1 The Secretary's Advisory Committee on

2 Infant Mortality,

3 US Department of Health and Human Services

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8 Virtual Meeting

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12 Wednesday, June 23, 2021

13 12:00 p.m.

14 Attended Via Zoom Webinar

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22 Reported by Garrett Lorman

23

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2 P R O C E E D I N G S

3 **FINALIZE RECOMMENDATIONS TO HHS SECRETARY**

4 EDWARD EHLINGER: Good afternoon and
5 good morning to everyone. Vincent, could you put
6 us on gallery view and take away the screen share.
7 Thank you. Welcome to day two of this momentous
8 meeting. Thank you all for the work that you did
9 in preparation for the meeting and particularly
10 for the work that you did yesterday during the
11 meeting and for many of you, the work that you did
12 after the meeting to get us ready for today. So,
13 it was -- it's very much and greatly appreciated
14 and I want to just check my mic just to make sure
15 that I'm coming through okay. Is it being heard
16 okay? All right, because yesterday there were
17 some problems.

18 So, when I was Health Commissioner in
19 Minnesota, every summer I would put on my knickers
20 and my suspenders and my bow tie and I'd go around
21 the state and organize something called Pitch the
22 Commissioner. I'd go to communities and pitch

1 horseshoes with county commissioners and health
2 board members and hospital administrators and
3 school board members and members of the community,
4 and they would pitch me ideas while we pitched
5 horseshoes. It was great for a whole variety of
6 reasons, we were outside with some physical
7 activity. At least in Minnesota, often times
8 people share more when they're not looking you
9 right in the eye and actually when they're looking
10 in the distance and walking side by side. The
11 other is that the horseshoe pitching was a good
12 metaphor, and list most metaphors, they're not
13 perfect. But certainly that stake in the middle
14 of the horseshoe pit -- the individual in the
15 middle of community was a good metaphor and the
16 fact that many people couldn't get into the
17 horseshoe pitching area or have access to
18 horseshoes themselves was sort of the social
19 determinants of health. How do you actually have
20 access to the game itself? And then the
21 horseshoes were sort of the public -- were sort of
22 the policies and programs and you certainly didn't

1 want them to go too far to the left towards just
2 prevention or too far to the right to treatment.
3 You wanted them right in the middle where you had
4 a balance between treatment and prevention. And
5 you also didn't want them to go too far over the
6 stake or too short when you had too much public or
7 too much private in terms of policies and
8 programs. You want them just right in the middle,
9 a good balance. And then certainly the horseshoes
10 themselves, the policies and programs, if they
11 would turn just right, if they really focused on
12 equity, they could get around that stake and
13 actually score the maximum or have the maximum
14 amount of impact. And that sort of that equity
15 theme.
16 But also in horseshoes, you know, you
17 don't -- you don't just move ahead with the
18 ringers, you know, the successes -- switching
19 metaphors -- the home runs, the grand slams.
20 Sometimes in horseshoes, the closer you get, the
21 more likely you are to at least score a little bit
22 of points. So, that's what I'm hoping today or

1 that's actually why I'm wearing my horseshoe tie.
2 I usually -- my bowties usually have the theme
3 that I'm talking about. So, we're pitching ideas.
4 We're here today -- we're going to be pitching
5 some recommendations to the Secretary and to the
6 federal administration, and I hope that our
7 recommendations bring everybody into the game,
8 that nobody is left out, and that we get as close
9 to getting a ringer with all of our
10 recommendations, recognizing that we may get --
11 not get a ringer every time, but we'll get --
12 we'll get close and that everybody has a chance to
13 play. And then we're looking at programs and
14 policies and public and private efforts.
15 So, I'm really excited about today
16 because I think we have the opportunity to really
17 move the ball -- the horseshoe forward in
18 advancing the health of mothers and babies. And
19 so, those recommendations that we're going to come
20 up with today are going to be an important part of
21 it and we have some other members joining or other
22 folks joining us today that are going to push us

1 even a little bit further in terms of data and
2 also the whole issue of racism. So, this is going
3 to be an exciting day, an important day, and one
4 that I hope that we can all really weigh in on and
5 move things forward.
6 But to start, I do want to ask Lee to
7 talk a little bit about our conflict of interest
8 and the ethics because yesterday a couple of
9 times, it came up that there are members who are
10 doing things that relate directly to what we're
11 talking about. So, I want to make sure that we're
12 clear about conflicts of interest and how we may
13 want to keep ourselves from certain bullets if we
14 come to that point. So, Lee, could you give us a
15 little fill-in here?
16 LEE WILSON: Sure. Thanks, folks.
17 Good morning, good afternoon, good evening,
18 Jeanne, and wherever each of you are. It's good
19 to see you again today and thank you for all of
20 the hard work you did yesterday and yesterday
21 evening. We really do appreciate it. I was
22 pleased to see the degree to which so much of what

1 you're talking about in the recommendations that
2 you're making align with some of the questions
3 that we have about program direction. Regardless
4 of whether what you're talking about makes it into
5 official recommendations to the Secretary, we are
6 using your words at our program level in the
7 design of supplements for doula, for the Healthy
8 Start Program, for targeting some of our efforts
9 on some of the most -- most needy places in the
10 country for infant mortality and maternal
11 mortality. So, it is very practical work for --
12 for our staff. So, thank you there.
13 There are a couple quotes that came
14 up yesterday that I just want to reiterate for you
15 that I think struck me and they lead into this
16 discussion of ethics.
17 First was one comment, which I just
18 found funny, that you can't fatten a cat by
19 weighing it and although we spend a lot of time on
20 data and data collection, there needs to be action
21 that follows that data and I think that's
22 important.

1 Also, Magda had pointed out that
2 there's -- we should always take time to
3 acknowledge good work and offer thanks. So,
4 thanks to all of you for this work and your
5 continuing work.
6 And the final thought was the one
7 that I'd had as I was listening to the
8 introductions from folks yesterday about the work
9 that they do and their background and what brings
10 them here, and that is for all of us, our
11 professional lives and our personal lives are
12 intertwined and they're not separate from each
13 other, that we live what we work, and we work what
14 we live. And so, in the work that you are doing,
15 the work that makes you experts, means that you
16 are engaged in some of the programs very
17 personally that you're making recommendations on.
18 It is why you qualify as experts here and it is
19 something that we have procedures and policies for
20 addressing through the ethics process that come
21 down in the laws for the Federal Advisory
22 Committees Act, why we have an Ethics Official who

1 works with us, why we have a Designated Federal
2 Official, and why you all fill out the forms that
3 you. We are going to ask each of you to make sure
4 that the forms that you have submitted reflect the
5 currency of the work that you're doing so that you
6 can be an honest, good, true, reputable civil
7 servant as a Federal Advisory Committee, which you
8 are accepted Federal Officials and that you're
9 keeping with those requirements. We do do those -
10 - we do checks to make sure that you are covering
11 all of that. But I would ask you to make sure
12 that if things have changed in the past, if you
13 over -- if based on oversight, you did not include
14 something in those -- in those descriptions, that
15 you update that.
16 Second, we understand that not all of
17 them are things that necessarily disqualify you
18 from being able to comment and reflect on or opine
19 on in recommendations. And so, we would just ask
20 you to be cautious when it comes to a vote that if
21 you -- if you are feeling like there is a conflict
22 of interest or that you have -- especially in

1 something like financial -- potential financial
2 gain or benefit from those decisions -- that you
3 respectfully recuse yourself from making a vote on
4 those activities or those -- those recommendations
5 that could be seen as potential conflict of
6 interest as it relates to the federal government,
7 the appearance of conflict of interest is conflict
8 of interest. So, please be aware of that.
9 I do intend to treat all of you as
10 expert professionals. We are not going to call
11 out any individuals. We are not going to ask any
12 individuals to name what they're involved in or
13 not involved in. That is a personal matter
14 between you and the Ethics Officer. But we are
15 going to assume that you are abiding by those
16 rules in good faith. So, if you do need to have
17 further conversations or discussions with us, I'm
18 available, Vanessa is available, and you have the
19 contact information for the FACA Officials that
20 did you're clearance. So, going forward from here
21 as you make those votes, if you chose to recuse
22 yourself or not -- not vote, just make a statement

1 about that.
2 The second item that I would just
3 like to raise, and this is a follow-on
4 conversation with Ed, and then if you have any
5 questions, we can -- we can take them, is you have
6 made a number of recommendations -- tens of
7 recommendations to go to the Secretary and we all
8 know that busy people have narrow attention spans.
9 Some of your recommendations are more central to
10 the committee and the legislative requirements and
11 authorization of the committee and what its
12 purpose is. Some of them are very valuable, very
13 worthwhile. They may not be either as specific as
14 one might like for making a policy decision or
15 they may be a step removed from what the actual
16 mission or purpose is from the committee. So, I
17 would ask you in your discussions and
18 deliberations to, as best possible, refine and
19 clarify your priorities in some of these areas.
20 If there are two, three, five, ten that you think
21 are essential, I think it would be a great add-on
22 or, you know, refinement to your work. That's

1 your call. It is a committee that operates
2 independently and you have the choice to make the
3 recommendations that you choose. But I do think
4 that it may add value.
5 That's all I have. Are there any
6 questions or followup that you would like to take
7 up with me at this point? All righty then.
8 EDWARD EHLINGER: Good, thank you.
9 Thank you, Lee. You know, and speaking of
10 conflict of interest, Belinda Pettiford had a
11 conflict of interest yesterday. She was before
12 the legislature defending her budget, so she
13 couldn't be in two places at one time. So, she
14 was not with us yesterday, but she's here today.
15 So, Belinda, could you introduce yourself to the
16 other -- to the committee member and everybody
17 else on this Zoom call and answer the three
18 questions that I had all of the other members do,
19 you know, what do you bring to the table here,
20 what are the -- what's the issue or issues that
21 are of most importance to you, and why.
22 BELINDA PETTIFORD: Sure. Thank you,

1 Ed, and hello everyone and please know I would
2 have much rather been with you all yesterday. So,
3 it's good to see so many faces and names that I
4 recognize.
5 I am Belinda Pettiford. I work with
6 the North Caroline Division of Public Health, and
7 there I'm head of the Women's Health Branch, which
8 includes efforts around maternal health, family
9 planning, preconception health, as well as our
10 state Sickle Cell Program is also part of the work
11 that I'm responsible for. I have been doing this
12 work for thirty-plus years. Actually, I just had
13 my 34th anniversary doing this work. I started
14 off at the community level. I worked at a local
15 health department for the first eight years of my
16 career. I had a wonderful health director that
17 told me I could try anything in the community as
18 long as I didn't get him in trouble and myself in
19 trouble. So, I spent my first eight years of my
20 career really working in the community, going door
21 to door working with beauticians and barbers and
22 faith-based organizations and had a wonderful time

1 doing that and it was actually a difficult
2 decision for me to leave that, but for the sake of
3 [inaudible] my work is focused on maternal and
4 child health and specifically on addressing health
5 equity.
6 So, from -- looking at your
7 questions, my background is the thirty-plus years
8 and I would say the committee to me, I am always
9 focused and continue to focus on health equity
10 including anti-racism because I think it is what
11 will help drive our work to improvement and I
12 think our data is very clear and it tells us what
13 our challenges and our concerns are. But I think
14 some of that includes we've got to listen to the
15 voices of those impacted, the voices of our
16 communities, and spend that time in building those
17 trusting relationships.
18 I think some of the priorities for me
19 for SACIM is looking at the public health
20 workforce and looking at how we identify who is a
21 member of that public health workforce. I think
22 the committee's recommendations are moving forward

1 around doula services, community health workers,
2 lactation specialists. I think all of those are
3 very important. I think many of those are people
4 that are part of the communities were trying to
5 have an impact on and to partner with, and I think
6 that helps to build that level of trust. So, I
7 think that is very important. I think programs
8 that are supporting individuals and families, you
9 know, I truly love working in the arena of group
10 prenatal care as well as with some of the group
11 parenting work I think is critical. Ultimately, I
12 think any of the work focused around health equity
13 and anti-racism is very important to me and I
14 think I second we need to champion that work.
15 So, thanks everyone, and it's again,
16 good to see you all.
17 EDWARD EHLINGER: Okay. Glad you
18 could join us today, Belinda, as always.
19 All right. So, now for the next at
20 least forty-five minutes, we're going to be
21 talking about the recommendations. Just a little
22 bit of background, just my role has been to try to

1 get as much input from the members, and members
2 broadly define those in the workgroup, into the
3 recommendations. So, I tried to incorporate in
4 all of the recommendations the wording that is
5 given to me by folks, editing a little bit along
6 the way, but so these, I hope, reflect the input
7 of all of the members who have already
8 contributed.
9 I did -- we talked about language and
10 I know that the general vernacular right now is to
11 think about -- speak about Black, brown,
12 indigenous, and populations of color, BIPOC. So,
13 I'm using that acronym because I think that's
14 generally being used. So, if you see -- through
15 this document, you'll see BIPOC, Black, brown,
16 indigenous, and people of color. Yeah. And so,
17 that -- that is there.
18 And if there are other issues related
19 to language as we go along, you know, bring those
20 up because we will try to be consistent as we go
21 through this. I do like the input that I received
22 from the members of the Equity Committee just to

1 make sure that we're being respectful and focusing
2 on assets rather than deficits and moving from
3 there.
4 What I did -- what I sent to you this
5 morning is our documents -- a cover letter, which
6 basically is the same as what I'd sent earlier.
7 There's no major change other than that Jeanne
8 pointed out that we are chartered by Congress
9 rather than the Secretary. So, it changed that
10 focus. That's the only really big change in that.
11 The background document, I think, needs additional
12 work. But I'm not going to go through that
13 because it is just background and if anybody wants
14 to add some additional things, I think we need to
15 put, as we talk through this, we need some
16 additional work like Paul Wise said yesterday, you
17 know, he had all those numbers, that would have
18 been nice to put -- will be nice to put into the
19 background piece on migrant and immigrant health.
20 I think if we want to do -- if we end up with some
21 recommendations related to the Indian Health
22 Service, I think we need some background

1 information on Indian Health Care. So, similar
2 kinds of things just as background. But we're not
3 going to go through that. We're going to go
4 through the recommendations, and in the
5 recommendations where there have been significant
6 changes or new recommendations that have been
7 brought forth since the document that we talked
8 about yesterday, those are highlighted in blue,
9 and that's what we're going to be focusing on.
10 I'm not going to go through each of the
11 recommendations again. However, if there are some
12 recommendations that you want to talk about that
13 are not highlighted in blue, please let me know
14 and we can do that. I don't want to ramrod things
15 through. I want to make sure that everybody, if
16 they have any concerns or suggestions, that they -
17 - they have a chance to put those forward. But I
18 don't want to -- I don't think we have time to go
19 through all of those again. I think we went
20 through them very well yesterday and I had a sense
21 that there was consensus of most of the issues.
22 So, we're going to start this session

1 going back to where we ended really talking about
2 data and research and action because we cut Magda
3 and her work group off a little bit short. So,
4 she's going to start and we're going to go through
5 those recommendations, and then we'll go back to
6 the other ones that had been added on. So,
7 Vanessa, can you go back down to the bottom part
8 of the recommendations? And Magda, you're on.
9 MAGDA PECK: All right. How about
10 that? Does that work better now?
11 EDWARD EHLINGER: Now, I'm hearing
12 you.
13 MAGDA PECK: There you go. It muted
14 -- you know, technology has a mind of its own.
15 Thank you for artificial intelligence. And Ed,
16 thank you for reminding me about horseshoes. I
17 remember the first time that you challenged me
18 when I came to give a talk in Minnesota. First
19 one I got a ringer and it gives a false sense of
20 security and accomplishment when you go straight
21 to the ringer. So, to follow that out, it -- it
22 is incremental and essential collaborative work.

1 So, great metaphor.
2 Thanks again to my colleagues and
3 also those who took time overnight to send me
4 additional comments, which have been forwarded to
5 Ed and are reflected here. And so, a couple of
6 additions, which is why I'm -- can we put on mute
7 someone who has children? That would be great. I
8 love the sound of children, but it's hard enough
9 hearing without that. Thank you.
10 And so, we have added, actually, and
11 so I'm going to start in the beginning but not go
12 into full detail under the first item. But I want
13 to reflect some of the input that came in without
14 having adequate discussion yesterday.
15 Yes, Lee, we have six recommendations
16 and they likely can be consolidated and some of
17 the research and data recommendations from the
18 other sections could be consolidated here. We
19 will work on a way to make this more compact and
20 toward this end, I want to acknowledge input on
21 the first item about strengthening research and
22 data for equity, being the anchoring and centering

1 piece.
2 Workforce section did not include
3 essentially the research component of workforce.
4 And in the scientific enterprise, there is
5 underrepresentation of people of color, Black,
6 brown, indigenous, tribal more broadly and other
7 underrepresented groups. And so, we have added
8 for your consideration under strength and research
9 and data for equity encourage engagement and I
10 would add, Ed, to your edit, encourage engagement
11 and support scientists from diverse backgrounds
12 and invest and promote the use of strength and
13 data sources, protocols, surveillance, evaluation,
14 and research methods. And so, by putting in the
15 notion of who does this work, data do not manifest
16 themselves. Research is not the immaculate
17 conception, to borrow a phrase. So, we need to
18 have people in the pipeline and people in practice
19 in our data and research part of the larger team
20 beyond the care team.
21 Towards that end, we add a new A,
22 which is to engage with organizations,

1 institutions, and entities that are
2 underrepresented in the scientific workforce and
3 provide pathways -- I would say provide and
4 support pathways -- to enhance career development
5 of individuals from BIPOC communities and other
6 underrepresented groups in maternal and infant
7 health. So, that is a workforce addition for your
8 consideration.
9 Otherwise, in this number 1, it is as
10 we reviewed yesterday, and I will not repeat. If
11 you have additional comments and conversation,
12 let's have it. So, if we can move on to number 2.
13 Enhanced data systems,
14 interoperability, and sharing. In this case, we
15 have listened to the input from the Data and
16 Research to Action Work Group in the prior SACIM
17 meeting an outline with the addition of pre-
18 pregnancy and maternity care. We may also add
19 under B, 2B, the notion of postpartum care,
20 although that may be incurred in maternity care.
21 We wanted to make sure in adding the pre-
22 pregnancy, we also -- and we want coverage into

1 the first year of -- following delivery. We may
2 want to make that more clear. But these are the
3 notion that not only do we want to have stronger
4 data systems, we want to make sure that they work
5 together across sectors and across disciplines and
6 across parts of government. And that is where we
7 have number 2 that we quickly reviewed yesterday.
8 And number 3 is a specific investment
9 given the flourish and quick utilization of
10 Maternal Mortality Review and the MRIA system and
11 the Mortality -- the MUM Users Group is over here
12 with CDC funding and then the FIMR over under HRSA
13 funding and so, we've been hearing in the field
14 about how we can begin to have greater alignment
15 between these two sentinel event review
16 methodologies as an example and then look at the
17 augmentation of sentinel event methodology around
18 severe morbidity and other events that would
19 welcome, if you will, qualitative data, lived
20 experience, and family perspectives so that
21 community voices are an integral part of our
22 definition of what is our data system. So, that's

1 what you will see in number 3.
2 I'm going to stop there again because
3 this is as far as I got in my abbreviated six
4 minutes yesterday and I want to take a breath and
5 invite with that friendly amendment from what
6 surfaced over the evening's time and into this
7 morning, a call for any conversation, questions,
8 concerns, additions in this first 1, 2, and 3.
9 EDWARD EHLINGER: if you have any
10 questions, just raise you hand in the raise hand
11 area or just speak up.
12 MAGDA PECK: I'm originally an East
13 Coast girl, even though I lived in the Midwest for
14 thirty years, and so I have that count-to-five
15 rule, like Magda, count to five. So, hearing none
16 immediately and seeing none in the chat for right
17 now, I want to thank you for giving a chance to
18 digest that first 1, 2, and 3 with some friendly
19 suggestions from this morning and move onto 4, 5,
20 and 6. If we could do that, Vanessa. They're
21 shorter, they fit on one screen.
22 The first thing I'd like to do is I'd

1 like to defer conversation at number 4 for a
2 moment and just go to 5 and 6. These were offered
3 with suggestions of members of the DRAW Group. It
4 is included in the preamble about the importance
5 of centering the work around policy to include
6 perspectives of maternal and infant health. But
7 research, and we found that particular in COVID,
8 we were late to the game to have a special
9 consideration, an inclusion of women of
10 reproductive age, pregnant, and breastfeeding
11 women and their infants in health services
12 research including vaccine and medication studies.
13 This is a lesson learned from COVID that we would
14 offer as an additional strengthening data system
15 through the lens, in this case, of population.
16 And then last, another lesson learned
17 from COVID, which will not be the only or last
18 public health emergency, and we have seen this
19 time and again, whether that's hurricanes, floods,
20 fires, natural disasters, there are those that
21 threaten specifically the lives and well-being of
22 mothers and infants and disproportionately moms

1 and babies of color and of other marginalized and
2 often erased groups. And so, we have this one-
3 size-fits-all for public health emergency. I
4 think we've learned that we need to look at social
5 inequity during emergencies, which is why we'd
6 like to have an ending-COVID, we hope, time to
7 include a broader lesson learned in 5 and 6. I
8 want to thank the input from our colleagues in
9 DRAW and particularly Alison Cernich for -- for
10 helping us consider these possibilities. And I'd
11 like to open any discussion about 5 or 6.
12 JANELLE PALACIOS: Magda, this is
13 Janelle. Just again looking at the language and
14 again our New York City midwife, Pat Loftman, is
15 just calling our attention to rewording a
16 sentence, eliminating the two underrepresented
17 words that maintain the spirit of the
18 recommendation. So --
19 MAGDA PECK: So note. I saw it come
20 up. Pat, thanks so much, and Janelle. We will --
21 my assurance as a member of SACIM is that we are
22 continuing to use what we learn with intention and

1 consciousness and respect. And so, yes, we'll be
2 delighted and important to modify language in that
3 spirit. And Vanessa, if you can help me make sure
4 that happens.
5 VANESSA LEE: I'm sorry. Just so I -
6 - Magda, sorry, which -- was that under
7 recommendation 1, just to get -- be sure I'm clear
8 which lines we were talking about for Pat's
9 comment.
10 MAGDA PECK: And Janelle, can you
11 help us here because I believe that it is --
12 JANELLE PALACIOS: It's 1A. It's in
13 1.
14 MAGDA PECK: 1A. I think the
15 question here is underrepresented in the
16 scientific workforce, and I think that's
17 technically correct. However, this is something
18 that you and I have spoken, given your own
19 background, the alternative language from you and
20 Pat would be?
21 EDWARD EHLINGER: I would suggest
22 that if you have some specific suggestions, you

1 put those in the chat or give them to us as an E-
2 mail later. We will do everything and go through
3 all of those things. But trying to edit it online
4 now will take a lot of time. So, let's just --
5 we'll come back to that.
6 MAGDA PECK: Thank you. Provide -- I
7 just want to make sure it's noted there, Vanessa,
8 so that it's recorded to go back to. That's my
9 point here, Ed, not to wordsmith, but to make sure
10 it's reflected in Vanessa's comments.
11 Then, if you could go to the very
12 last one, please. One of the suggestions that
13 came up yesterday was -- which I raised, I take
14 responsibility for it-- which is not only do we
15 want to have data that translates to action, that
16 we use data, but that we are making, as we noted,
17 a slew of recommendations, which we hope can be
18 perhaps consolidated and, who knows, prioritized,
19 in the more strategic packaging. But the notion
20 that in each of the sections except for workforce
21 and maternity care services and systems, we have
22 no measurement recommendation about the impact of

1 those policy recommendations. And so, instead of
2 putting it at the end of each section, we're
3 crafted language that says measure and monitor
4 impact -- that means across all of the
5 recommendations that are forthcoming -- to support
6 data and research to monitor and assess or data
7 and assessment -- we can look at the language --
8 to monitor and assess the impact of these -- of
9 all of our recommendations.
10 And so, this is a way for us to hold
11 ourselves accountable for having made these
12 evidenced-informed recommendations and encourage
13 someone -- encourage investments, if you will, in
14 knowing what is the difference that they may have
15 made. A more general blanket, but that is a
16 remedy to the recommendation suggestion that was
17 made yesterday.
18 So, I want to open it there with an
19 understanding that this will be the segue back,
20 Ed, to going back to the very beginning. But this
21 notion of measure and monitor the difference we
22 make by what we recommend so that word goes to

