 improved universal access. And I think that
7 really goes to the area, the issue of -- you know,
8 probably Medicare for all. But that's certainly
9 one recommendation that I think would bear some
10 fruit.
11 And then, of course, some of the other
12 barriers that would need to be disrupted, and so
13 recommendations I would recommend recommendations
14 addressing those would -- say would be to various
15 -- to access to providers and in areas where we
16 have medical deserts.
17 So how do we get -- how do we improve
18 access? Not just universal access, but how do we
19 improve the systems and structures that are needed
20 to improve the ability of individuals to access
21 health care?
22 So I think a lot of this has to do with -

1 - with history, and then how do you overcome those
2 historical barriers that would prevent individuals
3 either from accessing, say, the vaccine, which is
4 where COVID comes in, or just presenting
5 themselves for -- for continued health care?
6 **MS. BELINDA PETTIFORD:** Thank you, Pat.
7 And I understand the connection your
8 making, but as you're thinking through individuals
9 of reproductive age, are you making the
10 connection, the whole issue of trust? It's a
11 trust issue, and that we're dealing with,
12 especially with older adults and then they pass
13 their message on down to their children?
14 **MS. PATRICIA LOFTMAN:** It's actually --
15 it's actually both. I don't -- yeah, when I --
16 when I, you know, listen to programs on -- on
17 black radio, you -- you would understand why so
18 many African Americans -- it's -- the language
19 that's being used is vaccination hesitancy, or
20 vaccination reluctant. It is neither hesitant or
21 reluctant. There is a desire not to accept the
22 vaccine.

1 And so -- so, number one, we're not even
2 using the correct language. When -- so that's a
3 problem. Because if you don't use the correct
4 language, you're not talking -- you're not talking
5 about the same issue.
6 So, I would recommend, and I would be
7 willing to hear what other people have, but
8 vaccination hesitancy and vaccination reluctance,
9 not the issue. People, generations, there's
10 intergenerational transfer of information not just
11 about Tuskegee. And keep in mind that many
12 individuals are aware that black and brown doctors
13 and nurses were the main avenue getting black men
14 into that study.
15 So, again, the narrative around, you
16 know, communities using people that they trust,
17 well, they trusted black doctors and nurses with
18 Tuskegee, and we know what happened.
19 But there's also beginning information
20 around the whole Guatemala study, and people are
21 beginning to talk about that more.
22 So, I think we have to begin to really

1 tackle it honestly, what the -- it's a barrier.
2 It's not a reluctance, it's not a hesitancy, it is
3 an absolute barrier.
4 **MS. BELINDA PETTIFORD:** Thank you, Pat.
5 So, Rachel, your hand is up.
6 **MS. RACHEL TETLOW:** So -- thank you.
7 From a slightly different kind of not --
8 yeah, I think that's an incredibly important
9 point. I -- one thing that we are hearing from
10 some of our immunization experts now is a real
11 concern that it, you know, we've -- we've come out
12 with this recommendation for pregnant individuals
13 to be able to receive the vaccine, and there is
14 real concern that they are about -- about what
15 comes next? Is the data collection and -- the
16 research continuing to happen that is really
17 needed to advance our understanding of the
18 vaccine?
19 So, kind of on the other end of it, once
20 folks get the vaccine, then what -- what happens?
21 Are they getting the follow up that -- that is
22 needed?

1 And so that we can understand how the
2 impacts on pregnancy, the long term -- the things
3 that were not uniformly gathered in the research,
4 kind of in the trial phase now that this vaccine
5 is happening, people are getting vaccinated,
6 what's happening now.
7 And I think, you know, with a new
8 administration coming in, with new folks who are
9 involved in this work, I think it's really
10 important to -- that we continue to push for that
11 type of information and data collection to happen
12 because I think, you know, there's -- in all the
13 competing priorities around COVID, this is the
14 population that we're concerned will be left
15 behind still.
16 **MS. BELINDA PETTIFORD:** I wonder Rachel
17 are you extending that also to not just pregnant
18 women, but individuals of reproductive age that
19 might get pregnant after they get the vaccine?
20 And is there follow up with them as well?
21 **MS. RACHEL TETLOW:** Well, I think
22 absolutely that would be ideal, an ideal scenario.

1 **MS. BELINDA PETTIFORD:** Pregnant women
2 first?
3 **MS. RACHEL TETLOW:** Yeah. But if we're
4 going to ask for expansive data collection and
5 understanding, I think that it makes a lot of
6 sense to do that population as well.
7 **MS. BELINDA PETTIFORD:** Thank you.
8 Paul, did I see your hand up a moment
9 ago? And then I'll come back to you, path.
10 **DR. PAUL JARRIS:** I was -- and you may
11 have noticed, Michael's comments -- Michael
12 Warren's comments in the
13 **MS. BELINDA PETTIFORD:** Oh, no, I'm
14 sorry, nope, I had not.
15 **DR. PAUL JARRIS:** When we get to it
16 later, basically, the things – well one of the
17 things we should look at are specific
18 recommendations this committee has on some of the
19 MCHB and programs with regard to promoting equity.
20 Because as Michael raised earlier, someone made
21 the point -- sorry, Michael to talk to you because
22 I would forget why later.

1 Michael raised earlier, someone raised
2 the point, well, why -- can -- can we, in fact,
3 push some of the states toward including equity in
4 their work?
5 And I think that's a really important
6 thing for this committee to look at, it could be a
7 really tangible recommendation.
8 **MS. BELINDA PETTIFORD:** Michael, do you
9 have the authority to do that under MCHB?
10 **DR. MICHAEL WARREN:** For MCHB programs,
11 yeah. I mean, as long as it's not contradicted in
12 our legislative authority, we have an air amount
13 of latitude within our program. So, for example,
14 Healthy Start, you know, there are broad lines on
15 the road for the way we operate Healthy Start.
16 But in terms of performance measures, we require
17 people to report on or specific activities or
18 areas of focus, the same with the block. MCHB is
19 probably more prescriptive than any of our
20 programs just in terms of that -- that law is --
21 is written pretty specifically.
22 But we would absolutely welcome -- and I

