The Secretary's Advisory Committee on

Infant Mortality,

US Department of Health and Human Services

Quality and Access to Care

Workgroup Meeting

4:30 p.m. – 6:00 p.m.

January 25, 2021

Attended Via Webinar

Reported by Ashleigh Simmons

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WORKGROUP MEMBERS - continued

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Lisa Satterfield
Senior Director, Health Economics and Practice Management
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Also Present:
Dante Orlandini, LRG

C O N T E N T S

P R O C E E D I N G S

DR. STEVE CALVIN: So, I'm Steve Calvin. I think most of us have met. And I -- you know, just happy to be involved with this group. And there's so many things on quality and access. And the things we've heard today I think really outline a lot of the challenges. And there's some -- you know, some interesting things that I was going to just share as well that I think might be helpful.

But other members of the committee, of the -- currently, so Ed is our acting chair. And I think Colleen will be joining us.

DR. TARA SANDER LEE: She is actually trying to get access. Can we send her the link?

DR. STEVE CALVIN: Yeah, I think

DR. TARA SANDER LEE: I don't know if she's driving to pick up her kids or

DR. STEVE CALVIN: Oh, boy. Dante, is there a way that we would maybe --

DR. TARA SANDER LEE: Can we send it personally to Colleen's email?

MR. DANTE ORLANDINI: Sure thing. Is her email -- let me pull it up and make sure that I have the right one.

DR. STEVE CALVIN: Well, yeah, if you could send that to her, that would be great. Because we would like to get

MR. DANTE ORLANDINI: Yeah, sure. I will send it over to her email now.

DR. STEVE CALVIN: Okay. Well, and Cathy too. Why don't you introduce yourself to us? I assume you're in Oregon right now?

DR. CATHY EMEIS: I am. Hi, everybody. It's about a quarter of 2:00 where I'm at. And I'm Cathy Emeis. And I am in Portland, Oregon.

I direct the midwifery program and two faculty practices at Oregon Health and Science University. But I was asked to be a part of this group through my HAT, through the American College of Nurse Midwives, as well, where I chair the national committee on quality and safety for them. So, a -- I'm a relatively newcomer, but very interested in contributing in any way I can.

DR. STEVE CALVIN: Well, you're bringing a unique perspective, that is for sure. And also, maybe, Lisa, why don't you introduce yourself as well?

MS. LISA SATTERFIELD: My name is Lisa Satterfield. And I am the senior director of health economics for the American College of Obstetricians and Gynecologists. I'm just happy to be a part and work with Dr. Calvin (inaudible) and quality access for these patients.

DR. STEVE CALVIN: Thanks.

And Juliann DeStefano. Am I pronouncing that correctly?

MS. JULIANN DESTEFANO: Yes, you are. Thank you very much. But sometimes DeStefano. Hi, everybody. How are you?

DR. STEVE CALVIN: Fine. So please introduce yourself.

MS. JULIANN DESTEFANO: I work in the Maternal and Child Health Bureau in the Division of Healthy Start and Perinatal Services. I am a senior project officer. I work on -- I'm the lead

for the maternal health within the Healthy Start Program. And I work on the SACIM.

DR. STEVE CALVIN: Great.

MS. JULIANN DESTEFANO: Thank you.

DR. STEVE CALVIN: Thank you for being part of this. So, it looks like we have twelve people. And I think quite diverse perspectives. We have a pediatrician, and neonatologist, and others.

So, what I was going to maybe do since -- Tausi, could you give us some background in -- or just some insights in what's going on in Texas right now? Were you able to listen in on Paul Wise and Annie Leonnie's (phonetic) presentation?

MS. TAUSI SUEDI: Yes. Thank you so much for that opportunity. So, I recently joined Texas Department of State Health Services. And I serve as the women and prenatal health coordinator. And so, I was able to listen to all of the presentations. Unfortunately, I apologize, I cannot chime in as much because I recently joined the department. And I am still kind of learning

the ropes myself.

DR. STEVE CALVIN: Oh, sure. Yeah, we won't hold you to any kinds of commentary of --

MS. TAUSI SUEDI: Absolutely. Thank you.

DR. STEVE CALVIN: Yeah, but just understanding maybe -- you know, what you see as some of the challenges in Texas. You know, there is obviously rural maternity and newborn care, and urban -- but what are your thoughts?

MS. TAUSI SUEDI: Absolutely.

So, in my position, I do work with partners of the grassroots (inaudible) that are providing prenatal health services, preconception, and maternal health services. And also, really implementing different interventions to reduce infant health disparities.

And one of the challenges that I definitely have seen, not only in Texas, but even previously, because I did work with Baltimore City Health Department, was that access and what -- some of those social determinates of health, and how they play into women's ability to access

services on time, to (inaudible) receive quality services when they go to see their providers. And even just being aware of the different resources that might be available in that community, that disconnect of not knowing what's available to them.

So, there is definitely all across the world -- I mean, all across, you know, the country, in terms of, you know, how women, especially disadvantaged women in marginalized communities, how they might face certain barriers when it comes to accessing health services. Whether it's not having health insurance, whether it's not understanding their Medicaid benefits, whether it's not having a provider within their community and having to travel long distances before they can see a provider.

So those are some of my, you know, observations, not only in Texas, but even previously working in Maryland.

DR. STEVE CALVIN: Okay. Well, thank you for that. I would be interested in, Cathy, what

you have -- what your thoughts are when we were hearing about HRSA's -- I guess, there was one of the bullet points was a focus on training of midwives.

But to my knowledge, there is nothing like -- you know, the residency training supports for physician -- for physician training. There is nothing similar to that for midwifery. What are your thoughts? Just because in the future, you know, I'm convinced that midwifery care is going to be a much larger part of -- you know, of the care system.

But what are the barriers, possibilities, and what's your assessment of the landscape at this point?

DR. CATHY EMEIS: It is a problem, a long-standing problem for all advanced practice nursing education. So, when we think about, you know, our rural areas where we really need a lot of advanced practice providers, especially in primary care or in our critical access hospitals, this has been a long-standing problem is that we

have preceptor crises. And many times, we're competing against for profit educational institutions who are able to pay a stipend to a preceptor or schools of medicine, or residency programs where there is a payment program.