1 deed and deed is accountable.
2 EDWARD EHLINGER: I would think that
3 we may even want to put this in -- in the initial
4 recommendation.
5 MAGDA PECK: Preamble.
6 EDWARD EHLINGER: Yeah, in the
7 preamble and say that, you know, we're putting all
8 of these recommendations forward and we want to
9 make sure that we evaluate those and, you know,
10 find some way to actually raise it up in that
11 opening paragraph or two paragraphs.
12 Any other thoughts from folks?
13 MAGDA PECK: Well, that's a good
14 count-to-ten East Coast style. Again, I want to
15 end with extraordinary gratitude to the Data and
16 Research to Action Work Group and its
17 collaboration with the other two work groups.
18 Both our ex-officio members, our SACIM members,
19 and our robust external members, who have
20 contributed perspectives and voice. And with
21 that, I pass it back to you, Ed.
22 EDWARD EHLINGER: All right. Thank

1 you, Magda, and thank you for the work that your
2 group has done on this.
3 So, let's go back to the very top and
4 put out a couple of things. We'll kind of walk
5 through this and people who have been working on
6 this can jump in when it gets to that point. It
7 was highlighted in the very first paragraph, which
8 I didn't have in blue, but I just want to say that
9 we went -- we changed the wording from should to
10 must. You know, SACIM believes health care system
11 da da da da must be of the highest as opposed to
12 should be, you know, and I think we wanted to kind
13 of proactively state what we really believe in.
14 so, just -- just highlighting that.
15 And then, we get into the care
16 systems. Let's go down to the care systems and
17 particularly, we added something about risk-
18 appropriate care. Steve, do you want to talk
19 about that? Steve, unmute your mic.
20 STEVEN CALVIN: Here I am. I'm back.
21 Thanks to Wanda Barfield for the assistance with
22 this. One of the benefits of being on the

1 committee is that I know all of us, but I, in
2 particular, all of the various resources of the
3 federal government. I mean, it's obviously a
4 large entity and HHS has many parts of it that
5 I've become more familiar with. She pointed out
6 that the locate or the -- I think it's location of
7 -- oh gosh -- it's a tool that allows better
8 utilization of resources in states and the tool is
9 really useful.
10 So, Wanda pointed out that we need to
11 include risk-appropriate -- risk-appropriate care
12 recommendations. So, she sent this and the one
13 thing that we added to it is that there are times
14 where babies being transported in utero are
15 actually the ideal transport. I recall during
16 medical school just being impressed about the fact
17 that transporting in utero can sometimes be the
18 best thing for a baby to a better level of care.
19 But in any case, we added the fetuses
20 who are identified with some problems that can be
21 managed or treated in utero -- that's happening
22 around the country, Tara pointed that out -- and

1 for those who will need neonatal care. So, I
2 think this is a really important thing and I'm
3 sure we're going to do some consolidation of the
4 recommendations in the area of care system and
5 financing. But this is one that I think is right
6 very near the top, probably at the top. Anyone
7 have any comments or questions about that? I
8 don't know if Wanda is with us today. Maybe
9 hearing a little bit about the locate -- CDC
10 locate tool, it's something I was not familiar
11 with. I was familiar with the concept, but it's a
12 federal tool that's really useful for a number of
13 states. Some are participating, I think, twenty-
14 two states, unfortunately, not Minnesota.
15 BELINDA PETTIFORD: We are using it
16 in North Carolina, Steve. It's the Levels of Care
17 Assessment -- I know there's another letter there
18 that I'm missing as well.
19 STEVEN CALVIN: And transport maybe
20 BELINDA PETTIFORD: Right. Levels of
21 Care Assessment Tool, and we actually, you know,
22 it is -- it's part of the process if you're trying

1 to either develop or create levels of care in your
2 state. Like in my own state of North Carolina, we
3 don't have maternal levels of care. So, we have
4 actually partnered with and contracted with some
5 entities to work with all of our delivering
6 hospitals in our state to go out and work with
7 them in completing this Levels of Care Tool -- the
8 CDC tool. We've been working with CDC a couple of
9 years on it. It started with some of the work
10 with the -- the COIIN work that HRSA came out with
11 several years ago -- I want to say like 2014,
12 2016, the Collaborative Improvement and Innovation
13 Network, and it was around perinatal
14 regionalization. So, there were multiple COIINs,
15 but this one was specific to perinatal
16 regionalization and that's where some of the
17 conversations began with Wanda Barfield and others
18 at that point in time. But it is a tool that kind
19 of helps determine based on your capacity as a
20 delivering hospital what you actually have in
21 place and what should you have in place, and it
22 connects really with the recommendations that have

1 come out of ACOG and the Maternal and Fetal
2 Medicine Society for the Maternal Levels of Care
3 and then on the neonatal side, it's coming out of
4 the American Academy of Pediatrics. So, all of it
5 does connect, but it is one step -- it's not the
6 only step -- but it is a first step in really
7 making the determination around determining what
8 you're levels of care are for your hospitals if
9 you don't actually already have a system in place.
10 EDWARD EHLINGER: Yeah. And this
11 might be someplace we want to work with MCHB that
12 Dr. Warren made some comment about, you know,
13 things going in MCHB where we may want to
14 harmonize what's going on and clarify this
15 recommendation so that it gets all of the tools
16 that are out there.
17 All right. Any concerns with this
18 approach that people might have? If not, let's
19 then go down to number 13 and 14. And let's start
20 with 14 because that is what -- Steve had brought
21 this up and we have not talked about number 13.
22 So, let's start with 14. Steve, you raised the

1 whole issues about financing.
2 STEVEN CALVIN: Right. Yeah, and I
3 was, I think, pretty transparent about kind of
4 what I've been working on, which was -- actually,
5 when I came on the committee, I was told this was
6 a reason that because I was working in this area.
7 But this actually also is a contribution from
8 Wanda. Centers for Medicare and Medicaid
9 Innovation is clearly working on bundled payments
10 and there's almost -- there's a commitment for
11 bundled payment for services whether it's
12 capitated primary care service over a period of
13 time or things like joint replacements, spine
14 surgery, bariatric surgery, or other areas.
15 So, this -- this came from a
16 suggestion by Wanda to fund pilots that will test
17 the costs, benefits, and limitations of a bundled
18 payment model for maternity care financed -- or
19 pregnancy care financed by Medicaid. And it -- it
20 will require to appropriately compensate for
21 collaborative comprehensive care. And, for
22 example, she included -- it was just one -- that

1 there are times where maternal and fetal medicine
2 care is involved during a pregnancy and general
3 OB/GYN physician care as well, but a midwife can
4 attend the delivery and that postpartum doula
5 service can be incredibly helpful. So, it's just,
6 I think, recognizing that a team approach that's
7 probably facilitated by bundled payment.
8 The last line too, I've been thinking
9 about a little bit more. She did have a
10 suggestion about facilitation of information
11 sharing and I think we can just maybe reword this
12 sentence to suggest that the Office of the
13 National Coordinator for Health Information, that
14 we -- I mean, I can craft something and maybe
15 present it to the group a little bit later -- but
16 just a sentence that recommends that the Office of
17 the National Coordinator have -- be part of the
18 description and implementation of pilots for
19 bundled payment for maternity care. Anyone have
20 any comments or questions about that?
21 MAGDA PECK: You can see -- this is
22 Magda -- that the language I suggest is not

1 facilitate but encourage, and this is -- this is a
2 data-related recommendation for interoperability.
3 So, there's -- it's -- the information sharing
4 piece is -- there may need to be some incentives,
5 and maybe that's implied in incentives. But I
6 just think that folks won't do it unless it's more
7 than facilitated as you wish to work the language.
8 STEVEN CALVIN: Sure. I will and
9 noting as well a comment from Lisa Satterfield
10 from ACOG suggesting the use of alternative
11 payment models. I think the reason for the use of
12 bundled payment is because in the Learning and
13 Action Network and other entities, Cattle for
14 Payment Reform, I mean, this isn't some new idea
15 that -- for maternity care that only a few have
16 come up with. This is something that's been
17 pushed on for probably a decade and there are
18 levels of alternative payment models and some of
19 them are as simple as, you know, we'll pay you a
20 little bit more if you ask about smoking all the
21 way to there should be a different way to pay for
22 the entire package of care, and I think this is

1 kind of a level 4. This is like the ultimate in
2 alternative payment models. So, I would say the
3 bundled payment part of it is -- is something that
4 is -- it's being promoted by -- within the federal
5 government, some state governments are doing it,
6 and a lot of other entities.
7 EDWARD EHLINGER: Any other comments?
8 Jeanne?
9 JEANNE CONRY: Yeah, this is Jeanne,
10 I've got my hand up. Yeah, I also would urge
11 using alternative payment models. I come from a
12 very alternative payment model, which is managed
13 care approach, which has clearly collaborative
14 comprehensive perinatal care and a system and
15 that's, to me, an alternative model of care. I
16 believe that we need the data specifically looking
17 at maternity care, maternity outcomes, and
18 challenging us to come up with these other models
19 of care and a bundled approach is one of them, but
20 certainly there are others that are equally
21 valuable with very strong outcomes data.
22 EDWARD EHLINGER: I concur with that,

1 yes. All right. Any other comments? So, Steve,
2 if you could sort of work on that, we can come
3 back to that, you know, this afternoon or early --
4 later on when we get to finalizing these things.
5 STEVEN CALVIN: Sure.
6 EDWARD EHLINGER: All right. And
7 then, Janelle, let's talk about number 13. I know
8 you were engaged with this. Unmute yourself.
9 JANELLE PALACIOS: Better?
10 EDWARD EHLINGER: Yeah, there you go.
11 JANELLE PALACIOS: All right. This -
12 - this derived from the last sort of three-person
13 Healthy Equity meeting group that happened a
14 little bit spontaneously with short notice where I
15 brought up that we have discussed before Indian
16 Health Service and I believe -- I'm trying to
17 think of who in particular -- an invited speaker -
18 - I'm not sure if it was Arthur James or maybe it
19 was around that time but we briefly talked about
20 Indian Health Service, and for the most part, we
21 haven't heard recently from an expert on Indian --
22 from Indian Health Service or on Indian Health

1 Service issues. But it is a longstanding fact and
2 documented in a recent report where Indian Health
3 Service has been chronically underfunded, and if
4 we're trying to improve the health of indigenous
5 women, this is definitely one direct way we can do
6 that by increased funding to their -- to Indian
7 women and their families.
8 So, this comes out from just a
9 request to immediately increase funding to Indian
10 Health Service in accordance with historical trust
11 obligations. So, this is agreements that have
12 been -- agreements historically between Sovereign
13 Tribes and the US government -- a nation-to-nation
14 relationship where in exchange for giving up our
15 land and resources, we have rights to particular
16 things including health care.
17 So, from the report I believe that I
18 shared -- the 2018 report -- some of the
19 recommendations included increasing funding
20 specifically to urban Indian Health Centers,
21 support job training programs to address staff
22 shortages, increase preventative services,

1 increase culturally and linguistically concordant
2 maternal and infant health workforce was in
3 addition to what we have been working on largely
4 through SACIM, and provide funding to upgrade
5 Indian Health Service buildings and
6 infrastructures to meet the needs of tribal
7 communities.
8 In the report from 2018, I'm just
9 kind of paraphrasing, but I think I recall that
10 many of the facilities that Indian Health Services
11 uses are forty-plus years old. And when I shared
12 this recommendation with some colleagues that are
13 more familiar with Indian Health Service, they
14 definitively wanted a measure part, you know,
15 where you improve maternal and infant health
16 compared to what. So, this health equity achieved
17 by measuring the parody in maternal, infant, and
18 child health outcomes to white women. Are there
19 any thoughts or questions about this?
20 EDWARD EHLINGER: My -- my question
21 is, this is a huge issue, and I don't think we
22 have really dedicated enough time. There are two

1 approaches that we could do -- try to craft
2 something in this recommendation or actually make
3 part of our next meeting or the meeting after that
4 that focuses on health care to Indians, how to get
5 through the Indian Health Service. And so, we
6 have a much more focused discussion and broader
7 discussion so that we can come up with a more
8 referenced recommendation. That would be, you
9 know, two approaches. Try to do something here or
10 actually set aside some time in one of our SACIM
11 meetings to really focus on this issue, because
12 it's an important issue. Magda.
13 MAGDA PECK: Janelle, thank you, and
14 thanks to Dr. Warren and others who have been my
15 teachers and mentors in learning.
16 I wanted to go back to something I
17 said yesterday about in the recommendations we
18 make, barring from Mark Friedman's model, what has
19 data power, communication power, and proxy power
20 to be able to inform policy? That goes back to
21 Ed's quote in the very beginning of yesterday of
22 Abraham Lincoln about will. And so, I'm wondering

1 about a hybrid. Ed's approach definitely, but
2 kicking cans down the road has been done a long
3 time, so I'm feeling reluctant to yell we'll pay
4 it forward. So, towards that end, I'm wondering
5 about how to make the case here that within the
6 Indian Health Service, if we were to advocate or
7 promote a recommendation to adequately fund
8 maternal -- you know, pre-pregnancy, maternal --
9 maternity care, and through the first year
10 following delivery, in the Indian Health Service,
11 anchor it on that specific to our mandate. Then,
12 it would be a proxy in my -- my hope assumption
13 and I believe it's supported that as you invest in
14 women and infants, so will you improve the broader
15 system and better outcomes.
16 So, I'm wondering about how to take
17 this large global recommendation, specify it to
18 the -- our charge, which is addressing infant and
19 maternal mortality, with the understanding that if
20 we do that, we are impacting the rest of the
21 Indian Health Service funding potentially if we
22 take a life course approach. And the language

1 you've offered here can then be put -- some of it
2 -- into the background document. So, that's an
3 alternative approach to do something now and do
4 more later.
5 JANELLE PALACIOS: I totally -- I
6 understand what you're advocating for, Magda, and
7 I appreciate that. I do -- I guess I would like
8 to make sure that we continue to discuss this
9 issue, and I see some comments finding their way
10 through and I admit that I am not an expert on
11 Indian Health Service. I received care from
12 Indian Health Service, I can share a lot about
13 that. But I do not directly understand how it
14 works or how it's funded and I did not -- I'm not
15 aware of funding going directly through states
16 versus directly to Indian Health Service.
17 So, I do like the idea of making a
18 specific recommendation targeting maternal and
19 infant health with regards to Indian Health
20 Service funding, and I see Susan's comment about
21 transportation. I mean, a lot of -- most tribes
22 that are funded or served by Indian Health Service

1 are rural, so transportation is going to be a big
2 issues. I get that.
3 So, as long as we can carve out a
4 good amount of time to really discuss this issue
5 for the future, Ed, I would agree to retracting
6 the global request for immediate increased global
7 funding to Indian Health Service in exchange for
8 specific targeted funding for maternal and infant
9 health with the understanding that we would have a
10 more dedicated discussion later.
11 EDWARD EHLINGER: I like that
12 approach, you know, let's latch on that. Let's --
13 let's have a more targeted recommendation so that
14 we have it on the board that we're making some
15 recommendation related to Indian Health and then
16 we'll set it up as part of the agenda for the
17 upcoming meeting.
18 JANELLE PALACIOS: Okay.
19 EDWARD EHLINGER: Great.
20 JANELLE PALACIOS: Vanessa is typing
21 things. What would -- what would we type in this
22 area?

1 EDWARD EHLINGER: Let's -- let's work
2 -- let's work on that sort of offline here because
3 I want to get to a couple of other things before
4 we break for the -- the 1 p.m. session.
5 JANELLE PALACIOS: Okay.
6 EDWARD EHLINGER: All right. So,
7 let's go down to workforce. Working faster than
8 Vanessa can type. And this is one where actually
9 we had two recommendations. One was related to
10 community workforce and then the perinatal
11 workforce and they seemed -- they used the same
12 words and I tried to put them together so that, I
13 mean, it gets to be a little clunky, but it was --
14 it was merging two of those. So, expand sort of
15 the community focus and then also the perinatal
16 workforce. So, this is the new wording that came
17 out and it could be certainly improved. Those of
18 you who have been working on that, any
19 suggestions, or does it make sense? Magda, do you
20 have your hand up or is that just not taken down
21 from previously? All right. All right. Not
22 hearing any comments on that, we can certainly

1 come back to that a little bit later because it is
2 -- and I'll take actually another look at that
3 myself.
4 Let's go down to one that -- the
5 number 3 was a new one that -- that came in last
6 night, equitable funding among care providers. I
7 think this came in from the Health Equity group.
8 JANELLE PALACIOS: Yeah. This again
9 was a little bit jumping off from also yesterday's
10 conversation with one of the -- one of the
11 recommendations from Steve's group where there
12 seemed to be like two recommendations in one. And
13 so, this was to address the equitable kind of pay
14 for the same amount of work. And it was trying to
15 get at the means of Medicaid reimbursing for equal
16 work done among physicians, you know, probably
17 physician's assistants, and midwifes, or nurse
18 practitioners related to perinatal care. So, if
19 it was antenatal care, postpartum care, or a birth
20 delivery, that -- that it would be reimbursed at
21 the same rate.
22 EDWARD EHLINGER: Thoughts of people?

1 JEANNE CONRY: Same rate is different
2 than equal.
3 JANELLE PALACIOS: Sorry.
4 JEANNE CONRY: So, equitable and
5 equal are different terms. I would support
6 equitable.
7 JANELLE PALACIOS: Okay.
8 EDWARD EHLINGER: Any other thoughts?
9 JANELLE PALACIOS: I guess I would
10 add to this that it would be support Medicaid to
11 equitably fund midwives and other Allied Health
12 service providers, just acknowledging that it's
13 more than just midwives, it's including other
14 advanced practice nurses and physician's
15 assistants.
16 EDWARD EHLINGER: All right. Let's
17 do one more. Let's move on to number 6 before we
18 -- we break for our second session. This is one
19 related to doulas. It says HRSA should work with
20 CMS and state Medicaid programs to identify ways
21 to adequately and sustainably fund the work of
22 doulas and community health workers. It adds

1 community health workers to this conversation.
2 And then there is a parenthetical clause here that
3 explains some of the reports and historical
4 recommendations supporting that kind of an
5 approach and linking it to essential benefits.
6 STEVEN CALVIN: I'd be interested in
7 hearing Belinda's perspective on this since --
8 since you weren't here yesterday, Belinda, I know
9 you have a lot of experience with this.
10 BELINDA PETTIFORD: I was reviewing
11 it, Steve, and I agree with the actual language
12 here. I'm fine with this language because I think
13 it's important at multiple fronts. But I think
14 it's important to make sure that people view them
15 as part of the care team but also making sure that
16 they are appropriately, you know, reimbursed for
17 their time and their services and people
18 understand the importance of that. So, I am good
19 with this recommendation.
20 STEVEN CALVIN: So do I.
21 EDWARD EHLINGER: I think this does
22 move the ball forward a little bit is what I'm

1 really trying to do -- just move the whole
2 community health worker and do a little workforce
3 forward. So, this -- this finds ways to do that.
4 Any other comments on this?
5 MAGDA PECK: One quickie, sorry. I
6 would -- then option of funding versus
7 reimbursement or remuneration, I just want us to
8 tag that language because funding, maybe you've
9 seen as discretionary, and reimbursement and/or
10 remuneration may be part of payment. And I just
11 want us to harmonize that language.
12 EDWARD EHLINGER: Yeah. I always
13 thing about financing. How do we -- as Jeanne
14 pointed out -- there are multiple ways to do
15 anything. There are multiple ways to pay things,
16 there are multiple ways, and we want to find a
17 generic term to make sure that we have sustainable
18 funding --
19 MAGDA PECK: Right.
20 EDWARD EHLINGER: -- sustainable
21 resources, sustainable financing.
22 MAGDA PECK: Right. And so --

1 sustainably remunerate is funding may just be
2 discretionary. That can be come and go. It
3 really is about payment for services provided and
4 we can talk more about that language. But there's
5 nuance there that may have an inference of control
6 and power and I want us to be thoughtful about
7 that.
8 EDWARD EHLINGER: Right. Very good.
9 All right. All right. So, we have a few more to
10 go through, but we won't do that now because we
11 have a session that we have planned for right now
12 that I think we really -- which will help inform
13 some of our conversations.
14 Certainly over the last couple of
15 months, we have seen some reports and some plans
16 and some statements come forward first by -- not
17 first -- but by the -- an -- the Consortium of
18 Maternal and Child Health Organization putting
19 together a statement on racism and then the AMA
20 put together a report on and a strategic planner
21 on Health Equity, and then the Aspen Health
22 Strategies Group put out a report just within the

1 last month on -- on maternity care and raised the
2 whole issue of racism, particularly with a couple
3 of important articles as part of that report. So,
4 we have three -- we have representatives from each
5 of those efforts, and that's going to take over
6 our -- shape our discussion over the next forty-
7 five minutes. And I've asked Janelle Palacios,
8 who chairs our Health Equity Work Group, along
9 with Belinda Pettiford to lead this discussion and
10 facilitate this discussion. So, Janelle, I'm
11 turning it over to you.

