The Secretary's Advisory Committee on Infant Mortality

US Department of Health and Human Services

Virtual Meeting

Day 1

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Reported by Garrett Lorman

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Paul H. Wise, M.D., M.P.H., Richard E. Behrman Professor of Pediatrics, Health Policy and International Studies, Stanford University

Ex-Officio Members

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Wanda D. Barfield, M.D., M.P.H, FAAP, RADM USPHS (ret.), Director, Division of Reproductive Health, Centers for Disease Control and Prevention

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Paul Kesner, Director of the Office of Safe and Healthy Students, U.S. Department of Education

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Dorothy Fink, M.D., Deputy Assistant Secretary, Women's Health Director, Office of Women's Health, U.S. Department of Health and Human Services

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C O N T E N T S

P R O C E E D I N G S

WELCOME, CALL TO ORDER, AND INTRODUCTIONS

VANESSA LEE: Good morning or good afternoon, depending on where you are. Welcome to the Advisory Committee on Infant Mortality, our September meeting.

I'm Vanessa Lee. I'm the new Designated Federal Official, or DFO as we fondly call it, for the committee. I have big shoes to fill with Captain David de la Cruz's departure for another position, and I'm just really honored and excited to be in this new role to support the committee.

I'm officially calling the meeting to order and opening it up. So, before we do introductions, I'll turn it over to our meeting Chair, Ed Ehlinger, for another welcome.

EDWARD EHLINGER: Thank you, Vanessa. And good morning, good afternoon, and good evening to everyone on this last day of summer. The autumnal equinox is coming. Tomorrow is the first day of fall, a good place when we have equal night and day. So, welcome to this virtual meeting of

SACIM.

Also, this is the United Nations International Day of Peace. And as you're probably well aware, the World Health Organization puts peace at the top of their Social Determinants of Health Pyramid. So, it's a good day to be thinking about peace. That would really help moms and babies throughout the world.

Also, this is the beginning, the first day of Sukkot, which runs through the next week. And the first two days of Sukkot, which are basically today and tomorrow, tradition instructs Jews to eat and sleep in the sukkah, a traditional hut or tent. And they do this to inhabit the experience of living without and the experience of having an impermanent home. And this is what many generations of Jews have experienced while fleeing persecution and poverty for many centuries.

But today, thousands of other families don't have access to safe and stable homes. Not only because of war or expulsion, but because of poverty and housing and economic

policies. And certainly, we know that safe, stable, and secure housing is a major determinant of health, especially for infants and children.

So, and Sukkot is also experienced as a way to gain a new perspective on vulnerability. So, I want you to keep Sukkot in mind, two days when the first two days of Sukkot are the first two days of our meeting. Let's keep Sukkot in mind for the sake of the vulnerable. Let's inhabit the experience of being vulnerable.

It's also in that spirit of experiencing being vulnerable, I have to share that in the last year I have had the privilege to work with several state and local health departments and health care systems, particularly maternal and child health programs across the country. In my 50 years of working in health care and public health, I have never seen public health and medical care professionals so stressed and feeling so vulnerable as at this point in time.

At a time when their expertise and experience are most needed, many are feeling

unappreciated and unsupported. At a time when we have more health care and public health tools than ever before, public health and medical care recommendations are frequently being challenged, ignored, or even contradicted.

At a time when we have the greatest need to change systems to advance health and health equity, these professionals are constrained to act. In fact, many cannot even use the word "equity" or talk about racism. And at a time when everyone should be coming together to address an existential challenge, like the pandemic, people seem to be further apart than ever before.

So, this reminds me of Charles Dickens 162 this month when he wrote about the French Revolution of 1789. He said, and you know this well, "It was the best of times, it was the worst of times, was the age of wisdom, it was the age of foolishness, it was the epoch of belief, it was the epoch of incredulity, it was the season of light, it was the season of darkness, it was the spring of hope, it was the winter of despair. We

had everything before us and nothing before us."

As I interact with public health workers across the country, and even people in my neighborhood, we seem to have come against this worst of times more so than the best of times. Certainly, now in this day and age, just like in 1789 and 1859 when Dickens wrote that, the worst of times scenario is precipitated by a conflict of seemingly incompatible ideologies and perspectives that shut down dialog and mutual problem-solving.

And that is why our work, the work of SACIM, is so important because we have the opportunity to have some of those needed conversations about issues that might be controversial, or we might have conflicting opinions. And we need to model how to discuss issues in a respectful and responsible way. We can do the things that many public health officials throughout the country cannot do. So, this is why our work here today is so important.

And core to discussing this kind of discussion is maintaining a focus on the values,

not on the ideologies, which all of us present -- we all have ideologies. But let's focus on the values like equity; community resilience; lived experiences objective data, both qualitative and quantitative; prevention; openness, and humility.

These are the values that will help keep us grounded and help us to recognize that issues are rarely black and white. These values will help us to come to conclusions which will benefit all members of our community. So that's what I hope drives the work of SACIM today and forever.

And among those values that I think are important are being bold and strategic. I those up because at our last meeting, former Secretary Savilias (ph.) told us to be bold. So, I want you to be bold. I want you to bring forward ideas. We need to have a good, robust discussion.

And think about how we can advance the work of SACIM beyond just our virtual Zoom and among our members. We need to be able to have the

ability to be bold and advance the agenda's recommendations that we put forward.

INTRODUCTIONS

So, let's add a little background. I want you to be bold and introduce yourselves. Normally, I would have longer introductions, but we do have a tight agenda. And we have a time constraint with the Assistant Secretary of Health, who will be joining us at the bottom of the hour.

So, I would just like to go around and have people introduce yourselves, both the members and the ex-officio members.

I'm Ed Ehlinger. I'm the Acting Chair. Here in Minnesota and Dakota and Chippewa land. I am glad to be your Acting Chair.

And I will go around and -- Tara.

TARA SANDER LEE: Good morning. I'm happy to be here. My name is Tara Sander Lee. I'm a scientist and the Senior Fellow Director of Life Sciences at the Charlotte Lozier Institute. And I'm looking forward to a couple of days of great discussion. Thanks, Ed.

EDWARD EHLINGER: Jeanne Conry.

JEANNE CONRY: I'm Jeanne Conry, past President of the American College of Obstetricians and Gynecologists and President-Elect of the International Federation of Gynecology and Obstetrics.

EDWARD EHLINGER: Welcome.

Magda Peck.

MAGDA PECK: Good morning. I woke up in Richmond, California, on Ohlone, Muwekma, and Chochenyo lands. I am an independent consultant for public health and equity with MP3 Health. I'm the founder and senior advisor to CityMatCH and adjunct professor of pediatrics and public health at the University of Nebraska Medical Center. Also, the co-lead for the Data and Research to Action Workgroup on SACIM. Good morning.

EDWARD EHLINGER: Good morning.

Steve. Steve Calvin.

STEVE CALVIN: Hi. Steve Calvin. I'm a maternal/fetal medicine doctor here in Minnesota, and I work with midwives to try to provide a different model of midwife-led primary

maternity care that's integrated with the current system. I'm happy to be here today.

EDWARD EHLINGER: We're glad you're here.

Paul Wise.

PAUL WISE: Good morning. I'm Paul Wise, Professor of Pediatrics, Health Policy and International Studies at Stanford. And for the past two years, I've been appointed to the federal court overseeing the treatment of migrant children in U.S. detention. Thanks, Ed.

EDWARD EHLINGER: All right. Glad you're here.

Janelle Palacios.

JANELLE PALACIOS: Hi. Good morning, everyone. My name is Janelle Palacios. I'm Salish-Yokuti. I am a nurse-midwife. I have been for the past 11 years. I work in the Bay Area. And I am a co-chair of the Health Equity Workgroup with Belinda Pettiford. I am a research consultant and have expertise in American Indian women's health.

EDWARD EHLINGER: Glad you're with us, Janelle.

And Janelle will share that she doesn't have childcare, so we may hear some little voices in the background periodically.

JANELLE PALACIOS: Yes. And everyone's voices.

EDWARD EHLINGER: Colleen.

COLLEEN MALLOY: My name is Colleen Malloy. I am a pediatrician and neonatologist in Chicago. I work for Lurie Children's Hospital and Northwestern University Feinberg School of Medicine. And I work in level 2 and level 3 NICU.

EDWARD EHLINGER: Good. I'm glad you're with us.

Belinda. I don't see your picture here. Belinda, I hope you're on.

EMMA: Belinda shared that she had to reboot her computer. So as soon as that is finished, she'll be able to log on.

EDWARD EHLINGER: Right.

And is Paul Jarris on? I don't see

him.

All right. So welcome to all of those SACIM members. Let's go through the ex-officio members.

Wanda Barfield.

WANDA BARFIELD: Good morning and afternoon to everyone. My name is Wanda Barfield. I direct a division of Reproductive Health. I currently reside on the land of Creek, Muskogean, and Cherokee. And I am also an immunologist (ph.) by training. Great to see everyone.

EDWARD EHLINGER: Alison.

ALISON CERNICH: Good morning, everyone. I am Alison Cernich. I am the Deputy Director of the Eunice Kennedy Shriver National Institute of Child Health and Human Development. I'm (inaudible 00:21:05) patron.

EDWARD EHLINGER: Karen Remley.

KAREN REMLEY: Hello. Karen Remley, pediatrician and the Director of the National Center of Birth Defects and Developmental Disabilities at CDC. Thank you.

EDWARD EHLINGER: Kristen Zycherman.

KRISTEN ZYCHERMAN: Hi. I'm Kristen Zycherman. I have a background in labor and delivery nursing and research. And I am at the Centers for Medicare and Medicaid Services as the MIH lead and the lead of the Maternal Infant Health Initiative.

EDWARD EHLINGER: Joya.

JOYA CHOWDHURY: Hello. I'm Joya Chowdhury representing the HSS Office of Public and Minority Health.

EDWARD EHLINGER: Anybody else? Any other ex-officio members whom I haven't identified?

KAMALA VISTRY: I'm Kamala Vistry (ph.) from ARC. I'm the Senior Advisor for Child Health Inform and Present, and also the advisor for Externalities for Education for a Happy Nation.

EDWARD EHLINGER: Good. Welcome.

MICHAEL WARREN: That means Michael Warren. I'm the Associate Administrator of the

Maternal and Child Health Bureau.

DANIELLE ELY: I'm Danielle Ely from the National Center for Health Statistics, and I work on the Linked Birth and Infant Death Forum.

EDWARD EHLINGER: Some of these names just pop up out of nowhere. So, sorry I didn't connect with you earlier.

Lee.

LEE WILSON: Good morning and afternoon. My name is Lee Wilson. I'm the Director of the Division of Healthy Start and Perinatal Services in the Maternal and Child Health area. Thank you.

EDWARD EHLINGER: Good.

Well, welcome to you all.

RECOGNITION OF DAVID DE LA CRUZ

EDWARD EHLINGER: Before we get into the major part of our agenda, we have another major part of our agenda, which is to recognize Captain David de la Cruz, who was our Designated Federal Officer, our DFO, for 15 years. And during his tenure as DFO, he has onboarded and guided and supported several cohorts of SACIM, and

he's the one who brought all of us into this committee and provided the support and guidance, and direction of more of our in-person and our virtual meetings.

As Acting Chair, which I've been acting chair now for three years -- I don't know how you ever get to become actual Chair. But anyway, as Acting Chair, David was very responsive and always looking for ways to enhance the impact of and effectiveness of SACIM. He did that in addition to all of his multiple other duties at MCHB and at HRSA.

Recently, as part of his work as a commissioned core member of the U.S. Public Health Service, he has been detailed to work on COVID issues both in Texas and now at U.S. Customs and Border Patrol Headquarters in Washington, D.C. And this has taken him from his work in his MCHB role.

So, I really wanted to bring David back so that we could all recognize him. He's been a joy to work with.

So, David, thank you for all of your work with SACIM and particularly working with me. I've really enjoyed it. And really, best wishes for whatever lies ahead for you.

So, everybody on this call, why don't you just give him a clap and great thanks for the work that he's done over all of these years.

(Chorus of "Thank you, David")

DAVID DE LA CRUZ: I want to thank you. That's incredibly kind and very unnecessary. It was really an honor and a privilege to work with so many outstanding leaders.

Many years ago, when I started this, I felt very fortunate to be in the presence of some of the people I studied when I was in school and some of the people I really looked up to. And to be able to sit at the same tables was a real honor. And I thank you all. This was very unnecessary, but very much appreciated. So, thanks very much.

EDWARD EHLINGER: I'm going to put you on the spot, David since you're here. What

have you seen SACIM do in the 15 years that you were DFO?

(Simultaneous conversation)

EDWARD EHLINGER: -- that you're proudest of for the committee that you basically supported?

DAVID DE LA CRUZ: Yeah. I think that continuing to be a voice of a population that doesn't always have a voice. To increase the visibility of some of our most vulnerable populations and communities to the very highest levels of HHS and beyond I think is something that is good and noble work and should be remembered and should be something that is continued, a continued priority.

And you all are under very good leadership with Dr. Warren and others. These are folks who are committed to making sure that the populations that we serve and the communities we serve are given the best possible chance at optimal society and optimal life.

And I think that raising these issues

to the highest members and the highest levels is incredibly important and something that needs to happen and something that you all remain committed to and work very hard at. And it isn't always recognized. Perhaps it isn't always thanked. But it is something that is incredibly important.

And one of my very first mentors, Dr. Vince Hutchins, was one of the people who always described this as good and noble work. And it's work that will never make us rich or famous. But there are lots of ways to measure wealth and to measure value. And I think each of your lives that every day. It's just a real pleasure to have been an extremely small part of that.

Really, it's raising the visibility and raising these issues, keeping in the forefront of the people who make some important decisions whether that's policy or funding. I think that's probably the greatest that we've done as a committee.

EDWARD EHLINGER: We'll be talking about that when we talk about the recommendations

that we submitted to the Secretary.

Do you have any suggestions on how we can actually increase our effectiveness? Are there any strategies that we should be thinking about?

DAVID DE LA CRUZ: Now that I'm not at HRSA, maybe it's easier for me to say this. Be persistent. Don't give up. The work that you are doing is too important to stop at the first no. Just keep going. Don't be satisfied with the status quo, don't be satisfied with a general response back.

I was teasing Vanessa earlier, saying that, as this being her first meeting as the official DFO, somehow, she managed to score the ASH. You know, what a great opportunity to not only hear from her but perhaps even more importantly share with her the good work that you all are doing.

Just keep pushing to be heard and seen because too often the populations you serve are not being heard and seen.

UNIDENTIFIED MALE SPEAKER: David, can I ask one question? Would you share with the group what you're doing now?

DAVID DE LA CRUZ: Oh, sure. So, I'm at Customs and Border Protection's Office of the Chief Medical Officer. I'm the medical operations and emergency response coordinator. So, when I started back in March, it was really mostly COVID. But it has quickly changed to, you know, dealing with the increase of people crossing over the border.

And Dr. Roth-Wise (ph.). You know, I work with David Day (ph.) and with Jerry Perasca (ph.), whom I know you work with, with some of the issues, you know, the treatment issues and the advocacy work that you do.

So, I provide coordination, support, and leadership for different teams that are down along the border, making sure they have everything they need to succeed as they work in these border patrol stations for the Office of Field Operations. It's very different work than

where I came from. I'm reminded on almost a daily basis this is a law enforcement agency. That is not my background. But very luckily, I'm able to bring in a lot of my maternal and child health experience in this work, because so many people that we're serving are unaccompanied minors.

EDWARD EHLINGER: Thank you, David. Thank you for the work that you're doing now and thank you for all of the work that you did for SACIM. I really appreciate it. And I hope I get to work with you sometime in the future again because --

DAVID DE LA CRUZ: It would be my pleasure, sir. It would really be my pleasure. It was great working with each of you.

EDWARD EHLINGER: Very good.

I see Belinda is now on.

Belinda, could you introduce yourself?

Yes. Hello, everyone. I was going to say, "good morning," but it's not morning where I am. But hello, everyone. It's good to see

everyone.

I'm not sure what my challenges were this morning, but I'm on a second computer, so we're going to hope this one works.

I am Belinda Pettiford. I'm in a North Carolina local State Department of Health and Human Services. And there I serve as head of women's health, which includes the maternal/child health programs in our state, including reproductive health, as well as our state cycle-cell program. So, good to see y'all.

EDWARD EHLINGER: I think we've got all of the members except for Paul Jarris, and I know Paul Jarris was biking across the United States, because I know he came through Minnesota. I assumed he was going to be done by this time. So, maybe he's still in -- I don't know -- Pennsylvania or something and can't get on. But I haven't heard from him. So, we've got everybody else.

Anybody else who's come on that's from -- any ex-officio members whom we haven't

introduced?

(No audible response)

EDWARD EHLINGER: All right. If not, I will turn it back over to Vanessa, who will introduce Diana Espinosa.

WELCOME AND COMMENTS BY HHS LEADERSHIP

VANESSA LEE: Hey, thank you. And it is just now my pleasure to introduce our Acting Administrator of HRSA, the Health Resources and Services Administration, Ms. Diana Espinosa.

She has been the Deputy Administrator of HRSA since March of 2015, and prior to that served as a senior advisor to the HRSA Administration from 2013 to 2050; provided counsel to our Administrator at that time on a wide range of policy, program, and management issues.

Before joining HRSA, she was with the Office of Management and Budget, serving as the Deputy Assistant Director for Management. And before her federal service and all of the work she's done with us at HRSA, earlier in her career she served with the Miami-Dade County Government where she held a number of posts, including

operating budget coordinator.

Ms. Espinosa attended the University of Michigan, where she received her Master of Public Policy. And now I will turn it over to her.

DIANA ESPINOSA: Thank you and good afternoon, everyone. I just want to wish good afternoon to our committee members, ex-officio members, HHS, MCH leadership, everyone in attendance.

As Vanessa mentioned, my name is Diana Espinosa, and I am HRSA's Deputy Administrator. And I'm currently serving as the Acting Administrator. So, I'm very excited to be with you today. I think it's been several years since I've had a chance to visit with this committee.

And at the outset, I just really wanted to thank you all for your service and commend you for the great work, hard work that you've been doing for a while, but especially over the last year-and-a-half.

I think there are challenges in doing everything under COVID. Obviously, this is one of the biggest public health challenges that the world has experienced in the last 100 years or so. And I just really appreciate that you all have remained engaged and passionate about the work that you do.

Your committee is a widely respected group. And our Agency very much appreciates the counsel and thoughtful advice that you have provided it over the years. We share your goals of preventing infant and maternal mortality and improving the health of all mothers and children. I really wanted to assure you that HRSA does value your feedback, and we continually work to integrate your guidance and recommendations into our programs.

Your commitment to eliminate disparities and achieve better maternal/infant health in vulnerable populations is clear in your most recent recommendations to the Secretary and aligns very much with the priorities of the

Secretary.

Today I will just mention a few updates on some of the work that HRSA is doing that I think relates to your priority areas. And before I do that, I would also like to take the opportunity to acknowledge Captain de la Cruz. David has served as this committee's Designated Federal Official for many years. And I obviously had the opportunity to also work with David in his great work with the Healthy Start Program.

I guess it's a strange world where I get to say goodbye after people have already left and haven't seen you for months. I don't have those passing-in-the-building kinds of things. But I just wanted to thank you, David, for your leadership in managing this advisory committee and your steadfast support of its members and their work.