So, I don't know that we have momentum yet federally, but this has been brought up with many of our organizations, professional organizations, either via academic organizations, or like the American College of Nurse Midwives has had this as a legislative priority for some time.

And there are a lot of competing priorities too because then in for advanced practice nurses and midwifery -- obviously, I'm most interested in -- there are the practice environments that are different from state to state, which can make it challenging as well.

I do think there are some innovative ideas that I have seen coming forward. And that is a midwifery program that is a partnership between Jefferson University and Baystate. And they have replicated this program to work with

hospitals, to basically have the clinical portion of the educational program come through the hospital so that that the hospital can get CMS money for essentially residencies for advanced practice nurses and, especially in this instance, midwives.

So that's a little bit different way of doing things. And we traditionally have our educational programs set up. You know, some of us can connect through rural health programs in our institutions, which can be helpful. But the bottom line is we have a very patchwork, homegrown approach to this problem. And there were probably over a thousand midwifery -- 1200 midwifery students, or potential students, that were declined in our last educational trends report because of a lack of preceptor sites.

And preceptors have a lot of pressures on them. And it would go a long way to be able to either reimburse them or somehow compensate them for taking on an extra learner.

Another example of a patchwork solution

quilt is the -- basically a -- maybe a tax break in certain areas -- in rural areas where a provider may host a learner. But there's not anything that's on par with being able to support the residency of advanced practice nurses. In this case, midwives, compared to the residency program for a physician.

DR. STEVE CALVIN: That has been -- it's been a chronic problem. I mean, it's through Medicare that the support is provided for residency slots.

DR. CATHY EMEIS: Right.

DR. STEVE CALVIN: And I think -- you know, we've got a fair amount of time here. So, at a certain point too I wanted to maybe go over a little bit of the MOMS Act that I'm sure many of you are familiar with, that that might have a little bit of revision to it to maybe even make it more comprehensive. But we can talk some about that too.

Lisa Satterfield, does ACOG have any kind of position on support for training of advanced

practice nurses, and specifically, CNM's.

MS. LISA SATTERFIELD: You know, I don't know the answer to that question. I would have to go and look and see. I mean, I know -- obviously, you know that we have positions on training obstetrician and gynecologists. And we work closely with the nurse midwives. But I don't know if we have an official position or not. So, I will look into that.

DR. STEVE CALVIN: Sure. Let's see -- Colleen or Tara, do you have things right now that -- you know, that you would like -- I'm taking kind of notes. I know notes are also being taken by the HRSA folks as well.

Do you want to go ahead, Colleen? Bring us back to the focus -- you know, the neonatal and the newborn focus too. I just want to hear what's on your mind.

DR. COLLEEN MALLOY: Yeah. I mean, that was a lot of information to digest from today, like all of the different topics.

My first part of the day, my head was

spinning with the COVID details, because what I wanted to talk to them about -- some of those graphs, or a lot of the graphs didn't have like level of significance. So, when we were talking about thirteen percent or nine percent -- and I didn't know, I assume that's statistically significant, but it didn't really say. So that was kind of one of my questions.

Because I mean, even if you look at the percent of women who ended up on ECMO with COVID, I have to think that the baseline for that age range, less than forty, who end up on ECMO with COVID is miniscule. And then pregnant with COVID so -- I would think that going from a miniscule number to another miniscule number wouldn't be statistically significant. But I would have to -- I was going to ask the question, but then I didn't -- trying to get through the presentation.

Anyway, I just have a hard time thinking that maybe more than one or two women with COVID ended up on ECMO. I mean, it has to be a very rare and tragic occurrence. So, the first part of

my brain was just trying to go through all of the numbers and trying to figure out what -- you know, on a graph -- as you know, like you can make a bar graph look significant or not significant. So, like -- it was hard to tell.

And then -- I mean, obviously the border crisis is not going to be solved in an hour. And my head was spinning with that also. So, I guess I'm trying to -- and then also the vaccination information.

I mean, I think to give credit where credit is due, to have basically created a vaccine and begun the disbursement of it in nine months is a feat unknown to any civilization before this. So, I mean, I think that was pretty amazing, in nine months, that they got some degree of rollout, and created it, and tested it. And I think that was -- that that was amazing.

I have a very kind of mixed feeling about the vaccine for pregnant women because I want that data to be -- you know, what's the risk benefit? If it's a miniscule chance that you're going to

end up with COVID, do you want to get a vaccine that hasn't really had longitudinal studies. It hasn't.

So, I don't know -- I don't know what exactly we're sometimes -- we're selling people. Like what -- and one of the people that I work with, a physician who is eight months pregnant, and she really wanted to get the vaccine. And I guess her -- she was afraid of COVID. And I said, well, you know, you're going to give birth in four weeks. Like what's the chance in four weeks. And it wasn't really a pregnancy fear, it was just COVID fear in general. Like what would -- wouldn't you just wait to have the baby and then get the -- I don't know. I feel like there's so much panic, there's so much fear, there's so much like tragedy around this disease.

And then I want people to make the best educated decisions that they can be making. And sometimes when we throw fear in there, then that like adds another element to it. Instead of looking at the numbers and the statistical

significance -- kind of that's where my head is kind of at right now, just thinking of all of the things that we saw today.

And, you know, I thought the presentations were great and interesting, it's just they made me have a thousand more questions. So, I think in an ideal world we could take everybody into the country and have available resources. I don't know -- my head is spinning right now. But obviously other people tried to solve these problems. And we'll see. I mean, I don't know if we can solve it in a two-day meeting. If we could, I think we would all deserve the Nobel Peace prize.

But they were great. I loved all of the stories. And the people, you know, working on all of these issues have such tremendous hearts and it's great to learn about it all. So, I mean, I guess that's where I'm at.

You know, ever since -- I mean, it's no secret. Like ever since I started this committee, like it's really -- I've listened to some various

hot shots taken at the last administration. And now I'm hearing the streets will be paved with gold with this administration.

So, I kind of try to not make it a political -- we should be bipartisan. We should be just -- in like working to improve the health and lives of babies, and mothers, and families. So, I guess that's where I'll -- I will leave it at that.

DR. STEVE CALVIN: We definitely will have a challenge as the committee gets together later to figure out what is an appropriate letter to send. I think, you know, we'll just have to think -- think that through.

The COVID statistics really were very interesting. And I'm amazed at the work. It's Allison (inaudible), was she the --

DR. COLLEEN MALLOY: Yeah, she was great.