12 **UPDATES FROM THE STAKEHOLDERS ON EFFORTS TO**
13 **ADDRESS RACISM'S IMPACT ON MATERNAL AND INFANT**
14 **HEALTH**

15 JANELLE PALACIOS: Thank you, Ed. It
16 is my pleasure to introduce the next panel of
17 invited speakers. I have worked closely with my
18 colleague and co-chair of the Health Equity Work
19 Group, Belinda Pettiford. Belinda's partnership
20 and leadership has elevated the work of the Health
21 Equity Work Group and has produced much of what we
22 have discussed today, and we are so happy to have

1 you invited speakers. I want to publicly thank
2 you, Belinda, for your guidance and partnership in
3 this.
4 This next issue is one I'm both
5 familiar with and have personal experience with.
6 I am a white person in some realms, but at home in
7 my community, I'm identified and othered as
8 Indian. My reservation in Northwest Montana is
9 home to my ancestors among the Salish and Kootenai
10 tribes and growing up, I saw the effects and
11 responses of nearly six hundred years of
12 systematic colonization and assimilation on my
13 family and community take form in poor physical
14 and mental health, self-medication to forget our
15 pain through alcohol and substance use, and
16 violence as a reaction to the intergenerational
17 grief that we have not been able to work through.
18 Today, Black and indigenous women and
19 infants are dying between three to five times that
20 the rate of white women and infants in our shared
21 nation. Black and brown men, women, and children
22 are incarcerated at higher rates than white men,

1 women, and children. Housing and food insecurity
2 affect Black and brown families at higher rates
3 than our white neighboring families. Black and
4 brown people are higher risk of living in areas
5 greatly impacted by environmental assaults.
6 For decades, the onus of our deficits
7 and poor outcomes were laid upon our shoulders,
8 not the policies and institutions that have
9 created the conditions from which we lived and
10 tried to survive. Structural racism is now a term
11 that is safe to say. Think on that.
12 Not too long ago, those doing this
13 work spoke in code to describe this lived
14 experience. Mounting evidence has finally
15 identified in scientific terms what many people of
16 color live day to day. SACIM has purposely
17 centered our work around equity and have
18 identified structural racism as the major reason
19 for our inequities and disparities in maternal and
20 infant health outcomes. Our SACIM briefing books
21 and past briefing books have said in numerous
22 studies addressing racism insidious effects onto

1 health and well-being. Given we SACIM committee
2 members are all the shared understanding on
3 structural racism related to health outcomes, we
4 look to our invited panel to share their vision of
5 how SACIM can move forward to address these grave
6 disparities.
7 We are at a time for growth. Growth
8 as a nation. This work is difficult. And as my
9 colleague and friend Belinda Pettiford likes to
10 say, just because it's hard to do does not mean it
11 should not be done.
12 The first panel I will introduce is
13 from our Consortium on Maternal and Child Health
14 Organization, whose guidance will influence the
15 guides and policies and programs. I am happy to
16 introduce Dr. Arthur James, member, Franklin
17 County Board of Health and former SACIM member,
18 Jonathan Webb, CEO, Association of Women's Health
19 Obstetrics and Neonatal Nurses, Scott Berns,
20 President and CEO of the National Institute of
21 Children's Health Equity -- sorry -- Health
22 Quality, Denise Pecha, Deputy Executive Director

1 of CityMatch, and Debra Frazier, CEO, National
2 Healthy Start Association, and finally Caroline
3 Stampfel, Interim CEO, Chief Strategy and Program
4 Officer from the Association of Maternal and Child
5 Health Programs. Welcome.
6 I would like -- you are welcome to
7 start presenting. Dr. James -- Arthur James, are
8 you presenting first?
9 ARTHUR JAMES: Yes, yes. Thank you
10 very much and thank you for that very powerful
11 introduction to this section of the meeting. On
12 behalf of the collaborative that will be
13 presenting initially, I'd like to thank SACIM for
14 inviting us to today's meeting. As someone who is
15 not a president or CEO of a national organization,
16 I also want to express my sincere appreciation to
17 those of this group who are presidents and CEOs
18 for allowing me the honor of beginning this
19 session.
20 Twenty years ago, the Genome Project
21 proved that we are 99.9 percent the same. We no
22 longer believe that our physiologic racial

1 differences account for the centuries long
2 inequities in birth outcomes. How our country has
3 issued the issue of race is the biggest
4 contributor to these disparities. We also
5 acknowledge that the persistence of these
6 inequities represents the most troublesome and
7 complex challenge facing maternal and child
8 health.
9 During January of 2013, SACIM stated
10 our ability to prevent infant deaths and to
11 address longstanding disparities is a barometer of
12 our society's commitment to the health and well-
13 being of all women, children, and families. Yet
14 today, as was stated by Janelle, African American
15 and Native American mothers and babies continue to
16 die at three to five times the rate of whites.
17 It is our hope that this bold
18 collaboration of AMCHP, CityMatch, the National
19 Healthy Start Association, and NICHQ will empower
20 all of us to take the necessary steps to face this
21 challenge and thereby begin the hard work of
22 eliminating race-based differences in the

1 opportunity for mothers and babies to survive
2 pregnancy, childbirth, and the first year of life.
3 I now turn it over to Jonathan Webb.
4 JONATHAN WEBB: Thank you, Dr. James.
5 Thanks so much for that framing and for all of
6 your efforts in moving this work forward. You
7 have truly been a catalyst for this work and so
8 instrumental in bringing this to fruition. It's
9 exciting to see how this has evolved since our
10 first conversation about this type of work and
11 this joint effort more than a year ago.
12 As you mentioned, I'm Jonathan Webb,
13 the current CEO for AWHONN and former CEO for
14 AMCHP. As a brief history, when this concept was
15 first discussed, we were interested in bringing
16 together leading public health organizations to
17 not only identify racism as a public health crisis
18 but to commit to actionable items that we could
19 collectively hold ourselves accountable to and
20 thus lead by example. We discussed reaching out
21 to a large number of organizations in this effort
22 but ultimately landed on a handful of key

1 organizations to begin with, AMCHP, NICHQ,
2 CityMatch, National Healthy Start Association,
3 ASTHO, NACHO, and March of Dimes. In fact, you
4 may remember, these organizations jointly
5 presented our intentions to SACIM last year.
6 As you may have noticed, we have lost
7 a few organizations along the way, and we'll talk
8 about that a little bit more in a second. We knew
9 this effort would be challenging, and we've
10 learned firsthand how difficult this work is. We
11 have thankfully learned a lot in the process that
12 will benefit us as we move this work forward with
13 those who have had to sit this round out and for
14 those that will engage in the future.
15 A few quick notes on how this work
16 has evolved and what we've learned. So, from an
17 evolution standpoint, our statement addresses
18 multiple areas of focus and over the life of our
19 conversations drafting this document, we decided
20 that commitment to this should be all in, meaning
21 that although we acknowledged it would take time
22 to comply with everything, the expectation was

1 that you would eventually comply with all these
2 areas of the statement. We asked organizations to
3 be all in in their efforts to being anti-racist.
4 The second area for evolution was
5 that we started focusing on action, not optics or
6 statements. We finally agreed this document will
7 be a declaration on outlining items to which we
8 and others could be held accountable.
9 A few of the things we've learned,
10 one, there are many well-meaning organizations
11 doing this work and leading in this work, but even
12 in those cases, there must be a thoughtful
13 approach to navigating the politics of leadership
14 and on various memberships even if there is
15 general agreement on the final destination.
16 The second item we learned was that
17 the devil is in the details. Even organizations
18 who are leading in this space must be mindful of
19 the financial and resource implications of
20 committing to an effort like this and the timing
21 of this must fit into the strategic process within
22 each organization.

1 The third thing we learned was that
2 the all-in commitment requirement was challenging
3 for some because it would commit them in advance
4 to action items that would normally require more
5 board and leadership involvement. So, in that
6 vein, we learned that board and leadership
7 commitment to this is essential.
8 Additionally, a number of
9 organizations shared that for future
10 consideration, we may want to consider a tiered
11 commitment process that would allow more to
12 participate and build over time. This is
13 something we might consider down the line, but for
14 now, we wanted people to be all in. We will learn
15 and reassess over time how this -- this effort
16 turns out. But for now, we wanted to stick with
17 the all-in approach to avoid the possibility of
18 diluting our efforts.
19 Lastly, we learned that all the
20 organizations are committed to this work, and even
21 though they weren't able to sign on this time,
22 they are still interested in partnering on efforts

1 around this, and a door was left open for sign-on,
2 even for my new organization, once the
3 organizational processes and policies have been
4 navigated.
5 I'm so thankful for this work and to
6 begin and look forward to bringing those who
7 started with us along but couldn't sign on at this
8 time back into the fold. The all-in declaration
9 in the near future as well as the new partners,
10 like my organization, AWHONN and others in the
11 private space, I'm thankful that we've had a
12 chance to start this work and I'm looking forward
13 to continuing with new partners as we engage. And
14 at this point, I'll turn it over Scott Berns from
15 NICHQ to dig a bit deeper into our first joint
16 commitment statement.
17 SCOTT BERNS: Thanks, Jonathan. I'm
18 going to transition into the three commitment
19 areas. Next slide.
20 Our first joint commitment focuses on
21 internal processes, which are a foundational part
22 of this action plan. Similar to how change must

1 begin within ourselves as individuals, the
2 critical organizations systems change we are
3 talking about today must begin within each
4 organization's core, the processes and policies
5 that shape our behaviors and actions. Commitments
6 in this section include ongoing training of all
7 staff in undoing racism, assessing skill and
8 racial equity, health equity, and social justice
9 when hiring new staff, as well as in performance
10 evaluations, analyzing and setting metrics for
11 diversity in our service vendors and subject
12 matter experts, auditing our internal practices
13 and policies with a racial equity lens, examining
14 and intervening in the racial and ethnic makeup in
15 our staff and boards with a focus on retention,
16 and annually assessing our organizational culture
17 of inclusion.
18 At NICHQ, our ongoing internal
19 racial/ethnicity work is supported by monthly,
20 all-staff equity in services that feature subject
21 matter experts and small group discussion.
22 Although we've been working as a remote team for

1 more than a year now, these conversations have
2 continued and deepened as we witness and
3 experience conflicts and issues like racism
4 collide with critical current events including the
5 COVID-19 pandemic.
6 In 2020, we initiated an annual
7 assessment of NICHQ staff understanding around
8 implicit bias and health equity. In 2021, we
9 established a measurable goal on staff perception
10 of their ability to impact equity.
11 This section of the joint commitment
12 can be leveraged by SACIM and our partner, MCH
13 organization as a starting point, can meaningfully
14 examine their internal processes and policies and
15 the way those policies affect the experiences of
16 their staff and those they engage with
17 professionally. And now, I'll turn it over to
18 Denise Pecha from CityMatch to discuss our second
19 commitment. Denise.
20 DENISE PECHA: Thanks, Scott. Next
21 slide. Okay. Our second joint commitment focuses
22 on external work and includes the following

1 commitments. To examine local, state, and federal
2 policies for impact on equity and advocate against
3 those that perpetuate inequity and racial
4 disadvantage. Promote life course theory.
5 Partner with impacted communities and
6 organizations. Ensure contractural awards,
7 processes, and decision-making practices are
8 inclusive, accessible, transparent, and support
9 equitable access to resources. Work with social
10 movement towards creating alliances and
11 integration with MCH and other social systems and
12 encourage our members to understand the racial
13 histories of our nation, their states, counties,
14 and cities, and the impact on racial inequities
15 and health outcomes.
16 At CityMatch, in addition to our
17 internal racial equity work, we are currently
18 establishing goals to measure our progress on
19 these external commitments. We also have
20 resources available for folks working in some of
21 these areas. One of the practices that CityMatch
22 is doing includes honoring indigenous presence and

1 land rights by offering land acknowledgements. I
2 am in Omaha, Nebraska, the ancestor home of the
3 Omaha and Sioux people. SACIM and our partners
4 MCH organizations are encouraged to engage in any
5 of these practices. Thank you. Now, I'll turn it
6 over to Debra Frazier from National Healthy Start
7 Association for commitment 3.
8 ARTHUR JAMES: Debra, you may begin.
9 DEBRA FRAZIER: Thank you. Thank
10 you, Denise. Our third commitment begins with the
11 acknowledgement that racism is a public health
12 crisis. This effort has been deliberate in
13 stating that this crisis requires remedy in both
14 action and communication plan that addresses the
15 contributions to racism. A big part of this
16 effort is honest communication and conversation
17 about our use of language. Language that demeans
18 and disparages populations and communities and
19 ultimately perpetuates racism. We also encourage
20 examination in honest communication about our
21 policies as well as our own bias and privilege
22 that contributes to racism. And while undoing

1 racism may be not comfortable conversation,
2 creating safe places for these critical and
3 necessary communications demonstrates respect for
4 each other and for the communities and people who
5 serve. And our hope is that these candid
6 dialogues result in the ultimate and the long
7 overdue goal mentioned by Dr. James to eliminate
8 race-based disparities in this country.
9 At National Healthy Start
10 Association, we've learned to grow and to learn
11 from the diversity of our Healthy Start
12 communities that represent BIPOC communities in a
13 range of geographic areas in urban, rural, tribal,
14 and Appalachian communities. Their voices guide
15 and drive our work and serve as a community
16 barometer for the impact of racism and disparities
17 that range from birth outcomes to the disparate
18 impact of COVID and social determinants and the
19 impact on our fathers and the health of men.
20 Our internal and external
21 communications reflect our relationship and
22 commitment to these communities and we know that

1 words are important and that people and
2 communities are not defined by health outcomes.
3 These are rich diverse communities and in keeping
4 with this communications commitment, we encourage
5 population and community descriptions and language
6 that is respectful, culturally appropriate, and
7 includes the examination of systems of care that
8 are lacking, underserved, or have failed these
9 communities.
10 We are all in this effort to end
11 racism and disparities and this group would like
12 to leverage our efforts with those of SACIM to
13 encourage ourselves and others to use respectful
14 communication internally and externally and to
15 begin honest communication regarding racism. And
16 Caroline from AMCHP will provide our final remarks
17 from this group.
18 CAROLINE STAMPFEL: Thank you,
19 Deborah. The four organizations will be meeting
20 regularly, and one of our first goals is to
21 identify measures of accountability that we can
22 track and the goal is to track quarterly. Each

1 organization already has some accomplishments to
2 share, and you've heard some of them. For
3 example, at AMCHP, we've initiated staff training
4 around racism as the root cause of inequity and
5 declared racism as a public health crisis. We
6 plan to share best practices around the actions
7 we've already taken and obstacles that we've
8 overcome. The strength of doing this work
9 together comes from honestly sharing our
10 challenges and assisting each other with
11 solutions. We're committed to moving forward
12 together, even when it means stumbling together.
13 We believe SACIM and other MCH
14 organizations will be interested in the measures
15 that we identify, and for those of us with
16 memberships, sharing our progress on those
17 measures with our constituents is part of that
18 accountability. We also realize some
19 organizations may be interested in joining the
20 commitment, and we're open to having people join
21 and be all in, and we're open to additional asks
22 from this committee, and we thank you all for your

1 time.
2 JANELLE PALACIOS: Thank you. Thank
3 you very much for that. I really appreciate the
4 catch phrase all in because that's what it's going
5 to take, and I love that education about our
6 history -- our nation's history is a part of that
7 because back when Ed first shared his thoughts on
8 what would be the handwashing of, you know, the
9 previous century that would help improve health so
10 much, and I believe the handwashing of today is
11 actually educating our nation and this truth about
12 our nation's history as a place to start. Thank
13 you for that.
14 All right. The next panel speaker I
15 am happy to introduce is Dr. Aletha Maybank, Chief
16 Health Equity Officer and Senior Vice President of
17 the American Medical Association and leading much
18 of the work done on racism and its effects on
19 health. Please, I am so happy to welcome you,
20 Dr. Maybank.
21 ALETHA MAYBANK: Thank you. Really a
22 pleasure to be here and a pleasure to be in

1 community with many of you and seeing some
2 familiar old faces or older -- people I knew in
3 the past, I should say. Just really appreciate
4 being in community with National Healthy Start as
5 well. I was very much engaged in that work when I
6 was Deputy Commission in the New York State
7 Department of Health and really overseeing
8 Brooklyn and the work we did there.
9 So, I am going to share just a few
10 slides as well. So, hopefully I'm able to -- I
11 have permission to share my screen, if that's at
12 all possible. Okay, here we go. Okay.
13 So, I have now been at the American
14 Medical Association for about two years. For
15 those who don't know the AMA, it's a physician
16 organization. It's been around since 1847
17 representing physicians predominantly; however,
18 it's known to have larger influence as it relates
19 to the health care system. Our mission is
20 inclusive of public health as well, and I've been
21 working my best to leverage that opportunity and
22 reality around public health.

1 And so, my task coming on board two
2 years ago as being their Inaugural Chief Health
3 Equity Officer was to really figure out how to
4 facilitate a process to embed equity throughout
5 the entire organization. There was a management
6 team of 1,100 folks, there are the members,
7 270,000 physicians, and then there's the medical
8 community at large, again understanding there are
9 intersections with public health. And so, you
10 know, I spent two years of learning the culture.
11 I've been in governmental public health most of my
12 career and kind of learning the culture of
13 medicine and health care, where the gaps are, and
14 where the opportunities are within the space of
15 medicine, but then more specifically within AMA.
16 COVID came around and, as we all
17 know, exposed the inequities that have been
18 existing in our country since the beginning of
19 time here, and also then the public murder of
20 George Floyd propelled our national reckoning or
21 conversation around racism and naming racism.
22 And so, AMA was not immune from that

1 and definitely for many of us who have been
2 leading this work for a while and people even
3 before my time, it was an opportunity and an
4 opportunity that definitely needed to be seized
5 and especially from my perspective, the health
6 care community.
7 And so, during the summer, our board
8 of trustees did leverage that and put forward a
9 statement to name racism as a public health
10 threat, and that AMA would do whatever we could do
11 to actively dismantle these policies and practices
12 -- discriminatory policies and practices across
13 health care.
14 To formalize it though, our House of
15 Delegates did pass policy and formal policy in the
16 fall off this past year to formally name racism as
17 a public health threat to also rid our health care
18 system of racial essentialism, which I think is
19 actually the more forward-leaning part of the
20 policies. It moved beyond just the declaration of
21 racism as a public health threat, but it actually
22 started to speak more toward action, and then

1 supporting the elimination of race as a proxy for
2 ancestry, genetics, and biology in med ed,
3 research, and clinical practice, and this is going
4 to have tremendous impacts across our space of
5 health care.
6 So, these policies provided this open
7 door really for myself, my team, and many others
8 across the AMA to be much more bold and much more
9 direct and forthcoming, and I feel like where we
10 needed to be as AMA in the medical community to
11 this work of undoing racism and anti-racism work.
12 But we had to really push ourselves, you know, to
13 make sure, as it was already mentioned, how are we
14 going to move beyond the declaration and really do
15 the action of it.
16 So, we released our strategic plan
17 about a month ago -- almost two months ago now --
18 and it definitely generated a lot of attention,
19 and I'll come to that in one second. But this was
20 the plan, it's a long plan, intentionally long, 80
21 pages long. But I thought it was really important
22 that we took the time to educate and bring folks

1 along because it was clear, especially in the
2 health care community, that not everybody really
3 understood these terms, valued these terms, just
4 really didn't get it and really weren't fully
5 embracing it. And so, I didn't want to put a
6 document forward in which we named strategies and
7 folks are just really completely clueless to where
8 these strategies are coming from. And so, a good
9 part of the document actually has a primer to help
10 support education and doing some level of a shared
11 analysis so that when people got to the
12 strategies, we would have some level of
13 communication that was hopefully -- hopefully
14 aligned, but we know that there are challenges to
15 that fully being accomplished.
16 But overall, you see the statement
17 here in terms of our vision, and you know, we are
18 very explicit in using terms beyond just even
19 dismantling racism but talking about white
20 supremacy and dismantling white supremacy as a
21 system and also the under -- the undermining of
22 that system and how it impacts and undermines

1 health equity.
2 We have theories of change that we
3 wanted to put forward. We think in order to make
4 sure that we were kind of all aligned with the
5 same values and strategies and that does speak to
6 the left that this is to really talk about
7 righting the injustices of our past. Somebody
8 mentioned already about the narratives and the
9 importance of narratives and deconstructing
10 narratives that are malignant and pervasive,
11 centering the voices and ideas and experiences in
12 people of those who have been most marginalized in
13 any space, making sure that we lead with race and
14 racism, but have an intersectional approach as
15 well. Embracing public health frameworks of
16 health and acting upstream. That's really
17 important from the medical context. You all are
18 kind of in the public health space. And then
19 implementing the inside-outside strategy for
20 organizational transformation, which was brought
21 up in the previous presentation as well.
22 So, what is really, I think, powerful

1 what I'm seeing now is a lot of alignment. You
2 know, I've been doing the inside-outside work for
3 the past fourteen years or fifteen years now, and
4 usually it was focused on doing external work, how
5 folks were engaging with community. But what's
6 really powerful is that now I'm seeing this really
7 intentional effort to focus on embedding internal
8 to the organization and I wouldn't add anything
9 different to some of the slides that were just
10 shown. But we have to also be explicit about how
11 we're building alliances. We want to be explicit
12 about innovation, pushing upstream, and then
13 lastly, I think two points lastly.
14 The one part that I do think is
15 really missing from the internal conversation
16 often is the need to build in trauma-informed
17 supports and systems, even for your staff and
18 teams as you move through this work. It
19 naturally, you know, there is already trauma
20 that's existing. There is the opportunity to
21 retraumatize folks, the opportunity for conflict,
22 and it's creating spaces, absolutely, but how do

1 we -- how does that become a system and supported
2 in the culture of doing this transformational work
3 at the organizational level is really important.
4 And then lastly, I'll say, I don't
5 believe any institution can really move forward
6 with anti-racism work unless they look at their
7 own past and many folks are very well aware of
8 AMA's history. The document that we did release
9 has several pages of some of the harms that we
10 have caused as the American Medical Association.
11 And so, we need to really be explicit and
12 intentional about fostering pathways for truth,
13 racial healing, and reconciliation for our past,
14 and there are many ways that we need to go about
15 doing that, quantifying and qualifying those harms
16 and figuring out what we're going to do to repair
17 them. And I think that's in line with
18 conversations at the federal level. It's work
19 that other countries have started to do. But I
20 think it's time in medicine and we kind of start
21 from that point of really leading this work of
22 equity.

1 And I just always end with this slide
2 because often times in doing this work, you know,
3 I hear so much hyper-intellectualization of harm
4 and just really reframing and reminding people
5 that this is about people and bodies and hearts
6 and spirits and always just keeping the focus on
7 that because I think sometimes in these
8 conversations, we get caught up in the academic
9 aspects of this work. Not -- and I use we in the
10 -- in the very loose term, and I don't mean to do
11 that. But many folks who are in positions of
12 leadership and many physicians tend to do that.
13 So, that is it. Thank you.
14 JANELLE PALACIOS: Thank you, Dr.
15 Maybank for that. I was really happy to see that
16 trauma-informed care as part of the healing
17 process because it is. As a clinician, I see this
18 as part of my everyday work where I'm working with
19 people who have been traumatized and how to engage
20 caringly or dare I say lovingly to another human,
21 and that is the work we're doing. We're doing
22 human work, right? To see each other as humans.

1 And often the most difficult work is looking in
2 the mirror and seeing what you and your history
3 have done. So, it's our nation facing its history
4 and looking at the mirror -- a very hard step, but
5 work that is much needed.
6 The next person I would love to
7 invite to speak is our invited speaker. She is
8 the cochair of the Aspen Health Strategy Group and
9 it is my pleasure to introduce to you, now the
10 former governor of Kansas, who then went on to
11 become the 21st Secretary of the US Department of
12 Health and Human Services. Secretary Sebelius,
13 the Zoom floor is yours. Welcome.
14 KATHLEEN SEBELIUS: Thank you very
15 much and I'm delighted to join the advisory group
16 in this important discussion. And I wanted to
17 just, first of all, recognize that many of you are
18 regular providers and experts in this area and I
19 appreciate the opportunity to share with you some
20 of our discussions. But to make it very clear,
21 the Aspen Health Strategy Group is, as the slide
22 indicates, a group of about twenty-two people who

1 come together representing payors, providers,
2 advocates, policy makers, and what we do is choose
3 and tackle a single issue, focus on that issue for
4 deliberations, and then try to come up with what
5 we identify as sort of five big ideas. And we do
6 not represent organizations, we do not have the
7 kind of, you know, deliberation and discussion
8 that has been discussed already, which is so
9 critical, unpacking racism and reexamining
10 organizational efforts. But I think what led to
11 this invitation was our focus for 2020, which was
12 on maternal mortality and the health crisis of
13 maternal mortality, which directly involves what
14 we feel is a deep strain of racism, that has run
15 through this medical practice and continues to
16 present as a huge health crisis that unfortunately
17 is too long in being called out in America. I
18 must share my own chagrin that in my term as
19 Secretary, while we focused on a lot of issues and
20 equity issues and disparity issues, this was one
21 that did not have the drum beat it should, and if
22 Black Lives Matter, if we really believe that we

1 need to tackle systemic racism, it starts by
2 having particularly Black mothers and their babies
3 live in the United States of America and Native
4 American mothers are second in line for mortality
5 rates that are really shocking in the United
6 States of America. We're the only country that
7 since 1987, our mortality rates have increased and
8 for every death, we see about 100 incidents of
9 severe morbidity. So, the deaths are just the tip
10 of the iceberg in what should be a very natural
11 process.
12 So, I'm just going to -- if we could
13 go to the next slide -- focus on a couple of the
14 areas that we talked about because I think while
15 many of you have an opportunity and are doing a
16 deep dive into kind of organizational looks and
17 effort at confronting racist practices and racist
18 history, I think this is an example of the kind of
19 specific issue, which can be impacted by not only
20 a recognition of what has brought us to this
21 point, but a real call to use all the tools in the
22 tool box. The federal government can play a huge

1 role. The legislative branches can play a huge
2 role. States can, insurers, providers, and this
3 is really an all hands on deck effort. So, you
4 know, the first issue really is just a national
5 commitment at all levels of government and the
6 private sector. It has to be a public-private
7 partnership that really calls out maternal
8 mortality as the -- the health crisis, but really
9 the racial disparities in maternal mortality where
10 a Black woman is less safe giving birth in Texas
11 than she is in many developing countries, and we
12 have a situation where Black mothers are four
13 times as likely to die as non-Hispanic white
14 women. And that's just a totally unacceptable
15 situation to be in. So, it's everything from
16 revisiting the 2030 goals for healthy America
17 where there's a modest increase, as suggested, for
18 the next nine years. Not nearly sufficient enough
19 to take on this idea, and not nearly ambitious
20 enough. I think the notion that we use CMMI, the
21 research and development arm of CMS, and
22 particularly in the Medicaid area to look at what

1 has worked. California has some models, which are
2 marginally successful. Almost no other state has
3 done that kind of work. But drive really some
4 improvements in this area and begin to really
5 collect data and measure it and call it out.
6 I think one of the big missing pieces
7 is that we have not announced this loudly enough.
8 And when I share data with people outside of this
9 discussion about what happens to pregnant women in
10 this country and what happens particularly if
11 you're Black or brown and pregnant in this
12 country, folks are shocked. But it is not a well-
13 known fact and it is something that I think
14 deserves a real highlight and focus as we look at
15 broadly structural racism, this is an example,
16 unfortunately, of that in practice.
17 The issue about supporting and
18 building community care models really is about
19 recognizing what has happened in this area of
20 giving birth in America and it -- it really is the
21 hospitalization of birth and driving frankly out
22 of business what were a very successful group of

1 Black midwives who operated and practiced across
2 the south and when the shift occurred to urge
3 women -- to encourage women, and to change the
4 payment system so women went to hospitals, that
5 began to change, and it is now recognized that for
6 lots and lots of people, giving birth is a very
7 low-risk endeavor and should be in a community and
8 culturally appropriate setting and should be with
9 providers who the patients, and in this case the
10 birthing mother, chooses to be attended. But that
11 includes not only lifting up those models and
12 making sure that they are paid for and encouraged
13 but also looking at what CMS will pay for, what
14 Medicaid pays for in terms of midwifery, how we're
15 training people, what the issues are. I'm
16 impressed that this group as an advisory group to
17 the Secretary and I can tell you, as a Secretary,
18 I took these recommendations very seriously from
19 advisory groups, so I would not shy away from
20 making very specific recommendations to the
21 Secretary around issues that you take on.
22 Insurance -- and in one of my former

1 lives, I was an insurance commissioner for a
2 number of years -- insurance is really not
3 designed around women. Health plans for a lot of
4 years included Viagra and not contraception. But
5 one of the things, if you look at where a woman
6 becomes Medical eligible -- mandatorily eligible -
7 - it's when she is pregnant and often, that really
8 doesn't put her necessarily in the best of health
9 before she becomes pregnant. That's a big issue.
10 Long-term contraception is really important in
11 lots of situation for women who want to space
12 their children, who are not healthy enough to be
13 pregnant, but often they don't qualify for
14 insurance until they're pregnant. So, having a
15 discussion with Medicaid about that and also
16 looking at the mandatory extension of Medicaid for
17 the first year of a baby's life. So, the women in
18 too many cases, even if she has access to
19 insurance and health coverage for a limited period
20 of time while she's pregnant and for sixty days
21 after she delivers a baby, that insurance
22 disappears and is cut off in way too many states.