This committee has always been one of our more active and engaged committees, and I'm sure that that is in a large part due to David's leadership and dedication as a DFO.

I know we will all miss you at HRSA, and you're doing important work. Thank you for sharing that. I also appreciate that during your time at HRSA, you always stepped up where you were needed. And that obviously was also with your commission core responsibilities since you were deployed many times over the last few years. So, I just wanted to thank you.

DAVID DE LA CRUZ: Thank you, ma'am.

DIANA ESPINOSA: Oh, sure.

And you can always come back and visit us when we're all back in a place where you can visit us all at one time.

So, moving on to our updates, I just want -- as I mentioned, I wanted to share some of the priority areas that HRSA is working on that align with your recent recommendations to the Secretary. For example, we know that the longer that the pandemic lasts, the more health workers, especially those serving in rural areas and communities of color where the pandemic has hit the hardest, continue to face challenges,

including mental health challenges.

Because of that, I am especially pleased to report that through the American Rescue Plan, HRSA received some funding and has $100 million that we will be awarding for organizations to work on reducing burnout and promoting mental health among the health workforces.

So, I think all of you appreciate that it's essential that we provide behavioral health resources for our health care providers, and this doesn't -- you know, obviously this includes physicians and nurses, but also it includes paraprofessionals and public safety officers, and the wide of range of people who are truly on the front lines so that they can continue to deliver quality care to our most vulnerable populations.

And I think that these three new programs that we have will hopefully help begin to address these issues and make sure that we built this in as a regular part of health professionals' training, that wellness being incorporated for the

long term, as well as addressing the current, immediate needs that we're all facing.

Later today you'll hear more about these efforts from our HRSA Bureau of Health Workforce.

We've also made important investments to strengthen telehealth services in rural and under-served communities, and to support pediatric mental health care access. And we've also recently elevated that telehealth function in our Agency because of the importance of telehealth in providing health care, especially to under-served communities.

In addition, we're responding to recommendations you've made to support pregnant women, mothers, infants, and children, in particular those near our country's southern border. And already, you know, I'm proud to report that HRSA has dispatched our own staff, both members of the commission corps and civilian employees to provide as much assistance as we can to help keep families safe and together.

And finally, we at HRSA are resolved to continue our emphasis on health equity through all of our bureaus, as you outlined in your recommendation. I think health equity is core to our mission, it's built into all of our programs, and where it can be strengthened, we will make sure we do that.

I think that we will always really value this opportunity to bring a concerted focus on health equity, as it is central to everything we do in our Agency.

And you'll hear more specifics later from our Maternal Child Health Bureau on our efforts to improve health outcomes before, during, and after pregnancy. You will also hear an update on our work to reduce racial and ethnic disparities in infant mortality rates, including supplemental funding for Healthy Start grantees that supports community-based doulas and infant health equity efforts that we announced on September 17th.

So again, I just want to thank you

and just emphasize that your recommendations, ideas, suggestions, feedback are all critical as we continue to support women, infants, and families. I look forward to our continued collaboration. And thank you for your service.

So now it's my pleasure to introduce our Assistant Secretary for Health, Dr. Rachel Levine. Dr. Levine serves as the 17th Assistant Secretary for Health, or HHS, where she fights every day to improve the health and wellbeing of Americans. HRSA is fortunate to have her as an excellent partner, as much of our missions overlap and complement and are working in the same direction.

She's working now to help our nation overcome the COVID-19 pandemic and bring a brighter future, one in which every American can achieve their full health potential. Dr. Levine's career includes a wide variety of work in different fields, from academic medicine, working as a physician, serving as Pennsylvania's Physician General, and more recently as

Pennsylvania's Secretary of Health.

As a physician, she focused on the intersection between mental and physical health, often treating children, adolescents, and young adults. She's also the author of numerous publications on the opioid crisis, adolescent medicine, eating disorders, and LGBT medicine.

With that, I will turn it to Dr. Levine.

RACHEL LEVINE: Thank you. Thank you so much for your very kind introduction.

I'm really pleased to join you all here today. And I told you before I love HRSA. I think HRSA does such a fantastic job supporting public health and health care really throughout the United States. And I'd really like to thank your outstanding team at the Maternal and Child Health Bureau for all of their efforts supporting this advisory committee.

You know, I certainly recognize the importance of my role as the Assistant Secretary for Health. As Diana had talked about, I come

from a career in academic medicine at Mt. Sinai in New York City and Penn State, where I worked for about 20 years. And I am a pediatrician in my initial training, and then an adolescent medicine subspecialist. I've also, as you mentioned, been the Physician General of Pennsylvania and the Secretary of Health in Pennsylvania.

So, you know, I certainly understand the value of public service. And I really would like to thank you all for your commitment and dedication to serve and provide leadership to reduce infant mortality and improve the health status of pregnant women and infants. It's absolutely critically important.

I also will talk about the COVID-19 pandemic at HRSA. It has been a very difficult and challenging time. It has caused tremendous challenges and suffering for millions of people in America and really throughout the globe. We all have felt the strain.

It has been particularly challenging for public health professionals and, of course,

for medical professionals. And it continues to be the biggest public health crisis that our nation and the world has seen in over 100 years. It has impacted all of us, and it has impacted our health, our families, our hospitals and health care system, our schools, our businesses, and has impacted governments at the local, state, and federal levels.

I certainly want to encourage anybody who has not received a COVID-19 vaccine to please go get vaccinated and refer it to your family and friends and communities to get vaccinated. We have actually a very, very vigorous community core for coronavirus.

So, we encourage people to be spokespersons, whether it's officially or unofficially, of our safe and effective vaccination program. Because the more people who get vaccinated, the quicker we can work through this pandemic.

As you all are aware pregnant and recently pregnant women are at a higher risk for

severe illness and COVID-19 than non-pregnant women. Additionally, pregnant women are at the highest risks for preterm births and higher risk for other adverse pregnancy outcomes.

In August CDC released an analysis of data from the v-safe pregnancy registry that assesses vaccinations in pregnancy. The CDC found that there was not an increased risk of miscarriage among nearly 2,500 people who received one of the mRNA COVID-19 vaccines before 20 weeks of pregnancy.

Miscarriage typically occurs around 11 to 16 percent of pregnancies. Miscarriage rate after receiving the COVID-19 vaccine was around 13 percent, which is right within that expected rate. Previously, data from three safety monitoring systems did not find any safety concerns for pregnant women who were vaccinated late in pregnancy or for their babies. That is late in pregnancy or for their babies. So combined, these data with the known severe risk of COVID-19 during pregnancy demonstrate the significant benefits of

receiving the COVID-19 vaccine for pregnant women and has outweighed any known or potential risk.

The increased circulation of the highly contagious Delta variant and the increased risk of severe illness in pregnancy complications related to COVID-19 infection make vaccination for pregnant women more urgent than ever. We need to encourage all pregnant women or people who are thinking about becoming pregnant and those breastfeeding to be vaccinated to protect themselves from COVID-19.

The vaccines are safe and have an excellent safety record. They are effective. And it has never been more urgent to increase vaccinations as we all face together the highly transmissible Delta variant. We see the severe outcomes from COVID-19 among unvaccinated, pregnant women.

This is such a big issue. It is absolutely tragic to see the illnesses and the deaths that we are seeing. An important lesson of the pandemic is that we are all interconnected.

We are all interconnected, and we have to make sure that a healthier future includes addressing COVID-19 and addressing the health disparity that COVID-19 has shown -- the health disparities that exist in the COVID-19 response and those health disparities that COVID-19 has shown us.

So, health equity, as Diana was mentioning, is an absolute priority. As secretary of the staff, and as the Secretary of HRSA, and it's a priority of HRSA, and it's an absolute priority for OAS as well. And in the child maternal health space, it's a priority.

COVID-19 has certainly impacted some communities more than others. Communities of color, among the African American communities, the Latinx community, among the American Indian and Native Alaskan communities, among the AAPI groups, it has underscored the founders' disparities in health that have plagued our nation.

So, we want to pursue a comprehensive approach to advancing equity and health equity for all throughout the Biden–Harris administration and

throughout HHS. This includes the creation of the COVID-19 Health Equity Passports, which we will be making recommendations to the President. I want to highlight that our next meeting is Thursday, the 30th, in about a week and a half at two o'clock. Please participate and submit your feedback.

As you are aware, racial and ethnic disparities in maternal health exist and contribute to poor health outcomes. Pregnancy-related mortality is two to three times higher for non-Hispanic, Black, and American Indian, and Alaskan Native women compared to White, Hispanic, and AAPI women.

I want to share a few projects that two program offices within OS, the Office of Women's Health and the Office of Minority Health, are working on related to these maternal health disparities.

So, OS's Office of Women's Health is working to expand available maternal health data and create a network of at least 200 hospitals to

deploy clinical evidence-based best practices and maternity care. Over 150 measures will be captured. It will look at and understand clinical and non-clinical factors and impact maternal-infant outcomes so it will focus on health equity.

OWH will leverage these data, including performance improvement methodology, scale advancement, and care for mothers and infants across the nation. OWH has also launched a national competition to identify effective pre-existing programs that care for people with hypertension and where programs can be applied for women with hypertension who are pregnant or postpartum as well.

The goal of this innovative competition is to focus on racial, ethnic, and urban/rural disparities, and demonstrate sustainabilities and the ability to replicate or expand a program that provides effective monitoring and follow-up. In October, the Office of Women's Health will lead National Women's Blood Pressure Awareness.

Now, in support of HHS's maternal health action plan, the Office of Minorities, and CDC's Division of Reproductive Health launched a series of partnerships to support state maternal mortality review teams. We did this actually in Pennsylvania, where we established an MMRC to help expand the reach of CDC's Hear Her campaign to American Indian and Alaskan Native women.

So, this partnership with OMH and CDC to expand this campaign is absolutely critically important. And I understand the CDC will be discussing the details of these projects later.

Finally, I just want to mention that we're working on the issues of mental health and substance abuse as well. This is something I worked on significantly in Pennsylvania. And we're working with a diverse group of stakeholders to develop a standard definition of neonatal abstinence syndrome, which includes a bio-ethics analysis to address unintended consequences. And we're grateful for the feedback that we've received.

So, at the end of the day, I know I am motivated by being able to help people in the public health sector. I know that all of you have that motivation as well. We are in a position to make a difference in people's lives, and that's what you've done through these unprecedented times to make a difference to moms and babies.

So, we will face all of the many challenges that we have together. We will work together to build a safer and healthier world for all of us.

So, thank you. And I believe we have time for a few questions. I do have a hard stop right before one o'clock. Thank you so much.

EDWARD EHLINGER: Dr. Levine, thank you for being here and thank you for your comments, and thank you for the support that you give.

I have just one comment and one question. One comment is that you talked about the pandemic as being the greatest public health challenge in the last 100 years. I think that it

is a syndemic. It goes along with the structural racism that actually causes the same number of deaths.

So, I think we should blend those things as syndemics that exist simultaneously and feed each other in negative ways.

But the question I have is, a year ago this committee made recommendations to Secretary Azar about COVID-19. And many of those recommendations are related to moms and babies. They're still current. And then in August, we sent some recommendations to Secretary Becerra.

I'm curious. How did those recommendations ever come to you? And in what form did those recommendations come to you so that they can inform the work that you do? I'm just curious about that process.

RACHEL LEVINE: Sure. Well, the process is that -- it's -- certainly that our Office of Women's Health will bring those to me. And also, HRSA and OS collaborate really, really closely.

Diana, do you want to comment?

DIANA ESPINOSA: Sure. I think that as far as recommendations from the previous administration, we can certainly re-up and look at those. Because, you know, as you know, they're still relevant.

As Dr. Levine mentioned, she and I meet on a regular basis. But staff are interacting almost on a daily basis on a variety of issues. And we can certainly take a look at that, to take a look at those recommendations.

You do raise a good point, though, as far as we probably should think about building in some regular, routine, structured way of making sure that OS has an opportunity to engage. Because when they go to the Office of the Secretary, you know, various people get involved. But we can certainly from the HRSA end actively engage OS on those recommendations.

UNIDENTIFIED MALE SPEAKER: Thank you. We're very pleased to collaborate and work together in any way.

EDWARD EHLINGER: And any members, if you have a question, just raise your hand on the little raise-hand thing at the bottom of your screen.

While we're waiting for that, Dr. Levine, how can you leverage SACIM, and how can SACIM leverage your office for the things that we're in similar work of, same mission, same vision of what we've like -- how do we leverage the work that you're doing and you the work that we're doing?

RACHEL LEVINE: Well, I think that again we're very pleased to meet and to work together and collaborate. I think one of the things that you all can do as an organization, but also individually, is to advocate for vaccinations for COVID-19 and specifically to advocate for vaccinations for pregnant women.

You know, we are speaking with ACOG about this, about how we can leverage the work with our nation's OB/GYNs about this. But, you know, we are just seeing far too many pregnant

women getting COVID and either suffering severe medical complications, having potential complications for their babies or tragically dying, quite frankly.

So that I think that the more that as an organization you can speak so that we're all of one voice, and the more you can speak in your local areas and local tested professionals, the better that will be.

EDWARD EHLINGER: Good.

Tara, do you have a question?

TARA SANDER LEE: Yes. And I apologize for the background noise. But just a quick question.

First, Dr. Levine, thank you very much for your presentation, and I share your concern about vaccination. I just wondered if you could give a quick update on what HRSA, and HHS are planning to do to increase vaccination rates at the border with those who are crossing on a daily basis?

RACHEL LEVINE: So, there are

specific efforts to address the border. It's an all-government response. You know, it involves HHS, it involves the Office of Homeland Security, et cetera. But the Secretary is actively committed to the mission. It does involve aspects of OS because it involves the Public Health Service Commission. And we have officers who are stationed at the border.

ASPO has a very large, important role in terms of that, as does the Office of Children and Families and the refugee office as well. So, we are working to address all aspects of that, but also particularly, when possible, immunizations for COVID at the border as well.

TARA SANDER LEE: Thank you.

EDWARD EHLINGER: Dr. Levine, as both of us being former presidents of ASPO, recognizing that public health is under attack. And its credibility has been sort of threatened over the last year.

What are you doing to generally increase the credibility, restore the credibility

of public health to the general population? But also, to support the public health workers themselves who are stressed in this really, really traumatic time?

RACHEL LEVINE: So, you're entirely correct. You know, COVID-19 has been such a challenge for front-line medical workers, whether they be in the emergency department, whether they're in the ICU, whether they're in their offices, whether they're in the delivery room, whether they're on the wards.

But it also has been tremendously challenging for public health professionals. And I've seen that at the state level as the Secretary of Health in Pennsylvania, but also now at the federal level.

I think that we need to view public health professionals, whether they are state health officials or whether they're epidemiologists or vaccine managers, whatever, as front-line workers, as well, in terms of that. I think that we need to support them. I think that

we need to have collaboration and coordination at the state, local, and federal levels.

In fact, the call that I'm jumping to at 1:00 is a call that we have weekly with NACHO (ph.) and ASPO and big cities and CSPE and ACHL (ph.) and others to make sure we're exactly on the same page. And I think that we're going to need sustainable funding for public health on all of those levels to be able to learn the lessons from the pandemic and be continued.

EDWARD EHLINGER: Thank you.

Dr. Peck.

MAGNA PECK: I want to thank you, Dr. Levine. As an old Philly girl, it's great to see you in the leadership role. Thank you so much for what you're doing in governmental service at the next level.

I'm curious about what advice you have and how you're handling the politicization of data. I lead the Data and Research to Action Workgroup of SACIM, and we are certainly advocating for stronger data systems, greater data

capacity.

How are you handling the doubt of data and the pushback and the messaging when science doesn't speak for itself? Just wondering if in your short tenure there, and obviously previous tenure in other leadership roles, how do we deal with the doubt of science and the suppression data in some areas and the politics overriding the science and the evidence?

RACHEL LEVINE: Well, that's an excellent point. I think that we all need to work together on this. I think one of the significant challenges of our public health response to COVID-19 at all levels has been the politicization of the response. I think that this is not in any way a political issue; this is a public health issue.

And we need to let public health medical and public health professionals lead the way. We are doing that in the Biden–Harris administration. So, many of us in the public health leadership positions, we meet together on a regular basis, several times a week to talk about

the data, to review the data. The CDC is being very transparent with their data.

And we want to work with state and local public health officials in terms of that transparency as wells. And then letting data drive the decisions, the public health decisions that we're making. I think we do the best we can to explain them. I think we can always do better in terms of our communication about data and our communication about our public health decision-making. And we will continue to do that.

My last words are -- and then I'm going to have to jump, I'm sorry -- we're going to need to push back about this information. Our Surgeon General, Dr. Murthy, has had a whole program about that and public about that in terms of trying to push back on misinformation in social media and in the media in general.

And we need your help again as an organization and as trusted local leaders to be able to do that.

So, thank you so much. I'm actually

going to have to jump to the next call, which is that call with local and state health officials and other public health leaders to whom have to be able to explain about boosters and to talk about childhood vaccination, to talk about schools and how we can do a better job in terms of trying to keep our kids in school.

And then, you know, potential new information about childhood vaccines, that we hope to be receiving data from Pfizer, and then how the FDA and the CDC will be looking about that. So that's my next call. And I'm being totally transparent about everything that we're talking about.

Thank you so much. Take care.

UNIDENTIFIED FEMALE SPEAKER: Thank you so much.

EDWARD EHLINGER: We really appreciate it. And also thank you, Ms. Espinosa, for joining us also. We really appreciate that. It's nice to have an HRSA administrator and ASH. At the same meeting, it's really a treat to have

that.

DIANA ESPINOSA: Thank you.

DISCUSSION OF JULY 2021 RECOMMENDATIONS SUBMITTED TO HHS SECRETARY

EDWARD EHLINGER: On our agenda, we have a little discussion, a short period of time really to discuss the recommendations that we put forward in August. And I put that on there just to really make a couple of points. And you notice that Dr. Levine really didn't talk about our recommendations. And that's why I asked the question. How do those things get up to the space where she can actually see them? What is the process?

Because if the recommendations we make don't go anywhere, why would we want to continue to do this? And I know Lee probably has some response to that. But I'll hold onto that for a second.

But I want to increase the visibility of our recommendations. And I want to find some way to evaluate how those recommendations move and how they get acted on. Because otherwise, maybe

some would feel like the effort is not really worth the effort if we don't do that.

So, I've done a couple of things, and I ask some questions of you. How have you shared the recommendations that we've made? Have you shared them with your partners in the public health and medical care field? I mean, I shared them with all of the organizations representing maternal and child health and with ASPO and the American Public Health Association.

I also shared them with my two Senators and my Representatives. And I asked them to say -- asked Secretary Becerra to copy them on his response to our recommendations. I'm just wondering if any of you have had anything that you've done with those recommendations to make them visible, to make them front and center in the conversation?

Has anybody done anything with those recommendations?

Magda.

MAGDA PECK: Well, I just want to

respond to that in a couple of ways. I think the first is that certainly in my relationships at the local level, with CityMatCH and others, there has been a regular set of feedback and communication that will happen.

And I think that if you were to go around for each of us who has connections who are colleagues through professional organizations, whether that's global like Jeannie or local as in CityMatCH, that's one way that's a natural flow. And it's not just in forums, but to engage.

The issues that I've found are the folks don't still get what SACIM is or have any evidence to prove that SACIM can leverage. I think that that's beginning to change. It's not just presenting the recommendations, but it is about putting it in the context of opportunity and leveraging what we can do that they cannot do so it's of mutual help.

