The Secretary's Advisory Committee on

Infant Mortality,

US 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

DR. EDWARD EHLINGER: Good morning, committee, the Ex-Officio members of the committee, and everybody else who is joining us for this second day of our January virtual SACIM meeting -- Secretary's Advisory Committee on Infant Mortality.

Yesterday certainly was a content-rich day filled with lots of updates about what's going on in MCHB and HRSA, also what's going on with maternal health throughout the federal government, just really lots of interesting information. Then certainly, the work on COVID, all of the new data that we're receiving and information on the vaccines. And then the powerful presentation related to immigrant health, which I think touched all of us in multiple ways.

So, lots of information and then your workgroups. You had big assignments, a lot of stuff to cover in the workgroups. So, I'm really looking forward to hearing the reports from the three workgroups.

You know, as I thought about today yesterday, I thought, you know, there's some nice things about virtual meetings, but being in-person would have allowed us to, you know, go to some weird restaurant in Rockville and sort of debrief about what happened during the day, and it's sometimes those off-channel conversations that really add a lot of richness to this, we get to know each other a little bit better, and get to know how we're thinking about issues, and do a little strategic planning. So, I miss all of those things. So, I'm hoping that at some time in the near future, we can get back together and meet in person in addition to the virtual meetings that we have.

And as I also thought about, today is the anniversary of the implementation of the Americans with Disabilities Act in 1992, and it just struck me. You know, we focus a lot on inequities and equity and having access. Zoom has really improved access -- in some ways, it's really improved access to many things. There are people

who couldn't physically be present can now be virtually present and having closed captioning is also, you know, a nice way of making sure that we include folks. So, despite some of its limitations and ways it creates some inequities, it reduces some other ones and increases ability for people to join us. So, I'm hoping that as many people as possible could join us on this Zoom platform.

It's also the anniversary of the death of Edward Jenner, who, you know, discovered the smallpox vaccine, which is the only disease that I know of that has been totally eliminated from this planet. And I think it's also remarkable that he -- the impetus that was working with somebody in one of the lower classes of people -- the milkmaids -- somebody on the margins who wasn't part of the elite in society and recognizing that oh, we could learn something from the life experience of individuals in the community working with the milkmaids to discover that cowpox could be used to vaccinate -- as a vaccine against

smallpox. So, we will keep Edward Jenner with us today, the Americans with Disabilities Act with us today as we move forward.

Any striking comments that people have related to yesterday? Is there anything briefly that anybody wants to bring up that really struck them?

DR. MAGDA PECK: Hi, this is Magda. I would just concur that the quality and caliber and gravitas of every presentation yesterday was extremely high, and as a member of SACIM, I'm just appreciative that all of our colleagues and partners brought their best to this moment so that we can make our best recommendations. So, I just want to thank everyone for the caliber and quality and contributions that they made yesterday and looking forward to it today.

DR. EDWARD EHLINGER: That's on my agenda. I had the same perspective like oh man, all of these presenters really took it seriously and really gave it their best, and I will be sending them letters of thank you in gratitude for

their work.

All right. Then, let's get into our agenda. We've got an ambitious agenda today. We're going to probably tax your buttocks on the chair. So, if you do have some need to stand up during this time, please feel free and I hope we may be able to -- I don't have any break built into this, but we may want to take, you know, twenty seconds to stand up at some point in time to just move just a little bit.

So, let's start with our workgroup reports. Let's start with the Equity Workgroup. Belinda.

MS. BELINDA PETTIFORD: Good morning, everyone. This is Belinda from North Carolina. We have our report today. I first want to thank our committee for their time and energy yesterday afternoon. We had really good discussion. [Inaudible] exciting about that. If you can pull our slides up, thank you. The next slide, please.

These were the ones that were able to participate from our workgroup yesterday. At

least I think we got everyone's name. I just realized I think we're missing Wendy. But as you can see here on the slide, we have lots of folks that participated. We have representatives from MCHB, from the Office of Minority Health on the federal level, we have Healthy Start representatives, we have several nurse midwives, we have ACOG, we have AMCHP, and a host of others. I think we had someone from the Ohio Department of Health who was able to join us as well as the Community Health Coalition, Incorporated.

So, you know, a good representation as we were having our follow-up discussions on Health Equity. Next slide, please.

The first thing we focused on was the draft letter that's being sent to President Biden, because we wanted people to have a chance to review it and give any feedback. We viewed that as the initial letter, but by no means not the final communication plan and that's why I think most of us were very pleased with the letter but didn't think it was the only contact we would have

in getting our message out.

There were a couple of suggestions for the letter as noted here. Suggest clearly stating that social determinants of health is included. I think the letter does a really good job -- the committee thinks the letter does a really good job of mentioning social determinants of health, specifically calling them out, but not using the terminology social determinants of health. So, there were several people that felt we needed to say the words social determinants of health.

There were a couple of questions around why did we frame the letter around the Executive Order versus the broader issues impacting infant and maternal health. And so, we had good discussion there and I think people understood that rationale.

And we also suggest including in the letter a request to meet with the new Secretary for HHS and copying them on the letter, depending on when the letter is sent. Of course, if the person hasn't been confirmed, we would not be able

to copy them. But if they are confirmed, to copy them. And if the planned new HHS Secretary is selected, we did determine yesterday that apparently his wife is an OB/GYN and has been very active in the MCH community. So, there may be some opportunities there. Most of us did not know that, but we did have some of our participants yesterday who were able to share that. Next slide, please.

So, those were our suggestions around the letter, Ed, hopefully, and the rest of the committee that you'll have coming from the Equity Workgroup.

We then spent time on the other areas because we wanted to have some recommendations to share with the larger group. The first area we looked at was COVID-19. This has provided recommendations around COVID-19 a couple of times. So, we just really went time to look at some of those, but, you know, we added to those. One was around improving universal access to care, and we actually have a whole sub workgroup, the Health

Equity Workgroup, that's takes on access to care in the workforce and how we diversity that workforce. So, we have a report from them that committee will be reviewing next month so we can share more information shortly from that report. But we did feel the need for improving universal access to care was critical.

We had a good discussion around the difference between vaccine hesitancy versus individuals who really have no plans to take the vaccine, and that is, you know, issues of trust, we talked about intergenerational concerns. You know, I gave the example that my own mother, who is in her late 80s, had told me she was not going to take this vaccine, and she had told me that for a couple of months. So, I stopped the discussion, as they say, she's an adult, and I know my mother. But a good friend of hers, she talked to her, and the two of them together decided to take the vaccine. So, she actually gets her second one this week.

But the intergenerational conversation

has really been around how her grandchildren and her greatgrandchildren have dealt with that, and how some of them have said still they're not going to get the vaccine but what is moving them into the direction that they may get the vaccine is the whole conversation around wanting to be around their grandmother, wanting to be around their granny. So, some of the intergenerational concerns, you know. You know parents, they said no, they don't trust the vaccine or grandparent, so that may have an impact on the younger generation.

We also suggest with COVID-19 to clarify the plan for follow-up of pregnant women after the vaccine is received. You know, what type of data will be collected, how will we do follow-up? Because we still don't know the impact of pregnant women with the vaccine -- we understand they were not included in clinical trials -- but we feel the follow-up should be in place and data should be collected there. And we're hoping that maybe we can have some follow-up conversations [inaudible]

in figuring that out.

We also looked at not just pregnant women but developed a plan for follow-up of individuals of reproductive age who get pregnant within a year of receiving the vaccine. Is there a way to capture some data on them and any impacts of the vaccine on reproductive health in general and ultimately birth outcomes?

So, those are some of the key recommendations coming around COVID. Next slide, please.

The next area we focused on was immigrant health. And as you mentioned, Ed, at the beginning, we all loved the presentation that came from Paul as well as Ms. Leone, the certified nurse midwife, and we agreed with her recommendations coming from her as the final speaker on immigrant health.

We added some suggestions, one around rescind the public charge regulations for pregnant women. We know that this is a challenge. We know that providers don't like [inaudible]. It

encourages people not to access services that they qualify for. So, we really feel like this should be rescinded.

We also do not separate pregnant individuals from their primary support person, where it's their boyfriend, their husband, their best friend, their parent, whoever it is. They should not be separated from their primary support person.

We suggest to reinstate the pre-release of pregnant individual, the presumptive release from detention centers, that they definitely should be reinstated.

And as our speaker had stated, support for community health workers. Doulas, birth workers, and certified nurse midwives are critical to this work. Next slide, please.

And then, we specifically came up with some additional recommendations on racism. Again, this is the workgroup that has come up with them before. We added a little bit to it. We were fortunate to have Michael Warren in our discussion

so we could ask some pointed questions surrounding MCHB. So, we discussed the role of MCHB that they can play with requiring an equity focus with funded programs including providing some specialized technical assistance realizing that not all funded programs may know what to do, but they do have the ability to do it with appropriate support.

Requirements to collect and report data by race and ethnicity. We think this is happening a lot, but we wanted to put it out there just to ensure that it continues or if there are gaps.

We talked about doing an equity assessment of all HHS as well as all federal programs. This could come from the President, this could come from the HHS side, or it could just come from the Secretary, but an equity assessment from those programs. But we also talked about that if HHS is actually funding a local program, whether it's with a university, a state, a community organization or health center, that those funded sites should do an equity

assessment, and there should be a requirement for receiving the funds.

We talked about anti-racism training and connecting it to outcomes. Next slide, please.

And we also talked about that we definitely wanted to move -- that training is important but we had to move beyond training, and that is why we started the conversation around the health equity impact assessment tools as well as some of the other areas.

We had a good discussion around value-based care, you know, what gets paid for, gets improved. So, we felt like it was important with value-based care that there be a requirement equity be a component, that, you know, some of the information is reported by race and ethnicity.

And we also continued to come back to the issue of the lack of paid family leave. And we know for many individuals, they don't get it from their employers, and a lot of times, there's an overrepresentation of those employees coming from communities of color. So, if that was up to us,

it would be a concern. Next slide.

The last area that we focused on was environmental health. We had not heard the presentation but we wanted to at least share a couple of recommendations on environmental health.

One is we feel very important to make sure it was inclusive of environmental justice efforts -- not general environmental health, but environmental justice and reminding everyone that this should be part of it.

A recommendation what the Secretary of HHS partner with the Secretary of EPA in order to recognize that toxins impact birth outcomes and maternal health. We don't know what that relation is between those two Secretaries in those two departments, but we really feel like it's important to strengthen it and that they understand the outcomes of the impact on birth outcomes and maternal health.

And we also encourage the EPA to use the Social Determinants of Health framework in addressing environmental issues.

And so, all of those were very important to us. And I think that is our last slide from the Health Equity Workgroup.

DR. EDWARD EHLINGER: All right. Boy, you covered a lot of work. We have about five minutes or so. Any comments -- or three to four minutes, actually.

So, any comments that people have or any questions they might have just for people who are on the -- who are listening in may not know that prior to our meeting, I sent a letter related to racism to the members of the committee -- not to the Ex-Officio members or anybody else -- and that's the letter that we're going to be talking about later on today. But people should have a clue what we're talking about with that letter to the President.

MS. BELINDA PETTIFORD: We did share the letter with our actual committee as mentioned earlier, Ed.

DR. EDWARD EHLINGER: Yeah, which is good.

MS. BELINDA PETTIFORD: Yeah. And I know we have a couple of our members that participate in the Health Equity Workgroup. So, I don't know if Paul or others have anything else, they want to add.

DR. PAUL JARRIS: I think that was a great summary. You've been busy. [inaudible] really falling out because I think it's Section 5 of the President's order also on agencies to do an assessment themselves around are there populations who are not accessing the services in an equitable manner and I encourage you to read that section.

So, it is an opportunity to say HHS, but then HRSA, but then perhaps MCHB. Let's have them take a look at how equitably the programs that they're supporting are being implemented as Title V, MIECHV, whatever, and that could include even -- that could move toward requirements that the recipients of those grants also take a similar look at the structure implementation of their programs around equity. Because I think, as we saw yesterday, although Michael had said that many

agencies are looking at equity, only half a dozen or so named it as the top initiative, and it would be nice to push that a little bit.

MS. BELINDA PETTIFORD: Thank you for bringing that back, Paul, because that is true. I think we had a really good discussion around that and how important it is. You know, I think I mentioned yesterday something about political will and sometimes if the grant requires you to do it, it increases your political will. You may get pushback within your own entities or your own organizations, but you can say this is a requirement coming from my funders. So, it gives you -- those entities that opportunity to strengthen their approaches.

So, we thought it was a great idea. And we, you know, we started conversations with Dr. Warren, and we definitely want to continue them with him. But he gave us the impression that unless there's something in the legislation, you know, around the Block Grant or whether it's Healthy Start or whether it's MIECHV that they,

you know, have the ability to make some changes with those programs.

DR. EDWARD EHLINGER: Great. Any other brief comment?

MS. BELINDA PETTIFORD: I definitely want to thank the LRG team -- Vincent and the team -- because they provided excellent notes for us. I did forget to mention them, but I do want to thank them.

DR. EDWARD EHLINGER: I forgot to look at the hand-rise thing. So, Jeanne, and then Magda.

DR. JEANNE CONRY: I just was going to say thank you for your committee. I think you'll find that the complementary aspects of it are incredible with the topics and how you focus and you take the Data and Research Group, that we really complement one another, and I think that's the strength going forward.

So, I want to say -- give my appreciation to all that you covered. Thank you.

MS. BELINDA PETTIFORD: Thank you.

DR. MAGDA PECK: Let me just add -- and

I'll be giving that report in just a sec -- but one of the things we can have an opportunity to do is be evidence-based and thoughtful and strategic about how we define assessment for equity and the methodologies around this, the definitions, the historical context because this is a part of accreditation of local health departments, as an example. But the actual way that people go about doing it other than checking a box and doing it proforma can actually do more harm than good.

So, I think we have an opportunity to bring rigor and research and evidence and best practices to this and diffuse it out so that it doesn't become proforma and therefore without the gravitas and opportunity to bring people along.

I'm sure you talked about that. But I've seen it fall short and then people check a box and say well, we did that. This is not that.

UNIDENTIFIED MALE SPEAKER: Like the assessments and the IRS regulations.

DR. EDWARD EHLINGER: All right. Magda, since you have the floor, let's just have you go

into the Data, Research, and Action Workgroup report.

DR. MAGDA PECK: That will be great. If I could have the slides up, that will be quite wonderful. I'm going to make an assumption as a matter of inclusion that there is at least somebody on this call that doesn't really know what these workgroups are.

Three workgroups -- we've been meeting for about a year and next slide please. We have the opportunity to have put forth a series of praxes that you'll hear about later. We just went back to make sure that we were grounded in our charge, that this is about available evidence and science that are credible, reliable, timely, and relevant so that we're informing our recommendations as an advisory committee. Next slide, please.

Just a little update administratively that brought us into the room yesterday at about -- whatever time zone you're in -- about 4:45 with for seventy-five minutes of time together. We

have recently been adding new members in addition to those who have an opportunity to just participate through this vehicle of the SACIM meetings. So, hearty welcome to Ndidi Amutah Onukagha from Tufts University and to Rosemary Fournier from the Michigan Public Health Institute who leads FIMR work.

And we covered over the last couple of months since October or September time together a continued focus on COVID-19 and a beginning look to try to recommend environmental health. We thank Jeanne Conry, one of our members, for taking the lead in putting together this afternoon's panel and to assure with Ed the scientific and research rigor that will allow us to do our policy work.

We have continued to compile and advance research and data in the field by compendium around the influence and impact of racism and we had actually drafted a letter prior to the rescinding on the 20th of Executive Order 13950 around "Combating Race and Sexual Stereotyping"

though that is moot in the positive. We now have the opportunity to think of other communications to infirm how we will champion anti-racist work with scientific basis as the research and data continue to make more known the direct impact and indirect impacts through the life course on women, children, families, and fathers.

That's what we've been up to. But bringing it to yesterday, can I have the next slide, please.

Coming from an old Jewish tradition, we had four good questions that drove our seventy-five minutes. What did we discover and learn -- our ahas? What are the questions that remain unanswered? What are the key gaps? And what are some immediate leading opportunities for action grounding that in a sustained focus on health and racial equity? So, we did a bit of like jeopardy. If you could put up the next piece here.

You'll see that we created essentially a working board around not yet getting to environmental health but addressing what we heard

around the Maternal Health Initiative, the MCHB Title 5 updates, clearly COVID-19 and the pandemic, and the emerging knowledge base and urgency around border health and pregnancy. So, within this framework, I'm going to give you our leading ideas for action. Next slide, please.