1 So, redesigning insurance around whole-woman
2 needs, healthy in the first place, making sure
3 that she's taken care of.
4 I think that the racism
5 recommendations, which are many, deal with
6 everything from provider respect and retraining to
7 listen to their patients, to listen to women. We
8 have some great examples like Serena Williams, one
9 of the most famous African American women in our
10 country, who had a terrible time having her
11 doctors pay any attention to her when she brought
12 up issues around her pregnancy, and she nearly
13 died giving birth to her daughter. And if she had
14 a hard time getting attention, imagine the number
15 of people who are just dismissed from the outset.
16 That's unfortunately a pretty regular part of
17 women's care where over and over again in
18 specialty areas, women are listened to less than
19 men. Women's needs are paid attention to less
20 than men. But it is amplified, I think, for women
21 of color where they are dealing in a system where
22 their needs and their issues are just not

1 respected.
2 We must do a better job in recruiting
3 a diversity of providers and, again, not just in
4 doctors and OB/GYNs, but looking at midwifery and
5 doulas and health care workers who really can
6 support this process and are paid for equitably
7 and adequately, are licensed equitably and
8 adequately, are respected and encouraged to become
9 part of the solution to what is a health crisis.
10 And then finally, I think really
11 focusing on the research, data, and analysis.
12 Again, the federal government is in a unique
13 situation to really count who is dying, who is
14 suffering when they try to give birth. We do not
15 have a systemic way of counting. We don't have a
16 way of analyzing it. CDC research is desperately
17 needed to set standards and set definitions. But
18 this is an example of an area which has a huge
19 impact on not just the women and their families
20 who end up in a situation of death or near death
21 that could have lifetime impacts, it affects our
22 community, it affects our country, and it is

1 something that I think really deserves the bright
2 spotlight, not just that the advisory committee
3 has given, but along the way.
4 The Aspen Report relied on papers of
5 experts, which are really excellent. The entire
6 report is available online and has some very
7 specific recommendations. But I just want to
8 thank you for the opportunity to at least
9 highlight in one issue area that is really
10 available for action and really available to make
11 a huge difference, the kind of ideas that were
12 generated at our discussions last year. So, thank
13 you for including me.
14 JANELLE PALACIOS: Thank you. Thank
15 you, Secretary Sebelius for sharing your five --
16 the five big ideas from the Aspen Institute. Two
17 issues stuck with me the most, recognizing that
18 communities know what is needed, and so partnering
19 with communities and asking them what they need
20 and giving them power to shape the tools needed to
21 promote health has been elevated again through
22 your report. And additionally, recognition that

1 women's health directly affects our nation is
2 reflective of our cultural view and practices
3 through our policies and programs. Women are only
4 valued when they are pregnant -- that's the
5 message I heard -- not before or after. And as an
6 example, sanitary napkins, a needed aspect of
7 women and girls' health is still taxed as a luxury
8 item in most states, while condoms and Viagra are
9 not.
10 The medical model, a model that
11 privileges white men is used as the model of care
12 for women, but this model has not met the needs of
13 pregnant women. So, other models are needed.
14 That is the next message I heard.
15 So, I see that with the allotted time
16 for this session that we have, with Ed's blessing,
17 I would request that we carve out an additional
18 fifteen minutes for question and answer.
19 EDWARD EHLINGER: Go ahead.
20 JANELLE PALACIOS: Thank you. The
21 first, you know, in general, what we're looking
22 for are the one to two recommendations each of you

1 -- from each of you representing the organizations
2 that you do that SACIM can take and move forward,
3 and then I will open up to any other questions
4 that others may have.
5 Maternal child health. Would anyone
6 like to speak about one to two recommendations
7 that we, as SACIM, can take to the Secretary?
8 ARTHUR JAMES: I'll turn it over to
9 Caroline, who summed up our recommendations and
10 see if she can offer those for us, if you don't
11 mind, Caroline.
12 CAROLINE STAMPFEL: Sure, absolutely.
13 And Janelle, you started to touch on some of them
14 and those come from some very concrete things that
15 we've committed to across the internal, external
16 communication area. So, recommending that federal
17 agencies are partnering with impacted communities
18 and organizations with a very powerful
19 recommendation to listen to the people who are
20 most impacted and to do that in a way that is
21 giving power to their words and their needs, not
22 just sharing, but giving. And to encourage

1 through different opportunities and engagement,
2 encouraging partner agencies and grantees to
3 really truly pursue anti-racist commitments and
4 actions and through our commitments that we've
5 made to each other, we've really emphasized not
6 just a statement or a declaration, but a
7 commitment that comes with measurement and
8 accountability. And so, we feel that those are
9 extraordinarily important as we make
10 recommendations.
11 I think in the internal processing,
12 there is always work to do to say how is it true
13 about me or how is it true about my organization,
14 so really meaningfully examining internal
15 processes and policies and how those policies
16 affect the experiences of the people who are doing
17 the work. We recognize and so appreciated the AMA
18 approach to the trauma-informed process not just
19 for the people you are working with and serving,
20 but the people who are doing the work as well.
21 And I think the last thing I'll say
22 is that we just know that we are out here doing

1 this, making this commitment together, and role-
2 modeling, and that is something that the advisory
3 committee most certainly could recommend that
4 there are steps to be taken that will serve as a
5 model for other agencies.
6 JANELLE PALACIOS: Thank you. Thank
7 you for that. I see that, Secretary Sebelius,
8 that you need to leave very soon. But is there
9 anything that you can share with us that will help
10 advance our work?
11 KATHLEEN SEBELIUS: Well, I would
12 just urge the committee to be as specific as
13 possible and call out. I think it's important to,
14 you know, acknowledge that work will go on in the
15 AMA and other organizations. But I think for the
16 Secretary to call out what the tools are within
17 HHS, what are the action items, that he and the
18 new team can take and make really are helpful
19 because I just -- there's a lot of incoming when
20 you're in that office and eleven operating
21 agencies and lots of things going on. So, as
22 really direct as the committee can be and as

1 specific, you know, HRSA should do these -- it
2 would be helpful to do these five things, you
3 know, we need midwives. I mean, whatever it is
4 that the committee comes to consensus on, I would
5 make them very, very specific and tie it to, you
6 know, what kind of difference it makes because
7 it's just the more practical and sort of the less
8 processed because that can, you know, be acted on
9 quickly.
10 And I would just finally say this is
11 a moment in time, you know, for this particular
12 issue. You have Lauren Underwood, member of
13 Congress now, a Black nurse, who was in HHS during
14 the Obama administration, who is a leading
15 champion of the Momnibus Bill in the House. You
16 have Kamala Harris, who was her co-sponsor on the
17 Senate side, who now happens to be the Vice
18 President of the United States. You have a
19 majority -- you have an administration, I think,
20 that is very eager to, you know, tackle some of
21 these issues. So, I would say this is a very
22 unique moment and it's kind of an all hands on

1 deck, so coming out with Congressional
2 recommendations, HHS recommendations, and things
3 at the state and local levels, and things that,
4 you know, the AMA can push through private
5 providers. I mean, all of that -- all of the
6 above would be just extraordinarily helpful and I
7 think you're in a moment that won't fall on deaf
8 ears.
9 EDWARD EHLINGER: I'm going to jump
10 in as the Chair. Secretary Sebelius, I noticed --
11 I was struck with the fact that all HHS
12 Secretaries were involved in this process.
13 KATHLEEN SEBELIUS: That's right.
14 EDWARD EHLINGER: They were all part
15 of the advisory committee.
16 KATHLEEN SEBELIUS: That's right.
17 EDWARD EHLINGER: And you raise the
18 issue that we need to raise the visibility of
19 maternal mortality as an issue and the fact that
20 all of the previous HHS Secretaries were involved
21 in this, does -- does that give us some leverage
22 to say let's do the narrative change that makes

1 maternal health a priority. Also, AMA is doing
2 the same thing as the leading medical care
3 organization. How do we leverage this kind of
4 power at this point in time to change that
5 narrative and make this the center point of what
6 we do as a country?
7 KATHLEEN SEBELIUS: Well, I think you
8 ask the Secretary to either have the Surgeon
9 General or the Secretary himself call it out as a
10 public health crisis and use the bully pulpit of
11 that office to say this is unacceptable, it's been
12 going on, you know, our rates have gone up since
13 1987, enough is enough and, you know, there's a
14 sort of structural racism at the heart of this,
15 and if we're looking at health disparities and
16 health equity, this is it. I mean, we're going to
17 call this out as a crisis that we have the tools
18 to solve, we have the knowledge how to solve it,
19 and we just need to have the will.
20 And to remind you, and you all may
21 know this, but Secretary Becerra's wife is a high-
22 risk OB/GYN. She works on these issues on a

1 regular basis. She knows a lot about high-risk
2 moms and deaths and so, he is well-suited to be a
3 in a position to act on this issue, and I think he
4 listens to his wife. So, you know, what the hell.
5 As every wise man should. Thank you all for
6 having me and let me know if I can help.
7 MAGDA PECK: Absolutely. Thank you.
8 KATHLEEN SEBELIUS: Okay. Bye bye.
9 JANELLE PALACIOS: Thank you very
10 much. We have just a few moments left. I would
11 like to ask Dr. Maybank, is there anything
12 additional that you would recommend that we can
13 take to the Secretary with regards to our aims?
14 ALETHA MAYBANK: Additional to what
15 has been said? Not much -- Ed actually just took
16 exactly my -- the key point that I wanted to get
17 across. But I just think about the sustainability
18 of this beyond political administrations, and most
19 of us have worked in government, and that's our
20 challenge. And I think sustainability really ties
21 closely to accountability and metrics, but it also
22 ties closely to having enough resources and actual

1 dollars and funding and money to do the work of
2 the anti-racism work -- I'm just doing to say that
3 explicitly -- that's connected to maternal
4 mortality work. There are too many assumptions.
5 I still see it to this day of what it takes, and
6 it takes a lot. I have to really be thankful,
7 honestly, to the AMA that has given the resources
8 and all of AMA is in terms of their history,
9 that's one thing that I can -- I can say that I
10 have gotten the resources to do this work and the
11 support and leadership to do this work that allows
12 for an opportunity to think about sustainability
13 and then to that point of what Ed was bringing
14 together, I think so many folks, and I learned
15 this more through the release of the plan, are in
16 this space of trying to figure out what to do, as
17 you all are. And there is an opportunity to
18 create power in a way that we haven't had before,
19 and it would be great for us to fully leverage
20 that. So, when I think about HHS and their
21 ability to be connected to all those agencies, not
22 only within HHS, but outside of HHS, how are they

1 all coming together to help support kind of a
2 long-term outcome of improved maternal mortality
3 and closing of the gap of maternal mortality.
4 Things we've heard before, but this is the time, I
5 think, to fully really consider operationalizing
6 it. Somebody mentioned it in this like health in
7 all policies kind of approach. You know, this is
8 the time to do it. I think the door is open. We
9 haven't had enough will in this country to do
10 that, and so, I just think if we don't capitalize
11 on it, I think we really lose the opportunity for
12 sustainability and power of this work.
13 JANELLE PALACIOS: Thank you, Dr.
14 Maybank. And it goes back to identifying the
15 problem, having the will, acting on it, and then
16 sustaining it definitely, and that is a huge issue
17 and just knowing that times can change every few
18 years. Yeah.
19 I know that, Ed, that we are at our
20 time right now at this moment. But is it possible
21 just to ask if anyone has a burning question?
22 EDWARD EHLINGER: Yeah. Let's take a

1 couple of questions. We can -- we can go a little
2 bit longer.
3 JANELLE PALACIOS: Thank you. Are
4 there any questions from the committee?
5 EDWARD EHLINGER: Magda has her hand
6 up.
7 JANELLE PALACIOS: Magda, please.
8 MAGDA PECK: Profound gratitude to my
9 colleagues for movement forward with tenacity and
10 absolutely unwillingness to compromise on what is
11 core. So, gratitude, number one, with commitment
12 to action so words go to deed.
13 Speaking of words, Ed, you speak out
14 and had a conversation just now about the
15 importance of narrative. Dr. Maybank, you spoke
16 about the essential nature and challenge of
17 changing the narrative. So, two narrative-related
18 questions.
19 One is the language of public health
20 threat, emergency, crisis, and I was curious if
21 you have recommendations for what the leading
22 language and most strategic and thoughtful

1 language can be about urgency, because they all
2 speak to urgency. Without urgency, there is no
3 change.
4 And the second is the leading edge of
5 now maternal mortality, and this is the
6 Secretary's Advisory Committee on Infant Mortality
7 in name with an expanded charter. How do we
8 assure the alignment in the message of maternal
9 mortality and severe morbidity and infant
10 mortality and severe morbidity in the context of
11 being an anti-racist organization? How do we
12 harmonize that part as well?
13 So, urgency language and population
14 language -- what do you advise so that we are
15 being crisp, clear, and compelling?
16 ALETHA MAYBANK: I can answer the
17 first part and then if the other group wants to
18 answer the second part. So, in terms of, you
19 know, and Magda it's good to be in the same space
20 with you. I haven't seen you in a while. So,
21 good to see you.
22 MAGDA PECK: Great to see you. Thank

1 you, Aletha.
2 ALETHA MAYBANK: Yeah. So, you know,
3 I -- you know, we use threat and I think from the
4 context of urgency, I think threat is true, I
5 think crisis is true, and it's immediate as well,
6 and it creates a sense of urgency. What I shift
7 to though, and this is my -- my challenge
8 honestly, and all of our challenge, is that once
9 we start naming things as a threat, and I think
10 it's important for the urgency. But then we start
11 to lose track of what's the vision of where we're
12 trying to go and -- and what are we -- what are we
13 working towards redesigning, what are we working
14 towards deconstructing, decolonizing, redesigning,
15 reimagining even before redesigning? Like, we
16 have to get to those parts as well, I think, as
17 soon as we start to name something as a threat
18 because when you name something as a threat, the
19 urgency happens, the funding happens, people come
20 together, then what?
21 MAGDA PECK: It's not sustainable.
22 ALETHA MAYBANK: Exactly. And so, I

1 think we have to be a little bit more prepared for
2 when that opportunity does come and the Surgeon
3 General does announce, you know, maternal
4 mortality as a public health threat or crisis, and
5 you all are prepared in so many ways, you know,
6 because you've been doing this work. But let's
7 get that vision, I think, together faster and have
8 it ready as well, I think, is really important.
9 MAGDA PECK: Thank you. Um-hum,
10 Jonathan?
11 JONATHAN WEBB: Dr. Peck, good to be
12 with you again as well.
13 MAGDA PECK: A pleasure, Jonathan.
14 JONATHAN WEBB: I was just going to
15 build onto Dr. Maybank's comments and I'll turn it
16 over to the rest of our group to see if they have
17 anything to add. But I agree with everything that
18 was offered. I've used threat as well as crisis.
19 I have trended more towards using crisis because
20 threat, to me, gives the implication that
21 something is on its way versus being in the moment
22 now, we're in a crisis and we have been in a

1 crisis for a while. So, the thinking that we need
2 to actually focus on is where we are. It's not
3 something that's coming, it's here that we're
4 dealing with, and using that as an impetus for
5 some urgency to apply our operationalizing of
6 efforts to make this more sustainable.
7 SCOTT BERNS: Yeah, and Magda, I'll
8 just -- I'll jump in on the second question.
9 MAGDA PECK: Hi, Scott.
10 SCOTT BERNS: Hi. Just as
11 challenging if not more challenging, and I'll just
12 give a relatively straightforward answer, which is
13 that I think that -- that the emphasis should
14 really be on the dyad, right? When you think
15 about, you know, maternal health, maternal
16 morbidity and mortality is like wow, look at how
17 poorly the US is doing and that's a bit of a shock
18 and a revelation, but there are still lots and
19 lots of babies -- too many babies dying, and there
20 are disparities in both, right? The disparities
21 in maternal mortality line up with infant
22 mortality pretty much.

1 And so, I think that part of what the
2 advisory committee could do is to bring that
3 dyadic approach that both are important, you know,
4 show the data, and then present what the actual
5 items could be. I mean, we've spent a few years
6 putting the M back in MCH and we're really quite
7 there now, importantly so, but the maternal-infant
8 dyad, I think, is the key to, for me, to that
9 answer.
10 EDWARD EHLINGER: Let's let Jeanne
11 Conry have the last question, and then we have to
12 move on.
13 JEANNE CONRY: Well, thank you so
14 much, and I want to thank this esteemed panel for
15 just the incredible breadth and depth of the
16 discussions. I think you really helped all of us
17 with a vision. And I've got one statement and one
18 question because I -- the last comments about
19 facing this as -- looking at this as a national
20 emergency with the Surgeon General and the
21 Secretary, to me, hits home. I would like to
22 point out that September 17th is World Patient

1 Safety Day and we -- the theme of World Patient
2 Safety Day this year is Safe Maternal and Newborn
3 Care. The slogan is Act Now for Safe and
4 Respectful Childbirth. So, if ever we were going
5 to look at this as an emergency and say what can
6 the United States do, I would suggest that.
7 Sorry, that just came to mind as you were
8 discussing and I saw this.
9 My question is really about looking
10 how compelling the Affordable Care Act is and how
11 much it can do. But the restrictions we have and
12 the limitations that have come about without full
13 adoption and not being able to do what we would
14 like in all states. Where do we go? How do we
15 bring about changes? What's the direction for us
16 with improving access to care, improving just the
17 ability to be able to be seen and care for with
18 universal health coverage and universal rights?
19 Anybody? Well.
20 SCOTT BERNS: Great question, Jeanne.
21 I mean --
22 JEANNE CONRY: Hi, Scott.

1 SCOTT BERNS: I wish we had the
2 answer. I think, you know, that we'd be doing it.
3 I think, you know, Michael Warren, mentioned in
4 the chat, you know, looking upstream and, you
5 know, access to care is absolutely vital and all
6 the bits and pieces that the Secretary mentioned
7 earlier and, you know, expanding coverage to
8 pregnant women, that's all important. You know,
9 access to care is part of the equation. It's an
10 important part but looking at those upstream
11 issues and you all discussed them, including
12 racism, is really critical. So, I'll put that out
13 there. I wish I had the --
14 JEANNE CONRY: Thank you.
15 SCOTT BERNS: -- magical answer for
16 you today. But thanks.
17 JEANNE CONRY: Yeah, thank you.
18 Thank you for everybody's comments.
19 EDWARD EHLINGER: Janelle, do you
20 have any closing thoughts before we move on?
21 JANELLE PALACIOS: Yes, thank you.
22 It has been such a pleasure to be able to moderate

1 this session and to be able to learn from experts
2 in the field and knowing that I'm in and that
3 we're all in, and how can we change the language
4 and move our nation to be all in? Like that is --
5 that is the greatest -- that is the greatest, I
6 think, journey that I'm looking forward to for the
7 rest of my life.
8 So, and to Jeanne's comment about
9 having universal health care and access and Scott
10 Berns, your, you know, understanding yes, that
11 acknowledgement that access to care is important
12 but understanding also that that access to care is
13 important but that it doesn't mean equity. We're
14 not going to achieve better outcomes just because
15 of access, right? And that -- and I firmly
16 believe that it goes back to reconciling -- this
17 truth in reconciliation as a nation. And so, it's
18 moving beyond the borders of MCH. It's moving
19 beyond the borders of just maternal-infant, and
20 can you believe we had to fight for maternal? I
21 cannot believe we had to fight for the word
22 maternal to be a part of this discussion and it's

1 still sometimes a battle today. But recognizing
2 that it is a -- it's a population, it's a human
3 thing, it is a community thing, and we have to see
4 each other as human beings for us to move forward.
5 So, we can do what we can with our
6 children and their children's children, and so,
7 it's the steps that we're trying to take now that
8 we're trying to identify which best -- which steps
9 to take us now to move forward. Thank you so much
10 for this.
11 EDWARD EHLINGER: Thank you, Janelle,
12 for leading this session so well. You really did
13 a great session, and it left me with some -- some
14 real sense that now is the time to act. We have -
15 -
16 MAGDA PECK: Absolutely.
17 EDWARD EHLINGER: We have public or
18 leading medical care, physician-oriented medical
19 care on board ready to take this on. We've got
20 the maternal and child health leadership
21 organizations on board ready to take on. We have
22 all the HHS Secretaries on board saying this is a

1 crisis, not only racism as a crisis, but maternal
2 health. So, we have a time and we heard it from
3 Secretary Sebelius, be bold, now is the time. I
4 think -- and as I heard Jeanne say, you know,
5 September 17th or whatever, we draft -- draft a
6 recommendation that we can put in there that we
7 can get to the Secretary to sign onto that day. I
8 think we should move forward. Now is the time for
9 us to act. Now is the time to be bold. And AMA
10 has incredible marketing tools to help us leverage
11 that message. Just looking at your document,
12 Aletha, that is a well-crafted thing and need to
13 use those -- those kinds of techniques to change
14 that narrative, to get it out there. We should
15 have maternal mortality as the -- and infant
16 mortality -- as the centerpiece of all public
17 policy.
18 And as related to the second part of
19 Magda's question, I'm advocating with MCHB that we
20 actually change our name, add another M to SACIM -
21 - Secretary's Advisory Committee on Infant and
22 Maternal Mortality, which really reflects what we

1 do so that we have that.
2 So, thank you to the panelists, thank
3 you for all of the work that you've done, and
4 thank you for your suggestions to us on what we
5 can do. I got some good ideas. I think you were
6 really clear in saying this is what we can do and
7 we are pledged to push you as best we can to do
8 what you already want to do. And so, our job is
9 to, you know, it's the inside-outside game in a
10 couple of different ways. So, thank you very much
11 for -- for being with us today.
12 Let us now move on to the data piece,
13 and I've asked Magda to kind of take this on since
14 she is the chair of our working group on Data and
15 Research to Action and I know that Dr. Barfield
16 has some particular data elements that she wants
17 to discuss, and I know the -- we had some work
18 related to the -- I can't remember -- the Governor
19 Accountability Office related to data. And so,
20 we're going to work on this over the next half
21 hour. So, Magda, take it away.
22 **DATA AND SURVEILLANCE UPDATES AND ISSUES**

1 MAGDA PECK: Well, may I just
2 encourage thirty seconds for people just to take a
3 breath. This is -- this is a moment for self-
4 care, and without any bio break built in and
5 sitting, being an extraordinary contributor in
6 excess, whatever you need to do for thirty
7 seconds, just to stretch, and create the space to
8 shift from the macro, if you will, of addressing
9 racism as threat, crisis, emergency, with urgency
10 in this time with the dyad of women and children
11 together, mothers and their babies, and fathers
12 and families. So, this is my way to create a
13 little bit of space just to stretch and breathe
14 and for -- for all of us -- two more intros real
15 quick -- for all of us who are managing, as Tara
16 said yesterday, and Colleen, our lives and our
17 work. And as somebody who is an immediate, now
18 cancer-free thriver, as a woman, as of Thursday, I
19 just encourage us to do as much self-care as we
20 can. As we talk about them, we talk about us and
21 take care of our own well-being in ushering this
22 work forward.

