NWX-HRSA MCHB

Moderator: David Delacruz
June 17, 2020
10:00 am CT

Coordinator: Thank you for standing by. At this time, all participants are in a listen-only mode until the question-and-answer session of today's conference. At that time, you may press star 1 to ask a question. I would like to inform all parties that today's call is being recorded. If you have any objections, you may disconnect at this time. I would now like to turn the conference over to Mr. (Lee Wilson). Thank you, you may begin.

(Lee Wilson): Good morning. I'd like to open the Secretary's Advisory Committee on Infant Mortality today, June 17, 2020. My name is (Lee Wilson) and I'm the acting director of the Division of Healthy Start and Perinatal Services, and the Maternal and Child Health Bureau at the Health Resources and Services Administration. I'm also acting as the designated federal official for this meeting, in the absence of David Delacruz. And I appreciate you taking the time this morning to be here with us. Your work and advice on infant mortality and maternal health is very important to MCHB, to HRSA, and to the Department of Health and Human Services, and ultimately for the wellbeing of America's mothers, babies, and families. A great deal of effort and attention has gone into the planning and logistics of this meeting. Although this meeting has always been planned to be a virtual meeting, this is

the first time we've done one with the entire system soup to nuts virtually.

This is also the first time we have done one with a pandemic, with many of our staff deployed to address the public health crisis directly, including our DFO, David Delacruz, and the real churning that has arisen from months of quarantining, job losses, and economic uncertainty, and the spoiling over of social frustrations on matters of race and equality and significant longstanding disparity. That work that you will be doing over these next few days will speak directly to those issues. We encourage you to give your full and open participation. We will be taking notes and recording the proceedings. Minutes from the meeting will be presented back to the committee to be voted on at our September meeting. We will also be allowing time during the meeting tomorrow for public comment.

At this time, I'd like to - I have a standard set of reminders for the committees that I would like to go over. I want to remind the committee members that, as a committee, we are advisors to the Secretary of Health and Human Services, not to the Congress. For anyone associated with the committee or due to your membership on the committee, if you receive inquiries about the committee, please let Dr. (Ellinger) and I know prior to committing to any interview.

I also must remind the committee members that you must recuse yourself from participation in all particular matters likely to affect the financial interests of any organization within which you serve as an officer, director, trustee, or general partner, unless you are also an employee of the organization or unless you have received a waiver from the HSS authorizing official that you may participate. When a vote is scheduled for an activity and is proposed to have a question about a potential conflict of interest, please notify me immediately. Are there any questions? If there are, please note them for the record, and we will try to address them later.

At this time, I'd like to thank you again, and I'd like to turn the meeting over to Dr. (Ed Ellinger). Dr. (Ellinger)?

Dr. (Ed Ellinger): Good morning, everyone, and thank you, (Lee). This is a unique situation. I think most of you on this call have not seen me for a couple of years, when we had our meeting in D.C., when I was there. I was not able to join you in December of this last year when I had a little medical misadventure while I was in D.C. So, you can see I'm doing well, and I thank you for all of the support that you've given me, and I particularly thank (Paul Garrison) and (Belinda Pettiford), who stepped up in the December meeting and took on the chaired tasks and ran the meeting. In reviewing the minutes, it looked like was a great meeting. So, thank (Paul) and (Belinda), thank all of you for the work that you've been doing, and it's nice to be back with you.

Also, the last time that we had a virtual meeting, I was able to be in Rockville at the center of the action. So some of the technical things were done by people who are much more facile in the technology than I am, so I apologize for the delay in the start of the meeting. I called in the wrong number. And so, I accept the responsibility for that, so thank you for the acceptance of that miscue. We've got a busy agenda, and I had some opening comments, so I will share a little bit later in the agenda than right now, because I don't want to infringe upon the time of Mr. (Thomas Engles), the HRSA director.

So - and we can review the minutes a little bit later also in the agenda. We built in some flex time. So, I would like to really now turn it over to Mr. (Thomas Engles), who's the HRSA administrator, and really be interested in his comments. I have to let you know that I was in D.C. a couple of - last year sometime, and I got to meet with Mr. (Engles) in person, and it was a great conversation. He was very supportive of the work that SACIM was doing, and

really supportive of the work of MCHB and all of the work related to maternal and child health, so I think we have a partner in that office. So, Mr. (Engles), are you there?

(Thomas Engles): I am.

Dr. (Ed Ellinger): Great. The floor is yours.

(Thomas Engles): Thank you, sir. Thank you, Dr. (Ellinger). I appreciate the quaint introduction, and I wish we could have a chance to meet again. I know we will at some point in the future, but these are definitely unusual times. Thank you for inviting me here today. I want to share with you how HRSA is working tirelessly on strengthening systems to deliver critical services to our communities during this unprecedented COVID-19 pandemic. HRSA has responded quickly to organize its efforts to support the American people affected by COVID-19 while continuing to oversee more than 90 programs. HRSA works hard to support the most vulnerable populations in our country, such as pregnant women, infants, children, and families in rural areas.

We at HRSA understand pregnant women and moms are fearful and uncertain during these unprecedented times, for not just themselves but for their children and their loved ones. Responsibilities like taking their baby to the pediatrician or visiting the OBGYN to maintain a healthy pregnancy can be challenging during the best of times, for vulnerable populations. But now, are significantly more difficult during the COVID-19 pandemic. HRSA understands these challenges. It's stepping forward as a leader to provide assistance to our vulnerable populations. Let me tell you about some of the great work we've been doing here at HRSA, helping the American people during the time of crisis. The history-making responsibility given to HRSA by HHS to oversee the provider relief fund is another reflection of our

preeminent leadership role in addressing the unprecedented public health crisis.

On April 1, HHS was charged - HHS charged HRSA with managing a $175 billion pool of funds set up by Congress, an amount that is nearly 17 times larger than HRSA's annual budget. These federal dollars will provide relief to hospitals and other healthcare providers on the front lines of the coronavirus response. The funding will be used to reimburse healthcare-related expenses or lost revenue attributable to COVID-19 and ensure uninsured people are tested and receive treatment. Funds started flowing to providers eight days after the time that President Trump signed in the law and will continue to do so until all the funds are expended.

As part of the provider relief fund, HRSA launched the COVID-19 uninsured portal, allowing healthcare providers who have conducted COVID-19 testing and-or provide treatment for uninsured individuals with a COVID-19 diagnosis on or after February 4, 2020, to submit claims for reimbursement. HRSA has awarded more than $2 billion across our programs to combat the coronavirus, since the Coronavirus Aids, Relief, and Economic Security Act, known as the CARES Act, became law in late March. HRSA has awarded multiple rounds of funding to nearly every HRSA-funded health center across the nation to address COVID-19. These awards expand COVID-19 testing, build health centers' capacity to diagnose and treat the disease, and strengthen access to telehealth and distant care services for healthcare providers.

To further support health centers, HRSA awarded $8 million to 73 organizations that provide training and technical assistance to HRSA-funded health centers. These organizations will provide critical COVID-19 resources to health centers, including support and expertise to advance health centers' ability to prevent, prepare, and respond to the COVID-19 pandemic. HRSA

centers across the nation are playing a vital role in supporting the local community response to COVID-19 public health emergencies. Nearly 93 percent of HRSA-funded health centers report testing patients with more than 73 percent offering walk-up or drive-up testing. Health centers are currently providing more than 143,000 weekly COVID-19 tests in their local communities, and that includes antibody testing now.

HRSA Federal Office of Rural Health Policy awarded approximately $150 million to hospitals funded through the Small Rural Hospital Improvement Program. Hospitals will use these funds to provide testing and laboratory services and support the purchase of protective equipment to minimize COVID-19 exposure. HRSA provided $225 million to rural health clinics for COVID-19 testing. These investments will support over 4,500 rural health clinics across the country to support COVID-19 testing efforts and expand access to testing in rural communities. The funding may be used for a wide range of COVID-19 testing-related expenses, including for planning of implementation of COVID-19 testing programs, procuring supplies to provide testing, training providers and staff on COVID-19 testing procedures, and reporting data to HHS on COVID-19 testing activities.

Funds may also be used for building on or construction of a temporary structure, leasing of properties, or retrofitting facilities as necessary to support COVID-19 response. HRSA also awarded $500,000 to support technical assistance efforts to rural health clinics as they expand testing capabilities. This includes activities such as conducting webinars, providing resources and guidance for implementation and management of testing programs. In addition to these rural investments, HRSA also awarded $15 million to 52 tribes, tribal organizations, urban Indian Health organizations, and other health service providers to tribes across 20 states to prepare, prevent, and respond to COVID-19 in rural tribal communities. These awards were based on their

needs and capacity to implement COVID-19 related activities in their rural communities, and allow tribes maximum flexibility in how they respond to COVID-19 within their communities.

Additionally, since April of this year, we have invested $46.5 million throughout our programs to increase telehealth capabilities in response to COVID-19. We want to help those in need to be able to access healthcare. We want to make it so individuals will not have to choose between healthcare and social distancing. When individuals can get healthcare through telehealth, we protect ourselves, our families, and our communities as a whole. Through increased telehealth capacity made possible by these funds, organizations will be able to maintain primary care services when clinics and medical facilities are not available to individuals for in-person services. This is especially valuable for COVID-19 positive, quarantined, and other vulnerable populations, including pregnant women, their children, and their families.

Telehealth funding will better enable physicians, nurse practitioners, nurses, physicians' assistants, and other caregivers to provide COVID-19 screening and testing, case management, outpatient care, and other essential services while protecting the health workforce and consumers alike. The HIV/AIDS Bureau awarded approximately $90 million in coronavirus assistance to 581 organizations serving clients of our Ryan White HIV/AIDS Program. The Awards will help grantees support critical programs that provide services for people with HIV during this pandemic, such as home-delivered meals, emergency housing, and transportation.

This infusion of funds will help grantees better respond to the COVID-19 threat while maintaining the ability to provide HIV primary medical care, medications, and support services to their clients. HRSA has also improved capacity to poison control centers by making nearly $5 million in awards to

poison control centers across the country, to improve their ability to respond to increased calls due to the COVID-19 pandemic. HRSA-funded poison control award recipients make use of these funds to increase outreach and education, to reduce the risk related to poisoning, and to enhance readiness and training to respond to and manage the increased calls related to COVID-19 related poisoning. Dr. (Warren) will provide more specifics about the CARES Act funding that the Maternal and Child Health Bureau received, when he talks with you this afternoon.

In closing, I want to thank you all for your hard work and the dedication each of you demonstrate as committee members and professionals in the maternal and child health field. You have a critical charge and your expertise, knowledge, advice, (unintelligible) in the department are needed, even now more than ever. We appreciate your leadership in the field and on the committee, and look forward to working together as we develop policies and improve systems of care to decrease infant and maternal mortality in this country. Thank you all, and to all the fathers on the phone, I want to wish you a happy father's day this weekend.

Dr. (Ed Ellinger): (Tom), thank you very, very much. Obviously a lot of stuff going on, and I know you have to take off for another meeting. But if we have any questions, we will get them to you through (Michael), or Dr. (Warren), so good luck. I can't even think, 17 times your annual budget. That must be an incredible undertaking, just administratively and organizationally, to take advantage of that. So, thank you for your work and we'll get back in touch with you later.

(Thomas Engles): Thank you, Doctor. I appreciate that.

Dr. (Ed Ellinger): All right. Now we're going to go into a follow-up of that. We'll ask Dr. (Michael Warren) to give us an update on MCHB activities and put into the

sort of maternal and child health context all of the stuff that Mr. (Engles) sort of teed up with his presentation. Dr. (Warren), are you there?

Dr. (Michael Warren): Good morning, Dr. (Ellinger), and members of the advisory committee. It is great to be able to join you all this morning and be able to follow (Tom Engles), our HRSA administrator. We are so fortunate to have (Tom)'s support for our activities related to maternal and child health broadly, and specifically the departmental priority around addressing maternal health and improving maternal health. I appreciate the opportunity to give you a bit of an update from the Maternal and Child Health Bureau this morning. Thank you to Dr. (Ellinger) and the folks who are involved in planning. This is, as you may be able to imagine, a herculean feat to be able to pull off a virtual meeting of this size, and so we appreciate the flexibility of those who are doing that work, and also for all of you in joining. Just as a reminder, (Tom) talked broadly about the work that HRSA is doing.

Here in the Maternal and Child Health Bureau, our mission is to improve the health and wellbeing of America's mothers, children, and families, and the work of this advisory committee certainly helps to influence that work we do, not only at the departmental level, but specifically within the Maternal and Child Health Bureau. We are working on a strategic plan for the Bureau, and I'll spend some time talking about that just a bit later, and talk about some opportunities for you to weigh in on that strategic plan. But in the meantime, I wanted to share with you the framework that we're using to think about improving maternal and child health, and that framework is called accelerate upstream together.

And I'll tell you a little bit about what we mean by that. When the Bureau was first founded as the Children's Bureau in 1912, there were approximately 300,000 infants who died every year in this country, before reaching their first

birthday. And so clearly, we've made dramatic improvements since then. Even in the past 30 years, we've cut infant mortality rates in half in this country, and so we celebrate that. And at the same time, folks wonder, "Well, what does it mean to have an infant mortality rate of 5.6 or so?" Well, it translates to about 22,000 infant deaths every year, and when you try to translate that into numbers that others might understand, you say, "Well, that's the equivalent of a jet plane crashing once a week, every week, for an entire year." And imagine for a moment, if that happened in this country. After a few weeks, we would suspend air travel. We would start doing things very differently. We would call for investigations. We would say, "This is not acceptable. We have to do something different." And yet, we still have the situation where 22,000 infants die every year before reaching their first birthday.

And so while we've made great progress over the last 108 years in existence of the Bureau, we have much work left to be done, and we have to accelerate that pace of change. Part of that acceleration also has to do with eliminating disparities across a variety of MCH indicators, and so if we stick with the infant mortality rate for a moment, I'm reminded of the work that was illuminated by my colleague and friend, Dr. (Arthur James), who looked at the lag between black and white infant mortality rates in this country. And Dr. (James) has shared with some of you before, that in 2017, the infant mortality rate for black infants finally became the same as white infants. But it was the same as white infants in 1980, so a 37-year lag.

And so, we don't think just globally about infant mortality, but we think about infant mortality for the entire population and for all subpopulations, and we think about accelerating that pace of change and accelerating the elimination of disparities. So how do we do that? I've just given you one example of infant mortality. We could have similar conversations about a variety of MCH indicators. But one way we do that is by looking upstream. We recognize that

clinical care accounts for only a portion of our overall health and wellbeing, and I'm going to advance my slides for a second. I got behind in advancing, I got so busy talking. So clinical care only accounts for a portion of our overall health. A number of studies have pointed this out. Maybe 15 to 20 percent of our overall health and wellbeing. Other factors, as shown here in these various charts from a variety of publications, contribute more broadly to our overall health and wellbeing.

And so if we're going to think about accelerating the pace of change, we have to think about moving upstream and looking at these other factors, including community and environmental factors, health behaviors and policy. We also have to think about upstream across the life course, and so, this builds on the work of colleagues for decades who have recognized that we all have this optimal health trajectory as we age. And there are health risk factors that can dampen that trajectory, but there are also health promotion factors, which can elevate that trajectory. And our ultimate outcomes are really about a balance between those health promotions and those health risk factors.

But it's not just about our own life course. It's really about this multigenerational approach, and we know so well when we talk about infant mortality and maternal health, about this life course approach, that the health of an infant is directly related to the health and wellbeing of the mother. And we can't have a healthy baby and a healthy birth outcome without having a healthy mom. Similarly, as we think about improving maternal health, we can't wait until prenatal care starts, or until labor and delivery, to take that focus. We have to think across the life course, and so we have to think about the health and wellbeing of young girls and adolescent females and young adults, as we think about improving maternal health.

So, all of this really requires that we look upstream beyond the here and now,

beyond the clinical situation that's in front of us in a hospital or in an exam room, to look broadly out into the community and to look broadly across the life course. The together part of that accelerate upstream together framework really means we can't do this alone. Certainly, we as the Maternal and Child Health Bureau don't do that alone within HRSA. We partner with, for example, the Bureau of Primary Healthcare that works with community health centers. We partner across the government. Later, you're going to hear from my colleague and friend, Dr. (Wanda Barfield) at CDC. They are doing tremendous work, not only at the national level but supporting states and communities, and we're so fortunate to get to work with Dr. (Barfield) and colleagues and also others across the department.

And, across other federal departments, but we also partner with states and communities, NGOs, academic partners and, importantly, families and consumers. This very meeting of the advisory committee is an example of together. We need your input, we need your wisdom to guide this work, moving forward. So, this accelerate upstream together framework is guiding us as we move forward with development of our strategic plan. I'll come back to the strategic plan at the end of my presentation, but I did want to spend some time talking about the work that we're doing in response to the COVID-19 pandemic, and appreciate (Tom) giving the overview.

It has been remarkable to watch the work that has been done across the federal government and across the government and particularly here at HRSA. We know that the pandemic has had profound impacts on maternal and child health, and you see a number of those listed here. A lot of fear and worry about risk of exposure to the virus, and that results in changes in the way that people access care. Some of that is because care may not be available in traditional forms, and even where it is, folks may not be accessing care. We know, for example, our colleagues at CDC recently published on a decline in

pediatric immunizations after the declaration of the public health emergency. There are also challenges with standard approaches to care, so labor and delivery care, for example, and the ability to have support personnel, other family members, or doulas present. That has been a challenge.

Similarly, challenges for systems of care for children and youth with special healthcare needs, and a loss of a variety of community supports. As folks have navigated this pandemic, we have seen social isolation and increased mental health challenges and needs pop up in communities. Certainly, increase with socioeconomic stressors and the needs that families are facing as they care for one another, and also concern about intimate partner violence, and the exacerbation of underlying health disparities that were existing before COVID, but have seemed to be exacerbated as a result of the pandemic. Our concern is that these impacts that we're seeing certainly extend across the life course and may impact the MCH population for generations to come, and so we want to be responsive to those needs where we can, and support states and communities in addressing those.

And we may want to ask for folks who are not speaking to mute their lines, we're getting quite a bit of feedback. So, to give you an idea of what we're doing in the Bureau in terms of monitoring impact on MCH populations, soon after the emergency declaration, we stood up an incident command structure within the Maternal and Child Health Bureau to get a better sense of the various impacts across Bureau programs and across MCH populations, and to help us coordinate that response. Part of that involves standing up an internal workgroup so that our project officers and program staff could have lines of communication with their colleagues to make sure we were being consistent in responses to grantees across the country, but also so that we could build situational awareness and gain some insight into what the on the ground needs of children and families were, to help guide our response.

We've been deliberate in engaging partners. So for example, we participated now in five (unintelligible) town halls. These are happening every other week, with national representation from states' Title V programs, and programs that serve children and youth with special healthcare needs.

And so, through those and through a variety of other meetings, through continued contact with colleagues at CDC and the Administration on Children and Families, we've been able to find out what those needs are and how best our HRSA programs can respond. We have provided an extensive amount of technical assistance to our grantees. You'll see a screenshot there of our Web site, where we've added COVID information, with a variety of grantee flexibilities. Those have been handled based on specific program legislative authorities and requirements, but we've extended a tremendous amount of grantee flexibility during this time. We've also tried to share a variety of resources through technical assistance investments and through direct interaction with project officers and grantees, to help them support their work during this pandemic. (Tom) mentioned a variety of the grant funds that have been made available from HRSA.

We were able, in the Maternal and Child Health Bureau, as part of the CARES Act, to award $15 million related to telehealth, and so you can see the four grantees there. We awarded these funds in four broad categories: maternal healthcare, state public health systems, family engagement, and pediatric care. The awardees are listed on the slides. You'll see them there in italics. I think the titles speak for themselves. I will say, on the state public health systems awards, that one focused on state Title V and MCH programs, and specifically on newborn screening and early childhood home visiting.

So those awards were made at the end of April, and the awardees are starting

to implement their project plans. We also have been aware that grantees all across the country are innovating in response to the pandemic, doing things like adapting to telehealth and tele-education platforms, piloting innovations that allow them to meet emerging population needs, and so just as a few examples, in home visiting, we've seen a rapid expansion of virtual home visiting models with support from our rapid response virtual home visiting project.

One of the things that has come to life there, and I think speaks to the importance of understanding the needs of children and families, is that while many of our program staff and state and local health department staff were able to switch to a virtual environment to provide these services, families may not always be able to access them. They may not have devices, they may not have minutes on their cell plan, they may not have access to broadband in their communities. So this has, again, unearthed other challenges that we need to think about as we think about providing services to kids and families. Other innovations in Healthy Start, for example, they're looking at virtual client services, including virtual breastfeeding education classes.

So, we appreciate the innovations that our grantees are making, and we're excited to think about how we share those to other grantees across the country in thinking about scaling those various innovations. I wanted to wrap up my comments by talking a bit about our strategic plan in the Bureau. It has been many years since the Maternal and Child Health Bureau has had a strategic plan, and the work that we do and interface with you all on around infant mortality and maternal health is just one piece of that work. We actually have 11 different legislative authorities with multiple dozens of programs that are funded under those authorities.

So it's important for us to develop that strategic plan really to serve as a north

star for the work that we do. Often, we find ourselves sort of in the middle of the trees, doing our work every day, and as the old saying goes, it's important to step back and be able to see the forest from time to time. But if you think about the work that we do as a national entity, we really need to take this national sort of approach.

So, I love this image from NASA that looks at tree canopy coverage across the country, and so as we move from the tree to be able to see the forest, we really want to be able to step back even further and look across the country and the landscape. What are the needs, what are the challenges, where are the opportunities as we think about our strategic planning work? And really, the goal is that various inputs, input from stakeholders, a variety of needs assessments, the Title V needs assessments, the (unintelligible) needs assessments, our 11 legislative authorities, priorities from the administration and the department and the agency, various surveillance data, survey data like the National Survey of Children's Health and PRAM, program experience, all of those things would feed into the strategic plan, which ultimately will guide our budgeting, our performance measurement system, and the generation of ideas so that as new funding becomes available or new legislative authorities become available, we're able to act on those quickly.

All of those things then feed into our ongoing program development and implementation work, which is of course followed by data collection and analysis. And ideally, we're doing periodic self-assessments to understand how well are we doing, based on the objectives that we set and the data that we collect? We know that, based on that program data, and how do we feed that back into ongoing work and assessment for is our strategic plan working and what do we need to do to make adjustments, to make sure that we continue to be aligned with that strategic plan?

So it's important for us to take that kind of approach, and as many of you know, when you typically think about a strategic plan, you think about a three to five year approach for an organization. So we will certainly be doing that, but we're also looking further ahead. We're taking a look down the road 15 years. So, this year, 2020, Title V turns 85. It was passed in 1935 as part of the Social Security Act, so we recognize the 85th anniversary of Title V, but we also ask what will Title V look like when it turns 100? So in 2035 - so we're looking ahead to 15 years. What do we anticipate the needs of MCH's populations being? What do we anticipate the need for the work of the Bureau to be, and how do we try to look ahead to address that?

So right now, we are in a phase of information gathering and synthesis, which we will do through calendar year 2020. As we move toward the end of the calendar year, we'll be pulling together all that information, finalizing our plan, and disseminating some very high level strategic objectives. And after that time, we'll move forward with further developing specific objectives for each of our MCHB divisions and offices, and working on an evaluation plan. We are relying on a variety of stakeholders for input for this plan, so you will see, on the upper right-hand corner, an email inbox we've set up to get your input. It's MCHStrategy.HRSA@HRSA.gov. These slides will be available to you, so you'll have these slides, but we would very much welcome your insights and input into the strategic plan.

As I mentioned, we want to look ahead. Where will we be in ten to 15 years? And so, what can we anticipate for MCH populations in the future? Some of you have heard me say before, I'm a hockey fan, and one of my favorite quotes from hockey great Wayne Gretsky, he was asked how did he get to be such a good hockey player? And his response was he skates to where the puck is going to be, not to where it has been.

And so I think as we think about the work that we do in MCH, where is the puck going to be in ten to 15 years? What are the things we need to be planning for now, in terms of the way we structure our programs and the terms of the services that we provide to populations? In terms of the way we fund various items, what do we need to be planning for now, to meet the needs of populations in ten to 15 years? And so we've set up a number of questions that we would throw out to this group as discussion starters. Again, these will be available to you, and we would encourage you to take a moment, when you have time, to look at these questions, and to send responses to us.

Again, that email is MCHStrategy.HRSA@HRSA.gov, and we would welcome any and all comments that you share. We're engaging a variety of stakeholders, existing grantees, but also folks who aren't our grantees and a variety of stakeholders in the field, and we would welcome your contributions to be added to that input.

So with that, I will close. Thank you again for your time today and tomorrow, as part of the advisory committee, but also for your ongoing work every day. I think, as (Tom) mentioned, the pandemic has really highlighted some of the vulnerabilities of the MCH population, and I think that event, even over the recent few weeks as we are wrestling as a country with challenges of racism and discrimination, and the known impacts on MCH populations, it really underscores the importance of you all being gathered and doing this work and continuing to partner with us and advise us in this way. So thank you for those efforts. We look forward to the ongoing partnership, and I look forward to being a part of the rest of the meeting. Thank you.

Dr. (Ed Ellinger): Thank you, Dr. (Warren). I appreciate those comments. I know I've built into the agenda, because I know you have to go to another meeting, sometime right after lunch for us to have a broader conversation with all the members about

MCH issues. Would you be available for about ten minutes to take some questions right now?

Dr. (Michael Warren): Yes, absolutely. And I do look forward to that conversation later. I have to step away for about an hour at 2:30 for another meeting, but I should be with you all the rest of the time today and tomorrow.

Dr. (Ed Ellinger): All right, very good. So, while we're getting these questions, I just have one question. What the administrator said, you've got $175 billion, and most of it seems to be going to the healthcare part. And given your slides saying, you know, it's more than just healthcare, it's actually some of the other things are actually more important than healthcare, talk to me about the conversations within MCHB and HRSA around how to balance investments at this point in time.

Dr. (Michael Warren): Thank you, (Ed), for that question. So, the money that you mentioned largely is coming through the Provider Relief Fund that was set up to support providers. And so, certainly that does support clinical care work. I would say that many providers, though, are also thinking about how they address some of those other needs in the work that they do with patients and families and in the broader work that they do with communities. Our funding, of course, is always directed based on the legislative authority, and so there are times where we have more flexible funds. Our block grants is a great example of that, where there's some broad strokes in the legislature that tell us how that money is to be spent.

But there are other times where the funding is much more prescriptive, and the funding for the Provider Relief Fund certainty would fall into that category. At the same time, I would say it is important to note my comments on clinical care were not meant to diminish clinical care at all. It's absolutely important.

We can't have health without clinical care. But the point of the comments was to say it is just one piece of the approach. Certainly in talking to clinicians and in my own clinical experience, I recognize I can't fix all of the health challenges that my patients face in a 15 or 20-minute office visit. Even if I have the luxury of an hour office visit, there are broader challenges that influence their health. So, it's important to continue that conversation, and I would go back to say we always have to make sure, with our funds, that we are spending those in the manner in which they're appropriated by the Congress.

Dr. (Ed Ellinger): Thank you, (Michael). We've got a few comments, questions. (Cara Sandra Lee), unmute your mic and ask a question of Dr. (Warren). (Cara), can you unmute your mic?

Coordinator: As a reminder, if you would like to unmute your mic, please press star 1. Thank you.

Dr. (Ed Ellinger): (Cara), are you there? Star 1. We're going to - (Belinda), you're next.

(Belinda Pettiford): Can you hear me?

Dr. (Michael Warren): Yes.

Dr. (Ed Ellinger): I can hear you. Thanks, (Belinda).

(Belinda Pettiford): Okay, thank you, and thank you, (Michael), for that presentation. Appreciate it, and I'm really applauding the additional COVID funds that were able to go out in communities. I guess my one question is around the whole issue of equity. I mean, if we look at COVID in this country, and as you know, I work with Title V in North Carolina, and we're fortunate to have also

have a Healthy Start site, and you know, I'm on the (unintelligible) board and I'm also on the National Healthy Start Association Board.