Speaking specifically to COVID-19, we had in the letter that was sent by Acting Chair Ed Ehlinger on our behalf to the prior Secretary of Health and Human Services at the end of June, we added two specific Data and Research to Action Workgroup -- DRAW, another good acronym, that's another theme across the last two days -- recommendations. I put them here just to let you know that we stand by these. They are still relevant and fresh. Next slide, please.

Given specifically in September, we added some meat to that. So, if you could just bring the next piece up as well.

Of these two recommendations around greater cross-sector standards of data and linkages especially around upstream, social,

political, environmental, and economic determinants of health, and we see that happening in the Maternal Health Initiative, albeit grounded, we hoping in the work to racial equity and health equity.

And we also had a theme last September about enhanced data systems so that we could link records, particularly in the mother-baby dyad and looking at electronic health records and birth registries.

So, that's what brought us into the room and we found a need to go back and make sure that we are either affirming these to see where the gaps are in our gap analysis and what will come next.

Here, besides all the affirmations, here is what we say should be next. Next slide, please.

We would like to see language supporting the inclusion of pregnant women in vaccine trials with monitoring vaccine safety. I think that Alison Cernich' s point about not protecting women

from and seeing it as vulnerable, but inclusive in, cognizant of the need to be mindful of safety. So, inclusion of pregnant women in vaccine trials.

There was an opportunity raised that we may want to explore further that there are disproportionate women in the workforce of being frontline workers in Group 1A and of reproductive age, and so, that is a captive group of folks who may either be of reproductive age or be pregnant, and we want to be able -- similar to the recommendations put forth separately by the Health Equity Group -- monitor and do research and data and surveillance on this population of pregnant people.

We need to be anticipating where we're going to be in three months. Given that we know there will be egregious and growing social inequalities in vaccine provision, much like in testing, much like in cases, how can we be at the ready to advance surveillance and monitoring systems to know and target those growing gaps?

We again encourage better linkages in the

maternal-fetal-infant data in electronic health records and you'll see more recommendations when we get to the border, but we are just mindful that we must be working across agencies, beyond HHS to DHS for better COVID surveillance and policies both within detention and in care and kudos and thanks to Paul Wise for helping us find some clarity about the complexity at the border, which I'll refer to in just a few minutes. Next slide, please.

Our second area that we asked what might be further possible ideas and recommendations to cook now, I'm going to go to the Title V column that we'll do [indiscernible.] And similar to what has been put forth in the Health Equity Group, we would like to see perhaps mandated greater participation in states in performance measures and action plans to eliminate racism and racial disparities, specifically about common measurement and metric and monitoring systemic racism with tools, addressing implicit bias, looking at other strategies for racial equity, and

how to embed this in guidance and other requirements.

There is strong support that says if AIM is working, scale it up and continue to monitor and evaluate both its impact and return on investment.

And last, the qualitative data about voices and stories must continue to guide our policy, and we affirm the mandate to listen and lift up those voices.

So, that is what we're directing at MCHB and HRSA responsive to Dr. Warren's presentations about Title V.

In addition, in response to the Maternal Health Initiative, we have five possible areas, but we want to most say one of the biggest ahas was aha, all of the agencies across HHS, I mean, including FDA and CDC, and primary care, and -- and having a whole of government collaboration to prevent maternal mortality and morbidity -- wow. Please strengthen and sustain this and have it be a model for how that can lead from communication

and collaboration to, in fact, consolidated constructive policies that will have greatest impact.

Towards that end, as you have got connectivity, align and link and integrate the data across all those systems, methods, and findings and apply it to our related programs and policies.

Again, another plea to please look at universal electronic health records and update data systems. There's no reason that territories should be having to put paper to MCH around basic vital statistics at this time in 2021. An uplift of a minimum standard around electronic records and the transfer of that so we have maternal and child health data that will inform us around maternal and infant mortality.

And last, sustain the attention across the agencies to structural racism and implicit bias. So, we put these side by side because it is both the leadership of HRSA and MCHB working vertically and the horizontal all in government

approach that we feel wildly enthusiastic about and would love to see sustained.

Our next area -- next slide -- is around border health and immigration, and we heard and felt those stories and their importance for impact. We have two kinds of recommendations to put forth from our group.

First, as outlined so clearly by Paul Wise, we have limited direct impact, because it's a different part of government beyond HHS and beyond the purview of this Secretary's Advisory Committee, when we look at Homeland Security and Customs and Border Patrol and ICE and Immigration policy, it is beyond us, but it impacts the humans and the humanity that is part of Health and Human Services. So, we would like to influence detention policies and practice through greater research data, and strategic stories.

The systems, we heard, -- and this is a great quote -- were built for single Mexican men in detention, which are harmful to the women and children who come alone or accompany them. So,

redesign them as family-friendly in the nature of detention and we can inform those policies to get [inaudible - audio cut out] including fathers and others who have support as egregiously harmful through the life course to women and infants in their well-being.

We've heard stories of confiscating medicines and medical records at entry on the Border Patrol side on detention that precludes the ability to have quality care once through detention and placed in the caring system, which we have impact on.

So, we'd like to call out these harmful practices of taking treatment away and information away as people are detained. We should be anticipating an increased surge in people at the border. It should not surprise us, and now we should be scaling up capacity, building in a particular focus on minimizing harm to pregnant women, lactating women, and women with infants and their families.

And again, a very clear look at the

COVID-19 policies to look at prevention, treatment, diagnosis in detention through the lens of our population is warranted. So, a detention strategy to influence from HHS to other parts of government.

And what we can do -- next slide -- is that we can focus on care once humans are released from detention and HHS does have purview through the Office of Refugee Settlement to ORR and other parts of government, that's when we would like to assure that everyone leaves detention connected to an electronic medical record system so we can begin the capture of data and know who they are and never lose them or lose information about them and integrate them into our systems to ultimately prevent maternal and infant morbidity and mortality and collect better data just to know them and find them on unaccompanied infants and children. Unacceptable.

Increase priority on the data side around pregnant women, infants, including women who are lactating, and children with special health care

needs, which currently is under MCHB jurisdiction. How can we elevate this up in our data and surveillance systems and expand the assessment, data, tracking of both physical and mental health conditions after detention as we can see that this becomes in the web of acute childhood experiences and chronic [indiscernible] load and emotional toxicity?

So, separate our recommendations between detention and care, have influence, and direct impact where we can through research, data, and stories.

Finally -- next slide -- we did, of course, focus at the end about what we shall continue to do to impact systemic racism and its impact on maternal and infant mortality, and we had recommendations that you shall see here. Remember from back in September -- next slide please -- and that includes standard ways to capture, link, and use data. You've heard us refer to this already. This, we stand by and -- next slide -- encourage that we extend the kind of

innovation like the MMRC Racism/Racial Equity methods that we heard about in the maternal mortality review processes and other such processes and practices and assessments that are linked data systems so the mother-baby dyads for this better data, not just clinically, but upstream.

And we strongly support aligning with affirming the new administration's explicit commitment to advancing racial equity as articulated in the recent executive order including Section 9, which called for data equity. How we do that strategically, effectively in communication, we will talk about this afternoon. It is a how, not if, to the President, to the Secretary, to both. We would like to have that conversation in greater depth, but we know that we want to be able to align with that.

And, as of yesterday, the US Preventive Services Taskforce and the National Academy of Science and Engineered Medicine both released explicit statements around racism and health.

This is no longer a shift in race to racism. It's a shift from racism to practice and policy, data, and assessment. Next slide, please.

Thank you. Thanks to all the members. We had a smaller group -- a little bit of a technical glitch. Some folks did not have the link of how to come in. So, I met with each of them afterwards one-on-one. Thanks also for the transcription and notetaking, and virtual communications. I know I didn't get my notes until close to 9:00 my time on the West Coast, which means that they worked really hard to make it happen. We are delighted to talk about any and all of our findings and recommendations and align them with the other two workgroups. And I think that's the last slide. Questions and comments come next.

So, this is open it up if you put in gallery view, and that's a lot. You gave us seventy-four minutes, and we used every ounce of it, Ed.

DR. EDWARD EHLINGER: Well, let's take a

couple of minutes here and we'll have a little bit of time at the end. But any comments from any other members of the group or any questions -- clarifying questions that anybody might have.

DR. MAGDA PECK: I particularly want to turn to Paul and to Jeanne, who are my fellow SACIM members that were present. Paul, is there anything that you want to -- I'm not sure I did you justice in terms of the expertise that you brought yesterday and clarifying questions should go to you. But anything you want to underscore? And also, Jeanne for the recommendations you made as my fellow SACIM folk?

DR. PAUL WISE: So, thank you, Magda. You did an excellent job, as usual, in conveying the heart of our discussions. So, I have nothing to add. I expect as we begin to transform the slides into some written document that there will be opportunity for refinement.

DR. MAGDA PECK: Thanks for all your help.

DR. JEANNE CONRY: And I agree. Yeah, no

comments. Great complementary work.

DR. EDWARD EHLINGER: Good. Well, great, great work everyone, and we'll get back. Clearly, as we're seeing these recommendations coming up, keep in mind how can we merge -- there's a lot of overlap, there's lots of complementary. How can we put them together so that when we get together again, how do we work on these bringing them all together so that we can see them up for some real action at our next meeting. You know, and so there's going to be a lot of work coming that the workgroups are going to be doing between now and May. So, that's what you signed up for. All right.

MS. BELINDA PETTIFORD: Ed, there's some questions in the Q&A Box. I don't know if you can see them or not. One is for the Data and Research to Action Workgroup.

DR. MAGDA PECK: Thank you. I'm going to be monitoring those. May I suggest, let me take a look at them Belinda, and we do all conversation, I'll come back to it so we can get to the third

presentation. Thank you for bringing that up.

MS. BELINDA PETTIFORD: Right. I mean, I think it's just one question.

DR. EDWARD EHLINGER: All right. Let's go to Steve with the Quality and Access Workgroup.

DR. STEVEN CALVIN: We were also a small group. I don't have slides, but I have a summary that I can share with everyone. Thanks to the LRG folks who took notes and what not and those that joined us -- Colleen Malloy and Tara Sander were committee members that were also with us, and it's pretty clear that we have identified specific significant problems. I mean, the disparities are really well documented. The causes and solutions, I guess, we're working toward. The data group, you know, thank you, Magda, and thank you, Belinda, for addressing those things and also pointing out the importance of data because that -- to me, it seems like we have a lot of information but in a lot of different buckets, and it's really -- it's hard to put it all together.

But since our group is the Quality and

Access Group, you know, two of us in our group, Colleen is dealing with newborns all the time and I'm dealing with pregnant women and the care that they are being provided. Cathy [?] joined us as well from Oregon, and she's a national leader in ACNM and a leader in Oregon as well.

But one of the major issues for access to care is you have to have the providers of care, and ACOG has, you know, really done great work on workforce issues. Jeanne is probably quite familiar with that, the fact that there are not going to be enough maternity care providers and the collaboration between ACOG and ACNM is a good thing because workforce issues are going to become even more acute and especially as we -- as we find areas that are -- a lot of the disparities could be addressed by having more providers, especially from the communities that are being served, and that's going to be a challenge, and a lot of that has to do with financing. So, we have those sorts of things.

What it really gets down to when we look

at access and quality, we look at the way the money is spent basically. So, following the money is important and Medicaid is an extremely complicated system, but it's designed that way as a federal state partnership, and it's like that above at least $40 billion, maybe closer to $50 billion are being spent for the $1.5 million to $1.7 million mother-baby pairs who get care through Medicaid every year in the United States. That's an almost four out of ten births are paid for by Medicaid.

So, that just leaves us with we have a system that's paying for care that is a system that's quite diverse across the country in the amount spent per pregnancy episode varies dramatically, probably on the order of between, in some states, three times the amount spent in some of the lower-spending states. Recently, I've become aware -- and some folks on this are probably participants, some folks that are on our committee -- are aware of MACPAC, which is the Medical and Chip Payment Advisory Commission.

That is a commission that was formed out of the Affordable Care Act in 2009 that has seventeen members -- seventeen commissioners -- that are addressing issues of how Medicaid operates.

And we made some connections, and I wanted to tie that into just some thoughts that we have regarding how can we get things to change. I mean, we have -- we learned yesterday that we have a great resource and it's been operating for a long time and the presentations put together by the HRSA folks, from MCHB were really astounding. And some of them by people who their original specialization is not maternity care, but they have become incredibly knowledgeable.

So, we have great data resources and we have a problem though that the majority of Medicaid funds are being administered in ways that don't really tie the administration of the funds or the spending of the funds to data outcomes. So, I think this sort of ties into the DRAW group. For sure, it ties into our equity workgroup that we're sort of left with not having a really good

idea of how the money is spent and what the outcomes are. So, in a general sense, I would say that our Quality and Access Group would like to start to focus on following the money because once we can figure out ways that things are currently being spent with the outcomes related to those expenditures, we can then address many of these things including the immigrant needs at the border and certainly addressing the disparities.

So, some of you probably are familiar with a House bill that passed in September of last year. It's called the Helping Moms Act. It's related to Medicaid. It passed with bipartisan support in September of last year but didn't go anywhere in the Senate. It is a bill that the main focus includes number one, when we're talking about quality and access, the current Medicaid situation is that coverage is usually not more than sixty days postpartum and it's usually a one-time visit and there's a lot of opportunity for doing a better job, and it's become very well-recognized that the twelve months after the birth

of a baby are a time for the mother that are incredibly important. So, this bill gives states the option of expanding to what's been referred to as the fourth trimester, at least extending it beyond sixty days but really aiming to try to get twelve months for the mother because babies are covered for twelve months as well.

Number two, our doula services, and that, I think, will be part of our work going forward into this year and further. The doula services are encouraged. Some states pay for them. There are tremendous barriers to access to doula services and when we're addressing disparities, having women from under-represented communities, women of color who can be doulas and more quickly trained as doulas would be a really beneficial thing. And so, there really should be more support for doula services.

And the third part of the Moms Act is in Section 5, and it mentions that MACPAC. It's a legislative body. It's under the General Accounting Office under the Comptroller of GAO.

There is a requirement in this bill that bundled payments be evaluated and really you get what you pay for in any kind of care circumstance, and if you are just paying for pieces of care, that's what you'll get. And so, there's a lot of interest in figuring out different ways to pay for care, and I've seen it as a possible solution, I think, actually the most likely solution.

So, getting back then to the data, if we can get a way of linking up or making the data collection and analysis resources of HRSA and MCHB to be able to get the information from each state from the various entities that are administering the care and what's most common now is I think two-thirds to three-quarters of all maternity care is administered by managed care organizations, usually large payer companies. So, we just need to get that data in the hands of those who are within HHS that can analyze the data and give us better information on what's working and what's not and how the money is being spent.

We had some discussion as well about

telehealth. Telehealth for maternity and newborn care is valuable in some ways. The personal experience I've had here in the Twin Cities with our midwife team is that mothers prenatally really want to see real people. There is a benefit, but telehealth is not the complete solution, but it is a tool.

And then we also have interest in how newborn care is provided. I mean, our committee is infant mortality originally and obviously we know that the maternal aspect of things is incredibly important. But Colleen has appropriately brought up, you know, what are we doing with newborn care? How are we providing it? How is it paid for?

And with that, I will stop and ask the two committee members who are on, Tara or Colleen, what are your comments before we go to the wider discussion?

DR. COLLEEN MALLOY: I don't have any additional comments. No, that was a great summary. Thanks so much, Steve.

DR. TARA SANDER LEE: Yeah. No, thank you, Steve. That was a great summary of everything. I think that, you know, you hear often in health care that iron triangle of quality, access, and cost. So, I think we're trying to, you know, if the paradigm is that one side of that triangle affects the other, I think that's where we're trying to actually come up with some concrete ways to improve quality in line with costs and improve access as well.

I think the telehealth option is definitely more important for the infant side of things, especially with parents who are in stressful situations and need some kind of connection to a professional in terms of taking care of an infant, and obviously it's not the best way to expect them to come in for an office visit to talk about, you know, coping with crying, those types of programs that exist to try to decrease the amount of infant child abuse that occurs.

So, I think that, you know, Steve has a great grasp of kind of how all these funding

initiatives affect different parts of access and quality. So, I think you did a great summary and thank you for putting it together.

DR. STEVEN CALVIN: Okay, back to you, Ed.