1 And last, as a proud member of the
2 CityMatch board, ex-officio, as the founder of
3 CityMatch, and, as you heard, their [?] practice
4 that they put forth as an example of being all in,
5 I just want to say what an honor it is with
6 humility and respect to have woken this morning in
7 Richmond, California, which is the sacred Native
8 land of the Ohlone, Muwekma, and Chochenyo tribes,
9 who come as ancestors before us, and I would
10 encourage us as members of this organization to
11 adopt ways of honoring tribal ancestry and
12 sovereignty and respect to the land upon which we
13 stand.
14 And towards that end, one of the
15 ways, one of the languages of power is the
16 language of data. Data, which we in our
17 recommendation that we will all come to hopefully
18 have some consensus on before we close today.
19 Data of both qualitative and quantitative,
20 numerator and denominator, and data, which welcome
21 community and human voices to inform out decision-
22 making, lead to action, and accountability. And

1 Arthur James put in the chat just now, constantly
2 measuring the difference in disparity and the gap
3 will lead to our sustaining a sense of call to
4 conscience in a work in anti-racism and in undoing
5 racism and promoting equity.
6 Towards that end, this session
7 focused on data and surveillance around issues and
8 updates allows us to go from that macro to the
9 specifics around data systems as we hearing from
10 four colleagues who are in government and need our
11 assistance as SACIM to be able to -- to help them
12 do their best work, and they are here to advise us
13 on how to do our best work.
14 They will introduce themselves beyond
15 what is in the agenda. I don't need to read that.
16 But I want to thank my colleagues, Wanda Barfield,
17 Lee Warner, Ada, and Ada, just help me, Dieke, and
18 Lee Wilson, for helping us get to the heart of the
19 precision and purpose of data, which is to lead to
20 action.
21 Dr. Barfield, would you start us off,
22 and then we'll go straight through. If you would

1 then introduce Dr. Warner and then Dr. Dieke, and
2 then Dr. Wilson. I'm upgrading you all to Dr.,
3 honorific, if it was not there otherwise, to make
4 it an equal playing field. And then at the end,
5 we will have a bit of time for some comment and
6 question. So, Wanda, give us a start.
7 WANDA BARFIED: So, first of all, I
8 just want to thank the committee for providing the
9 time for us to talk with you today. As you all
10 know, there are many surveillance systems within
11 the Division of Reproductive Health, Maternal
12 Mortality, including Assistive Reproductive
13 Technology and other surveillance systems. But
14 the one unique system that we have that really is
15 an opportunity to listen to women and to really
16 understand the challenges as well as the
17 opportunities for them through pregnancy and the
18 postpartum period, is the Pregnancy Risk
19 Assessment Monitoring System or PRAMS. And given
20 all of the recent issues that are going on
21 including this rich discussion, we have a real
22 opportunity to do good surveillance in terms of

1 understanding the perceptions, the beliefs, the
2 risk factors that affect pregnant and postpartum
3 women in the United States.
4 So, in this vein, we have an
5 opportunity that we want to present to the
6 committee, and that's the Phase 9 revision, and
7 will have Dr. Lee Warner and Ada Dieke talk more
8 about that. Lee Warner is the Chief of the
9 Women's Health and Fertility Grant in our
10 division. He has extensive experience with
11 surveillance including PRAMS and Ada Dieke, who is
12 a project officer on the PRAMS team, former EIS
13 officer who has also done extensive work in terms
14 of understanding racial and ethnic disparities,
15 particularly in infertility and assisted
16 reproductive technology.
17 So, without further ado, I would like
18 to introduce them and have them really share with
19 you. We want to hear from you because we see this
20 as a unique opportunity to inform the survey.
21 Thank you.
22 MAGDA PECK: Thanks, Wanda.

1 LEE WARNER: Thank you, Wanda. Can
2 you -- everybody hear me?
3 MAGDA PECK: Absolutely.
4 LEE WARNER: Okay. So, like Wanda
5 said, we really appreciate the opportunity to
6 present in front of SACIM. I very much appreciate
7 the last discussion and the importance of data and
8 collecting data in surveillance related to racism
9 and discrimination. This is one of the things
10 that you'll hear from Ada when I turn it over to
11 her in a few minutes. One of the things that we
12 are exploring for consideration to include in our
13 Phase 9 Survey.
14 So, what I'm going to do is give a
15 quick overview of PRAMS, a couple public service
16 announcements about recent updates, and then I
17 will turn it over to Ada to bring it home. Next
18 slide, please.
19 For those who may not be as familiar,
20 PRAMS has been around for nearly thirty-five years
21 as an ongoing population-based surveillance system
22 that has reported every year. We collect self-

1 reported maternal behaviors and experiences around
2 the time of pregnancy. Our sampling is drawn from
3 the birth certificate. Therefore, we are linked
4 with birth certificate data to further enrich our
5 -- our data and we provide jurisdiction-specific
6 and near-nation estimates. The PRAMS website is
7 also on the slide. I encourage you to take a
8 look. Thank you, Wanda, for posting the chat.
9 Next slide.
10 So, two updates. The first one, we
11 just announced our new funding cycle -- five-year
12 funding cycle back in May and we are currently
13 funding fifty jurisdictions from 2021 through 2025
14 including forty-six states and four cities and
15 territories, including our newest addition, the
16 Northern Mariana Islands. We represent 81 percent
17 of live births, even for states that are not
18 currently in the PRAMS, we liaise with them to
19 increase the representation of PRAMS. Next slide,
20 please. Hello? Thank you, thank you. It was a
21 delay on my end.
22 I'm also please to announce that

1 PRAMS has been working very hard to make more
2 recent data available, especially in the recent
3 years. In April, we released our 2019 data that
4 is from 2019 births. It also includes new
5 indicators for prescription opioid use during
6 pregnancy and maternal disabilities. Those two
7 were in select jurisdictions. Again, that data is
8 available. You can hit on the link below. If you
9 have any questions about how to access the data,
10 feel free to reach out directly to me, and we will
11 get you that data.
12 And then for 2020 data, we're
13 expecting to release that later this year in the
14 fall and we will have an additional new indicator
15 that is looking at the COVID-19 experience that
16 caters around people during their -- around COVID.
17 And we've implemented that in, I believe, thirty-
18 four sites. Next slide, please.
19 Our current Phase 8 Questionnaire,
20 you can see we have established topics that we've
21 been collecting data on for a long time ranging
22 from pre-conception care to intimate partner

1 violence to breastfeeding and infant sleeping
2 environments. And so, our questionnaire has not
3 been -- we've not had a new questionnaire in this
4 field since 2016, which is why this moment is so
5 important, why we appreciate the committee
6 allowing us time to present, because we are now
7 looking for feedback. So, what we've been doing
8 is to collect data on emerging MCH topics, and you
9 see them on the slide chronologically. We've been
10 adding questionnaire supplements to our survey
11 ranging from E-cigarette to, as I mentioned,
12 prescription opioid use and maternal disability,
13 and most recently on COVID-19 experience in 2020.
14 With our 2021 survey, we will be adding a
15 supplement on COVID-19 vaccines as well as social
16 determinants of health. So, the time is -- timing
17 is very good. Next slide, please.
18 And now, I'd like to turn it over to
19 Ada Dieke, who will summarize what we've done so
20 far in our Phase 9 Questionnaire Revision and why
21 we are here today to seek input from the
22 committee. Again, thank you for your time, and

1 I'm going to turn it over to Ada.
2 ADA DIEKE: Okay. Thank you, Lee,
3 and thank you, Wanda, for the introduction and the
4 opportunity to share the activities of the Phase 9
5 Questionnaire Revision process. And good
6 afternoon, committee members.
7 UNIDENTIFIED FEMALE SPEAKER: Good
8 afternoon.
9 ADA DIEKE: Okay. So, for the
10 revision of the PRAMS Phase 9 Survey, we have
11 three main goals. Number one is to update the
12 survey content. We want to ensure that the topics
13 are still relevant for use in the current
14 environment and that the survey addresses emerging
15 priorities in MCH. The second goal is to make
16 sure that we engage with an array of internal and
17 external partners to capture priority topics. And
18 the third goal is to align with national
19 performance measures such as Healthy People 2030
20 and Title V performance measures that I'm sure all
21 of you are familiar with. Next slide.
22 So, I want to review with you the

1 timeline of activities for Phase 9. Earlier this
2 year, we did internal planning and consultations
3 within CDC and with other federal partners,
4 including HRSA, on how they have managed the
5 questionnaire revision process within their
6 surveys and surveillance systems. We completed
7 the solicitation of Phase 9 topics where we saw
8 input from 300-plus partners on priority and
9 emerging areas relevant to MCH. I'll discuss this
10 in a bit on the next slide. Next slide.
11 Here are examples of feedback that
12 we've received regarding the core survey. So,
13 both enhancements of existing topics from the
14 current survey as well as new topics to consider
15 that were identified by colleagues in our
16 division, PRAMS' grantees, and our partners.
17 Areas recommended to be added to topics already
18 found on the core survey range from an expanded
19 focus on mental health, especially anxiety, to
20 aspects of pregnancy care such as counseling for
21 and awareness of urgent maternal warning signs,
22 cardiac indicators, and management of chronic

1 conditions, and maternal vaccinations, especially
2 Tdap and COVID-19.
3 New areas proposed for the core
4 survey include adverse childhood experiences or
5 ACEs, social determinants of health, emergency
6 preparedness, patient-centered and respectful
7 care, and maternal stressors. Next slide.
8 And here are a few upcoming
9 milestones. So, from now until August, we will
10 evaluate the question proposals related to these
11 topics that come in from our partner solicitation
12 send in June, and just a reminder that the
13 proposals are due July 9th, and then, we will
14 start to develop questions for the survey. Some
15 partners have also approached us about supporting
16 topics and questions and we do welcome funding
17 support; however, the ability to fund questions
18 will not be considered in the selection or
19 evaluation of the proposals. We will also
20 continue to engage with our partners throughout
21 the revision process.
22 Our goal is to have the questionnaire

1 content finalized by December 2021 and to launch
2 Phase 9 in the field in April 2023. Next slide.
3 Okay. So, with that, I'd like to
4 open it up to the committee for discussion, and
5 here are a few questions for you all to think
6 about. What topics would the committee like to
7 see revised from the current Phase 8
8 Questionnaire? What are the committee's thoughts
9 on the proposed additions to Phase 9
10 Questionnaire? And what other MCH topics should
11 the Phase 9 Questionnaire capture?
12 MAGDA PECK: Thank you, Ada.
13 ADA DIEKE: Sure.
14 MAGDA PECK: I open it for our
15 members to give immediate comment, and we also
16 have a followup opportunity given the limited
17 amount of timing we have today for the Data and
18 Research to Action Work Group to be a place to
19 assure that you get input prior to July 9th so
20 that it's not only today's interactions. So,
21 colleagues?
22 STEVEN CALVIN: Hi. Steve Calvin

1 here. Thank you for this work. It's really great
2 to know that, you know, four out of five
3 pregnancies are covered by PRAMS and what are the
4 barriers that are -- that are present in some
5 states to get them involved?
6 LEE WARNER: I'll take that one. So,
7 I think for some of the states, they're able to
8 support internally with their own funding and
9 structure. What it does, they miss out under the
10 PRAMS infrastructure, and we've worked really hard
11 the past decade or so to increase the number of
12 states and territories that we have. So, like the
13 slide said, we're currently at 81 percent, but I
14 mentioned we -- with California and Ohio, we align
15 on questionnaire items, we do our best to align on
16 methodology, too. And so, if you include
17 especially California and their system, we're
18 around 96 or 98 percent.
19 STEVE CALVIN: Wow. And then just a
20 quick followup question. Is there a coordination
21 between the Office of the National Coordinator in
22 what you're doing and are there any thoughts of,

1 you know, a lot of -- a lot of patients are cared
2 for and, you know, have access to patient portals,
3 you know, for the electronic health record. Are
4 there kind of longer-term plans on ways of just
5 kind of making it really easy to do multiple
6 surveys throughout, you know, the life course
7 using those? I mean, I'm kind of going off in a
8 bunch of different directions.
9 LEE WARNER: No, I love the thought.
10 I mean, we're here to talk about Phase 9, but I
11 enjoy the -- the dialogue and we need to be
12 thinking forward all the time. So, we actually
13 have gone about -- the plans for sponsors actually
14 are very good in the current environment. We are
15 hovering around 60 percent overall, which is
16 fantastic, and that's a lot due to our -- the TA
17 part of our project officers. But we've even
18 thought about doing some followup surveys in which
19 you have the folks who participate once, would
20 they be willing to do followup surveys later on as
21 their infant progresses in age. And that's one
22 thing we thought about with -- we recently

1 completed our first call-back survey with PRAMS as
2 part of our opioid response work. and so, that was
3 very successful. So, it is something that's on
4 our radar. We're trying to get the data out
5 faster first, but we certainly want to pay
6 attention to that.
7 STEVEN CALVIN: Okay, thank you.
8 WANDA BARFIELD: Yeah. I think just
9 another thing to add, Steve, in terms of issues of
10 data linkages, we're currently exploring with
11 [indiscernible] funding, the linkage of PRAMS data
12 to hospital discharge because we do know that
13 women, although they, you know, are great at
14 reporting certain experiences, medical information
15 and history may not be as well reported. We also
16 are thinking about doing some linkages with the
17 [indiscernible] Survey that also looks at
18 facilities in terms of breastfeeding rates and
19 success. So, that's an opportunity as well.
20 And at the state level, depending on
21 state capacity and, as you may know, some of the
22 relative challenges of what I call the permission

1 slip, there are data linkages between grants,
2 hospital discharge, Healthy Start, ART
3 surveillance data in some states, so that they're
4 really trying to cover a broader base.
5 On the national level, I think we are
6 learning some things as we think about our data
7 modernization efforts and where are the
8 opportunities to get national data.
9 MAGDA PECK: Thank you for that, Dr.
10 Barfield. Dr. Ehlinger.
11 EDWARD EHLINGER: Yes. I support --
12 I really like the fact that you're putting ACEs.
13 When we added ACEs to the BRFSS in Minnesota, we
14 really got a lot of really important information
15 that helped.
16 The other is, I know the National
17 Academies of Sciences, Engineering, and Medicine
18 looked at the Healthy People 2030 objectives and
19 added some things, and there some things that were
20 rejected, and they just had an article in JAMA
21 that came out just a day or two ago, and they
22 added ACEs as one of those things that should have

1 been there. But they also talked about mental
2 disability, but environmental factors, housing
3 disruption and segregation, and heat vulnerability
4 and voting. I think these are things that
5 actually -- like voting, for example is a power
6 message for pregnant women, and I would love to
7 see how many people are voting, and I think that
8 should be something that could be part of PRAMS
9 along with a lot of the environmental issues, the
10 housing segregation and those kinds of things.
11 MAGDA PECK: Right.
12 LEE WARREN: Can we go back to the
13 slide with all the suggested topics, please.
14 MAGDA PECK: Thank you. I was going
15 to suggest that, Lee, so people don't --
16 LEE WARREN: Yeah, and I just want to
17 comment -- oh.
18 MAGDA PECK: There you go.
19 LEE WARREN: I also wanted -- yeah,
20 okay -- and I also wanted to just comment that we
21 are trying to align with HP 2030 and so Holly
22 Shulman from our PRAMS program has been a

1 representative for the vision on this. I also
2 want to draw your attention to the note Michael
3 put in the chat. We -- we've had a large program
4 -- thanks, Michael -- we've tried to gather data
5 in PRAMS for Healthy Start participants to look at
6 the effectiveness of that program and that project
7 is now complete and we are in the analytic phase.
8 MAGDA PECK: I'm going to go to --
9 are you -- are you done, Ed, with your hand up,
10 because will go to Belinda and then I will add a
11 comment after that, and we're going a little past
12 time, but we're going to -- we're going to give
13 this its due diligence. Belinda.
14 BELINDA PETTIFORD: Thank you. Lee,
15 I was looking at the new topics where you talk
16 about experiences of discrimination and racism. I
17 thought there was already maybe an optional
18 question in PRAMS that talks something like how
19 often do you think about your race or for some
20 reason, I thought it was another question that was
21 already there, not to say that we couldn't expand
22 upon that and, you know, add to it, but I was

1 thinking it was already one question. Am I wrong?
2 LEE WARNER: There is one. Yeah,
3 there is one question. That's a great point
4 Belinda. I want to point out, these are additions
5 to the core and we're looking at -- and the core
6 is precious real estate. So, we want to make sure
7 we get the exact right topics, the most important
8 MCH topics and that they're worded properly, that
9 we can leverage the birth certificate for all it's
10 worth, but the other issues with it being on some
11 of the state -- state questionnaires is that
12 sometimes the wording is slightly different, and
13 it makes measuring comparability between states a
14 little difficult.
15 So, again, I also want to emphasize -
16 - going back to Steve's question -- these are not
17 -- these are the proposed additions. The
18 decisions have not been made at this point, and
19 that's why it's really, really important that we
20 hear from this committee not only now but until
21 July 9th, and we'd be glad to have a separate call
22 or dialogue with the committee about this.

1 Ada, is there anything you wanted to
2 add to Belinda's question about racism?
3 ADA DIEKE: No. You -- Lee, I think
4 you covered it perfectly. The PRAMS Questionnaire
5 currently has different iterations of
6 discrimination, whether it's based on race or
7 based on gender or language. There's different
8 iterations. But like Lee said, this is looking to
9 propose it for addition to the core so that it's
10 standarized.
11 BELINDA PETTIFORD: But you need to
12 hear from us if this is something we definitely
13 want to make sure is on the core.
14 LEE WARNER: We need to hear from
15 you. I can't emphasize it enough. This is a --
16 probably once in a decade opportunity and we are
17 relishing this time with the committee. It's very
18 important for the future progress of PRAMS.
19 MAGDA PECK: Well, in the interest of
20 time, I would like to thank our colleagues and to
21 recognize we have one more speaker today, Lee
22 Wilson, to come on board. We can guarantee that

1 we will look at our Data and Research for Action
2 recommendations and see the opportunity to call
3 out a specific recommendation at this time that
4 would be relevant to strengthening the existing
5 surveillance system of PRAMS and its
6 interoperability and articulation with other data
7 systems and the notion of adding social
8 determinants and including the experience of
9 homelessness and eviction, particularly given
10 CDC's own ban on eviction in the context of COVID
11 would be essential for the core but at least
12 salient and timely as a topical issue.
13 And we get to model in PRAMS again
14 what are the standarized metrics to operationalize
15 how we're going to measure the impact of racism on
16 maternal and infant health outcomes. So, we will
17 convene the DRAW group with an invitation to our
18 other colleagues within the next week to be able
19 to operationalize this and come back to you in
20 this window of opportunity.
21 Thank you Ada, thank you Lee, thank
22 you Wanda, for bringing this forward. In the

1 remaining time that we do not have, but we will
2 borrow back, I want to invite Lee Wilson, who is
3 Division Director in Healthy Start Perinatal
4 Services, to give us an additional update of data
5 implications. So, there you are, Lee. Good to
6 see you again, back in a new capacity.
7 LEE WILSON: Thanks.
8 MAGDA PECK: So, if you would take
9 off the old hat and put on your current hat for
10 this particular one, we welcome you back into this
11 bringing your many talents to bear.
12 LEE WILSON: Thanks, Magda. And
13 thank you to the CDC folks Wanda, Ada, and Lee for
14 making the presentation on PRAMS. We're glad to
15 be able to make a space, and I'd like to offer to
16 any of the committee members if you would like to
17 have us convene another opportunity for another
18 discussion, please let Vanessa Lee know, and we
19 will make a space and do all of the logistics for
20 making sure that something is -- that there's a
21 space created for that exchange, because it is
22 very important and we value the good work that

1 comes out of it. So, thank you.
2 I'm going to be very brief, mostly
3 because there is not a lot of additional
4 information to provide to you from the GAO report.
5 But I will give you an update and I will give you
6 the links to the GAO report on maternal mortality
7 and morbidity, the process and findings that took
8 place from January of 2020 until this April when
9 the report was release. Just a quick summary
10 report. As you know, the Government
11 Accountability Office conducts audits, surveys,
12 and studies of federal programs and activities at
13 the request of Congress to assist in the
14 development, administration, and oversight of
15 their duties and authorities at the legislative
16 branch. And, as you know, maternal health -- both
17 maternal morbidity and mortality -- has received a
18 tremendous amount of attention over the last five-
19 plus years, both attention programmatically and
20 legislatively but also through funding, which has
21 been reflected both in the work that we do and the
22 broadening scope or broader scope of this

1 committee.
2 Congress is very aware that along
3 with the numbers being troubling on the maternal
4 morbidity and mortality side nationally, there is
5 even greater risk for maternal death during
6 pregnancy or shortly after both in rural areas and
7 in other underserved areas and this affects areas
8 that are -- it makes it harder to provide services
9 to address these issues and that there are lots of
10 shortages of health care services to these
11 populations.
12 So, Congress has, which is no
13 surprise, directed GAO together and analyzed
14 information on morbidity and morality and programs
15 and data associated with that. In this case, on
16 the information data collection programs
17 addressing rural and underserved areas were the
18 request given to GAO. This is the second GAO
19 study that has been undertaken in recent years and
20 the programs and the other efforts to address
21 morbidity and mortality have been covered in both
22 of these programs. So, this particular study was

1 interested in the data, it was interested in rural
2 and underserved, and it was interested in whether
3 or not our programs were targeting those
4 populations and whether we were collecting and
5 able to report on the populations and in
6 subpopulations within those groups. So, rural and
7 African American, rural and Native American, rural
8 and economic insufficiency.
9 So, we were invited to participate in
10 this engagement, which I would say many GAO
11 studies are relatively tense for the agency
12 because they are looking to make sure we have
13 systems and protocols in place to ensure that we
14 are discharging our responsibilities effectively.
15 This was a relatively light touch engagement.
16 They were very much partnering with us, exploring
17 what we were doing and what we might do better.
18 So, it was a very pleasant set of engagements. As
19 I said, it began in January 2020. We had a series
20 of meetings. They generally approach it through
21 an entrance [inaudible], then there's data
22 collection, statements of facts, draft reporting.

1 We have an opportunity to comment on that report,
2 and then there's a final report and a statement of
3 action.
4 So, what I would say is that GAO met
5 with ARC, CDC, CMS, NIH, HRSA, and a number of the
6 agencies or staff divisions within the department
7 who provide support to the Department on Maternal
8 Health including the Office of Women's Health and
9 the Office for Disease Prevention and Health
10 Promotion.
11 GAO called out the CDC for special
12 focus as the federal agency responsible for
13 surveillance, the continuous systematic selection
14 of health-related data on pregnancy-related
15 deaths. GAO called out ARC as the primary agency
16 responsible for collecting hospital administrative
17 data and its use for identifying and analyzing
18 rates of morbidity and mortality. And GAO called
19 out HRSA as the primary federal agency charged
20 with improving health care for people who are
21 geographically, economically, and medically
22 vulnerable.