So I think I bring a unique perspective. I guess my question is, as the COVID funding was going out the door, it's not clear to me that we have a strong focus on going to - down to the community level. And I'm thinking through, in my own state, and I'm hearing data from around the country, that we're seeing a greater impact with COVID in communities of color, especially African American communities and Latinx communities. And I'm wondering, with the $15 million in telehealth and some of the other monies, were there conversations around trying to get the money down to the community level? I mean, I'm very familiar with the money that's going to UNC Chapel Hill. We partner with them on numerous things, and again, I'm a (unintelligible) board member, so definitely support that. I know the work with family engagement is typically around children with special healthcare needs, and then you've got the (unintelligible) side.

So I'm trying to figure out in my head, how do we put any money down into communities of color? I'm wondering why Healthy Start wasn't considered, because it is one of the programs in your bureau where you're looking at perinatal health disparities. But I see where Healthy Start is mentioned. I don't see where the resources went there. So were there conversations around that, and are there plans to put some additional support there, and support meaning resources as well?

Dr. (Michael Warren): Yes. Thank you, (Belinda), for that question. So, the intent of those funds, and again, if we think about going back to the legislative intent of those funds, were around telehealth. And so, the intent is actually that those funds do support the work so that patients and families in communities have better access to care. And so, whether it's in the maternal health space, whether it's in

the pediatric care space, whether it's relating to newborn screening and home visiting, that was the intent.

And so, while those awards went to a small number of entities, the intent is that those awards support work that diffuses out across the country, to support telehealth access for patients and families. So, that would involve work at communities, at the community level. Certainly if we were to get additional funding or if we were to have broader funding, we could look at other options there for how we might make use of that funding. I will say that across our existing program, even where we've not gotten additional funding, we have looked at where we have flexibility.

So, how can we spend existing funds? Healthy Start is a great example, on virtual services to meet the needs of families where they are. I gave the one example of virtual breastfeeding classes that one of the Healthy Start programs is doing. But folks are providing a number of services virtually, or looking at how they can use grant funds to meet other needs of families in those communities. Those are handled on a program by program basis, so I want to be careful that I don't say you can use funds for X, Y, or Z, because the different legislative authorities sometimes limit us into what we can do.

But certainly as programs have been reaching out to us, we've been exploring where there are opportunities to use their funds in a way that's consistent with the legislative authority, but also responsive to these unanticipated needs that have arisen as part of the COVID pandemic. I'll also say that with all of these telehealth awards, there is a thread running through those, of thinking about equity and how do we use those awards to further health equity?

So whether it's in maternal health or pediatric or in the public health award space, thinking about how these awards and where we're asking these

grantees, "How do we do this work to further this work toward equity?" As you know, this $15 million is not going to be enough to get us to healthy equity for MCH. This is ongoing work that we'll have to look at across our portfolio, not just in these telehealth awards, but across all of our investments, and specifically across our larger investments. So the block, McV, and Health Start I think really are our biggest levers to continue to move that equity work forward.

Dr. (Ed Ellinger): (Cara), do you still have a question? I see your name dropped off. And if there's any other questions, raise your hand. (Michael), I have just one with that $175 billion coming into HRSA. Obviously, that's a big stress on the infrastructure that you have and the organization. How are you - do you have enough staff, and how are you being asked to participate in all of that, and how are you keeping some of these other essential programs front and center, when there's a need to get out $175 billion? I imagine that this is stressing the whole organization, and how are you protecting MCH with that?

Dr. (Michael Warren): Thank you, (Ed), for that question. It's a good prompt to remind me. I want to give a shout out to colleagues in the Bureau and across HRSA. It has been remarkable to watch how folks have transitioned to a virtual environment. Prior to three days ago, so this Monday, virtually all of the HRSA staff were working virtually. We transitioned the week of March 16 to a maximum telework environment, and that was true for many colleagues across the federal government.

And I will say, it felt like colleagues in the Bureau didn't miss a beat. They were responding to a massive volume of grantee inquiries, while they were also living and living in communities that the D.C., Maryland, Virginia area has been one of the areas that, as you all probably know, very much impacted by COVID-19. And they're navigating that with children at home or with

caregiver responsibilities. And so, they've really done that flawlessly. A number of them have also been deployed, and so as (Lee) mentioned at the beginning of the call, Captain Delacruz, who is our designated federal officer for this advisory committee, has actually been deployed multiple times. He's part of the United States Public Health Service Corps, the commissioned corps. And many of our MCHB staff have been deployed across the country, in a variety of settings. Some of those have been to provide patient care or public health support as part of the response.

Broadly, within HRSA, there have actually been a number of folks pulled to be involved in distribution of this provider relief fund. Our deputy in the Bureau, (Laura Cavanaugh), who many of you know, has actually been on detail since mid-April, to the office of the administrator working on the provider relief fund. One of our other senior leaders within the Bureau, and then several of our program staff.

So, we are stretched, and I'm happy to say folks have been doing a tremendous job. We are certainly working to try to make sure we're checking in with staff, to make sure that folks feel supported and looked after. We are supporting them with a variety of flexibilities, recognizing that these stresses of working from home and having caregiver or parent responsibilities can be challenging. And so we're working to support them as we need to, but it has been a heavy lift and colleagues across HRSA have really done a phenomenal job of getting not only those provider relief funds but all those other supplemental grants that (Tom) mentioned, getting those out the door in a timely fashion.

Dr. (Ed Ellinger): Great. We'll take two more questions, from (Cara Sandra Lee) and one from (unintelligible). (Cara)?

Coordinator: As a reminder, if you'd like to unmute your mic, please press star 1.

Dr. (Ed Ellinger): (Cara), are you there? Star 1. All right, let's go to (Magda).

Dr. (Magda Peck):(Unintelligible) voice check, is it working?

Dr. (Ed Ellinger): Yes, it is.

Dr. (Magda Peck):Excellent. Thank you. Dr. (Warren), a pleasure to speak to you virtually, and hearty thanks to the extraordinary above and beyond work that folks are doing on behalf of our nation's women and children, families, and fathers. I noticed that the legislative intent and the response that you have done through HRSA and specifically MCHB, has been under the rubric of COVID-19. And we also know that COVID-19 has elevated, amplified, and revealed and accentuated the underlying drivers of racism.

And so, I'm wondering if you see opportunities to go from talking about racial disparities to speaking more directly about the impact of racism as a public health crisis, specifically to women, children, families, and fathers. And so, given that these are - some have called twin pandemics, or others have called it the shadow pandemic of racism revealed, particularly anti-black racism, how do you see that we might be able to further double down and invest upstream as an uninvited opportunity from COVID-19?

Dr. (Michael Warren): Thank you, Dr. (Peck), for that question. Absolutely agree that the impacts of racism on MCH populations are profound, and I think it's important to acknowledge, and many on this committee know well, that while there may be a relatively recent revelation and maybe increased attention to these challenges, they are not new, and populations of color have been dealing with these challenges for centuries in this country.

And the impacts and the outcomes that we see in the MCH population reflect that, and are reflected in those disparities. And so, we have tremendous opportunity, and I think there's an opportunity now, with conversations that are going on, to really ask deeply of ourselves and of all our partners, what can we do and what can we do differently? I think it's important for us, as the Bureau, to listen and to listen to communities and to listen to states, and to listen to individuals about what you think we might be able to do and do differently. The timing, in conjunction with our strategic plan development gives us a great opportunity to think about how do we shape that strategic plan to assure that we achieve equity across MCH populations, and so I would encourage, as folks are responding to those questions or to provide other comments, whatever you'd like to share, to please let us know what you think the Bureau can do about equity.

Certainly, as I mentioned earlier, we always are found by the legislative authorities that we have with the programs that we have, and there is often flexibility. And some of our programs are more flexible than others, so we would absolutely welcome your ideas, we welcome hearing from you about your experiences and lessons learned. For us, lessons you have to share for us about what we can do. Our commitment is to listen and to explore how we can best respond, both with the resources and with the authorities that we have, and we are committed to doing that, we've been committed to doing that, and we will remain committed to doing that, moving forward.

Dr. (Magda Peck): Thank you, (Michael).

Dr. (Ed Ellinger): Thank you, Dr. (Warren). Thank you. And I built in time in the agenda right after lunch to have really an open conversation with you and Dr. (Barfield) and other (unintelligible) members and SACIM members, to really talk about

what are the MCH issues we're seeing in the communities, and sort of collectively give you some input on your strategic plan and other federal agencies on what you can do. So I look forward to that conversation, so thanks for your comments this morning.

Dr. (Michael Warren): Thank you.

Dr. (Ed Ellinger): All right. Now, I'm going to take about ten minutes here to - if I can get my slides up here, alright. Now, I'm going to start off the meeting with some opening comments, but given my inexpertise of getting on, because we started a little late, we're going to take a little time before we have our presentation related to COVID and other issues, to sort of set the frame.

So, first of all, again, welcome and thank you for being part of the SACIM committee. It's an important committee. I think it's increasing in importance, and you know, virtually it's really hard. I know, you know, most of us are getting used to doing Zoom conferences and Facebook Live and those kinds of things. But two days of virtual meetings is going to be a challenge, and so let's hang in there together and see what we can do. When I was planning this meeting, you know, I wasn't at the last in-person meeting.

But going through the minutes and seeing what you did in terms of setting up work groups, as we started the planning, all of a sudden, out of the blue came COVID-19. And it was very obvious that this was changing our whole perspective, and it was going to take a lot of our emotional energy and a lot of our physical energy and a lot of our time to deal with COVID. So, we started really looking at setting up this meeting, thinking that here in June, COVID would still be front and center in people's minds.

And so, that started the plan, this meeting, around COVID-19 and its

implications, particularly when we were finding out that it was really impacting the most vulnerable populations, and it was particularly having impacts on pregnant women and babies and the delivery. And it was from those conversations and those concerns that we've generated the March letter that I sent to the secretary, related to how can we respond from a maternal and child health, from a pregnant women and infant perspective, on how to deal with COVID, with those recommendations, really talking about those after lunch. But I thought it was interesting that, as we were talking about, you know, personal protective equipment, this is a picture, an artist's rendering of what, actually, facemasks looked like during the bubonic plague.

And that is an accurate perception of what the facemasks used in the Middle Ages. They filled in that nose with astringents to try to protect the people from bubonic plague. But as we were dealing with COVID, certainly everybody became aware, just three weeks ago, of that - as (Magda) said, sort of a shadow pandemic, the institutional and structural racism that's in our society, and which really was manifested and culminated in the murder of George Floyd, here in my city. And this has become sort of a - not sort of, has become a central focus in our community and a lot of conversations around this memorial, that I took a picture of just the other day, the fact that, you know, there's - it highlights the sort of underlying reasons why COVID is having such great impact on populations of color and indigenous individuals, indigenous peoples, because of all the structural disparities and racism that is built into many of our systems.

And it struck me, at the same time, that this was going on. We had an exhibit at the Minneapolis Institute of Arts, related to refugees. And that had to close because of COVID-19, but it pointed out the fact that this is a picture of the Minneapolis Institute of Arts, just a few blocks away from the George Floyd memorial. And what those are, are lifejackets that have been discarded in

Turkey and in Greece, and that were collected by the artist from refugees from Afghanistan and Syria, hundreds of thousands of refugees.

And the whole point of the exhibit was when home won't let you stay. And it really struck me that this is - where we live has to be supportive and it has to be conducive to being able to be safe and thrive. And it also reminded me that the land that I'm on right now, talking to you, was Dakota land, and I suspect that you can identify the people, the indigenous people whose land you are now on, wherever you are on this call. And so really, it started me thinking about, you know, when people are not safe.

And certainly, when home is not safe, when home doesn't want you, it really leads to a lot of stress. There's a new term called (solastalgia), which is a combination of solace and nostalgia, which highlights the fact that when your community doesn't support you, you feel lost. You feel homesick, and it actually impacts your health. And when we know that we can't breathe in our community, when the police are disproportionately impacting some populations over others, when they're using force upon peaceful protestors, it really highlights the fact that, for many people, where they live is not safe. Home is not safe, home doesn't want you there.

So it made us - made me change - not change, expand the focus of this meeting, so that it was not just about COVID and its relationship to maternal and child health and disparities, but also we needed to add the fact that structural racism, institutional racism, has - is also part of that, and we can't separate it. Those are parallel or twin, as (Magda) said, twin pandemics or parallel pandemics, or interacting pandemics that really enhance all of our things. But it also gives me some thoughts that we really do have some opportunities, because when we look back over history, pandemics have actually changed things. Yes, they've caused lots of damage, but the bubonic

plague actually helped eliminate feudal governance in Europe. The yellow fever plague actually led to the stopping of the slave trade. The cholera epidemic really led to some major changes related to sanitation and changed how our system works.

So, the pandemic is giving us some opportunities. Despite all of the struggles and all the pain that it is causing, there are some opportunities and potentials that will come from that. So, plagues can change history, and I'm hoping that's why this time is so important for SACIM, this time is so important for all of us and the work that we do throughout the country. At the same time, I was really struck by this last week's bestseller list at the New York Times. Look at those titles. These are what people are reading. These are all books on the bestseller list that really relate to the struggles that are going on with racial equity and racial inequity, and racial injustice in our society. That tells me that people are reading, are interested, are wanting to have a conversation, are primed for the kinds of activities that can bring forth some change. And we see that in protests throughout the country, and I think that this opportunity that we have now is unique, and we need to take advantage of it.

And so, we're looking back at, you know, sort of how we've traditionally done things, particularly around infant and maternal health. How have we kind of organized all of our thoughts? And these are slides that I did share back in December, when I wasn't there. But you know, usually we have, you know, a predictable timeframe, we use - try to develop comprehensive strategies, and we try to get all of the data into a perfect form and get them into a completely polished document. And then we develop a plan.

So that's traditionally how we've worked, but now I think we have to really think about the fact that timeframes need to be really short. Things are changing so rapidly that we need to think more in terms of short-term

opportunities. Yes, we need to plan for the Title V celebration in 15 years, the 100th anniversary. But we can't wait for a plan for 15 years. Yes, we need to think long-term, but we have to act now, and the strategies that we have really are based on the opportunities that we have right now, and we need to be open-ended because the opportunities may not fit into a linear framework, and it needs to continually change.

And so we need to really develop an adaptive approach, an adaptive action approach, and that's what I'm hoping SACIM can do, and I think that's what we tried to demonstrate when we put together our letter to the secretary in March, about how to advance changes related to COVID. And so SACIM is dealing with lots of complex issues and complex systems that are nonlinear, that there are multiple factors.

All of these factors are interactive and they're constantly changing, and there's no endpoint. You're constantly redefining what's unacceptable, and they're unexpected, and rules can change, and there are multiple players. So given all of this, we're dealing with some complex things, and when you're dealing with complexity, I think we know that - at least the people who know about complex theory, know about developing simple rules. You know, how do you think that the murmuration of starlings and the V shape of geese? It's because they follow some simple rules. Fly through the middle, don't bump into one another, and match each other's speed. That's what allows them to do complex things. And I think that in - with SACIM, I think we also need some simple rules, that if we think about everything that we do related to these rules, we will be able to work collectively, we'll be able to work collaboratively, we'll be able to move forward, and we'll be able to adapt as things change. The simple rules, and we may want to pare these down at some point.

But remember, every baby and mother, centered on equity, listen to

community voices, build capacity, focus on connections and those partnerships, ask powerful questions, and seize opportunities. And so that's what we're doing today, and we're trying to listen, we're trying to center on equity, we're trying to build capacity and we're building those connections, and seize the opportunities.

And I think it's a good day that we're having this meeting, because this is the birthday of James Weldon Johnson, one of my heroes. He was a writer, a poet, a civil rights activist, who worked with both W. E. B. DuBois and Booker T. Washington, in a whole variety of ways. He was the first African American, actually, to lead the NAACP. For the first ten years, it had been led by white people. Florida bar, first African American. He said the battle was first waged over the rights of the negro to be classed as a human being with a soul. Later, as to whether he had sufficient intellect to master even the rudiments of learning, and today, it is being fought over his social recognition. That was true 100 years ago, and sadly, it's true today, still fighting for that social recognition. And let's highlight the fact that he also wrote the words to Lift Every Voice and Sing, what's considered the negro national anthem, "Lift every voice and sing, 'til earth and heaven ring, ring with the harmonies of Liberty," "Stony the road we trod, bitter the chastening rod, felt in the days when hope unborn had died. Yet with a steady beat, have not our weary feet come to the place for which our fathers sighed?

We have come over a way that with tears has been watered. We have come, treading our path through the blood of the slaughtered. Out from the gloomy past, 'til now we stand at last where the white gleam of our bright star is cast." I think he was highlighting the fact that all of these struggles that many populations in our country have had, many populations of color and indigenous folks have struggled with. Our job is to work collectively with them, to stand with them, to work with them, to work collectively so that we

can all have our bright stars shine.

And so that's the frame that I want to have with our meeting today, that we follow some simple rules, that we focus on equity, that we've built partnerships, that we've learned from the COVID experiences and from the racial justice work that is being done, and have our work, you know, move forward with those things in mind. So with that in mind, we've got a panel coming up that I think is really, really important for us to hear. We've got (Rahul Gupta), who's the Chief Medical and Health Officer and Senior Vice President and the interim Chief Scientific Officer for the March of Dimes. We've got (Joia Crear-Perry), founder and president of the National Birth Equity Collaborative, and (Ken Harris), Senior Project Director of the National Institute for Children's Health Quality, or NICHQ, and I've seen a presentation earlier on about - from a couple of these individuals, related to COVID, and recognize that the issues of COVID and the issues of racial injustice really merge.

And so I've asked them to each take ten minutes to talk about their perspective on that, and then we'll have a 30-minute conversation with all of the SACIM members and (unintelligible) members about some of these issues. So I think I'll turn it over - I think Dr. (Crear-Perry) is going to go first. All right, you have to unmute your phone, and somebody in central can help us out with this.

Coordinator: To unmute your phone, please press star 1.

Dr. (Ed Ellinger): Do you have any other way of unmuting her?

Coordinator: You can also press star 0.

Woman 1: Dr. (Ellinger), she asked in the chat if we can - if you want to go to somebody

else while she tries to figure out her audio. Do you want to start with somebody else? Dr. Ed (Ellinger): Is Dr. (Gupta) on board?

Woman 1: Yes, he said he's happy to, in the chat.

Dr. (Ed Ellinger): Okay, very good. Let's go to (Rahul).

Dr. (Rahul Gupta): Can folks hear me?

Dr. (Ed Ellinger): Yes, very good. Good to see you, (Rahul).

Dr. (Rahul Gupta): Thank you, Dr. (Ellinger), and thank you, everyone, for having us today on the panel. We really appreciate both the time as well as the focus on these issues. They are critical, as Dr. (Ellinger) just mentioned, and they are very, very important. So I will start with that. Let me just first of all talk about, you know, both the maternal and infant health, as well as COVID-19. And the equity issues, why they're important is every pandemic, every issue we have, when it impacts population within the United States, it's like peeling a layer of the onion.

And when we peel that layer, very similar to COVID that we're seeing, we begin to see really the underbelly of our society. So today, we know that African Americans are likely, 2.3 times more likely to die, as a result of COVID as opposed to white and Asian populations. That's the underbelly. The March of Dimes' mission, I want to share with everyone, is the ideas of ending preventable maternal health risks and death, as well as pre-term birth and infant death, with the lens on understanding that we can never achieve that goal unless we first end the health equity gap. That's a very important gap, because today, a black woman is three to four times more likely to die during pregnancy and child birth, as opposed to a white woman, and the risk of pre-

term birth is about 50 percent higher for a mom giving birth to a baby if she's black.

Similarly, we know that infant mortality - too many babies are still - about 22,000 deaths happen. Similar numbers of stillbirths. And there's more than twice the rate in African American populations as opposed to white populations, so this is a really important piece of our mission. What are organizations like ours doing? We're certainly helping lead the work, but before that, I just want to make sure that - and I'm sure it's been covered before, that we have very limited pregnancy-specific data. So the second issue beyond the way we see pandemics is the way we see pregnant women treated, typically. We saw some lag in H1N1 pandemic.

Similarly, we're seeing, you know, that while pregnant people are at risk, as the rest of the population for contracting COVID-19, but pregnant people are at high risks for serious complication, primarily because we have more women that are giving birth for the first time who are older, with more complications of health. So as our aging population, we also have an aging pregnant population. As a result of that, all of those risk factors that apply do apply to pregnancy as well. We know that vertical transmission has not been demonstrated, but cases - individual case reports of babies born to moms with COVID-19 and contract the virus soon have been recorded.

We also understand that postpartum, the rate is quite low for infants, either symptomatic or asymptomatic. Limited data suggests that COVID-19 does not transmit through breastmilk, and mothers are encouraged to breastfeed. We are making sure, in hospitals across the nation, that we have more opportunity when the environments are safe and appropriate to do so. The mothers are able to have both birthing in the presence of their - her loved ones, but also being able to breastfeed, because that is still the primary public health intervention

to ensure, is both a mother-baby dyad, but also from a science standpoint.

And really, pregnant people should continue their routine prenatal care, although certainly the shape of that has changed today. We have been fortunate to be an organization that had already some advances within technological aspects of it, so we were able to really move forward quickly. But as you can see on the right-hand side, the work we do is really with a lens of health equity. During this time, we are continuing to advocate for efforts to improve data collection, as well as research, especially in pregnant women. We are continuing to robustly support the requests for ensuring that CDC and others have the ability to collect real-time, close to real-time data for pregnant women. We're continuing in engaging and educating both professionals and consumers on the latest information, but also thought leadership. You might see this today, you'll see in The Washington Post, we've got a (unintelligible) talking about (unintelligible) and why this could be a baby bust, contrary to what we think, and there are some parallels. It's interesting (unintelligible) Brookings economists have done a parallel assessment to the piece that I've written about, that we can see between almost half a million fewer births next year.

Now, understand that the United States, our total fertility rate is already about 1.71. We've been dropping about two percent a year. We've also had significant, which is good, drops in teen pregnancy, about eight percent a year. So it is not unusual, and if you look at the history of the '19, '18 pandemic, if you look at the uncertainty with 40 million job losses, a ban on immigration, if we look at the fact that most of the fertility services are stopped, there is a real serious long-term concern about the economic viability, but also the finance as well, with all the other demographic aspects of having a tremendous drop in births. We're also virtualizing our programs.

So we've had a number of programs in the nation across hospitals and NICUs, like NICU family support programs. We're also providing group prenatal care programs to sites across the country, and we've actually worked to virtualize some of those, knowing that it is not a time where women can get together in a room and talk, so we're doing some of that work through (unintelligible). We're continuing to work with both registries domestically, in the country, and supporting that both in legislation as well as in advocacy, but also then working with others like (unintelligible) University Hospital in Switzerland, to encourage that underserved population, including those registries.

So for example, working with researchers there, to not only include data from western Europe and the United States, but also we're helping fund some IT work that every - we've now been able to get access to about three countries in Africa that can also enroll women for pregnancy - COVID-related pregnancies.

And of course, we have COVID intervention support funds, through which we're distributing things like blood pressure cuffs, breast pumps, building face coverings, creating face coverings through our volunteer engagement and distributing those, as well as other activities that are ongoing, including educational webinars. One of the important parts that Dr. (Ellinger) mentioned and I would like to reiterate is we have something called the implicit bias training. We have worked about a year and a half on this, to actually create a training program that increased the awareness of implicit bias and (unintelligible) action. This is the only training focused on maternity care providers.

We believe this is the, you know, very important tool. It is not the only tool to address implicit bias in maternal healthcare, as well as the structural and institutional racism. We're happy to share more details upon request. We still

have challenges. We still have challenges because we expect, as I mentioned, to see further declines in fertility, but also expect to see higher preterm birth rates and higher severe maternal morbidity in the future. We do have, as I mentioned, a lack of real-time data surveillance across the country, and it's really unacceptable. We have clearly inadequate testing surveillance capacity, as well as enrollment, making sure that there is enrollment of pregnant, lactating women in vaccine drug trials.

The inequitable burden of disease, regardless of hospitalization and deaths, as I mentioned, is one that is unacceptable, and that's why we're making sure that we have appropriate testing as well as the ability to maintain surveillance on a real-time basis. It's so critical, while we're addressing those social determinants that impact really the core of our societies. We're focused on research policy and equity, as I mentioned. It's very important for us, as we move forward, to have an equity lens in order to make those changes happen, and be those sustainable and societal changes across the board. Things like broadband become important, and your support for broadband (unintelligible), because one of the things - what happened is, again, the spirit of exposing the underbelly of systems and structures, when we start to have virtualization and untested payment models for virtualization, which is good.

But on the flipside of this, we could really exacerbate the racial inequities that already exist because of (unintelligible). It becomes an access issue, so it's very important to make sure every American has the same ability to have access to broadband and to sort of this. With that, I will turn it over and really look forward to the discussion, thank you.

Dr. (Ed Ellinger): Thank you, (Rahul). Let's see if we can now get to (Joia). Dr. (Crear-Perry), let's see if we've got the phone issues working. (Joia), are you there?

Coordinator: Ms. (Joia), please check your mute button. Dr. (Ed Ellinger): I'm not hearing anything. Can we go to (Ken)?

(Ken Harris): Can you hear me, Dr. (Ellinger)?

Dr. (Ed Ellinger): I can. I can hear you well.

(Ken Harris): All right. So when the presentation comes up, I can go ahead.

Dr. (Ed Ellinger): All right, go ahead.

(Ken Harris): All right. So, thank you, Dr. (Ellinger), and I also want to thank Dr. (Warren) for his presentation earlier, and Dr. (Gupta). And thank you to the members of this secretary's advisory commission on infant mortality. It's a pleasure and a great honor to be with you all today, along with Dr. (Joia Crear-Perry) as well. So, racism is killing black people. It's sickening them, too. This is a recent article that I read by (Michelle Williams) and (Jeffery Sanchez), in last week's Washington Post. And the question to ask is really what led to disparities in the first place, if we want to really address them?

So inequalities, and inequalities then led to these inequities. In growing up, my father was an organizer in Memphis, Tennessee, but in our household, we heard this saying, "When America gets a cold, black people get pneumonia." And when we look at disease in this country and then conditions, almost anyone you pick out, you're going to see that there's disparities, and black people are doing the worst. So again, when America gets a cold, black people get pneumonia. We also see that African Americans are disproportionately diseased and dying from coronavirus. Again, the report - the early report in The Washington Post let us know that African Americans have three times the rate of infections, and almost six times the rate of deaths, where white

residents are the majority.

And so coronavirus hits the poor and it hits minority communities harder than it hits others, and we also know even from Dr. (Gupta)'s presentation, it's going to impact pregnant women and impact vulnerable black woman even harder. So under these crises, black women are struggling to survive. Many of the families that are served by Healthy Start programs, for example, live in poverty, and were already on the edges of life, have fallen off. They've been disconnected from a myriad of services. They've been displaced by COVID-19 from jobs and resources that have made everyday life increasingly more difficult. They've also been distressed by the effects of social isolation from their families, from their social support communities, and now today, they're disheartened by racism.

So what happens when you combine a pandemic requiring three months of social isolation under stay at home orders and emergence of data reminding us of the gross disparities that cause black people to bear the greatest burden of disease and death in America, and another assault of racism at the hands of - excuse me, knee of a white police officer who has no regard for human life? We knew that when COVID-19 hit America, that black people would bear the greatest burden of disease and death. Disparities and health outcomes continue to emerge as the theme of the lives of black Americans and people of color in this country.

And as if the mental health impacts of social isolation wasn't enough, black Americans were met with the trauma of racism the very moment that they stepped out of their homes for the first time in months. It's the kind of thing that takes your breath away. While we're wearing masks and gloves to protect us from the exposure to a deadly disease, what will protect us from a disease that is alive in America, in its very structure and its systems? And what was it

or is it about George Floyd's killing that's caused what some are calling a tipping point? Gaps and cracks, gaps in services and the cracks in the system have been exacerbated during COVID-19, creating even more challenges now than before. We think about data, data that's needed to combat these two pandemics is the live data that's (unintelligible) in the many voices that are screaming out for justice and equality. The data that we have in hand needs to be disaggregated by race and ethnicity to tell the stories that need to be told about the people bearing the burden of disease. Real-time data, but I want to introduce real life data.