1 think to the earlier conversation about an infant
2 mortality approach to -- to bypassing healthy
3 people 2030, or bypassing that target, I should
4 say, and getting to equity by 2030, how do we do
5 that? What should we -- what should we do? Who
6 should we engage? Are there things we can do
7 within existing programs? Are there levers that
8 we're not pulling right knew?
9 Because everybody always says, oh, we
10 need more money, we need to do this. This may
11 well be the case, and until then, I don't want to
12 sit and wait until we get more money because who
13 knows when that will come. I want to say what can
14 we do now, and what can we do moving forward?
15 **MS. BELINDA PETTIFORD:** Thank you,
16 Michael. We'll definitely come back to the that
17 at the end if we have a moment.
18 Pat, was your -- was your hand up about
19 COVID?
20 **MS. PATRICIA LOFTMAN:** Yeah, and I think
21 my only concern is, and I'm going to harken back
22 to my HIV days, when there was concern about

1 including pregnant women in HIV trials, is the
2 same analogy today, pregnant weren't included in
3 the COVID trials so there's really no
4 recommendation.
5 But I think ultimately, we understood
6 that women had a right to autonomy and decision
7 making. And I -- and I think at some point we
8 have to figure out what's -- you know, in terms of
9 informed consent, what do we -- what information
10 do we share with women in terms of informed -- I'm
11 talking about pregnant women now, and even women
12 of reproductive age. Because I think that is the
13 issue. The -- the informed consent and the
14 content in that informed consent.
15 **MS. BELINDA PETTIFORD:** Thank you, Pat.
16 Cheryl, I see your hand is up? Well,
17 your hand was up? Is that
18 **DR. CHERYL CLARK:** Okay. Hi, I'm sorry,
19 yes. I'm just trying to manipulate all these
20 icons. I'm getting confused.
21 I just kind of want to just support owe
22 there's so many things to talk about, I don't want

1 to make iffy comments, because I could.
2 But I do want to say, is there going to
3 be anything there for the supporting of
4 information collection? I think Rachel was kind
5 of mentioning that. Because it was so poor with
6 testing and -- and even incidents, you know, and
7 the prevalence in the community and whatever, is
8 there any language in the letter, maybe I can step
9 out for a second, that kind of makes -- provides
10 some support for assuring the infrastructure of
11 collection? Because we're not going to know
12 anything if we have -- it's going to be dribbled
13 out, kind of like it has been, if we don't get the
14 reporting and then our -- our information
15 collection systems up.
16 And then also, too, able to collect
17 things that are not just disease presence or not -
18 - or you know, antibody presence or not. But
19 also, some of these social determinant
20 information's that I'm -- I'm fully agreeing with
21 Pat, just from anecdotal Facebook, you know,
22 people in my family do not want the vaccine. You

1 know, and so how are we going to address that if
2 you don't have the information to kind of see
3 where the -- what's behind some of those
4 decisions.
5 Thanks.
6 **MS. BELINDA PETTIFORD:** Thank you,
7 Cheryl.
8 It's interesting, because my mother is 87
9 years old, and she had told me she was not going
10 to get the vaccine. You know, she and I talked
11 about it for about two months. And then I said
12 she's an adult, she makes the decision on her own.
13 And then one day, her dear friend, who is
14 also 87 years old, the two of them were talking.
15 And they made the decision that they wanted the
16 vaccine. So immediately I had to get her an
17 appointment. I mean, just like immediately. So,
18 this was a Tuesday, and Thursday I had her in a
19 drive through appointment, and my girlfriend had
20 her mother, who is her friend, in a drive through
21 appointment.
22 And they both got their first vaccine,

1 and they have done well. And I think because they
2 have done well, they have shared it with their
3 other network.
4 But it -- but for two months, she told me
5 no. And I don't know what the tipping point was
6 other than the two of them made a decision. But
7 she's not been able to tell me well, what changed
8 your mind? And I decided I don't need to know.
9 But what was interesting to me is my
10 great nieces, who have missed being around -- my
11 great nieces and my nieces who miss being around
12 their grandmother, their granny, whoever they call
13 her. And so, when I told them she had gotten her
14 first vaccine, only one of them said, well, I plan
15 to get mine, and the rest of them said no.
16 And my statement to them was, that is
17 totally up to you whether you get it or not. But
18 you're not going to be able to hang out with your
19 grandmother until you do.
20 And so that is what has changed their
21 mind, is that family dynamic is what's changing
22 their mind. That and it goes with the second

1 dose, their granny gets the second dose.
2 But I do agree there's a lot of variation
3 there. Even in my own state, we immediately, back
4 in April, when this first started, stood up a
5 second whole work group within our department on
6 partnering with historical marginalized
7 populations and hearing their concerns and their
8 issues, and who their thought leaders were, and
9 who people wanted to get their message from.
10 And we still meet every week, and we're
11 trying to figure out whether you call it vaccine
12 hesitancy, or what -- we moved to the whole
13 conversation of so as we're tracking data and
14 who's got access to the vaccine, we're seeing
15 disparities there. But that's because we started
16 off with health care workers, and if you look at
17 that, that was going to be a disparity there.
18 And so now you're getting a conversation
19 around how many people -- what percentage of the -
20 - of communities of color have actually had an
21 opportunity to get the vaccine if they want the
22 vaccine. So, it's been interesting going back and

1 forth.
2 But I want to make sure, Cheryl, I've got
3 yours. You want to make sure we're collecting
4 information about race and ethnicity and all of
5 the different categories of data collection that
6 we do. And this is for individuals that get the
7 vaccine and those that don't?
8 **DR. CHERYL CLARK:** Right. And I just
9 want that collected for everything, actually. But
10 I just think that we're just -- we're just not
11 pushing that message. I mean, all the other
12 messages are very important, but if we are not
13 documenting that anywhere, or you know, I'm trying
14 to kind of find out who is getting it, who exactly
15 is not. And then maybe some of the -- I won't say
16 reasoning, because you may not be able to find
17 that out on the surface, like you were saying,
18 Belinda, but just trying to really hit at that
19 angle to see what is that tipping point for folks
20 to either go ahead and get it done or not. And
21 then -- how to get at that through -- help
22 learning theories and things like that. So, I