1 So, those are the three agencies that
2 they focused a good bit of attention and the
3 review, although they did also look at ARC when it
4 came to data collection as well. Let me see,
5 where are we. They analyzed the data that they
6 found and they made three general recommendations.
7 The first two recommendations were -- well, so
8 their finding was that the agencies were not
9 collecting in a systematic way data on maternal
10 morbidity and mortality that could be used as
11 effectively as they might like to see. And their
12 two -- their three recommendations were that the
13 Director of CDC and the Administrator of HRSA
14 should stake steps to systematically disaggregate
15 and analyze maternal health program data by rural
16 and underserved areas and make adjustments to
17 program efforts as needed. In the response, both
18 agencies accepted this direction, and we will be
19 working on action steps to fulfill those requests
20 from GAO.
21 The third request was that there are
22 two working groups that were identified, the

1 Maternal and Infant Health Working Group, Infant
2 and Child Health Working Group, through the
3 Healthy People Project, and then there is an
4 interagency working group that is led by the
5 Office of Women's Health, both doing data
6 collection program development activities at the
7 department level. So, that third recommendation
8 was that these two HHS work groups develop and
9 implement a coordinated approach to track and
10 monitor maternal health efforts across HHS. So,
11 in other words, saying please work more closely
12 with each other and work more closely with the
13 agencies. That recommendation was also accepted
14 and we are in the process this summer and fall of
15 working on action steps to ensure that we are
16 complying with -- or not complying, that's too
17 strong a word -- that we are meeting the
18 expectations of GAO in their report.
19 I will follow up shortly with the
20 link to the report for you in the chat box, and if
21 there are any questions -- sorry I've rush through
22 this very quickly, but I know our time is short --

1 if you have any questions, let me know.
2 MAGDA PECK: Lee, I just want to
3 start with a thank you for putting that forward.
4 It was not front and center for some of our work
5 for crafting some of the recommendations for
6 today, and we will look through that lens to
7 further support the follow through and the GAO
8 recommendations because interoperability and other
9 aspects of what you've put forth is certainly what
10 we are already recommending. So, it looks like
11 there is alignment, but let's talk about strategy
12 about that alignment. And we will make sure that
13 this is shared more broadly so that we have that
14 lens.
15 Immediate burning questions for Lee
16 and we can also bring it up in the DRAW Followup
17 Group, which will convene within the next week or
18 so, so that we're being timely in response.
19 Then, towards this end, I want to
20 thank you all for -- the four of you for being
21 part of helping us help you so that we can be more
22 strategic and impactful for the women, children,

1 families, and fathers that are counting on our
2 leadership and follow-through to make a difference
3 together that is measurable and accountable and
4 sustainable. Ed, I give it back to you.
5 EDWARD EHLINGER: Thank you, Magda.
6 And thank you for all of those presenters. The
7 data piece is really important, obviously, and
8 it's nice to see that -- that we're in alignment
9 and our recommendations are really in alignment
10 with what's going on --
11 MAGDA PECK: Very much so.
12 EDWARD EHLINGER: -- various other
13 aspects. So, we have one further update before we
14 get to public comment, and that's with my --
15 comments by Karen Remley, Director of the National
16 Center on Birth Defects and Developmental
17 Disabilities, who has been in that office now for
18 a little over a year. So, Karen, it's nice to see
19 you in that position. So, give us a little
20 update.
21 **UPDATES FROM THE CENTERS FOR DISEASE CONTROL AND**
22 **PREVENTION - NATIONAL CENTER ON BIRTH DEFECTS AND**

1 **DEVELOPMENTAL DISABILITIES (NCBDDD)**
2 KAREN REMLEY: Great, thank you. Ed,
3 I have to say it's not a year yet, we're at ten
4 months, and three of those months were spent in
5 the response. But the good news is infants, moms,
6 and babies have been dear to my heart and part of
7 everything I've done my whole career. I apologize
8 for not being here earlier today, but I was giving
9 a talk about adolescence and COVID vaccination to
10 local and state health officials. So, I
11 appreciate being able to talk with you now.
12 You all know Dr. Cheryl Broussard.
13 She's also on the call and she is really the
14 expert about what the center does. We're going to
15 talk about that. I would tell you to remember the
16 center started twenty years ago with a vision to
17 be able to really have an impact on birth defects
18 and developmental disabilities. But funding is
19 very interesting and different for our center in
20 that for 2021, we have twenty-one different
21 funding lines, and we are the smallest center at
22 the CDC. Our vision is that babies are born

1 healthy, children reach their full potential, and
2 everyone thrives. And we do that through studying
3 and addressing the causes of birth defects,
4 helping children reach their potential by
5 understanding developmental disabilities, and
6 protecting people by reducing complications of
7 lead disorders and improving the health of people
8 with disabilities.
9 So, we cut across the life span, but
10 also significantly, as you can imagine, all of
11 those areas stigma and an unwillingness for the
12 general public to think about a lot of these birth
13 defects, disabilities, and diseases are really a
14 major issue for the groups we serve. Next slide.
15 I want to very briefly today talk to
16 you about what we are doing to address infant
17 mortality. We'll talk about preventing birth
18 defects, reducing the use of alcohol and other
19 substances, monitoring emerging threats, and
20 monitoring and understanding risk factors for
21 fetal death. Next slide, please.
22 Birth defects are a leading cause of

1 infant mortality causing -- and I think we talked
2 about this yesterday -- one in every five deaths
3 or 20 percent of infant deaths in the first year
4 of life, which equates to over 23,000 babies dying
5 before their first birthday. Next slide, please.
6 This is an important slide. A CDC
7 Morbidity and Mortality Weekly Report for 2020
8 reported that approximately eleven infant deaths
9 related to birth defects occurred for every 10,000
10 babies born in the United States. However, these
11 rates differ by race, ethnicity, and gestational
12 age. And I'm sure you, like me, looked at this
13 slide for the first time and said so why do we not
14 -- why does this happen and what do we know. And
15 the answer back is we don't have the research to
16 understand that yet. We think it might be
17 influenced by access to and utilization of health
18 care before and during pregnancy, the variability
19 in prenatal screening, losses of pregnancies with
20 fetal anomalies, insurance type, but also what's
21 not on this slide is care for the infant and
22 access to care for the infant and the quality of

1 that care after birth. Next slide.
2 We have state-based birth defects
3 tracking. We fund ten out of the forty-three
4 states that have state-based birth defect tracking
5 programs. Information is used to understand if
6 birth defects are increasing or decreasing over
7 time, planning and evaluating prevention
8 activities, referring babies and families to
9 services and helping states allocate their
10 resources. Our data -- we're not getting data
11 from those ten population-based programs yet in
12 that the funding was not adequate to bring the
13 data to CDC for full analysis. But we work
14 closely with those states to help them understand
15 their data and work with them. Next slide,
16 please.
17 So, identifying causes of birth
18 defects. The Centers for Birth Defects Research
19 and Prevention, CBDRP, are research centers across
20 the nation that have been funded by the CDC to
21 understand the causes of birth defects. These
22 centers have been conducting one of the largest

1 studies of birth defects ever undertaken in the
2 United States, the National Birth Defects
3 Prevention Study or NBD. The centers are built to
4 promise success, to further examine promising
5 findings within the birth defects study to
6 evaluate pregnancy exposures affectionately called
7 BD Steps and findings of this research helps
8 inform clinical factors.
9 The Committee on Obstetric Practices
10 of ACOG wrote an opinion piece on drugs used for
11 urinary tract infections and birth defects based
12 on using this data. We confirmed previously
13 observed associations, generate new hypotheses for
14 further study, identify areas for prevention, and
15 provide information to the public. We also inform
16 clinical practice in that doctors in Great Britain
17 must inform patients about possible risks of birth
18 defects after use of in vitro fertilization based
19 on its data. Next slide, please.
20 We're going to look more closely at a
21 couple of specific types of birth defects. I will
22 share with you the progress toward survival with

1 spina bifida and with heart defects. Between 1979
2 and 2003, the survival of infants born with spina
3 bifida improved. However, improvements really
4 vary based on race, ethnicity, and Black and
5 Hispanic infants continue to have poor survival
6 compared with white infants. And again, think
7 about prenatal care, care at the time of delivery,
8 rapid access to specialized care for the baby, and
9 that continuing care.
10 We also promote the use of folic acid
11 among all people who can get pregnant to prevent
12 spina bifida and other neural tube defects and we
13 conduct public health research to decrease
14 mortality and improve the health of those with
15 spina bifida.
16 Our work here -- we were funded for a
17 registry, which is run by the Spina Bifida
18 Association -- which is, of course, you have to
19 access care in order to be in the registry. We do
20 not have a population-based way of looking at
21 overall care of spina bifida right now.
22 We have worked very much in the last

1 few years to try and make sure that while cereals
2 and wheat flour are fortified with folic acid, to
3 include corn masa flour, which is voluntarily now
4 fortified in our country. Next slide, please.
5 Turning to congenital heart defects,
6 these are the most common types of birth defects,
7 and they affect nearly 1 in 110 births in the
8 United States. One-year survival for infants with
9 critical congenital heart defects improved between
10 1979 and 1993 and 1994 to 2005, yet mortality
11 remained very high. Newborn screening using pulse
12 oximetry can identify the defects before infants
13 leave the hospital, reducing infant mortality.
14 In a JAMA article published last
15 year, CDC and collaborators were able to show that
16 mandated population-wide critical congenital heart
17 disease screening using pulse oximetry reduces
18 early infant deaths from critical CHD by 33
19 percent or 120 early infant deaths from critical
20 congenital heart disease averted every year.
21 We're working with partners to track
22 state implementation of screening and how it is

1 being implemented nationwide and we're doing
2 public health research to improve health and
3 reduce mortality of those living with birth
4 defects.
5 Importantly, another area that needs
6 to be investigated is, are there differences in
7 disparities between babies of color and mothers of
8 color, and how much of that is secondary to access
9 to care. Next slide, please.
10 Another key division priority is to
11 reduce in utero alcohol exposures through
12 implementation of alcohol screening and brief
13 intervention approaches and awareness and
14 education efforts for women of reproductive age
15 and their health care providers. Alcohol SBI or
16 that brief intervention has been shown to reduce
17 risky alcohol use in a variety of settings and
18 among multiple population groups. It is
19 recommended by the US Preventive Services Task
20 Force for people 18 and older, including pregnant
21 women and widely supported by federal agencies,
22 medical groups, and professional organizations.

1 We're also taking lessons learned
2 from our many years of studying fetal alcohol
3 syndrome and fetal alcohol spectrum disorders to
4 see how they can be applied to other substances of
5 concern including opioids and marijuana use. And
6 I won't -- in the interest of time -- I won't read
7 the whole slide, but I know you all have access to
8 them. Next slide, please.
9 Through competitive funding from the
10 Assistant Secretary for Planning and Evaluation
11 PCOR Trust Fund, we established MAT-LINK, which is
12 a network to monitor maternal, infant, and child
13 health outcomes associated with treatment for
14 opioid use disorders during pregnancy. We have
15 been able to expand the number of funded clinical
16 sites from seven -- to seven and extending the
17 time children are followed up to six years,
18 because you can imagine how important it is to
19 look at long-term outcomes. These additional
20 sites will increase the study population of
21 pregnant people and improve racial, ethnic, and
22 socioeconomic characteristics and expand the

1 geographic reach. Results will inform clinical
2 practice recommendations and clinical decision-
3 making around treatment for opioid use disorder
4 among pregnant people. And I must tell you, I
5 can't announce last week because it's not public
6 yet, but we paid close attention to geographic
7 representation, travel representation, and groups
8 that were less represented in the first sites.
9 Next slide, please.
10 And then, surveillance --
11 surveillance for emerging threats to mothers and
12 babies. And as many of you know, this is built on
13 the work that we did during the Zika response. We
14 established SET-NET, which is a mother-baby linked
15 longitudinal surveillance system, which can detect
16 the effects of new health threats like COVID-19 on
17 pregnant women and their babies by collecting data
18 from pregnancy through childhood. We used
19 evidence-based actionable information to help save
20 and improve the lives of mothers and babies with
21 Zika, Hepatitis C, Syphilis, and now COVID-19.
22 We were able to pivot that

1 surveillance for COVID-19 in collecting
2 longitudinally linked surveillance data on
3 pregnant women and their infants through 6 months
4 of age. And as of May 2021, twenty-five
5 jurisdictions have submitted birth and infant
6 outcome data through SET-NET, and CDC has received
7 data from nearly 19,000 pregnant women and their
8 infants.
9 The data did show that women with
10 COVID-19 may be at increased risk of having a
11 preterm infant, which may lead to serious health
12 problems for the infant. We partner very closely
13 with Dr. Barfield in her division on this work.
14 Next slide, please.
15 This gives you an idea of where the
16 jurisdictions are that are currently funded for
17 SET-NET through either the ELC cooperative
18 agreement or separate contractual mechanism, and
19 where staff is also there to help start -- where
20 staff are there to help. You can imagine in a
21 world where funding was not an issue that if we
22 had SET-NET across the country and in territories

1 and tribes and would be able to look at not just
2 emerging infectious disease threats but other
3 cause of birth defects, we'd have an abundance of
4 information to be able to make important decisions
5 on. Next slide.
6 And finally, I want to briefly
7 mention the work we're doing to monitor and
8 understand risk factors of fetal death. Each
9 year, about 2,400 babies are stillborn in the
10 United States. Because the annual number of fetal
11 deaths in the United States is [indiscernible] to
12 the number of infant deaths each year, we are
13 working to monitor and better understand the
14 causes and understand how we can prevent fetal
15 deaths.
16 So, we have funded two of the Centers
17 for Birth Defects, Research, and Prevention in
18 Arkansas and Massachusetts to better understand
19 factors that might increase the risk of
20 stillbirths. These states' birth defects tracking
21 systems have been expanded to identify all
22 pregnancies that result in stillbirth, not just

1 those with a birth defect. Next slide, please.
2 The knowledge about the potential
3 cause of stillbirth can be used to create
4 recommendations, policies, and services, and
5 hopefully potentially reduce the risk of stillborn
6 and stillbirth in women and families. And as you
7 can see, Black mothers are more than twice as
8 likely to experience a stillbirth than pregnant
9 Hispanic and white mothers, and that is one of the
10 reasons why we wanted to invest in understanding
11 this problem more. Next slide.
12 With the coming of Dr. Wolenski and
13 with me being in the center, we're very
14 aggressively looking at what information we don't
15 have to be able to fulfill the CDC's core
16 commitment to health equity. Some data we are
17 unable to collect. Some data, we don't have the
18 funding to expand to be able for many rare
19 condition to get the information we need. But we
20 are definitely working in every way we can to
21 cultivate comprehensive health equity science, to
22 optimize our interventions, to reinforce and

1 expand robust partnerships, and to enhance
2 capacity of the workforce engagement. All of our
3 work in the entire center is being looked at with
4 a lens of these four components this summer to
5 make sure that we are maximizing our work and that
6 we are not ignoring disparities that exist and
7 working to understand those and make a different.
8 Last slide.
9 And you've also heard that the CDC is
10 undergoing a process of data modernization. We
11 are hoping through our center to be able to
12 leverage existing systems that exist that bring in
13 information to the infectious disease side of the
14 house. Think about reportable diseases and all
15 electronic health record data and claims data that
16 have come and birth data and death data that come
17 into the CDC. How can we connect those to better
18 understand infants, birth defects, newborn
19 screening results? There is no national place
20 where newborn screening results are collected. We
21 hope to be able to work together with our partners
22 at HRSA and NIH and at the CDC to better

1 understand not only metabolic disorders of
2 metabolism in newborns but also birth defects and
3 causes of stillbirth and prematurity. Next slide.
4 And in doing that, this is just one
5 example where we use machine learning to show
6 promise in predicting birth defect spaces. Up
7 until now, medical providers had to review each
8 chart, which can be very cumbersome and requires a
9 lot of work. But by using machine learning, we're
10 able to develop algorithms that help us to be able
11 to maybe surveil for birth defects in a more cost-
12 effective and actually a much larger scope.
13 And I will stop there and see,
14 Dr. Ehlinger, if anybody else has any questions.
15 I know we're at time, so I'm happy to talk to
16 anybody, you know, at any other time too.
17 EDWARD EHLINGER: Yeah. Okay, thank
18 you, Dr. Remley. I appreciate that. Good
19 information. Sorry it's taken so long to have you
20 guys back to the committee. So, it's good to get
21 that update. Tara, I figured you might have a
22 question since that was -- birth defects was the

1 issue that you brought up yesterday as your
2 primary.
3 TARA SANDER LEE: I did. Thank you,
4 Karen. Thank you. I really, really appreciate
5 your talk. That was a lot of great information.
6 Just a quick question. When you brought up the
7 data that you're collecting about spina bifida and
8 congestive heart disease and, you know, really
9 monitoring like the folic acid and newborn
10 screening, can you talk a little bit more about
11 whether you've been monitoring fetal -- any fetal
12 treatment options that are available that women
13 are, you know, that they are accessing, you know,
14 as far as like fetoscopic procedures or spina
15 bifida or fetal surgery? Just if you have any
16 thoughts about that.
17 KAREN REMLEY: That's a wonderful
18 question, and actually I spent very early this
19 morning listening to, and I think Alison had to
20 leave early. The NIH had a series of three
21 different large four-hour events on gene therapy
22 and fetal surgery and all of the things that are

1 out there, and I've actually talked with
2 Dr. Barfield, Dr. Warren, and Dr. Bianchi at the
3 NIH to have us have an opportunity to sit down and
4 really understand where do we think the field is
5 going. Are we at CDC and my center doing the
6 appropriate surveillance? You know, the center
7 was a hope of being a national surveillance system
8 for birth defects, but we never really were able
9 to fill that promise because the funding didn't
10 come. But how do we connect carrier screening,
11 prenatal care, what is being done in prenatal
12 surgery and fields that are constantly evolving?
13 And I think the point that you made, Cheryl, that
14 I heard you yesterday that's passion to me is
15 making sure it's available to everyone so that
16 it's not, you know, if I'm a potential new mother
17 and father that, you know, are brilliant and read
18 everything and know everybody at Harvard, I have
19 access to therapies, and if I'm a mom who doesn't
20 have access to all of that information, I don't
21 have access to those therapies. So, better
22 understand what's there, what should be a public

1 health commitment? You know, we know that newborn
2 screening, critical congenital heart disease
3 screening, and early hearing defects are all
4 public-health centered and that every child in
5 every state and territory and tribe gets access to
6 that. But what does that look like when we start
7 to talk about all those other therapies? So, I
8 think it's an excellent question.
9 TARA SANDER LEE: Okay, thank you so
10 much. That really helps. And just one final
11 quick question. Just you mentioned the SET-NET
12 data. Does that data include COVID-19 vaccine
13 data or just COVID-19 experiences?
14 KAREN REMLEY: We have it through a
15 pilot, and I'm looking at Wanda and Cheryl,
16 because they can help me here too. But we have
17 the Be Safe System, which you -- any of you who
18 got vaccinated may have been asked to enroll in Be
19 Safe, which is a text message-based way to when
20 you've gotten a vaccine, to be able to give
21 information back to CDC. Very large numbers of
22 women identified themselves as being pregnant at

1 the time of being vaccinated. You can imagine,
2 early on, it was health care providers and many of
3 those are women, and many of those are child-
4 bearing age. So, we're closely following them
5 post-vaccine too. And I don't know -- Wanda, I
6 see you're off mute, so you may want to add a
7 little bit more to that.
8 WANDA BARFIELD: Yes. That's a great
9 question, and Cheryl may be able to add. You
10 know, this has been an airplane that's been
11 constructed while flying and the wonderful
12 opportunity of the, you know, pilot team, again in
13 collaboration with NCIRD and with Karen's centers
14 as well as our center to really think about
15 monitoring women's reaction to vaccination has
16 been quite robust and they are currently
17 collecting data, I think now close to 5,000 women
18 or over 5,000 women.
19 And then your question about the
20 linkage to SET-NET, I think that opportunity may
21 present itself, but right now it's really
22 collecting the data in terms of the Be Safe System

1 and asking women questions with regard to their
2 reactions, if any, to the vaccination.
3 TARA SANDER LEE: Great. Thanks so
4 much Karen and Wanda, very helpful.
5 EDWARD EHLINGER: One last question.
6 CHERYL BROUSSARD: This is -- this is
7 Cheryl. I just dropped in the chat the website to
8 the Be Safe Pregnancy Registry to check that out.
9 MAGDA PECK: Thank you so much for a
10 terrific update, Karen. I'm delighted to see that
11 collaboration happening. Two very quick comments.
12 One is that I challenge us, as we look towards the
13 end of the day and our recommendations, in the
14 Data and Research to Action, we have called out
15 for an expansion of Maternal Mortality Review and
16 for Fetal and Infant Mortality Review as one
17 specific surveillance system that is community
18 engaged to move forward. There are gaps,
19 obviously, in SET-NET and others that would be
20 better if brought to scale. And so, I just will
21 assure that we will be broader in our lens as we
22 consider the conversations today and presentations

1 on PRAMS and from Birth Defects and Developmental
2 Disabilities for SET-NET about what is the
3 opportunity gap by not expanding and harmonizing
4 and integrating our maternal and infant mortality
5 and morbidity related surveillance systems with
6 greater infusion of resources. We can say that,
7 you can't. So, we would like very much to augment
8 our lens a bit.
9 And the second is for -- Ed, you
10 talked about yesterday what are emerging issues.
11 The data modernization that you have brought about
12 using machine learning and artificial intelligence
13 to be able to predict birth defects will only be
14 as strong as equity is built in, and the implicit
15 bias and artificial intelligence systems means
16 that the people who write the code are the ones
17 that bake in racism and bias. And it is implicit,
18 not explicit upon and the onus is on us, to inform
19 through the lens of maternal and infant mortality
20 prevention and the promotion of women and
21 children's health that any use of artificial
22 intelligence, the modernization of data that is

1 going to try to further us in our work, has got to
2 be able to be looked at in its baking and making
3 for potential implicit bias in the design itself.
4 So, at some future part of our agenda, as I've
5 been talking about the last two years, we need to
6 be ahead of this curve and looking at the lens of
7 maternal and infant health could be a fabulous and
8 powerful proxy for influencing design and policy.
9 Thank you so much for your time and for your
10 presentations.
11 KAREN REMLEY: Thank you. And Magda,
12 I would say you're right about both counts. When
13 I ask questions of the scientists and
14 epidemiologist we have, when we're collecting
15 information, not from across the country, about
16 their birth defects or diseases and we never get
17 enough numbers for tribes. We never get enough
18 numbers -- and especially if we don't have a
19 center in an area that has a large tribal
20 population.
21 So, constantly, if we look at
22 potential ethnic or racial differences to really

1 understand then, you have to have enough data to
2 really make the decisions and that's part of data
3 modernization is really making sure that we have
4 enough data to make those decisions and we don't
5 just default to whatever the largest group in that
6 state is. You also know if you're looking at
7 birth defects in Massachusetts, the environmental
8 impacts and the toxic exposures and epigenetics
9 and infection, everything else is really different
10 there than it might be in Arizona or Montana. So,
11 as we expand this reach and think about infant and
12 maternal mortality, I couldn't agree with you
13 more. Having access to data early to prevent
14 infant and maternal mortality and to have optimal
15 life for that child is so critically important.
16 So, I appreciate it. Thank you.
17 EDWARD EHLINGER: Thank you, Karen,
18 for your presentation. Great presentation, good
19 information. Magda, thank you for bringing up
20 that point, and I actually look to you and your
21 group to actually potentially add some comments
22 about that in our background paper, for just

1 raising that equity issue, I think would be good
2 to raise as something that needs to be concerned.
3 I think most people will not -- that will be new
4 information to them, so it will be good get out.
5 So, again, thank you, Dr. Remley and
6 Cheryl, for all of this good information.
7 Let's now, before we get into our final
8 work, let's have the public comment. Lee, do we
9 have any public comment?
10 **PUBLIC COMMENT**
11 LEE WILSON: Yes. Hi, folks. We're
12 now at the public comment period. One person has
13 requested in advance to make public comment,
14 Brenda Bandy. Dr. Bandy -- Ms. Bandy, we are
15 allowing three minutes for public comments. If
16 you would press *1 on your keypad to alert the
17 operator to unmute you, we will give you three
18 minutes to discuss the comments you made around
19 integration of breastfeeding into infant mortality
20 -- into the infant mortality conversation. Thank
21 you. Vincent, are we hearing from Ms. Bandy?
22 VINCENT LEVINE: No. We do not see