Since that landmark report of the IOM, unequal treatment, evidence continues to demonstrate that even after these differences are accounted for, race and ethnicity remain significant conditions of the equality of healthcare received. People of color experience poor treatment based on their assignments of lesser values. What is the experiences of mothers, and what is our expectation of ourselves as we serve mothers, children, and families during these times? As we look across the timeline from the beginning of Title V, the Children's Security Act of 1935 up until now, we've seen great innovation in maternal childcare. We continue to pursue and be better, but we also have another timeline aligned with that, and that is from 1619, when the first Africans were enslaved, and each century, we saw different things happening to communities of color and black people in particular.

But it's this timeline that's had that maternal child health legacy. We see that black women have been struggling for a long time. Even as we look at disparities in maternal mortality, black women are dying three to four times the rate of white women. black women are struggling, and they have been for a long time. So as we look ahead for the next 100 years, what do we want in the next 100 years? Basic needs, we've seen what they are. We know that common (unintelligible), what it's going to do about these basic needs. We've

discovered other needs that have emerged in the awareness of things happening around us today. What are we going to do about those things? What's evident is that we need to continue supporting moms, the impact on the infants, the children, families, and their communities. We have to reach for something better. Still, today, too many babies are dying before their first birthday, and certainly low birth weight continues to be a leading cause, and preterm birth is increasing.

And we know the impacts, again, of (unintelligible) in pregnant women. There are 101 Healthy Start communities, all with infant mortality one and a half times that of the national rate of 5.9, and the majority of which are in communities where there's been a history of redlining in communities. Today, when I hear five percent or 25 percent, I'm reminded that the United States has five percent of the world's population, but 25 percent of the world's incarcerated, according to The Sentencing Project. Most of the men incarcerated are black. According to data from the National Fatherhood Initiative, 92 percent of incarcerated men are fathers, and among them are grandfathers and sons. We have to reach for something better. Certainly if we want to celebrate the triumphs in parts of our past, we have to be willing to confirm the negative parts as well, reaching for something better.

With that, I would say hope probably starts with the first community-driven community-based program (unintelligible) infant mortality disparities, and disparities in black infant mortality particularly. In fact, the name of Healthy Start when it was introduced was Healthy Star (Thomas Engles): A Community-Driven Approach for Addressing Infant Mortality. I echo the words of some, the questions that came earlier, of really engaging the community, but Healthy Start was the first program to emphasize community-driven approaches.

A significant financial investment of MCH for 30 years helped grow from 15 original programs, Healthy Start programs, and then seven additional ones funded by the March of Dimes, we grew from 22 programs in 1991 to 100 programs today. Why? Because the programs are working, and the programs continue to work and investments continue to be made in Healthy Start, as we even heard from Dr. (Warren) earlier. There's also a social (unintelligible) that's seen in certain Healthy Starts' design, where each of these programs have a consortium, a community action network, and that's a guarantee that these programs are engaged at a community grassroots level.

These resources ignite partnerships that help leverage and maximize resources in a community, and it encourages that change is the same at the community level. The CAN or the Community Action Network has always been a required component of these programs, and it's what has made the difference to communities that have been involved. And in times like this, it's great that the community is already engaged. Out of the young activists in Boston, one of the original Healthy Start programs was in my neighborhood of Mattapan, one of the highest infant mortality rates in the city, and my second son, (Austin), his outcome's being part of that infant mortality statistic. I view the consortium as being the heartbeat of the Healthy Start program, because it involves the people and solutions to the problems that impact them. It works. Involving people in the problems directly works.

So the heartbeat of these Healthy Start communities around the country, (unintelligible) allowed even in the wake of our current crisis. It's a great opportunity for Healthy Start to continue to beat to the sound of justice and equity. This initiative is not new to this party. The Maternal Child Health Bureau and the Division of Perinatal Health Systems official name for this program is Eliminating Racial and Ethnic Disparities in Birth Outcomes. This funding (unintelligible) in particular is focusing on life course approach, the

social determinants for health, equity and the impact of racism, and for the first time ever, within a maternal child health framework, we've included fathers, partners of the women and fathers and the infants that we serve.

We've been reaching for something better for almost three decades, and when we think about 400 years of enslavement, we think about 150 years of Jim Crow, there's been 85 years of maternal child health, 56 years of civil rights, but there's been three decades, 30 years of Healthy Start.

So as we look back, let's leap forward and start reaching for something better. These times have further amplified and illuminated the disparities and inequities that always lie right beneath the surface, looking for opportunities to reveal themselves, and programs like Healthy Start and other MCH programs know how to pivot and innovate. I'm proud to be at NIHQ, and an organization that is committed to the health and wellbeing of children. I'm happy that we're leading the Healthy Start (unintelligible) support center and working with the Bureau and the division, and partnering with these 101 Healthy Start communities across the country. We're standing with them, standing, Healthy Start strong.

And Dr. (Warren) said a word earlier, together. We're standing together, reaching for something better. Next week, the Bureau and division is hosting the first-ever grantees meeting, with these 101 programs, and I tell you that it's been designed, enhanced and (unintelligible) in its design by what's happening around us, COVID-19 as well as the racial upheaval in the country. But we're reaching for something better, Healthy Start strong. But again, I'm happy to be part of the panel today, and look forward to the conversation. Thank you very much.

Dr. (Ed Ellinger): Thank you, (Ken). Really appreciate that. All right, let's try again for (Joia).

(Joia Crear-Perry), I hope you're on board.

Dr. (Joia Crear-Perry): Can you all hear me?

Dr. (Ed Ellinger): Yes, finally. Great to hear your voice.

Dr. (Joia Crear-Perry): Yes, great. Okay, now let's see if we can get the webcam going.

(Morgan): (Ken), if you could disable your webcam so we can enable Dr. (Joia)'s, that'd be great.

Dr. (Joia Crear-Perry): We're good? Can you all hear me? Hello?

Dr. (Ed Ellinger): Yes.

Dr. (Joia Crear-Perry): Okay. So, where'd the slides go? (Unintelligible) what happened to my slides?

(Morgan): Hold on, I'm not sure. Let me check with the Adobe Connect. They were there a minute ago. Give me just one moment.

Dr. (Joia Crear-Perry): I'm like -

(Morgan): Sorry about that.

Dr. (Ed Ellinger): The joys of virtual meetings.

(Morgan): Apologies.

Dr. (Joia Crear-Perry): No, I saw a thing come up and ask about me sharing the slides, and

I don't - I didn't think I was doing that. So did you want me?

(Morgan): Yes, we have them. I don't know where they went. We're getting them back, just a second.

Dr. (Joia Crear-Perry): Okay, cool.

(Morgan): Sorry about that.

Dr. (Joia Crear-Perry): So thank you all so much. I'll just talk while you guys are looking for my slides. I am honored to be a part of this SACIM meeting. I honestly am following both Dr. (Gupta) and (Ken Harris) as a hard act to follow. I feel like they probably have said most of the things that I'm going to say, but you know, there's not too many times - there's not too many moments where you don't - that you can't face racism too many times in a day. So, it is important for us to - okay, the slides are back. It's important for us to talk about our work in the context of where we are today. I just want to take a breath, because this has been a little harrowing, trying to get with you all. But I'm happy to be here now, and we're going to talk about the work we've been doing and in the context of respectful maternity care, and how important it is for us to have, going forward, respectful maternity care. So, next slide, please (unintelligible) okay.

(Morgan): Yes, I've also - I've made you a presenter, so you can advance your slides, but I can still do it for you, if you'd prefer.

Dr. (Joia Crear-Perry): Thank you. All right, so the mission of our organization, we were founded at a Healthy Start meeting, with the amazing (Deborah Frasier), who has been a mentor of mine since I was small, a small child, and making sure that I understood kind of the importance of grounding and community, and

making sure that maternal child health is grounded in communities, so it's great to follow (Ken) and the work of Healthy Start.

But our mission really is to create solutions that optimize black maternal and infant health for training, policy and advocacy, research, and community-centered collaboration, (unintelligible) that we've been missing so much in the maternal and child health field, and as a person who was a city maternal and child health director, I can tell you that we have not created a structure to include community in how we build or implement or evaluate programs when it comes to maternal and child health, except for a few programs.

Next slide, please. Oh, I have the controller, I'm sorry. I'll do it myself. So today - so, I have the honor of presenting at the UN in Geneva a couple of times now, and when you get outside of the US context and we're looking at some of the countries that have better birth outcomes than we do, they have a human rights framework, and we have not had a conversation in the United States about what that means. What does it mean when you have human rights? Some of our elders and some of my mentors fought really hard for us to have civil rights, and people are still fighting every day to get civil rights around access to LGBTQ and disabilities and around race.

So when you have a human rights framework, you're not fighting for individual rights for each group. We start from the beginning, so that all people have the ability to live to their full potential, and so that when you have that fundamental desire and that fundamental understanding as a country, as a nation, that all people have the ability to live to their full potential, you create infrastructure very differently than you do when you have an underlying principle of (unintelligible). So about 25 years ago, some - during the first iteration of healthcare reform under the Clinton administration, there was a lot of conversation around reproductive rights.

So as an OBGYN, or as a healthcare provider, we do reproductive health. So that's the pap smears and hysterectomies and making sure that people have all the things that they need for their health. Reproductive rights (unintelligible) the laws that dictate that, right? So I learned a lot of that when I moved from working in private practice to working inside of city government. So I made the policies around who can have access to sex education, how we decide whether birth control goes. All those are laws and policies that are created at a city, state, federal, and international level. And so many of our reproductive rights are created through laws.

But in that first iteration of healthcare - or in my last iteration of healthcare reform, there was a lot of conversation around reproductive rights and the laws, but there were black women who were really sitting on having access to birth control is not the ultimate for our reproductive freedoms. And I right now, I have a nine year old son, and I worry about him playing alone in a park with a toy gun, right? So for a black woman, we worry about even outliving our children.

So our reproduction doesn't end when we have a baby or if we have access to birth control. Our reproduction is our entire life. We want our children to have joy and to live a long life. Reproductive justice is the term that came out of that movement, which really is the fundamental belief that we use in our work. It's human rights and maintaining personal body autonomy, so that means if I don't want to (unintelligible), I don't want a (unintelligible). If I don't want a (unintelligible), you can't make me want one. I have personal body autonomy. It also means that if I want eight kids, if I want to have children, I can have as many children as I desire. I can tell you that for me, I have three children, and when they're all here together with me, I feel like the little old lady who lives in the shoe.

But if people want to have more children, that is their choice, their desire, and we are not here to dictate those choices. And not have children - you should think about this. We have policy in the United States where you don't qualify for insurance, for Medicaid, if you have not had a child. You are a childbearing adult, that's who qualifies. In my own state of Louisiana, up until Medicaid expansion, there are generations of people who did not have - black and white, who did not have access to health insurance because they never birthed a baby.

So this (unintelligible) or highlighting or only believing you're valuable if your uterus is used to birth a baby, and therefore that's how you can get insurance is also something that's not sitting inside the reproductive justice framework. And then this last one is really where we talked - where my son comes into play, right? Being able to parent our children in safe and sustainable communities, and (unintelligible) founding Mothers for Reproductive Justice would say we can't let our reproduction - if you can't show up to our movements around black Lives Matter, (unintelligible) justice, and we're not going to be able to continue to work only around reproduction. It's all those things, all those different powers and intersectional (unintelligible) are really important to marginalized communities, and we cannot just focus on only one intersection.

All of those are parts of our identities. So there's a difference between an indicator and a framework, and a lot of you - we've never really questioned under what framework we have our current indicator. So our indicator is a data point. It's a measurement that's limited by our current reality, it's a product of our past understanding of public health and science, and systems are more apt to adhere to specific prescribed indicators than to determined alternatives.

So let's think of some of the indicators we currently use. For example, marital status, right? So we love counting who's unmarried and who's married. I love my husband, he's super cute. But me marrying him does not improve my birth outcome. It's a proxy. It's a proxy for wealthy, it's a proxy for having access to wealth, generational wealth. So if two people who don't have wealth get married, that doesn't make their birth outcomes improve.

So if you want to calculate wealth and improve people's wealth, that's what we should be counting, right? Pregnancy intention, that's another indicator that we love to count. We use it for all kinds of things. I intend to run a marathon, right? One day, maybe. That requires me to one day actually exercise and walk around the block. So, if we want people to have middle class intentions without giving them middle class support and middle class access, at some point, instead of us measuring pregnancy intention, we could think about other measures, like pregnancy wellbeing. How do we support people in their pregnancy choices? What are we doing as a country and as a world, to allow people to have mental health and the support systems that they need for pregnancy wellbeing? So then we have to question under what framework were those indicators chosen? The framework is a vision. It expands our current reality. It allows freedom to explore language and indicators.

So to say things like, "I don't really - pregnancy intention has, for 50 years, been around, and it hasn't tracked for anything except for maternal mental health. It doesn't track for infant mortality or maternal mortality, so we can stop counting it and using it as an indicator," and look for alternative data collections, like pregnancy wellbeing.

And we should also question our historical instructions, right? Like, how do we come to decide that marital status is intention? What framework are we

using when we pick those indicators? I can tell you that when you use a framework of reproductive justice, of human rights, of birth equity, you really pick very different indicators for how you're going to measure your success, because success to get to a human rights - to get to reproductive justice or birth equity will not come through marital status or pregnancy intention.

So birth equity, when we created our organization about five and a half years ago, there weren't any definitions for birth equity. There were definitions for health equity, for equity in general, but not for birth equity. We looked at all those different definitions and we created what really fits our mission and vision, and it's assurance of the conditions of optimal birth. We don't want people to survive a pregnancy and say, "Thank god I got out of that." How do we live our best lives, right? And we have to be willing to address both racial and social inequities in a sustained effort.

So although we're super excited to have five year grants, it's a long time in the federal government, you know? Two year grants, three year grants. It took us 400 years to get here. It's going to take a long time for us to turn this ship around, so don't expect, at the end of two years or five years, that everything's all equal and now we (unintelligible) things.

However, we do expect to be moving towards some equality within that time, right? So we have to put the assurances, the conditions, the policies. These inequities were created by people who sit in the same seats where you all sit. Policymakers who work inside of federal government, state government, local government created policies that were unequal for black people, for women, and those policies have outcomes that cause us to have inequities in health, based upon them. So we - the good news is, you all are the new policymakers. You all can make different ones, and make different choices. You can look at different indicators to ensure that we close the gap, and we're not assuming

that people of color or marginalized communities are broken.

So what are some of these root causes? You know, what's happening? How did we get these inequities? So this is a slide that comes from the Michigan Public Health Institute, which is adapted from (unintelligible), from (unintelligible). And this is really, you know, in 2005, when I was the Director of Maternal Child Health in New Orleans, you know what was happening in the city of New Orleans, right? The president flew by and waved at us, but we also had the World Health Organization that came. I was a young person. I was much younger than I am now, in 2005.

Sitting in the room, listening to these brilliant people from WHO talk about this idea of social determinants of health, that it wasn't your choices or your genes that caused differences in outcomes, but there were things like living wage, quality education, social safety and connection, and those things caused psychosocial stress and unhealthy behavior, which lead to a disparity in the distribution of disease, illness, and wellbeing.

So this is super important, right, because for the first time, instead of blaming and shaming communities of color and marginalized communities and saying, "Oh, you're just different," we said, "Look at these social determinants, these causes. This is what's causing unhealthy behaviors." So we have childhood obesity, not because children just like kiwis - although I like kiwis, I think they're good. The reason we have childhood obesity is not because kids naturally like kiwis. We have it because we have food deserts, because we cut out having physical education in schools, because we don't allow - because children are stressed in their environments, that have (unintelligible) that we're not investing in things in their communities that allow for them to live freely.

And so, we see the top of my slide is still empty, because we haven't had a

conversation around it as a country yet, is where do these social determinants of health come from? Not just as a country, as a world, how do we have some countries, some places, some people who have access to a living wage and others don't? And that is because we have a power and wealth imbalance, and those are things like our labor markets, our housing policy, our education system, our social safety nets. In the US context, we have three main root causes, which are racism, classism, and gender oppression.

So although it's really important that we work on these social determinants of health, if we do not undo these root causes, we will continue to make programs and policies around the social determinants of health. So it's exciting that we've moved up to this space of social determinants, instead of blaming and shaming, but we really need to get into the root causes. For example, every woman that we interviewed talked about not having access to transportation in the United States. That's rural, urban, suburban. They're the big break when it comes to transportation.

And so, if you are only addressing the social determinants, you would give people access to Uber and Lyft vouchers and say, "We fixed transportation." If you're really undoing the root causes, we would build a set transportation system across the United States, where people have the ability to move freely, not just for doctor's appointments but for work, for play, all the things that they need in order to live.

So, how to rethink, just only focusing on these social determinants, undoing the root causes and acknowledging the history of racism, classism, and gender oppression. So, it's racism (unintelligible). This is a really important point. Next slide, hello? Here we go. So racism affects the body both directly by chronic stress and indirectly, through race-based discrimination from multiple systems, which creates differential access to high quality schools, safe

neighborhoods, good jobs, quality healthcare, and other worries.

And when we were able, with some funding from March for Mothers, to disaggregate data at multiple sites, because we knew when this data came out, that black women were dying in childbirth at three to four times the rate of their white counterparts, what was going to happen is what always happens. We were going to be blamed and shamed yet again for these birth outcomes. But when you look at the data, black mothers who were college educated were worse than women of all other races who never finished high school. Obese women of all races have better birth outcomes than women - black women with normal weight.

So I can't even (unintelligible) weight, right? Black women in wealthy neighborhoods were worse than white, Hispanic, and Asian mothers in the poorest ones, so we moved to gated communities and racism just follows us and finds us there.

And this is one that is hard for my public health and my OBGYN colleagues to really absorb. African American who initiated prenatal care in their first trimester still had higher rates of infant mortality than non-Hispanic white women with late or no prenatal care. We loved believing that we're the answer, right? If we come to the doctor, we can fix everything.

And the truth is, that is not so. That healthcare visit is only 20 percent of your health, right? So what this also tells us is that it's important. Of course, we want to go to school and get a good job and exercise and move to nice homes, and this is all of our public health strategy. We've only focused on what people should do. When we do all of those things, when black folks do all those things, we're still more likely to die.

So at some point, the systems and structures have to change that are harming us, because when we show up educated and exercising and you still see us and you still treat us as if we're broken, we're going to have the same poor birth outcomes. So, it's our time now to say, "What is the system going to do differently? How are we going to really work differently?" So, we interviewed black women around the United States, around - who had had infant deaths, around their experience. And we - the title of that article is Look at the (unintelligible). We then did - created a diverse equity index where we listed about 50 different social determinants of health to see which ones had a positive predictive value for black infant mortality. Some of them you would expect, like things like having obesity or smoking, and other typical public health strategies.

But some of them you might not expect, like the higher the rate of air pollution in your community, the higher the rate of infant mortality. So, public health systems could work on air pollution and improve birth outcomes. And that's not an individual accountability, that's actually holding systems and structures and institutions and businesses accountable for the harm they're causing on the infant mortality and communities. Things like racial residential segregation had higher rates of infant mortality, and that doesn't mean black folks just need to move to white neighborhoods. That means we need to invest in black people where they live, so they can have better outcomes and be able to thrive. This is the birth equity index. The worst city was in South Carolina, out here, and the best was San Diego.

So, instead of us all moving to San Diego, we really should look at what are the ways that they're - what is the infrastructure that people are building, that are allowing people to live longer? So what are some of our opportunities? So what's missing from the care of black women is their centered voice, the validation of their experience, and the freedom to choose and be informed.

Black women need respectful care that is free of implicit and explicit bias. It is a provider's responsibility to address those biases. To address the issues in maternal mortality, we need care that originates from and is defined by black women-led organizations, practitioners, and community members, and this is (Jessica Roche), who is my co-lead of the care working group for the Black Mothers Matter (unintelligible).

We just recently had black Maternal Health Week. This is a list of all the current partners and members of the black Mothers Matter line. But really, have members with everything from researchers to doulas to midwives, physicians, policymakers, and so as you probably know, we have the black Maternal Health Caucus now, and so we're really pushing for policy change, because race is a social and political construct, and so the policies are going to be the way that we're going to end inequities, not through looking at my genes or figuring out if my telomeres elongate. My telomeres and my genes have nothing to do with the reasons that I have worse birth outcomes.

We created a black paper, not a white paper, entitled Setting the Standards for Holistic Care of Poor black Women. It's on the black Mothers Matter Alliance Web site. A couple of the organizations that we work with, one here in D.C., (unintelligible) Village, is another strong member of the black Mothers Matter Alliance, and also (unintelligible) doula service. My computer just died. Can you all hear me?

Dr. (Ed Ellinger): Yes, we can still hear you. It's interesting, I lost connection to Adobe a couple of times during your presentation. I am not sure what's going on.

(Morgan): Yes, I think it was an Adobe issue. The same thing happened to me. I think it might just be a connection issue.

Dr. (Joia Crear-Perry): Okay.

(Morgan): But yes, we can hear you. We've been able to hear you the whole time.

Dr. (Joia Crear-Perry): (Unintelligible)

(Morgan): Right. Now, the slide that's up says Respectful Maternity Care.

Dr. (Joia Crear-Perry): Okay, great. So I'm almost near the end. So I'll just say that we're working with the American College of OBGYNs, who is our subcontractor, and the - shoot, the John Hopkins Center for Health Equities, to create a respectful maternity care. We've interviewed black women around the United States, around what that could look like. It's a term that's used globally. The WHO has some standards for respectful maternity care, and so they have been working on it also in New York City, with the New York City Health Department, and so really trying to socialize this idea. There are things that women want in their care, all of them want in their care, to be listened to, to be heard, to be valued.

And those are things that have not historically been a part of how we take care of women. We really see ourselves as the authority for birthing people, and they should just listen to us. And so, this is an important move for us to really start respecting the needs of others. Can you push to the next slide? I can't get back on. What does the next slide say?

(Morgan): It says Birth Equity During COVID-19.

Dr. (Joia Crear-Perry): Okay, great. So what we were able to do, from the stories that we heard from women, when we interviewed them and really thinking through what respectful maternity care would look like, and then thinking about our

current moment in COVID-19 and some of the stories we've heard, so pre-COVID, black birthing people were already being policed around who could come in the room with them. I can even say for my own self, when I had my daughter, I was only allowed to have one person in the room with me. And so I had to choose between my partner and my mother, and so those are the kind of hard choices that black birthing people have had to do, and controlled and policed for a long time.

So now you see, during this COVID-19 crisis, the continuation now extends to everybody, because - when you have scarcity, we see systems respond by saying, "Well, we can't have people in the room and you can't have a partner and you can't have a doula support." And so that's that feeling of scarcity.

And really, we're hopeful that at the end of this, we will see that we're both under-resourced, both labor and delivery, the hospitals. None of us have the things that we need in order to survive, and having a partner there is not a fringe benefit. It's critical for us to have support when we have birth. We have a baby, birthing is a community event. It's a communal event. It's something that we share with others, and it's important for our growth. Okay, next slide. Can you hear me? (Morgan)?

(Morgan): We can hear you (unintelligible).

Dr. (Joia Crear-Perry): What's the next slide say?

(Morgan): Segregation and Assimilation (unintelligible) Antiracist.

Dr. (Joia Crear-Perry): Ah, my last. This is the closing story. We made it, folks! So, my favorite book is (Ibram Kendi)'s Stamped from the Beginning. I should start saying my second favorite book. My favorite book is my husband's book,

Know Your Price: Valuing black Lives and black Cities. This is going to be my second favorite book, is (Ibram Kendi)'s Stamped from the Beginning: The History of Racist Ideas in America. And in this book, which you all should read - he has a new book now, titled How to be an Antiracist, and there's baby antiracists and there's even a children's version of this.

But anyway, he describes three groups of people. People are either segregationists, assimilationists, or antiracists. And in the book, he follows several people, and one of them is Abraham Lincoln. And Abraham Lincoln is a really critical and important person in our history, right? He freed the slaves, excited to have him as a president. But imagine, at the end of his presidency, he brought in the top five black people to the White House.

And you can picture it, right? You get to go to the White House and you're sitting there and he says to them, "Hey guys, here's $3 million I have. Why don't you go back to either Liberia or go to Panama, a black or brown place," because both places he thought were not good places for people to live. "Go back to those places. You need to leave," and so the black folk says, "We don't think so. We've been here for, you know, 250 years, building this entire country for free. We feel like we should get the benefit of our labor, that we've been here and we're American." And he said, "But guys, you're being so selfish.

If you would just leave, the war would end and we can go along and have our white nation and everything will be fine." The truth was, although Abraham Lincoln is a good and moral man, he believed slavery was bad, he also believed black people and brown people and indigenous people were broken. And so therefore, we had served our purpose in building this country and we needed to go back to our respective nations.

So, much of our healthcare, much of our public health is built on this premise that peoples of color, indigenous people are broken. And so if you are doing this work as a public health researcher, as a provider, as a policymaker, and you think your job is to save us because we are broken, we don't need you in this work. We need people who understand that we're all equal, we're all created equally, and that policies have been trying to break us. So, we are in this together to make sure that everyone is able to thrive. And that is it.

Dr. (Ed Ellinger): All right. Thank you, (Joia). Finally.

Dr. (Joia Crear-Perry): I'm trying to get back on, but I appreciate your patience.

Dr. (Ed Ellinger): Yes. We have time for a few questions. If people can somehow raise their hand or just jump in? I'm not sure that what I've got loaded with my Adobe is allowing me to see a hand raised at this point in time. Something's going on with Adobe, so if anybody wants to jump in with some questions, we'll figure out some way to do that.

All right, now it's come on. All right, raise your hand if you have some questions. I have a question for (Ken). You know, you talked about Healthy Start, but as I look at the data over the last 80 years, the only times that we really had a decrease in the disparities in infant mortality was during World War II, and then during the early 60s - well, from '64 to about '70. What - and since that time, the disparity - the black-white disparity's been increasing, even after the start of Healthy Start. What should we be learning from those two times when we really had reduction in infant mortality disparities that could be applicable now?

(Ken Harris): Yes, I think - and our colleague, Dr. (James) talked about this a lot. But in the 60s and 70s, we had this infusion of resources into those communities. And

then, right after that, we have policies that began to target these communities, black and brown communities, black and brown men in particular, as you look at the growth in incarceration. So those policies that began to go in place after those resources were put into communities, and then they were taken out of. And so, I think that's one of the reasons why we saw - we know we can do better, and improve, but then those resources were taken out.

Dr. (Joia Crear-Perry): Hey, this is (Joia). Can I just build on what (Ken) just said?

Dr. (Ed Ellinger): Sure.

Dr. (Joia Crear-Perry): Yes, and it's important for us to think about every time we've in the past had war or crisis, we do seem to invest - we've not always equally invested in - we've never equally invested in black and brown communities, but there are opportunities that we choose to invest.

So right now, this pandemic is yet another opportunity for us to invest and to do policy level things at a federal, state, and local level, to invest in black and brown communities that has been disinvested in. And so, we can see that gap close, like you saw after the civil rights movement a little bit.

Dr. (Ed Ellinger): All right, we have a couple questions. (Janelle), (Janelle Palacios)? Unmute yourself and ask a question, or make a comment.

Coordinator: As a reminder, to unmute your mic, please press star 1.

(Ken Harris): It looks like (Janelle)’s phone is disconnected.

Dr. (Ed Ellinger): All right. How about (Jean), (Jean Conry)? (Janelle) or (Jean), either one, whoever gets there first.

(Janelle Palacios): Great, it's (Janelle). Can you hear me?

Dr. (Ed Ellinger): Yes, go ahead.

(Morgan): Yes, we can hear you, (Janelle).

(Janelle Palacios): Okay, perfect. Right when I was (unintelligible).

(Morgan): Oh no, you're breaking up.

(Janelle Palacios): Oh no. Is that better?

Dr. (Ed Ellinger): Yes.

((Crosstalk))

(Janelle Palacios): I will ask my question really quickly. It seemed, from both Dr. (Gupta)'s presentation and Dr. (Joia)'s presentation, that there is this given that history has shown us this decrease in fertility during, you know, at the flu or a world war.