1 just want -- I just think that should be
2 mentioned.
3 And I think Paul put something in the --
4 in the chat that kind of went along with some
5 things I was saying.
6 **DR. PAUL JARRIS:** So, the providers are
7 required to enter all their vaccines into the
8 State immunization information systems within 72
9 hours. We know that's not happening.
10 But what I saw -- what I don't know, and
11 maybe someone else does, what kind of demographic
12 information is collected in the IIS. I think the
13 other -- and that's probably generally knowable.
14 The other thing that we need to be
15 careful is that the way the vaccines are rolled
16 out don't introduce institutional biases. There
17 was a question in DC where people were -- it was
18 online registration initially. And there was
19 concerns that some groups are quicker to get
20 online than other groups.
21 And what they found that even when they
22 reserved that seat in, like, Ward 8, there was

1 people from Ward 3 coming to Ward 8 to get it.
2 Now, they have changed that now so you actually
3 have to demonstrate that you live in that ward to
4 get the vaccine.
5 But even with that, my son was contact a
6 tracer in DC, who also was a -- who moved them
7 over to do appointments for the vaccines. 900
8 vaccines filled in two minutes reservations. Two
9 minutes, it's gone. It's like a rock concert.
10 **MS. BELINDA PETTIFORD:** But you're right,
11 it does create disparities because not everyone
12 has access to online systems, nor do they have the
13 expertise. My mother, I had to set up a whole e-
14 mail address for her when I went online and
15 completed information because I couldn't use mine.
16 **DR. PAUL JARRIS:** Yeah.
17 **MS. BELINDA PETTIFORD:** She doesn't have
18 an e mail, but they went off mine, because they
19 said when I go and get my own vaccine, my e mail
20 would have already been used. So, then it
21 required an e mail. And I was like, oh my
22 goodness, you got to set up a whole e mail

1 address?
2 Are there others on COVID before we
3 switch over to immigrant health?
4 And I'll pull some of the other
5 recommendations that we had from COVID earlier to
6 see if they still apply.
7 I don't want to cut anyone off.
8 **DR. PAUL JARRIS:** Belinda, I'm not sure
9 how to articulate this, but one of the things that
10 concerns me is with a lack of paid time off in
11 this country, many people in the service sector
12 don't have sick time, they don't have maternity
13 benefits, family leave or a place where pregnant
14 women has to put themselves at risk by going to
15 work in potentially a high risk situation. So, I
16 don't know quite how to get at that other than
17 some universal -- some level -- it may be too
18 remote or --
19 **MS. BELINDA PETTIFORD:** Well, there were
20 special -- at different points in time, it was
21 interesting, depending on I guess where you
22 worked, there was some special leave that you

1 could take. And I can only speak for my state
2 because I'm a State employee, we were given some
3 special COVID leave if you had to take care of a
4 person that had COVID, or if you had it yourself,
5 it was leave above and beyond. But we know that
6 we were not the norm, and who knows how many other
7 companies had that when we still have so many
8 businesses that offer no paid family leave.
9 So, if you add that on top of, that's a
10 good point Paul.
11 Thank you. Why don't we move over to
12 immigration?
13 We heard presentations today, those of
14 you that you were in the larger SACIM meeting, but
15 immigrant health.
16 We have several recommendations. We
17 actually had some recommendations from our
18 speaker. She came up with some recommendations
19 right there at the end.
20 Immediate entry into health care system
21 at border, network and then support systems; allow
22 the federally qualified health centers to accept

1 all prenatal patients, expand CHIP and Medicaid;
2 low robust routine postpartum care; contraceptive
3 access and coverage. And then she mentioned
4 centering group care model. She mentioned nurse
5 family partnership, migrant clinicians' network.
6 **DR. PAUL JARRIS:** One of the things that
7 I got from Paul Weiss was this notion that some of
8 the immigration policies and some of the policies
9 for caring for individuals. And I -- I took what
10 he said very seriously, and if we change the
11 incentive to disincentive, we may have more
12 children and families coming in, we better be
13 prepared this time, you know, so that people get
14 adequate care rather than completely shameful
15 things that they are running into.
16 I mean, that's going to be really
17 important, to make sure that -- well, first of
18 all, it's so good when you're -- this family
19 separation policy was so immoral to begin with.
20 I'm glad that's gone. But still, we have a
21 responsibility to take care of people when they
22 get here. And it sounds like we may not if we

1 have another surge.
2 **MS. BELINDA PETTIFORD:** Thanks, Paul.
3 Can we make a recommendation of people just have
4 some empathy? It would go a long way in this
5 world.
6 I know I can't -- oh, Rachel, yes?
7 **MS. RACHEL TETLOW:** Sorry. So -- I'm so
8 sorry that I missed part of that presentation of
9 the recommendations that you just mentioned,
10 Belinda, overall sound very great and right in
11 line.
12 One thing that I would recommend also
13 including is reinstating the presumptive release
14 of pregnant individuals from immigration
15 detention. This is a policy under the Obama
16 administration that was reversed early on in the
17 Trump administration I think to a real detriment
18 to the health of pregnant detainees.
19 So, I would recommend that we include
20 that as -- on the list of recommendations, again,
21 the presumptive release of pregnant individuals
22 from the immigration detention.

1 **MS. BELINDA PETTIFORD:** Thank you.
2 **MS. RACHEL TETLOW:** Thank you.
3 **MS. BELINDA PETTIFORD:** The other
4 recommendation she mentioned was a mandatory
5 curriculum for providers on trauma informed care,
6 racism, bias, trafficking. And I thought she
7 mentioned something about -- didn't she mention
8 nurse midwives and doula programs? Am I confusing
9 my presentations today? I don't see it on her
10 slide, but I thought she mentioned that.
11 **MS. PATRICIA LOFTMAN:** I thought she did,
12 too. I thought she was saying that community
13 health workers in -- in birth assistance, account.
14 **MS. BELINDA PETTIFORD:** Thank you.
15 I was trying to remember her name. Maybe Annie,
16 she's a nurse midwife herself.
17 Other recommendations, are you all good
18 with the recommendations she suggested? Any –
19 you're more excited about some than others?
20 **DR. PAUL JARRIS:** One caveat. I think we
21 really have to look into the fact that QACs were
22 not taking – or are unwilling to take women who