DR. STEVE CALVIN: That was very impressive. And I looked up her background. And, I mean, she's -- her specialization is traumatic brain injury. She is a neurophysiologist. And

she is obviously very knowledgeable about this -- this whole area.

And I think, you know, the more we know, the better. The combination of that -- that MFM network, where there's a bunch of, you know, (inaudible) sites that have, you know, NICUs and all of that, that's really valuable information. I know when you were mentioning ECMO, I do know of one mother here in Minnesota who was on ECMO. And I don't know what her outcome was while she was pregnant.

But it fortunately is the case that the majority of women who are pregnant are not going to get real sick. But if they get real sick, their pregnancy probably puts them at a higher risk of getting even sicker and being in more danger. So, I guess the more we know, the better from the stats.

Tara?

DR. TARA SANDER LEE: Yeah, like everything -- as I mentioned, there's a lot spinning around in my head. I have pages and

pages of notes. Just some thoughts, I really -- just kind of coming off the heels of what was just said, I really enjoyed the talks by Allison Cernich. I think it was great to hear that the NIH is investing time and money into getting the data that we're going to need to analyze what actually is the impact of COVID and maternal fetal outcomes. I think that's just going to be key.

And so -- and I think to actually see the statistical significance in those categories is going to be huge. And so, I was very interested in that.

I think I was questioning it a little bit -- you know, why there was so much push with the language of eliminating or -- you know, like somehow pregnant women are within a vulnerable population. And why this language now -- in the past, like as I mentioned in my question, that previously women have not been -- you know, because of extreme risk to the -- wanting to make sure that the women and the babies are protected, they have not been included in clinical trials by

the FDA. You know, it hasn't been a requirement for testing these vaccines.

So, I guess I'm just wondering now where there's this push for the language to eliminate them, you know, as being vulnerable. And I understand, you know, them wanting to provide -- have them make the choice. But I think the question that I was kind of getting to -- but I don't know what happened to the CDC representative, whether she had kind of logged off. But I think that was my question.

I think -- one, in my own profession, and what I'm realizing is that there's going to be -- there's a lot of information out there right now about vaccines and there's a lot of misinformation that is going out there about vaccines, a lot of fear, and a lot of inaccurate information.

People are confused, the general public are confused. I mean, a lot of people -- there's people that are -- all these accounts, like the vaccines have, you know, like little (inaudible) robots that are going to take over your brains,

and it's going to -- you know, and cause infertility. And I just think there's a lot of inaccurate information.

I think the big thing -- something that we need to really think about is how are we going to not only provide -- how are we going to -- how can we use the information that we have to make sure that women have access to the vaccines if they want them. But how are we going to actually provide them with the education so that they have accurate information as it comes in. Because I think it's just so many people are confused and fearful.

And one of the other issues that I wanted -- that I'm concerned about is some of the information and data that is being generated based on diagnostic testing and the antibody testing. As a person that directed the clinical diagnostics lab, just from what I have read is that these -- some of these tests, just the reliability has been horrible. And so, I do worry that they are not accurate and specific enough to be able to provide

the data that we need to be able to analyze, you know, some of this that's coming out.

So, I just think that we have to be -- we've been fed a lot of data. I just think we have to look very carefully at the data that came through, and how accurate. But I think they were great presentations. And there's a lot we have to think about. And a lot of work that we have to do.

DR. EDWARD EHLINGER: Steve, I chose to come into this work group for a couple of reasons. One is there are some specific things that we have recommended back in June that were really related to COVID that came out of this committee. Like doulas, and midwives, and expanding to the scope of practice. I think that -- you know, (inaudible) around the midwives, there are things that we could recommend now. Because I'm not sure how much it was in place and we could reinforce that.

The other related to doulas. Just to set the stage is -- what I'm hoping and I want to get

some feedback from you -- what I'm thinking about for the main meeting is actually having somebody from the U.S. Preventative Services Task Force talk about the level A recommendations. And I -- because I want to push doula services as a level A preventive service, because then it would get funded. And that's where we would get -- be able to get doulas of color to actually get paid for what they do.

And so, I'm just curious -- so one, what are some of the issues that we raised in June that are still relevant or that could be pushed a little bit more looking down the road to doulas. And then just -- you know, practically when Colleen responded to my letter last night she copied, you know, Tara and Steve as the only two other members of the SACIM committee. So obviously, this is -- you know, you know what her perspectives are. So, I just wanted to get some chance to talk about that if that's possible, just because

DR. STEVE CALVIN: Sure.

DR. EDWARD EHLINGER: To address some of the issues that came up.

DR. STEVE CALVIN: Yeah. No, I think that that's accurate and appropriate. You know, I think -- you know, the listing -- I mean, there is a sense -- we want to be a bipartisan committee.

I mean, I am currently -- Tara and I are providing some information for the eighteen new GOP house members, who are all women, to give them a perspective on some of the areas that you just mentioned, doula services, other healthcare reform things where they could work in a bipartisan way with their democratic colleagues. You know, because -- you know, in two years, it's only -- it would only be a two-seat difference. Or not two seats, six seats would change control of the U.S. House.

So, we do have new members of the U.S. House who are interested in ways they can work with their democratic colleagues to do some of these things, like the doula services, enhancing midwifery care.

And the MOMS Act -- so I think actually right now it might be helpful -- and I will get back to your question too about the -- you know, the concerns that Colleen raised, just about how are we going to word a letter that ten of us can really sign and be comfortable with. But what I was going to ask is -- you nodded, Cathy, when I mentioned the MOMS Act. And do you want to give us your perspective on that? I mean, it passed in September of last year, the U.S. House, and didn't go beyond that. It didn't go to the Senate. Could you give us some background on the MOMS Act and what that is?

DR. CATHY EMEIS: Well, I'm just -- you know, as a midwife we have been advocating for this type of legislation for so long it feels like it's -- you know, it's a dystocia. So, I mean, and it's one of those things that there's nothing in it that's super controversial. But it would certainly move forward, you know, midwifery education. And that would be a wonderful thing in this country.

I mean, I happen to live in a place where probably twenty to thirty -- sometimes in some counties, fifty to sixty percent of the births are attended by midwives. But, you know, we just have a lot of deserts across this country for obstetricians and midwives. And this would be something -- and I think we partnered with ACOG, working on this together as well. As well as working on healthcare provider shortage reform.