And then also in - with that, Dr.(Joia) just shared with us that there's this investment in communities of color. Maybe at this time, when our nation is facing a national crisis of some kind, we're all (unintelligible) viewed as human, possibly, but during the times we see a decrease in fertility, it seems with Dr. (Gupta)'s presentation, that in going forward with COVID and this possibility that the US nation will have a decrease in fertility, but an increase in preterm birth and maternal morbidity, that maybe some resources should be really addressing women's decisions for controlling their birth options or

delivery and space and timing options. And it seems like that would be, like, a very important, key feature to highlight or to support during this immediate COVID-related and pandemic. So, do you have any thoughts on that, Dr. (Gupta), Dr. (Joia)?

Dr. (Joia Crear-Perry): I don't want to keep over talking, if Dr. (Gupta) wants to.

Dr. (Ed Ellinger): Do you want to respond to that?

Dr. (Joia Crear-Perry): Yes, I can go ahead until Dr. (Gupta) comes. It's important that we, especially right now, really make sure that women have the ability to take control of their fertility, considering that resources were going to be in a recession for a while after this. So even when this pandemic ends, there will be less opportunity for having access to wealth and wealth building.

And although we want - it's also, at the same time, important that we invest in wealth building and use all those levers that we have at the federal level to invest in wealth building. But if we don't make sure that women have (unintelligible) and reproductive - individuals have access to all the things that they need to control their choices around fertility, that we will worsen their ability to rebound after the pandemic.

((Crosstalk))

Dr. (Ed Ellinger): Any other comments?

Dr. (Joia Crear-Perry): Yes, go ahead.

(Wanda Barfield): Hello, this is (Wanda Barfield). Just to answer some of those questions, some of the work that CDC and CHS is doing is to really try to look at selecting or

planning some of the information on the WHO maternal COVID-19 status, and they're going to be looking at that through birth certificate reporting. And they're hoping to also look at maternal COVID-19 counts by month and state, starting probably late this month. And that will - that information will be on their Web site. They're also thinking about ways to look at vital statistics reporting, in terms of some of the wording and formatting, so that we can understand COVID-19 items within birth certificate reporting.

And also, some of the issues that you brought up with regard to issues around delivery, looking at timing, caesarean delivery, preterm births by month, they're going to be looking at that in the context of COVID-19, really, again hopefully starting soon, and also they're going to develop a report on some of the changes in terms of the percentage of home births by month and jurisdiction, because we have been hearing that, you know, maybe a hospital is a concerning place to be in the context of COVID.

And so, better trying to understand where women are delivering. And also in the context of hearing from women, in the Division of Reproductive Health, the pregnancy risk assessment monitoring system, we're also hoping that we're going to have an opportunity to ask questions of women around COVID-19. So, I think there are also other forms where we can hear from women and find out more about the context of their concerns.

Dr. (Ed Ellinger): Thank you, (Wanda). (Jean Conry)? You had a question? (Jean), let's see if we can get you in here.

(Jean Conry): Yes, (unintelligible)?

Dr. (Ed Ellinger): I can hear you.

(Jean Conry): Perfect. Thank you so much. I just want to congratulate all the speakers this morning for a very interesting and dynamic session. It's been very eye-opening and very rewarding. Dr. (Gupta), I appreciated your comments about the international importance of registries, so making sure that we're all aware of those, and I would like to offer up a (unintelligible) as having a Web site that is listing all of the registries. We'll talk about that this afternoon, but we do have a site that lists every registry as people say it's important, and let us know, Dr. (Barfield), especially, knowing that we have registries taking place. The most important ones are those where the data are collected across the entire country, rather than optional sites that are taking place. Dr. (Crear-Perry), I want to thank you so much for your focus on a human rights perspective. With that framework and universal healthcare, I think that's the way we need to be, and that's the only way to go forward.

So, keeping that as a backdrop for all these discussions, to me, is absolutely critical. And then finally, with the perspective from the (unintelligible) Dr. (Michael Warren) on the (unintelligible) approach is well within healthcare. So, making sure that we're looking at the health and wellbeing of women, so if and when (unintelligible), and if or when (unintelligible) healthy pregnancy. Thank you very much.

Dr. (Joia Crear-Perry): Can I just respond to Dr. (Conry)? Is that okay?

Dr. (Ed Ellinger): Sure.

Dr. (Joia Crear-Perry): Yes, so thank you so much. I love following the work that you do in the UK, and the importance of having also (unintelligible) relation with midwifery, and I think it's going to be really important for us here in the US, as we build out and move forward more robustly. And we're the only high income nation that does not have - has not agreed upon that health is a right,

and we get stuck in the how to get to health as a right, without us agreeing that that's our vision as country.

So I do hope that this pandemic will allow for us to really start embracing that, that we know that everyone - that we're one - if one of us is sick, all of us is sick. The virus is proving that to us. It doesn't matter your income or your education, and that we have to agree - we need to agree that everyone is valuable and should have health as a right, and then we can work on, "Well, how do we get there? What is the way - there's a lot of different models for them, and a lot of different labels for that." But I hope that all of my fellow colleagues will agree that health is a right.

(Jean Conry): Agreed completely. Thank you so much.

Dr. (Ed Ellinger): Any other questions from the crew?

Dr. (Magda Peck): This is (Magda Peck). May I?

Dr. (Ed Ellinger): Yes, go ahead.

Dr. (Magda Peck): Thank you. I just want to thank all three presenters for pushing to the normal and to the center the centrality of racism, and it's the starting point. It's not and if, it's a how. So, thank you very much for that. A particular question, Dr. (Joia), if you would, your slide specific to the one that said indicator does not equal framework.

Dr. (Joia Crear-Perry): Yes.

Dr. (Magda Peck): Brilliant and thank you. You know, knowing you a long time, I just want to thank you so much for elevating and clarifying what's on the left side and

what's on the right side. And so toward that end, I have the privilege of - well, many here, I have the privilege of co-leading the data and research to actual work groups that will be convening and deliberating later this evening, or late afternoon, depending on one's time zone.

And so this is - I just want to thank you for this gift. I'd like to see if you could go a little deeper on your right side under framework, where it says allows freedom to explore language of indicators, because language is narrative and language matters. And peppered through our discussions this morning, we've heard a shift to the language Dr. (Gupta) said, of people being pregnant. We heard the shift to Latinx. We heard the shift in terms of reproductive to larger human rights. We've heard the shift in embracing and defining what is a birth equity index?

So if we're going to reset the social DNA, if you will, of our efforts to eliminate maternal mortality, promote women's health and equity, and have all babies blow out that first birthday candle, can you tell us a little bit more what your wish list would be around what language we use in SACIM, which can accelerate that new lexicon for this movement? And I'd be grateful for that.

Dr. (Joia Crear-Perry): Yes, so that's a great question. Thank you so much. So that's why I try to talk a little bit about pregnancy wellbeing, and I try to give that as an example of what would be the difference between if you were looking at a framework of human rights or a framework of reproductive justice or a framework of sexual and reproductive wellbeing. Then if that was your actual framework for what your vision was for a human being or for Americans or for the world, then what are the indicators you would use to get there? And so pregnancy wellbeing, reproductive wellbeing, these are languages and new words that we're starting to build out in some of the work that we're doing.

My colleague, (Christine Bellindorf) at UCSF and with some of my colleagues - I want to drop some names on some people, but really, if we pick, say, pregnancy wellbeing, which is a term that we're using at the National Birth Equity Collaborative, then you would build a system that says, "Okay, if this is our indicator for success, then what are some things people need to have pregnancy wellbeing? They need access to mental healthcare services, because we don't invest in postpartum anxiety or depression. We know they're both under-resourced and they're underdiagnosed because we don't invest in the resources to address it."

And so we would then create a system and a structure that ensures no matter a person's birth choice, that they have pregnancy wellbeing. What we do now is say, because you're poor or because you're not in a community that we desire, that we think should be procreating and having more children, and because you're - whatever reason, we think you should make the choice, your intention should be not to get pregnant.

So we then try to give you birth control to make sure that that does not happen, and make you, as an individual, make a choice without ever investing in the things that would create a wellbeing for an entire country. But then we see outcomes like premature birth, like higher rates of maternal mortality, because we are not fixing the infrastructure that allows the people to have pregnancy wellbeing globally. Does that make sense, (Magda)?

Dr. (Magda Peck): Absolutely. Any other advice you would have for us would be welcome from all the speakers.

Dr. (Joia Crear-Perry): Well, I'll tell you what. I'm in a lot of measurement data committees right now, and we try - almost all of them start so much in trying to take measurements without looking at what framework their measurement

is coming out of.

So I just want people to take a moment and I'm going to be really honest, that I would say the framework for most things in healthcare has been a hierarchy of human values, based upon gender, race, age, so everything that we take as ways to keep that hierarchy in place. So if we want to get rid of hierarchy or get rid of racism, classism, and gender oppression, we really have to look for our framework of freedom and justice. What are the things we would measure to get there?

Dr. (Ed Ellinger): That's a good way to end this conversation. This has been a great presentation and great conversations. We've been going for a long time, but we need to take a little lunch break. So, thank you all for, you know, the great conversation and questions this morning, and let us take a half-hour break, and we will be back at 2:00 Eastern time, for our open conversation with (Michael) and others from federal agencies about MCH, and be able to share some of your perspectives. So, we'll see you back in a half-hour.

Dr. (Joia Crear-Perry): Thank you all.

(Morgan): Thank you.

Dr. (Magda Peck): Thank you.

Coordinator: You will now be placed into conference.

Coordinator: Thank you for standing by. As a reminder, all participants are in a listen-only mode until the question and answer session of today's conference. At that time, you may press star 1 to unmute your mic to ask a question. I would like to inform all parties that today's call is being recorded. If you have any

objections, you may disconnect at this time. I would now like to turn the conference over to Mr. (Ed Ellinger). Thank you, you may begin.

Dr. (Ed Ellinger): Great. Good afternoon and continuing good morning, for those on the west coast. We made it through the morning, despite all of the technical difficulties, and I'm learning as we go. I wish it wasn't this hard, but it is what it is. And if people could mute their lines and then just unmute them whenever you're talking, that would be great.

We have - I built into the agenda time right now to really have an open conversation. We heard from (Thomas Engels), a HRSA administrator and (Michael Warren), the MCHB head, and we have, I'm hoping - I know we have (Wanda Barfield) from CDC on, but I'm hoping we have some of the ex officio members from federal agencies to really - and particularly for the SACIM members, to really bring up the issues that you're seeing in the communities from where you live and work, to have this open conversation, because I want the feds to know what the community folks are seeing and hearing and learning, and also find out from some of the feds what others are doing, what other agencies are doing. I did ask several of the federal agencies to give us an update on what they were doing on - related to COVID, and we got some really good responses back from several of the agencies, so I hope that you've had a chance to look at those. But let's just open it up, and you can either put things in the chat, or you can raise your hand, or you can just jump in to see what kind of a conversation we have.

And I'll just open it up in terms of, you know, for our federal partners and really just ask the question, I'm seeing - or I'm seeing that, as I said in my kind of opening remarks, with COVID identifying all the deficiencies in both our public health and our medical care system, and then the racial justice protests that have come on, have just shown the really deficiencies in our whole

socioeconomic structure. It's having people in our community really look at doing new ways of thinking.

So even my community, you know, defund the police. I mean, it's looking at a totally different paradigm, a different way of doing things, and I'm just seeing this as an opportunity for us to take advantage of that openness that seems to be there in the community, to do things differently. Because obviously, what we've done for the last 30, 40 years related to disparities in maternal and infant health hasn't worked, so we have to do things differently. And so I'm wondering, you know, is - are the feds seeing the same kind of things, saying, you know, maybe we need to relook at what we're doing and are there some opportunities to do things differently? So that's just sort of an opening sell of this conversation.

(Morgan): Dr. (Ellinger), this is (Morgan). I'm going to switch into discussion format, so other committee members can share their cameras, if they would like.

Dr. (Ed Ellinger): Okay. All right, so we're going to put you into discussion mode, so if you want to share your camera, you can actually - we'll be able to see you, which I hope we can. So, turn on your cameras, raise your hand, jump into the conversation. Ah, good to see some other people finally. Dr. (Barfield), let's see. Since you're the first one that came on the screen, give us an update of what you're seeing. What are the issues that you're seeing that we need to be aware of?

Dr. (Wanda Barfield): So today's MMWR talked about the large disparities that we're seeing in COVID-19 in Atlanta, Georgia, for black versus white patients in terms of hospital admission and severity, and I think that that's just one highlight of the issues that, you know, COVID is highlighting, that disparities were already there, but we're seeing an even greater issue.

And with all of the events that are going on around racism and unjust treatment, I think that now, we really have an opportunity to look at this and to study this more carefully, and then think about the programs that will really help and support things in a different way. And so, as some of you know, I'm within the National Center for Chronic Disease Prevention and Health Promotion, and a lot of the populations that we're caring for include, you know, minority populations, but also those with heart disease and stroke, those who are at risk for obesity, those who are at risk with regard to aging, and so all of these issues are really coming to bear in light of COVID-19.

And so, how we can think about it is to really hear a lot from the communities as well, the communities that we serve. We're thinking about how we can modernize our data system, so that we can view these issues much more rapidly. How can we hear much better from communities? And so, there's a lot that we need to think about right now.

Dr. (Ed Ellinger): Okay, and for the group, Dr. (Barfield) sent some information out, and we shared it with you last night, so you should have those slides that she prepared, that gives a lot of information of some of the things that are going on. And I do have to highlight the fact that Dr. (Warren) has to leave at 12:20 - or at 2:25, so he will be here until that point. And I do want to ask (Cara), since you had your hand raised several times during the morning and we never got to you, what comments were you - did you want to make? We'll get your voice here sooner or later, keep trying. Try star 1. Can't hear you. All right. I can't tell on the screen.

Dr. (Wanda Barfield)

: While we're waiting for (Cara), I think, you know, we do have an

opportunity now to really still continue to look at issues around maternal and infant health, that are really affecting particularly African American and other minority populations. And I think that this is really important and that we should still stay steady in our focus on those issues. But now, I think we understand that there's a lot that we can do in terms of thinking about issues of communities, issues of quality of care, other factors beyond hospital treatment. I really appreciated what (Joia) was saying in terms of thinking about respectful care. That's an area that we're looking at in the context of maternal mortality review committees at CDC and how we can really look at issues with regard to racism and how women feel that they're being treated. We're also looking at a national campaign that will also bring awareness in terms of listening to women's concerns. So, I think there's a lot of new and different ways that we can approach this.

Dr. (Ed Ellinger): All right, good. (Cara), let's try again. Can we hear you? No. All right, (Belinda). I know you had your hand raised.

(Belinda Pettiford): I did. I was wondering on a couple of things, because I know I'm familiar with the campaign that Dr. (Barfield) just mentioned, because we've been waiting for it to come out in North Carolina. And I know one of the things that we're looking at with our maternal health innovation grant, Dr. (Warren), is around, you know, having some listening sessions with women. And one of the reasons is because we stood up telehealth services so quickly, we were having conversations in our state around how to do - you know, how to (unintelligible) telehealth work and then COVID hit before we could actually reach out to women themselves, to find out, you know, how do you feel about it, how do families feel about it? We knew there were a host of areas around broadband access, not wanting to use - you know, not having access to cellphone minutes and things of that nature.

And so we're getting ready to do the listening sessions, but some of our anecdotal information we're hearing already has been around - it's been a mixed bag, you know? Some people really like telehealth services. We're hearing from some of our providers, they really like it. They feel like they have more time to spend with their patients when they're doing telehealth services, and it's more focused time. And so we're - anecdotally, we're hearing mixed information. But I think the listening sessions will give us better information.

But we are still hearing from - anecdotally, from pregnant women, and because it takes us about a year to determine if our home births are going up, our nurse midwives and the others are telling us to be on the lookout for home birth increase. And I don't know if you all are hearing that. We have, you know, in our end, if it's a home birth, they have a year to submit their - you know, to turn in the birth certificate. So it may be a year from now before we know if our home births are going up.

But I'm wondering are you all hearing that? And then Dr. (Barfield), if you can share a little bit more around the pregnancy surveillance related to COVID? Because I'm hearing that - I know we talked about it on our region four call the past week for AMCHIP, and I think we only had one state that was participating. And so I'm also wondering is there a way to get more states engaged in that and maybe share that information, if that is a priority?

Dr. (Wanda Barfield): So I think I will ask (Danielle) to talk a bit about some of the work that MCHS is doing in terms of trying to monitor out of hospital births. But with regard to work with states, as you probably understand, a lot of state health departments currently are really taxed in terms of their need to respond to COVID-19 and also to currently needing to redirect staff to focus on other areas, such as contract tracing.

And those are really sort of important, acute issues. But we are trying to do our best in terms of supporting states by seeing if there's an opportunity that we can get questions out in the field, that will ask some of the questions around COVID-19. It's still, you know, in the works, but it is really important to get a sense of, you know, how women are doing with this particular issue, what are some of the practices that are going on that are important to prevent disease transmission.

Dr. (Ed Ellinger): (Danielle)?

Dr. (Wanda Barfield): (Danielle) said that she was having some technical difficulties, so yes.

Dr. (Michael Warren): I can give a little.

Dr. (Ed Ellinger): Yes, (Michael), talk about the home births.

Dr. (Michael Warren): Yes, so I think part of (Belinda)'s question, the first part was directed to MCHB, too. So that - I appreciate you all using your state innovation funds to do that. That's exactly what those are for, and I would be remiss if I didn't point out the flexibility. Our largest flexibility is the block grant, which gives states and jurisdictions the need to respond quickly to emerging needs in states. So that's another opportunity, and to some extent, Healthy Start has flexibility, and certainly we want folks to engage their project officers. But the goal is to improve both infant and maternal health, and so there's flexibility in communities for how to do that. I think it raises a big issue that we, in the Bureau, are looking critically at how do we create flexibility to be able to respond nimbly to emerging issues? Because I mentioned earlier, legislative authorities, and the reality is, you know, we as a Bureau can't give out money for reasons that aren't specified in our legislative

authority. That's - we are bound by law to spend that money on the things they're appropriated for.

And so, we're very interested in looking at how do we work within those and be flexible to meet emerging needs, and also recognize that grants typically run in three to five-year cycles? And so, how do you, as a federal agency, build in that ability to be nimble and responsive, recognizing that you also make those commitments through grants and programs? So, I would welcome you all's feedback as we think through that. But glad you're doing your state innovation work that way. We would love to hear what you're hearing back from folks. We can certainly share that with our other telehealth awardees, those four. But also with the other state health innovation grants.

Dr. (Ed Ellinger): Thanks. (Danielle)? (Unintelligible)

(Danielle): Can you hear me?

Dr. (Ed Ellinger): Yes.

Dr. (Wanda Barfield): Yes.

(Danielle): Okay. Sorry about that. I, for some reason, can't do the audio on my computer, so I have to call in, and then I can't hear exactly correctly. So, MCHS is attempting to do a few things with states in terms of collecting data. Birth certificate data - I shouldn't say unfortunately. There are only a handful of states that are going to be working on this. We have found out that there are a couple more that are trying to get something going on, but one of the issues that we do run into and that we do acknowledge is that it does take us a lot of time to get the data out and get clean data out. So I do know that some states are trying to put out COVID-related data. One state, for example, would be

California. I believe they've started, or they were about to start releasing data more frequently. I'm trying to remember what part of the other questions were, but I can't.

(Belinda Pettiford): I'm just wondering, are many states actually participating in the pregnancy surveillance?

(Danielle): Thank you.

Dr. (Wanda Barfield): So I can answer that. So with regard to PRAMS and COVID, at this point, currently - again, several states are limiting their operations, because of their need to actually respond directly to the response. But we are hoping that we'll be able to get things started, and there is a PRAMS NOFO that's currently out, in terms of the announcement. And you know, that will be another opportunity we see to address COVID, as this issue will likely not go away. And those applications are due August 11. And if folks go to the grants.gov Web site, they can see the application for the pregnancy risk assessment monitoring system, or PRAMS. There's also other - no, go ahead.

Dr. (Ed Ellinger): (Steve) had his hand up, so I thought (unintelligible).

(Steve): That's fine. Can you hear me?

Dr. (Ed Ellinger): Yes, I can.

(Steve): Good. So, just anecdotally for (Wanda) and for (Danielle), too, so I work with a birth center and midwives, and I'm pretty in touch with the out of hospital community here, out of hospital birth community in Minnesota. We don't - I don't think we're seeing a lot of out of hospital births occurring. That may happen in other parts of the country. But we've had a real increase in interest

in accredited birth center births, where mothers are wanting to come. You know, we follow CDC guidelines as well. We have been more flexible as far as having partners, fathers with the mom, plus a doula, because we believe doula services are essential.

And so, we're noticing that. You know, I - if the reality had become an overwhelmed healthcare system around the country and it didn't even really happen in New York, then I think we would have had - I think something where you would have to step up a whole bunch of other alternative sites (unintelligible) that happen. But it's really caused a change in a mother's desire to be away from the system, although they're very happy to be cared for by the safety net of the system. That's incredibly important, too.

Dr. (Wanda Barfield): So (Steve), I think you bring up an important point. But there is variation in terms of the availability of birth centers, you know, by location. And so, that may be another issue, and I think, you know, (Joia)'s

presentation alluded to that.

(Steve): Yes.

Dr. (Ed Ellinger): All right, (Jean Conry) has her hand up, but I don't see (Jean)’s face or her square on this. (Jean), can you - are you hearing us?

(Jean Conry): I can hear you, and can't get my picture to come up, so I finally gave up on that.

Dr. (Ed Ellinger): Okay, so just talk.

(Jean Conry): I'll talk. It's probably one other little button I'm supposed to push, and it keeps

saying start, but it doesn't, so I apologize. I think what I heard very clearly, and what I'm still hearing, is this speaks to the absolute importance of not just a voluntary registry, but registering all of the information about every delivery across the United States. If we're going to go back and look at COVID outcomes without having to be selective or looking at voluntary input of data, it's going to be a national registry of births. When we're looking globally at where we're getting the best information, Germany is awesome. Australia's got a great registry, because they already have every delivery. You know, the Nordic countries.

So I think, looking forward - and (Wanda), I'm sure with all the research that you're always doing, this could be one of your greatest laments. But this speaks so strongly about why we need not just the birth certificate information, but the details on every delivery and some critical information about the prenatal care.

Dr. (Wanda Barfield): So you're bringing up some important points, and okay, I won't whine about the lack of longitudinally linked data that the United States does certainly need. But there are - there is some work that's going on. So you know, within the response in COVID-19, we are supporting pregnancy surveillance and internal and infant health studies, and that's being done with our division in collaboration with the National Center for Birth Effects and Developmental Disabilities.

And they're also doing some work on surveillance for emerging threats to mothers and babies, called (unintelligible), and trying to do a lot of work to characterize the epidemiology of COVID-19 in pregnancy and infancy. But we're also supporting various networks through, you know, clinical groups, to include AEP in (unintelligible) network, to look at the information that they're collecting. So, really welcoming lots of different opportunities.

With regard to the national piece, one of the steps that we're doing is in collaboration with (unintelligible) and looking at a linkage of PRAMS data and hospital discharge data for several states as a pilot project, to try to get more of that broad spectrum information around pregnancy and delivery that you're mentioning. So, we're trying to move forward on that, and that's a (unintelligible) funded project.

Dr. (Ed Ellinger): (Michael), I know you have to leave shortly. Are there any issues that you want to raise, or any questions that you have of this group, prior to your leaving? I know you'll be back later, with - for the rest of the meeting, but anything you want to raise now?

Dr. (Michael Warren): I am curious if there are ways that you think we can, as we approach fall and as folks think about going back to school and resuming childcare, the impact on mothers and families and what considerations we need to be thinking about there. Clearly, not all of those things are within our lane or CDC's lane, but there may be other federal partners we can share that information with. But what are those other sources of stressors, as there may be moms who have been able to telework thus far, and now are being asked to return back to work? What is that looking like?

So I think as we're seeing those shifts, as maybe social distancing requirements or stay at home orders are being released, what are those shifts looking like on the ground, and what are those real time impacts on kids and families? We would love to continue that dialogue with you all, and I will be - like I said, I'll be out of pocket from 2:30 until about 3:30, but I'll be joining you back after that.

Dr. (Ed Ellinger): All right. Thanks, (Michael), and you do raise - bring up a couple of issues.

Certainly what I'm hearing, a lot of childcare issues and how important that is, and then also just broadband. Given the fact that we're doing this virtually and so many other things are being done virtually in telehealth, is there - the lack of access to adequate broadband is turning out to be one of those social determinants of health.

And we have to pay attention to that. And then certainly, the other issue that we're seeing is, particularly in our immigrant communities, is the decrease in vaccination rates. You know, again, because of COVID and access, and so we - those are the issues that I'm seeing. You know, childcare, vaccinations, broadband, among other things that are just front and center.

Dr. (Michael Warren): Yes, and as I'm hopping off, I'd be remiss with your last comment. We've - I'm getting a lot of feedback. I think someone needs to mute, maybe. We launched today a social media campaign, #WellChildWednesdays, to address the decline in immunizations and well child visits. So if you are on social media at all, if you can help us amplify those or have your organizations amplify, that would be great. If you could go to the HRSA social media feeds, you'll see those and you can retweet or share, and then use the hashtag #WellChildWednesdays. But appreciate our colleagues at CDC raising attention to that a few weeks ago, and MMWR, lots of interest in that.

Dr. (Ed Ellinger): All right.

Dr. (Michael Warren): See you in a bit.

Dr. (Ed Ellinger): All right. (Magda), you had a question.

Dr. (Magda Peck): Yes, everybody's going to have technology issues at some point today, so it's my turn. I take it willingly. So, I am here. I am curious about beyond the

generic or beyond the broader populations that are being greatest impacted, what are we hearing about incarcerated women, around women who have housing instability as a evictions holds come off in terms of housing insecurity, or in homeless shelters or hotels to bring back that bottom line. What are we hearing on the border around contained children and women and families in limbo?

So I want to push the question about some very specific, in (Michael)'s words, vulnerable populations, because vulnerability is amplified at this time in the era of COVID. And how are we measuring and monitoring the disproportionate impact on those that have greater (unintelligible) and greater risk? So, anything that you have on the ground on that would be very helpful, because now is the time not to forget those who are structurally marginalized and made more invisible.

Dr. (Ed Ellinger): Thanks, I'm not sure if any of our federal partners want to comment on that.

Dr. (Wanda Barfield): Yes, so (Magda), I don't have information about incarceration, but I think what we are learning in terms of some issues are what is going on for tribal populations, particularly in terms of issues around housing and housing size and challenges there. And there are real challenges, in terms of the practical implementation of, you know, guidance with regard to social distancing and other things in that context, in those communities.

Dr. (Ed Ellinger): Yes, and (Magda), you're sort of leading up to part of our conversation about the recommendations to the secretary, because the ninth recommendation we had was about data collection during this time of COVID. And that will - I think if we want to be more - maybe even get more specific on our recommendation to raise some of the issue that you had about data collection for those populations. (Janelle), you had your hand up.

(Janelle Palacios): Okay, let me mute everything. Okay, can you hear me?

Dr. (Ed Ellinger): Yes.

(Janelle Palacios): Okay, perfect. Okay, yes, just to echo the different social structure systems of families that cannot shelter in place or that have multigenerational family members living with them, or even, for example, in my county, 75 percent of the people who have COVID is actually the Hispanic Latino population. And you know, it could be largely because of the factors that this is a population that they are - you know, they have to go to work, they're in a service or different communities or different businesses where they are mandatory workers. They may also be, you know, living in multigenerational or multiple families in one household, in one shared space.

And this is - and then, you know, leading child - a leading use of childcare, especially during school time, is school, right? So we have now families that have all these people that can't appropriately socially distance, and that move around the community pretty quickly. So being able to work with communities and cultures, you know, for example American Indian Navajo, Dine culture, where families are together, will be interesting to see what community organizers or community health workers are able to help inform or help find culturally appropriate or socially appropriate ways to help minimize COVID exposure and spread.