1 are further along. Look at that, verify it and
2 see what's going on there.
3 **MS. BELINDA PETTIFORD:** Yeah, we do need
4 to know why that is an issue in not accepting all
5 prenatal patients, is that some disincentive
6 there?
7 **DR. MICHAEL WARREN:** I reached out to
8 colleagues at the Bureau of Primary Health Care.
9 I have not yet heard back, but when I do, I will
10 let you know.
11 **MS. BELINDA PETTIFORD:** Wonderful, thank
12 you.
13 **DR. MICHAEL WARREN:** It does make me
14 wonder, someone earlier speculated about quality
15 measures really that's a timing of entry into
16 premarital care. I don't know. I can't speak for
17 them, but I -- I asked.
18 **DR. PAUL JARRIS:** I believe there is a
19 measure of percentage of patients who are starting
20 prenatal care in the first trimester, which is a
21 good quality measure. And I have seen, back when
22 I was working with managed care organizations, I

1 had pediatric practices who refused to take
2 patients because they were too sick and would mess
3 up their quality parameters. So, I'm hoping
4 that's not what's going on here. But there are
5 unintended consequences sometimes.
6 **MS. BELINDA PETTIFORD:** No, thank you for
7 sharing that, both of you all.
8 Others on immigrant health?
9 **DR. PAUL JARRIS:** I remember – I'm not
10 coming up with the term, is it public burden a --
11 the -- we issue that an immigrant will start using
12 social services or governmental services, that can
13 count against them if they -- public charge, thank
14 you, Rachel.
15 So that is a problem, as we have pregnant
16 women who need prenatal care. We don't want any
17 disincentive to prenatal care.
18 **MS. BELINDA PETTIFORD:** So are we
19 suggesting that we remove it
20 **DR. PAUL JARRIS:** Or, yeah, so there --
21 I mean, if we want to. I mean, there's a very
22 narrow interpretation, remove it from pregnant

1 women and newborns. But there's a whole other
2 issue of whether it should exist as all.
3 **MS. BELINDA PETTIFORD:** All right.
4 Rachel, you put in the chat, there are calls --
5 wait a minute -- there are calls broadly to extend
6 the public charge regulation?
7 **MS. RACHEL TETLOW:** Oh, yes. I mean,
8 that's like uniformly supported by the medical
9 community, the maternal health community as far as
10 I know, the reproductive health community pretty
11 much universally just like that, yeah. Just as
12 was said it says -- serves – it serves as a
13 disincentive to use services even if you are -- if
14 you are eligible to receive them. And -- so
15 there's been a lot of concern around the chilling
16 effect it's had, even for those that wouldn't be
17 subject to public charge because -- because of the
18 confusion around it.
19 **MS. BELINDA PETTIFORD:** I see Lilly, you
20 echo that trauma informed care training for
21 providers as essential, all to completely agree
22 that doula programs would be helpful and general

1 but specifically related to this topic, especially
2 when pregnant women are separated from their
3 partners, their main support.
4 So, should one of our recommendations is
5 that they are not separated from their partners?
6 Or we would not make that as a recommendation?
7 **DR. WENDY DECOURCEY:** Or whoever their
8 primary support is.
9 **MS. BELINDA PETTIFORD:** Thank you.
10 **MS. BELINDA PETTIFORD:** I'm missing a lot
11 of conversations in the chat box. You all can
12 just chime in.
13 Others on immigrant health? Paul -- Paul,
14 you want to share your note in the chat around
15 conducting an equity assessment in federal
16 agencies?
17 **DR. PAUL JARRIS:** Sure.
18 In looking over the Presidential order,
19 there -- it does call for --- some of the guidance
20 for agencies specifically to look into issues
21 around access to their services or -- I can't
22 remember the term used, vulnerable populations or

1 whatever, underserved populations.

2 So, when the issue is raised about
3 whether or not MCHB in particular could be a
4 little more prescriptive in terms of people
5 addressing equity in the states, I think this is a
6 mechanism for which to do that.

7 We could -- we could ask the President to
8 it have the Secretary do -- you know, do an
9 assessment of -- from an equity lens of programs
10 and services within HRSA including the Maternal
11 and Child Health or grants, you know, with
12 everything else. And to address them.

13 So, in other words, that -- that may give
14 an opening to have a little more -- have some more
15 standard questions, measures, and even
16 requirements about addressing health equity by the
17 recipients of the HRSA grants.

18 A tortured way of saying what I wanted to
19 say. Hopefully it came across.

20 **MS. BELINDA PETTIFORD:** Understood. It
21 helped. Thank you, Paul.

22 Anyone else have any questions about

1 that?
2 Other comments on immigrant health?
3 Okay. We're going to jump over to
4 racism. I know we have talked about it before. I
5 would like to pull up my latest note.
6 I know we had a work group that looked at
7 access to care and workforce issues.
8 Anything that we want to have focused on
9 racism in general?
10 **DR. PAUL JARRIS:** I'm hoping that it's
11 been rescinded, but there was an order,
12 Presidential order several months ago prohibiting
13 the federal government from supporting any
14 programs around implicit bias and any association
15 with --
16 **DR. MICHAEL WARREN:** It's gone.
17 **DR. WENDY DECOURCEY:** It's been
18 rescinded.
19 **MS. BELINDA PETTIFORD:** Yeah, I thought
20 -- I thought that was the one that was rescinded.
21 **DR. WENDY DECOURCEY:** It is. Trainings
22 -- it's the one about trainings, focused in on

1 sort of anything with trainings with certain
2 words.
3 **DR. PAUL JARRIS:** Yeah.
4 **MS. BELINDA PETTIFORD:** We want to move
5 on a recommendation to make sure training is
6 occur, though?
7 **DR. WENDY DECOURCEY:** Yeah, maybe after
8 reestablishment or something.
9 **MS. BELINDA PETTIFORD:** After
10 reestablishment -- is that you Wendy talking?
11 **DR. WENDY DECOURCEY:** Yeah, I shouldn't
12 be talking. Sorry.
13 **MS. BELINDA PETTIFORD:** No, you can talk.
14 **DR. WENDY DECOURCEY:** I was probably too
15 long. No, I'll be quiet.
16 **MS. BELINDA PETTIFORD:** You can speak,
17 Wendy.
18 **DR. WENDY DECOURCEY:** I know. But as an
19 ex officio member, I'm just -- I'm really getting
20 some power from listening, so thank you.
21 **MS. BELINDA PETTIFORD:** Okay. Please
22 know that everyone on this meeting is open to

1 speaking.

2 **DR. WENDY DECOURCEY:** Thank you, Belinda.

3 **DR. CHERYL CLARK:** This is Cheryl again.