DR. EDWARD EHLINGER: All right. Any other comments or questions from the committee for the Quality and Access Workgroup?

All right. If not, we've got a couple of minutes before we introduce our wonderful guests from Flint, Michigan who I see are visible on my screen. So, thank you for being here. Belinda.

MS. BELINDA PETTIFORD: I have one and I can forward this to Steve. But within the Health Equity Workgroup, we did have a subgroup that's focused on access to the workforce and I think that it might be helpful to look at some of the recommendations of that group also because they spent time within that group of just looking at recommendations related to equity and to looking at things like increasing funding for students enrolled in accredited midwifery programs to make

sure we're trying to diversify the workforce, support research, [inaudible] care, and looking at ways to diversify the workforce.

So, I can see you share their recommendations as well. It's just our full Health Equity Committee has not reviewed them in detail, and we plan to do that at our February meeting, and then I can share them with you.

DR. STEVEN CALVIN: Thank you.

DR. EDWARD EHLINGER: And I'm wondering about if our three chairs of our three committees, as you were listening to these presentations, where do you see the overlap, which is a good thing, not a bad thing. Where do you see the overlap? Where do you see the complementariness? Where do you see we should be focusing our effort to pull in from each of the workgroups some of the information so that we can start to work on formulating an approach to how to pull this all together?

DR. MAGDA PECK: Well, I wouldn't limit it to just the three of us because I rely very

heavily on the extended membership, you know, the fourteen or fifteen people that hang with us. But I will say that -- and I heard it perhaps more between the equity group and the data group -- an example being that following up some of the specific recommendations for border health in the wake of the excellent presentations yesterday. So, I think that it's a combination of what to do programmatically and what assures there is sufficient data and research to support those actions. So, that's one of the areas.

And particularly, elevating the population of pregnant women, women of reproductive age, early parenting women, and as was added appropriately so in the chat box, lactating women and breastfeeding women. So, this notion about someone should be championing from a federal level through the lens of preventing maternal and infant morbidity and mortality, this group of women around these policies, these programs, these procedures, and making sure that we've got the data and the research both now and

going forward to follow and make impact. And I think we have a greater opportunity to do that now and the opportunity with anticipated policy change. And I also think with the anticipation of policy change, there's going to be, as has been said, greater surge and, you know, greater demand at the border, and we should not wait for our current systems as they are to be able to handle them without taking preemptive action. So, it's a great time to seize the opportunity. So, that's one example of synergy.

DR. EDWARD EHLINGER: All right, good. That's the term I was looking for, synergy. Not overlap, synergy.

One of the things I heard -- and this was brought up in all three of these groups and it's one of my interests -- is doula services with the US Preventive Services Taskforce focusing on racism and knowing that doulas are really one of the ways of doing that. And as the workforce issue and the equity issue, my hope and my plan is to actually bring in somebody from the US

Preventive Services Taskforce at our next meeting and actually see if we can't put doula services as a level A preventive service, which would then allow payment for those services. That's one -- that's another area where I see some synergy that we might be able to work on.

Any other --

MS. BELINDA PETTIFORD: Ed, on the doula one for that, I do think you're right, that it crosses all of the work of our whole committee and it addresses several of the issues.

I also think when you're looking at access issues and how it overlaps with our groups around especially the work with COVID and how we're looking at the data, and how we're, you know, wanted to do follow up with individuals, pregnant women and their infants, I think there is some overlap there in the work between our committees -- our workgroups. So, I think that's important for us to make sure we keep that on our radar.

And I think the work -- I think the work

on the equity assessment has the ability to cross over all of us. I don't think it's just one -- even though it's a recommendation coming out of Health Equity -- I think it's part of the data that we need from the DRAW group. I think it impacts our issues around Quality and Access. So, I think that's another area that we need to have further discussion about and put some parameters around it and think about what that could look like as well.

DR. EDWARD EHLINGER: Great. Great idea.

Steve, any thoughts that you have?

DR. STEVEN CALVIN: No. I think the overlap is really -- it's important and there is -- there will be synergy. We have to decide as a committee what we're going to be asking of or recommending to the Secretary.

DR. EDWARD EHLINGER: All right.

DR. MAGDA PECK: If I could add one more, Ed, and that is schooled by many people on the workgroup that have been so terrific in the DRAW group. To be strategic -- and we heard this about

where is our leverage as SACIM -- specific to MCHB or HRSA, we are housed, we have an incredibly welcoming and willing partner in Dr. Warren and others about how to influence Title 5 and how more broadly to be within HHS to be able to work in all of government. So, the notion that we advise the Secretary that we have our sphere of influence is to make sure we leverage that as much as we can.

DR. EDWARD EHLINGER: Right.

DR. MAGDA PECK: And to be strategic about when we get outside the boundaries of Health and Human Services exemplified by COVID in terms of housing security or education or exemplified by border crises, exemplified by Homeland Security. How can SACIM be a driving force to work beyond the boundaries of HHS as influence and raise our visibility because we have content that can inform their process and their policy if, in fact, we have the opportunity to do so in a way that any individual agency might not.

So, I would like us to be thinking about where is our influence both inside HHS and beyond

and to maximize that as SACIM.

DR. EDWARD EHLINGER: Thank you. And Colleen, you had your hand up?

DR. COLLEEN MALLOY: Let's see. Yeah. No, I was just going to say that in light of, you know, we talk about data a lot and I think I really enjoyed the presentations yesterday because there was a lot of data, maybe just because I come from a science background that I appreciate that.

So, I think a lot of the groups, you know, talk about data, and it always helps to kind of show I don't know if we're speaking in general terms or like specifically, like it helps me to know like which data you're referring to. But we talked yesterday about, you know, what numbers are statistically significant when you're looking at data. So, I'm sure that it's out there if I pulled the studies that they presented yesterday, but a time for me to know, you know, what number with a numerator and a certain denominator is statistically significant.

So, say for a mom who ends up on ECMO,

that seems like a very unusual outcome for a pregnant woman with COVID, but it happened. But I just kind of -- for me, when I see numbers, I need to know like is that statistically significant or not. So, it's just, you know, I loved the presentations yesterday because they were kind of -- I could see data graphically, and it was helpful to me.

So, more of a note of encouragement than anything else, but I think the data really helps with all of this and knowing like what numbers are statistically significant or not.

DR. EDWARD EHLINGER: Great. Thank you.

All right. Now, we're going to move onto a new area for us. Jeanne Conry, since she was put on this committee about the same time I was, she's been advocating for focusing on environmental health issues and I said good, I agree. But it wasn't until I went to the APHA annual meeting and heard Daryl Hood talk about what was going on in Columbus, Ohio, and it was very place-based focus and I said, all right, now

I understand what Jeanne was really trying to get me to see. So, we decided to have a session where we really look at the environmental contributions to maternal and infant health and health outcomes.

I asked Jeanne to put together a panel, and so we've got a great panel. But or -- and what we'd like to do is we'd like to have Voices of the Communities to sort of kick off and lead off our conversations because we need to be responsive to the community, we need to listen to the community, we need to hear the voices from the community, and we are really fortunate to have two people from the Voices for Children in Flint, Michigan, which all of us recognize as a sort of the centerpiece of a lot of the attention about how community actions -- how the environment can influence the health of moms and babies.

So, we have two people from Voices for Children, Amanda Brousseau and Kinea Kandi Wright, and I'm so pleased that they are here to share their stories. Amanda and Candy, this is a group of maternal and child health experts and

community-connected people from throughout the country who are ideally making recommendations to the Department of Health and Human Services about how to improve health, and your voices will be important for us to hear and hear your story. So, I'm going to turn it over to you to tell us a little bit about yourself and what your story is. So, why don't we start with Amanda. So, unmute, Amanda.

MS. AMANDA BROUSSEAU: Sorry, I have Zoomed before.

Thank you for having me. I was pleased at being offered this opportunity to speak. I was in DC two years ago to speak before HRSA and it was really powerful, and I appreciate you wanting to hear Voices of the Community and input from us.

I have been married almost twenty years. I have an almost 6-year-old. We live in Flint. I am a co-facilitator for our only Genesee County Postpartum Depression Support Group and apparently, they're with the Great Start Collaborative and Great Start Parent Coalition.

So, that's just a little bit about me.

When I got pregnant in 2014, I was surprised because it wasn't something we were expecting. I didn't know what to expect. But I felt like I could learn enough to, you know, raise a mildly decent child and be an okay parent. But when Ava was born in March of 2015, I felt overwhelmed, as most new parents do, and on top of that, I was blindsided with a pretty bad case of postpartum depression and I had little outside support. There wasn't anything in our community at the time.

And then, when the news about the tainted water hit, it was -- it devastated me even more because I was worried, well, was I poisoning my baby before she was even born, and that just -- I couldn't get over that. And even though we took precautions, you know, there's always some sort of -- some sort of risk. But bath time was a really bad time for me because with the depression and everything, I couldn't -- I didn't have the stamina or the mental ability to just like bathe

her in bottled water, so I did use tap water, and that bothered me. So, instead of having a happy bonding moment with bath time, it became a nightmare for me. And as she got older and was definitely sucking on the washcloths and drinking the water, I had to stop. I had to hand the bath duty over to my husband because the anxiety of that, it just pushed me over the edge and I couldn't -- I couldn't see her in the bath sucking on a washcloth because I was like, what is it doing to her.

We struggled with rashes and creams, and I was constantly worried about the effects the lead might have on her because obviously, she's still developing, and I'm still worried. I know some of the effects might not appear until adolescence, and she was tested -- lead tested -- and she tested low, but that was after the, I believe, the 28-day period. So, we don't know how much lead level she actually had in her blood. So, whenever she struggles with something or has a setback, I wonder if it's developmentally

appropriate or if it has something to do with the lead, and she has been affected by that.

I also worry that if she decides to have children in the future, her bones and organs may release that lead that had absorbed and affect her unborn baby. I feel this will never end. And even though our service line has been replaced, I'll never trust tap water anywhere, and it frightens me.

With the grant that HRSA has given Voices for Children and the Genesee County Health Department in order to facilitate our Leap, I have learned a lot through professional development that has been offered through the grant in meeting other like-minded parents. I have become a better parent, and I've been afforded the opportunity to share my knowledge with others and pass on much needed resources in our community. Best of all, Ava and the children of the other parents are learning that they can try to make a difference, and I am hopeful that Ava and the others will be the next generation of advocates in our community.

DR. EDWARD EHLINGER: Amanda, thank you very, very much. Thank you for sharing that. I know it's difficult and I appreciate your willingness to come and talk.

Let's now hear from Kinea and then we'll have some questions from the group and some comments from the group for both of you. So, Kinea.

MS. KINEA KANDI WRIGHT: Hello, everyone. Thank you. Like Amanda said, thanks for having us and allowing us to be a voice.

So, I am a mother of a miracle baby boy, Tarek, who is 5 as of December of 2020. My journey has not always been easy Healthwise, and it sure didn't get easier when I was pregnant.

In August of 2014, the 12th to be exact, I had a severe asthma attack. Now, this was really strange for me because I was 34 going on 35 on the 21st of August and I have never in my life had asthma before. But there I was in the hospital on serious rounds of steroids because my lungs had gotten suddenly weak.

I was released on my birthday on the 21st, but that was short-lived because I was rushed back to the hospital because I couldn't keep anything down. When I arrived less than 24 hours after being released, I was given the third-degree questionnaire by the medical staff as to if I was suicidal or what was going on and why my liver enzymes were so high. They were actually ten times higher than they were supposed to be. One was over 900 and the other was over 1,400 and I was accused of overdosing myself. And I was in a furious state and I aggressively told the doctors that I wasn't suicidal or taking anything. The only things that's changed is me coming into the hospital, being on steroids, and being released.

So, they called the infectious disease team and then they told me I had hepatitis, which was not the case. The infectious disease team released me after saying that everything was okay. But they did do a liver biopsy after I was on heparin shots the whole time. So, my liver bled

out. I had a big hematoma on the inside of my liver and on the inside of my abdominal wall, and talk about painful, I could barely even move or lay on my right side.

But long story short, after about two months' stay in the hospital, I was finally diagnosed with lupus and was released September 29th of 2014.

Now, if we fast forward a little bit to April 2nd of 2015, I went to the hospital for severe pain and come to find out I was pregnant. Now, this pregnancy was a shock because it was kind of, you know, turbulent a little bit because of everything that I have been through previously, just finding out about lupus and other autoimmune disorders, which I have never had before. But I also learned about the high lead in the water.

So, I was concerned about that. The possibility of exposing my unborn child to the lead, how it would affect him developmentally. I constantly was breaking out in rashes, getting colds, and I ended up having a really hard

pregnancy and I had to have a cesarean section a few weeks early. My dogs even got sick from the water.

So, after I delivered by baby, we both kept getting sick. He ended up in the hospital when he was 2 months old for a severe infection, and we were only in the hospital for five days, thank God. But the water -- drinking and being exposed to the water did some damage to both of us.

We kept getting constant illnesses, breaking out until I just couldn't take it anymore. I did have postpartum depression because of everything that I had went through and the unknown of what I did unknowingly to my unborn baby if he were even going to survive or make it or what kind of life he would have had due to the lead, due to all my health issues. And so, that was really hard on us. I actually had to go to a counselor because of the unknowns and just looking at my baby and already struggling trying to raise an African American child -- a male child -- all

these things that I had to deal with with that, plus on top of that the lead and what it could have done to him mentally, physically, whatever. I got so stressed out from making numerous trips to the stores to get bottled water or to the free sites to get bottled water just to cook, just to bathe, just to clean, whatever. So, I ended up getting a home/house filtration system because I just could not trust the water anymore because of everything it had done to us.

My baby is only 5 years old, so it's still unknown as to what effects the lead has had on him. But we have been a part of several services including early on in Head Start since he was 11 months old. We have also been a part of different parenting and family groups. That has been super beneficial to my family, including the Leap program through Voices for Children. Being a part of the Leap has given me the encouragement and the courage to be an advocate for my family, to stand up for what I believe, and to push for change that will make not only my family life

better but make the community better as a whole.

Leap has supported my growth, my leadership, and provided the resources to my family to succeed. And most importantly, they show their appreciation for the family through honorarium funds to show that they value our time and efforts. They treat our families and all of the individuals that are involved with the program like a family and equals and they give us the support that we all need to help us succeed. Thank you.

DR. EDWARD EHLINGER: Thank you, Kinea. Thank you for -- and thank you for turning on your video. I like to see your face. I appreciate that. Thank you for your story. I applaud your resilience in moving forward.

So, we're going to open up for some questions for a couple of minutes if anybody has any comments about the stories from Amanda and Kinea or any questions that they have.

DR. COLLEEN MALLOY: I'll ask a question. How do you -- I don't know if you know the answer

to this -- but how do you, I mean, how do you ever trust the system when you've been -- it's just like what you said like you'll never feel comfortable drinking tap water ever again. I don't know how if someone did a liver biopsy on me, I'd ever be comfortable letting them stick another needle into me. I mean, it's just -- it's so hard when you've gone through something like that to have to then trust any of large-scale government decisions that are made for us and any kind of environmental action.

We had a similar situation where I live where they were basically spewing radioactive material into the air and, I mean, it took five years for them to finally shut the plant down. It's so hard, like it seems so obvious that this would be horrible to do to people's water supply and then, so it makes you -- it's just like what you said, how do you ever trust a system that's done that to you in the past.

MS. KINEA KANDI WRIGHT: It's so hard to trust because we were -- honestly, if I can be

candid, we were lied to. We were told that the water was okay. We were told that everything is going to be fine. But you know -- people don't know, and it was all such a coverup for so long that it's going to be -- it's -- I don't know if we will ever bounce back or recover. I mean, you can only move forward but the true trust will never be there when we were lied to for so long and it was covered up and it still hasn't really been really addressed. Yeah, they got the lawsuit, but how much is that going to help when we've got so much other damage to our babies? You know, it's just -- it's going to be hard. I don't even know if we will ever get over it.

DR. EDWARD EHLINGER: Amanda, any comments?

MS. AMANDA BROUSSEAU: That's exactly it. It's the trust in any system is really difficult and the fact that really no one has been prosecuted yet. I mean, that's not going to solve what happened, but I think it would be a good step forward to show the residents of Flint that, you

know, something is going to happen instead of, you know, charges keep getting dropped or dismissed and then charges are being brought up again. But there is a statute of limitations, from what I understand, so this needs to be addressed very soon or else there's not going to be any repercussions for the people responsible for poisoning a city and like we still don't know, you know, like Kinea said, we don't know how this is going to affect our children.