And my second point, and the last, is I think that the current structure, at least with the Data and Research to Action Workgroup, because

of this extensive participation from many, has allowed there to be a ripple effect so that when we want to be able to give not just recommendations nationally, but serve as a sounding board for PRAMS, we're able to turn something around within two or three weeks and be able to consolidate that feedback and go forward.

So, I think that there are ways not only within whom we talk to, but how we can influence based on the deliberations that are here that are the structure of these working groups gives us greater diffusion. I'd be curious to see what others have experienced.

EDWARD EHLINGER: Thank you.

Lee, could you talk to us about the process in visibility? I assume that's why you raised your hand to try to tell us actually how things work with the recommendations.

LEE WILSON: Sure. There are a couple of things.

First, I'm not an explainer of the Secretary or, you know, given authority to speak

for or on these issues. But as a political official who is relatively new in the position, I don't know that she is as fully briefed about those operations and protocols that we use within the department or making sure that recommendations like this are on review within the department.

So just as an update on the recommendations that you submitted, they were submitted to the Secretary, as you know, and we've provided that input to, or acknowledgment back to you.

We have since received feedback from the Secretary to go forward and pursue a review within the department across the agencies for application and interpretation of the recommendations that you're providing to the various agencies that would be related to or be affected by the recommendations that you're making.

So, the process now that it has arrived in the Office of the Secretary, they have reviewed it and they have given us the go-ahead to

then meet with, share this information with CDC, with NIH, with FDA, with CMS officially to review and interpret the information that you've provided to us of your recommendations and how we might respond to that.

So that's sort of the protocol and the process that we go through internally.

Where there might be opportunities or interest in having follow-on discussions as to the way we interpret this information that you've been providing and absorbing it into our future plans, we will then have meetings about that. And there will be some information provided to you in writing about that process.

Also, I wanted to let you know from our end, as we have spoken in the past about this discussion and recommendations to the Secretary and whether or not there's a report that's generated or not, we have been working internally with LRG, who is the logistics contractor, to compile the information that you're generating through the deliberations and meetings, and the

on-the-ground community-based input that you've been receiving and the sort of history of the committee as it's proceeding along.

We're incorporating into that document the recommendations that you're making and that you've made, for purposes of generating some sort of a report that will be there for us to use when we decide to move on any policy issues that are related to your activities so that they can then be used to say, "These are supported by the advisory committee on this particular issue."

I don't know if that's helpful or do you have other questions?

EDWARD EHLINGER: That's very helpful.

And I would, just for Vanessa now, I would really like a report in December about how things have moved along. I think we need sort of an evaluation piece of how effective are our approaches in terms of just getting information, whether or not they get accepted?

But again, I don't want the members

to feel like it's just an exercise in futility. I want to see some action, get some feedback of, "All right. This is what we've done."

What you said just now really helps me. I wasn't aware of that process. And I think reporting back in December about more of what just happened in that process would really be helpful.

Any other comments or questions about our recommendations?

Magda.

MAGDA PECK: Just a quick follow-up. You know, one of the things that I'm mindful of, and I appreciate the tutelage I've received from Michael and Mark Kavanaugh and others over the years is that there are other Secretary advisory committees that relate to maternal and infant mortality prevention.

I'm curious about what the alignment is or the interplay between those within, say, where the Secretary is at MCHB, or elsewhere in HRSA or elsewhere across HHS. Because our purview is HHS. Or even in EPA and others.

So how do we as a focus group on preventing maternal and infant deaths and promoting maternal and child health, how is our secretary's advisory committee in alignment or able to leverage or be leveraged by parallel efforts that are going on within HHS or across government?

EDWARD EHLINGER: Well, I certainly can't answer that.

Michael, can you?

MICHAEL WARREN: I will try.

Thank you, Dr. Peck.

So, I think some of that happens at the bureau level. Just speaking about just within the Maternal and Child Health Care, we have two federal advisory committees. So, this committee, as well as the Advisory Committee for Heritable Disorders in Newborns in Children. So, a big portion of what they oversee is the newborn screening process, making recommendations to the Secretary for adding items to the recommended uniform screening panel. So, there are obvious

connections there.

I think the other is the work that we are doing, and it's relatively new and I'll talk a bit more about it when I share my update in a few minutes.

But it is our engagement of other federal partners, not only within HHS and various operating and staff divisions within HHS but with other agencies and departments across the Federal Government. And so, I think that really is an opportunity for us to stay connected with what's going on in those areas.

And then similarly, our staff serve as ex-officio members on a variety of those other federal advisory committee meetings. So, they take with them, we take with us those recommendations, that experience to those committees, as well.

EDWARD EHLINGER: Thank you.

Belinda, you had your hand up?

BELINDA PETTIFORD: I did. You know, I'm similar with Magda from the standpoint, you

know, I share this with AMCHP, as well as with the National Healthy Start Association. And I shared it within my own state.

I mean, I think it was good to see that the alignment of things that were already happening, and people were excited to see that our recommendations were in line. I think part of the challenge has been, once we're in the middle of a pandemic and their bandwidth to just try to pick up another issue and try to move it forward has been the challenge.

Because even in my own state, we have several strategic plans and lists of recommendations. But we're not moving as fast as we would like to move, but that's because they don't want us focused on the pandemic.

And I do think they appreciate it's in the recommendations related to COVID. But when you're dealing with a workforce and community members and just individuals who are living in a pandemic world, it has been a challenge to elevate this as a priority.

And I think it will come. I just don't think it will come right now, because people are trying to just survive, in many instances.

EDWARD EHLINGER: And actually, that's one of the reasons -- I mean, I agree that people are overwhelmed. And I wish they could walk and chew gum at the same time. But it's really hard just to walk. And this isn't sort of chewing gum.

And so, our job is to get out some of these recommendations where those organizations that are stressed with the daily day-to-day activities. So, I'm trying to figure out some way to do that.

And I know we don't have, and NCHB and HRSA does not have a marketing person, you know, to put out press releases for this kind of thing. I inquired about that when we put out those COVID recommendations. But I think we have to find ways to get it out there.

Just it strikes me that there are so many articles recently about maternal mortality

and infant mortality. And SACIM is never mentioned, or their recommendations are never mentioned in that. We just don't have enough visibility to do that. And I invited a reporter to our meeting the last time, and she never showed up.

But I think somehow, we have to get this into the press that we actually have some good ideas, that we have some recommendations, things that could move the needle. And that's why I think it's dependent upon us as SACIM members to be a little bit more proactive in some of that kind of marketing and education framework, mindset.

All right. Any other thoughts before we move on?

Magda.

MAGDA PECK: At the risk of spending all of my airtime in this session, I just want to specially ask both Jeanne and Paul to respond. Because we have recommendations that go beyond HHS in terms of environmental health and in terms of

immigration.

And I'm just wondering, what's the cross-fertilization specific to those recommendations that would allow them to grow some legs? And I was wondering if Paul or Jeanne have any perspective on that? Or if, Michael, you have a sense of how in that populating other committees there's a chance to be able to be very focused on the specific recommendations that are sitting there right now?

And I know it's being farmed out. But I'm just wondering if there's anything further that can be done around these areas that transcend HHS.

EDWARD EHLINGER: Jeanne.

JEANNE CONRY: Well, I haven't viewed it as anything where we are in a position of advocacy from this. I'm in a position of advocacy for the other work and roles, but not in terms of what is happening here. So, I'm happy that we're in an advisory position to the Secretary and provided as such. And then I look at taking that

same voice in other positions, but not anything where I would have thought, "Okay. SACIM said such-and-such. What are we going to do with that?"

And maybe that's something that Lee can help me understand better. In terms of our role here, I take the same role and voice in my other organizations. In fact, that's what I was going to ask Dr. Levine about, just rural patient safety data. I was at a huge event.

I don't know what we did in the United States about it. I know what the rest of the world did, and it was a focus on childbirth and infant mortality. I have no idea what the United States even did on that day if anything.

EDWARD EHLINGER: Thank you. And I mean, there's always this question about advocacy versus education. What I've been doing is just saying, "This is what SACIM approved. These are the recommendations. Be aware of them and incorporate them in your work as best you can."

And not pushing for any particular

policy as a SACIM member, but just say, "Here are the recommendations. I hope you're aware of them. They have some good information; please use it.

Paul, any questions, or your response?

PAUL WISE: My approach is to strengthen accountability, to follow up on the recommendations both within HHS and beyond. There's the potential that respect for the process becomes timidity. And these issues demand more than being timid. And certainly, the issues on the border.

It's clear that HHS, as well as DHS and other agencies, are intensively engaged on the border. But that is not sufficient, in my view, for this committee. We need to ensure that we are holding HHS and its component parts and collaborative agencies to task, to gauge the response.

Now, the response may be not to take action. And it may be completely legitimate. But we have a responsibility to hear why inaction has

been embraced and why it may be the product of bureaucratic inertia or strong scientifically based or politically based logic.

And I think that's our only protection that the procedures and process under which this committee operates becomes a mask for inaction. And my hope, particularly given the expertise and commitment of the agency partners that we work with, that we will be able to gauge both actions taken, and actions not taken.

EDWARD EHLINGER: I appreciate that. I appreciate that.

All right. Well, thank you all for this discussion. This has been very helpful. And I hope it's helpful to you.

FEDERAL UPDATES

EDWARD EHLINGER: So, now we've got the next 45 minutes or so to get some federal updates, which I think are also going to be quite interesting. A lot's going on.

So, Dr. Warren, I turn it over to you.

MICHAEL WARREN: Thank you, Dr.

Ehlinger.

Good afternoon, everyone, or good morning, depending on where you're joining from.

Just very briefly, a few updates from the Maternal and Child Health Bureau. We are rapidly winding down fiscal year 2021, which will end in nine more days.

And so, we have been looking at ways to make sure that we leave no resource untapped, and make sure that we maximize use of those resources. And as we have the opportunity to do that, really making sure that we align with the priority specifically around equity and the interests of this committee.

So, I wanted to share a few updates. We actually did a pretty broad public release of these last week. But in case you did not see them, it was about a $350 million release that was announced last week. Of that, $342 million of that was for the Maternal Infant Early Childhood Home Visiting Program or MIECHV.

Those awards went to states and

jurisdictions. Those are formula awards and support voluntary evidence-based on visiting. In those states and jurisdictions, they identified the communities where they would like to deploy those services, and those funds are now available to them.

Also included in that $350 million rollouts were supplements to our Healthy Start grantees. So, these were competitive supplements that existing Healthy Start sites could apply for.

One set of those supplements was related to increasing the availability of doulas. So, we made 25 awards for $125,000 each to Healthy sites across the country.

And then we also made 21 awards to support the development of infant health equity plans. Those were 21 awards for $80,000 each.

Those awards really will start to be a stepping stone to our further work that we've mentioned to you before around achieving equity in infant mortality by 2030.

We know, for example, that in the

Healthy Start sites as they currently exist, if you map out all of the excess infant deaths -- those are the deaths that are in the gap from where we currently are to where we need to go to get to equity -- among Black infants, 50 percent of those excess deaths are in counties that are already served by a Healthy Start site.

So, we really have an opportunity to leverage Healthy Start and to accelerate that work to getting to equity in infant mortality.

So, the goal of those infant health equity plan supplements is to help them engage partners in the community who have not previously been engaged, particularly as we think about social and structural determinants of health and how they might incorporate that work into the work of their community action network, as part of their Healthy Start sites.

So really excited to see those awards go out. Again, trying to maximize use of those resources so that they aren't unspent, and make sure that they are maximally aligned with our

interest in equity.

The last part of those awards that went out was a supplement to 10 states, $60,000 per state, to enhance the quality, timeliness, and accuracy of their data related to maternal health. So, these were supplements to a state block grant, NCH block grant recipients, who get our state systems development initiative, or SSDI, funds.

Those funds have been around for a long time and helped build basic NCH data capacity in the states. This was additional funding to supplement them specifically around maternal health care.

So collectively all of those accounted for about $350 million that was announced last weekend. And we're really excited to have those funds out the door.

In terms of looking ahead to FY22, which will start in nine days, excited that there are a number of efforts in President Biden's budget that relate to the work of this committee, both in the space of infant and maternal health.

So, I just want to highlight those for you. And there's a $5 million increase for the AIM program, the Alliance for Innovation on Maternal Health.

There's a $30 million increase for state maternal health innovation programs. These are grants to states to support the convening of a Maternal Health Task Force to leverage data that come from maternal mortality review committees and vital statistics from other population and data sets to be able to identify the areas of greatest need and then implement innovations in response to that.

There's a proposed $1 million supplement to the Maternal Mental Health Hotline. This is something that was new in the current year budget that is out for procurement as we speak. There were $3 million allocated for that to be a 24/7 national-level hotline. So, the President's budget contains an additional million dollars proposed for that.

There are new initiatives, $25 million proposed for a pregnancy medical home

demonstration project, $5 million for implicit bias training grants for health providers, and $1 million for a National Academy of Medicine study.

So that's the proposed President's budget for FY22. As you all know, if we don't have a budget passed by September 30th, we'll be under continuing resolution. So, we are watching for developments there.

The last thing I'll mention very briefly is the Infant Health Equity Initiative that I've mentioned. This is how do we get to equity by 2030 and eliminate those excess infant deaths, to truly get to equity for all infants? We have engaged a contractor from Milwaukee in region 5 to help us with initiative planning, basically helping us to understand, within existing resources, what can we do? And then if additional resources were made available, what paths would be most effective for us to pursue?

We convened federal partners, initially, partners within Health and Human Services, for the first meeting. And the second

meeting, which was just held last week, also engaged -- started to engage partners outside of HHS, for example, HUD.

And those have been very productive meetings, lots of good information-sharing about what folks are currently doing, what folks are planning to do in the next fiscal year, and how we might align and leverage the investments across HHS there.

And then in early November, we'll be convening a group of stakeholders in region 5. So, HHS region 5, six states, Minnesota, Michigan, Wisconsin, Illinois, Indiana, and Ohio have historically the highest rates of Black infant mortality in this country, as well as the highest absolute gap between Black and white infant mortality.

The states in those regions approached us and asked us to think about how we could support their work in achieving equity in infant mortality. So, for the last year, we've been engaged with them in a learning series,

looking at root causes of inequities in infant mortality.

We had planned to convene an in-person meeting in Chicago in the second week of November. That's now moved to a virtual meeting. But where states had all five teams, Healthy Start grantees, community partners, state leaders, folks whom the state identified as wanting to come together -- and come together to talk about that commitment to get to equity by 2030, and for us at HRSA to better understand where our opportunities are to support them.

So, we can report back to this committee when we meet in December about that region 5 meeting. And that's the update for us. Thank you.

EDWARD EHLINGER: All right. I want to hold questions because I'm sure there are a bunch until we have all of our presenters. So, hold onto your questions, and we'll have some time at the end.

Sheila Williams.

SHEILA WILLIAMS: I'm here.

EDWARD EHLINGER: Good. I saw your picture, so I know you're there.

SHEILA WILLIAMS: Thank you. So, I'll be giving some updates for the Bureau of Health Workforce.

Next slide. I don't know who's advancing the slides. Thank you.

So real briefly, the Bureau of Health Workforce, our mission basically is to improve the health of underserved communities and populations. And we do this in two ways. We do this basically by strengthening the health workforce and then connecting that health workforce to those communities that are in need.

So, we have grant and direct service programs that are funded by our bureau. And we really seek to impact every aspect of the health professionals through the year, from education to training, as well as service. So, we do this through trying to be flexible and innovative in our response through our programs.

And we really look at education and training in the community, so one of the threads that run throughout our programs is making sure that individuals are educated and actually trained in the communities where we want them to serve. So, there's a lot of academic and community partnership that happens in our programs.

And then ultimately, we want to make sure the distribution of the Health Workforce is reaching those areas, both rural and underserved areas that we want to make sure have access to care. So that's another set of our programs that we have.

Next slide, please.

So, to look at our focus areas in the last year and in the upcoming years 2021 and 2022, we're really focusing on health equity.

You know, as we emerge from COVID-19, we're looking at two priority areas for the bureau. And those are behavioral health and community health. And they really align very nicely with the department's priorities for COVID-

19 response, maternal and child health, health equity, and behavioral health.

And as we emerge from the pandemic, two off-cutting themes for us have been provider resilience, and diversity and health equity, which is where our maternal health, some of the programs that we have really looked at for maternal health, including maternal health resides.

And so, we have really had to really think about our policies and our program development as we've gone through COVID-19. It's presented us with some unique opportunities and some unique challenges.

Go on to the next slide. I'll talk a little bit more.

In BHW, which you know, we love acronyms, so this is the acronym BHW, our program aims really, these are the levers. These are the areas in which our programs really try to impact. The first is access to care. So, through the workforce, one, we want to make it easier to get care. So, we have to have that available

workforce that is in tune with the community, that understands the community, and that is in those types of facilities where regardless of your ability to pay, you can access and receive care.

The next is supply. So, we really look to balance the supply with the demand for health care. So, we really start looking at things like adequacy, and we look at expanding our programs, so expanding of professionals. So, for instance, we have expansion programs in behavioral health, expansion programs in nursing.

So really, I think as we move forward, there's going to be a lot more attention and more programs coming out that really are ramping up the supply, especially deal with the aftereffects of COVID.

And then we have a distribution. We have programs that focus on distribution. And basically, we literally again try to do that balancing act between supply and demand and make sure that there's adequacy. We know that there are some maldistributions that occur. Sometimes

it's regionally, sometimes it's particular states and particular professions.

And so, we constantly are looking at those data. We do a lot of that work through our National Center for Health Workforce Analysis and through our projection, and supply and demand reports.

And then quality. So, in a lot of our education and training programs, we're looking at, how do we improve the quality? How do we look at evidence-based care? How do we promote that patient-centered care, culturally competent care, and make sure that we have the outcomes?

Because we have over 40 programs, one of the things that we've been very, very intent on doing is, where we can, really aligning our programs and integrating them so that we're not just looking at one piece of this, but we're looking at all of these things in connection with each other.

Next slide.

I'll just give you a little snapshot

of some of our programs in terms of diversity. So, some of the ways in which we look at increasing diversity in the workforce are we look at trying to increase the pipeline, so individuals coming into the health profession's education. So, I'll just give you a snapshot of some of the ones that have in their statutes, actually, they have diversity goals and purposes.

So, the first one I'll talk a little bit about is the Area Health Education Centers Program, some you may be familiar with. But basically, that's a program that operates. We have them in just about every state. And they really aim to improve that academic improvement-based partnership and do a lot of longitudinal training and building the pipeline of individuals from underserved communities.

So, individuals from rural backgrounds and individuals from disadvantaged backgrounds, minority backgrounds. And so that really is a program that has been around for a while. And we continue to invest in those

programs to get people into the communities where we want them to serve. Get the experience, get the education.

And longitudinal, so we want them to go back over the course of their professional education and serve in these communities. So, they're very familiar with the patients there. They're very familiar with any of the cultural issues, the linguistic, and all of that.

The next is the Scholarship for Disadvantaged Students Program. And this is a grant program, as well. And this program funds health profession schools to provide scholarships to disadvantaged students. And so disadvantaged students are those who have economic needs So, they meet criteria that have been established for financial aid.

As well as educationally, so those who are educationally disadvantaged as well. So, they come from a background in some ways that has not necessarily prepared them the best, or they've had to overcome some obstacles in order to gain

admissions into health profession school.