4 You know, and Belinda, you know this
5 because of your work with the Health Equity
6 Committee, we're -- we're trying to move it just
7 beyond training, and what does that mean? You
8 know, are you training for -- to have equity
9 across your operations? You know, and that means
10 everything. You know, everything you do as an
11 organization or entity, that you are putting at
12 the forefront from hiring. And not only, you know
13 -- and also inclusion in your activities, funding,
14 distribution, you know, the whole nine.

15 And so, if it's -- I don't know. And I'm
16 -- I'm really tired, so I don't think I have the
17 words to say exactly what you put as a
18 recommendation. But it needs to go a little bit
19 further than this training and be more specific
20 about what are you training for. And what do you
21 hope the outcomes of that training will be, and
22 how are you ensuring that -- that whatever you

1 were hoping for is implemented and
2 operationalized?
3 **DR. PAUL JARRIS:** Yeah, I think it
4 really will go beyond what are the policies, what
5 are the procedures, what is the grant making
6 process? It's the grant making process of
7 reinforcing equity and equitable access to grants
8 and funds and training.
9 Because just training people doesn't
10 necessarily accomplish anything.
11 **MS. BELINDA PETTIFORD:** So when we're
12 saying training, but also at the funding level --
13 we're seeing something on the funding level about
14 doing a health -- an equity assessment, should --
15 is that -- should we not say the same thing, if
16 you're getting funding from the federal program,
17 your organization should do your own assessment?
18 And then develop recommendations from that
19 assessment to address the issues?
20 Because what good is just a federal
21 agency to do their impact assessment or -- I can't
22 remember exactly what -- equity assessment of the

1 HHS and other federal agencies, we need -- if
2 you're getting funding from the federal agencies,
3 that those organizations are getting the funding
4 are showing that they are doing an assessment as
5 well. Because we tonight know just the federal
6 agencies to be an equitable place, we need all of
7 us. If you think of all the organizations that
8 get federal dollars to go down to them, and they
9 were also required to do an equity impact
10 assessment, or some version of that, then we could
11 have a stronger impact.
12 **DR. CHERYL CLARK:** I never know, you
13 know, the difference between recommendation and
14 what the arm of the federal government can and
15 can't do. You know, I'm always confused about
16 that.
17 **MS. BELINDA PETTIFORD:** We can always
18 make a recommendation and
19 **DR. CHERYL CLARK:** Then they say no we
20 can't do that.
21 **DR. PAUL JARRIS:** It can certainly be
22 investigated because there are requirements on

1 federal grantees -- like, all federal grantees are
2 supposed to -- I mean, you have to have language
3 accessibility and all kinds of different -- I'm
4 spacing on the particular laws right now, but
5 **MS. BELINDA PETTIFORD:** Right.
6 **DR. PAUL JARRIS:** But there are
7 requirements. You want to
8 **MS. PATRICIA LOFTMAN:** Yeah, Belinda,
9 this is Pat.
10 It would seem to me at minimum, there
11 should be some -- some contingency, connection to
12 some kind of antiracism training that is connected
13 to some outcome -- some measurable outcome that
14 one could devise. But at some level, there should
15 be something. And I would -- I would really
16 recommend starting an in-depth antiracism
17 training.
18 I remember years ago, you know, everybody
19 began to do, you know, diversity training.
20 Usually it's one and done. And there was never
21 any way to document what was the outcome of those
22 types of training.

1 So, I would say not only the training,
2 but the training tied to some outcome measure.
3 **MS. BELINDA PETTIFORD:** Thank you, Pat.
4 **DR. MICHAEL WARREN:** I would add,
5 speaking of outcomes, you know, in the QI world,
6 people talk about what gets measured, gets
7 improved. And I think if we think about improving
8 care, what get paid for gets improved. And with
9 the push towards value-based care and people
10 looking at quality indicators, that's all we don't
11 have quality across the board.
12 In equity in those quality measures, you
13 haven't solved for disparities.
14 And so, you know, to the extent there are
15 opportunities to think about value based care
16 being driven down to stratifying levels, so -- so,
17 for example, it's not just good enough to reduce
18 your primary C section rate in your hospital, but
19 have you done that equitably? And I don't think
20 that is being taken up by and large with folks.
21 But that's -- I mean, that's the big lever, right?
22 Do you get paid for it?

1 Beyond that it's the right thing to do
2 morally as humans, and we know that money makes
3 people move. So that might be something to think
4 about.
5 **DR. PAUL JARRIS:** The science isn't --
6 you know, the measurement isn't there yet, so if -
7 - at a minimum, they need to put some research
8 dollars into developing the methodology.
9 When we did the first population health
10 work group for National -- for NQS, the National
11 Quality forum, our subgroup tried to put forward
12 that thought that there needs to be a goodness and
13 fairness measure for every quality measure.
14 Goodness of the overall outcomes, closing the gap.
15 And the response from the group, well, that's too
16 new, we're not ready for that, even know it was a
17 2002 World Health Organization recommendation and,
18 you know, this was like in the teens.
19 So really, it's going to have to -- we
20 should move in that direction, both measures. But
21 also, you know I mean, it would be nice if every
22 grant you put out required both an equity and an

1 overall goal.

2 Okay. And that will take some -- some

3 technical assistance to get people there, but it

4 would be a wonderful place to arrive at.

5 **MS. BELINDA PETTIFORD:** Yeah, but we're

6 asking for ourselves as well.

7 Others?

8 Okay. I'll pull from our other list as

9 well and add to it.

10 Our next area is environmental health. I

11 know we've not had the presentation on

12 environmental health yet. We'll have that

13 tomorrow.

14 But based on people's interest,

15 knowledge, comfort level with the subject matter

16 already, are there any recommendations anyone has

17 around environmental health?

18 **DR. PAUL JARRIS:** Yeah, there's also

19 your related field of environmental justice, which

20 is very tied what we're talking about now.