So, I would love to see maybe this committee put some, you know, emphasis on that as a solution to more access for patients.

DR. STEVE CALVIN: Yeah, that's a good point. And I think, you know, we probably will end up having Xavier Becerra as the HHS secretary. And I think it will be important for the administration -- the new administration to know what some of the beneficial things would be that once it goes through -- I'm pretty sure that something -- the MOMS act, and possibly an expanded MOMS Act will probably, you know, come through the house again, and probably the senate,

and probably be signed. I mean, I would be really surprised if that didn't happen.

And I think the more people from both sides of the aisle that can get on board and be comprehensive with here are the, you know, the aspects of this doula services. So, Ed and I think -- is it next week we're talking with some folks about doula services that would have an interest here in Minnesota?

And I'm convinced, and Katie (inaudible) here at the University of Minnesota has been a tremendous resource for proving -- you know, she's working a lot on rural healthcare too. But doula services are absolutely necessary. And the more we can get from communities that are being served that have disparities, I think the better we are going to be. And then eventually it's going to take more training to get more midwives that are women of color. That's obviously a challenge too. So, I think that's great.

DR. EDWARD EHLINGER: Isn't the senator's wife a maternal fetal medicine doc?

DR. STEVE CALVIN: She is, yes.

DR. EDWARD EHLINGER: That's a good

DR. STEVE CALVIN: Well, yeah, hopefully he's gotten some perspective that way. And, you know, we'll see. There's a lot of -- I just feel a groundswell of support. You folks probably -- many of you are probably more familiar with MACPAC. Lisa, you're -- yeah, Lisa, you probably are more familiar with MACPAC, which is the Medicaid -- Medicaid and Chip Payment Advisory Commission. Do any of you have any connections or contacts with that entity? Does that ring a bell?

Okay. Well, I became educated about it yesterday. I mean, I've been trying to -- you know, Medicaid pays for four out of ten -- to a little more than that, of all births in the United States. And the Affordable Care Act had a provision to make a commission that was -- it's under the general accounting office. So, the comptroller is the person who -- you know, who runs that. And I didn't realize that the comptroller in the GAO is actually someone who is

in that job for fifteen years. So, the GAO frequently scores things and says, hey, wait a minute, this is going to cost a lot or it's not a good idea.

But anyway, this commission, the Medicaid and Chip Payment Advisory Commission, has been in existence now for a little over a decade. And it has seventeen commissioners. It's housed in -- so it's a legislative advisory body. And it's different from us because we are an executive branch advisory body. Is that accurate, Ed, to say that.

DR. EDWARD EHLINGER: I'm sorry?

DR. STEVE CALVIN: What we are. And so, the executive branch makes appointments to this committee. The commissioners for this -- for MACPAC are made -- I'm not sure exactly how they're made, although if anybody wants to be on it, I know none of us would say, hey, let's take something new on. But they have a new application process. But they are also looking for people from the served communities as well.

In any case, there is a midwife on that, on MACPAC, whose name is Martha Carter. Does she ring a bell, Cathy, have you ever met her? So, she started a birth center thirty years ago in West Virginia. And then she eventually -- it morphed into being an FQHC. So, she is on the MACPAC. And they -- just go to MACPAC, they have data books that come out. And the one from December of 2020 has more information than you'll ever want on eligibility, payments, payments by state, what percentage is federal dollars -- all of that -- I have become more convinced that the way things are paid for is really the route.

I mean, many of these programs that we heard about today, they are all great. And they are all grants, and they're all grants given to states, and states doing a little bit here and a little bit there, all of which are very important. But there's not a comprehensive national strategy on how do we do things differently so that we get better outcomes that these racial disparities are going to go -- you know, they are going to be

addressed.

And I think I sent an e-mail to some of you that I said some of the institutional or structural problems that we have are related to payer organizations and large provider organizations that refuse to do things differently.

I mean, we know -- I think Cathy is very much aware that we know that the strong start study gave us information two plus years ago about what works, you know, and some -- some midwife colleagues that I know, they are beside themselves saying we know what works, why can't we do it? And so that's part of my goal, is to just keep pushing on legislators and policy makers to say try this in certain places. You have to start doing it because otherwise we are going to be stuck five years from now being disturbed about the same disparities.

So anyway -- and then the other thing, Ed, I was going to mention is this actually brings me back a little bit to the email that Colleen

sent. MACPAC sent a -- or has a letter, or a document, that they put together last year addressing racial disparities. And it's a much more -- I don't know, from my perspective, it seemed to me to be something that was more nonpartisan.

And so, with your permission, I think I will send it to everybody on the committee, or send it to you, just so that people -- when we have a discussion tomorrow, they can just read what MACPAC did. They are a much better funded, much larger organization.

But does that make sense to just send along that as saying here is a suggestion of what an advisory committee that is from the legislative side, how they address the issue. Because it was sent in June or July last year.

DR. EDWARD EHLINGER: I think that would be great. The more information that we have, the more models that we have, that we can borrow and steal from, I'm fine with that.

DR. STEVE CALVIN: Sure. And I know a

lot of people put a lot of work into the letter so far. You know, and I -- you know, I don't want to minimize that. But I think we -- we want to put something together that we can all agree on.

DR. COLLEEN MALLOY: I guess that's kind of a question I have. Because we received the letter -- sorry, I'm in the dark right now. I will go in the other room. We received the letter like on a Sunday night. And I don't remember any kind of input or anything like that.

So, there is obviously some work being done in the letter. And so -- I guess, Ed, you probably had a question like why did I just send it to Steve and Tara. And it's probably because I didn't want to get into a huge political fight on a Sunday night, and what party is better than what. I mean, that wasn't the point.

The point I was just making -- and I know if I had sent it to everybody, I would have had emails back saying Trump is a horrible person and this and that. And I just didn't want to -- that wasn't the point. The point I was making is that

like -- we never sent a congratulatory letter to a president before. So -- and I don't think it's appropriate and I don't think that's our role. I don't think that that is -- that's way beyond the scope of our committee. And this committee lives on if there's, in four years or in eight years or whatever, if there is another administration change. And I don't think that like -- if you -- I mean, it's pretty obvious where people's allegiances lie. And I don't think if there was a change in administration that, you know, people would be super happy and people like, oh, there's a new day is dawning and we are going to send this letter. And we're congratulating you on environment, and racial disparity -- there was like ten things.