1 her in the audience. If she wants to -- if she
2 has a raise-hand feature or if she's under a
3 different name -- but I think we saw her this
4 morning and we don't see her this afternoon.
5 LEE WILSON: All right. So, I am
6 going to -- she -- she had a sentence or two in
7 her request to us for public comment. I will
8 insert that into the chat box for you, and we'll
9 make sure that that's in your notes. If there are
10 no other -- why don't we provide thirty seconds
11 for anyone else if they have any other public
12 comments. We generally do this if there's a
13 little bit of available time. I'll allow thirty
14 seconds, Vincent, if anyone raises their hand.
15 VINCENT LEVINE: Okay. Pat Loftman
16 is now unmuted. She had her hand raised.
17 PAT LOFTMAN: Am I on?
18 LEE WILSON: Yes, ma'am. You are.
19 Please, you have three minutes to provide a
20 comment.
21 PAT LOFTMAN: Hi. My name is Pat
22 Loftman. I'm a midwife from New York City. I've

1 been a midwife for forty years, thirty of those
2 years were in clinical practice, and I've been
3 retired for the past ten years, however, not
4 quietly. I'm on the New York City Maternal
5 Mortality Review Committee.
6 But when I was in clinical practice,
7 part of my work was with -- was with precepting
8 midwifery students and the mantra that I always
9 gave them was that the two most important aspects
10 of care was number one, establishing your
11 relationship, and number two, providing respectful
12 care because I think we talk about all of the
13 systems and all of the wonderful services that we
14 have to provide women to have excellent outcomes.
15 But, you know, this is -- it becomes a test of if
16 we build it, will they come. So, in as much as we
17 discuss this -- there's been a lot of discussion
18 about listening to women, I'm not certain if
19 you're familiar with there's a British midwife
20 whose name is Saraswathi Vedam. She published
21 this study a few years ago about the integration
22 of midwives in terms of improved maternity

1 outcomes, and she also published a study called
2 Giving Voices, where women describe their -- their
3 maternity experience during birth, and their
4 experience was described as coercive and
5 disrespectful during their birth experience. So,
6 I -- and so, one data point that existed in the
7 presentation was that she asked women in their
8 subsequent births, whether they would opt for an
9 out-of-hospital birth and what surprised me was
10 that 25 percent of Black women said that they
11 would opt -- they would consider an out-of-
12 hospital birth and the reason that stunned me is
13 because traditionally Black women want a hospital
14 birth. And so, the fact that they would even
15 consider an out-of-hospital birth for their next
16 pregnancy was surprising.
17 And so, I think we have to consider
18 that while it's really important for us to develop
19 systems, one of the things that they talked about
20 was really wanting race-concordant care, and
21 that's something that I don't think really came
22 through. I didn't really hear it, and that's

1 something that I would really want to emphasize
2 because I don't know how much social media you
3 see, but I see on Black social media, women who
4 would absolutely to avoid going into a hospital
5 have an unattended out-of-hospital birth, and that
6 for me is very frightening.
7 LEE WILSON: Thank you, Ms. Loftman.
8 I appreciate your comments. If you should have a
9 letter or any documentation that you would like to
10 submit as part of your statement, please feel free
11 to do so, and we will follow up and make sure that
12 it's provided to the committee.
13 PAT LOFTMAN: Thank you.
14 LEE WILSON: You're welcome. Have a
15 nice day.
16 Ed, I'll turn it back over to you.
17 Thank you all for taking the time.
18 **COMMITTEE DISCUSSION AND VOTE ON RECOMMENDATIONS**
19 EDWARD EHLINGER: All right. Thank
20 you, Lee. We've got about forty-five minutes
21 left. As we looked the recommendations that we
22 had, there was just one that we hadn't gone

1 through, and that was -- and I'm glad that Paul
2 Wise is now back with us -- it was in the section
3 related to immigrant and migrant and border
4 health. It was a suggestion from Jeanne Conry to
5 add on the fourth recommendation HHS should
6 support reinstatement of ICE's Presumptive Release
7 Policy that applied to pregnant detainees and that
8 was -- we hadn't had a discussion on that one. Is
9 that something, Paul, that would make sense in
10 that recommendation?
11 PAUL WISE: Yes. I think that --
12 that that would be helpful. It's fairly
13 technical, but it is a recognition of the -- of
14 importance of addressing the special needs of
15 pregnant women in immigration detention. So, I
16 think that that would be useful to keep in there.
17 So, thank you.
18 EDWARD EHLINGER: All right. All
19 right. We've gone through all of the new
20 recommendations very briefly. We've gone through
21 all of them yesterday. Are there any
22 recommendations that -- and the process will be

1 there will be some wordsmithing that needs to go
2 and I hope to be working with the chairs of the
3 various work groups to just clarify the wording or
4 get it down to as precise as we can without
5 changing the meaning. So, I would like us to be
6 able to approve these recommendations, the general
7 meanings of them, the approach that they're
8 taking, with allowing us to sort of kind of
9 crystallize the language and make it a little bit
10 clearer if there's some redundancy in that.
11 But are there any recommendations
12 that people would like to pull out and have a
13 discussion on at this point in time?
14 MAGDA PECK: Ed, is it helpful to put
15 them back up again?
16 EDWARD EHLINGER: First, I wanted to
17 see if there was -- you should have those with
18 you. But if it would be helpful, we can certainly
19 do that. Vanessa, can you put up the
20 recommendations?
21 VANESSA LEE: Sure, one second.
22 WANDA BARFIELD: Ed, I just had a

1 comment.
2 EDWARD EHLINGER: Yes.
3 WANDA BARFIELD: So, there was a
4 recent publication in Pediatrics that talked about
5 race and ethnicity among pediatric residents and
6 subspecialists and there is, of course, incredibly
7 low percentage of pediatricians of race and
8 ethnicities that reflect the populations that they
9 serve, and it's even more dire for subspecialists.
10 I guess one of the questions is -- and we do try
11 to address that in terms of trying to increase
12 diversity, you know, across the board in terms of
13 all areas of clinical practice. But in the
14 meantime, you know, what do we do?
15 And, you know, I had an incredibly
16 unique experience spending time in the military as
17 a pediatric intern and resident where the group
18 was far more diverse and it wasn't so much about
19 concordancy but about the opportunity for a
20 collective group of people to have a better
21 understanding of the diversity of the populations
22 that they served and informing each other. And it

1 may be that until we get to the point where there
2 is actually enough diversity of providers for
3 patients to select, we have to think about other
4 solutions.
5 EDWARD EHLINGER: Good point, good
6 point.
7 UNIDENTIFIED FEMALE SPEAKER: I know
8 in other iterations of this, we've talked about
9 implicit bias training, and that would definitely
10 follow along with what we do now to kind of
11 facilitate this general openness. And I -- we can
12 -- I understand that there have been movements
13 towards this already. So, I -- I don't think it
14 would be redundant to include it or if we just
15 include it in the background information as well
16 as something that is being instituted. But to
17 Pat's comment about race concordant care, I
18 definitely think we can readdress this in the
19 workforce implementation of diversifying the
20 workforce.
21 EDWARD EHLINGER: We have some
22 statement in there, and actually as we talk about

1 next steps, it's on my list of issues for our
2 September meeting that I would like to really
3 actually focus on this concordant care and have a
4 more in-depth discussion because there are
5 multiple factors to it.
6 MAGDA PECK: One of the things I'm --
7 I'm mindful of is the creative tension -- and
8 that's how I will name it -- between the clinical
9 provider -- the community workforce in terms of
10 laying on hands and having the direct patient
11 experience and the public health workforce that is
12 working more at the denominator in terms of
13 systems change. We have talked about race
14 concordant care and implicit bias on the clinical
15 side. I think it would behoove us, if not now, as
16 we do that next iteration, to think about what is
17 involved in public health graduate and
18 undergraduate education as a way of seeing the
19 linkage between the now burgeoning number of
20 bachelors in public health programs and masters in
21 public health and Title V investing in maternal
22 and child health training programs and to have a

1 refreshed look at how do we bring anti-racist
2 work, how do we bring systems change around
3 undoing racism more explicitly into the public
4 health training and then encourage joint training
5 so that there can be public health education along
6 with clinical education that's not done as a -- in
7 a tandem bicycle way but in a much more integrated
8 way up front.
9 I am a recovering dean of a school of
10 public health dedicated to social and
11 environmental justice, and so, I speak from an
12 academic perspective at this moment, not in my
13 current role and calling for the integration, if
14 you will, and the intersectionality from an
15 education perspective around anti-racist education
16 in professional and public health education.
17 So, too much for now, but I'm just
18 noticing that we've really gone far on the
19 clinical side and made it implicit that that's
20 part of some public health workforce when we have
21 investments being made directly through over 150
22 schools and programs in public health and it could

1 be a missed opportunity, particularly as the
2 bachelors in community college pathways for public
3 health education have been expanded.
4 EDWARD EHLINGER: I'll raise the
5 point, the attention that I have is that we have
6 spent a year getting to this point and, you know,
7 with these recommendations to have a chance for
8 input along the way, and the recommendations will
9 never be complete, and they'll never be totally
10 comprehensive.
11 What I first want to get is -- is the
12 list of recommendations that we have right now in
13 front of us, with some tweaks, something that we
14 can move forward? Because if we -- if we add a
15 whole lot more and try to get concordance on
16 opinion, we probably won't get this out until
17 September or November or December. I wanted to
18 see if we can -- if this is a document that we
19 have with some tweaks that still need to be made
20 that we would feel comfortable moving forward to
21 the Secretary.
22 MAGDA PECK: Yes. I think -- I think

1 that we are -- perfection is the enemy of the
2 good. The notion that Secretary Sebelius said,
3 now do something, right? Now. And be very clear
4 in the cover letter about what's coming next. A
5 year ago on your cover letter, you said, we're
6 going to address COVID now and be ready for more
7 work coming and recommendations around racial and
8 ethnic disparities, more directly anti-racism, and
9 undoing racism. You gave that. And so, that is
10 infused here. I would encourage us to act now
11 based on the collaboration and consensus we have
12 with an understanding in the cover letter about
13 what coming attractions may be and for us to work
14 in expediate action as SACIM to continue to have
15 this approach; recommendations, put them out;
16 recommendations, put them out, and not belabor it
17 to perfection.
18 EDWARD EHLINGER: Good. That's my
19 belief also. So, thank you for that.
20 MAGDA PECK: One person, one member's
21 view. I'll be curious about my colleagues. But I
22 have a sense of urgency just to catch the wave,

1 and I think we've done enough work and teaching
2 and learning from each other and with each to move
3 forward.
4 EDWARD EHLINGER: Any other comments
5 about that? All right. There -- there are a
6 couple that need some work. The one on the Indian
7 Health Service. We need that recommendation, and
8 it's going to be -- Janelle, if you could sort of
9 articulate what -- and Magda, I think, brought it
10 up -- what -- that we adequately fund Maternal and
11 Child Health Services and Indian Health Service,
12 something fairly generic but keeping it on the
13 radar, sort of. That would be the one that would
14 be, I think, is most unclear at this point in
15 time.
16 MAGDA PECK: I'll be glad to work
17 with you, Janelle.
18 JANELLE PALACIOS: I agree. Are you
19 suggesting we do it on -- offline or right now?
20 EDWARD EHLINGER: What I want is give
21 us a general sense of what it would be -- not the
22 words, because we can work on it offline -- but I

1 want the committee then to say yeah, that's the
2 right direction and we'll give approval, you know,
3 even if they don't see the final wording of it.
4 Because otherwise, to actually vote on that
5 wording later on, again, will take a lot of time
6 to get to that point.
7 JANELLE PALACIOS: Okay.
8 EDWARD EHLINGER: What was the -- I
9 know, Magda, you had sense -- you made a statement
10 about that would sort of entail.
11 MAGDA PECK: It would be to specify
12 adequately fund the Indian Health Service --
13 Health Services programs and services to address
14 or to prevent maternal and infant mortality. I
15 mean, to specify it in the very first sentence so
16 that it is focused in its work. And that would be
17 in the first line. And increase immediate funding
18 to the Indian Health Service to improve health, to
19 -- to meet the needs of indigenous people in
20 preventing maternal and infant mortality and
21 severe morbidity. So, it's a way to contextualize
22 it and to put some of the remaining work -- some

1 of it could go into the -- into the background
2 section. But those are two examples of what I
3 speaking for. Janelle.
4 JANELLE PALACIOS: Okay. So, I agree
5 with those recommendations, Magda, and we can
6 leave the specific money allocations regarding job
7 training and increase providers and addressing the
8 staff shortages and infrastructure for a later
9 date but include that in the background as
10 identified sources of attention. I would advocate
11 to keep the little phrase in there that, you know,
12 the funding to Indian Health Service in accordance
13 with historical Trust obligations between
14 Sovereign tribes and US government.
15 MAGDA PECK: Right.
16 JANELLE PALACIOS: I would advocate
17 to keep that in there.
18 MAGDA PECK: I would agree with that.
19 I would add that, you know, these are excellent
20 examples. Again, the more specific we can be, the
21 better. The idea is pick out the specifics but
22 make it population anchored because that is our

1 mandate.
2 JANELLE PALACIOS: Yes.
3 EDWARD EHLINGER: All right. Well,
4 what I will do is this. When we get the specific
5 words for this, I'm going to try to get approval
6 for this document with the recognition that we
7 will send out working on this specific one to all
8 members and then I can get feedback on it
9 independently, not on the whole thing, just on
10 this -- this one recommendation. Are there any
11 other recommendations that need to be pulled out
12 and discussed?
13 MAGDA PECK: I have a question about
14 how to operationalize a comment I made earlier
15 after the data presentations this afternoon. We
16 have, based on the recommendations that came out
17 of the last SACIM meeting, of which I was not
18 present, and also out of the DRAW group, a
19 particular focus on one surveillance system as an
20 example from Maternal and Infant Mortality Review
21 processes.
22 I don't have enough information to be

1 able to then specify, you know, SET-NET or PRAMS,
2 but I'm curious about -- about whether or not the
3 committee would want there to be that maternal
4 mortality -- Maternal and Infant Mortality Review
5 processes to be less narrow and focused or to have
6 something that -- that could be broader and having
7 the sense that we can do something right now and
8 maybe revisit it again. But I do want to make
9 sure the message is we're not done yet. We're
10 just trying to be very specific about this
11 particular surveillance system and in particular
12 because it brings in community voice, as does
13 PRAMS. So, I'm -- I would like to get any sense
14 about if -- if it's too narrow given what we've
15 heard this afternoon and make sure we've given
16 full respect to the people who spoke their
17 information and truth to us today.
18 EDWARD EHLINGER: One of the other
19 things on my -- on my list of agenda items for the
20 next meeting is actually looking at having a
21 deeper dive into maternal and infant mortality
22 reviews, and that might be someplace where we can

1 get again additional information to be more
2 specific on our recommendations.
3 WANDA BARFIELD: This is Wanda. I'm
4 happy to help inform that.
5 EDWARD EHLINGER: I think this is --
6 this is general enough to move us forward, and I
7 think one of the recommendations -- one of the
8 statements in the cover letter to the Secretary is
9 that -- that we will be having ongoing
10 recommendations based on what we continue to learn
11 about each of these areas. So, like you say,
12 we're going to be pestering him with a variety of
13 recommendations over the next 18 months.
14 Any other thoughts?
15 BELINDA PETTIFORD: Ed, this is
16 Belinda. One quick thought. One area that I just
17 thought about is did we cover anywhere around
18 preconception health? I mean, it's really -- I
19 mean, if you're thinking about maternal and infant
20 health and just thinking about the health of women
21 of reproductive age, I just did a quick search,
22 and I don't see the word, but we could have called

1 it women's wellness, we could have called it maybe
2 pre-pregnancy, or something of that nature.
3 MAGDA PECK: Yeah.
4 BELINDA PETTIFORD: I just want to
5 make sure that's not an area that we missed.
6 EDWARD EHLINGER: Yeah. We're
7 calling it pre-pregnancy. That was one of the
8 things we said earlier on.
9 MAGDA PECK: Yes.
10 BELINDA PETTIFORD: Okay, thank you.
11 EDWARD EHLINGER: And it is mentioned
12 several times and women of reproductive age, I
13 think, is what we also talked about.
14 BELINDA PETTIFORD: Yeah, and I think
15 pre-pregnancy is fine. I think individuals that
16 are not thinking about getting pregnant don't see
17 themselves in that. So, I think that's why a lot
18 of times you see the terminology women's wellness
19 or something of that nature. Just keep that in
20 the back of your mind.
21 EDWARD EHLINGER: Yeah. Thank you.
22 MAGDA PECK: Thank you. It's

1 helpful, Belinda, to hear you bring up issues from
2 yesterday to make sure that you're part of that
3 conversation. So, an opportunity to have you take
4 a fresh look. Thank you.
5 BELINDA PETTIFORD: Thank you all.
6 EDWARD EHLINGER: All right. Any --
7 any others that people want to have additional
8 discussion on?
9 Hearing none, I would like to have
10 somebody make a motion that we approve these
11 recommendations that will be sent to the Secretary
12 with the understanding that any clarification that
13 by the -- in the opinion of the chair goes beyond
14 what we really talked about will be brought back
15 to the committee with separate response through E-
16 mail. The Indian Health Service one is going to be
17 one that relates to that. And that we forward
18 those to the -- and that -- that the specific
19 wording -- cleaning up the wording will be done by
20 the chairs of the work groups in collaboration
21 with me and that -- that we will then move that
22 forward. Can I hear that motion from somebody?

1 MAGDA PECK: So moved.
2 JEANNE CONRY: Can I just ask one
3 quick question?
4 EDWARD EHLINGER: Sure.
5 JEANNE CONRY: World Patient Safety
6 Day. Is there a place for putting that? To me,
7 it is all about maternal and infant outcomes and
8 it's September 17th. Wanda, I know I've got you -
9 - Wanda is a key person and her team are key
10 people for it. It is a global event that will be
11 marked everywhere. So, it seems like given the
12 topic is specifically maternal and infant
13 outcomes, it would be nice for us to say
14 something.
15 EDWARD EHLINGER: All right. Maybe
16 that could be in the cover letter, actually.
17 JEANNE CONRY: Okay.
18 EDWARD EHLINGER: You know, really --
19 MAGDA PECK: Yes, right.
20 EDWARD EHLINGER: So, let's get a
21 second to Magda's motion first.
22 JEANNE CONRY: Okay.

1 EDWARD EHLINGER: Is there a second?
2 JEANNE CONRY: I'll second it.
3 EDWARD EHLINGER: All right. And
4 then before we get into the discussion -- yeah, so
5 -- what I'm going to -- I'll come back to a motion
6 to actually add that sort of recommendation in the
7 cover letter, which we'll come back to that. But
8 any discussion about the motion? That's my five
9 seconds. And then -- I'm a Midwestern guy, so I
10 go eight or nine seconds because, you know.
11 MAGDA PECK: And you've got to
12 breathe with it. And Jeanne, I would be glad to
13 welcome that as a friendly amendment.
14 JEANNE CONRY: Thank you.
15 MAGDA PECK: To put it in as the
16 person who made the motion, and to put it -- to
17 have it added strategically in the cover letter so
18 it has primary attention before getting the
19 recommendations given the timeliness involved.
20 JEANNE CONRY: Okay. And I'll get
21 you the -- the literature on it.
22 MAGDA PECK: Assuming this passes.

1 JEANNE CONRY: Okay.
2 EDWARD EHLINGER: Very good. Hearing
3 no comments, all in favor, say aye.
4 [Chorus of ayes.]
5 EDWARD EHLINGER: Any opposed? Any
6 abstentions for any or all parts -- I don't know,
7 Lee, how do we do that in terms of --
8 LEE WILSON: Unclear.
9 EDWARD EHLINGER: I'll take that as a
10 unanimous approval of our -- of our
11 recommendations. Thank you, thank you, thank you
12 for all of the good work. I appreciate that.
13 **NEXT STEPS**
14 EDWARD EHLINGER: The other issue is
15 related to the background material. That is a
16 document that I'm not going to seek approval for
17 because it's really general and we've had a lot of
18 input. But I do want to use it as an educational
19 tool for others who read that. So, you see what's
20 in front of you in terms of sort of the general
21 comments. I do want to again put a little bit
22 more in there in terms about payment reform, and I

1 do want to put some in there about Indian health
2 care. I think I'd like to put something in there
3 about data equity, the point that Magda made, just
4 so that the context is compelling enough and also
5 what Paul Wise had mentioned in terms about the
6 numbers. I think that was a powerful statement in
7 terms of why our recommendations are important.
8 And so, I would like to get a sense
9 that are you okay with us modifying that, adding
10 to that so that it accompanies the recommendations
11 a background piece that puts context to anybody
12 who wants to go into that level of detail?
13 MAGDA PECK: yes.
14 JEANNE CONRY: Yes.
15 EDWARD EHLINGER: Anybody disagree
16 with that? All right, excellent.
17 Then, the last thing from -- from my
18 standpoint related to this, and Lee mentioned this
19 earlier on when he was talking about prioritizing.
20 We've not prioritized any of these, and I'm not
21 quite sure how we want to do that. But I know
22 that we can rearrange this document without -- and

1 frame it a little different way. I was thinking
2 of maybe once we sort of outline the, you know,
3 finalize this, send a poll out to folks to say
4 what are the priority recommendations? What would
5 be the, just like New York City did rank choice
6 voting yesterday, you know, we could have rank
7 choice voting about the priorities that we could
8 forward to the Secretary saying, you know, these
9 are -- we did thirty-eight recommendations. These
10 are the top ten that we really think are immediate
11 or they could be here are recommendations that
12 need to be acted on right now. Here are some
13 recommendations that will form some of your
14 thinking as you plan for moving forward. Here are
15 some longer term recommendations, something like
16 that they we can -- can frame these. Any thoughts
17 about how we might prioritize these
18 recommendations, if we want to prioritize them at
19 all?
20 MAGDA PECK: Another way to do it
21 versus sticky dots, having been to all those
22 meetings, is there anything that can wait?

1 Another way to frame it is as we go through our
2 sections, is there anything that could be deferred
3 to another time? So, that's another way to both
4 put what rises to the top but also what doesn't
5 have the same sense of urgency. Because one of
6 the things about prioritization is what are the
7 criteria we use? Are we using the same criteria
8 and there is a methodologic piece here of process
9 that I think is tricky. So, that's -- that's one
10 addition to consider about how we go about this.
11 And I also am mindful of the
12 challenge from our partner organizations who are
13 taking anti-racist approaches about who makes
14 decisions and how are decisions made. So, in
15 setting priorities without having necessarily,
16 other than our individual perspectives, talked
17 about what constitutes a priority and what are the
18 things we're going to consider, are we comfortable
19 with just independent prioritization without some
20 conversation about what will influence our
21 decision-making. I think we need to be
22 transparent about the processes we use.

1 EDWARD EHLINGER: Well, given that, I
2 would then move just that we move the document
3 forward without prioritization.
4 UNIDENTIFIED FEMALE SPEAKER: Yeah.
5 JANELLE PALACIOS: Because I also
6 feel like deferring, you know, if we're going to
7 meet and talk about our recommendations again, the
8 list is going to grow. We're going to build upon
9 what we have. And so, deferring until another
10 time, it's just going to be a longer list and
11 additionally, in thinking about ranking, you know,
12 maybe we don't assign numbers to them.
13 Definitely, we can just leave it as it is listed.
14 But another idea is to think about it in terms of
15 the red zone, which is urgent, right, and the
16 orange zone, which is a little bit less urgent but
17 still very important, and the yellow zone. So,
18 there's no green because there's never a
19 greenness, but you could rank -- you could not
20 rank them but prioritize them according to zones
21 or just include it all together. And one of the
22 issues that we didn't discuss is a group. Since

1 our panel discussion on racism, what I heard and I
2 believe we all heard, that we have the opportunity
3 to be bold and specific in terms of discussing how
4 we want to advocate that racism is -- is at the
5 forefront -- or no. Maternal and infant morbidity
6 and mortality is at the forefront of a public
7 crisis -- in crisis mode, and we haven't discussed
8 that, but that should be definitely on our list
9 next meeting of how to talk about the language to
10 encourage the Surgeon General or the Secretary to
11 use some sort of strong terms -- terminology while
12 we're elevating this.
13 EDWARD EHLINGER: Well, certainly, I
14 tried to address that and we'll even strengthen
15 the wording in the introduction --
16 MAGDA PECK: In the preamble.
17 EDWARD EHLINGER: -- in the cover
18 letter and in the preamble. I mean, it's there,
19 and I'll see if it's strong enough in the
20 background paper and in the cover letter but
21 reinforce that. And, I mean, that's going to be
22 one of the conversations. So, what I'm -- in our

1 September meeting is where I hope that we again
2 can move that forward, because that's coming up
3 fairly quickly.
4 So, what I will do is I will -- I'll
5 clean up this document as best I can, get input on
6 the recommendation related to Indian Health
7 Service. I hope I can get some feedback on
8 expanding the -- the context piece from the
9 various folks who are engaged in those various
10 sections and then get back out to you any change
11 on that -- that one recommendation and then
12 finalize it with MCHB staff to get this moved to
13 the Secretary as rapidly as possible.
14 MAGDA PECK: And that's question,
15 Belinda, what is the timetable?
16 EDWARD EHLINGER: Yep, okay. I
17 didn't see that. All right. So, that's that.
18 So, what we're doing, we're going to
19 -- any other conversation about our
20 recommendations and all of this stuff moving
21 forward?
22 [Simultaneous speakers.]