And then, we also have to think about - I think this is something that we've all kind of considered, like, reading articles and watching epidemiologists kind of predict that we may have a future surge up ahead of us, that right now, we have maybe a lull, but there may be another surge coming our way. And especially with fall looming and possibility of children going back to school

and for the state of California, that actually is not necessarily - we're going to have children go back to school, but it's going to be a hybrid system. It's not going to be children back in school as they used to be. It'll be social distancing school and education.

Dr. (Ed Ellinger): (Steve), you had your hand up earlier.

Woman 1: I think (Janelle) was still talking, and we lost her.

Dr. (Ed Ellinger): Oh, sorry.

Woman 1: Maybe not. It may have just been delayed on the monitor.

Dr. (Ed Ellinger): Okay. (Steve), did you have a question or comment?

(Steve): Yes, it was just, again, for (Michael), when he comes back. It was, as you were talking about the - some of the challenges, the childcare and other things, I mean, we have a fairly young group of midwives, and you know, they're - if we had a midwife or two go out, we would really have trouble serving the community that's seeking care.

And so, I was just going to ask him, you know, the HRSA (unintelligible) for however to increase the number of midwives. I know there's - that's a long-term question, but you know, there are issues regarding training of midwives and support of training of midwives. I'm sure (Janelle) would understand that, and so would some other folks on. (Ellen Tilden), from Oregon Health Science University, too. But that's a question maybe to ask (Michael), when he comes back.

Dr. (Ed Ellinger): All right. And I see (Belinda) has her hand up, but I also have a question of

(Belinda) and (Janelle), is that a lot of the issues that we're seeing are going to be decided at the local level for sort of support for a lot of these things. Who's working with city council members and mayors and state legislators and governors to actually push the policies that are going to be needed to address all of these issues? You know, we - you know, we're making recommendations to the federal government or to the HHS secretary, but a lot of these issues are really going to be state and local, and (Belinda), are you in North Carolina? Who's working with the policy makers where the rubber hits the road, more or less?

(Belinda Pettiford): Well you know, in North Carolina, the leadership for our COVID response is coming out of our Department of Health and Human Services. And so, you know, we're in constant contact with our secretary, with the general assembly and others. But the other thing is, we have set up a host of teams within our department, and one that we've spent a lot of time focused on is historically marginalized populations, and how to do - especially around how to reach communities of color that are definitely impacted by COVID at a different level.

And so, if you take the work we're doing with our historically marginalized populations and you lay on the fact of issues of racism and the stress associated with it, and the different level of stress that women of color who are pregnant are dealing with now, you know, that's a gigantic piece that we are trying to get a handle on and figure out. But we are in conversations with, you know, our general assembly. This is an election year, you know, and so, you know, it's an interesting conversation when you're dealing with an election year than with some of the other ones. One of the other things we're hearing from pregnant women is, you know - and I think you mentioned this earlier, someone did, is the whole issue of, you know, each hospital system in our state has decided differently as to whether they will allow a doula support

person come in with the mom.

Each one has done it differently, and so we've got a handful of hospitals that will allow her this extra support, and we have another handful of hospitals, you know, others who won't, and we're looking at 85 birthing hospitals and that much variation and trying to get people all together, so that - to make, you know, a similar decision. It has been a challenge. But you're right, a lot of this is - you know, we still don't have budgeted all of the federal dollars that are coming into our state around COVID. Some of it has been budgeted by our general assembly and our governor, but some of it has not, because we're still trying to figure out and get feedback from people in our communities as the best way to use some of those federal COVID dollars.

Dr. (Ed Ellinger): All right, (Lee), you had your hand up?

(Lee Wilson): Can you hear me now?

Dr. (Ed Ellinger): Yes, I can hear you.

(Lee Wilson): Good, okay. Thank you. So, (Steve), just to comment back for HRSA on the question that you had raised around midwives -

(Belinda Pettiford): What time, (John), on Saturday?

(Lee Wilson): There are a number of - I think somebody needs to mute their phone. There are a number of issues that we're working on from the HRSA perspective around this issue. First of all, as (Belinda) had talked about a little bit, the - our MHI activities are focused on states providing innovative solutions within their states. We know that some of the issues and restrictions that might be in place in bringing (unintelligible) nurse midwives or using them fully are not

really at the federal level, but at the state level.

And so, hopefully some of those initiatives are working on ways to help nurse midwives, midwives and other care professionals in the perinatal space to be able to operate more fully. We are embarking on a series of new health workforce-type activities, with the idea that we would then be able to fund and support the training of nurse midwives. And as you stated very observantly, that some of these initiatives are not going to resolve that issue in the next six months or year, because there's a (unintelligible) fund for the establishment and training for those types of programs.

So we are working in that area. We're also working on institutional initiatives where we're trying to embed within training programs additional supports and trainings on issues that could help people retool into that sort of care. So there's a lot going on, but we're also mindful of the fact that there is some disagreement as to who should be qualified, separate from what's going on at the state level, in delivering this sort of care. There are some longstanding beliefs and preferences about what the training is that's necessary for providing this support, and I'd like to believe that all of the parties are operating with their own perspective on what best intentions are for the way to deliver that care. But those are some of the other, more sticky, sometimes political issues that we're trying to deal with. So, I'm not sure if that's helpful, but.

(Steve): Yes, that was very helpful. Thank you, (Lee).

Dr. (Ed Ellinger): Thanks. (Lisa)? We're not hearing you, (Lisa).

Coordinator: As a reminder, to unmute your phone, please press star 1.

Dr. (Ed Ellinger): All right, (Lisa). Well, can you hear us?

(Lisa): I can hear you. Can you hear me?

(Belinda Pettiford): Oh yes, no.

(Lisa): Okay, good. Sorry about that, it was the star 1 thing. Thanks for having this meeting and this great discussion. I wish I could offer more up on the underserved issue. I didn't prepare anything for that, but I know that we have, at ACOG, our underserved committees, and I'm sure that they're tracking all this. So, I can go back to them and see what they've heard and report back through email, if you'd like me to do that.

Regarding the grassroots efforts on telehealth and who's talking to the governors at the local levels, we are initiating a widespread collaboration with our state, section, and district on getting the COVID telehealth leniencies permanent in the state, if possible. I mean, the federal government did a lot, but like you mentioned, it's at the state and the local levels that all this has to continue. So, we are working with our sections and our districts to talk to the right people at the right place, and it's different for every state, as you can imagine.

One of the messages is also making sure that people have the durable medical equipment they need to be monitored appropriately at home. That's really important, and we made pretty significant headway in that over the course of COVID, we know of several private health plans that are including durable medical equipment and sending those to pregnant women. So, that's been helpful. We're also in conversation with all the big private health plans. You know, United Healthcare and Anthem and Sigma, and many others, and we have one on one conversations scheduled within the next two to three weeks

with their medical directors on how we can partner to make sure telehealth continues appropriately after the public health emergency is finalized, whenever that would be.

Dr. (Ed Ellinger): Good. Thanks, (Lisa). (Janelle)?

(Janelle Palacios): Sorry, can you hear me?

Dr. (Ed Ellinger): Yes, I can.

(Janelle Palacios): Okay, good. So, just listening to - through our discussion, and thank you so much for clarifying and making it widely known, Dr. (Wilson), just regarding the number of (unintelligible) or red tape and political issues around statewide recognition for healthcare providers and who is qualified to care for women. One of the issues that the institution I work for is looking into is how to actually partner with doulas, right? How, in this time during COVID and women, different hospitals are deciding who can have their partners or not have anyone with them while they're laboring, what do we do to help support women? And so we've seen some women - we've given women some iPads, so that they can call someone and do Facetime with a doula that they were working with, or a beloved family member or friend.

But as we go through COVID and hopefully we can have a different kind of normal, we are looking to increasing doula use throughout our institutions, throughout our hospital. And we're wondering how - and this is also coming from a perspective from myself, but how can we - the steps needed to help reimburse doula services as a path and avenue for women who are definitely vulnerable? As we know, someone who is paying for a support person like a doula privately, it can be very expensive, especially in the Bay area. It can be $5000 to $10,000, just to have a - someone who has experience doing support

during prenatal and inter-partum, postnatal care.

So, we're looking at I guess the different policies that we can look into, of how to support women during this time, with perinatal healthcare, of especially inter-partum care, the delivery with doulas, and then are there any strategies or thoughts of how to have increased - trying to increase the number of midwives or providers in this country, to help care for women? Maybe looking at how to - I'm sorry. I think - I don't know.

Woman: We can still hear you.

(Janelle Palacios): How to help increase the number of midwives through other means of - I am so sorry, I'm having - I think I'm so nervous that I'm having a moment here. So let me collect my thoughts.

Dr. (Ed Ellinger): Now you know how I feel, trying to run this meeting virtually.

(Janelle Palacios): And you are amazing. You're amazing. Let me run through my notes really quickly. Right, I think that if we can - so what does the data show us as far as (Steve) has brought up - the issue for the Healthy Start research that looked at birth centers, they're looking at prized winning research that looked at ultimate modes of care and delivery for women and how to spot like this, also recognizing that when we compare ourselves to other European countries for example like the Netherlands and even England and looking at their birth outcomes just knowing that definitely there's different societal issues.

But they also have very strong one-to-one individual-centered women care when it comes to delivery timing. They often have devoted midwives - nurse-midwives with them into that and how can we try to rise to a standard where this is something that we can implement in our country.

Man: Thank you. Magda?

Dr. (Magda Peck): (Bristol) it's good to see you all and it's good to be seen. Thank you (Jeannie) for being the tech wizard that we've been doing behind the scenes troubleshooting. Go West Coast contingent. There are two additional points I'd like to raise up and I'm trying to figure out where they park both for the consideration and opportunity. The first has to do with qualitative information.

It came up during Dr. (Joia)'s presentation that came up and in (Tim)'s presentation and it's come up here about elevating the voices of women and for special studies that are going on. And I want to underscore from the data and research action workgroup that when we break out we will be trying to elevate up the methods and approaches within women-centered care, within family-centered care to hear those voices.

One example is that the fetal infant mortality review coming out of the Michigan Public Health Institute and the National Center is embarking on a story-telling project which is borrowing and learning from black Mamas Matter alliance about how the maternal interview can now be layered with an opportunity for both the capacity for storytelling as well as elevating up her or his or their stories directly.

So I just want to talk about valuing at this time when we're waiting for the data systems change to happen to hear her, his and their voices, point one. And then point two is a little darker and they're working with folks at Harvard on the midst info-demoics work. The work of understanding that the dis-information intentional campaigns that are happening on our social media platforms which are undermining confidence and public health data and systems and which are giving particularly around anti-vaccine at a greater

amplification to doubt.

And so I think we need to be extraordinarily mindful in our work about the opportunism of misinformed (demics) or the opportunity to exploit how people get the majority of their information on Instagram or on Facebook or on other social media platforms and how that is now an intentional campaign by some with an agenda that is not our own. And so I'm wondering how we can add to our data and research for action and awareness of the (unintelligible) of this to (unintelligible) speak to disrupt, dispute and essentially discount our data systems.

And I'd like to hear comments either on stories or qualitative data and how they can be helpful now and/or if you have any sense of systematic monitoring and surveillance of misinformation that are women and children, families and fathers are consuming.

Man: You've got a good agenda for your workgroup with those two issues.

Woman: But before I take it there it would be - Wanda, you as the city sealer or (Danielle) when you're the official data folk and so I'm wondering or if the academies - is this something that's on anybody's radar? That's what I'm asking.

Man: I see (Paul Jaris) and he raised his hand visually, not just electronically. (Paul) do you have some comments?

(Paul Jaris): Yes, interesting thing to learn as I'm working with (MINOR) which is an organization historically engineering software engineers and others. So we have whole teams that do the monitor social media around different topics and for lots of different agencies. You can imagine intelligence agencies and

others are very interested but we have a team monitoring around COVID-19. So we may not re-release the software program to help public health agencies monitor - find contacts and monitor people in isolation and quarantine. And unfortunately it's just the fact of life and public health now that you need to monitor the social media for mis and disinformation of the public health campaign. And so we have teams doing that and we get daily reports and we've already had threats on our lives from people that appear to bee survivalists, right nationalists (unintelligible) local health departments and the law enforcement potential threats.

So there is technology to do this and again, unfortunately, it is now a part of public health or anything else. I think what - we were picked up in Bright Park then that's when things took off.

Woman: Right. (Paul) thank you for that because local public leaders, even in Omaha, Nebraska among others those who are standing out and speaking for the work that needs to happen around COVID-19 and particularly the most vulnerable are now receiving death threats as well. And so it is not a light matter and I would encourage us if we're cutting edge as SACIM to build off of those assets that (Paul) that you're bringing forth and take it seriously.

Man: I'm going to take one more comment. I'm going to take one more comment before we get to the next item on the agenda. Belinda?

Belinda Pettiford: Yes. One of the things that we have spent some time talking about more recently in our state is around - with our historical and marginalized populations and specifically, the Latin population because a percentage are undocumented and their fear of coming in for care, treatment, testing or anything and wondering are there - have there been any conversations or any considerations during this pandemic. Can there be a conversation I guess with

ICE because they're basically concerned about they're not coming in for testing?

They're not going to get treated because of the fear that they're going to be deported. But we also know that many of them are of reproductive age and you're dealing with pregnant women who are going to have children that are going to be citizens. So it's almost like we're missing this opportunity because we're so busy trying to just get rid of a population of people. So we're trying to figure it out in our own state but wonder has ICE been given any additional guidance or do we even know what they've been told is the status quo even though we're trying to increase our testing and our contact tracing?

So that's something to just keep us on the forefront as well. And I know (Wanda) mentioned the recommendations that are coming out of the maternal mortality review committee around the state. The maternal health innovation site and the our mom site, the rule obstetrical management site, they're also charged with developing in their (unintelligible) statewide maternal health strategic plans. So they have task forces so that may be another way to get some information about what is happening locally.

Man: I know (Paul Weiss) has been actively on the board (unintelligible). He's not here right now because he had to go to court, work with the federal courts on a lot of these immigration issues. And so we may want to tap into his expertise to answer some of your questions, Belinda. All right we're going to come (unintelligible). Does somebody have a comment?

Man: I was just going to say that the unfortunate thing Belinda is who is it that could give you a reassurance that you can count on. It's almost an unanswerable question.

Belinda Pettiford: I know.

Man: All right. So if you have any more thoughts save them because we will have time at the end of our meeting tomorrow again, carry on this conversation and come up with some issues and then recommendations. And then you'll also - some of the questions that have come up will be carried forward into the workgroups that you're going to be working on over the - in the latter part of today. But I do want to take time now to go back and review the letter that I sent to the HHS secretary back in March and have some discussion about those recommendations.

When we put this together COVID had just come onboard and there were lots of unanswered questions. There still are but it was high visibility and there was some concerns about what hospitals were doing and how they could manage the influx of patients and what would happen to pregnant women and infants. And we've looked at what ACOG and what AAP was doing and the Society for Fetal and Maternal Medicine was doing and came up with these recommendations (unintelligible) conversations with the group because it was not an official recommendation because we have to - in order to do an official recommendation from SACIM we have to have a publicized meeting and add a bullet and so that it's visible to the general public.

So it was an unofficial recommendation. So I'm bringing it back now because a lot has changed since March but a lot continues to be the same. And so I want to review these recommendations and get a consensus from the group of what we can officially move towards the - to the Secretary. And I hope you have in front of you the nine recommendations and let me just - and if you don't stand up hospital link, non-hospital based labor and delivery units and expand the capacity of freestanding birth centers, expand the use of license for certified midwives in these centers to allow them to practice to the full extent

of their certification, expand access to telehealth in a broadly defined subpart community based, postpartum and newborn care, support broad financing including Medicaid for telehealth, permit states to configure eligibility for Medicaid for a full year after delivery, (unintelligible) the federal financing for home visiting, provide professional liability insurance and then expand data and surveillance systems.

So given those you've had three months to think about those. Are there concerns about any of those that are - they can go longer applicable or are there new ones that we should add to the mix? Magda?

Dr. (Magda Peck): I would just back off from the - got some background here. Is there a possibility on your first bullet point given the conversation that we've just had to augment this is a simpler one to specifically cite and document it? And to take a look at the special populations that have been mentioned today, we don't need to go into details. I think that if it's not explicit it's not there. And so the first would be to make sure that the populations of greatest marginalization or risk or vulnerability are called out in the first bullet point.

Man: Okay. So - yes, okay. So the overall cover letter raised a lot of issues but the specific recommendations, I wonder if we need to put that into any specific recommendation. (Elisa)? I'm not hearing from anybody.

(Elisa): So were you asking if Magda's suggestion could just be a standalone recommendation?

Man: Well I'm wondering - so the letter - the letter that I wrote covered a whole - it gave a context for it all. It gave some assumptions.

(Elisa): Right.

Man: And it came down to nine specific recommendations.

(Elisa): Correct.

Man: Now we can redo the letter and make sure that it runs with the context a little bit more then you can make those undocumented as part - specifically in that context. But should we actually put it in any of the specific recommendations that may be taken off, that was my question.

(Elisa): Yes. My point is that given what we've heard this morning, given the explicit nature of racism exposed and amplified by COVID I would be open without wordsmithing to look at how the therefore, yes put it upfront but more broadly. Protect all pregnant women. This is something about our opportunity around COVID which this was written prior to the break open of the nation and racial unrest. And I would be curious if the equity committee could help us with that or more broadly, but (unintelligible) like the number ten, something that says that calls it out because it's there. And it feels like it's glowingly missing so I gave the document as an example upfront but I am thinking backing off of Janelle that if it's not in there and the question what would be the specific recommendation. I'd have to give that some thought but I just feel like pay particular attention at this time of the exposure of racism.

Woman: Yes I agree with that. And I want it to be actionable. It's got to be actionable, I get that. But right now it's not there at all and this was written prior to May 25.

(Elise): Yes. And I don't know...

Woman: (Unintelligible) long before May 25.

Man: So what I would recommend is that in the equity committee workgroup, maybe come up with some recommendation that you can bring back to this group so we can add - if people agree, add that to our list of nine recommendations. (Lisa)?

(Lisa): Yes.

Man: (Unintelligible).

(Lisa): Yes.

Man: Okay let's go to (Jeannie).

(Jeannie): Okay thank you. I am concerned about the wording in protect pregnant women and infants from harm, the stand-up hospital link non-hospital base labeling delivery units and expand the capacity of freestanding birth centers. To me that - you're looking at a long term, not intermediate possible solution. And I say possible because again being part of the data group I want to look at. But what I clearly heard from patients and from the clinicians providing labor and delivery care is the safety for our part, and safety meaning if you're in not a standalone. You're a hospital-based labor and delivery unit and the hospital takes the personal protective equipment over to the ICU because that's the greatest need.

It's the autonomy of a labor and delivery unit. You can have autonomy and still be in the entire hospital. So being able to be autonomous and place labor and delivery at the distinct and important entity to me is the most important and clear statement that we need to make. We've got existing labor and delivery units. We've got existing birth center units. So how do we make sure that the patient's perception is that they are safe? And I think addressing that,

not saying that we need to build more. Look at what it takes to build any other unit. It's an extremely costly and very unlikely to happen in the near future but we can address the autonomy of our labor and delivery unit to where they function and can assure patients that they will receive a safe environment, that they're - that their protection is first and foremost and I don't think this captures that.

Man: So your concern is the stand-up part or in the non-hospital part? I'm not quite sure if I understand.

(Jeannie): Yes. I would say - I would call it labor and delivery. That any labor and delivery unit has an autonomy because to me I'm seeing this is - we're going to expand the capacity of existing freestanding birthing centers. I don't know that that needs to happen in an immediate response around COVID if this is what we're addressing, whether you have existing labor and delivery units. You want them to be as safe as possible for the patients that are delivering there.

You want patients' perception in the community to be that they're a very safe location to go and making sure that the hospital is able to say this is how we achieved autonomy and this is what we're doing that's absolutely critical.

Man: I heard from (Steve) tell them that there is an increasing demand for birthing and birth centers. And so - and that there's a capacity issue related to that because it's just the number of providers that they have. So it does sound like there is a demand currently during this crisis for that kind of service. (Steve) is that what you're sensing?

(Steve): I actually - I agree with (Jeannie) about we have to - we should recraft the language. I think the language in the letter you wrote or directed (unintelligible) that was mapped. That's the way I heard it described, mapped

set up, maternity...no we're not there. I would suggest putting language in there that just says that mothers should be given the option for care in all accredited birthing environments that they're available and that their wishes are respected.

What we're getting is just that the patients that come are saying I feel like I'm going to the hospital and I'm going to be told it may change tomorrow where not only can you not have a doula. You may not have your partner with you, that sort of thing. So I agree with (Jeannie) pushing towards whether it's autonomy for those sorts of things but just respecting the wishes of mothers and what they're looking for. That make sense (Jeannie)?

(Jeannie): Yes. And I think we can all look back. I'm in one of the physician mothers groups and you'll be mom groups. And I'm speaking every day with physicians who are moms taking care of mom and listening to their vulnerability and their fears too. So you've got fear on both sides and this is a situation unlike anything that we've ever had. So making sure that we have created a safe environment for the healthcare providers and for the patient because that's what they both want to hear so whether it was the PPE that they couldn't get, they couldn't get access to a N95.

They're on labor and delivery. You only need N95 for an ICU tubation or something like that. So I think those are the issues that you're hearing both from the clinician and from the patient. So you want it a broader description of circumstances and not just saying I think that was the wording (unintelligible) again. Expand the capacity of existing freestanding birth centers. I don't think that's the solution. I think that's one element of the solution but we've got hospitals that have capacity. How to make a patient's perception that those hospitals are safe?

Woman: (Unintelligible) clinician.

Man: So could you and - could you and Steve work on some of the wording for that with the workgroup, (Steve)'s workgroup and so that we can - and email it to me later on tonight so that I can see it and we bring it back to the group?

(Jeannie): Okay. And (Lisa) you might have some - (Lisa) you might have some suggestions for all the scenarios that came through ACOG. I'm seeing just probably a fraction of what you all saw at ACOG in the groups that I'm speaking with.

Man: All right. So if we could get Steve and (Jean) - (Jeannie) could work on the wording for that we can craft that. How about any of the other nine - eight points over there? Any concerns with any of them, moderations or things and/or at hand?

Dr. (Magda Peck): I heard this morning clearly and again we're - it's like we're getting a new snapshot on a refrigerator because we're now three months into or 2 1/2 months past when this is done. So thanks for the opportunity. On number 3 I think we can be more rigorous. I think it stems but it's more than access to telehealth.

I think we need to explicitly mention the combination of sustained - it's not just expand but it's expand and sustain access via reliable broadband. And I think the broadband notion has been coming up again and again. It's not that people don't - either they're in a broadband or they might have one screen at home and at one screen that screen is being shared with mom's doctor visit or doula visit and kids being homeschooled or at least at home for school.

So there's - I've been watching the internet companies, Verizon and others

give these we're expanding your broadband. We're expanding - but the value is that's short term and that's going to go away. And so I want to encourage us to put the language of expand and sustained access to telehealth to include access to reliable broadband and efficient hardware at home. I don't have the right word exactly too because - I'll leave it at that. Does that resonate for anyone else? I just think if it's not in there it can't be implicit and we've been hearing about it and hearing about it this morning.

Man: All right. That one is simple enough that I can add that to the wording. I agree with you on that. So we don't need the workgroup to work on the wording for that one. Thanks, (Magda). (Paul)?

(Paul Jaris): Yes. So broadband is - and telehealth is important but I think it's also important to consider in the context of the whole health system in a community because it actually can have some very detrimental effects potentially. For example, if you had a telehealth come in and started picking up lots of patients and let's say there's one LB and one nurse practitioner in town and they're losing that business. They are losing the income to support the practice.

Then on top of it when one of those patients needs to be seen the telehealth provider can't see them. They're the ones that have to come and the (unintelligible) see them. And so there's potential here to really destabilize or if the telehealth means that people are - high-risk people are being maintained and managed in that community which is good and an emergency happens. They may go into an ER and it's an ER doc who does a delivery or whatever. So we have - we looked at the whole system to make sure that the remaining docs in the community can handle what's coming at them. So that's why I'm saying that it's - in of itself telehealth is not a panacea.

It has to be part of a comprehensive system of access for women in the community. And in those unfortunate cases where it means it skimps patients off with community hospitals so they can no longer support their OB unit then it's really very harmful. Just another point.

(Jeannie): No I think that's a great comment. This is (Jeannie) again, sorry I interrupted.

(Paul Jaris): That's fine.

(Jeannie): I was just going to say do you want to hear an example for a group of really successfully done telehealth? It's the Kaiser Permanente. We've been doing telehealth there I guess eight years or longer. I know they went into overdrive with COVID but the video visits were an element. So being able to speak with some of the leadership there, what it took to integrate and I know the preventive health organization that they certainly have a lot of tips that people can learn from.

Man: And (Paul) I think it's really - what (Magda) said about the sustained and reliable and broadband and hardware and in the context of better healthcare community or better healthcare system I think would be a good point to make. So I can make them do that. I guess it's a good addition. (Steve) and then (Janelle)?

(Steve): Yes. Actually I got (unintelligible) question (unintelligible). I'm just working on something to maybe...about from the letter suggest.

Man: Okay. (Janelle)?

(Janelle Palacios): All right. One of the things that I thought, so again (Jeannie) was talking about (unintelligible) regime and telehealth. And definitely since March we've had

something like 120% increase of using of our telehealth, telephone and video appointments. And definitely with the government Medicaid covering video - Medicare and Medicaid covering video visits certainly helped support telehealth medicine.

I was just wondering if maybe the avenues for the institution of wherever the patient is being cared from being able to somewhat tether their device to that institution that allows them access to be able to participate in video health or - so that they are not using their data usage for that video visit or something. I'm going to ask if we go back to point 2, expand the use of license of our certified midwife, I believe with a prior discussion with a past participant who was invited to come talk with health equity, the issue of license versus certified midwife was brought up.

And our state - the states have a system for certified midwives and so that issue of licensed midwives is only used in California. So only my special state that I live in has that special term and licensed midwife that term does not have certain education tied to it. But if we can just take out licensed midwife and just use certified midwife I guess that would be the language that we should probably use in this recommendation.

Man: Anybody have a problem with that? That makes sense. Okay, that's easy. All right. Any other recommendations that we want to comment on?

Dr. (Wanda Barfield): I just to - this is Wanda. Can you hear me?

Man: Yes.

Dr. (Wanda Barfield): So I just wanted to comment on I know that it's important that we think about the maternity wards and our labor wards distinct and in need of support

during - particularly pandemics but I think there is a degree of interdependence particularly in terms of assessing search capacity that I don't want it to appear that it's an isolated distinct island in of itself. And I think that's very important because there's a lot of support that is shared in our labor and delivery unit whether it's laboratory support, respiratory therapy and support, transfer to the ICU if the patient gets worse.

The whole design towards a search capacity, we end up say for example (unintelligible) in the pediatric ward so that there's an opportunity to maybe bring in other patients and how can labor and delivery help with that. So I just don't want to imply that they're an institute in of itself. I was trying to say it earlier but I was having some technical difficulties.

Man: Yes I got (unintelligible) that you were also trying to link this part of the system and I was part of - I'm hoping it will come out of the new recommendation.

Man: Especially rural health is where.

Woman: (Unintelligible) the system. I think the emergency room is perceived for what it is, an emergency setting but you're right. You see that surge happen into and out of labor and delivery units and labor and delivery personnel, which the more that surge impacts the flow the more the perception is that any woman who's just coming in just (unintelligible) coming in to deliver a baby is no longer safe.

Granted there's so much variation that it's really hard to say but I know some hospitals are trying to for example avoid the emergency room altogether when a pregnant woman comes in so that she's not exposed. Those are the kind of things we continue to consider but the support is very important.

Man: Even rural hospitals of course. The nurses often will shift back and forth between med surge, ER and labor and delivery. So it really is - does have to be looked at as a unit.

Woman: This is something that I've just seen in the field working clinically, but when we were going through an increase of COVID cases within the hospital I work at there's something to be said for that one to one care that might happen more so in a birth center versus in a hospital setting. The nurses who are caring for when and whether or not she was a PUI, whether she was highly suspicious for COVID or not really we're not engaging with our women.