21 But you know, the environmental health

22 field is so politically wrought because it – there

1 are many who don't want because of the
2 implications it can have for their relative
3 industry.
4 But I think we're way underestimating the
5 impact of -- of partitioning in their -- what to
6 you call it? Waste disposal sites.
7 **MS. BELINDA PETTIFORD:** Yeah, you can
8 always tell which communities they put the trash
9 dumps, uh huh.
10 **DR. PAUL JARRIS:** Right, right.
11 **MS. BELINDA PETTIFORD:** And the -- and
12 the larger ones, you're right.
13 **DR. PAUL JARRIS:** The challenge there is
14 to sort that out, taking all the influences on
15 those communities, how do you sort the environment
16 in terms of particulate matter and optics from all
17 the other impacts that are There ought to be
18 something that gets stepped up.
19 **MS. BELINDA PETTIFORD:** Let me get
20 Rachel, and then Wendy.
21 **MS. RACHEL TETLOW:** Thank you.
22 I have someone, a little co-worker with me, so if

1 you hear a little background noise, that's --
2 that's why.
3 So recognizing some of the limitations of
4 kind of the scope of this particular advisory
5 committee, the purpose to be advising the
6 Secretary of HHS, and a lot of this, what is
7 happening at EPA, I would actually recommend,
8 including a recommendation -- sorry -- to that
9 end, that the Secretary partner with or work
10 closely with the Secretary of the EPA to -- in
11 recognition that -- that exposure to environment -
12 - to toxic environmental agents does have major
13 impacted on maternal health care, that it is
14 experienced inequitably, that there are certain
15 populations that carry this burden more than
16 others.
17 And so, to work towards addressing this
18 ongoing long-term problem, we need to break down
19 the silos between agencies. So that's one
20 recommendation I would make.
21 Because otherwise, you know, a lot of
22 this work, I think, happens at the EPA level, and

1 so it kind of hamstrings us somewhat in that
2 regard.
3 **MS. BELINDA PETTIFORD:** No, that's a good
4 recommendation, Rachel.
5 **DR. PAUL JARRIS:** Yeah.
6 If Michael, you're still on, you know,
7 Gina McCarthy was the EPA chief. She really got -
8 - and I think just when she left her -- soon as
9 she left the EPA, she went to on to talk about the
10 environmental impacts – health impacts of the
11 environment.
12 She's now, I guess, the White House
13 climate czar. I bet she would come talk to the
14 committee. And she is -- she really gets this
15 stuff.
16 **DR. MICHAEL WARREN:** Can you put her name
17 in the chat, Paul? Or tell me again? I missed
18 the name. Sorry.
19 **MS. BELINDA PETTIFORD:** You're breaking
20 up a little bit there, Paul.
21 **DR. MICHAEL WARREN:** Got it.
22 **MS. BELINDA PETTIFORD:** And Wendy, did

1 you want to make a statement?

2 **DR. WENDY DECOURCEY:** Yeah, and I think

3 it lays over this previous idea of an active

4 partnership between HRSA or Maternal Child Health

5 and EPA.

6 But I was wondering about pushing the

7 social determinant framework and asking EPA to be

8 using that, you know, if they're evaluating

9 communities in regards to environmental impact.

10 **MS. BELINDA PETTIFORD:** Thank you, Wendy.

11 **DR. MICHAEL WARREN:** And I think to

12 Wendy's point, like, with the infant mortality

13 work that we're thinking about, I mean, the usual

14 players will be at the table, but we need housing,

15 we need EPA, we need justice, we need ED. We need

16 all those folks around.

17 Because when we think about those levers,

18 and we think about supporting states and

19 communities to do this work, I mean, I -- I

20 promise I put Ed up to this comment earlier, but,

21 you know, you're talking about the block grant

22 which is, you know, in the grand scheme of the

1 budget, a small amount. In the grand scheme of
2 the State Health Department, a relatively small
3 amount.
4 So, if you're thinking about moving these
5 needles, we have to figure out to engage those.
6 So, I will -- I appreciate this reference to Gina
7 McCarthy. If you've got others, or other ideas,
8 we would love to think about those.
9 **DR. WENDY DECOURCEY:** And this is Wendy
10 again.
11 I'm not sure -- it's clear to me that
12 that's a central issue and also a central driver
13 right now for the globe, environmentally. But I
14 also wonder in terms of sort of more locally.
15 When you said environmental, it just occurred to
16 me, the more local varieties and the levels of
17 chaos in the local community from the disasters of
18 the environment, or from -- that are associated
19 with the environmental changes, or from -- or from
20 COVID, some communities being hit harder. And,
21 like, I'm just wondering if we're speaking more on
22 that climate left, or if we are also considering -

1 - I'm only speaking from the EPA level, I guess.
2 **MS. BELINDA PETTIFORD:** I think we are
3 open to all discussions on environmental health.
4 It's really difficult since we haven't heard the
5 presentation to see exactly how it's being framed.
6 I don't think there's a reason that we couldn't --
7 based on who our speakers are tomorrow, it looks
8 like we got a good group. So, it's going to be
9 group climate change all the way to, you know,
10 other areas. So, if you've got a recommendation
11 that's connected to one of those, I think it's
12 fine to include it.
13 I think we definitely can go beyond EPA.
14 **DR. WENDY DECOURCEY:** Yeah, I've been
15 working from the early childhood care and
16 education field, and you know, the sort of comment
17 going back and forth between ACE workers and their
18 families because they are in the communities being
19 affected by COVID and by impacted by hurricanes
20 and being impacted by fires. So, it's -- I'm just
21 thinking at that level for Maternal Child Health
22 is -- is pretty intense, but it may vary from zone

1 to zone.
2 I don't really have a recommendation.
3 That's just my thought.
4 **MS. BELINDA PETTIFORD:** To turn that
5 around, assure that individuals that are working
6 with families who have been impacted by disasters?
7 I'm just trying to help think of
8 something.
9 **DR. WENDY DECOURCEY:** I think if it goes
10 with the social determinants of health, I think
11 that that -- if that's a model that's considered
12 for that part -- or actually considered by that
13 partnership, you know, that's -- that tends to
14 include the individual and their individual
15 experiences, so --
16 **MS. BELINDA PETTIFORD:** Okay. Thanks,
17 Wendy.
18 Others? We've got 14 minutes.
19 And Avareena, did you have your hand up a
20 moment ago? Or was I seeing things? If you
21 didn't, don't worry about it, but I thought I saw
22 movement on my screen.