And then we have a Careers Opportunities Program, which is another pipeline program. And it's an earlier pipeline program, but it's one of the programs where we have a lot of flexibility. So, as we're looking at the pipeline, we're also beginning to look more at nontraditional for those pipeline efforts.

So, some of these programs will deal with individuals who were in high school, through their college, through undergraduate, and then getting them into a professions program.

But we're also looking at and have been funding more of nontraditional students as well, people who maybe are in some aspect of health care or support, health support services and want to have some career advancement and build a career in health care. So that's another program where we really can on the disadvantaged background of individuals, as well as individuals who are URM (ph.).

And disadvantaged could be meaning a

lot of things -- the area where you grew up in terms of opportunities, language barriers, first-generation college. So, there are numerous ways in which individuals identify as coming from a disadvantaged background.

We have the Centers of Excellence Program. This has been around for a while. And this is another grant program that focuses mostly on the institutions and developing and strengthening their capacity to diversify the health workforce to deal with health disparity issues, to help students gain experience in research on health disparity issues.

Also, it's specifically for underrepresented minorities, and in dentistry, public health, pharmacy, behavioral and mental, and family medicine.

(Simultaneous conversation)

SHEILA WILLIAMS: I think someone needs to mute their speaker.

Additionally, we have the Nursing Workforce Diversity Program, which is a Title 8

program, specifically to improve diversity in entry-level registered nursing. So again, another pipeline program that really helps individuals to be prepared to gain entry into the health progression.

Next slide, please.

I'll a little bit too about our Loan Repayment and Scholarship Programs because these programs, even though they're not always considered a pipeline unless we're talking about the scholarship aspect of them, we find that it supports diversity in the health workforce in a couple of ways.

On the scholarship side, you know, a lot of times its individuals from disadvantaged backgrounds have some issues funding their health professional education. And so, the scholarship programs are really important because it provides that financial support. And it also allows them to serve in underserved communities by agreeing to a service obligation.

So, we look at that and the Loan

Repayment Programs as well, which are very important for us in terms of retention in underserved communities.

We've done some things with some additional monies that we got in 2021 with some of the American Rescue Plan, $200 million. We really looked at how we could improve and how we could ramp up the supply of maternal care providers. And so, we dedicated $10 million for women's health nurse practitioners, obstetrics and gynecology nurse practitioners, certified midwives, and OB/GYN registered nurses.

Additionally, we added in the National Health Service Corps Student to Service Loan Repayment Program, nurse midwives are a new eligible discipline as of 2021.

Important to note when we talk about diversity as well is that 15 percent of NHSC positions are African American, and 15.8 percent are Latino. So, those are compared to, there are only 5 percent of physicians who are African American and 5.8 percent of physicians who are

Latino in the general population, nationally.

So, we know that these programs do support diversity in the workforce and diversity in the pipeline as well.

Next slide.

A new program that we funded in FY21 is the Primary Care Training and Enhancement, we call it the PCTE, a Community Prevention and Maternal Health Program. And that program had about $16 million. We funded it this summer.

And basically, it trains primary care physicians in maternal care, clinical services, or population health and really to improve and aiming to improve maternal outcomes and then to increase maternal health care expertise and the number of primary care physicians who are trained n enhanced obstetric care in rural and underserved areas.

This program had two training tracks. One was in community prevention, a community prevention track. And the other was in primary care obstetrics, obstetrics track. So, they're different tracks, but, you know, different aspects

of maternal care.

Next slide, please.

As I mentioned earlier, our National Center for Workforce Analysis is very involved in projecting the workforce so that we can contemplate what kinds of changes we're seeing or expect to see so we can really be prepared to develop policies and programs to address what we expect to be the anticipation in changes in the workforce and then the needs of the population.

So, by 2030 we project that the supply of women's health services providers, we project a 7 percent decrease in the supply of obstetricians and gynecologists. But other providers such as certified midwives, we project a 32 percent increase. An 89 percent increase in women's health nurse practitioners, and a 56 percent increase in women's health physician assistants.

We also anticipate a higher demand in full-time women's health service providers, including all of those mentioned above. So, we're

expecting increases in the demand, as well.

And I want to say, you know, as we look at these numbers, we don't see uniformities, though we do see in some states and regions we have an oversupply, and in other states and regions, you have an undersupply. And that can range anywhere from an undersupply of only having 56.8 percent of what's needed in the state or region, all the way to having 157 percent of the need, the demand being met in terms of the availability of workforce.

So, I'll stop there. That concludes my update for the Bureau of Health Workforce in this.

EDWARD EHLINGER: Thank you very much.

Now let's go on to Juliet Bui.

JULIET BUI: Thank you, Doctor, and hello, everyone. Thank you for your important work and for the opportunity to join you today to share updates on behalf of the HHS Office of Minority Health.

I'm going to highlight a few of our fiscal year 2021 grant initiatives that may be of interest to this committee beyond the efforts that Dr. Levine shared about earlier. Our initiatives are all aligned with OMH's mission of including the health of racial and ethnic minority populations through the development of health policy and programs that will help eliminate health disparities.

And they also reflect the enhanced focus and priority on equity across the Federal Government that's been underscored today by our HHS leadership.

While these initiatives don't have a direct focus on infant mortality, I think that they may address some relevant and cross-cutting issues and obstructing factors. You can find more information about the initiatives that I'll talk about today, and our other OMH initiatives, on our website at minorityhealth.hhs.gov.

So, the first initiative that I'd like to share about is the framework to address

health disparities through collaborative policy efforts initiative. And the focus of this initiative is on policies that create or perpetuate health disparities by contributing to structural racism.

The initiative comprises a coordinating center and demonstration project sites, and together they'll aim to demonstrate the effectiveness of a methodological framework in supporting the assessment and identification of policies that may create or perpetuate health disparities by contributing to structural racism. And they also modified development and implement policies to improve health outcomes.

Another initiative is our Minorities Leaders Development Program. This is a program that will support a fellowship program at HHS for early-career individuals to provide training focused on health equity issues, and also to help develop the skills and competencies necessary for federal leadership.

So, this program is expected to

support efforts to promote diversity in senior positions within HHS agencies.

The third initiative I want to highlight will establish a center for indigenous innovation and health equity. The center will support efforts including education, service, and policy development, and research related to advancing sustainable solutions to address health disparities and advance health equity specifically in the American Indian, and Alaska Native, and Native Hawaiian, and Pacific Islander populations.

Then finally, our Accessing Social Deterrents of Health Data through Local Data Intermediaries Initiative will seek to demonstrate whether existing local data intermediaries can facilitate community stakeholder access to and utilization of integrated community-level social deterrents of health and health data, and then increase community stakeholder's skill and capacity to use and apply those data to health disparities in all racial and ethnic minority populations.

So, our grant initiatives span a number of areas that focus on addressing health disparities and promoting health equity, from systemic issues and policy impact to public health or course development, to access to and use of data, to identifying and disseminating effective culturally centered approaches.

All areas I think likely align with discussions that the committee may have as early efforts to include maternal/infant health outcomes to center equity and to address disparities.

The awards for these initiatives have not yet been announced, but we anticipate projects to start September 30th. And again, you can find the latest information on our website at minorityhealth.hhs.gov.

Thank you very much for your time. I know that Joya is a member of this community and is a great point of contact should there be any questions and can provide any more information moving forward.

EDWARD EHLINGER: Great. Thank you.

And now let's open it up for questions. And I see Steve Calvin has his hand up.

STEVE CALVIN: Yes. Thanks a lot. And thank you for all three of the presentations. Captain Pradia Williams, as the recipient of a National Health Service Corps scholarship back in the late 1970s and then served in the early 1980s, the National Health Service Corps site. I appreciate your work a lot.

And it's really heartening to see that there is support now for nursing scholarships. And I've been aware for a while, too, and I know Jean Conry has, as well, that the workforce numbers for physicians will be dropping for a whole variety of reasons.

But, you know, happy to see that the nursing options are increasing, including the nurse-midwifery numbers. And then also the women's health practitioners. And I think even physician assistants.

The question I have: How is the word

getting out to potential scholarship recipients? What kind of engagement is HRSA doing? I'm sure there is some through the schools. And then the second question is, Is there any support for this specific training program, certified nurse-midwife or nurse practitioner programs?

SHEILA WILLIAMS: This is Sheila. So, in terms of how we get the word out. So, we've got different mechanisms. We actually have a presence on social media because these are direct service programs. So, we also get it out to the schools and through associations, through the associations, health care associations.

But we also have a direct presence on social media, where individuals -- that information is shared. We share it with the schools. We share it with -- for instance, a lot of the word also gets out through the facilities. Because these programs are a tool for health care facilities and providers to get clinicians in their sites. And so, there are those.

We also have quite a few virtual job

fairs. So, we have a workforce. We actually have a presence online for a workforce connector, which helps individuals to identify positions through the National Health Service Corps, and for a nurse to identify a nurse corps site.

So those are some of the ways in which we get information out.

I think your second question was how do we provide support to --

STEVE CALVIN: Yeah, I think to the programs? I know it's more of an individual thing with individual students. I'm just wondering if HRSA has ever thought of, even in growing the number, I think midwifery programs, there might only be like 32 or 34 of them around the country. So just a question generally.

SHEILA WILLIAMS: Yeah. As we look, so it really just depends on the authorities' views. But as we look at expanding, that is where you get a lot of grants. Our grants do have components to them on the grants side, not the direct service side, through the loan repayment

and scholarship. But we do a lot of grants as well to the institutions to strengthen their ability to recruit and to train.

And so, I foresee more expansion programs in terms of just revving up the numbers and supporting the infra for the actual nursing schools to increase their numbers. And so that's institutional capacity. So those are grants that we do provide some institutional grants.

But even in those institutional grants, there's a portion that goes directly to the trainings, if you will, to enable them to partake in training that's in the rural and underserved communities. It doesn't all go to them.

STEVE CALVIN: Great. Thank you for your work.

SHEILA WILLIAMS: Well. Thank you.

JANELLE PALACIOS: Hi. I think maybe I -- I'm not sure if I could go, but I'm going to go. Thank you.

Thank you so much for the

presentations. And, Juliet Bui, I'm really excited to read up on OMH that Joya sent out the link, especially on indigenous health concerns, the program that's being made on indigenous methodologies.

And then, Captain Sheila Pradia Williams, thank you. I am so excited to hear what is going on in your department, as well. And there was a question that one of the attendees asked, which I also had a similar question.

But, you know, the plans that you have to expand the PCTE CPMH model that is now being used for primary care physicians, and I'm assuming this is probably likely in rural areas. But is there a similar program that will include emergency department staff?

And then a second part of that is, for the complicated patients in these rural communities especially, what kind of linkages will these primary care physicians have through this program to use their knowledge to help our vulnerable women and infants?

SHEILA WILLIAMS: So, I think your first question was around emergency departments. And so, I think the programs do focus in on residency training and also some advanced training. You know, fellowship training includes family medicine and primary care.

And some of these areas, they are, to your point, maybe at some rural and smaller facilities.

I don't -- and I can get back with you on this. I don't recall seeing anything specifically for emergency medicine, usually. But I could certainly check in that. Some of our grants, because they are affiliated with smaller rural hospitals, sometimes there is an emergency medicine piece to that, but not always. So, I can check into that to your specific question.

And I think the second part of your question was in terms of linking them to other academic --

JANELLE PALACIOS: Right.

SHEILA WILLIAMS: Academic health

centers?

JANELLE PALACIOS: Yes, like the maternal/infant kind of like information that they will be receiving as primary care physicians in their roles, and how do they manage complicated patients with this information.

SHEILA WILLIAMS: Okay. Again, I'll have to get back to you. I think each one of them came in with their specific proposal as to how they would put these together. And there were some requirements in there. But I can certainly get you more detailed information about that particular program and how that is developed and aligned for the complicated patient.

JANELLE PALACIOS: Thank you.

EDWARD EHLINGER: Ms. Pradia Williams, since you have the floor, I have a question myself.

In our state here in Minnesota, we have about 250 foreign-trained physicians who cannot practice because we have not been able to get residency slots. They're usually from

immigrant communities, and they're willing to serve in primary care areas.

But there are so many structural barriers. And my guess is that other states have the same issue. And with new immigrants coming in and refugees coming in, it seems like a resource that HRSA should be looking at to figure out some way to get them into a -- to be able to use their training and their expertise and their connections with the communities.

Is HRSA looking at foreign-trained physicians and work that can be done to help them get into clinical practice?

SHEILA WILLIAMS: Basically, for our grant programs, the trainees for our grant programs usually have to be citizens or permanent residents of the United States to be trainees.

I don't think there's any particular one specifically focused on foreign training, physicians, and specifically trying to get them into any of our training programs. Some of them may be because they may have status to be part of

our training.

But right now, I can't think of a program that specifically has that as its theme. But I hear what you're saying. And we could certainly take a look at that. I think that would need probably some sort of legislation or some sort of statute that specifically points to that.

Because I've been scouring Title 7 and Title 8, and nursing or the medical side for our programs. And I have not seen a program that is specifically targeting foreign trainee positions.

UNIDENTIFIED MALE SPEAKER: Also, with COVID, most health resources and training and licensing is on the state basis. It's all state-focused. But with COVID, there are a lot of trans-state, interstate activities. There are coalitions where nurses can practice in multiple states --

(Simultaneous conversation)

UNIDENTIFIED MALE SPEAKER: Is HRSA looking at that in terms of, how can we actually

find out what benefits that plays in dispersing limited resources? Or when COVID declines and people start putting up the borders, walls in their state, will we lose some opportunities that we are getting right now?

SHEILA WILLIAMS: Yeah. I mean, I think in BHW anyway, when COVID really became an issue in terms of our being able to train and you know, we were looking at our programs and how our programs would be able to continue, we did see a lot of -- you know, we saw these nursing compacts get even stronger, really looking at being able to have the nurses trained and be practicing, be licensed in multiple states.

So, we certainly encourage that. Those are things that are taken up at the state level, but we certainly encourage it. We think that it only strengthens the workforce.

I think there are some things from the regulatory side in terms of scopes of practice and things like that that vary. So sometimes those things can play a part. But we did some

relaxing of some of that in terms of entering into compacts, not just in nursing, but in other professions as well.

So, from a workforce perspective, we certainly encourage you to promote it on to some of these state associations that we work with and licensure groups that we work with.

UNIDENTIFIED MALE SPEAKER: Well, I hope somebody is collecting something --

SHEILA WILLIAMS: Encourage. Something is being encouraged.

EDWARD EHLINGER: Janelle.

JANELLE PALACIOS: This isn't probably my last question, but it's a discussion that we've had a number of times in the Health Equity Workgroup, where we talk about diversifying the workforce in terms of different kinds of birth workers, including doulas, midwives, professional midwives, physicians, the whole perinatal force, but also diversifying the color and the ethnicity and the language among our workforce.

And so, the funding that is going to

especially nurse-midwifery schools or different programs even for physicians, is there some sort of tracking upon entry into a school that the school has X number of self-identified minority students? But then that cohort moves through, and they graduate X percent?

Because that is something that would be really important to help us understand what's going on and if there are issues that need to be addressed. Because anecdotally in the nurse-midwife forums that I'm a part of, and also Pat Loftman, who will be speaking a little bit later, it is nearly every day where we get email conversations from students of color talking about the difficulties they're facing. Thank you.

SHEILA WILLIAMS: And so specifically with our diversity programs -- well, we have diversity actually in the statute -- we will collect some of that information on the application side.

So, when an institution is coming in there might be priority points or something that

are awarded based on their meeting certain benchmarks in terms of URM, in terms of disadvantaged status, in terms of coming from a rural and underserved background.

We also collect in our performance measures, we're able to track and collect programs. We're not able to just collect it on an individual level; we certainly don't want to identify individuals. But we do know, and I think what your kind of getting at is, are they making a commitment, and are they graduating them, right?

So, there's one thing to have enrollment, and then you look at also graduation rate. And we do look at trends for that.

Something that we have this year, and it's not externally facing right now, but our grantings actually have a scorecard. We just developed a scorecard, so they're able to look at certain metrics and how they are comparing to others, to other grantees, and how they're comparing in general. So, they're able to gauge their performance in those metrics by the

diversity of their trainees and how well they are doing in terms of retaining them, supporting them, and graduating them.

EDWARD EHLINGER: Great session. Thank you. There are a lot more things to be talked about. So, thank you to Dr. Warren and Captain Pradia Williams, and Ms. Bui. It's really good information that you brought forward.

We're at a time to take a break for 15 minutes and come back. We've had an interesting quarter of a day so far, four hours. The first two hours were really interesting; I'm sure the last two hours are going to be just as interesting. So come back at quarter after the hour. We'll see you then.

RACE CONCORDANT CARE AND OTHER STRATEGIES TO ADVANCE RACIAL EQUITY IN MATERNAL AND INFANT HEALTH

EDWARD EHLINGER: Welcome back to everyone. I hope you got refreshed and got your coffee or your tea or your water or whatever else you need to stay hydrated on this last day of summer.

Certainly, in the first half of

today's meeting, we heard a lot about the workforce, and we heard a lot about data, and obviously all in relationship to moms and babies and infant mortality and maternal mortality.

So, the next half of our sessions today are going to be really focusing on again some more workforce issues, some data issues, and certainly your equity issues.

So, for our first panel, I'm going to turn it over to Belinda Pettiford.

Belinda.

BELINDA PETTIFORD: Thank you, Ed. And thanks, everyone.

So, the Health Equity Workgroup, we're excited to share today's presentation with you all. As part of our recommendation to the Secretary, race concordant care has been identified as a factor in potentially reducing disparities in birth outcomes. It has been discussed for years and has been actually achieved in some communities.

If you look into our history, it has

been available in the past. More recently, this issue was further discussed in the Health Equity Workbook of SACIM. It is also connected to SACIM's recommendation to the workforce being diverse and reflective of the communities that are actually being served.

Health equity workgroups' focus on race concordant care is based on relationship-building that impacts access to and utilization of care. Communities should have the option to have the provider of their choice.

Even though the research is just beginning, several articles have been shared, and they're in your briefing books. And if you're a member of SACIM, we hope that you will take time to review them.

As we approach race concordant care today, we consider the following:

The majority population already has access to race concordant care. They are able to select from a host of providers who look like them to schedule all types of appointments related to

their health care. Race concordant care is not segregation. It's providing individuals options so that they will feel most comfortable in their care setting.

We are aware that there are pipeline challenges. And we will hear more about them today.

Conversations need to also occur with individuals on what their specific needs are in regard to having respectful care. Patient satisfaction processes are important, and we feel like they should be conducted, when at all possible, anonymously or by a third party. If you like your provider, you're more likely to keep your appointments and share information that impacts your plan of care.

BIPOC populations would like access to race concordant care, as well as the majority population, who already has access.

As you will hear today, one option for strengthening our pipeline is through increasing utilization of midwives as well as

doulas. This is one of the areas that we will discuss.

If I can get the next slide, please.

For today's session, we're going to cover some of the following areas, as you can see on your screen. We'll provide an overview of race concordant care; importance of respectful care. We'll share some examples of race concordant care efforts, as well as discuss ways to strengthen the pipeline and increase access for BIPOC populations.

At this time, I would like to introduce you to our two speakers for today, because we're real excited to have both of them join us. First, we have Dr. William McDade. Dr. McDade is the Chief Diversity, Equity, and Inclusion Officer Accreditation Council for Graduate Medical Education. Thank you, Dr. McDade.