I mean, I just thought it was so kind of over the top. And I just didn't want to -- it's not like I'm hiding that from the other people on the committee. I just didn't want to get into a back and forth. So that's why I thought I would start with you, Steve and Tara, because I kind of

know how they feel about things.

And, you know, it's great that people want to support the new administration. I have no problem with that. You know, if you look at the pattern of what we've done in the past, we've never really -- well, we've never really supported the previous administration. And that -- I thought its kind of -- that was always hard for me to swallow. When you hear about all of the fantastic things that HRSA is doing, and CDC, and all of the amazing things, and then hear her campaign, and there were a lot of fantastic things that were going on the last four years, none of which we ever came out and publicly said, you know, this is great that you -- in this administration and in this time, by doing all of these amazing things, all of this -- the black grant money, all of the support for people, all of the -- you know, the things that I put in my email. We never did that.

So, like -- I think it seems a little bit -- I don't want to say hypocritical. But it seems

a little bit -- well, partisan, to send a letter in this regard when we never did that before. And so like -- I have no problem, you know, telling the rest of the committee -- and I realize I'm going to have to say that to them, I just didn't want to get in a back and forth -- I hate e-mail arguments, it's such a waste of time. So, I just thought I would start with you guys. And then we will have to talk about it with the committee. And if it means that, you know, you guys do something and I don't do it -- I mean, I just don't think that -- I don't -- this should be like a group effort. And we should have a common goal. And I feel like that letter was not -- it wasn't neutral.

So, like -- I guess that's all I have to say.

DR. EDWARD EHLINGER: Let me give you some background into the letter. Because I don't -- actually, I don't want to be bipartisan. I don't want to be -- I want to be nonpartisan. I mean, because I really want to follow the data.

And so, I am -- and the push that I got -- and you have to acknowledge we did say as a committee that racism was an issue. You know, and that was part of our letter back in June that said we -- you know, we know that racism underlies many of the things that are happening. And COVID is highlighting those deficiencies. And that's --

DR. COLLEEN MALLOY: And that went to the secretary of HHS, right?

DR. EDWARD EHLINGER: Yes, yes. That went to the secretary of HHS. And then so following that -- so that's -- that's -- you know, that's one of the issues that we've -- you know, all of us signed on and agreed on that. And then I got -- when Trump sent his Executive order about not doing -- what was the --

DR. STEVE CALVIN: It was critical race theory.

DR. EDWARD EHLINGER: Critical race theory. And so, they wanted -- several members of the committee wanted me to -- us to have a letter opposing that executive order. And I said I don't

want to do that. I don't like opposing things. Because I think that just gives -- you know, that doesn't cause -- that doesn't help at all. And so, I really avoided writing -- bringing to the committee a letter saying, you know, we are opposed to this executive order that came out back in mid-September or whatever.

And I said I'd rather be proactive and say what are we actually wanting to do, what are the active things to do? And so, when -- when there was a change in administration, I knew that the executive order would go -- that executive order would go away. So that helped me to say let's not send this letter because it -- let's wait until the election happens and then see what happens.

But now that -- since Biden had something very specific to racism, and we could say, all right, here is something that our committee has been supportive of -- so just like when you have a kid, when you say -- when you compliment them on their actions, they do more of it, as opposed to

saying we're opposed to it and they fight back.

So, this was an attempt to say, great, you're going in the right direction, we support that direction that you're going. So that's the -- that's the background of what we wanted to do. And I certainly -- I don't see it as partisan. But, you know, I mean, obviously it can be viewed from a whole variety of different ways to do that. But it's very specific about racism, and it's about being proactive, and moving that agenda forward that the committee has worked on in the past.

DR. COLLEEN MALLOY: Right. I mean, I understand that. Like I think the answer to that -- and again, like I -- this is why I feel this is so out of the scope of this committee. But like I think that the Trump administration would have said there are things that they were doing to combat racism. It might not have been what other people thought that they want. Like I don't -- there's 1776 United, there's other groups that are run by people of color that are different

approaches to racism that people in that administration were supporting.

So, I think that -- you know, when he didn't want critical race theory, that doesn't mean he doesn't want racial education. Like, he had other ideas for programs. So that's where that was going. So, like we never came out with something saying, oh, great, 1776 United, let's pursue that. I mean, again, it's like I hear you, I understand what you're saying. Like obviously there is a lot of discussions you're having with other people about this. And I understand that we're -- I signed off on that letter before. Like I understand that racism is an issue in healthcare and medicine, and I'm fine with it.

Like so -- when we start like -- I don't know, like now it feels -- it feels more political. Now we're writing a letter to the president. And like we're -- like why does that have to be on behalf of this committee? Why can't -- I'm sorry, my phone is going out. Like why can't like people can write that on their own.

And I think that

DR. EDWARD EHLINGER: They can. And that maybe it if we can't get to some sort of consensus. That may be where we have to go.

DR. COLLEEN MALLOY: But I don't want it to be that I'm opposed to -- you know, it's taking a different turn. Like I did sign that letter that -- and would have whole heartedly signed it before. Because I'm fine with that being part of the like -- platforms that we're working towards. I have no problem with that.

I just -- it seemed a little bit too over the top -- congratulations -- I don't know, it's just a little bit -- it was too over the top for me. And because I knew it was coming, I knew that the meeting was moved until after the election, I knew all of this stuff has been said kind of along the way.

There were a couple of times that there were pot shots taken at the President before and I never said anything. So, it's like been building, I guess. And so, this is like -- I probably would

have envisioned that this was coming also, to be honest. And it just makes it seem like so political and so far away from the mission of this committee. And I guess -- I mean, how would you feel if the administration changed and the people were like, well, let's send a congratulatory letter to the new president saying how fantastic -- I mean, it just seems like -- I don't know.

Like I wasn't comfortable with that degree of -- because I think it makes a lot of assumptions too on the outgoing administration, that they weren't concerned about situations of racism, that they weren't super concerned about maternal and child health, that they weren't concerned about advancing people of color. Because I do believe that they were. And people can disagree with me, that's fine. But like I -- that's why I sent you the email (inaudible) against this email fight back and forth.