1 Okay. So, we talked about COVID, we got
2 immigrant health, we got racism -- thank you,
3 Avareena -- environmental health. And we have --
4 we talked about the letter.
5 We did get -- and then we've got Michael
6 here who is always looking for feedback around the
7 work they are doing on infant mortality.
8 So, Michael, is there something -- a
9 specific question that we can help with or
10 something that will help you? I know you've been
11 listening to the discussion and you have the
12 notes, but is there a specific ask of this group
13 that we can start thinking about that?
14 **DR. MICHAEL WARREN:** Thank you.
15 Yeah, I mean, I think generally, I've
16 noted some things for ideas for generally
17 approaching our equity work. But I think if we
18 think about that goal of equity for infant
19 mortality rates by 2030, if you think about
20 existing programs in this space, and particularly,
21 the one where you've got the most flexibility is
22 healthy start, do you have any feedback or

1 guidance on Healthy Start, you know, the way we
2 organize Healthy Start, what we measure, how we
3 engage Healthy Start in the community to help us
4 move that along?
5 Because I mean, that's a 128-million-
6 dollar investment right now that is in place and
7 it's specifically designed to address infant
8 mortality.
9 So, are there additional things we can do
10 that there? Are there other -- other of our
11 investments that we could leverage in some way to
12 do that? Or are there new things people wish we
13 would do that would be helpful for us to think
14 about should new money become available?
15 **MS. BELINDA PETTIFORD:** Thank you all.
16 Any input? Any feedback?
17 And we can keep this on our agenda for a
18 little while, Michael.
19 And one thing, you know, I think about
20 Healthy Start, you know, because I've been in the
21 Healthy Start world since the '90s. And so, each
22 seen how the program has evolved since 1997, when

1 I first started working with it, until today.
2 Even though I'm not in it day to day, I still have
3 one of the programs is on my team.
4 And it has been an interesting evolution.
5 And it seems like earlier on we focused on systems
6 in the broader community, and now we have moved
7 back to the individual. And I wonder, has that
8 been as helpful for us?
9 And you know, how do we go back and not
10 forget the system piece? Because you know, the
11 system will help, the broader community. What if
12 we're just working one on one and capturing quite
13 a bit of data on that one person, what are we
14 doing with that data? How are we utilizing it?
15 And it just seems like we're getting
16 caught up in a lot of data collection that is
17 taken away from establishing the relationships
18 with families, because even now, families are
19 concerned, they don't want to share all that data
20 with you. Especially if they have already shared
21 similar data with their prenatal care provider or
22 another provider.

1 So, I would love to talk to you about
2 Healthy Start.
3 **DR. MICHAEL WARREN:** Any time.
4 **MS. BELINDA PETTIFORD:** But I would love
5 this group to think about it, too.
6 **DR. WENDY DECOURCEY:** I wasn't able to
7 make it to today's presentation. Have we had a
8 presentation on Healthy Start?
9 **MS. BELINDA PETTIFORD:** We had one on --
10 we had a Healthy Start presentation, was it two
11 years ago, Paul? It seemed like our first meeting
12 that I participated in as a member, we had a
13 Healthy Start presentation, because I think David
14 did that presentation, David Delacruz.
15 **DR. MICHAEL WARREN:** We can certainly
16 arrange that.
17 **MS. BELINDA PETTIFORD:** An update?
18 **DR. MICHAEL WARREN:** Yeah, I think given
19 the new focus, there's been the new clinical
20 dollars that have come in to support the -- the
21 clinical providers at Healthy Start sites is part
22 of the Maternal Health initiative.

1 And there's been the revamping of the
2 performance measurement so there will be some
3 opportunities there. Plus, we've now got -- if
4 that's when you heard the presentation, we would
5 not have had the results of the evaluation, which
6 we now have. Those have been shared with the
7 Healthy Start team, but we can share that with the
8 group.
9 Because I think there's some -- there's
10 some insightful things from that evaluation. This
11 was the one where they linked Healthy Start data,
12 vital records, and plans data together. It was a
13 challenge. And there was some -- some things that
14 came from there that may give us some direction.
15 **DR. CHERYL CLARK:** See, we did that in
16 Florida, and it was really -- for, like, mid-level
17 outcomes. Because, you know, some of the things
18 that we're aiming for, for Christmas --you know,
19 future, and things like that. But it was really
20 enlightening to know, you know, like placement --
21 sleep placement if -- or different things that
22 people indicated that they -- that we considered

1 to be maybe influential in birth outcomes, what
2 were the practices right -- you know, right after
3 delivery? You know, very interesting.
4 I would love to see that report, you
5 know, because I think that that is something that
6 we could directly address and maybe impact the
7 pathway, you know, instead of just trying to wait
8 until the -- you know, in the road which is
9 sometimes, you know, further away of things that
10 happened and we can't really mitigate it at that
11 point.
12 **DR. WENDY DECOURCEY:** Can I ask, do --
13 what the current number of Healthy Start projects
14 there are?
15 **DR. MICHAEL WARREN:** 101.
16 **MS. BELINDA PETTIFORD:** 101.
17 **DR. WENDY DECOURCEY:** 101. And is it
18 still being sort of selected based on need in the
19 community? Is that the approach, or is that just
20 what I recall from the preparation maybe?
21 **DR. MICHAEL WARREN:** Yeah, no, you're
22 right. So, it's a competitive application

1 process. To apply, you need to be in a community
2 where the infant mortality rates at least one and
3 a half times the national average.
4 But that's self-described. So, it's --
5 and people define communities in different ways.
6 We've got somewhere it's the county level,
7 somewhere it's a census tract, some where it's
8 some other evaluation.
9 **DR. WENDY DECOURCEY:** I know that
10 problem.
11 And then I think -- so defining that
12 might be of interest, but also wasn't a question
13 that arose in our earlier discussion that people's
14 effective programs would then grade them out of
15 funding?
16 **MS. BELINDA PETTIFORD:** I think that's
17 been a conversation over the years, and Michael,
18 you may know more. But I know there's been some
19 conversation over the years that if -- that some
20 people, as their data continues to improve, they
21 may volunteer to change their service area because
22 they no longer qualify, is my understanding,

1 Wendy.

2 **DR. MICHAEL WARREN:** So I think that's a
3 key question for us, right, as a federal agency
4 with limited resources and you -- you want to
5 focus and move the needle, so you should start to
6 get improvement in one area if you've got other
7 areas that are still lacking, how do you respond
8 to that?

9 And how do you build in sustainability
10 work into grants so that -- I mean, I used to tell
11 people when at the State, all the time, don't
12 depend on the State funding forever because it's -
13 - it's -- it could be fleeting. And -- and yet I
14 think this is not unique to any particular grant.
15 I think this is true of grants in general. They
16 become sort of the expectation, you know, we got
17 this grant, we'll keep getting this grant.