Right after Dr. McDade's speech, we're happy to have one of my Health Equity Committee members, Patricia Loftman. Patricia is

a certified nurse-midwife. She's Chair of the BILOC (ph.) Committee for New York Midwives. She's also a member of the New York Department of Health and Mental Hygiene, and also serves on the Maternal Mortality Review Committee.

So, at this time I'm going to turn it over to Dr. McDade, and both of them may introduce themselves further. We're going to hold our questions until the end because we want to make sure both speakers have sufficient time. But please start entering them in the chat, and we'll be watching the chat.

Dr. McDade, thank you for joining us.

WILLIAM McDADE: Thank you very much. I'm going to share my screen and get started.

The idea of racially concordant care is exactly as Belinda described it. It's care by a provider who shares your same racial/ethnic identity. The care provided by a physician who shares that same racial identity can really fall into two categories.

And the question is, why is it that

we receive our care in this way? Do individuals seek out physicians of the same race and ethnicity? And the answer is, yes, they do. Because of comfort, familiarity, because of language concordance, with communication, because of psychological safety, physical safety.

Because of trust, respect, because of a shared worldview of proximal location to where they live. All of these reasons might be why people choose a provider who's of the same race and ethnicity.

But the opposite question is, why do physicians who disproportionately care for people of their same race and ethnicity choose to do so? And part of it is from a race-conscious professionalism perspective. So, there's a sense of doing societal good. Recognition of a unique role that they may play, and job satisfaction.

One of the most satisfying moments I had in my life was taking care of my kindergarten teacher. I think there's an idea that when you give service back to the people from where you

come, you've actually done something as a member of a historically marginalized group.

It identifies the population that you served, and it gives you a sense of belongingness. And we find that when physicians actually leave one city and move to another, they often relocate in communities that have a very similar racial composition.

There's also the idea that physicians practice disproportionately in this model because of discrimination or racial -- that is, the inability to take care of people who aren't of their same race and ethnicity.

Or elitism -- schools that underrepresented physicians attend are often of not the elite category. The majority of them actually are from historically Black colleges and universities with advanced degree programs. So, there may be some elitism involved in the selection of candidates to be in certain environments.

But we understand that with racially

discordant care, the Black mothers are mistreated in our health system. And across race and ethnicity, including Asian/Pacific Islanders, Latinx, Black, and white mothers actually reported experiencing discrimination during childbirth.

And about one in ten women reported being spoken to disrespectfully by hospital personnel in a study done back in 2019 by the National Partnership of Women and Families. Ten percent reported rough handling by hospital personnel or being ignored after expressing fears and concerns.

And Black women were more likely to experience this unfair treatment and discrimination in the health system than were white and Latino women. So, the idea that that mistrust is earned actually comes into play in the treatment of women who were there.

Now, this important paper from our colleague at Johns Hopkins, Lisa Cooper, and her group, really suggests that patients see themselves in their physicians and that racially

concordant care allows physicians and patients to find those common personal beliefs, values, and communication.

And perceived personal similarities associated with higher ratings of trust, satisfaction, and adherence to medical advice, and that race concordance is the primary predictor of this perceived ethnic identity.

The benefits of racially concordant care are that it really addressed the unfortunate reality of how we trust in American society. We mentioned before that the intention to adhere to medical advice is heightened in these situations and that patient satisfaction is better when there are historically marginalized physicians and groups and providers who are concordant.

Then, in fact, there are improved clinical outcomes in certain categories, and we'll talk about that in a second, that you have improved clinical access to individuals who would rather forego care than to receive it in an environment that dehumanizes them is one of those

driving factors that cause people to seek these concordant relationships.

The idea is that if I have to go to a doctor where I'm disrespected, where I'm humiliated and discriminated against, I'd rather not have care. That really results in some of the disparities that we actually see among minoritized populations.

And this goes to the idea of vaccine hesitancy even in the COVID situation. This is a paper from my colleague, Fatima Cody-Sanford (ph.), who really said that it's not just the historical racism that's taking place in medicine.

And we all recognize J. Marion Simms's (ph.) experimentation of surgery in enslaved women; Henrietta Lacks's cells being used without her family's being compensated or acknowledged, the Tuskegee syphilis experiment that was done by the Department of Health Services, for many years withholding treatment for a disease that could be treated.

It is in fact everyday racism

experienced by Black and brown communities, historically marginalized communities, that really is the core of what the problem may be in trying to reach those who have chosen to be unvaccinated from racial and ethnic minorities.

There is a hazard, though, of depending on racially concordant care to eliminate health disparities. The hazard is that these discriminations aren't just medical; they're social. And these social determinants of health factors in along with that access question concordant providers. And that these social determinants of health across a variety of areas.

They include lack of access to healthy food and food practices, inundation with ultra-processed foods, community and interpersonal violence that takes place, and then the lack of access to green space for play and exercise. Environmental conditions that may include pollution and substance toxicity that impairs health.

Housing insecurity, poverty, and

wealth gap, LSTAT (ph.) load, the adverse childhood events, inadequate transportation, neighborhood disinvestment, over-policing, residential segregation, structural racism -- those are all factors that interplay with access to health care that contribute to inadequate health.

The political determinants of health, as our colleague, Dr. Jozz (ph.), would say that also factor in here, and it recognizes inequitable policies. Politics and regulations and laws have impaired access to care and contribute to health inequalities.

So, fixing the workforce isn't enough. And that's what this shows. This is data from the ACGME that show the number of or the percentage of underrepresented minorities in our health care programs across the country as a function of race and ethnicity.

And what you'll see there in the green bars are the African American percentage of residents over the last 15 years. And we see the

number hasn't changed a bit. The Latinx individuals hasn't changed significantly either.

And so, if we're going to increase the percentage of people who are of the racist background of those historically marginalized groups, we're going to have to do some different with respect to the workforce, as you discussed earlier today. We simply have not graduated enough Black, Latinx, and indigenous physicians in order to do this over the last 40 years.

We have to make sure that all physicians understand the importance of cultural humility in delivering care to patients from historically marginalized groups.

So that's what we're doing at ACGME. We'd like to improve health care and population health by enhancing the education of resident physicians through accreditation and education. We also now find diversity and inclusion as targets for all residency programs and fellowships that we accredit, and we accredit almost all of them in the country.

The thinking is, let's educate physicians who are more likely to serve underserved patients located in minority communities so that we can increase health care access and improve trust, communication, and outcomes for those most at risk for health inequity.

So, this is just a map showing the practices and cardiology in Chicago, with blue dots for every cardiology practice. And what I'll show you is that on the south side of Chicago, a very largely African American community, we see that there's a big gap with respect to where physicians practice. There's a community called Englewood here.

We see the same thing on the west side of Chicago, where there's another very large African American population. It's totally absent of cardiology practices.

The New York Times went to Chicago and looked at this and found that the life expectancy for someone in Englewood, which is

where I showed you before, is 30 years less than the life expectancy for someone who lives in Streeterville. And you'll notice an actual inverse relationship between the Black population in Englewood and that with respect to Streeterville.

So race is still a very important factor with respect to where physicians practice. And what we find is that the geographical location of physicians and disease is part of the problem in providing access. People aren't leaving their communities to receive the care that they need.

So, if you look at other data on residential segregation and the availability of primary care physicians, you'll see that the odds of being in a primary care physician shortage area is about 67 percent greater if you're in a majority African American zip code. And then as the degree of segregation increases in your zip code, the odds of being in a primary care physician shortage area also increased.

This really is the essence of it,

that you don't leave your communities in order to seek care.

If you look at dentists, this is a paper from Health Affairs. It suggested that racially concordant care happens even when dentists don't practice in underrepresented communities. If you look overall, that 54 percent of an underrepresented minority dentist practice is underrepresented minority individuals. Those individuals come and seek this care if they're in their communities and if they're not.

So even aside from the proximity argument, there's also a tendency to go to physicians of your same race and ethnicity. And this is probably due to some of those other factors that we talked about, such as trust.

This is a report from the US News and World Report, which looked at procedures done in cardiovascular, cancer, and orthopedic procedures. And for 2012 to 2018, Black received 67,000 fewer orthopedic procedures. That is in part due to the fact that there are not a colocation physicians

with the disease burden for African Americans.

So, people would rather forgo their operation than to go to a non-concordant care physician. And we see that's to the detriment of the wellbeing of African Americans.

So, you're willing to find out who's going to practice in an underrepresented community and who's going to serve underrepresented patients, ask a first-year medical student. What we see here is over 60 percent of first-year medical students who are African American say that they're going to practice when they graduate in an underserved community.

Well, after four years of medical school, do we beat that out of them? The answer to that is no, that in fact, still, African Americans lead the group of saying that that's where they're going to practice, in an underserved community. Still over 55 percent of Native Americans, still around 50 percent say that that's where they're going to practice when they graduate from medical school.

So, this is data from the Cambridge Health Alliance, which says that your odds of taking care of an African American patient, if you are an African American physician, compared to taking care of an African American patient if you are a white physician, are about 23.25 times great.

If you're a Latinx doctor taking care of a Latinx patient, compared to a white doctor, you're at about 19 times greater odds of seeing a patient of your same ethnicity.

If you're an Asian physician seeing an Asian patient, you're also 26 times more likely to see an Asian patient than if you were a white physician seeing an Asian patient.

These are data from Peter Bachmann (ph.) published in the New England Journal of Medicine that says that primary care, a Black physician is almost 40 times more likely to see a Black patient than as a white physician to see a Black patient in primary care.

So, it's not that we're making people

work where they don't want to work. It's not limiting patient access to the best physician. It's not forcing patients to only see doctors of their own race and ethnicity. Proximity is an important factor.

But you also have to have physicians who are willing to work in disadvantaged communities and take governmental reimbursement. Patient choice also plays a role as we've seen with respect to trust.

And then the question arises: What is this race-conscious professionalism? Is it that white and Asian physicians are choosing not to work in historically marginalized communities? Or is it that historically marginalized communities aren't welcoming to people from these different backgrounds?

I think the answer is it is that draw that brings people together because of racially concordant that really does it. There may be a factor of that marginalized physicians aren't so welcome in certain communities. But I think it

really is that professional consciousness that Black and brown physicians and indigenous physicians bring to the work that they do.

Well, this is an important paper that was published in the National Bureau of Economic Research by my colleague Marcella Alsan and Owen Garrett (ph.). She was at Stanford, and this is in Oakland. They looked at Black men in Oakland, and they randomized them to physician practices they established for a Black doctor or a white doctor.

And then what they did was they'd evaluate the interaction that took place and did some very elegant mathematics to do some projections on cardiovascular disease risk.

What they found is that when the Black men went to a Black doctor, that the subjects were more likely to talk to that Black doctor about more of their medical problems and more of their health problems, that Black doctors were more likely to write additional longer notes about these subjects.

Through the calculations that they predicted, the cardiovascular disease impact would be significantly changed by racially concordant care, and you can improve the morbidity, the sickness from cardiovascular disease by 19 percent and that you could reduce the mortality of cardiovascular death by almost 10 percent just because of racially concordant care.

They thought this was because diabetes screening was up. Cholesterol screening was up, and invasive testing was up 20 percent in racially concordant relationships and that return visits were up 20 percent in racially concordant visits. And even flu shots were more likely to be had in a racially concordant relationship.

This is the paper that really is of interest to perinatologists and OB/GYNs. It was published in the Proceeding of the National Academy of Sciences back in September 2020. It's an association paper, so causation wasn't really linked to what was reported here. They looked at 1.8 million live births in Florida between 1992

and 2015.

What they found is that Black newborn death rate was almost three times greater than that of white babies. But when they found that there was a patient baby perinatologist physician in concordance with respect to race, that having a Black doctor if you're a Black baby increased your chance of actually surviving by 53 to 56 percent.

Now, incidentally, there was no improvement based on maternal mortality based on racially concordant care in this particular study. But the study wasn't really designed to look at that particular variable.

If you look at what happens in OB care with respect to who's delivering it, we know and understand that family medicines physicians deliver a lot of the OB care that's delivered in the United States.

But what we find is that Black family medicine physicians are only half as likely to provide obstetrical care as do their white and Latin counterparts. They're less likely to

maintain continuous certification of obstetrical practice.

In fact, if you look at the workforce that takes care of patients who are in family medicine, you'll see that we need to have a more diverse and racially ethnic representation in maternal family care of people who come from historically marginalized groups. And we have to enhance efforts to diversify that workforce and encourage physicians to continue that care.

If you look at what happens with trust in respect to COVID, this is another paper by Marcella Alsan and Fatima Cody Stanford. And what they talked about in this one is if you show videos of physicians of various races and ethnicities, suggesting what they should do, what patients should do with respect to COVID, you find that as a function of race that people can view those videos whether they're Black, Latinx or other.

You'll see that if a Black physician delivers the message, Black patients are more

likely to seek additional information about COVID than if a physician of any other race gives the message.

It did not happen for Latinx individuals; they didn't have a greater tendency to seek additional information if a Latinx physician delivered the message.

But what Lisa Cooper actually commented on in the editorial in this paper is that ensuring that messages are accurate, available, and comprehensible is insufficient. Recipients must also trust the messenger. That trust is more likely when information is delivered by a messenger who is known and has a positive relationship with the community.

Patient-centered communication doesn't explain heightened satisfaction scores with respect to concordance. Race concordance visits are longer and, as we've talked about, characterized by more patient positive affect. We found that that's linked to continuity of care, given the tendency to come back for return visits.

But this association isn't just because you're doing patient-centered communication; there are other factors, such as physician and patient attitudes that may mediate that relationship. This is also work by Lisa Cooper.

This is an article in The New York Times that was really advising Black women how to protect yourself at birth. Now, that the Times had to actually tell women how to do this really speaks to the idea that people feel that they're not being taken care of in the same way. And they hear the statistics and maternal mortality, and people want information and knowledge to react to it.

One of the things that you look at is what happens when you have concordant care. It contributes to a more effective therapeutic relationship and improved health care in women. And so, what we find in this situation is that, for historically marginalized women, emergency department use was lower among white and Hispanics

than it was people without a discordant relationship.

Then, in fact, total health care expenditures were lower among Black, Asian, and Hispanic patients who had a racially concordant clinician, as opposed to those who had discordant clinicians.

So having concordance in your physician relationship improves your care and reduces health outcomes, health cost outcomes as well.

This paper came out in Northwestern, in which they looked at almost 10,000 women. And they found, compared to non-Hispanic white women, that Hispanic and non-Hispanic Black women had significantly greater odds of reporting a pain score of 5 or higher in the immediate postpartum period, and that they received significantly fewer morphine milligram equivalents, adjusted for race, and on non-adjusted data than their white counterparts.

And that in fact that they were less

likely to receive an opioid prescription at discharge. There was coverage in the Chicago Tribune about this article back in March of 2020. And it really talked about some experiences of individuals who talked about their pain afterward.

The idea that Hispanic and non-Hispanic Black women experience pain disparities less than white women is a significant factor in thinking about maternal care after delivery. And part of that was that physicians actually perceive that these women experience pain in a less-human fashion, unfortunately.

So, the conclusions that I'd like to bring are that we need to create and expand funded measures to support increasing diversity of historically marginalized individuals in health careers in medicine because we just don't have enough to even think about providing concordant care to all of the communities that need it.

We have to recognize the value of communication, trust, and safety, and educate all physicians as to how to deliver care in a way that

delivers both better care and cultural humility care that protects patients from being abused in that relationship.

We have to ensure that performance measures are valid, fair, and nonpunitive for marginalized physicians who care for patients in these communities, because of the great influence of the social determinants of health and politics.

Then we have to consider incentivizing non-marginalized physicians as well to work in communities of marginalized patients because some care is better than no care. But ensure that these individuals are equipped with cultural dexterity to manage these complex relationships with untrust patients.

Collect data on race and ethnicity of physicians because we don't always do it in federal data sets. We have to recognize that if we don't know the race, we can't think about doing concordant care.

Trust is earned. So, you have to think about what these physicians need to learn

and their training and where they have to be able to advance and work in order to deliver the care in order to improve situations.

And I'm going to stop there. Thank you for giving me the opportunity.

BELINDA PETTIFORD: Thank you so much, Dr. McDade.

Before we go on to questions, we're going to go on and ask Patricia if she'll come on and do her presentation as well.

Did we lose you, Pat?

PATRICIA LOFTMAN: I don't think so. Can you hear me?

BELINDA PETTIFORD: I can. Thank you.

PATRICIA LOFTMAN: I'm just waiting for my slides to come up.

(Pause)

PATRICIA LOFTMAN: Next slide.

I would actually like to thank Dr. McDade. Sometimes when you come behind someone who is presenting information that's similar to

yours, you wonder whether they were -- you know, in the olden days we would say, "copying off of you." So, some of my information is going to be somewhat redundant.

But a lot of the information that Dr. McDade presented was from the physician's background. So, what I would like to do is focus more on the midwifery situation.

So, we all know that maternal mortality is a key indicator of health, and inequity, which is impacted by social determinants of health more than behaviors and even clinical care, although -- next slide -- clinical care is very important.

Next slide.

Clinical care is extremely important, and it involves the immediate care team. So, we'll look at some determinants of the immediate care team. It's the woman, it's the care providers, and that includes the clinicians, the nurses, the pharmacists, all of the individuals who would play a role in the care of the

individual woman, and of course, her family members.

Next slide, please. Next.

So as Dr. McDade so eloquently stated, race concordance providers frequently reside in the same community and possess shared experiences of daily life -- language, values, customs, mores, and cultural norms.

Among clients who choose their providers, there was a preference for race concordance. And if you look at the Institutes of Medicine and the Sullivan Report back in 2004, it stated that upon graduation, professionals of color consistently return to work and serve in their community.

And actually, I am a product of that. I was a National Health Service Corps recipient. And I specifically chose to go and work in the public institution in the community in which I resided. So, this factor has facilitated the increased adherence with appointments and treatment plans. Patients report increased

satisfaction, increased connection, increased comfort, respect, and trust.

And as Dr. McDade stated, trust is earned. But before trust, you have to have developed a relationship. So, trust is important, but it's the relationship that is the foundation for the building of trust. And when that is achieved, the patients have more confidence in the providers. They also had the highest level of satisfaction.

And the goal of all patients, whether they are women, whether they are other individuals, the goal is to not only get them into the health care system but for them to remain in the health care system.

We have devised many services and programs and skills, skilled clinicians. But if individuals will not come into and enter the health care system and remain in the health care system, they will not take advantage of all of the services that we have to provide them.

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next slide.

So, a lot of the information that I'm going to share came from the Listening and Giving Voice to Mothers survey that was conducted by a group called the Birth Lab. The Birth Lab is a group of researchers and scholars that is based in British Columbia. And they have literally spoken to and surveyed a lot of the women in terms of their satisfaction with the health care that they received and what were some of the barriers in the care that they received?

Next slide.

So, women of color consistently report disrespectful care from obstetrical providers.

Next slide.

Mothers relayed a host of experiences with discrimination during childbirth and during their hospital stay. And it involved issues around race, ethnicity, language, insurance, and just a difference of opinion between the individual woman and her health care provider

regarding care for herself and care for her baby.

Next slide. Next slide.

Women were asked, "During your recent hospital stay, how often were you treated poorly because of your race, your ethnicity, cultural background, or language?

And as you can see, for African American women, regardless of whether they were cared for by an obstetrician or by a midwife, both women, specifically Black women, but also Latinx women reported experiences of disrespectful care.