But like -- that's why I don't think we should say, okay, now we are going to send a letter saying it's great. And I appreciate that

you stopped them from sending a letter saying we disagree with something. But, again, like -- I don't think we are supposed to be politically vetting the choices that the presidents are making on different issues.

DR. EDWARD EHLINGER: I'm going to reread the letter again. Because I purposely tried not to look back and take pot shots at anybody in the past.

DR. COLLEEN MALLOY: Yeah.

DR. EDWARD EHLINGER: I tried not to -- I mean, I really -- I wanted to stay focused on the data and focus on things that we had already talked about and that the data supports. And so -- and then obviously using some of the words that were in the executive orders because they complimented what we had already said.

So just highlighting the fact -- and I'm also trying to raise the stature of this committee beyond just HHS. I think SACIM has a role to play in the federal government overall. And since there is no HHS secretary right now, that's why I

went to the president as opposed to going to the secretary, because there is no secretary. And it hasn't been confirmed. So, this is a strategy also to raise the visibility of SACIM (inaudible) -- already been doing, as a way of maybe getting us more engaged in other activities beyond just HHS.

So that's sort of the background of why I put it together the way it was. And I'm going to have to read through it. I will put on a different lens to see like how -- you know, is this really political or is this just a -- well, is this political. I don't -- that was not my intention. And I was purposely trying to avoid politics in this knowing that we have a variety of different opinions on politics. But I hope we don't have a difference of opinion on this, the issue of structural racism as a component of causing some of the disparities that we have.

DR. TARA SANDER LEE: Well, but I think the issue -- and I appreciate your honesty in kind of what led to this. But I think by us signing

that letter, it almost gives us -- it almost says that we agree then with the executive orders that President Biden put forward. And I think we do have different views on this committee on how to address some of the racial issues that we see.

So if you're going to go to -- you know, go there -- if you're going to where do we really think that there are serious issues regarding -- and bring in everybody's voices -- then I think you need to address then our concerns for some of the executive orders that -- or some of the orders that Trump put in place that he's going to actually reverse. And that we think are actually going to maybe hurt people in the minority populations.

And so, I think that's one thing that we have to seriously talk about as a committee. If we're going to start looking at executive orders, and either the passing or the reversing of them, we need to look at this critically. And I do just think that this gets well above and beyond what our call is. I think we just need to -- we need

to stay focused on infant and maternal mortality. I don't think that this -- we are supposed to say stay neutral. We are not supposed to be arbitrary and capricious. We are supposed to be able to, you know, advise the secretary. And not, you know, put a -- basically do thumbs up or thumbs down whenever a president, you know, makes orders. I think that that should be left to separate organizations. You know, come together and (inaudible) you know, if you want to applaud.

But that's just kind of where I stand. I do think that it was a partisan written letter. And I think if we are going to be -- really include everybody's opinions, we need to look very carefully at everything that he has signed that we maybe might disagree with how that actually impacts our cause.

DR. EDWARD EHLINGER: So if we didn't reference the executive orders, but used some of the language that is being used to address racism and racial inequality, not linking it to the executive orders -- I mean, I can see now that an

executive order is a presidential act and overturns some from a previous president. So just by talking about executive orders may make it more political than what I had initially anticipated. But just using some of the language and not -- would that take away some of the tension?

DR. TARA SANDER LEE: I think the letter should wait until the new HHS secretary comes in play. I mean, because that's -- even if you look at our charter, it doesn't say anything about us -- you know, our charter says specifically that we are supposed to advise the secretary of HHS on department activities. It says nothing about, you know, being strategic and raising our -- you know, our position to a higher level and making direct contact with the president. I just don't -- I don't think that's in our charter. And I just -- I don't think we should go there.

DR. STEVE CALVIN: Yeah. It sounds to me like we're going to have an interesting discussion tomorrow. I mean, I think those points are good. And, Ed, I appreciate the way that you've, you

know, responded to it. I think we probably can think this through overnight. I will send this MACPAC thing. It's just -- from my perspective, it seemed like less of a partisan -- if that's the word we're using -- way of addressing the issue. So, I will send it to everybody, you know, the whole committee. Or maybe to you and you could send it out.

Is that okay?

DR. EDWARD EHLINGER: Yeah, that would be great.

DR. STEVE CALVIN: Okay.

DR. EDWARD EHLINGER: Send it to me and that would be great.

DR. STEVE CALVIN: All right.

DR. EDWARD EHLINGER: And then I'm going to check out here.

DR. STEVE CALVIN: Okay. You muted yourself.

DR. EDWARD EHLINGER: I'm going to check out and let you guys do your work.

DR. STEVE CALVIN: We will see you

tomorrow.

DR. EDWARD EHLINGER: Yes.

DR. STEVE CALVIN: Thank you. So anyway, just kind of -- just looking at the -- I would be interested, Lisa, just from the perspective of ACOG -- and I know you don't speak for ACOG. You are more fact finding. But you have a lot of insights. I would be interested in, you know, any insights you have about payment reform or other kinds of things that we should pay attention to.

MS. LISA SATTERFIELD: Sure. So as far as payment reform, we have seen in the -- even most recently in 4996 senate finance was trying to stick some payment reform language in there. But obviously that didn't make it to the senate. So, it didn't happen. But definitely everybody is talking about payment reform and the need for it.

What's actually being done though is pretty limited, right? I think, Dr. Calvin, you know more probably what's being done in payment reform than I do. So, I can tell you I'm from the ACOG coding and health policy perspective, that I

am working on a white paper of sorts for our coding committee on payment reform to encourage and help facilitate ACOG fellows and contracts from payers.

So -- and I do know that private payers are engaged in looking at payment reform as well. So, I am not privy to specific things that are going on.

DR. STEVE CALVIN: Sure. Well, I think you have your finger on the pulse.

MS. LISA SATTERFIELD: I'm trying.

DR. STEVE CALVIN: Yeah, well, and this -- I would encourage everybody just look up MACPAC. And the resources that are there, the enabling legislation for MACPAC -- or maybe it was the MOMS Act.

Cathy, do you recall, I think in the MOMS Act there is -- I think its section five of the MOMS Act, I was getting confused. Section five of the MOMS Act, which is not enacted into law. But it says that -- I think it was that there would be a report on bundled payment for maternity care

services within like a year or two years, which to me is -- that's a sense that people are really thinking about it.