Flint is significantly -- has a high number of children with special needs anyway, and since the number -- and I can't remember the number -- but it has increased a lot, and the resources aren't there for that either to address that. And the fact that we spend so much money on water that we don't even drink is a big slap in the face. So, yeah, trusting again, I don't think that I would ever trust water systems anywhere.

DR. EDWARD EHLINGER: The other thing is both of your stories highlight the fact that it is not just the physical trauma that you have to

experience but the emotional impact that it plays both short-term and long-term, and these are huge impacts, and I appreciate the fact that you're being proactive to come in front of us to talk with us to share your story. It's going to have an impact, and it really sets the stage for what we're going to be talking about over the next couple of hours is the environmental contributions to mom and baby health.

So, thank you for setting the stage. Thank you for taking the time to be with us and blessing on you and your community, and may all of Flint start to heal as quickly as possible. So, thank you.

MS. KINEA KANDI WRIGHT: Thank you so much for having us.

MS. AMANDA BROUSSEAU: Thank you.

DR. JEANNE CONRY: I'm Jeanne Conry, and from the bottom of my heart, I thank you for really kicking this session off because it takes a voice like yours. When we are talking, one of the first things we do is show slides of Flint,

Michigan, because you are the rest of the world, and unfortunately, you lived an experiment that nobody wants to live and continue to experience that. Our mantra has always been, "There is no safe level of lead," and yet somehow that doesn't get through. So, thank you, Amanda and Kinea. You're just wonderful for being here.

We also say, "It's the air we breathe, the water we drink, the food we eat, and the products that we use." So, keeping that and keeping aware of that is critical.

[Cross-talking on line.]

DR. JEANNE CONRY: I want to thank SACIM for allowing us to have this session, to the leaders for all the government organizations that are dedicated to help in women's and children's health, the Ex-Officio members and to the public. I'm going to be moderating this session and, yes, we've got an incredible group for you to listen to.

Our vision is founded in environmental justice to place it in perspective. It was fifty

years ago that the American Academy of Pediatrics started talking about environmental exposures and children's health outcomes, and they actually had to write a section on OB because obstetricians weren't paying attention to it.

Fast forward to 2013, and American College of OB/GYN and American Society for Reproductive Medicine wrote a joint statement saying we need to look at environmental exposures and that had to be considered when we're talking about reproductive health and women's health, and that statement came from our committee on underserved women because we understood the vulnerabilities. And then it was in 2015 that FIGO stated that environmental exposures need to be part of global women's health. WHO and the United Nations now identify environmental exposures and climate change as critical elements of the sustainable development goals. So, we are all messaging but it's the clinicians who aren't hearing the message or aren't aware of the message.

So, we got a broad panel to discuss the science, advocacy, and racial disparities. We've got climate change and then I like to call Dr. Collman our closer because she's going to take National Institute for Environmental Health Science and allow all of us to see what NIEHS is doing. So, I'm going -- I've asked each of our speakers to give a very brief overview, and I'm going to take the time to introduce each of them.

In Healthy People 2000, so look how many years ago, our goal was to integrate preconception health into everybody's view of medicine, but it was almost a decade later that we were introduced to Dr. Tracey Woodruff from the University of California at San Francisco because of her research on preconception health and the need to address environmental exposures. Dr. Woodruff is the Director of and Alison Carlson Endowed Professor for the program on Reproductive Health and the Environment at UCSF. She's a Professor in Obstetrics and Gynecology and an incredible visionary with experience from the EPA. Dr.

Woodruff, I'll turn it over to you.

DR. TRACEY WOODRUFF: All right, thank you. And thank you, everyone for being here, and thank you, Amanda and Kinea, with sharing your stories. I think it's so powerful to hear them, and I think it also speaks to how important it is that the government do it's job to protect people from environmental pollution. And I think that's why [indiscernible] -- I think that's how you pronounce your acronym -- is so important because you have the power to really speak on behalf of pregnant women and children and you also are situated because you advise the head of the Department of Health and Human Services who has the power to speak with EPA, who directly is working on and will be reviewing things like the lead and cooper rule, which directly influence lead and drinking water as just as example. And this new nominee for the head of Human Services is a former attorney general here in California, and I know he cares about environmental pollution. So, I think this is a really great opportunity for

you to be very influential in this sphere.

I am going to -- so, Jeanne introduced me briefly. I'm at the University of California, San Francisco, a few people are familiar with us. The goal of the program on Reproductive Health and the Environment is to create healthy environments for human reproduction and development. We have a very robust research program looking at prenatal exposures to environmental chemicals, which I will highlight. But we also do a lot of work integrating what we've learned from the science into the clinical care. So, we've partnered with Jeanne for many years and also, we do work to make sure that policy makers know about the science so that they can do the best thing on behalf of their patients.

So, I'm just going to give a brief overview. You heard about lead, and I'm going to talk -- I'm going to really go through a very brief overview about industrial chemicals and all the many things that an agency like EPA is dealing with. But I'm going to start with pharmaceuticals

because you probably are familiar with diethylstilbestrol, the small-manufactured molecule. Pharmaceuticals are small-manufactured molecules. This was prescribed widely to women in the '60s, '50s, -- '40s, '50s and '60s -- pregnant women.

Unfortunately, it also was later found to increase the risk of a number of different reproductive health outcomes, first starting with discovery of a rare vaginal cancer in the daughters, but numerous other health outcomes came from this chemical. It also was designed to be an estrogen because estrogens were thought at the time to prevent preterm birth and miscarriages. But unfortunately, if you have estrogenic substances during pregnancy, it can alter the trajectory of development, which is what happened with diethylstilbestrol.

So, other hormones are really important during prenatal development -- I'm pretty sure you're all aware of this -- I'm just highlighting estradiol as well as thyroid hormones. But I

think the thing that is not, industrial chemicals are very similar to small-manufactured molecules and they're also very similar to hormones. So, here are some ones you may have heard of because they tend to be more famous out in the world, which is BPA, it's used as plasticizer, it's found in the lining of cans. Phthalates, which is another plasticizer chemical that's used in many different types of products, and I'll talk a little bit more about this. And this other one, polybrominated diphenyl ether, which is a flame-retardant chemical, which is found in various products, and I'll talk a little bit more about this.

My point is that in the medical field, people deal a lot with pharmaceuticals. We also know that there are endogenous chemicals like hormones that are very important that influence development and these molecules that we're talking about that are in all these different products that Jeanne has mentioned, they also look like these different molecules. And so, the challenges

here for us for our health is that they act like these molecules, they influence these various physiological systems including disrupting the endocrine system.

So, I'm going to give some examples. This is one that we've done a lot of work on. You don't have to remember the name. It's basically a flame-retardant chemical, and it's found everywhere because it's been used in lots of home products, whether it's home insulation, upholstered furniture because it's used in foam, in carpet padding, baby products. So, this is the molecule and it looks a lot like thyroid hormones. So, thyroid hormones are very critical for proper brain development as well as other maintenance functions in the body. So, you can imagine that if it's used everywhere and it looks like thyroid hormones that consequently, we are all exposed to this flame-retardant chemical, and it's also been linked to neurodevelopmental outcomes, reproductive outcomes, and cancers.

And then importantly, when we're talking

about health inequities in the population, there are also groups of people that have higher exposure to these flame-retardant chemicals. Some of them are people in California, and this is due to the regulatory requirements -- certain regulations that have been in place in California that have been changed and required more use of these chemicals. But other groups of people are also more exposed to these chemicals including children and socially vulnerable lower-income and also communities of color have higher exposure to flame-retardant chemicals due to the differences in where they're used or disposed of, and this can -- is one concern we have about our contributions to health inequities.

Another group of chemicals, which you may have heard of as another example, are called phthalates. These are chemicals that are used in making plastics. They're also used in many different types of consumer products to convey scent. This is an example of the many different places you can find phthalates. It can be in

medical equipment, because they can make it in the IV bags, tubing, personal care products, we found it in toys, vinyl material. They are also found sometimes in pharmaceuticals, automobiles. So, it's just really widely used, and again, phthalates are found in pretty much 100 percent of the population and -- oh, sorry, there's somebody's noise. And they also can disrupt the endocrine system. So, they can influence estrogen and testosterone and they've been linked to --

[Loud background noise]

DR. JEANNE CONRY: Can everybody put their phones and computers on mute. Could everybody put their computers on mute.

DR. TRACEY WOODRUFF: Do you think I should keep talking?

DR. JEANNE CONRY: Yeah, go ahead. Hopefully, they got it.

DR. TRACEY WOODRUFF: Okay. So, because they can disrupt the endocrine system, they've been linked to male and female reproductive health outcomes. So, if people are familiar, there's

been data showing that there has been a decline in sperm count, 50 percent, over the last several decades. One of the suspect chemicals linked to that is phthalates have also been linked to preterm birth, metabolic disorders, including diabetes.

Similar to PBDEs, there's a racial disparity in phthalates exposure. Some of the beauty care products that are more highly used in communities of color are marketed through predatory marketing practices. Communities of color can have much higher levels of phthalate, and this again can contribute to inequities between groups in terms of exposures and health outcomes.

And I just gave two examples of some chemicals, but as Jeanne opened with, we are exposed to different industrial chemicals in multiple places every day. So, whether they are chemicals in our house, food-related, or agriculture related chemicals, pesticides, air pollution -- I know Nate is going to talk about

this -- drinking water. You heard about the tragedy of lead. But right now, there's also ongoing concern about fluorinated chemicals in drinking water, chemicals that are in food, and then in personal care products.

So, unfortunately, what this means is that there's widespread ubiquitous exposure to multiple different industrial chemicals. Lead is just one example. And so, pregnant women are being essentially assaulted with these chemicals. There's multiple chemicals that have been measured using biomonitoring methods in pregnant women across the United States. As an example from a study we did -- you don't have to look at these names -- but many of these chemicals are the ones I just mentioned like phthalates and PBDEs, and some of them are even chemicals that were banned a long time ago but because they are very persistent, they remain in the environment, so PCBs and MDDT.

And unfortunately, chemicals pass through the placenta to the fetus. This is from a report

that's a few years old now, but the National Cancer Institute is looking at the environmental contributions to cancer and they noted in that report that to a disturbing extent, babies are born pre-polluted.

And I think this will be touched on by some of the other speakers. But we're seeing an increase in chronic child health conditions. Things like asthma, obesity, behavioral learning problems that have been going up over the last ten to twenty, maybe thirty years, and that's also at the same time that we're seeing a rise in the production and importation of industrial chemicals into the United States.

Now, I just want to talk briefly about the difference between manufactured chemicals and industrial chemicals. I think it's really important because people who -- particularly in the clinical field -- are not familiar with how manufactured chemicals get to be on the marketplace. So, you're very familiar with how pharmaceuticals come onto the marketplace because

they are required to show safety and efficacy before they can be prescribed, and that is not true for manufactured chemicals. They do not have to show safety before they are allowed to be on the marketplace. There are some nuances about how the law has changed, but it still remains the same.

And I think this is important because I did have the opportunity to get on early and hear a little bit about some of the science. And so, our science is slightly different, and there's a reason for that. If you see here on the left, the clinical field, if you're developing a pharmaceutical -- and COVID has been a great transparent study about how this all works -- is that you develop in-vitro and in-vivo toxicity testing and then you go through extensive randomized control trials before the drug can enter onto the marketplace.

How chemicals are manufacture, they pretty much, I mean, there is some regulatory process, but most of the chemicals that we're

exposed to have gotten onto the marketplace without a lot of data being required, and now we're all being exposed to them. So, now what we do at Environmental Health Science is spend a lot of time trying to figure out where these chemicals are and what the health effects are. So, that's two important things I want you to know about is that the kinds of studies we do tend to be animal studies and human observational studies because you can't do a randomized control clinical trial with these industrial chemicals. And second, we're doing this post hoc. So, we need to be using the same tools in terms of evaluating evidence, but we have a different kind of evidentiary bar that we're trying to achieve because we -- if we find things are potentially harmful to the public, it's really important for the government to intervene.

I think the other speakers were going to talk about this, but I just want to note that there is the what we call the triple jeopardy of social inequalities that these exposures to

industrial chemicals can be additive to social and biological susceptibilities. So, things that already put people at risk -- poverty, racism, and discrimination, life stage, living in areas that already have other types of environmental chemicals -- those can add to the risk of environmental chemical exposures, and that's where we think there's a lot of opportunity to address health inequities.

I will just reiterated what Jeanne said is that we have the opportunity to work with ACOG and ASRM on their committee opinion that came out of the committee on underserved women, and I think it's important -- and I know that other speakers will talk about this -- that underserved and communities of color can have higher exposures and, in addition, address this with environmental racism. I think there are some really interesting programs in California to look at how to -- to look at these two factors together to address health inequities, and this is a really great article from the New York Times that talks about

this issue.

I want to note also that there are occupational exposures that can also produce higher risk, and we've addressed this in our program.

So, I'm going to conclude because I know we have a lot of other speakers and important topics. The environmental chemical exposures are ubiquitous and there is evidence to indicate they are adversely affecting health inequitably and science is very important in this field. But we really need, in order to make the systemic changes and to get the government to do the job they're supposed to do, we really have to have engagement by scientists and health care providers. And in partnership, we can work together to address these environmental contributors to maternal and child health, and reduce them, and improve health.

And with that, I'd like to thank everyone at PRHE and our funders and I am going to stop sharing so that Jeanne can introduce the next speaker.

DR. JEANNE CONRY: Thank you so much, Dr. Woodruff. Wonderful overview and perspective. I appreciate that.

I'm going to turn directly to Dr. Hood and then after that, I'm going to give Maureen Swanson a head's up that we're going to switch, and Maureen, you're going to go after Dr. Hood.

So, Dr. Hood is -- sorry about this -- is a nationally recognized environmental public health neuroscientist and an expert in environmental justice with the Division of Environmental Health Sciences from the College of Public Health at Ohio State University. He brings the environmental perspective and environmental justice perspective and I so appreciate you being here today. Thank you, Dr. Hood.

DR. DARRYL HOOD: Well, thank you very much, Madam Moderator. I'd also like to thank Mr. Chairman, or we call him down here in the Midwest the gentleman from Minnesota.

Yes, and so, we -- I'm sure you all are

aware of the fact that we have a serious problem with regard to infant mortality here in Columbus, okay? And that isn't all that we have distinguished ourselves with within the context of these disparities. And so, we here at Ohio State University have been engaged in an attempt to sort of redefine a different type of science of the health disparities, and that's what I'd like to sort of give you a glimpse of today.

This is one of the latest reports from the Brookings Institution indicating that, of course, life expectancies in the United States tend to be a function of what we might know on the gap and Columbus has once again distinguished itself in this regard. We are number 2 in this particular study with a 27-year difference in life expectancy, and that's based on, of course, the census tracts from which you come, okay? And so, we aren't very proud of that, but we have put together a multi-faceted, functional, interdisciplinary coalition led by Ohio State University with the City of Columbus to address on

infant mortality here in Columbus.

But prior to that occurring, when I came here from Vanderbilt in Vanderbilt Meharry Alliance in 2014, we noticed very, very quickly that there were some significant corollaries that we might want to address. It was very, very obvious that place was very much involved with respect to the disparate health outcomes and the maturation of health care disparities in these high-risk vulnerable communities in Columbus. And so here, consider for a moment if you will, the situation where an individual lives in a network, if you will and that network consists of that individual's community, of course, where that individual lives, works, plays, and, of course, because I'm Presbyterian, prays, okay? So, in the African American community, clearly the church is paramount, okay?

Now, within that network, the individual also has to interact on a daily sort of scenario with his built environment, his policy environment, his social environment, as we're

showing here, as well as the physical environment. And so, over the last six years or so, we have developed a new framework. We call it the Public Health Exposome Framework, which operates basically on -- it's a social life course framework, but what we added to that was big data to knowledge analytics that would give us an idea of the requisite associations, if you will, if not correlations between place and population-level disparities, okay? We've done this over the last six or seven years with several publications where we have sort of illuminated links with respect to place and disparate health outcomes and chronic diseases in cardiovascular disease, diabetes, cancer, low birth weight, preterm birth, and developmental learning.