And I share this because often we don't speak to women, we don't listen to women, we don't know what women's perceptions were of the care that they received. So, we're not really quite sure why they don't come back or why they discontinue their care.

Next slide.

Also from the Birth Lab, women described experiences of mistreatment during childbirth. One is six women who experienced mistreatment during childbirth. The four most

common types of mistreatment were being shouted at, refusing their requests for help, visitation, violation of physical privacy, threatening to withhold treatment.

And when you look at this broken down by race and ethnicity, indigenous women, Latinx women, Black women more often than not experienced more mistreatment in birth.

Next slide.

And this was from the Listening to Mothers in California experience in 2016. And the question that was attempted to -- the information that was attempted to be elicited was What were the women's future interests in birth center use based on their experiences that they had had in-hospital use for birth?

And as you can see, the majority, when you look at the breakdown by race, African American women -- and this was quite surprising to me -- African American women, Latinx women indicated that they were extremely interested in utilizing and would consider utilizing a birth

center for their next birth.

Next slide.

Now, this slide I used quite often because it was extremely intriguing to me. Because as a rule, at least my experience in a public hospital that served predominantly African American women, most African American women want their birth to be conducted in a hospital primarily because of the availability of analgesia.

But when you ask them, after your hospital experience, how many would you be open to giving birth at home? Almost 30 percent of women. Eighteen percent said would consider, 11 percent said would definitely want. And you're talking about almost 30 percent of women who said that they would consider or be interested in having a home birth for their subsequent births.

Next slide.

And again, this is just a breakdown with just a little bit more clarity in terms of race, in terms of having their next birth in a

birth center. The impact of place of birth on mistreatment. The place of birth impacts the rate of mistreatment. Twenty-eight percent of women reported that they had higher rates of mistreatment in a hospital setting than in a community setting.

When you look at types of mistreatments by birth, 12 percent said that they were ignored by their provider, or the providers refused help, as opposed to 2.5 percent in the home or 2.3 percent in a freestanding birth center.

If you look at place of birth impacts mistreatment of women of color, almost 34 percent of women of color who gave birth in the hospital documented that they were mistreated, as opposed to 6.6 percent of women who said that they were mistreated when they gave birth in a community setting.

When you look at violation of physical privacy, almost 11 percent of women said that this occurred in a hospital setting, as

opposed to 0.6 percent in a freestanding birth center and 0.8 percent in the home.

If you look at the women who said that they were threatened by care providers, 6.6 percent occurred in a hospital, 4.2 percent in a birth center, 3.2 percent in a freestanding birth center, and 1.8 percent in the home.

So, there's something that's happening in the hospital that is saying to women that maybe the hospital is not a safe place for birth. And I don't think that that is information that we want people to walk away from a hospital birth. That is not what we want them to take out of the hospital.

Next slide. Next slide.

So, I am a certified nurse-midwife, and my professional organization is the American College of Nurse-Midwives. So, when you look at ACNM in 2021, the midwifery community is extremely small. I think people believe that the midwifery community is actually larger than it actually is.

But nationally, there are only 13,500

midwives in the entire country. Ninety percent of those midwives are white and female; 10 percent are midwives of color. And midwives of color comprise Black, Latinx, Asian, and indigenous midwives.

So similar to the pattern that you would see with physicians, the geographic location of midwives demonstrates a similar pattern. So, you have midwives who are literally concentrated in the urban cities and then fewer in rural areas, and then fewer still -- well, mostly the urban areas and fewer in the rural areas.

Next slide. Next slide.

And when you look at the Midwifery Education Program, of the 40 education programs, 87 percent of them are headed by service directors who are white; three midwifery education programs are directed by a midwife of color; 75 percent of the faculty are all white. And all new midwifery education programs are in predominantly white institutions.

So, the message here is that if we're

going to begin to increase the number of midwives of color, there needs to be a migration away from academic institutions into institutions that have historically educated not only most Black physicians but mostly Black nurses. So, you have your historically Black colleges and universities.

At the moment, these historically Black colleges and universities do not have any midwifery programs. Some have certified nurse anesthesia programs, but none have nurse-midwifery programs.

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When you look at the ability to diversify the midwifery workforce, it becomes somewhat difficult because when you look at the admission of students by race and ethnicity, there appears to be an underrepresentation of students of color and an overrepresentation of Caucasian midwives.

So actually, the only racial group where they're congruent in terms of their representation within the diversity of the U.S.

population are Black midwives, Black midwifery students. But if you look at the Latinx midwifery students, they are severely underrepresented, as Asian midwives and indigenous midwives, Alaskan Native midwives -- their representation in terms of students is really underrepresented.

Next slide. Next slide.

So, what are some of the pipeline concerns?

Go back one slide, please.

What are some of the pipeline concerns?

Go back one slide. Can you go back to the pipeline slide?

So, what are the concerns for the pipeline? Well, number one, we need to increase the number of students so that, number two, we can increase the number of practitioners who ultimately graduate. Because we first need practitioners who subsequently become educators.

We need to increase faculty in midwifery education programs. We need to also

address the ability to retain our practitioners once they graduate from midwifery education program.

Because what we're seeing in the midwifery community, although there is a decline in the numbers of practicing OB/GYNs, and there seem to be an ability for midwives to fill this void, when it comes to midwives of color, once they have graduated, their ability to be employed, a lot of the data that we collect shows that they achieve employment at much lower rates, it takes them longer to be employed than their white counterparts.

And once they've become employed, the retention of them seems to be shorter. So, we need students to come in. They can graduate, become practitioners, become educators, become faculty, and also to become scholars.

But ultimately, we need researchers because it's clear that money needs to be allocated to research on race concordant outcomes. The information that we have and the data that we

have on outcomes based on race primarily we have gleaned from research conducted by private physicians. Most data are physician-based.

Although there's an argument that can be made that the correlation to other professions such as midwifery should also be the same.

So, there is a dearth of information available on midwifery, on the midwifery side on the impact of race concordance here, although anecdotally we know that this is what women want. So, we actually need to consciously and strategically begin to collect the data on these outcomes.

And actually, what we do see --

You can advance the slide, please.

That research is just beginning. There is a midwifery group out of the University of Illinois in Chicago that just received a $7 million grant to literally research this very issue. They just received this grant approximately maybe a month or two ago. So, the research on midwifery care, race concordant

midwifery care is just beginning.

What are some of the strategies that we could use on the midwifery side to address workforce diversity? Well, certainly there is federal legislation around workforce diversification. Certainly, there's a Mom's Bill and the Momnibus Bill.

The second thing is, the funding, however, that is included in those bills. Because unfortunately, some of those fundings lack accountability metrics. But I think it's really important if we really are to achieve a diversity of the midwifery workforce.

And some of those metrics really need to include how many students of color are enrolled? How many graduate? How many pass the certification exam? And then how long does it take them to become employed? Because the longer it takes a midwifery graduate to be employed, those individuals' default to the nursing position as opposed to continue and try to secure employment in the midwifery field.

So, the amount of time that it takes a graduate midwifery to become employed is an important issue. These are some accountability metrics that the grantors of the funding in some of these federal legislations, hopefully, if they are included, will address workforce diversification.

And I think that's it. I'm finished.

BELINDA PETTIFORD: Well, thank you so much, Patricia, as well as Dr. McDade.

At this point, we want to open it up. You have provided a wonderful perspective for us to have a discussion about this. So, we're going to open it up for questions.

I know there's one in the chat already, but others are coming up with their questions, I'll start it off and ask both of you all -- Are there any specific recommendations that you can pass over to SACIM that will really help us strengthen our current pipeline to diversify our providers? Do you have any specific recommendations to SACIM itself?

WILLIAM McDADE: Well, so there's legislation I know that's being prepared by House Ways and Means Committee. And my thinking on this one is that when Chairman Neal's work comes out it's going to address trying to enhance the pipeline of individuals who come from underrepresented minority backgrounds.

So, the thought is that we can look at people who are post-baccalaureate programs, as well as people who are in the undergraduate phase. I think that we can think about earlier learners. But I think one of the most immediate returns you get is with post-baccalaureate learners who are pursuing careers in health care.

Because these are people who may have had the preparation going in college, didn't do well in their first two years, but then caught up. And they represent a ready source of people who, with another opportunity, now that they're a little more mature, now that they've been exposed to college, they actually master those courses that they didn't matter in the first two years.

It stops them from being successful candidates for medical school.

I think there are a lot of individuals like me who would benefit. And if that legislation goes forward, my hope is that we support that.

PATRICIA LOFTMAN: Belinda, there's a question in the chat about, the focus seems to be on certified nurse midwives as opposed to certified professional midwives and certified midwife.

Now, ACNM represents certified nurse-midwives and certified midwives. So certified midwives are already taken care of. But the issue of certified professional midwives is actually an important issue because that's another profession of midwives that we don't really talk about a lot. And they are there. Certified professional midwives don't work in the hospital. Certified professional midwives care for women in the community, in birth centers, and in homes.

The problem with -- and it's not a

problem; that's the wrong word. Certified professional midwives are only legal in 38 states, whereas certified nurse-midwives and certified midwives are legal in all 50 states.

So, one avenue would be maybe for SACIM to support legalization of certified professional midwives in all 50 states. Now, certified professional midwives have their own professional organization, the National Association of Certified Professional Midwives. But that is something that they have been advocating, and that is another source of midwives and midwifery care.

The other group of individuals who actually could be a pipeline into midwifery education are doulas. Because keep in mind, there are doulas and birth workers out there who are already involved in that space and already doing some of the work. So, to involve them in formal education is something that would enhance the capacity of the midwifery workforce.

BELINDA PETTIFORD: Thank you,

Patricia.

And I see Janelle has her hand up with a question.

JANELLE PALACIOS: Thank you. This was a wonderful panel presentation. I feel like the presentation should be given as a standard throughout medical school and midwifery school, any kind of health education science. And then again, as people graduate.

I caught, Dr. McDade, that you shared about one of the pipeline issues that we could reach to earlier learners.

So, you know, knowing that we have an immediate need and knowing that we can effect some changes by looking at the current pool of students or post-bac programs, thinking long-term, knowing that there's going to be a shortage of nurses, physicians, likely midwives in the future for a growing population, what activities should we consider now that are going to cover that gap coming up in 20–30 years?

I don't want to pass this mantel onto

my children as they're adults or my grandchildren, saying, "Well, I'm sorry. We did what we could at the time." So how do we address this issue, and how early should we look? And what does that look like? Do we involve communities? So that piece.

But then also, looking forward, what kind of research should be done on race concordant care that is going to help further our understanding or help us understand that we are doing what we should be doing? Thank you.

WILLIAM McDADE: Well, my immediate is we'd have to do something to address the wealth gap that exists in our society with respect to underrepresented minority groups and the majority community. I think it really starts with education in general.

And you asked how early? I've often asked the question but have no tracking data on this. How many third-graders do you need to talk to in order to make one physician? And the answer is, you've got to talk to a lot of them, that they're an underrepresented minority from

historically marginalized groups.

The point is that we have to do something to build the infrastructure in societies that really fixes the issue of inadequate education, inadequate preparation for higher education. We've got to graduate people from high schools. We have to fix the social justice system so that so many African American men are incarcerated and dealing with the civil justice system as opposed to being able to be educated in higher education.

I think it has to start with societal change where you're going to recognize the under-structure of racism that exists that we have to eliminate most practices in order to increase.

With that said, I think there are directed things that you can do, bringing over people, such as exposing them to job-sharing opportunities, to research participation. When I was a professor at the University of Chicago, for many years I ran a program that we called SOMER, the Pittsburgh School of Medicine, Experience, and

Research.

We had another one we called YSTP, the Young Science Training Program. That one focused on high school students, and I had students from King High School in Chicago a few blocks away from the University of Chicago that ended up going to medical school. I've got one who's still there right now at Harvard in Emergency Medicine.

I mean, the idea is that you can take kids from the inner city, expose them to opportunities and research at excellent institutions, and then you can drive their entire careers to become very successful.

So, I think that you have to expose people. You have to let them know that more opportunities exist than the ones that they may see in front of them and that you have to then expose them to mentorship, directive mentorship. That's important. So those are the sorts of things that I think are really effective.

PATRICIA LOFTMAN: Can I just?

BELINDA PETTIFORD: Yes.

PATRICIA LOFTMAN: I'm going to echo what Dr. McDade just said. One of the things that was very interesting to me when I began my midwifery career in 1982, every patient I would meet always said -- first of all they didn't know that there were midwives, and they didn't know that there were Black midwives.

So very early in the careers of students, they have to be able to see us, let them know that we're out there, and they know that we exist and that we can be role models for what they can be.

And if you look at, just look at tennis and what has happened in tennis. If you look at the young group of tennis players that we have today, who were their role models? Venus and Serena Williams. Most of them if you ask them, grew up watching Venus and Serena play tennis, and they said, "Oh, I can do that." And they watched them at a very, very early age.

So, the other thing that we need to

do, and I'm going to comment on Dr. Conry's comment about advocating for various categories of midwife because, in fact, Dr. Conry is correct that the International Confederation of Midwives recommended minimum levels of education for training.

But we also know that there have been adjustments to that and that no one is advocating nonformal education. Formal education is absolutely what we want. We want people to be the best-educated, the best skilled, the best informed.

There are schools, certified professional midwifery schools. And for graduates of those schools, depending upon the state that they go to, they are not able to practice. So, the goal should be to enable any CPM student who graduates from an accredited formal education to be legal in the state that she would like to practice in. I think that would be the goal.

BELINDA PETTIFORD: Thank you.

I see colleagues' hands up as well.

COLLEEN MALLOY: Hello. Thank you for those presentations. They were fantastic. I have a couple of questions, like they're unrelated, but especially for Dr. McDade. And I live in Chicago like you do.

The physician basically doesn't that you showed on your map were comparing the north side to Englewood (sic). So how do you think, and maybe you kind of answered that in what you just said in reference to the last question, because it's probably more of a systemic issue? But when you think of the decreased life expectancy for the groups who come from that part of the city versus other parts of the city, like how does that overlap with the issues of like violence?

So, is it, yes, it's the component of -- are they receiving proper health care for sure? If they can't get to seek out medical assistance. How do you look at that overlap with the issues of violent crime that might be more -- well, they are more frequent in Englewood than the northern part of the city?

I was just part of a vaccination drive in Englewood. And the day that we were there, a seven-year-old girl was shot in the head and killed. So, I think that when you look at statistics for life expectancy, it's clearly other things besides just medical conditions. So how do you kind of -- is it like an overlapping circle, do you think? Or is it more of a pyramid shape? Like how do you kind of ferret out some details?

It's kind of, I think, related to what you just said where it's having more issues of helping education, helping decrease the wealth gap and things like that are just issues of daily living. So, I think you kind of answered it already. That's my first question, so you can answer that before I can ask my second one.

DR. McDADE: I can answer the first one, and then we can go to your second one.

COLLEEN MALLOY: For sure.

WILLIAM McDADE: So, the first one, I think you're right. It's the social insurance health, it is political determinants of health

that we talked about in the presentation. And I don't think that gun violence contributes significantly to the overall deaths and longevity.

I think that the life expectancy has been pretty low for African Americans in this country who really preceded the immense handgun violence and gun violence that's taken place in Englewood over the last few decades.

When I was a medical student, one of the things that was said about the life expectancy of Black doctors, as it turns out, was that the average life expectancy of a Black doctor was 64 years of age. That's in part because of the allostatic load that doctors have always had, that Black doctors have always had, that the Black community has always had.

So, the fact is that these violent peaks that we've been seeing lately have been contributory. But I don't think it explains even in a large factor why life expectancy is so low. I think it's the everyday sorts of lack of access to care, lack of access to good food, lack of

access to education and transportation.

All those social determinants of health that really explain it far more than I think violence. The violence is a part of it. And if we could reduce hand violence to zero, I'd be the first person in line to say we should do that.

COLLEEN MALLOY: Okay. Thank you.

My other question is just about the study about, from Florida that showed the increased rate of death for Black babies three times being that of white. And the second part of that about the discordance between providers. And obviously, you've read the study.

But I thought the study is frequently mentioned in the press and everywhere. And when you actually look at the study, I don't think most people know that like the way neonatology works is, you know, it's a team of people. So, this study looked at who would be admitting doctor for each baby? And then looked at a picture of that doctor. And then a panel had to decide, what race

is that person based from their picture?

So, I guess I have two problems with that. Because it's so frequently cited, this study. And neonatology, whoever your admitting doctor really could be someone who took care of you for one day versus the other two months of your hospital stay.

And there's a component of someone just looking at a phone number or a picture and deciding what race someone is. But it did kind of try to describe that it was kind of repeated. So that they showed some, I guess -- strengthened that approach. But like I don't know if you could tie in the outcome of the baby to the one person whose name was on the chart.

I work at Northwestern. There's one woman who's the director of the NICU. Her name is on every single chart. And she might not have taken care of any of those babies. But she is bureaucratically in charge of the whole place.

So, I feel like whenever that study is mentioned, there should be a little caveat

because I don't think that that's the strongest data set that they used to prove that point.

WILLIAM McDADE: So, I would agree with you that there are some limitations to the study. That's for sure. You know, I was talking to the Director of the HRSA Program for -- I'm blanking out on the name of the program right now. But this really deals with the underserved communities that are served by HRSA.

I was a member of the Board of the Joint Commission at the time. And I asked him whether we collect data on race and ethnicity of the practitioners who are a part of that program that served the underserved in that HRSA program. And he said, "Well, no." He actually had his deputy with him, and he turned to ask her whether it was true that we don't collect it. And the answer was, "No, we don't."

I think we need to collect race and ethnicity information from the practitioners so we can do more direct analysis of the impact of race concordance. Because looking at photographs is

certainly one of the most inferior ways that you could possibly imagine in trying to determine the race and ethnicity of providers.

I also think that, looking at it as a chart and trying to go backwards to see who was actually caring for a patient, because we do care for patients in teams. Now, admittedly, Northwestern has a huge practice, and they have an advanced group of folks who are taking care of people. So, you know, is it the nurse who takes care of the patient? Is it the physician team member who is a resident, who is the best person to associate? Is it the attending physician who actually supervises the teaching team?

We work as a team. And I wish there was some way to acknowledge that. But the impact is the case. But I think that the numbers that we saw, three to one, with the paucity of underrepresented positions that there are, I think there is probably some merit in that particular study in that the concordance thing should be studied at a much deeper level.

So, thanks for that question pointing out the caveat.

BELINDA PETTIFORD: Thank you.

COLLEEN MALLOY: Thank you for your presentation.

BELINDA PETTIFORD: Thanks, Colleen.

The last question, we're going to let Wanda Barfield ask the final question.

Wanda, you're muted, I think.

WANDA BARFIELD: Oh, I just wanted to thank our panelists for an incredible presentation. Thank you very much.

So, although we're trying to think about ways to increase the pipeline, I think it's also important to acknowledge the sort of missteps that have occurred in time. You know, I trained around the time of affirmative action, where there were increases in the diversity of providers. And then I was actually trained in Redding, California, and the blocking decision came out just about the time that I was ready to graduate from college.

And I wanted the panelists to talk a little bit about these systemic obstacles that do occur in addressing the pipeline. And also, what would you suggest, particularly in trying to advise young health professionals in going into these professions yet seeing debt as a major barrier. And maybe even tying it to the earlier discussion that we had, how do we create optimism about the opportunities before students already make the decision that they're not going to be a health professional? Thank you.