1 EDWARD EHLINGER: Yes,
2 congratulations to all of us for a job well done.
3 So what I did when I started this
4 meeting is I had you introduce yourselves with
5 what were the issues that were of primary
6 importance that we wanted to deal with, and I want
7 to try to tap into those -- your passion that you
8 bring related to all of those things, and I know
9 that we're not going to have enough time to go
10 through this to say how do we want to do that, but
11 I -- but I heard from Tara was about birth
12 defects, access to service, prenatal services;
13 from Steve Calvin racial outcomes, Medicaid
14 payment reform; from Magda about sustainability,
15 birth equity, housing and narrative; from Belinda
16 about health equity and workforce; from Colleen
17 about, you know, hospice prematurity and violence;
18 Jeanne Conry about universal health care, well-
19 woman care and environmental issues; from Janelle
20 sustainability and action and truth in
21 reconciliation. Those are some of the things that
22 I heard, and I would like to try to build those

1 into our conversations over the next couple of
2 meetings, and I was hoping that we could get to
3 the how and the what. But if you're interested in
4 moving forward your issue, I would appreciate it
5 if you could send me a note saying, you know, this
6 is the issue that I raised. This is what I see
7 needs to be done and how we might be able to do
8 that because it's not going to happen unless you
9 take some leadership in moving it forward. The
10 way things are getting done with this committee is
11 if people who show up and do the work move an
12 issue. And so, I'm, you know, I want to tap into
13 your energy. So, if you can give me some sense of
14 what you're willing to do and the approach that we
15 may want to move forward on.
16 But, for my agenda for September,
17 which is going to be -- I can't remember the
18 dates. The things that I have on my list are a
19 discussion about race-concordant care, about
20 transforming narrative to create racial and health
21 equity, something that the Robert Wood Johnson
22 Foundation and the County Health Rankings had

1 done, deeper dive on fetal and infant mortality
2 reviews and maternal reviews, Indian Health
3 Service, and financing reform. Those were the
4 issues that -- that I see are front and center
5 that I would like to sort of try to tee up for the
6 September meeting unless others have other things
7 that are more pressing.
8 MAGDA PECK: Paul?
9 EDWARD EHLINGER: Paul?
10 PAUL WISE: Yeah.
11 JEANNE CONRY: Did we pick a
12 September date?
13 LEE WILSON: We did. That's going to
14 be discussed shortly. Vanessa will bring that
15 topic up for how this will be considered.
16 VANESSA LEE: Yeah, and I did just
17 put it in the chat if anyone can't wait.
18 MAGDA WISE: Paul?
19 PAUL WISE: Yes. I think all of
20 those issues are important, and I look forward to
21 discussing them. But I would also welcome an
22 opportunity here directly from MCHB and other HHS

1 units direct response to the recommendations that
2 we make. I'm very interested in hearing what
3 they're doing differently or why they rejected or
4 delayed moving forward on the recommendations we
5 made. So, I think by September, that would
6 provide enough time to get initial response from -
7 - it's not just MCHB but HHS to see exactly how
8 they're responding to the specifics of our
9 recommendations, to know what, in fact, is
10 different in their approach than it is today.
11 EDWARD EHLINGER: Good idea. Magda.
12 MAGDA PECK: And to build on that,
13 Paul, welcome back, you know, the new data
14 recommendation but more broadly, which we're going
15 to move now up into the preamble, right, Ed, is
16 about being able to, you know, assess and monitor
17 the implementation and impact of these
18 recommendations so it's consistent with that --
19 the accountability piece and seeing return on
20 investment of this particular work.
21 I want to acknowledge two other
22 things I heard today. Because it's not just the

1 how are we going to do this, but who are we, and
2 so I'm -- I recall that there is a lengthy but
3 soon to be completed, Lee, process about who is
4 SACIM in terms of its composition. We are a small
5 and mighty group. We've been able to maximize
6 this time and we're about to be augmented. And
7 so, I'm wondering also in this September meeting
8 about how do we meld this group plus new folks,
9 and I -- you don't need to say it now, but I want
10 to name -- name that as a challenge so that the we
11 becomes we and we are being inclusive. So, that's
12 one question about context. I've got two others
13 of context.
14 The others are well, what are we
15 going to do in December? And as I like to think
16 about September, but the reality is that I'm in my
17 last year and I'm looking at what are we doing
18 over the next three times? Do I ask us to put
19 this in the next 12-18 months? So, I'd like to
20 have a sense of what's the trajectory versus time
21 by time and how -- how can we imagine when our
22 next actionable steps will be hopefully approved

1 by consensus as we did today. So, I'm looking for
2 a little bit longer arc or trajectory.
3 And the third is hoping that we are
4 in person in December or January, whenever that
5 next one might be given that we've gone to
6 multiple meetings and not twice a year, which was
7 one of our initial recommendations, I'd be
8 curious, when do we have the ear of the Secretary
9 and how do we plan for that as we elevated this
10 up, if we get our wish fulfilled and this is the
11 crisis, this is the emergency, we are the group.
12 Then, what are we aiming for for that audience
13 that will elevate up the political will for us to
14 actually translate what we're doing into action.
15 EDWARD EHLINGER: You actually teed
16 up what was on my agenda for the last part of this
17 meeting. So, thank you for doing that, Magda.
18 I'm going to turn it over to Lee to talk about,
19 you know, the membership and the meetings. But I
20 do want to highlight the fact that I am going to
21 be requesting that I, along with maybe some
22 others, actually get to meet with Secretary

1 Becerra between now and September or whenever it's
2 possible to actually have that meeting. I would
3 like to invite him to our first in-person meeting,
4 which I think is going -- which I'm hoping will be
5 either in December or January -- so that we have
6 that -- that kind of connection.
7 But Lee, maybe you could inform us
8 about membership and terms of office and how we
9 set the meeting dates.
10 LEE WILSON: Sure. Thank you, folks.
11 I have sort of a laundry list of cats and dogs to
12 follow up with you about. Some of them are
13 general administrative activities, some of them
14 are around scheduling, some of them are around
15 staffing, and some of them are around the content
16 of the committee. So, I'm going to run through
17 and please raise your hand to interrupt, do
18 whatever you need to do to get my attention if one
19 of them is a sticking point for you.
20 First, I do want to put out there
21 that we are mindful of the meetings and the
22 structure of what is taking place. We have very

1 regular meetings with Ed as we work through the
2 agenda, as we select individuals who might be good
3 presenters to add to the discussion and knowledge
4 of the body. These virtual meetings that have
5 taken place as a result of COVID back to back to
6 back to back are in some ways very productive and
7 in other ways might be improved. So, any feedback
8 that you have for this current process would be
9 helpful. I am finding that I like not having to
10 sit for eight hours virtually looking at the
11 monitor for this meeting. But I'm also finding
12 that the four hours that we take each day to do
13 this isn't providing a lot of time for discussion
14 other than the clearly stated objective. So, are
15 we having an opportunity to talk about timings of
16 meetings? Are we having an opportunity to do some
17 of that additional add-on business? We had
18 delayed some of this discussion until the end
19 because we didn't want to distract from getting
20 two decisions on the recommendations, which may
21 have been very effective from that end, but it
22 didn't provide an opportunity to discuss lots of

1 details around the next meeting and we've got nine
2 minutes left before the -- before we turn to
3 pumpkins.
4 So, please provide feedback on that
5 and I'm going to provide a couple minutes at the
6 end for Vanessa to talk to you about the next
7 meeting.
8 Second, I wanted to mention that Dr.
9 David de la Cruz, who has been the Designated
10 Federal Official for the committee for a number of
11 years has taken another position with Customs and
12 Border Patrol at DHS. He has been on a
13 deployment/detail with DHS for a couple months now
14 and he has been offered a very nice position there
15 working with the response to the immigration
16 situation at the border and will continue taking
17 on that position. He is a big loss to me as my
18 deputy and I imagine to you as the committee. He,
19 in many ways, is the diplomatic one of our little
20 pair. I have a tendency to be a little more
21 direct than David, who always seems to make
22 everything nice and friendly and accommodating.

1 So, I personally will miss him a great deal.
2 We will try to arrange an opportunity
3 for him to join us at the next advisory committee
4 just to maybe give you some of his insights on
5 working with the committee over time and if
6 anybody has anything to say, we'll try to provide
7 an opportunity to recognize his contributions to
8 the group.
9 I'm pleased to say that Vanessa Lee
10 has been selected -- offered and has accepted the
11 responsibility of continuing as the lead for SACIM
12 and will be serving as the Designated Federal
13 Official for the committee. She has done the
14 training work and has been working with the staff
15 in the agency and department to be qualified for
16 that role, and I'm happy to step back from this
17 acting role and turn it over to Vanessa. She has
18 big shoes to fill, and I have every confidence in
19 her knowledge, skills, and abilities to perform
20 the job well.
21 On the topic of topics for further
22 consideration, I held off from raising any of

1 these items until after you had all made your
2 recommendations. But from the position that I sit
3 in and the discussions that we have on a daily
4 basis around maternal and infant health, there are
5 a few topics that I would just like to put out
6 there as things that are tough nuts for us to
7 crack and anything that you could provide when it
8 comes to input, insight, recommendations, or
9 counsel would be helpful both to us in our
10 discussions as well as future recommendations.
11 One, we have been dealing for a long
12 time with difficulties around the definition of
13 severe maternal morbidity, classification,
14 counting. It is -- it is a difficult concept to
15 sell to define to get our arms around and I think
16 that it would be useful for an expert body like
17 this to weigh in at some point on what should be
18 or shouldn't be included conceptually in those
19 discussions because we are consistently pushed as
20 a federal agency to be counting, to be
21 quantifying, and that would be helpful.
22 A second data issue for us is

1 identification defining and counting of birthing
2 facilities. When we talk about AIM, when we talk
3 about shortage areas, determining what is a
4 birthing facility is -- is defined in many, many
5 different ways by different states. It's counted
6 in different ways and it is a confounding issue
7 for us when it comes to trying to define the scope
8 of the problem.
9 Another issue that has surfaced; it
10 surfaced in this meeting and it's surfacing on
11 many, many levels is the balance between this idea
12 that if you are a qualified, certified, authorized
13 health care professional, you should be providing
14 good quality care, no matter who the individual is
15 and the discussion of race-concordant care and how
16 that continuum plays itself out. We continue to
17 have these discussions, and there is a sea shift
18 in the openness to those discussions, and I think
19 it would be helpful for the committee to weigh in
20 on some level on sort of the controversies, the
21 issues, the context around thinking about this
22 particular issue.

1 And this brings me into discussions
2 of MCH terminology and how we are using it and as
3 Magda has repeated a number of times, who gets to
4 decide the words we use, you know, who is that and
5 what is the control or the messaging that is
6 reflected in that. We have heard many people
7 talking about pre-pregnancy, talking about
8 birthing people, talking about chest feeding.
9 Some of these terms are sort of current
10 progressive language that people want to use to
11 not be exclusive in some way, but we are also
12 hearing from the other side that many -- many in
13 the public do not necessarily understand those
14 terms, identify with those terms, or feel that
15 that is comfortable or representative.
16 And so, as we're moving forward as an
17 organization, we want to do the best job we can
18 and if you could counsel us on your views of that
19 and how that should play itself out because we do
20 write, publish, have postings on websites -- on
21 our websites and other places and it would be
22 helpful to hear from you on that point.

1 There are a number of administrative
2 details, and I'll turn it over to Vanessa for her
3 to jump in before I go into issues of bylaws and
4 charters and that sort of thing. Vanessa.
5 VANESSA LEE: Thanks, Lee. Before
6 the charter and bylaws, we did want to just
7 quickly touch bases, he said, on the next meeting.
8 I mentioned in the chat, we have two remaining
9 meetings in the calendar year, and they were
10 tentatively in the months of September and
11 December. We had really hoped September would be
12 virtual and then the next in-person would be
13 December. We have recently been advised to make
14 all remaining FACA meetings for the remainder of
15 2021 virtual because of the uncertainty still of
16 when the federal buildings will be reopening and
17 fully open and able to host FACA meetings and
18 other gatherings. So, while we really wanted the
19 December meeting to be in person, we have been
20 advised to just sort of plan for virtual at this
21 time, again, just due to uncertainties around the
22 building.

1 We haven't selected dates for either
2 September or December. We were planning to follow
3 up again with a Doodle poll to get your input, and
4 we will continue to use that process going
5 forward. We have, however, checked some calendars
6 here internally, and with Dr. Ehlinger, and we do
7 see September 21st and 22nd seem to work right
8 now. So, I did want to get a sense of how those
9 looked for all of you, and it would be two half
10 days again. So again, we're just sort of looking
11 right now at September 21st and 22nd, 12 to 4
12 eastern time again.
13 Thanks, Magda. We can explore
14 whether we push the December meeting into January
15 in hopes that we could be in person that month.
16 Just to go out a little further, as
17 Magda said, since some of you are looking at this
18 as your sort of last year of your term, the
19 remaining meetings in the next year would be then
20 March and June. So, again it was September,
21 December, March, and June schedule. We've been
22 trying to honor your desire to meet quarterly, and

1 I think you guys raised that in 2019, and I think
2 so far, we've been able to do that. So, just keep
3 in mind if we push the December meeting to
4 January, we would probably land where we are now
5 where we had an April meeting and then there was
6 only two months left before the end of sort of
7 this logistics contract we use. So, that final
8 meeting would be in June, but you'd have just
9 about two months in between the April and June
10 meeting.
11 So, I know that was a lot of
12 information again. We'll follow up over E-mail
13 and use some sort of polling to get your input for
14 all future meeting dates.
15 Lee, was there anything I missed or
16 Ed around the meetings?
17 EDWARD EHLINGER: Well, I know I
18 raised this issue once upon a time that could we
19 meet outside of a federal building. I was hoping
20 that we could, at some point in time, meet, you
21 know, at a community center where we could
22 actually get some community input, and that was

1 not encouraged by the MCHB and HRSA folks. But I
2 think if we're going to -- I would love to have a
3 meeting where actually -- we could actually take
4 some public testimony in person that's not part of
5 our meeting, but just a hearing -- a listening
6 session at some point in time where we can her
7 people and it would take some planning, because I
8 would like to have that done in an accessible
9 place rather than a federal building.
10 LEE WILSON: I'd be happy to have us
11 explore that idea. I don't know that given what
12 we know about or what we don't know at this point
13 about opening up that September would be a good
14 opportunity for that. But we can explore the next
15 meeting or two to see about a meeting -- a
16 gathering, a, of the members together and whether
17 or not that could or is logistically possible to
18 do someplace outside of the building. So, I hear
19 you. We will explore that and Ed, as you and I
20 have further conversations over the next few
21 weeks, we can -- we can look into that.
22 I think one -- one thing for me that

1 would be important to hear is your level of
2 satisfaction with having a virtual meeting in
3 December. I had been really firm with staff about
4 doing an in-person meeting, at least one in this
5 calendar year. Again, I'm not sure that that's
6 going to be possible. We may have to move it to
7 January. But I really wanted to hear whether or
8 not you felt that was a must have and if it is
9 must have, then we can push harder and maybe move
10 things around to do it in January if -- if you
11 feel the urgency in that. If you're fine or if
12 there are those who -- many of you may
13 insecurities about doing that as early as
14 December, and if that's the case, then we won't
15 push as hard.
16 EDWARD EHLINGER: What's the thought
17 of the committee? I mean, I personally think we
18 need an in-person meeting. There is so much that
19 we're missing and with the connections and the
20 discussions that occur outside of the meeting that
21 I think that would be high priority for me. Is it
22 absolutely essential? No, we're doing, I mean,

1 we're getting by with virtual meetings, but it's
2 not optimal. Unmute, Magda.
3 MAGDA PECK: Sorry about that. I
4 tried to keep my mouth shut. I'm -- I think that
5 there's multiple issues that have come together
6 that might have a sweet spot, and that is to be
7 able to travel to DC, Virginia, Maryland area.
8 Belinda points out that there's excellent Healthy
9 Start and other opportunities to be in community
10 and hear directly community voice. And so, I
11 would pursue the in-person together with an off-
12 site. That would make it far more compelling.
13 And I would also add that most organizations,
14 including the CityMatch, CDC, MCH epidemiology
15 meetings will be hybrid into December, and so a
16 hybrid model for those who can and will travel and
17 being able, as you have, to accommodate those who
18 would either not or would feel less comfortable
19 being able to do so. But I think getting outside
20 that building and seeing and being together with
21 an expanded SACIM and grounding that so that we
22 can hand off, that's critical.

1 EDWARD EHLINGER: Yeah, and I beg
2 your pardon. We are going to be -- we're going a
3 little bit longer than the 4:00 thing, but I think
4 stay around as long as you can, please.
5 LEE WILSON: So, we will continue to
6 explore. Practically, one of the things that
7 would be helpful for us to know is we had
8 scheduled December to be the date when we would
9 have the -- the second meeting -- the meeting
10 after the September meeting. I don't know the
11 degree -- there are many, many organizations
12 planning meetings that have been backed up or
13 delayed meetings. So, there is a lot going on in
14 December this year and travel takes up more time
15 to make a meeting happen. So, if there are
16 individuals who would not be in a position to
17 travel in December for a December meeting, please
18 let us know, because we don't want to have this
19 meeting and then only have four or five people be
20 able to attend.
21 MAGDA PECK: Absolutely.
22 LEE WILSON: Okay. So, I'm going to

1 move on and folks can either put their input into
2 the chat or send it to us directly. There are a
3 few other items that I wanted to mention to you.
4 One, an update on new members. As
5 I've said, the nomination package is continuing to
6 move forward. For those of you who may not
7 recall, the availability for members or the
8 maximum number of members currently is listed at
9 twenty-one. We have ten on the books, I believe,
10 at the moment. And so, we are moving forward with
11 trying to fill out as fully as possible the
12 numbers of members that we are recommending. I am
13 not in a position to tell you how many are current
14 on the list because some come in and some have
15 moved out because of the time and ethics issues
16 and those sorts of details and I don't know where
17 all of that is at this point. But we are in the
18 middle of processing that.
19 We are also in -- this is a two-year
20 cycle for the process. So, we are in the process
21 of generating the next list after that this month
22 in June and July to move beyond and get into a

1 cadence with the nomination process so that we are
2 never in a situation again of having as small a
3 committee as it is right now. Not that we don't
4 appreciate the number and the quality of work, but
5 we would like to have as robust and representative
6 a group as possible.
7 MAGDA PECK: Absolutely.
8 LEE WILSON: So, we are moving on
9 that and this is one of Vanessa's major
10 assignments with the committee at this moment. We
11 continue to accept names and nominations for
12 individuals for the committee and they will be
13 considered, although we have used the list that we
14 went out with last year for nominations as a base
15 because we received over 150 names. We've also
16 collected names from this committee of your sort
17 of nominations of other individuals we might
18 consider. So, we -- we continue to accept those.
19 They will continue to be considered, and we go
20 through a matrixing process to identify sort of
21 what areas of expertise, regional representation,
22 race, ethnicity, gender to make sure that the

1 committee is not slanted overly or overly weighted
2 in a particular way. So, feel free to continue to
3 submit names.
4 As it relates to the charter and the
5 bylaws, we continue to move through the process
6 with the charter. We need to have the charter
7 completed and approved by September 30th. Some of
8 these are in process and these bureaucratic
9 processes are -- there is sort of a waiting list
10 for the approval of these based on the urgency and
11 when the political decision-makers have the time
12 to do that. Many of have been to the airport and
13 you've stood in line for a while and then the
14 guard comes out and says anybody who has a flight
15 in the next fifteen minutes, cut to the front of
16 the line, and that seems to be where we are right
17 now with the administrative processes in a new
18 administration coming in, trying to make sure that
19 things don't expire. So, we are in the queue. We
20 wait, although we're also mindful of the fact that
21 there are those who are permitted to jump in front
22 of the line and I'm just being perfectly honest

1 with you about the process. We have no indication
2 that the charter will expire without getting due
3 attention because we're seeing them try as best
4 possible to ensure that none of the charters
5 expire. We have incorporated the recommendations
6 and suggestions that Ed and the rest of the
7 committee have made to both the charter and the
8 bylaws, and we're moving them forward as best
9 possible and as quickly as possible. Are there
10 any questions on charter and bylaws?
11 Vanessa has talked about remaining
12 meetings and I believe that -- let me just run
13 through -- I believe that covers all of my items.
14 EDWARD EHLINGER: Thank you, Lee.
15 Thank you for all of your work and welcome
16 Vanessa, as our Designated Federal Official.
17 Appreciate that. It will be good.
18 VANESSA LEE: Thank you.
19 EDWARD EHLINGER: Are there any other
20 issues that people want to raise in our last
21 minute?
22 MAGDA PECK: I want to express

1 gratitude to Dr. Ehlinger for just providing
2 Yeoman's leadership and work through -- to get
3 stuff done and thanks to all of you for anteing up
4 and doing the word. And thanks for the support
5 for MCHB and others, of course. And I want to
6 call out the design that we did two years ago to
7 be able to have working groups that bring in more
8 robust, diverse voices given how small we are has
9 been critical, and I would encourage us to
10 consider how we can continue to have that be a
11 doorway -- a welcome doorway for either broader
12 diverse views and perspectives as we strive in our
13 work for anti-racism. So, thanks, Ed, and thanks
14 everybody.
15 EDWARD EHLINGER: Thank you. The
16 work groups are -- they are not statutory. They -
17 - they are just pulled together to get a job done.
18 So, if you're going to send me a note saying, you
19 know, you want to work on something, we can have a
20 work group related to an issue that you want to
21 work on.
22 MAGDA PECK: Absolutely.

1 EDWARD EHLINGER: We don't have to
2 continue these work groups that we have as they're
3 structured right now. So, you have a lot of
4 opportunities. As I started out, this is a unique
5 group, a very small group, very -- you know, we're
6 privileged to be part of this. We have an
7 opportunity to make a difference. I think that
8 our work over the last two days will make a
9 difference. As I led off today talking about
10 pitching horseshoes, I think we've got a majority
11 of ringers. We really got the maximum benefit out
12 of the work that we've done. Some are close but
13 they're in the pit. They're in the right area.
14 They may be a little bit left, maybe a little bit
15 right, a little bit too far, a little bit short,
16 but they're getting close and we're getting better
17 as we do this. And we're going to be moving this
18 forward and we're going to make a difference. So,
19 thank you. Thank you for the work that you've
20 done. I look forward to continuing working with
21 you over the next 12 to 18 months, whatever it
22 might be. So, have a good rest of the week. Take

1 care.

2 LEE WILSON: Thank you.

3 [Whereupon the meeting was adjourned.]

4 [Off the record at 4:10 p.m.]

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1 R E P O R T E R   C E R T I F I C A T E
2
3 I, GARRETT LORMAN, Court Reporter and
4 the officer before whom the foregoing portion of
5 the proceedings was taken, hereby certify that the
6 foregoing transcript is a true and accurate record
7 of the proceedings; that the said proceedings were
8 taken electronically by me and transcribed.
9
10 I further certify that I am not kin to
11 any of the parties to this proceeding; nor am I
12 directly or indirectly invested in the outcome of
13 this proceedings, and I am not in the employ of
14 any of the parties involved in it.
15
16 IN WITNESS WHEREOF, I have hereunto set
17 my hand, this 7th day of June, 2021.
18
19
20 ____________/S/______________
21 GARRETT LORMAN
22 Notary Public