We'll talk a little bit more about that as we proceed. But this is all with regard to a person's exposure or not to chemical and non-chemical stressors, and that, we know now, is place-based, okay? And so, this framework as I show here, is sort of, as I indicated earlier,

it's a social ecological life course framework, okay, where we sort of contextualize the individual being, of course, in equilibrium with their community and within the context of these domains of the Public Health Exposome, that being physical, built, social, and policy environment.

Now, of course, we have a temporal as well as a spatial component to our framework, as shown here. And, of course, we have not ignored the potential moderating factors that are at work in every community across the United States of America. But, as I mentioned, here we've added to the mix here supervised and unsupervised clustering methodologies. We also used parametric and non-parametric statistical analyses that is typified by the use of very, very discreet combinatorial algorithms which are based on parable analyses.

To give you an example of that shown here, I've simply given you a snapshot of how these spatial and temporal components align very, very nicely with, in this case, the Southern

Community Cohort Study, just one of the studies out of Vanderbilt, and by the way, Bill Blot is retiring next month, and I'm very sorry to see that. But when you look, for an example, at the timeline of recruitment or the SCCS, as we call it, we can sort of look at these components of our Public Health Exposome as it's a 4.0 dataset now -- we're all the way up to 4.0 -- and look at how these align in terms of the natural, built, social environments with, for an example, Social Security index files, state cancer registries, Medicare and Medicaid claims data. It has a repository of about four or five survey waves right now. But under the national environment, you can sort of get a quick look -- a snapshot -- of some of the 20,000 variables that we have curated in the Public Health Exposome 4.10 dataset.

So, to make a long story short, we're able now to -- and I'll give you one example here -- we're able now to interrogate various hypotheses that are both data-driven and otherwise. This is just an example snapshot of

the socio-demographic health indicators in a couple -- well, three communities that are located in the high-risk communities of Columbus. Now, I'm showing you zip codes here, but these are the normal demographic indicators that we generally look at from an epidemiologic perspective, population in terms of race, ethnicity, education, employment and income, health insurance, pregnancy and birth outcomes adverse, infant mortality. Here, you can see we aren't very proud of this, but we're doing something about it. Health promotion, disease prevention, metrics, sexually transmitted diseases, and, of course, chronic diseases. And in the case, as is evident here -- I know this is busy, but I'm sure you have a copy of it -- this zip code, 43027, and requisite census tracts were daunting in this regard.

And so, the Public Health Exposome was used in this instance to sort of identify various socio-demographic and environmental variables that were pretty much associated with all of those adverse health outcomes. This is the agency

metrics shown here where you can see, for an example, some of environmental variables that popped out of the parable supervised clustering methodologies that were used were pre-1960 housing, proximity to traffic-related pollution, proximity to major direct discharges in water -- NPL sites, for an example -- facilities with risk management plans, ozone, and PM2.5. Particulate matter 2.5 microns, we think, in this framework actually serves as a proxy, if you will, for exposures, particularly when you look at inner city urban areas.

And so, we have a colleague at NASA who recent moved. He sort of allows us to extract data from the MODIS satellite so that we get PM2.5 at a 1-kilometer grid now. This is 3 kilometers that I'm showing you, but we have since made innovations to get this down to a 1-kilometer grid. Here's Columbus, Ohio, as you can see here, and the urban areas are in blue.

So, we can overlay multiple datasets, which is what the Public Health Exosome 4.0 is to

sort of look at preterm birth and low birth rate not only in those communities that I showed you but within all 88 counties in Ohio and, of course, EJSCREEN was folding into the Public Health Exposome and when we look at our dataset and when we look at Ohio Department of Health Data, we can then begin to model the complexity of relationships amongst the social determinants of health within the context of environmental variables and factors and, as you see here, this is one such construct -- this model -- where we have actually seen a link and association between low birth weight as well as preterm birth in all 88 counties in Ohio, and these lines are actually correlation points, and so, some of those environmental and socio-demographic variables that I have called your attention to earlier are -- show up right here.

Perhaps, you know, what we're working on now is in fact how to derive a pretty novel cumulative-risk trajectory model for infant mortality. That, of course, will be based on all

of those factors from the built, natural, social, environment. Here, I show you one example, which has on the left axis risk trajectory either increased or decreased, and on the right coordinate, differential resilience trajectories in these individuals because we have heard -- I guess it was Magda Peck or Paul or Steve earlier -- talk about resilience in allostatic load. And so, yes, allostatic load and resilience do feed into this equation. However, if you just simply look at high lead, one example, high PM2.5, and area where high chemical and non-chemical stressors occur, unhealthy diets, no exercise, perhaps the cohort is African American in this case, low SES, and negative neighborhood characteristics, and then juxtapose them to the opposite scenario, one can imagine how a model like this can be used to sort of be able to predict risk trajectories toward any chronic disease, for that matter, okay?

And then, perhaps the utility of the Public Health Exposome Framework can best be seen

here in an exposome-wide association study. This is from a paper that's coming out very, very soon and from the Northeast corner of Brazil, where we used the Public Health Exposome Framework to contextualize associations between social determinants of health and the components of the built, natural, social, and political environment.

These various colors represent, once again, correlation coefficients and what jumps out at you and, of course, this has to do with microencephaly, either plus or minus, with respect to the Zika virus, right? We can see the governance of the macroeconomic policy, income, social policy, education, public policy. This inferential network turned out to be extremely very, very revealing with respect to helping Brazil in its public health policies of, you know, sort of informing them going forward so that perhaps this won't happen again.

But I want to save some time for discussion here, so I just gave you an overview. I'll be happy to clarify in the question and

answer period, and these are many of the individuals that I work with and have worked with over the years, and my NIEHS support, Dr. Collman, is indicated down there on the left. Thank you very much, Madam Moderator.

DR. JEANNE CONRY: Thank you, Dr. Hood. What a fabulous overview and I won't say much now, but actually Sorbonne has some work on iodine uptake and up-regulation of thyroid in light of the Zika research and the pesticide up-regulating the Zika virus. So, there appears to be an environmental component there. So, that was very, very good.

DR. DARRYL HOOD: That certainly is, Madam.

DR. JEANNE CONRY: Yeah, thank you.

DR. DARRYL HOOD: Thank you.

DR. JEANNE CONRY: I did a little flip in our schedule just because Dr. DeNicola is in clinic still, and I'm going to ask Maureen Swanson to be our next speaker.

Maureen, I have known for several years

now and I am just delighted to present her. She is the Director of Environmental Risk Reduction and Project TENDR for The Arc. It's a national nonprofit organization serving and advocating for people with developmental and intellectual disabilities. Most importantly, Project Tender brings together epidemiologists, pediatricians, OB/GYNs, non-government organizations to really look at neurodevelopmental risks in children and it is a most incredible, very focused, but very broad group.

Maureen, thank you so much for being part of this.

MS. MAUREEN SWANSON: Thank you. Thank you, Jeanne, and thank you so much to the committee for this opportunity to speak to you today, to the other presenters, and the two women from Flint. I'm so moved by all of the work and experiences that you all are sharing.

As Jeanne mentioned, I'm Maureen Swanson, and I am Director of Environmental Risk Reduction and Project TENDR at The Arc, which is a national

organization nonprofit focused on serving and advocating for people with intellectual and developmental disabilities.

I co-founded and co-direct Project TENDR with Dr. Irva Hertz-Picciotto at UC Davis, and we are an alliance of more than 50 leading scientists, health professionals, and advocates who come together to act on our shared commitment to keep children's brains safe from toxic chemicals and pollutants. It's wonderful to note that Dr. Conry and Dr. DeNicola and Dr. Woodruff are all part of Project TENDR.

Children in America are at an unacceptably high risk for disorders that affect the brain. These include learning disabilities, attention disorders such as ADHD, autism, and intellectual impairments and children of color and indigenous and in low-income communities are more at risk.

We initially came together in Project TENDR to establish and publish scientific consensus that widespread exposures to toxic

chemicals in our air, water, food, soil, and consumer products are increasing children's risks for lasting problems with learning and behavior, as well as specific disorders such as autism and ADHD. Again, pregnant women and children of color, indigenous, or in low-income communities are often more highly exposed to multiple chemicals and suffer greater harm.

Dr. Hood mentioned low birth weight and preterm birth. Some of these same toxic chemicals that disrupt brain development also can contribute to low birth weights and preterm births, and those outcomes are in turn risk factors for learning and developmental disabilities.

The scientific evidence is overwhelming and continues to mount and we all in Project TENDR decided that this overwhelming evidence demands action. We need to take action because we can prevent the contribution of toxic chemicals to neurological disorders.

And I'll just very quickly because Dr. Woodruff mentioned some of the chemicals, but we

started by looking at some naming what we call exemplar chemicals are prime examples of toxic chemicals where the evidence is overwhelming and the exposures are widespread to these classes of chemicals and metals that are affecting child brain development both prenatal exposures and early childhood exposures.

So, as Dr. Conry mentioned, who we are in Project TENDR is nearly as important as what we're doing together, and that's because we've got such a highly regarded group of people with an extraordinary level of expertise in toxic chemicals and health outcomes and child brain development. I'm the only full-time staff person as the co-director of Project TENDR. Everybody who is involved donates or volunteers their time and expertise and energy to this shared endeavor. And we're received also generous support initially from two foundations with a vision for how to protect children's environmental health -- the John Merck Fund and Passport Foundation, and since then, other funders have added their support.

So, we have 28 scientists. We were very deliberate about bringing together scientists from a range of disciplines, health professionals of different disciplines and fields. We've got epidemiologists, toxicologists, exposure scientists, pediatricians, OB/GYNs, nurses, midwives, neurologists, and then our third prong is the advocates from National Health, Environmental & Disabilities groups, and we especially rely on some of our advocates involved with Project TENDR are part of NRDC, the Natural Resources Defense Council, and Earthjustice, and EDF, and they are fantastic at identifying policy opportunities where we can bring the scientific evidence to bear.

And I should say very quickly this bringing together of these three different constituencies has been so critical to what we've been able to accomplish and a quick example is that we know the scientific evidence is very clear that exposures in utero to fetal brain development from toxic chemicals are so harmful and that's

just an especially vulnerable stage of brain development. And even though we know this and the scientific evidence all points to that for different chemicals -- for phthalates and pesticides and flame retardants, air pollution -- sometimes we don't state that clearly in our consensus documents, and that's where Dr. Conry and Dr. DeNicola and others, you know, ae reviewing those documents and saying oh hey, we've missed an opportunity here to clarify and state clearly that it's the fetal development that's most at risk sometimes from these chemicals and where we need to be protective.

Our process -- we work on a consensus basis, and our process is to first, we form workgroups and translate the scientific evidence into policy recommendations that are published in top peer-reviewed scientific and medical journals. We began with the TENDR Consensus Statement published in 2016 in Environmental Health Perspectives that we all co-authored and signed onto, and that consensus statement was our

foundational document. It was never an end in itself, but it's our -- as I said, it's our foundation for collective action.

And then, since then, we've published articles on specific chemicals of concern. You can see there we have articles on lead, organophosphate pesticides, and on-air pollution, and the impacts on child brain development. We include clear policy recommendations in every article, and then we seek to act to help advocate for those recommendations with policy makers.

In the coming year, we have an article on phthalates that will be published in February, and we're working on a second consensus statement, and then we've got workgroups. We're in various stages of drafting articles that are then reviewed by everybody in TENDR and edited and revised on climate change and neurodevelopment, on disproportionate exposures and health disparities, and on autism and environmental factors.

So, first the evidence, then we seek to take action together on the evidence. I should

mention that in our second consensus statement, we not only identify some chemicals that now we feel the evidence is substantial enough to say these are also exemplar chemicals and that are harming child brain development. But we've taken a -- we make statements and seek to change some of the broader scientific -- the way research is done and the way chemicals are regulated. For example, we will be making a statement in part on replacement that once a chemical is banned or removed from commerce, it's often replaced with a chemical that turns out to be just as bad for children's health and brain development. We also have a set of recommendations on regulating classes of chemicals, recognizing disproportionate exposures and health burdens and assessing cumulative risks.

So, first we work to garner national media coverage on our articles as a way of bringing the issues to the attention of the public and policy makers, and then we take the science to the decision-makers. We hold congressional briefings, we submit comment letters, we hold

meetings with decision-makers to provide the science to advance policy change, and I'll provide an example in a minute. We provide expert testimony on the science, on the evidence on toxic chemicals at the state and federal levels, and our Project TENDR members include this information in their grand rounds and professional presentations.

And some of our results -- and I should say -- this is never Project TENDR on our own. These are all, you know, whenever policy change happens, it's because so many different community organizations and voices like Amanda's and Kinea's and scientists and health professionals and organizers have come together over the course of years to effect change.

But our partners in TENDR from NRDC and Earthjustice have told us that Project TENDR's science-based advocacy has tipped -- really tipped the balance in a number of specific ways including New York and California's state bans on the neurotoxic pesticide chlorpyrifos and in the DOW Chemical, they're now called Corteva -- but it's

their new name. But it's Dow Chemical's decision to halt production of chlorpyrifos by the end of last year. And in federal agency rulings in recent years on banning products that contain PBDE flame retardants and also federal agency rulings on lead standards in house dust and soil.

And very quickly, when talking about the -- when looking at the action that resulted on chlorpyrifos, you can see our process. We published an article on chlorpyrifos -- well, on organophosphate pesticides -- calling for a ban on all organophosphate pesticides including chlorpyrifos in 2018. Then, we worked with Earthjustice and NRDC to turn that article into a scientific letter that was then submitted to every state that was holding hearings on chlorpyrifos in 2019. And then, we also helped or equipped some of our scientists testified in half a dozen states that were holding hearings on chlorpyrifos and the results of all that is that we played a key role in the decisions to halt production and ban that terrible chemical. And now I understand

President Biden has issued an order to EPA to reexamine chlorpyrifos.

We have a policy resolution that calls for increased research on environmental factors for NIH, research and funding to be increased on toxic chemicals and brain development, and that also calls for a focus on cumulative exposures and impacts. And we have recently been holding meetings where we've identified some US legislators and people in the Biden administration who are interested in examining toxic chemicals in child brain development us.

And then, the American Medical Association has adopted our recommendations on eliminating child lead poisoning as AMA policy.

And with that, I'll conclude. What we hope for in 2021, you know, it's a hopeful time and we hope in Project TENDR to continue to bring our collective expertise and action to bear to help result in a future and world where children are no longer exposed to harmful chemicals and there are no disproportionate exposures to

children of color and low-income children and our kids are born into and live in a clean, safe, and healthy world where they can realize their full potential. Thank you very much.

DR. JEANNE CONRY: Thank you so much. You really brought forward on how a collaborative effort really can bring about changes. So, I appreciate your perspective.

We're now going to hear from Dr. Nate DeNicola, who is a long-term colleague of mine. He's an OB/GYN from Johns Hopkins University. He is an expert in telehealth -- so, we've always got him to give us advise there -- with a lot of good information in how it helps improve and change our practices. He is a leader in ACOG and in FIGO. He serves as the OB/GYN representative to Project TENDR, as Maureen said, and to the American Academy of Pediatrics. He is going to focus on air pollution research for us. So, thank you so much for being here, Dr. DeNicola. You're on mute, and I'll unmute you.

DR. NATE DENICOLA: Thank you. It's an

honor to joint this group. So, I will begin with the slides. I just want to see if they are loaded up here.

DR. JEANNE CONRY: Dante, you've got the slides for us to advance or Emily or Emma?

DANTE: Yep, we're pulling those up right now.

DR. JEANNE CONRY: Okay, thank you very much.

DR. NATE DENICOLA: So, like I said, I'm really honored to talk about this topic, and it's such a crucial one because even among the physicians who take care of pregnant women every day and take care of children every day, there isn't always the direct connection between the air pollution exposure that is ubiquitous and these really critical health outcomes. Next slide.

So, what I'll be presenting is the research from a systematic review that we published last June in 2020. So, myself and one of my co-authors is the lead author, Bruce Bekkar, looked at this question in a somewhat different

way. In my roles with ACOG and FIGO, studies come to our attention all the time. Maybe air pollution is associated with preterm birth. Heat might be associated with low birth weight. And we really kind of wondered, you know, what is the overall balance of evidence? Is there enough to make a statement on it? And so, we wanted to investigate what the whole picture was and not these kinds of piece-by-piece studies. We can go to the next slide.

And for a long time, the face of climate change or the climate crisis has been this polar bear stranded on an iceberg. And while I think most may care about animals and want their safety, this might not be something that we can directly relate to on a daily basis. Next slide.