PATRICIA LOFTMAN: Can I take the second question, the debt question, first? Because listening to Captain Williams this morning from HRSA, more and more at least midwifery students -- that's my area of expertise is midwifery. Most of the midwifery students qualify for national health training for loan repayment.

And so, to the extent that students are encouraged to apply for those plans, you know, that would eliminate and remove the barrier.

Your first question, however, is the

harder question. Because I grew up also during that time of the Bakke Decision. You know, I think as we focus on maternal mortality, there has to be serious discussion. A lot of what Dr. McDade showed, a lot of what I showed says that there has been an overrepresentation historically.

So there has to be a way to create that balance, somehow come to the middle. So that the capacity of providers of color, which was really the foundation for that whole Bakke Decision. They didn't want to do that.

But I think we need to revisit that because I think that's the only way, we're going to make progress. That discussion has to be put back on the table.

WILLIAM McDADE: I'll just say this then. I don't know why I was blanking on Federally Qualified Health System Centers.

PATRICIA LOFTMAN: Yeah.

WILLIAM McDADE: And that's what I was looking for.

But the idea was that, in the

legislation that we just discussed that's coming out of Chairman Neal's office, I think one of the things that is in there is, how do you impact those prospects? Because when you finish college, you've used up all your Pell Grant money. And you have to work eventually in order to do those post-bac programs, and they're very expensive.

And if you work while trying to do a post-bac program, you won't do as well as you would otherwise have done, and then that's your second shot that you're going to blow.

So, I think there has to be federal support that goes along with those programs in order to make them work. And you have really keyed on an important aspect of it.

I think that in order to -- well, as a politician once said, "Don't talk to me about values. Show me your budget statement and I'll show you your values." So that if we really value trying to drive people into the health sciences, we have to figure out how to value that by actually attaching aid that's going to support

those underserved individuals in being able to pursue it.

And that's really one way of addressing the wealth gap. Joya Cohn (ph.), who was the President of WAMC at the time, showed data that looked at impact performance, and that the higher your parental income, the higher you performed on the MCAP. And that 80 percent of medical students who are matriculants actually come from the top 1 percent of all earners.

And so, when you look at that disproportion, you can see why it's not really accessible, at least in the minds of many folks. And WAMC started a program over a decade ago called aspiringdocs.org that really taught them about this issue of finance.

But I don't think that's a sufficient effort. We have to figure out some way of making money available so we can educate people and do it at a cost that they can actually afford. When a year of tuition costs more than the house that your parents live in, you're not going to pursue

medicine.

BELINDA PETTIFORD: Please join me in thanking both of our presenters. This has been a wonderful discussion. I will say that we're just beginning it. By no means should this be the end?

But we appreciate both of your time and effort in participating today. So, thank you so much.

WILLIAM McDADE: Yeah, thank you for allowing me to participate.

EDWARD EHLINGER: Thank you, Patricia, for actually advocating for this session. Patricia was really the moving force for having this session. I really, really appreciate that.

PATRICIA LOFTMAN: Thank you.

EDWARD EHLINGER: And before we move on, we're going to go over 10 minutes because this was an important discussion, and I know that data discussion is also important. But I'm going to make one point of one of my biases. And this follows what you said about accountability.

It irritates me that all of the land grant institutions that were basically given indigenous land in order to develop higher education are not being held accountable for training the people in their states. That's what we pledged to do. And I think that we need to hold these institutions -- most of them are public institutions -- hold them accountable for the training of the people in the state who represent their state. That's what our job is at the state level.

So, with that, I turn it over to Magda for another important session.

DATA TO ACTION: STRENGTHENING MCH-RELATED SENTINEL EVENT REVIEW APPROACHES, SYSTEMS AND USES: MATERNAL (MMRC, FETAL/INFANT (FIMRI), AND CHILD (CFR) FATALITY REVIEW

MAGDA PECK: Thank you. Well, thank you, Ed. I welcome you all. This will take literally 30 seconds just to breathe. Because we're going to make a transition. And I want you to be ready to shift a bit. So, whatever you need to do for about 30 seconds, this is worthwhile so that you can focus your attention and then savor

the extraordinary presentation from our previous speakers.

(Pause)

MAGDA PECK: We'll also ask you if it's possible that when I am speaking, our technical folks, I have a profound hearing disability. So, I call in twice, and I would prefer when I am speaking if you could pin me, this one, and not the one who's speaking. So, if you can figure that out technologically, that will help.

And for all of you who share a hearing impairment, I'm your advocate. I am absolutely ready for advocacy in that area.

So, this last session today is about data, yes. But it is more importantly about data for action, data that are used, data that are usable, data that are used for accountability, advocacy, and impact. Because data alone never speak for themselves.

So, this final session, which you've titled Data for Action: Strengthening Maternal and

Child Health-Related Sentinel Event Review Approaches -- and I'll talk about that in a second -- Systems and Uses. So, we're going to focus on two, in particular, maternal mortality review, and fetal and infant mortality review.

And we'll also add child fatality review because it's part of a life course approach of being able to take vulnerable and extraordinary kinds of opportunities by looking at the numerator and not just the denominator.

There have been longstanding and plentiful aggregated public and population health data. We have looked for ratio T-values and proportions in our work to prevent infant and maternal mortality.

But there are egregious and significant events that demand more detailed attention and summon us to ask one by one every time three questions: Why did this happen? Could it, this have been prevented? And what needs to change at every level, individual through societal, for it not to happen again?

For about 40 years, four decades, sentinel health review methods have been part of our public health and population health and prevention toolkit. I know this because 40 years ago I worked on my dissertation at Harvard about preventable pediatric hospitalization, defining sentinel health events, use of data, to be able to look at cases one by one that should not have happened in the first place or not have been so severe.

Now, the Joint Commission of Accreditation of Health Care Organizations defines a sentinel event as any unanticipated or unusual event in a medical setting which results in death or serious physical injury to a person or persons. And it specifically cites limb loss or gross motor function, a clearly clinical event, is currently used by the joint commission.

And the intention is to improve quality of medical care. More recently, as social, and environmental determinants of health care have been incorporating into sentinel event

review, it's been to look at unmet needs. So, I would concur that maternal deaths and fetal deaths, and infant deaths most are indeed avoidable events.

And it is our obligation to look beyond the aggregate quantitative data systems alone to ask again, why does it happen? How could it have been prevented? And what needs to change at multiple levels?

Our sentinel health review system, so maternal and child, give us tools to do just that. And in December of 2019, this organization, SACIM, received comprehensive baseline briefing from the Maternal and Child Health Bureau and from CDC on maternal mortality and child fatality reviews.

We learned that fetal, infant, child, and maternal mortality review methods, systems, and approaches, how combining clinical, professional, and community-level expertise would give us insights to give recommendations that could matter.

We also heard from Dr. Wanda Barfield

about how maternal mortality review committees and the MMRIA program, and more recently Erase Maternal Mortality Initiative is strengthening capacity in more and more states.

And we also heard how case-by-case review approaches are being used not only in maternal, fetal, infant, and child death reviews but adapting these two maternal morbidities as a concept. Mother-to-baby transmission of HIV, opioid-related deaths, first impacted by Zika, and congenital syphilis. In other words, taking it from the mortality review to the morbidity space, where single events sound the whistle for us to pay attention.

This organization, SACIM, published a series of recommendations and put them forth to Secretary Becerra and August. And one part included the augmentation of mortality and morbidity review.

Today, nearly two years after our original briefing, we're going to dive a little deeper this afternoon into these comprehensive,

coordinated community-engaged case review systems that are designed to yield data for action, not data for interest. It will allow us to have greater, sharpened tools, and stronger tools in our toolbox for the prevention of maternal, fetal, infant, and child deaths.

And we'll hear from two panelists who will each have 10–12 minutes to be able to give us an update. And then they're going to talk to each other because one of our hopes is that there will be even greater integration in maternal, fetal, infant, and child death review processes than there are now. And I will be introducing you to Sara Kinsman and Julie Zaharatos in just a sec.

Let me tell you that I've geared them upfront to respond to four questions. So, you should know what they're responding to versus a generic presentation. You've had that. This is a strategy session on how to get the data stronger, use an upgraded utility in its integrated leveraged way first.

So, how is it working? Really well.

The impact policy in progress.

Two, how are they aligned with each other and leveraging each other and being used for greater impact across the life course, as well as outside of the maternal and child health purview?

What do they need to have to strengthen these unique sentinel health approaches and case reviews to have even stronger tools in the toolbox, especially to address health equity and to bring forth the voices of lived experience?

And if we were wildly successful, would this set of tools for data to action -- what does it look like once success is there to have the greatest impact?

Finally, we are in SACIM and in our Data Research to Action Workgroup highly cognizant of forces and factors that in some places constrain utility and use. There are limited resources and folks are more stressed than ever.

People working in maternal and infant and child death reviews have been pulled into COVID. And there aren't enough resources, to

begin with. So, folks are working in resourceful ways.

We know that there are concerns that are raised about defining fetal death and questioning what is viability and when should the reviews begin? And there are tensions that play out in many communities.

We know, as Ed mentioned upfront today, there is resistance growing to centering racial equity and asking the hard questions about why mothers and babies die to the point in some places not being able to speak or inquire about the impact of racism on outcomes.

And last, we know that when recommendations are perceived to be at odds with powerful positions or agendas, there may be withholding of findings they saw in evidence in the polonization (ph.) of data that has become more pervasive.

So, we've also asked our panelists to say how have your systems fared amidst COVID? And what more is needed for data and discoveries from

these processes to be able to have the impact and drive decisions that can prevent maternal and infant death?

So, toward that end, without further ado, we're going to start with Julie Zaharatos, who is the lead for partnerships and resources within the Panel Mortality Prevention Team at the Division of Reproductive Health and the National Center for Chronic Disease Prevention and Health Promotion at CDC.

Julie works with stakeholders around the country to promote better understanding of the causes and factors contributing in maternal mortality. She's on the front lines to producing technical decisions and reports including assigning test equity frameworks to the work of controlling mortality reviews.

Previously, she served as Maternal and Child Health Program Director at the March of Dimes in Georgia and has been actively involved in mortality review work, herself.

We'll also hear from Sara Kinsman.

Dr. Kinsman serves as the Director of the Division of Child, Adolescent, and Family Health in the Maternal and Child Health Bureau of the Health Resources and Services Administration. The division has a longstanding work to advance strength-based health promotion and has injury prevention schools and communities.

Before joining HRSA as of recent, Dr. Kinsman served as Director of the Division of Maternal and Child and Family Health in the Philadelphia Department of Health. And she has firsthand knowledge on how these different case review systems work in harmony in a major city in the country. Also, a former board member of Citynash (ph.).

She comes with a background in pediatrics and adolescent medicine and was a Robert Wood Johnson clinical scholar in epidemiology with a Ph.D. in sociology.

So, we want to bring both and thank them for their service. If you will, there are noble works that we do, according to prior AMCHB

Director Vince Hutchins. I'm going to ask them to give us an update of what we need to know now, not to tell us about the system, but how are they working and what needs to happen for them to be even stronger tools?

Julie, could you join us, please.

JULIE ZAHARATOS: Absolutely. Thank you so much for that kind introduction, Magda. And thank you to SACIM for having us here today. Can you see my full slides there on your screen?

MAGDA PECK: We can see your slides.

And you should have moved my spotlight and go to Julie's so you can see her.

UNIDENTIFIED FEMALE SPEAKER: Thank you.

JULIE ZAHARATOS: And thank you for the opportunity to provide an update on enhancing reviews and surveillance to eliminate maternal mortality. Again, I'm Julie Zaharatos of CDC's Maternal Mortality Prevention Team in the Division of Reproductive Health based here in Atlanta.

I know that the SACIM members have

heard about our work before, and I will focus this presentation on efforts to strengthen the state and local level maternal mortality review committee process itself to pave the way for better local-level maternal mortality data.

As a reminder, maternal mortality review committees (or MMRCs) seek to provide a deeper understanding of maternal mortality through understanding both the medical and nonmedical contributors to deaths and development and prioritizing recommendations that may reduce future deaths.

We do this by reviewing death certificates and any linked birth or fetal death certificates, medical records, social service records, mental health records, autopsy, and in some cases informant interviews.

Note that MMRC's include representatives from public health, obstetrics and gynecology, maternal-fetal medicine, nursing, midwifery, forensic pathology, social work, mental health, behavioral health, and members of the

community.

To learn more, you can refer to our review of a cardiomyopathy death that was published in AJOG and you can see link to experience an MMRC in action, that are both included in your briefing book.

Apparently, there are 50 existing maternal mortality reviews in the United States in 47 states and in two cities, and Washington, D.C. This represents significant progress since 2015. At that time, there were roughly 20 existing MMRCs.

Our CDC team began working with the existing reviews at that time. We learned that common definitions of maternal mortality and approaches to abstraction and review were necessary in order for comparable data to be gathered at the local level.

Starting in 2016, we embarked on a project called Building US Capacity to Review and Prevent Maternal Deaths. In three years, we've worked with the existing review committees to

build a data system. We also helped 25 new state and local reviews get off the ground with training for abstractors, analysis, committee chairs, networking opportunities via regional and national meetings, and job aids to support their work.

Now we specifically support 50 state and local MMRCs in this work by making the maternal mortality review information application available. MMRIA, or Maria, is a CDC data system that provides a common data language for MMRCs, facilitating their functions and promoting a national approach. Of the 50 existing MMRCs, 48 are currently using Maria.

Maria facilitates documentation of a wide range of data on the life and death of a woman to ensure a review committee can develop strong prevention recommendations. Over time we have added components to Maria based on feedback from users who have facilitated enhanced data collection on things like substance use, discrimination, and racism.

As more states collect comparable

review data with a truly multidisciplinary membership that is reflective of the communities most impacted, the data will improve and point the way to eliminate preventable pregnancy-related mortality in the United States.

Beginning in 2019, we were also able to provide direct funding to some MMRCs. In fiscal year 2021, Congress appropriated funds allowing CDC's Erase Maternal Mortality Program to directly fund 30 jurisdictions supporting review programs in 31 states.

To read more, you can refer to our Erase Maternal Mortality paper that was recently published in the Journal of Women's Health and is also in your briefing book.

As noted earlier, Erase Maternal Mortality supports all 50 states in their work to identify review, and document opportunities to prevent maternal mortality through Maria and other training and technical assistance.

Before I leave this slide, I want to answer the question of how MMRCs have fared amidst

the COVID pandemic. Largely, the work of our state-level MMRC awardees and other state partners has continued in the virtual space, providing us the opportunity to visit without travel. In addition, we have connected awardees through virtual peer observations, leveraging the opportunity of the new virtual norm for advanced peer learning opportunities.

Here are the steps of maternal mortality review. You can also refer to your briefing book to see our Maria Committee Decision Forum, which is referenced here. It starts with staff presenting each selected case to the MMRC, using a case narrative. The MMRC discusses and makes key decisions about each death. They enter key decisions into the MMRIA data system, then move on to analyze data, identify key issues and recommendation themes, and prioritize and disseminate findings.

Epidemiologists who support the work export the data from MMRIA to identify leading causes of death, timing in relation to pregnancy,

and to calculate the pregnancy-related mortality ratio.

Here is MMRC data on causes of pregnancy-related deaths by race. This can be an important tool for jurisdictions who want to reduce disparities by prioritizing interventions that address the leading causes of deaths to Black women, for example. You can also see here the leading cause of death for Black and white women are different. The contribution of mental health conditions to pregnancy-related deaths are captured by MMRCs, while other data systems cannot pass through this level of information.

MMRC data have also shown us that the distribution of pregnancy-related deaths varies by the timing of death in relation to pregnancy. Both cardiomyopathy and mental health conditions are leading causes of death overall, but also leading causes of death in the late postpartum period, which underscores the importance of examining the full year postpartum.

The last step is to prioritize

recommendations for action and to disseminate them. In 2020, fourteen state MMRCs published a report using their Maria data, a number equivalent to the total number of reports published by MMRCs between 2015 and 2019 combined.

And those data can lead to change. Illinois put their first maternal mortality review committee report out in October of 2018. The state legislature introduced 15 bills that addressed the recommendations from the MMRC. As a result, Illinois became the first state to extend Medicaid coverage to one year postpartum.

Perhaps it goes without saying that the quality of maternal mortality analyses depends on the quality of the maternal mortality data. We are working with MMRCs to ensure high-quality data by providing guidance on how to collect complete data or as complete data as possible, identified, abstracted, reviewed, and entered into our Maria data system in a timely manner.

To provide regular technical assistance on the data being abstracted toward

Maria's data entry being consistent and accurate. For example, maternal mortality review committees should be reviewing all suicide or overdose cases in a timely manner.

One example of what we've done is that since 2016, we have developed and disseminated guidance on how to comprehensively identify pregnancy-associated deaths and review them in a timely, accurate, consistent, and complete manner.

The data quality is dependent on process quality. We spend a lot of time with states on process quality. Who is at the table? Is your MMRC membership inclusive? Is it possible to bring in more context via community-level health indicators and informant interviews?

A focus of our technical assistance promotes the importance of diverse community members beyond clinicians. MMRCs have historically been led by and largely comprised of clinicians who bring medical expertise, years of experience, hours of unpaid time, and passion to

preventing maternal mortality. MMRC recommendations commonly focus on medical care, and that may reflect the comfort zone of clinicians.

However, clinician leaders are learning that they need to share that responsibility in handling and addressing maternal mortality. So, teams are bringing in more community-based and health policy perspectives. This can help them to identify more community-level contributing factors to make recommendations that recognize community context and draw on community strength and knowledge.

In addition, the training, we've published a Health Affairs piece on the importance of including diverse voices in MMRCs, which is also included in your briefing book.

I just want to note that in Erase Maternal Mortality funded states are held accountable for having nonclinical members to participate in their MMRCs. And more recently, through a formal collaboration with the Black

Mamas Matter Alliance, or BBMA, and MCHIP (ph.), they are considering how MMRCs share power and support community engagement.

In addition to the work to support community engagement, CDC has several efforts to improve components of the MMRC process at different stages, which also address health equity.

We've looked at some of the Maria quantitative data so far in this presentation, and that demonstrates the importance of supporting further review program capacity to analyze the qualitative data. Looking at qualitative data from Maria for substance use death, several important themes are captured. Qualitative analysis of these data allows programs to demonstrate where missed opportunities for screening and getting individuals into treatment for substance use disorder contribute to deaths.

As examples here, some individuals in the analysis had missed and incomplete prenatal care, narrowing the window for screening. It was

more common to see substance use screenings in emergency room records in Maria data, which are often not shared with primary prenatal labor and delivery or postpartum care providers.

Qualitative analysis has also helped to understand contributors to maternal overdose deaths such as loss of child, for example. That was a key stressor in overdose death review findings.

I share this to emphasize the importance of investing in routine qualitative data review programs. This context can tell an important story of ways to prevent future deaths.

Further CDC investments in MMRC processes quality include informant interview resources. Medical records capture perceptions of patients from the health care provider perspective. What's missing is patient and family perceptions of providers and systems.

We convened five jurisdictions to help us develop an MMRC informant interview guide that provides tools to help capture the woman's

perspective through next-of-kin interviews. There are currently a handful of states that are implementing interviews. One state MMRC chair said, now that she has them, she cannot imagine reviewing cases without them.

And there is growing recognition that discrimination, including interpersonal and structural racism, contributes to adverse maternal health outcomes. We have heard from MMRCs that bias and discrimination have played an important role as contributing factors leading to death.