There was really not a lot of one to one care happening for that woman and then taken into account that they're in a period of time where women could not have a support partner at all. So just thinking as we move forward and thinking of yes, hospital as a unit as a place if someone is very sick, it can be a very special, safe place for women and infants but also for women who are otherwise healthy or low-risk. And definitely birth centers appropriately have a long list of factors that would have a woman transfer out of their care. They would not be in their care in the birth center.

And so women are making the list and they're very low-risk and if they are choosing to use a delivery out of a hospital such as a birth center with seasoned and experienced providers expanding that mode of care might be necessary, might be important for our community.

Man: All right. Magda, you had a comment.

Dr. (Magda Peck): This morning we heard (Joy) talk about a reproductive justice framework and it's a more general comment. I still appreciate the pragmatism and strategy

about focusing on do no harm to pregnant women and infants. And I'm also mindful of what we may be hearing around limited or more constrained access to the full range of FDA approved contraceptive methods and devices and in the context of pre-conception health.

And I just want to ask you as my colleagues whether these recommendations boundary by pregnancy and newborns specific in the short run to addressing maternal mortality and infant mortality, whether there's any opportunity or appetite to even explore the intra-conception or preconception period as we think about the potential impacts of COVID-19. It's more of a - it's a framework question before I get to the specific of what would be the recommendation. And I just want to know if there's any interest in exploring assuring access to not just prenatal care or pregnancy-related but also contraception or family planning.

Man: What I'm thinking is that these recommendations were very specific related to the healthcare system relative to COVID and so I'd like to get consensus on this, and then tomorrow then say in addition to these that really came up in that letter and that we now have verified, there are some other issues that we would like to - recommendation that we would like to make to you while in the context of COVID and in the context of everything else that's going on. And that would be where we may come up with another recommendation add-on if we agree to add on to this list or have another sort of list separate from this list of COVID-related things.

Woman: I am absolutely at ease with that. I just - we were missed given what we know about life course and given what we know about upstream in the spirit of Dr. (Warren)'s comment this morning and what we know about the four between and beyond pregnancies and not address it. So if it can be brought up again intentionally tomorrow afternoon that would be acceptable to me. I just don't

want to remain silent on it.

Man: That's fine. Belinda?

Belinda Pettiford: I was trying to figure that same thing out Magda and I keep looking at somewhere between six and seven. On six we talk about it continuing Medicaid which should help with addressing - we don't actually say for a year. I was wondering do we mean to say for a year. We actually say for the duration of the emergency. We say the infant is already covered for a year but we don't say that for the woman because it could be an opportunity to address some chronic health conditions that would put her at greater risk for being infected with COVID.

So I was wondering could we put something there that would fall more in a conception language. And we talk about the full trimester but we only talk about it for home visiting. We don't talk about it in general. We pick that up in number seven. So I'm fine with waiting until tomorrow but those were the two areas that I've been looking at, trying to figure out if there's a way to get some interconnection on language there especially if we connect it around addressing chronic health conditions or disease.

Woman: That's a great point.

Man: So what I would like to do is I would like to this afternoon in the ten minutes that we have left actually get an agreement that if we change number one which - to really focus more on the safety of those units and the integration of healthcare system, expand number three to we talked about sustaining and broadband and the context, adding another recommendation related to equity (unintelligible) and documented. And then get a general agreement that we're not - on those when we can do some other wording during the evening to add

on to some of these recommendations so we can go back to specific ones.

We'll come back to number one again tomorrow and approve the language that's there and who the number can recommendation - so that's what I'd like to do and if we can do things right now adding (Magda)'s points and (Belinda)'s points to those, if you can give me the wording for those we can do that right now. Or we could just add those as a add-on to our general recommendations from the SACIM meeting later on tomorrow afternoon.

(Tara): This is (Tara). Can you hear me now?

Man: Yes.

Woman: Yes.

(Tara): Thank goodness. Okay. I don't have my video up because I don't know. Maybe (unintelligible) at the same time. One thing that I just wanted to mention as I think there's been a lot of talk about ethnic disparities and right now with COVID. And I definitely have seen some reports, a lot of reports and data about that but one thing I am seeing that's lacking is specific data about ethnic disparities in pregnant women.

And so I think I've been seeing some specific papers that have come out looking at the UK. There was a recent study that just came out by night at (AL) in the UK showing that the maternal mortality 5 out of 427 cases resulted in maternal deaths. And then they showed that there was racial disparity but we just don't have enough U.S. data and I know that that's in there. I know there's been a lot of talk today about racial disparity and I agree that that is definitely but I think we absolutely need to focus on getting that data - getting publishable data.

So I know that our 9th - getting back to the recommendations I think that falls right into recommendation 9. So I know we're expanding data and surveillance systems but i think we need some hard core facts to stand behind some of the - behind everything that's been said today. And I know that the CDC is working on that but I'm just not seeing it in a published literature.

Dr. (Wanda Barfield): This is (Wanda). Are you talking about in the context of COVID or more broadly?

(Tara): I'm talking in the context of COVID specifically. So I've been doing a lot of research on maternal mortality and infant mortality with COVID and I know that there are a lot - there have been reported ethnic disparities and incidents and outcomes especially in the UK. I'm just not seeing a lot of - if people have those reports I'd love for them to send them to me. And so I just think we need to make sure that these registries that are being established there's a lot of registries internationally and nationally.

I can only assume that they are collecting race data but I just think we just need to - I think we need to be more clear where that's data going to come from and who's doing it.

Dr. (Wanda Barfield): So ---? There are a number of registries that are taking place. Very few of them have published any of the information. Priority is the meeting every two weeks. They are UC San Francisco and UCLA. The priority group has tried to harmonize the data collection so that everybody collects a certain baseline and they share that harmonization. If you go to priority they've got it there and yes, race is one element of it but we've got Columbia (unintelligible). We've got a number of international sites with COVID registry out of the UK is linking with all this.

We're trying to harmonize the data and certainly race is one element of all the - that are being collected. (Unintelligible) the Vice President of the Royal College is going to oversee some of the harmonization for that. So if you want to keep linked with me I can let you know what's going on.

(Tara): Okay that would be great. Thanks so much.

Man: I do think those concerns are actually embedded in number nine. So I do think that covers those kinds of things. So I'm going to recommend (unintelligible) that we - I get a sense of general agreement with most of these things. However, if we rewrite number one with - based on what (Jeannie) comment was bringing up. So we'll redo that one. We will take up licensed and/or in the second one. In number three we will talk about sustaining and using reliable broadband in the context of the healthcare system.

We will do four and five and number six, we may want to do a little bit of tweaking in terms of adding more to the specificity and clarity around Medicaid and indirect - intra-conception care. Number eight and number nine we'll do the same generally and then we would add a 10th one related to equity that the equity committee would work on. Would people be in agreement with that summary? And then we could say yes, we agree with that and with knowing it we'll come back and officially approve number one and a new number - a new number one and a new number ten. Magda I see (unintelligible).

Dr. (Magda Peck): I'm just saying that I think that you captured the right things to do to take us to the next draft. I think there is a sense of timeliness and urgency to have somebody ready to go. And so I think that by the time you get to the end of the meeting we should be a lot - we should be ready to have something that

can be more tangible in a product that we can stand behind.

Man: Okay. So I would actually make an approval to say this is what we want. We're (unintelligible) at this fight knowing that we'll come back and finalize the vote tomorrow.

Woman: Okay.

Man: Add I'm sorry to add something at the last minute. I'm wondering - we're talking about monitoring pregnancies during COVID but the same database could subsequently used for monitoring children in the event there were effects of COVID on children in some capacity in the long term.

Man: And again what I'm seeing is that we have this very specifically focused set of recommendations and when we write the letter to the Secretary we could say in addition, these are some additional things that we can add on and that would be one, that some of these things could be used for children, that some of these things can be used for whatever and any other recommendations. I would like to move this set of recommendations forward as best we can.

All right. I don't see any - if anybody disagrees raise your hand. Moving ahead with (unintelligible). I don't see anybody's hand raised. All right so (Janelle) if your group could develop something, workgroup and give it to me by email tonight. And (Steven) your workgroup, do something with that first recommendation. (Jeannie), I'm not sure (Jeannie) where your - which workgroup you're in - can't be in two at the same time at this point and also give that to me, then we can put it together and share it with the group.

And Belinda if you had any recommendations that you would like to make, number six or seven to clarify that that would also be helpful. All right.

Moving on thank you for all your work. This is the kind of thing where I'm hoping we as a committee can say here's a unique opportunity. Something is happening right now. Let's jump on it and make some recommendations based on the best ability that we have with the best information that we have and not spend three years trying to get it through the most polished state ever. That time is beyond useful.

Okay. I'm going to turn it over now to (Lee) to talk about the PREEMIE Act and I'm also going to say we're not going to take a break because I think the PREEMIE Act conversation may not be that long. We'll talk about a little bit about the privacies and then we'll go into the break up. So I don't think we need to take a 15 minute break, at least I'm sensing that we don't because I'd like to move this forward. And if we do need to take a break just turn off the camera and come back later.

And so the PREEMIE Act, I put it on that agenda because this is a scenario where I'm confused in terms of what SACIM's role is and whether or not we function as the committee overseeing the PREEMIE Act. So I want to clarify where we are so we know what our responsibilities are and I know that MCHB has been working on a report that might meet some of the requirements. I'll turn it over to (Lee Watkins) to do that.

(Lee Watkins): Can you all hear me?

Man: Yes.

(Lee Watkins): Okay. So I'm going to do this without prop because I wasn't sure exactly the degree to which we were going to go into detail for the amount of information that you all would all be interested in having on the topic but we can provide more to you. So this advisory committee has been in existence for quite some

time now and it actually pre-dates the PREEMIE Act. We've had a series of conversations both internally at the department level and with Congress about the role of this committee as it relates to what has been proposed and has been authorized in the PREEMIE Act and is the best use of the resources that we have currently invested in these efforts and how we sort of accommodate the intent of that legislation with the appropriation situation.

So I'm going to speak from HRSA's perspective knowing that CDC also has a branch of the PREEMIE Acts that have not been funded and NIH also work that has done. Preemie is actually quite a large piece of legislation. The PREEMIE Act calls for an advisory committee and although the PREEMIE Act was authorized, it has never received (unintelligible). So there has been some debate back and forth as to the degree to which the agencies that are tasked with duties or assigned with duties under the PREEMIE Act are then responsible for fulfilling those duties and responsibilities.

So given the fact that there weren't - there was no appropriation and we're not obliged to although it is the intent of the agencies that have responsibilities or charges to work it up as outlined in the PREEMIE Act to continue on with the work that they have been doing. So I will respond back to Congress when they have inquired to us what we are doing to both fill those requirements is to say that A, we have had a longstanding committee that has been charged with working on infant mortality, and as you know in the new PREEMIE Act it does expand that work into maternal health and maternal mortality in a way that hadn't been before.

So we have tried to incorporate that piece into this committee as well as a clear charge in response to the intent of Congress on that point. However and (Paul Angelis) you had some dumb bells there. No, keep doing it.

Man: I was trying to hide it.

(Lee Watkins): So anyway the - we have been pursuing this committee with the idea of trying not to or trying to speak to Congress about the fact that because the committee exists that there is no need to create a redundant committee, that the intent that this committee that it has been in existence will fulfill that requirement. That said, the legislation has also called for a report back to Congress on the committee's deliberations and their recommendations.

We have not pursued completing that report because as I said since there has not been an authorization for such a report we are not bound and in the tracking systems that the department has put together corresponding back to reports to Congress. That is not listed in one of our requirements absentee appropriation. We are mindful of that balancing act and the desire to try to fulfill but also not to put (unintelligible) a case that we can do this work without the needed appropriation to make that happen and in an effective manner.

We are pursuing as we move forward the development of a report that would look at three different components. One would be a summary of what the work is that's going on and deliberations that the advisory committee is considering and discussing. Two would be any research or data activities that you are looking into or would like for us to pursue as a summary of the types of things that you're looking into and third would be a summary and report out of what the recommendations are the committee has been discussing and where you come out on those issues.

That is in the development here. We have not gotten very far with the process. We're actually executing that as it's planned for the next award the logistic activities of this contact if it goes forward and we have the resources to make

that happen. We will then be able to work with you on the development of the report. We are in this unusual balancing act of trying to live within the spirit of the legislation while arguing that resources cannot be taken away from other activities that the agency is funding in order to underwrite the efforts of what Congress has said.

So I know there was some back and forth a few months ago about whether we were meeting the intent of the legislation with a report or not. And when (Ed) and I have had these conversations he felt it would be important to clarify if you have any questions. I'm happy to address them with you and we can go from there.

Man: Thank you (Lee). You have any suggestions on when we as the SACIM committee should we doing related to the PREEMIE Act right now or do we just wait and see what the - this report starts to look like as we starting working on it and then get input on those three different areas and then come back and review it at a later date? Or do you have other recommendations (unintelligible) committee?

Man: My guidance to you would be to look at the legislation, the way the legislation is worded. If you have any recommendations either in affirmation of what the legislation says or changes that you think would be warranted as experts in the field, I would encourage you to acknowledge that. And I would encourage you to consider the situation as it exists if there is an authorization without an appropriation and what limitation that may cause you and the agency in administering or following through with that intent.

If there are recommendations that you want to make in that area by all means you are empowered as an advisory committee to the Secretary to make those recommendations. It is within the Secretary's purview to deliver it unto

Congress if he chooses to do but we are relying on you as experts at arm's length from the agencies to say what you believe is most important.

Man: All right. So general work like the work that we're doing with the three workgroups and to report what their preliminary recommendations are or the work that they're going to be doing can all be fed into what the bureau is thinking in terms of what its responsibility it is reporting this out and particularly run data and research and around the current work of second. As we monitor as I as the Chair can tell you this is what we're doing, this is how we're thinking and this is the stuff that the recommendations that we're working towards.

Man: Correct. I do want to point out that this report that we are generating because there is no appropriation is not a report to the Secretary as such because this is a report that HRSA is funding in working with you to come back to HRSA because there is no appropriation that makes that charge of you. So I would suggest not to rely on this report necessarily to the vehicle toward the next six months to a year on any program or policy recommendations that you intend to make because that report is going to take some time to get it worded, be generated and then be received by the agency.

If you have particular recommendations, so you've got your letter right now that you're working on and making recommendations. If there are other recommendations that you intend to make vote on them, make your decision. Send them to the agency and those recommendations will be transmitted to the Secretary. This report is not intended to be the vehicle thing. Here is what the committee is stating we want right now.

Man: Okay. So basically we just carry on with the work as we've done and that the PREEMIE Act is to me somewhat irrelevant that we're doing. We're already

doing the work and we've been doing the work for 31 years or so and this wouldn't really change how we do our work. You think it'll meet those needs at some point in time.

Man: It is relevant in that it gives you the added support of saying this is in keeping with the intent of Congress. However, it doesn't change your charge at this point in any way unless the agency chooses to do that. I do think that in my own opinion there are a lot of things that are called on in the PREEMIE Act that are valuable that actually mirror some of the points that have been made about the importance of data, the importance of reaching out to the community and some of those programs that are bailed out in the PREEMIE Act that you all are calling for funding or for additional emphasis.

So there is some alignment with what it sounds like the PREEMIE Act is trying to do. I apologize for throwing (unintelligible) on you. It appears that my neighborhood has lost power. So I'm talking to you over the phone but I can't see any of your responses. Also, I think it's worthwhile to allow CDC Dr. Barfield if you have any comments at this point and want to weigh in. Please feel free to.

Dr. (Wanda Barfield): Yes, hello. Yes, it's correct that it is an appropriated funding for the PREEMIE Act. Our division has sublines in safe motherhood and we have about $2 million in funding that has been dubbed for use for that. But it is an appropriated amount and we'll be providing information in the report along with HRSA and NIH.

Man: All right. Any other questions or comments from the (unintelligible)? I see Magda and Belinda's names. I don't know if that's from previous or not. Anybody else have any questions? Hello, you just clarified that completely. I can still see you. You may not be able to see us but I can see you.

Man: Now I can. Thank you, yes.

Man: Very good. All right thank you much. All right now we're into the home stretch for today. We're going to be looking at the workgroup privacies and then breaking up into workgroups. And so we started working on the workgroup charters since it was getting confusing at what the charter was. It was the second charter. It was a different charter so we changed name to praxis. So everybody has their own praxis. This is just a fancy term for charter I think and the work that you do.

And I was hoping that each of the groups can come up with a praxis to outline the purpose and some of the methodology or the outputs that they want. And then I wanted to really get everybody's input so that we're in agreement. We know what the workgroups are doing or we all understand and be supportive of it and that's where a lot of the work can be done for the committee as a whole through these workgroups.

So you've got the three - I think you've gotten drafts of the three praxes and I'm going to have each one of the Chairs (unintelligible) of those workgroups give you a little update on their praxis and then we have some conversation to see if there's anything else that people want to add to the purpose statements in particular and before we break up into the workgroups and do the work that fulfills the praxis goals. So let's start with Steve.

(Steve): Okay. Well, I actually took my cue (unintelligible) for my mod to put together and Janelle as well. So it's basically just focusing. All of our work I think (Doug) hit. Of course the equity and disparities is very direct focused and the data is probably going to be covered by all three of our groups. But from our perspective in the workgroup on quality and access, it was to identify what our

quality options for care all the way from the traditional system with many of the safety bundles to kind of a more expansive look at honoring mothers' choices and what they want for their birth experience.

So I don't know. That's kind of just - the focus in is on identifying higher - high-quality care and then trying to look at what are the access issues, what are the barriers. Sometimes they're regulatory and they're almost interpersonal, social. On many occasions, they're based on the financing and I think that's why tomorrow I'm looking forward to the presentation that folks from the Institute for Medicaid Innovation are going to be giving to the whole group. So that's pretty much the summary of our focus and we're doing this in a collaborative way and utilizing everybody's…

Man: So who from - we have each of these SACIM members. I think almost everybody in on our workgroup and while we do have the ex-officio members are there any ex-officio members that you'd like to recruit for your workgroup before we start going out for people beyond the members and the ex-officio members?

(Steve): I think the ex-officio members...

Man: Any kind of expertise you'd like in particular.

(Steve): Well the ex-officio member, I haven't heard from her but Suzanne England is an advanced practice nurse and she's the ex-officio from the Indian Health Service. So she has a really great (unintelligible) rural health and in particular challenges of the Native community. So I haven't heard from her and we have a committee (Tara) and (Colleen), neo-natal perspective and (Tara) representing the research perspective too. So that's who we have so far. Then we have a couple of outside folks who are joining us as well and I'm grateful

for that.

Man: All right. So if you need (unintelligible) recruit (unintelligible). Magda how about the data and research for action group?

Dr. (Magda Peck): Thanks. I do throw out a couple of slides. I don't know if they're available right now but I'm happy to talk about them if they're not. Also on page 39 of the 406 page briefing book in case you're looking for where it is you will find our draft praxis. I wanted to take an opportunity to thank the corp members, this workgroup for putting legs on this thing.

So if you could and I noticed that no matter how well you do your slides we throw them up in Adobe they're going to be corrupted a bit. So let's just all see it as it's messy and it's fine. I'm (unintelligible) the next slide please because I'm not sure I have the ability to advance it. I wanted to...

Woman: Magda I did you the ability to advance it if you'd like to...

Dr. (Magda Peck): You did. Well, either way I'm (unintelligible). There's only three of them, only three of them. So I want to acknowledge the who of this, specifically (Jeannie Conryan), Janelle Palacios working with us, with (Ed) and me as the four core members of SACIM. And special thanks to (Danielle), (Elay) and (Shell Desart) for joining us from MCHS and CDC (unintelligible) division to round up some of our initial core set the foundations members of the ex-officio.

And then today we also will be joined by a couple of additional outside folks who are bringing in local public health perspective and certified nurse-midwife perspective and academ as well as (Wanda Bolsio) will be joining us as well bringing in that robust other parts of CDC. So if you're listening in we've got a pitch for you to both build out that number nine of the

recommendations that you've been hearing about as well as try to articulate some of the issues and gaps and opportunities specific to COVID-19.

We've done our brainstorming. We've also developed the praxis which I'm going to talk about just for a minute right now. And specifically, if you could go to the next slide because I'm not quite sure and I don't want to break it. That'd be helpful. What we see the value of this particular working group for SACIM is to make sure that our deliberations and our decision making that produces strategic policy recommendations for preventing maternal-infant mortality by promoting health equity are based on available evidence and science that are credible and reliable and (unintelligible).

So I really appreciated the question that (Tara Lee) was asking earlier. Where are the data because we live in different worlds and it's always making sure that it's substantive and not opinion or ideology. We are an evidence and science-based group working together. Within that, we have identified a series of overarching goals specifically to COVID and pandemic and then more general. Yes, we will look to try to identify access and use of quantitative and qualitative data and research to do our work across sectors so housing, food, security, child care, economic development, (unintelligible), education, business.

We see ourselves as the interface for data and research for those ex-officio members who are coming in from housing and urban development and coming in from ACF and elsewhere. So we can be a bridge through data and research. We want to make sure we're identifying gaps and deficiencies in the data but also how do we build capacity. That has come up as well in terms of recommendations also around training as well as strengthening and revolutionizing in some cases systems that make the data sing for us.

We also left want to make sure that we're elevating the research results from a variety of voices and particularly community voices to illustrate our findings knowing as the (unintelligible) behind every number is a person, a face, a story. Specific to pandemic we're going to be applying that lens and last we want you to know that we are seeing this as an opportunity to advocate more broadly to a different 21st century surveillance and data system not anemic, not necessarily exactly as they have been but in extraordinary times, extraordinary things may be possible and particularly in terms of leveraging out the existing data systems and the more timely registries and other real-time data that are emerging in the face of COVID.

So towards that end, I can have the next slide. If you come to this particular session you're going to have a consultation time with a series of questions that are going to drive our conversations specific to COVID around how well our existing and emerging data systems and sources informing us and what are the gaps and deficiencies and how can we work across sector and what are these explicit recommendations now that can augment what we're putting in number nine.

And in the next slide we will be open to our ongoing question about how do we have amplified, robust, creative, innovative data systems aligned across sectors to prevent maternal and infant mortality overall. So the questions about major gaps and deficiencies as well as emerging qualitative and quantitative data and research that we elevate out, too much to handle in one breakout but we wanted to say that these questions align with our goals and the way we spend our time gets us the results we want to get as one leg of this three-legged stool.

So come join us. If you don't know where to go and you're listening online beyond all the folks - SACIM members, ex-officios if you're still there we

could really use your brilliant insight and hard questions and that's what I got.

Man: All right thank you Magda, good recruitment. Good recruitment. So Now Janelle and Belinda, health equity.

Woman: We can't hear you Janelle if you're speaking.

Janelle Palacios: Okay. Better?

Man: Yes.

Janelle Palacios: Okay. Belinda and I have been - are co-chairing the health equity workgroup and we started with the premise that everyone has an equal and just opportunity to live as healthy a life as possible across generations. Our current group has nine people of which four are SACIM committee members, (Paul Jaris), (Belinda) and I and (Wendy), representation from ACOG, ACNM and New York City Midwives, and (Wendy) is the ex-officio from the Office of Primary Research and Evaluation.

We are still in the pre-natal stages of creating health equity workgroup and recently we just started on - we've had a few drafts about praxis. So this is our pitch to have you come join us during the breakout. Okay, next slide. Given what our - the presentation that we have today I believe the praxis will change a bit. We started with the purpose to promote common understanding to identify gaps and generate plans and take action utilizing health equity as a framework.

This may expand given what we talked about today. We want to ensure that SACIM's considerations and policy recommendations are grounded by a shared understanding and commitment to health equity. And we intend to

work closely with data and research and access and quality to make sure that the recommendations are seamlessly incorporating health equity when needed.

We also want to include the social determinants of health to address the needs and health improvement among women and infants across (unintelligible) lands and territory. Next slide, please. We have a few goals. The first goal is just to discuss and promote the use of specific common terms grounding women and infant health and their lived social circumstances. We did this by creating a racial justice informed lexicon that is part of our - the appendix to our praxis. It's a very long list but a much needed list so that we can all be on the same page when we use certain terms.

We want to advocate and discuss for discussion and planning and actions taken by SACIM which addresses racism at a national and public recommended health crisis and a third goal at the moment is to ensure that all immediate and longer term recommendations made by SACIM that safeguard and protect maternal infant health during COVID pandemic include health equity measures. And then what are the actions that we've taken?

We've had three meetings to date largely working on the praxis and we discussed COVID in relation to women's health and then we provided a racial justice lexicon. So we are at this point in time where we would like to invite people to speak their thoughts and suggestions regarding SACIM how we can address health equity. What are the next steps and we really want to have an action piece. Please go ahead. I can't remember the next slide or not. It might be the end.

So we would like your expertise in helping us develop the future. What have we missed? What are the steps that we need to take? We would ideally like to hear thoughts on how to engage communities or which organizations or

institutions are leading us and engaging communities, vulnerable communities and communities of color to address health equity. Belinda, you're welcome to jump in and add any additional thoughts on what we would like to see as far as expertise on our discussion of the breakout.

Belinda Pettiford: No, I think you covered it, Janelle. We wanted to have conversations around - to ensure equity is included in all of our workgroups as well and all the work that you're doing. I think you did a great job covering it so thanks.

Man: All right. For the group as a whole is there anything that you would like if you're not in the specific committee would you like to other committees, other workgroups any ideas that you might have at this point in time that if you - that they could expand or include into their general purpose?

Janelle Palacios: I think that one of the things that has come up that we cannot - we can't turn away from, that we - all groups should probably consider adopting social determinants of health as the driving or underlying force for the work to contextualize the work that we're doing. So even though health equity is using social determinants of health to help guide recommendations or to guide our thinking in this it definitely should be a part of each of the other groups as a foundation to consider just basic access, access to prenatal care or delivery of care systems and modalities of care as well as the research involved and I believe the (DRAW) program already does this but I think that we should keep it a theme that all of us pay attention to across our workgroups.

Man: Okay. Any other suggestions for (unintelligible)? Magda?

Dr. (Magda Peck): I just want to say one of the things that I don't you mentioned (Ed) is that you have served as (unintelligible) for a liaison group where - and just for knowledge for those who are listening and not necessarily spending a lot of

time with SACIM now that we're not working in silos as Janelle inferred, that you have convened these and Janelle and I to meet frequently with you and to promote the cross fertilization. And so I've heard issues (unintelligible) bringing up. The equity group passed on to the data group given research for action group what we call the DRAW group their recommendation for data through the lens for equity.

So I just want to commend the structure on how it's been set up so that we're not across purposes but more efficient and how we're not only meeting within our groups and expanding out but making sure that regular cross talk is happening to fuel each other.

Man: Thank you. Thank you for bringing that up Magda. Yes, this is a very functional group. We interface quite frequently and share information that is - it's been now very obvious in the development of the praxes that they're in a new process among the group. So I appreciate that. Anything else that people potentially want to add to the praxes? All right. If not we're going to break into groups but I do want to mention one thing.

We have started a little bit late and also we had a very large group of folks on the call or on this thing so I didn't go through introductions. It would've taken a long time but I think that this time when COVID is keeping us isolated and keeping us from visiting each other in a personal way. And when we have lots of anger and frustration and anxiety and fear in our communities that is affecting all of us. It's not just affecting one group or another. I think all of us are in it so I would ask you as we get started in your groups take a little time to introduce yourselves to each other in a way that is more meaningful and share what you want about what's going on in your heart.

What's going in your community? What's going on that is causing you angst

or what is giving you hope? So take a little bit of time. Even though we couldn't do this in a large group I think it's still important because we are working together. We need to be supportive of each other. We need to be partners in this and also it's a way. So what we'll do is we'll break up and I think (Morgan) will figure out some way to get us into the right places and I figured there'd be no way we would be able to get you back again after the workgroup.

So once you're done with that go have dinner or go have a glass of lemonade or go take a walk around - at the beach or wherever you are and I'll see you as a group tomorrow morning at 11:00 Eastern daylight savings time. All right (Morgan) what's the next step?