Part of the thing that bothers me from a -- and this is -- you know, I think (inaudible) group of data. But, you know, quality and access -- you know, this is part of our purview, is that we don't have much information about the -- so there are somewhere around 1.5 to 1.7 million mother/baby pairs every year that are paid for by Medicaid. And if you try to dig deep and find out what the outcomes are for those mothers, it's virtually impossible.

And but the statutes for managed care organizations and their interactions with state Medicaid agencies, the statute says it has to be an actuary sound rate setting. And they set rates for newborns, for first year of life, which would be, I think, of interest. I would be interested in, Colleen, your perspective on that.

But the state Medicaid agencies -- and I ended up talking to your Illinois state Medicaid director,

who is, I think, becoming the -- he's the Medicaid medical director. And I can't remember his name, it will come to me.

But anyway, they spend a specific amount per month for Medicaid for newborns and for pregnant women. They spend a certain amount per month given to the managed care organizations. And here in Minnesota, there's actually an additional amount for undocumented women who are pregnant because Minnesota is generous. And I totally agree with that as a -- you know, as a benefit. But, you know, because of translation services and other things -- anyway, that money is spent specifically for pregnancy and for newborns.

But there is really no -- there is no way of digging out the information and saying what did you spend that money on. In some states, like Louisiana, I think for a total pregnancy episode -- if you include the whole baby's first year of life, spend probably 8,500. Some states, like New York, spend 27,000. Minnesota spends about 22,000. And I think, Cathy, Oregon spends in that

range, twenty to twenty-one thousand for a whole pregnancy episode.

And, you know, as the director of a midwifery service in Oregon, you're not getting, you know, forty percent of that for your -- it just doesn't happen. Medicaid pays so little. But they are giving money to managed care organizations.

So that's -- for some folks, that might be like, okay, you're getting into the weeds too much. But we'll never get things to change until we have bundled payment. And then accountability for outcomes. So that every entity that's paying for care can say here is what happens, here is the NTSV C section rate.

Just recently Diana (inaudible) and a colleague of hers -- and also Ellen Tilden has been working with us too. But we have been working on getting the information on -- it was 36,000 mothers. And it's through the PDR, the Perinatal Data Registry. Showing that patients who are first time moms cared for by midwives have

a C section rate that is like fifteen percent less than the overall rate.

N ow, that is obviously a very, you know, select group of highly motivated folks. But if you compare that to 108,000 mothers who get care that's not midwifery care, there is a dramatic difference in outcomes.

So, the data is there. And we need to just start pushing on entities. And all of the other things we are doing are great, the kinds of -- the grants being provided. But that's -- from my perspective, the reason I really wanted to be part of quality and access was to figure out ways to break down barriers for access to high quality care.

DR. COLLEEN MALLOY: And I think the other part of the committee was a degree of telemedicine. Is that something that midwives are getting into also? They tend to be, in my mind at least, more hands-on people. But I don't know, I imagine they are going the tech route also or

DR. STEVE CALVIN: Yeah, Cathy, what is

your perspective?

DR. CATHY EMEIS: I mean, even these group or centering pregnancy models are now moved into online. And that support -- still that network is still there, which I think we don't know exactly what the secret in that sauce is, but it seems to probably play a big role in that -- you know, that support, social support that they're getting that way as well.

DR. STEVE CALVIN: Yeah. Well --

DR. COLLEEN MALLOY: I was actually wondering if there is any role at all for that at the border -- my guess is no. But then sometimes -- I'm sure that -- I don't know, like do people have cell phones? Like is there any kind of -- that situation sounds so dire. But I don't know if there's any role at all for expanding services with technology down there? I just don't know.

DR. STEVE CALVIN: Yeah, we thought at the beginning of COVID, you know, because everybody wanted to stay apart, and we had -- we went immediately at our birth center -- so 450

moms per year were getting telehealth and video visits and all of those things. What we found actually is that part of the midwifery model really is an in-person hands on kind of thing.

And the more feedback we got -- you know, of course, in Minnesota, if it's snowing, in a blizzard, and you can't get around, just like it is in Chicago or Milwaukee, you're sort of -- telehealth is fine. Or even for visits like -- you know, maybe sort of mastitis, you know, so that somebody doesn't have to pack up all two or three of their children and go in.

But in general, the response we've had from mothers is they really don't like telehealth. They also don't like being able to come with their partner who -- you know, he cannot get any kind of insight into what -- you know, the partner isn't getting insight into what this is about.

So, I think there is a lot of -- there is a lot of benefit from telehealth. And there are certain things too where there are big emergencies or things that -- it's urgent matters. I think

telehealth is really helpful. But I was surprised, and I don't think that -- at least for midwifery care, you're not going to be able to switch to maybe having two thirds of your visits that way. That just doesn't --

DR. COLLEEN MALLOY: Yeah. I mean, there's really cool technology that we were talking about in class the other day. This whole -- the new thing of telehealth is not virtual visits as much as remote patient monitoring. So, you can even -- with an -- it's like a dermal device that can now get a constant read on someone's blood sugar. So, for diabetics and -- like it's going to be -- you know, instead of just checking them by checking their sugars, they can have -- just not even through an -- it's a needle-based technology. It's really cool.

And they are expanding that to you -- even with an app, will be able to check -- I think currently you can do that. You can check someone's saturation and their blood pressure.

So, like for issues in obstetrics and --

you know, maybe it's more for like an established kind of patient group that would be able to use the technology. But you can kind of monitor blood pressure just with a special device and an app. I mean, it is kind of interesting. It's in -- the new medicine will be more patient focused, patient centered, but using technology to do that.

So, I don't know how that -- it will be interesting to see how it all shapes up. But the vendors obviously are trying to sell it on a way to offer more personalized care. But I guess what you're saying is its probably less personalized care.

DR. STEVE CALVIN: Well, I think of face to face visits. But you're right, I neglected to address the monitoring. Because certainly for many groups, and black women in particular, having difficulty with hypertension that persists after pregnancy for six weeks, eight weeks, ten weeks, those kinds of things might be very helpful. That hear her thing where that one mother said I couldn't breathe. My chest -- I couldn't catch my

breath for like, you know, three or four minutes. And they're telling her, well, it's just pregnancy issues. You know, she's obviously having, you know, a pulmonary embolism. That kind of thing.