A workgroup of MMRC members and subject matter experts came together to understand and capture bias as a potential factor in maternal mortality review. The work culminated in the addition of discrimination, interpersonal racism, and structural racism as data fields available in Maria.

And now, as part of a partnership with eh Office of Minority Health, we are working with the American College of Obstetricians and Gynecologists to help MMRCs with tools to identify

discrimination and racism in medical records. That can ultimately be expanded for use in medical settings.

We are also working with the National Birth Equity Collaborative and BEC scholars on an early analysis of documentation of discrimination and racism in Maria and building on the BBMA work to examine how MMRCs connect with community partners, and to ask perinatal quality collaboratives, or PQCs, how they do this and ask PQCs if they see themselves in MMRC recommendations.

We also have worked with Emory University to develop case-level community vital signs dashboards. This will be a portal that will enable MMRCs to better identify points at which disparities occur, helping to put the woman's life and death into the context of her community.

Community vital signs dashboard will be complemented by guidance on how to integrate community-level indicators into abstractions and reviews, as well as a policy venue that will

assist MMRCs in developing recommendations, particularly at the system and community level to reduce maternal mortalities amongst all groups. We anticipate that Maria users will have access to the portal for generating case-level dashboards by September 2022. To learn more, refer to our Changing the Conversation, Applying the Health Equity Framework to MMRC's paper published in AJOG. It is also included in your briefing book.

American Indian and Alaska Native populations face a significant maternal mortality burden. While maternal mortality review committees have the capacity to identify and implement prevention strategies, there are currently no tribally led MMRCs, and too few state-based MMRCs have tribal representation. While having tribes represented on state MMRCs is important, it does not equate to a tribally led MMRC that serves native people's needs.

To achieve that goal, we are working with the National Indian Health Board. NIHB is working to assist tribes and tribal organizations

in designing and implementing tribally led MMRCs. In the coming year, NIHB will be providing in-person and virtual trainings and building a resource library on maternal health and maternal mortality in Indian Country. It will also be supporting Indian health boards or tribes directly via grants and technical assistance to conduct a readiness assessment.

The focus of our work together is to develop the foundations necessary for implementing tribally led MMRCs that respect native culture and result in meaningful and effective prevention strategies for native communities.

We have come this far with the help of dedicated and innovative partners, and our vision is that this data that the MMRCs are collecting, and reporting will inform action. Some examples are that maternal health care standards, tools, and resources will be implemented with a linkage to and understanding of the leading causes of pregnancy-related death within that jurisdiction.

And that these jurisdictions will be prioritizing right-place right-time interventions that are run formed by these Maria analyses and engaging community partners.

Thank you again for hearing us out. And happy to move on and get into the Q&A portion, too.

BELINDA PETTIFORD: Excellent, Julie. Thank you so much for that terrific update.

Without further ado, we're going to go to Dr. Kinsman. Knowing that we'll be running about 10 minutes past our time, so we give Dr. Kinsman her due today. And we'll hold off questions until the end.

Sara.

SARA KINSMAN: Thank you so much, Magda. I think the slides should be coming up soon. Here we go.

I want to start today as the slides come up. So, first I'm going to be presenting on behalf of the Maternal and Child Health Bureau's National Fetal Infant Child Death Review Program

and our cooperative agreement recipient, the National Center for Fatality Review and Prevention at the Michigan Public Health Institute.

With me today is Diane Hilkey (ph.), Commander Marion Manuel (ph.) from MCHB, and Abbey Kalia (ph.), and Rosemary Fornier (ph.) from the National Center for Fatality Review and Prevention. I mean, their work is so strong, and they have really, as you will hear today, responded to beautifully to many of the challenges we've had in the last year.

I was nominated to present most likely because, as Magna shared, prior to coming to HRSA, I was the Director of Maternal, Child, and Family Health for the Philadelphia Department of Public Health. And there I led the Fetal Infant Mortality Review Team for the City of Philadelphia. I served on the Philadelphia Maternity Mortality Review Team, which was just for the City of Philadelphia.

I served on the F33 Child Abuse and Child Fatality and Near Fatality Review Team. I

also served on the Prevention of Perinatal HIV Transmission Fetal Infant Mortality Review.

I have to tell you that the work that we did there, and I was able to experience, richly, richly expanded our understanding of vital statistics data. It made all the difference. And the power of developing a team of knowledgeable and passionate volunteers -- and I want to emphasize volunteers -- who collectively made a difference is one of the most important parts of my career and I think speaks to how valuable this work is.

Next slide, please.

So, I'm just going to ask -- there may be a delay, so I apologize if there's a delay.

Next slide, please.

The Maternal Child Health Bureau's -- oops, back one slide. Sorry, everybody.

The Maternal Child Health Bureau's vision is an America where all mothers, children, and families are thriving and reach their full potential.

Next slide.

So, what I may talk today is about our overall program, the National Fetal, Infant, Child Death Review Program. And we have supported this program at NCHB for over 30 years. These fatality reviews are integral to our state Title V block grant program, and also our Healthy Start program. And they provide insight into gaps in services, systems, and modifiable risk factors that can really, hopefully, empower folks to create the changes we need.

CDR's motto, along the side here, is really Keeping Kids Alive. And I think that being positive with this work is so incredibly important. Really, the way that these teams have developed is to think about what is with the future and what can we change? For FMIR, a model, so to speak, is more first birthdays. And the ultimate goal of these systemized reviews is to identify risk factors, individual, clinical, community system policy, and then most importantly, make a change.

Next slide.

So, for the child death review, I'm going to start with that first. And Child Death Review is a multidisciplinary process where teams meet to discuss information to better understand how and why children die and perform prevention efforts to reduce future child fatalities. Child death review typically reviews deaths from infancy through age 17.

Next slide, please.

So, there are over about 1,300 child death review teams in the United States. And we're included in all 50 states and the District of Columbia. Nine states are working to develop tribal CDR teams, and the center has been working really closely to expand this effort and to help these teams integrate CDR into their processes.

State legislation impacts the types of fatalities that are reviewed, and also some aspects of the review. Forty-four states mandate or permit child death review teams to do their work, and twenty-seven mandate or permit local CDR

teams.

The lead agency varies. In 29 states, the lead agency is the state health department. In 10 states, they are led by social service agencies, and in other states, they're led by medical examiners, attorneys general, or hospitals.

Funding is important, and some Title V block grant funding supports CDR in 23 states. And 22 states are supported by the CDC's SUID and SDY case registry funds and works in conjunction with our program here. So, we have a platform, and then they are able to provide support to enrich some of the work, looking at SUID and SDY. Other important funding is from CAPTA and state funds.

So, case selection varies by state. Now, this slide just shows the percentage of states that generally work at these types of deaths. So, we can see that most states are able to look at SUID deaths, unintentional injuries, underdetermined deaths, abuse and neglect,

homicides, suicides in children who have received protective services, opiate-related deaths. The less common are states that are able to review foster care and medical deaths.

Now, this does not mean that all states are able to look at 100 percent or 98 percent of SUID deaths. It just means these are the types of deaths that various deaths have the jurisdictional responsibility and ability to review.

Next slide, please.

So, the child death review process is depicted here. And really the reason I'm doing this is I want to be very helpful for all of you who might be familiar with FIMR and not CDR so then you can understand the difference between these two approaches to reviews.

A multidisciplinary child death review team comes together, and they share relevant information about the child's death from the perspective of their agencies. Their agency might be a social service agency, school, law

enforcement, or emergency medical services. So, folks from prehospital emergency medical services. And they would talk about what they know about the child, the family, or any other relevant pieces of that discussion.

Typically, the agency that has the most information starts to share. And then other folks add-in. And once the information is on the table, the team tries to identify risks and whether the death was preventable or what could have been done to prevent the death.

The lead agency typically enters data into the National Fatality Review reporting system, which we'll talk about in a little bit. And then the CDR team works to catalyze prevention efforts. Now, 43 states have state advisory boards that to some degree work to advance prevention efforts. And we'll share some examples as we go.

Next slide, please.

So, let's talk about fetal infant mortality review. So fetal infant mortality

review is a community-based action-oriented process of reviewing de-identified fetal and infant death cases to make recommendations and develop and implement innovative local actions and improve systems of care, services, and resources for women, infants, and families.

One of the important things for fetal infant mortality review is that it is de-identified data. That allows folks to stay more focused on some of the system changes that we'd like to see.

Next slide, please.

So, in total, there are 154 FIMR programs in 27 states, the District of Columbia, and the U.S. territories. And 82 percent are led by state or local health departments. Authorization mainly happens through local legislative mandates, such as local health surveillance or local health codes. A full 72 percent are funded by Title V block grant funding, and many get support from the Healthy Start Program.

As with CDR, case selection varies by community. And because this is a much more intensive process, not all cases are selected. Or as I mentioned, in the City of Philadelphia we might focus on one type of case for one FIMR, so the perinatal HIV FIMR focused on one type of risk factor.

And our general FIMR also focused just on sleep-related deaths, just so we can really home in on that. So, FIMRs tend to do that sometimes.

Next slide.

So, the way this works is that prior to meeting, records are abstracted and de-identified. The records come from multiple sources, medical records, prenatal care records, home visiting records, WIC records if they're available. And then there's a family interview. And that family interviews allow the voices of the parents and family and caregivers to share the challenges that led to the infant deaths.

Prior to COVID-19, about 62 percent

of FIMRs were attempting to obtain parental/family interviews, and 30 percent were successful. It is challenging to interview somebody and interview a family right after the death of their child. And it takes an incredibly skilled provider to be able to do that.

These stories provide significant information about health equity, disparities among diverse populations. And I just have to share one example, two fifteen-year-olds who were trying to keep their infant safe. And they worked so hard to do it. You know, they left their house, one person's house because there was work being done in the street, and the baby might get dust.

So, they went to another person's house, and they tried to set up the bed. And you just hear how hard they worked to do this example of safe sleep. And then sadly, they failed because they were not able to keep the child in their own specific environment, an infant-safe environment.

So, I have to tell you, I think this

is an incredibly important part of the reviews, and it's exciting to know that maternal mortality review is working to do that as well.

The other pieces -- so what happens is the case review team looks at all this information. So, they look at the de-identified data. They look at the family interview if they're there. Sometimes the family interview was being shared as the folks were trying to do the family interview and why it was so hard for the family to communicate, which is also very important.

And then that team looks at the data and develops recommendations. And the folks on that team are usually very clinically oriented or people who are in the field. And then that information goes to the community action team.

The community action team generally comprises those who have political will or the ability to take that case review team's assessment and recommendations and to prioritize those and to implement them, whether they be system change or

policy change. And this is to reduce whatever type of mortality they're focused on.

Next slide, please. Thank you.

So that's the process. And I didn't focus as much on the data, but at each point, the teams pull their data together, and many teams share their data with the center. So, I want to go through how the data are collected and how we use it.

So here on the right side, you will see a data entry page for a case reporting system. And it shows you how a child death review manager would enter data. And they can click on each question so that the data dictionary pops up. They can explain the variable. And we've really been working on increasing the capacity to have very strong data quality, in the last couple of years.

On the right side, I'll talk about this a little more, is what we do with the data and how they come out. And that is child dash.

Next slide, please.

So, the National Fatality Review–Case Review Reporting System is the core of our prevention efforts, in addition to what we've been sharing. The case reporting system is a web-based standardized case reporting platform. About 92 percent of CDRs enter case data, summary, findings, and team recommendations.

Since 2009, there have been 250,000 that have been entered into this system, which is about a third of all deaths that are in the Vital Statistics piece, reporting system. So, we don't see all of the deaths, but we see a good portion of those deaths.

In addition, an estimated 40 percent of FIMR teams are entering data, and the FIMR system came real later. So those teams are on a different curve in doing this. Since 2018, a full 7,000 cases have been entered into the system.

In the past two years, as I've shared, there's been a real focus on improving data quality, which allows us to create standardized and really useful standardized

reports.

I show you an example of infant safe sleep on a national level. And here you can see whether the age is at top, sex of the infants. And then if we look here, we see, obviously, that non-Hispanic, Black infants were overrepresented in this sample. This is a picture of some of the demographics of the cases that are in the case reporting system. It helps us to think nationally about what we should focus on.

Next slide, please. Great.

So here what we know is that 47 states have used the case reporting system. About 50 percent of cases are infant deaths. So, I think there is a misunderstanding sometimes, and folks think that all infant deaths are in fatal infant mortality review. But in fact, 50 percent of case review cases are infant deaths. So, we have, cumulatively, 127,000 cases.

This represents, as I mentioned before, approximately 33 percent of all infant deaths. And of the cases that are in the case

review system, about 3,000 are FIMR team cases in the CRS. Most common causes of fetal death reviews are congenital anomalies, prematurity, asphyxia, and SUIDS.

And here I just want to say, sleeping on the surface. So, here's a little snippet of what we can get from the cumulative data. And here we see the question, Was the infant sleeping on a shared sleeping surface with a parent? And here you see that the infants had died from a sleep-related death. Almost 60 percent, 56 percent were sharing a sleep surface with a parent.

Next slide, please.

So, this is new and it's really exciting, the National Center has created a dashboard. It is called the Child Dynamic Analysis and Statistics HUB, or Child Dash. The website summarizes information from a child death review. And it is really wonderful. It's important to know that the states own their own data still, even though it is part of this

national dashboard. So, they can actually see data from their own state.

And then we are able to see national-level data if you work with the center to be able to assess data and look at some of the particular areas of focus that the center has created dashboards for. And those dashboards are fire, infirm, drowning, motor vehicle, firearm, poisoning, et cetera. And of course, infant safe sleep, which we've shown you.

Next slide, please.

Magda asked for us to look at the impact of COVID on fatality reviews. And it has been significant, and it will be significant. Child death reviews in FIMR teams experienced delays in doing the reviews. They started doing virtual reviews. State and local staff were reassigned to help to manage that.

And in the national center, one of the wonderful things about their work has been to be able to be very mobile and allow for change. So, within three months of the COVID pandemic,

they were able to modify and include COVID-19 questions as of cause of death, whether it's directly related to the COVID-19 pandemic or indirectly related.

For example, a child whose parents were afraid to go to the hospital and passed away with asthma on route to the hospital. That system has been modified as the pandemic has changed. And so, we're grateful for being able to do this.

The other thing that the Center has been able to do is to really help the teams become virtual teams, which was new. And some states have absolutely loved it because it's easier for them to get together. And some of them are excited about going back in person.

And then self-care resources are really important. It is hard to do child death reviews. I think that the Center has been really helpful in assessing the needs of our coordinators throughout the country. Understanding that they are going back into the pandemic, not that we're out of it now, but they will go right back into it

because there is a lot coming into review. So, they'll be reviewing COVID cases going forward.

And the sensitivity to that in supporting that is really important for these teams to continue to work as hard as they have been working and will be working, going forward.

Next slide.

So, what is the impact? You know, one way is publications. So, I believe we were able to sneak these into your packet. Here are some of the publications in the last few years related to the fatality's reviews. It's very important.

Next slide.

MAGDA PECK: Sara, we're going to need to wrap up in just a little bit because we're running way over time. So, thank you so much.

Can you bring some of these examples forward? And then we'll have a little chance to close it up. So sorry to interrupt.

SARA KINSMAN: FIMR is working with the Wisconsin Department of Health Public

Services. I think I'm still live. Right? Just want to be sure. And they work with the Wisconsin Title V program. So really used to be our data to inform relevant, consistent, fairness, and decisiveness such as on infant safe, which have been great.

In Maryland, FIMR in Baltimore realized that 50 percent of women whose infants have died were not included in the Maryland Perineal Risk Assessment, which is a mandatory assessment for all women who receive or are eligible for Medicaid. And OB providers just have too much difficulty using that system. So, they did focused efforts to address that issue, which have been very effective.

And in Colorado, legislation was recently passed for paid parental leave. And while this was an effort of many, many folks throughout Colorado, data from the fatality reviews were used to support passing this Bill. And this was a consistent recommendation of the CDR in Colorado.

Next slide, please.

So, I hope I've been able to share that there are impacts that we can measure. And I've shared some of those wings. And then the process of doing a fatality review for a community is incredibly, incredibly important. It improves communication, improves data focus, and the focus on that. You improve health systems and agencies that work together, you know, working on a really profoundly moving experience, whether they be the death of an infant or, tragically, the death of somebody in the pregnancy period.

And I think that as we continue to do this work, we'll be able to even make a greater, greater impact in the future.

If you have any questions -- next slide. And go to the last slide.

You can find -- please feel free to reach out to me at any time, and I would love to hear your ideas and your thoughts.

Magda, I return it back to you. Thank you all so much.

MAGDA PECK: Thank you, Sara, for that terrific overview.

We have exceeded our current allotment for today. And I don't want to shortchange the conversation. But pragmatically, what I'd like to encourage you before I pass it back to Ed is that members of SACIM who have been listening during this time, as well as ex officio members, if we could have an opportunity for you to put questions that you have in the chat before we end for today.

Also, we'll open it for a minute or two tomorrow morning, which would be my morning and your afternoon. And to kick off so that we don't lose any thoughts here. And then the Data and Research to Action Workgroup will be looking to see how do we take these updates to further integrate the work of these two extraordinary systems and then leverage that for even greater impact?

With that, I'm going to not take questions in the interest of time now. But again,

put your questions in the chat. We'll revisit it first thing in the morning.

And Ed, I'd like to pass it back to you for a brief closing and thank you very much to Julie and to Sara for bringing their brilliance and their experience and expertise for us today.

Ed.

EDWARD EHLINGER: Thank you, Magda. And thanks to our presenters, Julie and Sara. That was excellent.

We will revisit this, but not at the beginning of tomorrow because I really don't want to interfere with the first sessions that we have. I'm hoping that after our break tomorrow afternoon, we will be able to get back when we have our sort of general discussion. We can add that time.

And Julie and Sara, I hope you can join us for some brief questions at that point in time. So, we will get back to that.

But put your questions in the chat. Also, be thinking about recommendations that you

want to make. Before you leave, before you turn off your computer and go off for a bike ride or a walk or whatever you're going to do to make up for these four hours of sitting, think about some recommendations that you may want SACIM to be thinking about as we move forward.

And my last thought was tomorrow we're going to talk a little bit -- I'm going to talk very briefly about narrative and how narrative really shapes a lot of the programs and policies. I remember back when Bill Fagy (ph.) and Michael McGinnis (ph.) went from death certificate causes of death to the real causes of death. And that changed the narrative about what creates health. Jim Marks had a paper on that also in the American Journal of Public Health.

From what we think of as the leading causes of death to the real causes of death. And what I'm seeing from the data that both of these efforts are doing is that we're actually going to be able to say, "Yeah, it might be maternal hemorrhage, it might be embolism. But the real

causes of death are" --

And I'm hoping that we'll be able to get that so we can start to change the narrative about health for moms and babies in this country in the same way that we brought tobacco and lack of physical activity and alcohol to say, "That's what we really have to focus on." And so, I think some of the racism, the poverty, the lack of education, the discordant care, all of those things.

So, keep that in mind. And now everybody else go take care of yourself. Stay healthy, and we'll see you tomorrow at noon Eastern Daylight Time on the first day of fall. Good-bye.

MAGDA PECK: Thank you, Ed. Excellent session. Thank you, Julie. Thank you, Sara. So, appreciate the work.

(Whereupon the meeting was concluded.)