Perhaps, you know, a little more relatable is our weather man, who is, you know, entrenched in these super storms and every few months is speaking in disbelief that yet another one has occurred that should have been an every-500-year-event and yet now is, you know, on a

monthly basis. So, this has become something of a spokesperson for climate crisis also. But I'm going to suggest by the end of this, there's a different face for it. Next slide.

And I think most people here are familiar with the urgency of the problem and the global scale of the problem. This former UN Secretary General says, "Climate change is the defining issues of our age." And it's very much appropriate that we're talking about how this affects the next generation. Next slide.

The medical societies, we mentioned Project TENDR. There's also the Medical Society Consortium on Climate and Health. They are rallying, and they are addressing this issue through collaborations and through professional statements. However, we do still need more penetration of this message to all the members of these organizations. You can go to the next slide.

And this is really the crux of the work that I've done -- that I'll present here is this

connection between the pediatricians and the OB/GYNs. We can go to the next slide. We have a budding OB/GYN in that picture right there.

Both societies have very strong statements on this. The pediatricians have a robust expert committee on environmental health with dozens of publications every year including numerous on climate change. Part of the way that I became involved in this role was to work with the pediatricians who realized across the numerous environmental exposures, by the time their patients were coming to them, they were often a little bit too late.

Really, we had to talk about the prenatal and preconception exposures because an entire generation really is at risk of being born pre-polluted and weakened at birth. So, ACOG joined forces with AAP, and I've served on these roles, and ACOG has also a very strong statement on climate change and women's health. You see things here about a disproportionate effect on global women's health, a call to national leaders to curb

greenhouse emissions. So, statements are there and they're strong. Go to the next slide.

But it's the overall picture and bringing the message home to what you're going to do in clinic tomorrow that we felt needed more attention. So, we wanted to approach this at first as a question of, you know, just how climate change impacts women's health. We very quickly realized that was way too broad of a topic to approach in paper in one research question.

So, we wanted to narrow it down to something that would be ubiquitous that was across the entire United States. so, in California, where my family lives, there are wildfires every few months now. In the Southern United States, there's again superstorm hurricane system every few weeks, it seems like, during parts of the year.

We were most interested in the things that applied to everybody here in the United States, and so, we looked at air pollution and heat as the most common ubiquitous and almost

inescapable exposures. And then we looked to a sampling of the literature to decide what outcomes to look at, and the signal from a brief search was that the obstetric outcomes -- preterm birth, low birth weight, and stillbirth -- had probably the most data around them. So, we framed our systematic review around those two exposures and those three outcomes.

When we first did our search terms, this is kind of a reminder to myself and everybody, before you say there's no data, there's no research on whatever topic, I want to pause because we got 1,800 studies came back on this topic, and we had designed it to really focus on the United States where we felt like the message was important and hadn't been focused yet. That was quite a bite to approach.

As we looked at our specific questions that were to the US population only and only affected these three obstetric outcomes, we excluded quite a few of those. So, 74 were left for full text review, and then a few were excluded

due to the wrong methodology. There was only modeling, for example, no acute observation, or some looked at other obstetric outcomes and then only peripherally talked about preterm birth. So, preeclampsia, for example, has also been studied, and several studies were excluded because they looked at preeclampsia and then how that contributed to preterm birth. So, we didn't count those. So, as you see, we ended up with 68 studies for over 32 million live births. Go to the next slide.

The first exposure we'll talk about is air pollution. You can advance, next, yeah. And here, we did not do pooled metanalysis because the varying types of air pollution did not lend itself to that. It would have been really kind of a disingenuous presentation of the date from all the different ways that PM2.5 can reach someone. But what we did want to do is tabulate kind of just the balance of the evidence. You know, where were -- where were the studies divided by the outcomes and what was the overall tabulation.

So, we looked at air pollution exposure in the United States in these observation studies. There were 24 that looked at preterm birth and 19 of them showed a significant association. In total, there were 7.3 million births in this one. And the range for increased risk was maybe not the tightest, but it wasn't, you know, far varied either. It was right around 11 percent.

For low birth weight, there were 29 studies, 25 of these studies showed a significant association. Again, 19 million births in this one with about the same increased risk, 10 percent.

You can see for stillbirth, 4 out of 5. There were fewer in this one. Go to the next slide.

And in addition to the obvious medical costs to this, which is, you know, often times lifelong disabilities due to prematurity, you can calculate the economic cost of this as well. So, Dr. Trasande did a systematic review looking at what percentage of preterm birth could be attributed to PM2.5 in the United States, and they

assessed that about 3 percent of preterm births here were due to that, which results in $5 billion of cost, $760 million of those are medical care. Next slide.

And, in our research, we also found some good news. I do not want this all to be doom and gloom. This was in our conclusion because it was not -- it did not meet criteria for our systematic review, but it was one of the more important findings, which was when you remove an exposure, does the outcome change. That was one of the most important questions for any association outcome. And here we saw from the experience in California over a 10-year period when they retired coal power plants, the preterm birth rate dropped 27 percent. Whenever I present this data to maternal-fetal medicine specialists, they look with genuine envy at the ability to have intervention that could reduce the preterm birth rate near 25 percent. Next slide.

We also looked at heat. I won't spend as much time on this, but I think it's important to

include it because they actually are related. This concept presents a heat island. A heat island is something that I think people are becoming more familiar with, but basically it's the phenomenon that different parts of a city have more concentrated amounts of heat and that affects the people who live there differently, and due to the way city planning has happened over the last decades and centuries probably, the minority communities are disproportionately affected by these heat islands. Next slide.

And so, when we look at our data on heat, there were definitely fewer studies in these categories. Preterm birth 4 out of 5 showed an association, low birth weight, all three showed an association, and stillbirth, all three showed an association. So, compared to air pollution, it's a little bit smaller. Overall, again, the numbers are not exactly paltry. You know, 800,000 in one, 2.7 million in the other. And so, we would present this as an important message also because it is a ubiquitous exposure.

And there does for heat to be something related to the timing in pregnancy. Several studies showed this, and so we called it out as one example that in the week before delivery, every 1 degrees of Celsius increase was associated with a 6 percent increased risk for stillbirth. And this was true across most of the exposures. We can go to the next slide.

So, I mentioned the disproportionate effect on communities living in the heat islands, which are mostly minority communities. There's another important finding from this study, and this was not our initial question or initial objective. But once we started seeing it here, we did keep track of it. And we present the number of racial health disparities found across all these outcomes. And as you can see, it was -- the majority of studies that looked it did find this association hold true, even accounting for other things that you might expect. So, all of our odds ratios listed should have a little a in front of them. They're odds ratios for things like

maternal age, socio-economic status, education. All those things were accounted for, and this still persisted. Go to the next slide.

And so, really, that's become one of the essential messages of this paper. The day that our paper was published, the New York Times ran the study that climate change is not only tied to climate risk or to pregnancy risk, but it also affects black mothers the most. Next slide.

And within 11 hours, then Presidential candidate Joe Biden was tweeting this exact message, which definitely brings, you know, a lot -- a lot of audiences and a lot of credibility to it. Next slide.

And so, we are not surprised to see that one of the first things that he took attention to was to bring the United States back into some climate policies. Go to the next slide.

Now, there certainly are messages that we can work at and look at from the clinical perspective. You seeing me wearing my white coat here, I'm in between patients, and I'll be talking

to patients about this later on today. I can talk about dehydration; I can talk about not exercising outside when there is heavy amounts of air pollution. Next slide.

But really, there is only so much that we can do there. So, I'll present there here very briefly just to show that, you know, we have done this kind of systematic and government approach to health and the environment in the past. Some people credit the picture of the moonscape or of earth rise taken from the moon on the cover of the 1969 Time Magazine as motivation for looking at earth as a whole and bringing about all these environmental policies from the Comprehensive Clean Air Act all the way to unleaded gas. Next slide.

And, you know, we're not talking about COVID a lot, I don't think, in this talk, but there was a clear pre-post looking at the amount of emissions we can reduce when we try when we have to. This picture of Heaven Temple in China, and these are very true to form pictures. Next

slide.

And so, we must do this kind of system approach again. And I think, as presented here already, there are numerous examples from Project TENDR, the Consortium, single-use was the Merriam-Webster word of the year in 2018 because of single-use plastic. Next slide.

Because this is what we're seeing not only in Washington, DC, but all around the world, that moms are demanding a different future for their children. And this, you know, there's a lot of -- I don't if you can see this -- but those shirts say it's getting hot in here on their pregnant bellies. Next slide.

And so, the image that I want to leave with is a different spokesperson for a healthy environment. We don't have to look just at polar bears and to the weather man getting drenched every few weeks. Really, you know, we need to look at the environment that a mom is exposed to as the beginning of the next generation. And so, we have this message here that "Healthy Mom,

Healthy Baby, begins with a Health Environment."

Thank you so much for your time.

DR. JEANNE CONRY: Thank you so much, Dr. DeNicola. What an unbelievable viewpoint and really, you brought together the science, the health disparities, and a vision for where we need to go in the future. So, thank you very much.

Our next speaker is Dr. Linda McCauley. She is a global leader in environmental health and the dean of Emory University School of Nursing. She has conducted extensive research on environmental and occupational hazards on health and created the Children's Environmental Health Center at Emory. Dr. McCauley, thank you so much for joining us today.

DR. LINDA MCCAULEY: Thank you so much. Dante, do you have my slides up, please?

DANTE: Yep, we can pull those over right now.

DR. LINDA MCCAULEY: Okay, thanks. These presentations have been fantastic, and I hope everyone is enjoying them. There is certainly a

lot to digest. The science is immense and I've spent the last 25 years of my professional career working with scientists and studying pesticides, climate change, an array of environmental exposures. But in the last decade, I've really come back to my nursing roots with really emphasizing that our scientific work can only go so far unless we really can impact communities and pregnant women and children and for those of you who were on early and heard the mothers from Flint, Michigan talking, I'm kind of going to bring us back to that while we do the work we do and the stories that we hear from the community. Next slide, Dante.

So, at Emory University, we're located in the deep south. Having a children's environmental health focus in that area is so very important because of the stereotypes and the history that's entrenched in the deep south. The racism, the legacy of slavery in the south, the distrust of so many of our neighborhoods and our communities. And so, when you're a scientist and you're really

wanting to know that your work is making a difference, there can be a huge barrier between what takes place in academic walls and the community context.

And so, it's not just the importance of our science. It's in the context of everything surrounding people and where they live, as our colleague from Ohio State described earlier. And so, environmental justices drive everything we do with this type of research. It drives the social determinants of health that are so important to our research programs today. This map that's in the lower righthand corner is just Atlanta, and if you want to see segregation, Atlanta is segregation. Everything that's blue are Caucasians. Everything that's green are African Americans. You can see that you're dealing with a highly, highly segregated community with a lot of distrust and even though they know they're at high risk, sometimes you have to work really hard with the context of that knowledge to really ever effect change.

And we're seeing it with COVID-19 today. There's no doubt that our African American populations are aware of the statistics for COVID and severity of the disease. But yet, we know in pushing out the vaccine, where are barriers are going to be with different communities. So, next slide.

So, one of the things that I love about being an environmental health researcher and a health provider is that I can -- I have this professional benefit of being a trusted health care provider and also as being a mother, I know how important health literacy is and how important environmental health literacy is, and how can we leverage the power of communities to help us become more environmentally health literate so that what we are learning every day as scientists, our communities take that, integrate it, and understand its impact to their lives. And so, this is hard work -- it's very hard work. It's multidirectional, and it's nurtured over time. But there's no doubt in my mind that we, as

scientists and health providers, can influence not only policy at the global and the national level but in the lives of families every day in what they do. It is absolutely trans-disciplinary where we have to work together and you're never fully done with this. Just when you think you've got your feet on solid down, you've got trust in the community, I can guarantee you they'll be a slipup. You have to reassess, you have to back up, you have to sometimes apologize, but you keep working.

And then, there's a philosophy that all the data that we've seen and heard today in this session, health providers and scientists need to realize they are not the ones to filter what individuals, families, and communities can hear. We have to trust the communities that we study that they own their data. Our challenge is to make it interpretable in a way that they can integrate it and use it. And so, it's very difficult work that you have to really examine closely, the tone you use, the context and how you

deliver messages, the visuals that you do, and in the issue of maternal mortality and infant mortality, moms are the gatekeepers. If you don't have that mother's trust, you will never effect change in the lives of people. Next slide.

So, what we try to do every day is we have a lot of health providers on our team. We also talk about environmental scientists to our health providers, whether it's med students, PAs, nurse practitioners, nurses in general, we talk about the history of obstetrics, we talk about the history of the workforce. Right now, there's some wonderful work being done at Frontier University in trying to bring diversity back into the nurse/midwifery workforce. The nurse/midwifery workforce became a very white workforce and Susan Stone who is the President of Frontier University has a professional mission to reverse that because pregnant women need to see care providers who they trust understand their lives, their communities, and their challenges.

So, we do a lot of reading around racism

today. We have our care providers of color educating those of us who are not underrepresented, we are purposely hiring black midwives, we need more black OB/GYNs. This is really critical, and you have to be able to accept criticism. Because I am a Caucasian woman, I have to own that, and when I sit down with communities of color, I have to bring a sense of humility into those discussions and work in very small ways to build their trust because their initial reaction would be why should we trust you with everything that has gone on in our history. And so, that's why I now believe it all comes down to communication and trust. And when I write grants now, it is promoting the trust that the community has of me to assist them in maintaining projects that are meaningful to them and also to give resources to the community. And sometimes those resources might mean to have a program in a high school where you're teaching -- you're giving resources to teachers in a high school who are more likely than a health provider to see a young

adolescent woman of color who needs education about preconception exposures. And there is, I think, I can tell you nothing is more joyous as a nursing scientist than to partner with the communities, invest in ways that communities can begin to address their own problems, and find solutions that work for them.

So, there's many, many different ways to build this trust, but it's absolutely essential that without it, we can't move forward. Next slide, please.

So, when we started doing this work in Atlanta, there wasn't -- no one had really studied the environmental exposures in the city of Atlanta. It wasn't like a lot of our larger cities in the United States where the disparities and environmental exposures had been studied for decades. We didn't know when we started this what we would find in the African American population in Atlanta. But we did know that we were seeing the health effects, the maternal deaths and the infant deaths. But when we started talking with

the community, the areas that they were concerned about -- lead, air pollution, and the endocrine-disrupting chemicals that Tracey started out our afternoon talking about, the personal care products, the cleaning products that they use every day -- and one of our strongest partners was the Center for Black Women's Wellness all of these -- these are health providers connected with the community who did all the focus groups for us in our partnership. Next slide.

So, as we worked with the community with our Children's Environmental Health Center, we had the science going on step by step as we did the community engagement and outreach, and we did find some very interesting things about the exposures in this population. First of all, we knew their prematurity rate was 17 percent in our total cohort, which is about almost now 500 women and their babies. But there was a difference. The women delivered in two hospitals. One is safety net hospital Grady, and then a hospital that's affiliated with Emory University, and there was a

disparity between the premature rate in the women who delivered in those two hospitals. We also found a difference in certain exposures like the paraben exposures, which are found in a lot of health and beauty aids.

Women who delivered in the private hospital had three to five times higher levels than nurses that -- women that delivered at Grady. It was reverse for BPA. So, these were all -- these differences are probably related to lifestyle differences. And so, you really have to get to know these women very well.

We found some interesting things about as we built trust with these women that they would be so candid talking to us about marijuana use during pregnancy. And interestingly, we found a significant association between marijuana use and cotinine levels. So, this could be a woman who doesn't smoke on a regular basis but reported using marijuana while she was pregnancy. And so, it raises very important questions not only for the scientist but for the community in terms of

why we found that.

So, those are just some tidbits of things that we're finding, and we don't know the answers, you know. The science is there but we can't always explain things to the community. But that doesn't mean we don't reveal things to the community. It's as fine for them to deal with uncertainty as it is for the scientist to deal with uncertainty. Next slide, please.

So, we're very fortunate at Emory to have a PEHSU, which is Pediatric Environmental Health Specialty Unit, that is region 4 -- EPA Region 4, Southeast United States. That is our partner with engaging health professionals. So, we do work with our academic programs. We work with some health systems. But PEHSU really gives us a strong platform to connect on a regular basis with larger numbers of health care providers. And so, every health care provider can and must be an advocate for moms and babies. So, it's not just pediatricians or OB/GYNS. We need to level all channels, resources, community health workers,

bringing different and diverse opinions to the table and develop meaningful messages to go back in the community.