18 **DR. WENDY DECOURCEY:** Absolutely.

19 **DR. MICHAEL WARREN:** Well, how do you
20 know where it's best targeted to generate the
21 outcomes we need?

22 **MS. BELINDA PETTIFORD:** I think at one

1 point in time, Michael, based on the data, there
2 was a conversation around there were 300
3 communities in the country that qualified for a
4 Healthy Start program. And so only a third of
5 them were receiving the resources. This was
6 probably 10 years ago, that this conversation was
7 going on.
8 So, I don't even know if that's still the
9 case, if you look at -- and then I guess it
10 depends on how you define community.
11 **DR. MICHAEL WARREN:** So, I think
12 generally speaking, there are more -- we would
13 have more entities that would apply for health --
14 well, I know we did. We had more entities that
15 applied that qualified than we actually had
16 funding for.
17 That's also true for MCHB, if you look at
18 the population of kids and families that are
19 served by MCHB versus what's estimated to be
20 eligible, it's almost embarrassingly low.
21 **MS. BELINDA PETTIFORD:** Yeah, we just saw
22 that.

1 **DR. WENDY DECOURCEY:** And just one final
2 question, I'm just wondering if there's any
3 sustainability data. So, after they are
4 discontinued, is there any look at them post --
5 post grant after those programs?
6 **MS. BELINDA PETTIFORD:** You talking about
7 Healthy Start, or are you talking about programs
8 in general, Wendy?
9 **DR. WENDY DECOURCEY:** Healthy -- Healthy
10 Start.
11 **DR. MICHAEL WARREN:** That's a good
12 question. I have not seen that. But I could ask
13 the team to look, particularly folks who got
14 funded previously but didn't get funded in the
15 last cycle, where -- where are they now and what
16 are they doing?
17 And also, I mean, we talk about
18 sustainability all the time, but what are folks
19 doing now, what are folks who are funded now doing
20 from a sustainability planning standpoint? And
21 what TA are we provided them?
22 **DR. WENDY DECOURCEY:** Right. And also,

1 if we have any examples of good sustainers, we
2 want to share that as well.
3 **MS. BELINDA PETTIFORD:** You know, one of
4 -- I know one in North Carolina, because at one
5 point out of our office we had three Healthy Start
6 sites covering three different parts of our state.
7 And they were the last applications that we could
8 only apply for once. And we had to prioritize and
9 figure out what part of the state we were going to
10 continue that partnership with.
11 And we were able to work with another
12 community-based program, with the other ones.
13 But one of the sustainability challenges
14 has been around so how do you keep serving that
15 number of individuals without the resources? And
16 the partners that we've -- you know, that we've
17 had has been Medicaid. So, there are individuals
18 that, you know, the things that Medicaid could pay
19 for that they hadn't been paying for and they were
20 open to paying for, which has sustained a full
21 program -- we were not able to sustain it in
22 several of our counties. It just -- you know,

1 there was just no additional resources there.
2 And we worked with the community to try
3 to come up with resources, but they were saying
4 the same thing.
5 **DR. WENDY DECOURCEY:** Yeah. All right.
6 So, it's not leading to any general recommendation
7 yet, but those were the things I remembered about
8 that presentation.
9 I was excited about those individual
10 grant efforts, and I was excited that they were
11 individualized for their communities, which is
12 really great.
13 **MS. BELINDA PETTIFORD:** Well, good
14 questions, Wendy. You got a good memory, too.
15 We got three minutes. Anything else
16 anyone would like to share?
17 I know we still have the information from
18 our sub-workgroup that looked at access to care,
19 specifically the workforce, and we did not get to
20 that on our agenda today. So, apologies to that
21 group. But please know that we will pick it back
22 up at our very next meeting. We definitely want

1 to great information.
2 And I think I shared it with you all, the
3 notes from that work group.
4 No, I think actually Janell shared it.
5 She sent it out to everyone. So is there anything
6 that wanted the information and did not receive
7 it, just let us know, myself or Janell, and we can
8 forward it to you all.
9 Is there anything else anyone else has?
10 They made recommendations to access to care in the
11 workforce. And so, we come up with some -- the
12 group -- the subgroup came up with some excellent
13 recommendations from around support, equitable
14 reimbursement for midwifery care to leveraging use
15 of existing funding within the national Health
16 Service Corps, supporting research, examining
17 successful models of team-based care. Several
18 recommendations there.
19 **DR. WENDY DECOURCEY:** So, Belinda, do you
20 know where that document will go? What will we do
21 with that?
22 **MS. BELINDA PETTIFORD:** That's an

1 excellent question. We have shared it with the
2 Chair, but we did not have a larger discussion
3 with it -- about it. And I'm thinking we're
4 probably not going to have it tomorrow, but we'll
5 probably be looking at it between now and our next
6 meeting and integrate it into some other
7 recommendations. Because you all did an excellent
8 job.
9 Joya, is your hand up? Or is it my
10 screen? My screen, never mind.
11 **MS. JOYA CHOWDHURY:** No, thank you.
12 **MS. BELINDA PETTIFORD:** You all want that
13 one minute back in your day, don't you?
14 Please know that Dr. Warren is open to
15 suggestions and additional recommendations. So,
16 we're going to keep this question on our to do
17 list for our next meeting. So, as you're thinking
18 about things, please bring them to our next
19 meeting.
20 Janell and I will get together and see if
21 we do another meeting, probably the latter part of
22 February. It will be about -- you know, because

1 we've been trying to meet once a month just to
2 stay connected because of all of the issues that
3 are going on.
4 And tomorrow, during the presentation,
5 those of you who can speak, if I left something
6 out, please either chime in or put it in the chat
7 box and get my attention. We're going to try to
8 take the notes that Mitchell, I think, is taking
9 for us. And we will have a presentation in the
10 morning. I think we actually go first this time.
11 So, I hope everyone has a wonderful
12 evening. Stay safe, and thank you all so very
13 much for joining us this afternoon.
14 Thanks everybody.
15 (Whereupon, the Health Equity Workgroup
16 meeting was adjourned at 6:00 p.m.)
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1 R E P O R T E R C E R T I F I C A T E

2

3 I, MITCHELL GIBSON, Court Reporter and

4 the officer before whom the foregoing portion of

5 the 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 Mitchell Gibson

22 Notary Public