(Morgan): So for (Janelle) and (Magda) if you can send me the names of your workgroups. Magda I think I have yours because you emailed me earlier, but Janelle you mentioned you have nine workgroup members and the list I had before the meeting only had I think four. So I want to make sure that we have everybody that's supposed to be moving in to your Adobe room. For any members of the public who are not active participants of the workgroup you're welcome to call in and listen to them.

Those phone lines are to listen in on the workgroup. It's on the agenda as well as this next slide here. I'm going to move the cameras away so that we can see that. So Janelle if you can send me your list that'd be great. Magda as well, I think I have all your folks but if you can send me that. And then (Ed) for time and reasons just to make sure we have the transcriptionist on, we're running a little early so if we're able to try to begin the workgroups as close to 4:30 as possible that would be great.

Dr. (Ed Ellinger): All right, yes. This is where people can take their breaks and go get a cup of

coffee or go to the restroom. And then we can get back together again at 4:30 to start. That would be great. All right any questions from anybody?

Man: Sounds good.

Dr. (Ed Ellinger): All right. So I will be working. I've gotten a little bit of input on this, on the chat box on some of the recommendations for the COVID-19 recommendations of the Secretary. I'll look on the list but I'll look for any further input from Steve and Janelle and then I will pull that together and I'll try to get it out to you tonight or in the morning so that you can see it. And then we can bull it on what we're going to go with that, how we're going to go with that. All right, have fun in the workgroups. Take care.

Woman: Thank you.

Coordinator: You will now be placed into conference.

Janelle Palacios: Perfect thanks (unintelligible). So I'm not - well as I do this patient I'm not (unintelligible) to see the participants. I will rely on speaking out so that I know what the conversation is going on while I'm...talk. Thank you for joining us during the health equity workgroup breakout session. I would love to take a few moments to just step back and do a quick introduction of attendees.

I'm Janelle Palacios. I am (unintelligible). I am (unintelligible) woman and I do (unintelligible) in Montana. I grew up in my culture and with my community and as I grew up at a young age a lot of my (unintelligible) and family members began having children very young and it was somewhat that attitude that I would follow (unintelligible) and those were my (unintelligible) opportunities.

And it was only after leaving the reservation on a school program that was funded by an Office of Minority Health that I got (unintelligible) all the reservation and I (unintelligible) Seattle through the University of (unintelligible) during this program and exposed (unintelligible) health and that (unintelligible) me and sustained me through my education and I became a nurse and a nurse midwife and I got Ph.D. and my (unintelligible) centered upon Native-American women's health and looking at their families and I wrote a few papers that based on my dissertation that looked at teen parenting among Native-American communities and a follow-up (unintelligible) looked at (unintelligible) fatherhood (unintelligible) Native-American women.

I believe that (unintelligible) work I did (unintelligible) where I looked at the ramifications of historical trauma and ongoing marginalization of, in particular, Native-American communities and Native-American women, piqued the interest of someone who then tapped the shoulders of the people who (unintelligible) that (unintelligible) be a part of (unintelligible) and I had (unintelligible) very proud to be able to be on this board.

Currently, I am a nurse midwife working at a Kaiser Hospital in California. I do have (unintelligible) children. I have been doing (unintelligible) basically home schooling since March with children and working (unintelligible) and try to include the work that needs to be done for SACIM and health equity in particular.

It is a passion of mine to help give voice and to help understanding of situated context and lived experiences and the health effects of individuals and communities.

So I will end with that and (Belinda), would you like to go next?

(Belinda Pettiford): Sure. I am (Belinda Pettiford). I am in North Carolina. I work for the State Division of Public Health and have been working in the field of public health for 33 plus years and have worked in the area of either women's health or health promotion or perinatal health my entire career.

I have much of my focus has been on working in the area of maternal and child health with a specific focus on adjusting disparities, improving health equity including institutional and structural racism.

It is, you know - it's an interesting time in our country. So a little different this time around our response to obvious racism in our country and so hopefully we will not lose that focus, but we do - I truly hope that it is - is a move into actionable items and not just be another conversation that we have and plan and still don't move things into implementation.

I am one of eight children, my parents, and I'm from a blended family. I don't have children myself, but at any point in time I can have them because I have over 30 nieces and nephews. So I am always concerned about them and how they are growing up in this country and have really good conversations with them especially the teenagers and the ones in their early 20's.

So I'm happy to also be on this committee and joining in with (Janelle) to support the work. So (Paul), would you like to go next?

(Paul Jaris): Sure. I'm (Paul Jaris). I'm a family physician practicing many different environments including rural health centers at federally qualified health centers including homeless shelters for adolescents and inner city school, but also was with Kaiser Permanente. I was the CEO of one of the Permanente medical groups for a while.

I was commissioner of health in Vermont. I had the responsibilities for mental health, substance abuse and public health. I came down and was the executive director of the (unintelligible) and state territory health officials for ten years and there along with the presidents over time was able to really establish a very important, strategic direction around health equity and racism, institutional and otherwise historic.

(Unintelligible) I went to the March of Dimes for the chief (unintelligible) officer and continued the work on birth equity there including adoption of policies (unintelligible) social determinants and health equity and launched a big multi (unintelligible) equity.

Then at Mitre Corporation now, M-I-T-R-E, we're a not-for-profit. We're exclusively with the government, in support of government. I'm the chief medical advisor there for our health work. So we have the federal research and development center for the Department of Health and Human Services at, you know - well, HHS federal level and involved - and advise across a number of areas including some research and development near maternal morbidity and mortality and recently been working pretty much full-time on COVID-19 response with state and local territorial and tribal jurisdictions. I'm happy to join the group.

Woman: Welcome. And (Ed), would you like to share anything?

Dr. (Ed Ellinger): Sure. I'm (Ed Ellinger). I'm the acting chair of SACIM. I do - when my mom grew up right in a - on a farm just next to the (Menominee) Indian Reservation -- which is now the poorest county in Wisconsin - and her brother married an American-Indian and he had lots of kids.

And so I have lots of Native-American cousins. But my mother was always incensed at the disparities that existed on one side of the line between the reservation and their farm and the communities around that.

And so she instilled in all of the kids the fact that this was unjust, this was unfair and it affected us directly because our cousins were impacted by the disparities that were so prevalent and the racism that was so prevalent in Wisconsin at the time.

And so it sensitized me to the book that I read in high school, "The Other America," by Michael Harrington that highlighted the fact that, you know, we have at least two Americas: Those that have a whole lot and those who have very little, those who have lots of privilege and those who are discriminated against and it really enhanced me and encouraged me to go into health care, into medicine and to work on trying to do that.

So all of the places that I've been working in...

Woman: (Unintelligible) and now I can't get the thing to (unintelligible) this always happens when I need to (unintelligible) to give you...

(Belinda Pettiford): Could someone put us on mute, please? Thank you.

Dr. (Ed Ellinger): And so that (unintelligible) you know, that has influenced my work, you know? Your parents make a huge difference on what you do.

So I ended up going to medical school and I ran the maternal and child health program for the City of Minneapolis and did the first disparities report on infant mortality in the early '80s, ended up also running a student health service in (unintelligible), Minnesota, and then was held commissioner in

Minnesota for seven years.

I'm not retired or more or less doing a lot of consulting and working on boards and committees and enjoy this work (unintelligible) SACIM because it is - I think it is - equity is an existential challenge for us in this country. You're seeing it right now.

The disturbances, the rioting, the protesting that are going on are really saying that our society the way it's set up is not just equitable and cannot persist this way for very long. So I think it's an existential issue for us and that's why it's been the focus of all the work that I've been doing over the last 40 years. So I'm glad you guys are all partners in that.

Woman: Thank you, (Ed). Thank you.

(Belinda Pettiford): (Janelle), we have other people on. I keep seeing in the chat box (Garrett Lowman) who's a court reporter.

(Janelle): Okay.

(Belinda Pettiford): He says he does not have any volume.

(Janelle): Okay.

(Belinda Pettiford): So I don't know (unintelligible)...

(Janelle): So that...

(Belinda Pettiford): ... if you can help him with that.

(Vanessa): Yes, I'm going to retype in...

(Janelle): That's...

(Vanessa): Sorry. This is (Vanessa). I asked the operator and he said everyone should be in the main room now with us that's in this breakout on the line. So I'll just resend the passcode (unintelligible).

(Belinda Pettiford): Oh, he says he has it now. He said...

(Vanessa): Oh, okay.

(Belinda Pettiford): ..."We have volume now." So he should be good.

(Vanessa): Oh, okay. Thank you.

(Janelle): Thank you, (Vanessa) for doing that. And then let me - so I opened up a new screen so that I could see maybe, but does it look like it's just the four of us, myself, (Ed), (Belinda), (Paul) and (Garrett)? Are there some other people also?

Dr. (Ed Ellinger): So...

(Belinda Pettiford): There are some others. It looks like you've got (Ashley Bilson) and (Garrett Lowman) and I'm getting ready to mess up (Avareena Cropper).

(Paul Weiss): (Paul Weiss) is on as well.

(Janelle): It's such a small group and I believe that we were - (Morgan) shared that we

can have everyone moved into the same room we are so they can speak.

I think we just have to let the operator know. How do we do that?

(Ed Ellinger): And is it possible so that we can...

(Vanessa): Hello?

(Ed Ellinger): ... see each other? We don't need the slide because I'd really like to see everybody speak, if possible.

(Janelle): Perfect.

Coordinator: This is the conference operator.

(Belinda Pettiford): I think someone was speaking.

Coordinator: (Unintelligible) open everyone's lines.

(Belinda Pettiford): Okay.

(Janelle): Oh, everyone's live? Thank you.

Coordinator: You're welcome. It'll be just one moment.

(Janelle): Okay.

(Paul Weiss): And (unintelligible) did you hear that (Paul Weiss) is also on?

(Janelle): I'm sorry. What was that?

(Paul Weiss): (Paul Weiss) is also on the call.

(Janelle): Oh, (Paul)? Okay. Perfect.

(Paul Weiss): Thank you.

(Ed Ellinger): Welcome, (Paul).

(Paul Weiss): Thanks, (Ed).

(Ed Ellinger): Yes, (Janelle), I'm going to do cut off in a little bit because I wanted to go to each of the sessions. So I - when I leave, it's not because you're not doing what I want you to do.

(Janelle): Okay.

(Ed Ellinger): It's I need to touch base with the other work groups.

Coordinator: All lines are now open.

(Janelle): Okay. So all the lines are open and we are the only ones that seems - because of the - if you're joining us now for the health equity, you are welcome to share your video camera if you'd like and join us by phone to speak up in the work group.

Dr. (Joia Crear-Perry): Hi. I introduced myself a little bit earlier, but this is (Joia Crear-Perry). I'm representing Rep. Admiral (Felicia Collins) from the HHS Office of Minority House.

(Janelle): Oh, perfect. Thank you. Okay. Now, I can see. All right. All right. Let's see. (Ashley Bilson), would you like to quickly introduce yourself?

(Belinda Pettiford): I know (Ashley), she's a project officer within the Division of Healthy Start in Perinatal Services within the Maternal Childhood Bureau. She's actually one of our project officers for our perinatal mental health grant.

So if she can't hear, I'm sure that's the same (Ashley).

(Janelle): Okay. Thank you. And then (Avareena Cropper), would you like to introduce yourself?

(Avareena Cropper): Sure. So my name is (Avareena Cropper). Can you hear me?

(Janelle): Yes.

(Avareena Cropper): Okay. Great. I worked in - I work for CMS, Centers for Medicare/Medicaid Services in our Office of Minority Health where I lead a couple of our maternal health projects, one in particular is our R5 that we submitted for comment. We actually just closed speaking comment on access outcomes and quality in maternal care for women-enrolled communities.

And also we recently convened a rural health forum where we brought quite a few experts in the CO to discuss barriers, challenges, and potential opportunities. So thank you for allowing me to be on this work group or just participate and observe. Appreciate it.

(Janelle): No, thank you. Please, love your expertise and insight. And then (Garrett), I believe that you are here to help us with taking all the notes, correct?

(Garrett Lowman): Yes.

(Janelle): (Unintelligible)...

(Garrett Lowman): Yes, I - yes, I just unmuted myself. I don't know if you can hear me, but yes, I'm muted here. I'm just transcribing what's being said.

(Janelle): Thank you. All right. And then myself, I'm here twice. And (Joia) introduced herself, (Paul Jaris) introduced himself and then (Vanessa). I believe you're also here to help with the transcription, correct?

(Vanessa): Hi, (Janelle). I'm (Vanessa). Yes, I work at HRSA MCHB in the Division of Healthy Start in Perinatal Services and I will be helping by taking notes to pass on today.

The transcriber will have these notes for your official meeting minutes and will come out after the meeting. So I'm just going to...

(Janelle): Okay.

(Vanessa): ... take some highlights (unintelligible) you have then for your (unintelligible).

(Janelle): Thank you.

(Ed Ellinger): And (Vanessa) also has quite a long history at HRSA and a lot of expertise. So I hope you'll free to speak up, (Vanessa), also.

(Janelle): Yes. Yes, please do.

(Vanessa): Thank you.

(Janelle): Thank you.

(Belinda Pettiford): And it looks - (Ashley) put in the chat box that she apparently is still muted. Operator, is there supposed to be Star 1 or - I'm trying to help (Ashley) get unmuted.

Coordinator: Understood. It looks like all of the lines in the conference are currently unmuted.

(Belinda Pettiford): Okay. All right. We'll keep reading her thoughts in the chat box. Thank you.

Coordinator: You're welcome.

(Janelle): Okay. Thank you. All right. So after the - thank you for doing all the introductions and now, let's get down to business. I want us to kind of imagine what the future will look like 500 years from now, 200 years from now, 100 years from now and working backwards what are the things that need to happen to get us there and we're definitely going to address immediate issues related to COVID and the current races going in our nation especially with COVID.

But I wanted to just kind of also think of the big picture of what it looks like, what does a health nation look like in the future and how do we get there.

Consistently, we're one of the worst-rated countries in terms of maternal child health even though we're a developed country and what are the steps that we need to take.

And from presentations this morning, especially with (Joya)'s presentation, addressing human rights as a fundamental framework for helping move forward with recommendations or moving forward with action, I believe that's something that health equity, this work group should incorporate fundamentally to help move this along.

One of the questions I have in terms of what we can do right now, what are the - to make immediate changes, what can SACIM do to recommend an action - take an action over the next 6 to 12 months to improve maternal/infant health and we've discussed this a little bit in the past 2 hours or so. We've talked about (Ed)'s letter as far as, like, a template of how we are going to - the general SACIM letter that'll be given to the secretary.

So we've talked about telehealth medicine, we've talked about access to out-of-hospital care and services. We've talked about testing. So - well, maybe - we've talked about testing a little bit, but I think that we've in previous conversations our group has also talked about pandemic-wide response and how not just testing, but contact tracing needs to be instituted.

And, of course, the policies that follow in hospitals and organizations regarding standardization for testing. And just recently, I don't know, who has read the news, but it was recently revealed that a New Mexico-based hospital in Albuquerque was found out to have been using racial profiling in their hospital by conducting tests - COVID testing on Native-American looking women and it is widely known that the Denay, the Navajo Nation, has been more disproportionately impacted by COVID, the COVID pandemic.

And so in this particular hospital, Native-American looking women were tested without their knowledge and then separated for their - from their babies.

So what do we do to rectify this? What are the policies that should be in place that would not allow something like this to happen? So I'm going to open it up for just general thoughts of what should SACIM do that would impact women and infant's health immediately addressing the underlying racism and historical (marginization) that continues to go on, on a number of vulnerable populations.

(Belinda Pettiford): And (Janelle), you're referring to things beyond telehealth and the things we talked about this morning or are we repeating some of those?

(Janelle): We can move beyond that, I believe, because we've had a lot of discussion on that, but we can - what are some, you know - if there are additional specific things that we should do or the - some consideration that we need to consider that we've already discussed today, you know, telehealth or access to delivery options or testing, but are there additional issues?

(Belinda Pettiford): You know, I think one of the areas that we have not talked about is that even though some people are where the historical trauma and just the historical issue of racism in our country, but different populations, not everyone is aware.

So I do think we've not really focused a lot on racial equity training or infant-advised training and how you connect it to overall efforts. I don't know how well it does if you just do the training and you don't do any follow-up or any other connections, but I just feel like we need to have some - we do need to include some informational importance of training on historical racism in our country, how it has impacted populations and how our own implicit biases that all have impact how we treat people, you know, how we respond to situations, how we develop programs and how we - you know, all of those moving parts.

So I think that's a piece we probably should be adding in.

Dr. (Ed Ellinger): I think there's also a real tendency to look at interpersonal racism as a problem among, you know, these bad people of which, of course, none of us are them as opposed to really looking at it from the point of view of the historical institutional and systemic racism, which is, I think, yes, we have the evil of interpersonal racism, but at the underlying institutional - historic institutional and systemic is so much more toxic and somehow moving from this, you know, a few bad apples to the real underlying problem is something we've got to do.

That - and a disconnected thought. We tend to really take note in this country when there's a big event, whether that's (unintelligible) or in this case - which is (unintelligible) or the death of, you know, the pattern, but each time it's somebody - another person of color is killed by police, we take note. We have to, but that's symptomatic of the underlying problems, as well as, a specific problem.

And I guess what we don't do is, you know, like, after a school shooting we get all outraged, but we don't consider the deaths that occur every day (unintelligible) particularly among certain populations.

And so somehow also moving - can - how do we create an environment in our - or take advantage of the attention now to bring force the daily disparities and how the daily births in equities they're not as traumatic, you know?

You don't see it on the video camera, but they're far more deadly. And I don't - I'm not saying it's an either/or, but somehow we have to move across because again, we can say oh, those police killings are a few bad apples or a few bad

departments or, you know, whatever, but it's much more pervasive.

We've got to get it systematically. So it would be a shame if we - I mean, it would be wonderful, I guess, to say can - is there an opportunity to get birth equity on the menu as part of this environment we're in right now.

(Belinda Pettiford): And I would agree with (Paul) because I also think when we go to specific issues that happen, so we're doing - you know, we've got George Floyd and we've got - so now, we're looking at the justice system and the police department and not looking at the entire system and realizing that an equity are built in our system throughout.

And so while we're spending all of our time trying to think through what could the police do better, we're forgetting about our health care system, we're forgetting about our housing system and - because we're just focused on one where the issues seem to be prominent at the time and not really stepping back and thinking through the foundation of our system was built on racism. So how do we move beyond that and help people be aware of those foundations?

I know the Racial Equity Institute here in North Carolina - and they do national training - they do what is called a ground water or a foundational three-hour training where they really step back and look at just the data to show where the gaps are and connect it back to the history without focusing - because we tend to blame the individuals versus thinking through the system.

And I see that (unintelligible) (Avareena Cropper), I don't know if you can speak, but I see your notes in the chat box.

(Avareena Cropper): Yes, (unintelligible) can you hear me?

(Belinda Pettiford): (Unintelligible). Yes.

(Avareena Cropper): Can you hear me? Yes. Yes. So one of the things as I listened to you all speak is really, you know, a lot has been talked about in the afternoon was not working in siloes and understanding that because of how these systems have evolved it requires a multi-disciplinary approach in that it's not just one sector, right?

So what we're seeing is just hey, representation of (unintelligible) every institution that is within (unintelligible) society. And so when we talk about creating a system to kind of break down what we see it also involves establishing and making commitment of health equity champions - champion or champions within the organization because one of the things that we've talked about was the health policy of, you know, testing, people of color from a ZIP code because that was essentially what was done in Albuquerque, New Mexico, was that they looked at specific ZIP codes and they marginalized or singled out those people from that ZIP code to justify separating mothers and babies in delivery systems - in labor and delivery.

So if you have health champions within these organizations that can specifically that the policy that you're moving forward are unjust and unduly unjust to a specific population that begins the acknowledgment that racism does exist.

Unless you establish a system that acknowledges these unjustices, the disparities, we will see the disparities to continue to grow.

(Janelle): Definitely. Thank you for that, (Avareena). This is, I believe, recently - not recently. Six months ago at SACIM we had a general meeting and I think I made the comment that one of the underlying things that we have to do is,

like, change social norm.

It has to be, you know, more than just a faux pas. There have to be consequences in treating people differently, you know? Right now, we're asking for, you know, real consequences for the justice system.

You know, one of the - it is - it's kind of hard to see that in general I, you know, get tons of emails, thousands of emails and I keep seeing a number of emails from businesses from, you know, people advertising makeup or clothing or a particular kind of food or just - I mean, there are businesses out there that are almost leading the way, they're ahead of health care in some aspects and that they are taking a step back and they are saying, wait a minute. We have to pause and we have to have training. We have to have people come to us and train us on our own biases.

So I believe Starbucks, right, they're planning to do a big racially-informed education training for their management, the upper management and CEO, as well as, people that work for them within their system.

So you have businesses that are taking a step backwards and saying where are the problems within us? It starts with us. What we - what can we do to help our community and what have we overlooked.

And (Belinda), that is exactly what I hear you saying as far as there needs to be some amount of training that goes on and to an effect to have, you know, impact - lasting impacts. There has to be some sort of awareness or a training recognition that we have these outcomes or life as the way it is because of our history and this nation has to somewhat come to an understanding of how we got here through some training.

So we talked a little bit about...

(Paul Jaris): Sorry. Go ahead.

(Janelle): Go ahead.

(Paul Jaris): This is, like, training support, but I don't know that it's efficient. I think - and, you know, (Ed), you really led the way in Minnesota when you did the - sort of the assessment of the Department of Health's any implicit or institutional bias within your department itself and I think so in addition to businesses or whether it's training their people, they truly need to look at all of their policies and procedures and how they operator to see what kind of implicit institutional bias is built into it and it may be, you know, not malicious at all, but it doesn't matter if the effect is (unintelligible).

So I - you know, that's why I want to go beyond just the training concept and say, you know (unintelligible) I'd say it's responsibly the board of directors (unintelligible) to do that and the CEO, not just a higher somebody as a diversity inclusion person to do it.

So I hope - I'm (unintelligible) trying to add to what you were saying in saying (unintelligible) again a whole look at the institution as well.

(Belinda Pettiford): No, I would (unintelligible). I think trying is one of the many steps that are needed. I mean, you need organizations to - they may even need to complete on health equity impact assessment tool or some version to really dig deeper into the organization to see where changes are needed, you know?

There'd easily be unintended consequences of policies and procedures that we have put in place that no one really thought from that perspective when they

were put in place. But, yes, I think training - when I was bringing up training I wasn't thinking it was the end all, be all, that was the only thing.

It is one of the steps, but you do need to increase awareness in order to move people through to some of the other steps.

(Janelle): Okay. I'm going to write down training as a step and we have more steps. What are some other thoughts of how to move us forward?

(Avareena Cropper): So this is (Avareena) again. One of the things - and I'm just throwing this out here and maybe this is a bold move, but I'm just going to throw it out here - is also including with that training simulation?

So I know with (unintelligible) bundles especially in emergency-type situations, there are simulations that are done so that you can practice - you can be aware of, you know, you improve that readiness to respond to emergency situations.

And so it's beyond role play. It's also understanding that when people are coming to get a health service or are seeking service they have compounded issues that they (unintelligible) to you and as a clinician, as a provider, I think someone mentioned about that (unintelligible) is peeling back those layers and understanding why this person's presenting to me in such a way in what we can do to get what they need at that moment and to be able to (unintelligible) follow-up service so that it can help this through their (unintelligible).

Dr. (Joia Crear-Perry): So this is (Joia Crear-Perry) from HHS LMH. We've actually been developing through, I think, cultural health contract, a maternal health sort of simulated training for providers and we've been partnering with community members and others that are experts in maternal health to provide feedback.

I'm actually - I'm not leading it, so I don't know how far it is. I can get some time links tomorrow, but the - we built in some of those simulations that you were just referring to, (Avareena), about situations that providers would come with...

(Belinda Pettiford): We lost you for a second there, (Joya).

Dr. (Joia Crear-Perry): Sorry about that. I (unintelligible) yes, sorry. I don't know what happened. It cut off. Technology issues. But basically, it goes through certain case studies and situations where providers go through a certain situation, you address with them in the simulation what went wrong and how would you address it.

And a lot of things...

(Belinda Pettiford): Well, is it...

Dr. (Joia Crear-Perry): ... that are covered in that is racism, implicit bias, explicit bias. So a lot of these concepts are covered in those simulations or case studies.

(Paul Jaris): Yes, I'm wondering about the class standards and whether - I mean, you know...

Dr. (Joia Crear-Perry): Yes.

(Paul Jaris): ... we're - at least is - from my profession a requirement that goes through them every few years (unintelligible) I'm wondering if there could be (unintelligible) one could they be directed at maternal child health and secondly, you know - because I think there is a (unintelligible) been through

some simulations as part of that, but it's one thing to do it as a continued education for three or four hours. It's a whole other thing to actually have to implement it and what kind of support do we have or could we have for (unintelligible) and all to really have them take a strong look at the class standards and the implementation of it.

The - I believe it's a requirement if you're accepting CMS money, but there's absolutely not teeth in it as far as I can tell. I'd love to be wrong, but...

Dr. (Joia Crear-Perry): Yes, and within those case studies there have been a lot of discussions because within our partners there's providers, there's a lot of different partners that are providing feedback on these sort of case studies and standards and a lot of the discussion was around timing and how long should these be in order for providers to actually take them because they're not required again.

So, you know, a lot of them have been cut to provide within 30 minutes and within an hour and, again, a lot of discussions around what is the balance between having the time to take them and also providing the sufficient information needed to make an impact.

So that has been listed in the discussion that's happening.

(Belinda Pettiford): So is it a - I did not realize the class standards were a requirement with CMS. So is it a requirement? That's the first I've heard of that. Do we know? Because it would be interesting to know what is CMS doing with those class standards, if they are a requirement for local Medicaid - with a state Medicaid agency.

Can someone put us on mute?

(Paul Jaris): (Unintelligible).

(Belinda Pettiford): I'm sorry. Could you repeat that?

(Paul Jaris): Oh, that the requirement was (unintelligible), but I could be wrong, but I thought they were. I mean, I - yes, I thought anyone accepting CMS money needed to implement (unintelligible).

(Belinda Pettiford): Maybe we can find out.

Dr. (Joia Crear-Perry): I can try to find out from...

(Belinda Pettiford): Thank you.

Dr. (Joia Crear-Perry): ... I can try to find out from one of my colleagues.

(Belinda Pettiford): Thank you.

(Janelle): All right. So we have - so I'm just kind of looking at the list that I'm writing up, you know, and where again - what are the immediate recommendations that SACIM can make in the next 6 to 12 months that can have an impact.

So definitely, you know, may not have immediate effects just yet, but training and steps with implicit bias and going just beyond just the training and given that they're - they can be limited and they're not even always mandatory, but actual - and going beyond role playing actual problem-solving will be important.

Recognizing the champions that are already doing health equity work within

organizations. How about what are some others that we can, you know - (Paul), I believe you shared with us that I think (Magda) brought up the - this information, this misinformation kind of network - wide-span network or net that's happening from a particular group of people and what about advocating for some sort of public service announcements related to maternal/infant health during COVID that would have some sort of underlying health equity piece in it?

And I'm just asking about this just as something to kind of battle misinformation or to try to help educate people on, you know, testing or treatments? This comes up to mind just because Kaiser has instituted a policy where they cannot deny testing, right, to anyone?

So if someone comes in and they say they want testing, you can't deny it and whether or not it's a good use of resources or even an antibody test that they can't deny an antibody test to anyone who's asking for it, so whether or not we have limited resources it's maybe not always in the best interest of someone to have this test.

And I'm just thinking in terms of trying to generate conversation on what are the next - what are some more steps that can be taken and certainly some sort of public service announcement kind of billboard or something, you know, are - is some sort of immediate step that could be taken.

(Paul Jaris): Yes, I think the way those things work you have to explain what the search is so that they can define the search terms and then they use natural process language, like, artificial intelligence to find messages that might be consistent with the malicious language and ideas.

The idea of being - and then there's ways for them to tell whether these are

magnified by bots and - or maybe come from a foreign national or a suspect group and then the idea is you contact the Facebook or the whatever the - to have them take it down or you hear the messaging and then try to develop counter messages. And counter might not be - the appropriate messages...