So, if you have a chance to ever work with your PEHSU network, it's just a phenomenal resource for scientists and community groups who are in this working together on this challenge. So, next slide.

So, basically what I want to say before Gwen sums this up for everyone is as scientists, as health care providers, as advocates, we have to listen. Never stop listening, and to be in it for the long haul. Your focus might change from one type of environmental exposure to another through the years but the process of building trust and partnering with the community takes time and remember that it's only with these open communication channels that we can ever effect change -- meaningful change and have some type of impact on maternal and infant deaths and morbidity.

So, thank you.

DR. JEANNE CONRY: Thank you so much, Dr. McCauley. What a fabulous look at community health, the community perspective, and how important it is to just listen and communicate. Your message is absolutely right on where we need to be and where you've gone. So, thank you.

I love your comments about the PEHSUs. When we met with them several years ago, we said gosh, can't we just rename them PREHSUs and have it Pediatric and Reproductive Health because they are so well-coordinated across the United States.

Now, it's my great pleasure to introduce who I call our closer. I've got the greatest respect for the National Institute of Environmental Health Science, their ability to see that large and powerful field of environment and health, the basic research that even gets down to the molecular role of disease and environment. Dr. Gwen Collman is the Acting Deputy Director of NIEHS where she formulates and implements plans and policies. They consider so many research projects, decide where the funding is going to go,

and then follow up on all that. And I know several of you have already mentioned your relations to NIEHS.

So, Dr. Collman, thank you for being part of this panel.

DR. GWEN COLLMAN: Thank you so much, Jeanne, and I hope that you can all hear me. It's a pleasure to be here, and it was actually a great pleasure and honor to work with Dr. Ehlinger and Dr. Conry on organizing this session. I personally have great passion for this topic, as I have in my -- throughout my career have worked in program development. Before I became the Acting Deputy Direct of the Institute, I was the Founding Director of the Children's Environmental Health Centers Program back in the day and then recently finished a stint as the Director of the Extramural Division of NIEHS.

So, I'm going to tell you a little bit about NIEHS for those of you who are on the call that may not be as familiar with us and the work that we have been doing for over 50 years. We're

the only NIH institute that's in Research Triangle Park, North Carolina. The mission of our institute is to discover how the environment affects people in order to promote healthier lives. So, we have a very much prevention framework, especially in this field related to the health and well-being of children and their development, we think prevention is paramount, right? Environmental exposures that don't get into your environment as a pregnant woman or growing fetus, you know, will lead to a better start in life, and we're all about figuring that out.

So, our institute has many components that are common to the NIH. We have intramural laboratories. We actually have two intramural programs. We have extramural funding in this area of maternal and child health. But, of course, in every disease area and covering a wide variety of exposures that we find in our environment.

We are the home of the National Toxicology Program, which is an interagency

collaborative program and one of our intramural programs, the Division of National Toxicology Program is the power horse of the research science that feeds into work with NIEHS and FDA and several other partners across the federal government.

We have our own clinical research program at NIEHS because we -- and actually, we have one at the clinical center at the NIH campus in Bethesda. Some of that work is focused on pediatrics, but it's all focused on how the environment affects aspects of our health.

So, I would say that for the whole lifetime of the NIEHS from its inception, we've been -- one of the areas that we have focused on to great detail is developmental toxicology and also building a framework in the population sciences in order to study the effects of environmental exposures through the lifespan. And as we -- as everybody has said today, studies of how environment impacts reproduction, the pregnancy window, and then early life of children

all the way through adults is critical. The combination of exposure time period, the genetic susceptibilities that we may have that make us more prone to the effects of exposure are all important. And another enormously important pillar that I think you've heard through the others speakers is that I think -- I hope -- I think that I can say that NIEHS pioneered these approaches under the direction of our past Director, Dr. Kenneth Olden is really working directly with community. Listening, partnering, working together, and translating the science and all of the things that we discuss today related to policy outcomes and all of that, I believe -- and I think the leadership of NIEHS over the many years believes -- that can't happen unless you have strong trust, strong partnerships, and you work hand-in-hand with your community partners.

So, the NIEHS and EPA Children's Environmental Health Centers program is really -- may be the cornerstone program at NIEHS' extramural work, began with a strong partnership

back in the late 1990s with EPA after there was establishment of legislation looking at EPA did a major report looking at the impacts of pesticides and other exposures on the health of children, and we started a collaborative extramural program with them in 1998. It had many iterations over these 20-some odd years and we built a large cadre of research in many areas, both experimental laboratory based work and mechanistic work on the chemicals of interest, the field of animal and clinical toxicology were brought to bear, and we also funded over -- I think it's over 16 birth and child cohorts where we studied the health of the mother, followed through pregnancy, and then have been following up the children, and many of those studies are still in place as those children have now become young adults, and we've been able to look at the trajectory of exposure by really characterizing the pregnancy exposure or all of the different factors that might affect the pregnancy including chemical contributors as were mentioned by many of the speakers today.

So, I think this program in itself was really seminal. It taught us a lot about what was going on in the field, and it led us to think about it in three important areas -- the research, the training of scientists, and the partnership of educating community members and researchers in the bidirectional work that we've been doing, and then also the translation of the research findings to a number of different impacts and outcomes.

So, this is just a slide to show you the distribution of all the children's centers across the country. There were -- over its lifetime -- over 20 different centers, some still in existence today, some which became really foundational components of the universities which they were funded and live on and have expanded in many other ways than just with dedicated funding from the EPA or NIEHS. I'd say they were really -- that we built some good foundations and cornerstones of this kind of work in all of these universities and the partnerships that each of these universities made with the communities have been very long-

lasting and have resulted in many outcomes.

And you can read about all of these outcomes in a report that EPA and NIEHS put out towards the sort of final days of the children's centers program. It's called -- we think of it as our impact report. It shows you a lot of metrics and a lot of outcomes, the vast broad nature of the exposures that were studied, the populations that were included, and the health outcomes across that wide range of pediatric, pregnancy, and childhood-related environmental health. And I think we sent that out to the committee, actually, in preparation for this meeting. There's a lot of really good stuff in that report.

So, I -- the next several slides are really just a long laundry list of stuff that we, as NIEHS, do. And let me put it in context.

So, one of the main -- we're one of the main funders in the biomedical resource world for this area of children's environmental health, and I would say that we -- I like to think that we had an important influential role in sort of creating

the field, not necessarily saying that, you know, we're so proud of ourselves because we're focusing on pediatric research. But I think we have the unique lens to bring together the different disciplines that were necessary to be at the table to add the study of the wide range of environmental and social factors that impact the health of the mother, of the child, not only during those early days but all the way through their lifetime.

So, there's always been a lens on disparate exposures. The role of our understanding of environmental justice, as many of you have discussed today, has always been very front and center in our work. We have partnered with other institutes at NIH for several of these programs. We've partnered with other federal agencies, strong partnerships with the EPA, CDC. Although we never funded directly the work of the pediatric specialty units that Linda just spoke of, we've always partnered with them and we've had many joint meetings with the PEHSU network and the

Children's Center network in order to facilitate that translation of information. And this year, PEHSU came to us -- the CDC came to us asking if we could create a program that would help in training in a gap area that they identified, and I'll talk about that in a second.

Also, things on this list are not -- we're not only in the borders of the US when we talk about the impacts of environmental impacts on women or on pregnant women. The Household Air Pollution Clinical Trial is in four different countries and is funded collaboratively with the National Heart and Lung Institute and the Fogarty International Center. That focus is on biomass burning, which is the main cooking approach in the developing world, and the impacts are very great on the health outcomes to the women themselves while they're pregnant as well as the babies that are born living in that environment.

Our Superfund Research Program has a strong focus on maternal and child health. Our intramural programs also have research groups in

perinatal and early life research. We have supported birth defects research with our partners at NICHD and the National Toxicology program. This last year, the Office of Research on Women's Health and the National Institute of Child Health and Development led efforts in maternal mortality and morbidity, and next month, there will be a special edition in the Journal of Women's Health that has, I think, it's about sixteen different papers from representatives from each of the NIH institutes and centers focusing on a variety of different issues and questions, and we at NIEHS also have a paper in that special issue as well.

Most recently, we have started to study the placenta in more detail, understanding that that's a critical organ in development and we know that the environment factors may cross the placenta or may impact the placenta's function and growth, and we have always, in the course of all these programs, had a focus on developmental disabilities. We partner with the other ICs at NIH around autism, and we've had many successful

programs looking at environmental exposures and autism risk. And there was legislative language last year or the year before focusing on Down syndrome research, and NIEHS funded several groups as part of that program, adding on environmental health hazard risks in Down syndrome studies.

The next area is training, and I mentioned that. So, we can't have a robust research trajectory here if we don't keep our minds on training the next generation of scientists and clinicians. And each and every one of them, whether or not they want to focus on environmental health as their own research area, really need to have the basic knowledge of the environmental hazards out there and be able to use it in a variety of different ways across their own careers.

So, the Pediatric and Reproductive Health Scholars Program is that program I mentioned with the PEHSUs. We're going to be funding fellows that have a connection with a PEHSU and in other areas that may have had other children's

environmental health funding, both to get clinicians more trained in environmental -- in children's environmental health and reproductive environmental health but also work on those translational trajectories. We have post-doc opportunities; we have early career investigator program as part of the children's centers but also as part of just the big portfolio at NIEHS.

And then, right now, we are in the process of reviewing a brand-new funding announcement and we will make awards later in the year. We have pivoted our focus from continuing the centers program as a research group to say we funded a lot of really formative observational and intervention-type work through those programs, and we want to get that work into the hands of the people who need it -- the public, the health care providers, our policy makers, other scientists, scientists who are, you know, in the pediatric environmental -- excuse me -- the pediatric research, or in the reproductive research worlds that have not yet even considered environmental

health as part of the causal web of the work that they're doing.

And also, we have had for over ten years now, an organization within our NIEHS called the Partnerships for Environmental Public Health, which is really a hub for a lot of this translational work, not only on infant mortality and maternal and child health, but of course all of the full spectrum of environmental exposures, populations, and really focusing on moving across. If you look at our little spider web design here of our framework, you know, what we really want to see happen is research in the purple, which is observational research and mechanistic research, moving it out along the translational spectrum so that you move from purple to blue to teal to black, and you see how that work can move in new directions to make change in the clinical outcomes, population outcomes, policy outcomes.

We also think that this framework is useful that if you see something at the policy level, you can then backtrack research to

understand the mechanisms of why these associations that we are seeing in our communities, what's the scientific and biological basis and hopefully that will help us to design prevention and intervention strategies.

So, I'll, I think, leave it there. I will say in closing that NIEHS has been happy to play the role of the funder and the thought leader, helping design frameworks for the researchers to be successful. We've invested in tools, technologies, resources, populations. We're looking now towards moving from observational or documenting these hazards to more interventions and policy implications, and we think our research framework -- research translational framework will help us to move in the future, and we look forward to working with other sister agencies across the federal government and in other spheres that this committee has purview. And we're always available for consultation in any way that you might need us. Thanks for including me today.

DR. JEANNE CONRY: Thank you so very much, Dr. Collman. What a great closing to show where the research funding is coming, the directions that we've got.

So, I appreciate this wonderful panel, and Dr. Ehlinger, shall we open it up for questions and I think we've got about fifteen minutes if I looked at our time properly. We've got fifteen minutes, and then I do have a poem I wanted to share. But we thought we'd get everybody up and moving as the poem plays just because we need to move.

DR. EDWARD EHLINGER: Yeah. Well, let's do some Q&A, and you can lead that.

DR. JEANNE CONRY: Okay. And Tara, I see your hand up.

DR. TARA SANDER LEE: Yeah. First, I just want to thank Gwen Collman for her talk. That was really interesting. I have a very kind of geeky science question, and I apologize. But you had mentioned the genetic susceptibility to environmental exposure, and I think that is a

really important point. I've done some work previously with genetic testing and pharmacogenetics. So, I'm wondering how -- just kind of as we look at this with environmental exposure and how people -- how this might be translated into policy -- how do you see -- perceive building into your framework any pharmacogenetic studies that you are doing? Because I'm assuming that you are doing a lot of pharmacogenetic studies looking at race-specific differences and how different people might be more susceptible to certain chemicals and have more toxic outcomes. So, can you kind of explain to me a little bit kind of what you've looked at?

DR. GWEN COLLMAN: Sure. You know, it's hard in a few minutes to go through the full breadth of what we support and all of the creative ideas of the scientific community. But be assured that for this topic and all of the topics of how environmental exposures and environmental chemicals affect health, we're employing the sort of full range of scientific disciplines. So, the

mechanistic work. We have many study investigators who have population studies that have collected DNA samples or are looking at epigenetics as genetics and genomics markers of the impacts of these exposures. We have resource centers for investigators to bring up samples, and we will be able to use omics like metabolomics and epigenetics and other omics to fully characterize the populations that are being studied.

And in our intramural program and in the world [inaudible] there are many investigators who are looking at a specific chemical and specific outcome and going very deep into trying to understand the mechanism of how these exposures cause -- biologically cause the outcomes that we are all interested in. So, it's too many to look at in [inaudible] but be assured that we're using all the tools of the trade here to understand these factors.

DR. TARA SANDER LEE: Great. Thank you. That was great, just general summary.

DR. JEANNE CONRY: Tracey, do you want to

comment too? Yeah.

DR. TRACEY WOODRUFF: Yes. I just want to follow up because there's one thing, I think, actually I was remiss in not mentioning, which Linda McCauley is also involved in is that NIH is funding the EICHO Consortium, which is Environmental Influences on Child Health Outcomes, which is focused on environmental factors and one component is environmental chemical exposures. It's a consortium of about 50,000 children and it is the evolution of the National Children's Study. It has about 70 cohorts that are linked across the United States. Linda and I both have cohorts in this, and in there, we actually have some really amazing resources around looking at a broad range of environmental chemical exposures. There is also going to be a genetic component to this and we have been over the past six months having a special emphasis on issues around race, ethnicity, and health inequity.

So, I just wanted to point out that that is another program that's very important and also

your question just raises that the issue of how we take this issue about genetic variability and then make it actionable is another area that I think we've done a lot of work with. That is the kind of thing that also can go to EPA, who actually takes, you know, has primary regulatory focus on these issues.

DR. JEANNE CONRY: Thank you, Tracey and Gwen. Next, I'll ask Belinda to ask her question, and you're on mute.

MS. BELINDA PETTIFORD: Thank you, Jeanne, and thanks to all of the presenters. To me, this session was very interesting, so I want to appreciate and thank you for your time.

Dr. McCauley, I was particularly impressed with your experience and understanding of environmental justice and how important it is to listen to the community and the voices of the individuals that are being impacted.

But my question is for Dr. Collman, because you mentioned in your presentation toward the end around community engagement core, and can

you share a little bit more about how you are defining that, and does that -- is that a requirement of all the funding that comes out of your office that community engagement is a critical component of it and again, how are you defining it?

DR. GWEN COLLMAN: Thank you very much for that important question. So, you know, there's a methodology to include communities and many kinds of population studies. It's a community based participatory research framework and it's considered in some circles as a gold standard. It requires trusting partnerships, full engagement of communities, equity in sort of design of the work, full buy in at all the levels, and I think Linda alluded to many of the components there. And we have supported a lot of work using that framework. But we think it's aspirational, right? We know that there are a lot of communities that aren't there with their scientific partners, and there are a lot of scientific partners who could get there, but it

takes years of work, working with communities to see the viewpoint, understand, and appreciate, and then work as real equal partners around any question.

So, our partnerships from environmental public health umbrella program is really meant to start somewhere with your partners, form those teams, and move in that direction, understand the principles, bring everybody to the table, work on compelling and important issues that the community wants to, you know, and need data for a variety of different things, and that's why, in that translational framework, you know, you can move all the way around as you're building up all of the partnerships.

So, we used to call it a community outreach, and we thought that wasn't the right terminology, because it implied that one group knew more than the other and we were going to give information to those others and we really understood over time that it's engagement. It's bidirectional communication. It's building trust

on both sides. It's building knowledge on both sides and then working together.

Under the leadership of Linda Birnbaum, who was our previous director, she insisted that every single one of our landmark programs -- and we had about twelve of them -- sort of evolved to include community engagement and have a community engagement core so a part of the research grant where this kind of synergy could happen and then that could frame the work going forward.