I think the tools are there. I would describe it as we have to change the models of care. The models of care won't change unless we start paying for the models to be different. And then the technology can be incredibly useful as a tool to enhance all of those things. That's just the way it seems in my mind how it's going to roll out.

DR. COLLEEN MALLOY: Yeah, I think it's interesting -- it's helpful for breastfeeding to -- you know, like this support lines and things like that. I guess that falls into telehealth. Well, it just used to be a phone call before. But now, young people of today, they are just watching -- oh, I do this and that. They are so used to using that instead of a voice, conversation, it seems like.

DR. STEVE CALVIN: Yeah, that's another

really good area too. And doula services, both prenatal and education wise, that might be possible. I can't envision a doula service intrapartum with the phone.

DR. COLLEEN MALLOY: Right.

DR. STEVE CALVIN: It would fall in a tub of water and that would be the end of it.

DR. COLLEEN MALLOY: Right.

DR. STEVE CALVIN: Or something like that. Are there any other thoughts that you have?

I think, you know, in the past you had proposals regarding data on -- you know, newborn outcomes and kind of where -- what was available and what was accurate. And I think --

DR. COLLEEN MALLOY: Well, I know we spoke about the overuse of NICU care. And I still think that's a problem. But I don't know -- we didn't really address that too much. But I think that there probably aren't enough midlevel special care nurseries as opposed to full blown level three NICU beds. You're right about that. We never really made too much headway with that. But

I still think that's an important issue to bring up.

DR. STEVE CALVIN: I will put it on our list so that when I give a summary tomorrow, just here is what we talked about.

Anything else, Tara? Or do you have any other thoughts?

DR. TARA SANDER LEE: No. I just feel like right now, kind of -- you know, my head is really into the vaccines right now. So, I think -- you know, I feel like I'm struggling a little bit. Because I hear exactly what Colleen said about -- you don't want women to go out and get vaccinated like crazy without a lot of data.

DR. STEVE CALVIN: Yeah.

DR. TARA SANDER LEE: But at the same time, you know, if they do choose to do so, they definitely need to have the most accurate information. And I am worried a little bit about just how complicated this is getting. Just as more vaccines are becoming -- I mean, it's great. I mean, it's a good problem to have, that we have

so many very efficient, you know, vaccines that have shown really high efficacy. Like, you know, the Operation Warp Speed, that's just been outstanding.

But I just -- I do think we have to think carefully about what our recommendations are going to be for these pregnant moms. And, you know, there was a -- there's a database that has been set up, that the CDC has set up. And I don't --

DR. STEVE CALVIN: V-a-e-r-s.

DR. TARA SANDER LEE: Yeah, V a e r s. And there is -- you know, like for example, there was a woman put -- a woman that was pregnant. And I think she was at like twenty-eight weeks or something -- maybe even further along. But she got vaccinated. And like a few days later, then she delivered a baby and the baby died. It was stillborn.

So, I think there is going to be more reports coming out. Without data, we are not going to know if it's a direct result of getting vaccinated. But I do think we just have to be

ready to address, you know, the fear. You know, getting accurate information. So that these pregnant moms can make the best decision that's good for them and for their baby, especially knowing whether they are high risk.

And I would argue that I think some moms are probably not at really high risk. And so, they probably don't need to. But I just think we have to think very carefully for how we are going to -- if we are going to make any recommendations how to go about the vaccine issue.

And I am not an MD. So, I lean heavily on colleagues like you guys. You know, what your thoughts are as far as whether to -- I know ACOG has recommended -- go ahead.

DR. STEVE CALVIN: I think ACOG has recommended offering

DR. TARA SANDER LEE: Recommended offering, yes.

DR. STEVE CALVIN: Which in a way -- I mean, what Genie said, that in the U.K. they have said don't get pregnant until it's been three

months since you were vaccinated. So when you get that kind of crosscurrent information, it's no wonder patients say I don't know about this, whether I should do this or not, I haven't -- I have just told mothers who ask -- because I do a lot of twenty week ultrasounds -- that we just don't know.

And, you know, if someone is morbidly obese, and they are early in their pregnancy, and they live in congregant living settings, I mean, that -- where they've got -- they live in a family setting where there are a lot of people, that might be a reason to do it. But, you know, we're just at a point where the whole way this has been handled on both the national and the local levels, and the state levels, has really called into question people's willingness to believe experts. Because the experts have been all over the place.

And, you know, we're seeing the number of folks that work in long term care facilities. You know, and many of them are immigrants. Those people are saying at like a rate of fifty percent

I'm not going to get vaccinated. You know, I'm just not going to do that. And it is certainly as well in the black community. For understandable reasons there are -- there's hesitation.

So, I guess we're just going to have to see. And I'm glad that the CDC is putting all of this effort into, you know, getting as much documentation rather than whatever the sixteen or eighteen states. Hopefully they will be all fifty states, plus territories, plus D.C. eventually that will get all of the information. And then we will really know.

So -- all right. Well, does anyone else have anything else? I am just going to summarize this for the ten or fifteen minutes that we are going to have our little report tomorrow. And I will send this thing to Ed that I mentioned from MACPAC. But I appreciate you getting on with us, Cathy, and Lisa as well. And then the folks that are from HRSA and the folks from -- you know, the tech aspect of this. I think we are all pretty dizzy from the whole day worth of this. So,

unless anybody else has anything to say, I think we will sign off about ten minutes early. Sound okay?

DR. COLLEEN MALLOY: Thank you.

DR. TARA SANDER LEE: Thank you so much.

DR. STEVE CALVIN: See you all tomorrow.

(Whereupon, the Quality and Access to Care Workgroup meeting was adjourned at 5:50 p.m.)

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

I, ASHLEIGH SIMMONS, Court Reporter and the officer before whom the foregoing portion of the proceedings was taken, hereby certify that the foregoing transcript is a true and accurate record of the proceedings; that the said proceedings were taken electronically by me and transcribed.

I further certify that I am not kin to any of the parties to this proceeding; nor am I directly or indirectly invested in the outcome of this proceedings, and I am not in the employ of any of the parties involved in it.

IN WITNESS WHEREOF, I have hereunto set my hand, this 10th day of February 2021.

_____/s/_____

Ashleigh Simmons

Notary Public