(Janelle): Okay.

(Paul Jaris): ... and get them out there. But I don't - I'm still learning about it since it's my first real experience with it. I don't know how - I'd have to think about how it would be used here.

(Janelle): Okay. All right.

(Paul Jaris): But there is a lot of underlying racially charged miss and disinformation out there. So it could be something that was looked for, but to the extent is an echo chamber, you leave it alone because they're going to talk to themselves. It - once it starts crossing into another area, then you want to - I mean, you want to take it down anyway, but it's free survivorless in Northern Iowa we're talking to each other on Facebook, just who cares.

But, you know...

(Janelle): Yes, okay.

(Paul Jaris): ... it's amplified and magnified. You really want to get at it to shut it down. So I don't know enough about it really. I'm still learning. So...

(Janelle): Okay.

(Belinda Pettiford): I wonder, (Janelle), did we want to - because I can't remember in our

earlier conversations if we talked any about, you know, the issue of community trust and just trust in general.

So do we want to think some about ensuring resources are getting to maybe community-based organizations or organizations that are hiring community health workers where the trusts may already - may not be as big of an issue because they're hiring people from the communities that are part of those communities and already have relationships in those communities?

I know one of the things we're doing in North Carolina right now is part of historical and marginalized populations is we issued an RQ for funding and we've specifically focused on organizations that were already embedded or were already serving minority populations and to try to get some resources down to the ground level, you know, we were - you know, we fund - typically when you release an RFA on RQ the people that can afford to hire grant writers are the ones that get the money because they can get them, they can write a nice grant and they can pull all of their stuff together because they have a team.

Sometimes you have a smaller non-profit community-based organization that, you know, they can do the work, but they may not have the experience in actually sitting down, writing one of the - a grant to the state or you can actually get the resources.

So we're trying to figure out ways to add that - to, you know, add some capacity to those organizations at the same time because they have the ability to reach some families and communities and help with contact tracing and testing that others want. And we are dealing with issues of trust as we are in our country.

You're going to have some populations if it's not someone they already know and have an established relationship with, no matter how many times the Health Department calls them, they're not going to pick up the phone to do contact tracing.

And to they've got to be reached with folks that are already in that community. So I think that is a piece sometimes we miss is that we forget about those smaller community-based programs and those programs that are hiring community health workers and others that are from those populations.

(Janelle): Great. I'm going to - you know, you're welcome to jump in any time. I'm just going to try to move us along to try to touch on different populations and different thoughts.

So, you know, how do we, you know, safeguard incarcerated women? In the past we've discussed having something, like, what (Belinda) was talking about, like, these, you know, known community advocates that are linked to incarcerated women to help them and we have - we've heard from a past presenter that spoke about doulas within an incarcerated system.

So doula support for women at that time. How do we, you know - how do we help improve maternal/infant health among those who are incarcerated, among those undocumented women in our country or women sequestered at the border? What do we do to help these women? We have community health advocates linking up to people who can help build trust, people who can get the inside story where all - you know, we're always (unintelligible) brought up, you know, bringing in that qualitative piece, but getting women's stories. So writing women's stories and experiences.

(Casey McGraw): This is (Casey McGraw). Can you hear me?

(Janelle): Yes.

(Casey McGraw): Okay. Great. I think one thing that kind of speaks to your specific ask, but also kind of reaches kind of throughout is that there needs to also be some sense of accountability, but with - specifically the folks who are in power and I don't know what that would look like specifically when it comes to training.

But it doesn't always have to result in the determination of a person who perhaps that can result if you - if one particular provider, for example, has, you know, increased number of complaints or issues with people of color or any other vulnerable populations, perhaps they need more training and we can make more targeted training for them.

So I think that's something that should be kind of a theme throughout all of the initiatives when it comes to equity because I don't know it's, you know, training in and of itself.

Maybe itself kind of provides the results we're looking for, but, you know, maybe an action as a result of the negative reaction or action would kind of speak to some of those folks that we're trying to reach.

(Janelle): Right. You know, perfect, (Casey). I mean, in reading the article about what happened with the Native-appearing looking women in Albuquerque and then being tested without them knowing and then separated from their babies, what happens to that hospital?

Right now, they're getting, you know, widely disseminated public recognition for what they did and the public is holding them accountable to some effect, but definitely looking at how the accountability part, that should be a piece of

it and how do we enforce that. That's a good question.

(Paul Jaris): It seems like a civil rights violation. I mean, if you presume separating a mom from a baby is harm - posing harm, this should be investigated from that point of view. But that is, of course, a political decision. So we'll see who makes that decision.

(Janelle): But it also seems, (Paul) - I mean, yes, there's the civil rights part to it, but the very fact of calling them out, right, so that - you know, there's action - a movement towards calling out racism when you see it, you're walking down the street and you see something happening that you call it out for what it is and there's a piece about, you know, almost, like, public shame, you know, there's - that there's a little bit of piece of public part to it and there's a - so I think that just the fact that this institution is, you know, now known throughout the nation as this (unintelligible) that has done this egregious thing, that's also definitely harmful, you know?

All the people that are - the white privileged people who are calling out - or who are calling the police on black men or men of color whether they're at barbecues or walking the dog or something like that, like, that public outcry of public shame for those people has actually resulted in some real-life consequences for them. Some people have lost their jobs. All right?

So that accountability. So definitely accountability with when women's health - when women are treated respectfully, when their care is not handled respectfully and that can be any woman especially vulnerable women.

Any other thoughts on how we can support in particular very vulnerable populations at this time? So (unintelligible) women, women undocumented - undocumented women, women in the board - at the border who are

sequestered, you know, black women, brown women, women who are in rural communities, women who are increased risk of mental health problems especially during this time.

We can come back to this. Yes, go ahead.

(Belinda Pettiford): So one thing that comes to mind is - and I don't know how you do this - but to ensure protection, right, people have to be able to be in a safe space to - so that they can have improved - well, not even improved - to deliver to speak help - when - they have to know that they can go to a provider, go to an entity or institution and know that what they're getting from them is what they say they're going to provide and that they're going to be heard.

I think that is the conversation that we're having right now. One of the things I was reading in a community in Indiana is that they understood that there was a disparity in low-income women who were getting, you know - they had poor access to care meaning they went - got their prenatal visit - they very rarely got their prenatal visits because of hospital closures and OB unit closures.

And so they created this program called, Project Swaddle, where they used paramedicine as a way to bridge a gap where a paramedic actually goes to women who are in this pilot program and offer services to women to improve just maternal health, but also infant health as well.

So they recognize that Indiana and certain ZIP codes had very high infant mortality rates and thought to utilize the community to provide service for these women to ensure talking or helping them through social issues, intimate partner violence, postpartum depression, like, they were almost are serving thing as a gap - bridging a gap in access to these women.

And a lot of the accounts, personal accounts, are appreciative of the service that these paramedics are providing in this small community.

(Janelle): Okay. Thank you. Are there any - if we look at social determinants of health, you know, housing, food security, education, are there any issues there that we could recommend that would accelerate health outcomes for moms and babies?

I believe we have a policy where is it - it's, like, it's - I'm - I don't remember where the money is coming from, but, you know, we have a policy in effect, right, that families, people cannot be turned out of their home at this point in time and that is paramount.

Like, that is a key piece of policy that was in place, that was enforced. What other pieces should be enforced? What should we institute?

(Belinda Pettiford): Right. And they also can have, like, their electricity turned off or their water turned off. I think those are some of the other areas that are protected at the moment.

There was a - I don't know if this was a national thing or if it just happened in my state where families that had school-aged kids and they were already - if the kids were getting free or reduced lunches at school, those parents got additional monies for food and are still during COVID because the kids aren't in school where they would normally get two meals a day.

So they were giving the parents more money per child. I think it's, like, $250 per child per month to help support food - for them buying food during COVID because the kids are not actually in school.

And so I know that was one of the areas that we've gotten a lot of positive feedback on. And I think, you know, unemployment went up. I think that came from the federal level, the amount of your weekly unemployment check went up for a while or it went up a sum until they ran out of money, but it did help some families for a while.

(Janelle): Okay. We talk about increasing access - we've talked about this before, about increasing Medicaid to cover mom for 12 months after she's delivered, you know, and that will be an important...

(Belinda Pettiford): Right.

(Janelle): ... piece of policy. Yes.

(Ashley Bilson): Hi, this is (Ashley). Can you hear me now?

(Janelle): Yes.

(Ashley Bilson): Oh, great. So possible policy-related items, affordable childcare and also paid family sick leave. I don't know if that's been discussed or recommended, but definitely these are barriers to families moving up the stream of, you know, being able to work and provide for your family, but also having that security of not losing your job if you can't show up to work, sick, also during COVID-19 is something important.

(Janelle): Yes. Thank you, yes, for bringing those up. Yes, definitely. Especially the affordable childcare with - yes, the school, the school's not being a childcare resource.

(Belinda Pettiford): And (Ashley), you know, some of our schools right when schools closed

pretty suddenly some of our schools kept providing the lunches and they would take - the school buses would run the route that the kids rode the buses and drop off their lunches per day or they would have - each county had to come up with a way to provide school meals for kids that normally would be in school.

So some of the counties were able to provide transportation with the school buses and volunteers and others had to help transport families to get to the food because we know food and security is a high need.

(Janelle): Yes.

(Belinda Pettiford): And we've seen - you know, I've seen some reports where it has increased even more in the midst of COVID.

(Janelle): Yes.

(Belinda Pettiford): I want to say I was in a meeting yesterday where they said 28% - had gone up to 28% is what I want to say it was, but don't hold me to that number.

(Janelle): Okay. So then that's a good example of - well, I mean, there is transportation although it was probably - it was school money, right, that probably ran those buses, but just advocating for linkages across the board, transportation linking with food security, with food, and housing and how to make that work, how to support these families.

Let's see. So we have a bit of a list here that's helping us - we'll - I will discuss this with (Belinda) and then these issues will be brought up again tomorrow.

And aside from what we've discussed earlier today and just now, any other

players that need to be involved in making changes? We have community - a need for community, we have a need for organizations to work across lines and especially within the government, a call for working across divisions.

(Belinda Pettiford): Well, we would need, like, the Department of Corrections if we're trying to figure out what's going on with incarcerated women.

(Janelle): Right.

(Belinda Pettiford): Yes, and that is a congregate setting when we're seeing high numbers.

(Janelle): Yes. Yes.

(Belinda Pettiford): We have done some work with faith leaders in our state and partnered with them in getting the message out and, you know, sharing information among their congregation and the wider community around where to go for testing, what are we call our 3 W's, you know, wear a face mask or wear a face covering, wait 6 feet apart and wash your hands.

So, you know, trying to get the message out in as many avenues as we can.

(Janelle): All right. So if - we can always come back to COVID-related things, but we have a few more minutes and in thinking about mid-term and long-term issues to how to improve infant mortality, what are some of the long-term things that we need to see change?

(Belinda Pettiford): Well, I think one of things is what (Martha) brought up earlier around the whole concept of we spent a lot of time focusing on women while they're pregnant and shortly after they deliver. So we really need to think about women for the live course because, you know, the healthier women is before

she gets pregnant the more likelihood she'll have a healthier birth outcome. Not a whole lot they can do while she's pregnant.

By the time she realizes she's pregnant, it's not that many months there. So I think we miss - sometimes we forget about that whole concept of just women being healthy and not always connecting it to conception because they use - lose a group of women that aren't thinking about conception.

So, you know, we just want women to be healthy. So what do they need to be healthy? I mean, they need access to care that can deal with chronic health conditions or they need all of the things you would need during COVID. I mean, it's the social service of health. You need, you know, housing, you need food, you need paid family leave so you can get to your appointments.

You need a livable way so you can take care of yourself and potentially your family. All of those things just we won't - we think women should have - well, we think all people should have. We're just saying women right now. But in reality, we think all people should have it.

(Janelle): Yes. And recognition that this work is going to take a long time, that true equity is going to really take a very - it's going to take a very long time. It's taken a few hundred years for us to get to this place.

(Belinda Pettiford): Right. And as you're thinking about equity and you're thinking about women being healthy and, you know, some communities you might have access or feel safe going out, doing exercise, some communities you don't, so you - and some communities have access to healthier foods at the grocery store, have a grocery store in their community.

I think of all the rural communities we have in our own state and I live in rural

North Carolina. And for me to get to a grocery store it's not like I can walk to one. I still have to get in my car and drive a good little distance to get to a grocery store and then trying to find one that is cheaper to buy fruits and vegetables than it is to go through the drive-thru at McDonald's.

I mean, so it's balancing all of those pieces. It's - to me, it's part of it. You need access to a healthy environment as well.

(Janelle): Yes. And part of your healthy environment is your community definitely. So at some point it's going to be, you know, the - I don't know if this committee will be around in a hundred years, but they might have to expand its name to include community, right, because it's the community. That is a large part of women's health.

Dr. (Joia Crear-Perry): So this (Joya). I'm actually working on my dissertation.

(Janelle): (Joia), you're on mute, I think.

Dr. (Joia Crear-Perry): I don't know why my system keeps on muting me. I'm working on my dissertation around pre-conception health and through the life course of women, of what we're discussing, and I think one of the things I've seen that is sort of a gap in-between care is, one, the number of visits that a woman has to deal with all this pre-conception health care issues, you only have one annual visit and if you have other co-morbid diseases, they're concentrating on keeping you healthy versus talking about your pregnancy intention or sort of how to be a healthy person in general and two, again, I think it causes the fourth trimester, sort of the visits that you need up until really a year after you give birth that really will address your postpartum or post-birth anxiety issues.

And then also the question about who takes care of the woman. I think there's

a lot of gaps in is it the family physician, is it your internal medicine or is it the OB-GYN because really when you get pregnant -- and this happened to me when I had my child two years ago was -- my primary care said I don't want to see you anymore for nine months. You're not my problem. Go to your OB-GYN.

And then after I had my baby, it was sort of a gap. I'm in health care, so I know I need to follow-up, but for somebody else there's no transition period to say you've had your baby, now, who takes care of you or go back to your family care. It's important for you to get that follow-up care.

So even in the literature, the family physicians and OB-GYN's sort of go back and forth and who's responsible for the care and I think that's something really important to delineate and to center again around who is responsible and who is going to take that responsibility.

(Janelle): Right. Thank you, (Joia). Perfect.

(Avareena Cropper): (Joia), that's a good point. I had the same similar situation when I delivered my baby. She's 2 now, but my primary care physician said, "Well, you just had a baby. You've already had a medical event. I don't need to see you until a year from now," however, I have hypertension.

I'm, like, wait a minute. We got to work this out. I don't feel comfortable not seeing you for a year. I want to make sure that I'm connected in a way that I'm safe not just for myself, but I'm able to care for my baby as well.

So that disconnect of physicians that claim that there may be some crossover and it's fine, but we have to make sure that the ball isn't dropped and you're leaving a patient out there in no-man's land and they don't know who to turn

to. So that's (unintelligible).

(Janelle): Yes. This is somewhat connected, but clinically I see since we're limiting the number of visitations that women come to our clinic, and to begin with we were already limiting the number of prenatal care visits, so I remember while I was in (unintelligible) school a woman would have something, like, 10 to 12 prenatal care visits and now, there's a movement at the place I work at actually where, you know, it's acceptable for women to have certainly less. It's considerably less, maybe, like, 6 to 8.

And then with COVID, the face-to-face definitely has gone down and one of the issues that we're trying to alleviate is how do we capture hypertension, for example. So, you know, you just reminded me, (Avareena), that for some women who have had an elevated blood pressure, right, we try to connect them to get a blood pressure cuff and, you know, women on certain health insurance plans get a blood pressure cuff automatically. Other women they have to make a choice if they are going to spend their money on that or spend their money - wait and spend it later if they really have a problem.

So looking at the devices of monitoring at home and connecting women to those resources. It's going to be a big importance issue if we return to sheltering in place and less face-to-face visits let along just during this period of time while we're doing social distancing.

So you're right that even though you just had your little one and you have another health issue, hypertension, and you are a - you're familiar with health care, and so you know to ask or you know to - you have health literacy to advocate for yourself. Many other people don't have that.

And it's been left up to providers to make efforts at meeting women where

they are financially in their locale to help them and to give them the resources that they can and then with that comes education, just to teach someone how to use a blood pressure cuff can take a while.

(Avareena Cropper): Yes. I mean, in my case I actually had to calibrate my blood pressure cuff with the office so that it was reading - the readings were the same.

The other thing that we can consider and we talked about a little bit, but, you know, not just having the health professional support, but also the support of who's the support system at home for the mother as she's recovering either from a natural or Caesarean birth.

So is it her mother that's helping her or is it her spouse or partner that is helping her and what type of information that they have so that you can ensure the continuity of care.

When I delivered, there was no discussion with my partner, you know? It wasn't a thing. We talked, but, you know, the professional, the medial professional, you know, when you get your discharge instructions, they're given to the patient. They're not given to the partner or whoever's supporting you, right?

And even I was (unintelligible) I had to read it over to make sure that I got it right. So there is that literacy as you talked. There is that disconnect and a challenge.

And then it (unintelligible)...

(Belinda Pettiford): You know, and that's a really good point because if you really think of all of the information women get at the time they're released from hospital and

they've got to keep up with what is most important for them to read and then you're dealing with issues of maternal mortality as well as severe maternal morbidity, we are missing that - it's, like, we're dropping the ball on making sure she has a strong enough support system after she delivers.

And it's almost, like, you need to have it in place before you deliver so you'll know what the support system's going to be and what happens with women that actually don't have that? They don't have a family member that can come and support them, they don't have a partner that's able to support them, you know, everybody - it's - you know, if they don't have paid family leave, everybody may have to go right back to work, and so we are missing that piece.

And I think it was, (Paul), you said on one of our calls something about, you know, we should make sure that a woman has - was it a community aide that could come in and help support her? Was it you, (Paul), that said on one of our calls? I'm trying to remember.

(Paul Jaris): I don't know, but I do believe that. That's also very hard to make that work. So when we ran regarding an HMO, we supplied every woman when they left the hospital a lactation consultant, a home health aide -- which (unintelligible) you know, house cleaning twice -- and the wife and I...

(Avareena Cropper): Right.

(Paul Jaris): ...(unintelligible) hospital, the hospital mentioned none of that to us. Just sign these forms and (unintelligible). And I'm the guy who was paying them (unintelligible). So, you know, to make this happen is hard.

But I do think we do need to make sure there's enough services wrapped

around particularly a high-risk woman which - well, we were high-risk for some reason, but, I mean, a woman without those kind of resources to do that on her own or family support that kind of social support is going to be critical.

(Janelle): This is an actual unintended kind of boom for prenatal - group prenatal care or centered care. So women who are doing group prenatal care together.

Now, some places are doing it online, but that - women create a social support system together if they get into a group that they identify with and feel really comfortable with and women, you know, who form with these groups related to, you know, health prenatal care issues often times would reach out and reconnect with each other after the group ended and they were report - they were a support system for each other and that's something definitely that could be used to help improve women's health.

So it comes with some health education and then the consequence of boom of them reaching out to each other for support especially for women who have very little or none.

(Belinda Pettiford): (Janelle), do we need to - I know we don't have that much time left. Do we need to go on and have a conversation around someone that was a recommendation that for tomorrow for the letter (Ed) was working on? Didn't they ask us to come up with a recommendation around equity? Did I...

(Janelle): Yes.

(Belinda Pettiford): Let me see what notes (unintelligible) - I wondered if we need to spend some time doing that.

(Janelle): Yes, let's do that. I am going to find my - so let me see.

(Belinda Pettiford): This is good conversation, but I also know that that's going to be an ask - he's going to ask of us tonight.

(Janelle): Yes. Yes. Okay. So one of the thoughts that I just came to with the presentations we heard earlier is, you know, (Belinda), I think that we should talk about incorporating language having do human rights as a foundation to help fuel the passion for health equity and get situated.

I'm looking for my notes from what (Ed) has asked us to do.

(Belinda Pettiford): Yes, I was trying to find my - I'm going back to the letter.

(Paul Jaris): It looks like the first bullet under the work-related COVID-19, first two bullets have some relationship to equity.

(Janelle): Let's see.

(Belinda Pettiford): (Paul), are you referring to the first two of the nine points or in the actual letters, the - that first paragraph?

(Paul Jaris): It says the (unintelligible) COVID-19 is based on the following seven core assumptions and the first two assumptions are...

(Belinda Pettiford): Got it.

(Paul Jaris): ... related. I'd say under substantial evidence and (unintelligible) from harm, the fourth bullet, I wonder if adding something saying that a particular focus must be made - particularly focus and resources must be directed towards vulnerable communities.

I don't know what to say about communities that don't have the infrastructure and the support necessarily, you know, the parks to walk in, the grocery stores nearby, the safe neighborhoods, you know (unintelligible) it's not just do this across the board, but particularly focus on, you know, those communities that don't have these resources in place or a challenge to have them.

And those, you know...

(Belinda Pettiford): But should we make that a recommendation and add a temp recommendation or are we just trying to strengthen one of the seven core assumptions?

So I think we said, like you said, in the first bullet that says - like you said, the COVID-19 pandemic will have this proportional impact on vulnerable populations, particularly women and infants who are low-income, homeless, immigrants, incarcerated or members of populations of color or indigenous groups.

(Paul Jaris): Yes, I - yes, I was thinking the easiest way through here is to strengthen these, but - and we were able to help this using bullets. It was a number of them. I think number four could be strengthened to have a real focus on communities that are - lack some of the underlying resources and...

(Belinda Pettiford): Number - then the fourth bullet or number four, recommendations?

(Paul Jaris): Yes, the fourth recommendation.

(Belinda Pettiford): Because I'm wondering...

(Paul Jaris): (Unintelligible)...

(Belinda Pettiford): ... do we want to recommend - our first recommendation to be something around, you know, professional attention should be given to these - the vulnerable populations that are listed above or something like that?

(Paul Jaris): Yes, that would be good.

(Belinda Pettiford): So instead of making it Number 10, make it Number 1? And because they've been saying to follow through with it.

(Paul Jaris): Yes.

(Belinda Pettiford): You know, our - with our history of inequities or - I don't know how to word it.

(Janelle): Right.

(Belinda Pettiford): A special consideration should be given to (unintelligible)...

(Paul Jaris): Well, it could be a particular attention that needs to be placed on...

(Belinda Pettiford): Special attention?

(Paul Jaris): ... communities and at-risk populations - at-risk communities and populations of communities (unintelligible). I don't know.

(Belinda Pettiford): I wonder should we - could we say vulnerable versus at-risk?

(Paul Jaris): That's - I'm - whatever language works for you. I'm trying to get

(unintelligible) language.

(Belinda Pettiford): Yes.

(Paul Jaris): My words is just, like, you know, think.

(Janelle): Right. But the key words are focused attention, word around vulnerable, at-risk and resources.

(Paul Jaris): And resources.

(Janelle): Okay. And that should be number one at the top?

(Paul Jaris): That's a good idea.

(Janelle): And then we can add...

(Belinda Pettiford): (Unintelligible) - so we would have nine recommendations instead of - I mean, ten recommendations instead of nine?

(Janelle): And I do think it's important to call out, you know, our nation's history or go widely recognized significant of our nation's history impact, right? There should be attention on this recognition.

(Paul Jaris): As its own bullet or do you want to add in historically vulnerable populations or...

(Janelle): Well, if you put historically it almost seems like we're removing ourselves from the problem. I don't know. I mean, it's definitely - you know, definitely, (Paul), the words have power. So...

(Paul Jaris): Oh, yes.

(Janelle): The three of us could maybe offline shoot and email ourselves together. We have one more minute. So I believe we have that to add.

(Belinda Pettiford): I'll start to draft something, (Janelle), and send it to you and (Paul) and if we could finish it up by email because I think - (Paul), I think (Ed) wants it this evening.

(Janelle): Okay. All right. Any other last minute thoughts before we (unintelligible)?

(Paul Jaris): Let me just say for number nine we do need to make sure that there's attention to, you know - that we do have - are adequately collecting information on with a - you know, granularly - granular in a fashion to determine this differential impact and vulnerability of impact of COVID because it - you know, for quite some time racial information wasn't being collected.

I don't know if you - pregnancy information is being collected in many...

(Janelle): And, I mean, it's almost - (Paul) in - you know, just one of the thoughts that I had just learning about what happened in Florida with health information about actual number of COVID cases where a statistician left and now has an independent business, you know, one of the thoughts - just a thought, but just the terms - the consistent terms, right, for use of data points that we're looking at, but that they're widely used or widely recognized that, you know, these are the data points that are standard - at minimum are a standard and then any thoughts about, you know, independent audits or external audits to make sure that our data is accurate.

We don't have to discuss that right now, but that was just something I wanted to say to you.

(Paul Jaris): Yes, it's going to be - it - and we're dealing with this with this (unintelligible) application because you need to use (unintelligible) based on accepted data standards so that the data's comparable across states and jurisdictions and interoperable, you know, electronic health records and a public health system.

So...

(Janelle): Okay.

(Paul Jaris): Yes, a collection of data based on data, you know - accepted data standards to allow interoperability - data sharing and interoperability is going to be really important.

And believe it or not, it sometimes becomes quite hard because in some places there's one state who wants us to collect particular information and we can't find these standards and we're building a national system.

It's really hard to say this to people no, we can't, we - we're - we can't figure out how to collect, you know (unintelligible).

(Janelle): Okay. I wonder if any of those terms you just shared could be used in number nine to strengthen it?

(Paul Jaris): Yes, I think so.

(Janelle): Okay.

(Belinda Pettiford): (Janelle), before we lose the others on the line, can we just invite them and let them know that this is an ongoing...

(Janelle): Yes.

(Belinda Pettiford): ...(unintelligible) and if they put their email address in the chat box if you're interested in participating in these committee meetings in the future we'll add you to the invitation list.

We normally meet - we agreed to meet every other month, correct, (Janelle)? Or we agreed to meet monthly? Do you recall, (Janelle)? Isn't it every other month?

(Janelle): Every other month. Yes, every other month. And for, you know, a brief period of time depending on how the work is welcome. And you have some suggestions, people you want to connect (unintelligible) please do. There are definitely - we wanted to connect (unintelligible) learn from your (unintelligible).

(Belinda Pettiford): So we would love to have you all stay connected with us if you'll just put your email address in the chat box. We'll add you to the invitation list. Thank you, (Julia).

(Janelle): Yes. Okay. Yes (unintelligible).

(Belinda Pettiford): Thank you, (Tracy).

(Janelle): Thanks, (Tracy).

(Avareena Cropper): This is (Avareena). I'm not sure if you saw my email address. It looked

like I got kicked out of the chat box. So...

(Belinda Pettiford): Do you want to just give it to us because I don't see it right now?

(Avareena Cropper): Okay. Yes, I can give you my email address. It's (Avareena).cropper@cms.hhs.gov.

(Belinda Pettiford): Yes, because you've gotten kicked out, can you spell your first name for us?

(Avareena Cropper): Yes, it's (Avareena Cropper).

(Belinda Pettiford): Thank you so much.

(Avareena Cropper): No problem.

(Belinda Pettiford): I was trying to write it down earlier when I was misspelling - when I was mispronouncing it. (Unintelligible) actually have it.

(Avareena Cropper): (Unintelligible) takes a while. It takes a while. Thank you.

(Belinda Pettiford): I think we've got - yes, we've got (Casey), we've got (Vanessa). So thank you, (Janelle). We have (Julia).

(Janelle): Yes. Okay. Unless anyone has anything else to say, thank you for joining us, helping us move along.

(Paul Jaris): Thank you for having the meeting.

(Janelle): Thank you.

(Paul Jaris): Bye. See you tomorrow.

(Belinda Pettiford): Thank you.

(Vanessa): Thank you so much.

(Avareena Cropper): Thanks.

(Belinda Pettiford): Thanks, everybody. Have a good evening. Thanks, (Janelle).

(Janelle): Thank you.

(Belinda Pettiford): I'll send you (unintelligible) in just a few moments.

(Janelle): Okay. Oh, perfect. And thank you (unintelligible) I got your email.

Coordinator: This concludes today's conference. All participants may disconnect at this...

END