So, now every single one of our large center programs at NIEHS is required to have a community engagement core, and we work with people who are funded using other mechanisms to promote this concept of community engagement and we work with it and on it and for it in lots of different ways, you know, multiple levels at the institute.

MS. BELINDA PETTIFORD: (Inaudible -- audio difficulties) happens when they leave the community because, you know, I have worked with CBPR processes before. I'm in North Carolina with you. We've been in North Carolina working with

some university partners and with our Healthy Start programs and pulling that in, and one of the challenges that tends to come back to if you don't share the power on the front end and you don't share that [inaudible] on the front end, then you leave a community not better off at times and you [inaudible]. So, the next time someone comes in and wants to work with them, they may have the expertise, but they just been left in a bad, you know, with a bad taste in their mouth because it just didn't work. So, it's making sure that all of that is, you know, shared on the front end and not an afterthought or not even shared at all.

DR. JEANNE CONRY: Belinda, what a great observation and I love, Gwen, you saying engagement and the bidirectional statement there.

I'm going to ask Ed to have the next question, then Magda is after Ed.

DR. EDWARD EHLINGER: Well, thanks to all of the panelists. These are great presentations. Sort of overwhelming, and so the question I have -- well for myself -- is how do we put this into

some usable format? But my specific question is to Dr. Hood. Given my experience in local and state government and public health and given your place-based focus and your work really in Columbus, which is one of those places that has a huge problem with disparities, how do you work with local public health and state public health, the actual -- and with city government and county government and state government to put a lot of the data that you're having into practice? How do you engage with those organizations?

DR. JEANNE CONRY: And we've got you on mute, Dr. Hood.

DR. DARRYL HOOD: Yeah. Can you see that?

DR. JEANNE CONRY: Yeah, yes.

DR. DARRYL HOOD: Okay, good. And so, this is -- I anticipated that question, Mr. Chairman, and this is how we do so. As Gwen Collman was just talking about in terms of community engagement models, we have a functional multifaceted, interdisciplinary framework. It's a

CBPR a little enhanced, if you will. And so, for an example, you just mentioned Columbus Public Health. Well, here they are here, okay? Let me just go through the organizations that comprise such a framework that allows you to interface with state and local government -- here's Ohio Department of Health. That's state. We're here in Columbus. Franklin County Health Department is right here, okay? We have two terrific intervention programs, Moms To Be, which is, of course, that program headed by Pat Gabby and Steve Gabby from Vanderbilt. They came here about the time I did, back here from Vanderbilt, okay?

Celebrate One, I think Steve mentioned, and all of the -- I heard you all's discussion earlier with Magda, Paul, and Steve Calvin were discussing the bundles that we need -- that should be there and how important it is for a child to make it to 1 year old. Well, Celebrate One is our quintessential program and that's the city overseeing that. The YWCA has a program, Columbus Early Center Program, that's our nursery and

kindergarten COVID-19 developmental slide pilot program, right, because it involves mass that is transparent, and of course for depression and so forth, St. Vincent's Family Center. We have a federally qualified help center, Primary One, and the largest Medicaid provider in Ohio known as Care Source. All of us work together.

This is a functional, interdisciplinary collaborative that interfaces with all of those communities in those census tracts that I showed you. That's the short answer.

DR. JEANNE CONRY: Thank you. That's a great answer.

DR. DARRYL HOOD: Yeah. The scheme there is the community individual and population level, but it would take an hour for me to go through that. Thank you.

DR. JEANNE CONRY: I'm going to ask Magda. Thank you very much, Dr. Hood. That was a fabulous example of the collaboration that we need. And Magda, and after Magda, we're going to have our poem.

DR. MAGDA PECK: Well, first of all, wow. Let's take a breath and wow and thank you. I want to have a comment and then a question.

The comment is the consistency across this entire almost two hours starting with the voices of extraordinary courageous women, hearing about -- from Tracey about the triple jeopardy around exposure and social vulnerability and then biology, hearing from Darryl -- Dr. Hood about with courage a policy environment of physical environment, built environment, a social environment, each of them of course again hearing from Linda about the levels of engagement reinforced by others.

I could summarize more deeply, but you all have embraced the complexity of this in a way that could be daunting for others and I am curious in your courageous vision of integrating systems across places, across time, across disciplines, how -- how can you envision that SACIM with a primary and dedicated anchor on the prevention of maternal and infant mortality can be an

extraordinary partner at this time for you? So, the offer is yes, we are and you get the breadth that we're looking at and we bring this one very essential anchor window. And so, I'm going to hope that you will come back to us and help us with all of your orientation be able to say here are the three things we sure hope you would help us recommend and take on. So, that's my comment is that now that we're stewed in it, we shared a lot, what's next.

My question -- putting on a very narrow hat. As a recovering academic and former dean of schools in public health, I'm particularly interested in how you are investing in education training fellowships. Some of you talked about bringing in implicit bias and systems, anti-racism, [inaudible] work. You've been talking about training a whole new level of fellows to understand this complexity. You've been doing EICHO-friendly trainings. How do you envision integrating our need to bring a workforce up that gets social, environmental, political determinants

of health? The whole notion of complexity of this triple jeopardy together with now adding on top of that the lens of environmental health. Can you imagine infusing or training that brings both together and if you already are, how are you doing that so it doesn't become environmental health here and anti-racism and social determinants of health over here? Just looking at how we get a new generation forward. Thanks for letting me take the time.

DR. JEANNE CONRY: Tracey, did you want to say something?

DR. TRACEY WOODRUFF: Well, you're really speaking -- I'm going to talk about your educational training component, because you're really speaking to something that we pioneer here at UC San Francisco. So, you know, we have professional school, medical school, and when I first got to UCSF, our goal was to bring environmental into the clinical community. I'm sure you're all familiar with UCSF as a powerhouse medical health sciences institution and they did

nothing on environmental health pretty much before I got here, and it was the chair, Linda Judy, who in partnership with me and Jeanne, we really made this happen in OB/GYN. So, the clinical opinion that you heard about -- ACOG and ASRM -- our strategy was how do we create a systemic change through recognition of the health professional society? From there, we can build on that to embed environmental health within the clinical community.

So, one thing that we have done is that that committee opinion weighs out the strategy that we've been following which is with policy engagement, and Jeanne could go on and on and on about what a great partner ACOG has been on very specific environmental health rules, laws, and regulations both nationally and in California and improve our research and then our training.

And so, UCSF for multiple years had dedicated lecture to medical students in the second year of medical school. We've expanded that to have a mini-immersion week. We're working

-- part of our funding that we get from NIHF is dedicated to expanding environmental health curriculum and social justice is going to be a primary focus of the medical school curriculum at UCSF, and we are working to integrated environmental justice and social justice because medical students want to talk about this issue. They're very keen on this issue, and I think we're going to use that -- developing that framework, and we're having a mini medical school on environmental justice that I'm happy to share with everyone that's coming up that Jeanne is speaking at.

So, I think we're going to focus on foundational change that's systemic, right, and we want -- by doing that, then it can support all these amazing community based partnerships because every community is going to have their different variation and need, and we are looking at how can we create a foundation that can make them successful in the future. So, I just say we're very excited about this and Jeanne knows that we

are here with us on this last kind of step. The strategy, we think, is really important.

[Simultaneous speakers.]

DR. JEANNE CONRY: I was going to say we'll call the questions now and turn it over to Ed. Do we have time to stand up and move as we transition?

DR. EDWARD EHLINGER: I thought you were going to do the poem.

DR. JEANNE CONRY: Okay. Dante, are we ready, I hope, or do I have to share my screen?

DANTE: We are. We can pull it up right now.

DR. JEANNE CONRY: Okay, thank you.

Thank you, what a fabulous panel. I just picked something that I thought kind of closed for us. And we can stand up and move, for all of us who have been sitting for a couple of hours.

[Playing video.]

DR. EDWARD EHLINGER: Jeanne, thank you for this session. We bracketed this real -- the science and policy, we bracketed it with stories

and poetry. We heard the stories that set us in grounding, we got the science, we got the policy, we got all of the content, which was really powerful, and we ended with stories -- with poem, and what a beautiful poet and a beautiful poem. It reminded me of what William -- Carlos William said, the physician -- a general practitioner from New Jersey. He said, "It's hard to get news from poetry but people die every day from what is contained there." So, I think as we look forward, we look at our other partners from, you know, the HHS and EPA and HUD and all of those, you know, federal agencies in our partner.

We also have to look for the National Humanities Council from arts and sciences, for the poets and the musicians and the dancers that are part of this world, because all of it is going to be necessary to move us forward. It's hard to get news from poems, but people die every day from what is contained there, and we have to get that out. That's why stories are important. That's why poetry is important, and that's why the

stories that all of these panel members brought to this was really, really so important and really made a nice package. So, thank you, thank you, thank you. Jeanne, thank you for pulling it all together.

DR. JEANNE CONRY: Thank you for everyone being a part of this, and great presentations and questions. All right.

DR. EDWARD EHLINGER: All right. We are now at the point where we're going to have some public comment. David, I know we had one public comment sent in written-wise. I don't know if we have any other public comments.

DR. DAVID DE LA CRUZ: Yes. So, Brenda Bandy, who I see is on the line, she submitted in writing but also as long as she is here, I would love to open up and give her a chance to talk a little bit. Brenda. So, she is the Executive Director of the Kansas Breastfeeding Coalition, and she submitted some remarks.

DR. TARA SANDER LEE: She's on mute. She's on mute. Can you unmute her?

DR. DAVID DE LA CRUZ: Let's see what we can do. Dante or Vincent, can you unmute Brenda?

DANTE: All I can do is prompt her, and I prompted her a couple times.

DR. DAVID DE LA CRUZ: Okay. The other -- we had a request for two other folks to provide oral comments. Joy Bentz, the Executive Director of Equity Before Birth and Latoshia Rouse from the Birth and Postpartum Doula Birth Sister Doula Services.

I don't see either one of them logged in but if they are under another name or someone else from those organizations are participating, we would love to hear from you.

So, while we're waiting, I can at least -- the Kansas City Breastfeeding Coalition encourages the committee to recommend HHS programs fully protect, promote, and support breastfeeding as evidence-based strategy to reduce rates of infant mortality. The KBC, which is the Kansas Breastfeeding Coalition, and other state breastfeeding coalitions stand ready to help

integrate breastfeeding support on the state level, and she offers to provide more information and support as necessary. But I again don't know if either Joy or Latoshia are on.

MS. BELINDA PETTIFORD: David, this is Belinda. I sent Latoshia a quick E-mail to see if she's joining.

DR. DAVID DE LA CRUZ: Okay. So, while we're waiting, Dr. Ehlinger, I don't know if you want to open it up to anyone else who may not have contacted us early, but if --

DR. EDWARD EHLINGER: Yes, I believe this is the time for public comment, and if somebody has been watching on with us and they want to make a comment, now would be the time to do it.

MS. BRENDA BANDY: This is Brenda Bandy with the Kansas Breastfeeding Coalition. Can you hear me?

DR. EDWARD EHLINGER: Yes, go ahead. Good, glad you're hear. We'd like to hear your voice.

MS. BRENDA BANDY: Yes. Thank you for

allowing me to participate as a member of the public. I have been attending the meeting over the last two days, and I can tell you what a joy it is to discover this group and to share with you our mutual passion for reducing infant mortality.

As our public comments that we submitted earlier state, we do see and remind the group about the importance of supporting breastfeeding families with the eye of reducing infant mortality. And while we are just in Kansas, there are breastfeeding coalitions in every state. There is also the United States Breastfeeding Committee, which also works on, of course, the national basis. So, I just want to let you know we're here and we support your work, and please let us know what we can do.

DR. EDWARD EHLINGER: Thank you, Brenda, and I know breastfeeding is one of those activities that actually helps reduce the disparities. So, thank you for your work, and we'll note that.

Anybody else want to comment from the

public? All right. Then, David, anything else from public comment?

DR. DAVID DE LA CRUZ: Nope, that's all.

You know, we always whether the comments are submitted in writing or if they speak here in person, we do add them to the official record. So, Ms. Bandy, your letter will be added to the record.

DR. EDWARD EHLINGER: All right. So, let us then move into our overall committee conversation and planning for the next session. And then, if we can, let's just go to the gallery view so that we can see all the faces.

There are basically three things that I want to make sure we get to, actually four things, in the hour that we have, and I really do want to be done by 3:30 because I think this has been a marathon day and we need to take a break. I want to talk a little bit about the organization and our terms of office and our charter, look at some possible dates, talk about the letter that I drafted that I sent to members, and then I want to

make sure we look at what we've heard over the last couple of days and how we can look for the synergies between the various three workgroups that we have and how we can use that to start to frame our movement forward over the next several months.

So, let's start with some of the basic stuff. David and Michael or, you know, the MCHB, you know, let's talk about, you know, we've got ten members now. We have an optimal number -- maximum number of twenty-one. What kind of terms do we have and how are things moving in terms of the process of getting new members?

DR. DAVID DE LA CRUZ: Sure. Dr. Warren, do you want to start?

DR. MICHAEL WARREN: Sure, I'm happy to give a high-level overview and if you need more details, we can go from there.

So, there was a call for nominations for members that occurred last year. There was a robust response to that call. And so, when those nominations came in, the team took the work that

had been led by this committee, and I think Belinda had led the group that had done that work, and so, we took those recommendations and considerations and applied that against the list of nominees while looking to make sure that when you think about the broad charge of the committee, we had diversity in representation of specialty and discipline and geography and gender and race/ethnicity along a number of different domains. And so, we are in the process of finalizing those lists.

The way that works within the system is that that will go to the HRSA administrator -- right now, we don't have a HRSA administrator permanent that is named, we have an acting administrator -- but those will then move from HRSA to the department and ultimately get signed off on. Because we are in this transition time, I don't have a timeframe for that, but we are ready to move that forward to the HRSA level so that when we get an administrator, that can be one of the things that is in the pipeline.

DR. EDWARD EHLINGER: And I hope you heard the need for some community voices, if possible, you know, and I think that was part of our recommendations back last year. That's an important piece of it.

DR. DAVID DE LA CRUZ: Yeah. So, the two professional area breakdowns that Dr. Warren didn't mention were both community member or voices from the community, people directly affected by infant mortality and maternal morbidity or severe morbidity. And then also, I know, Belinda, you in particular were interested in making sure we had a younger cohort and had some folks who are at the earlier part of their career, and we kept that in mind also.

DR. EDWARD EHLINGER: Good. And what about the terms of service of existing members?

DR. MICHAEL WARREN: David or Lee, can you answer that?

DR. DAVID DE LA CRUZ: I have it, sorry.

So, there's a -- Verizon is having a pretty major internet problem on the East Coast,

so I'm here but I'm also called in. So, I've got to unmute myself twice.

So, we do have the ten of you. We have what we originally had as your end dates, and they range from anywhere between June 15, 2022 to December 31, 2024. One of the things that we will do with the new folks -- the new members -- is stagger the length of their terms so that we have some consistent membership and not everyone is turning over at the same time. That allows for mentoring of you all to mentor with the new people, but then it also helps with institutional knowledge staying on for a longer period of time.

And some of the ways that we decide the length of terms is, as Dr. Warren mentioned, we have a very -- we were fortunate to get a very deep pool of people and one of the things -- not the only way we determine that -- but one of the things we keep into account is if we have a deep many people to choose from who may have the same professional area breakdown and are easier to find more of those types of people, they may get a

shorter term and allow more turnover of those areas.

I mean, I can read out the term length, but I can also just and maybe more appropriately E-mail them to you.

DR. EDWARD EHLINGER: That would be good. That would be good.

DR. PAUL WISE: If I could just jump in quickly, Ed.

I do want to modify one thing that David had said and that is we are proposing that there would be these modified or variable term dates. Again, the ultimate decision is going to be a decision that sort of winds its way through the clearance process. For those of you who are familiar with it, the Federal Advisory Committees Act is a very prescribed process and decisions are made above the sort of operating level of the program. So, we have gone about the process of generating sort of option memos for how we would recommend pursuing these activities, what the factors are that would be considered in sort of

age distribution and many of the other categories that are -- many of them spelled out in the advisory committee requirements.

So, as David had said, we are proposing that there would be some staggering so there wouldn't be a large turnover at any given time, but many of you know that from one administration to another administration, advisory committees may be politicized or not as politicized. So, we just don't know exactly how the process is going to play itself out since it is a new administration and we haven't received word on that.

So, I just -- I want to be very clear with you that we have listened to you, we have tried to be as responsive both to you and to what seems like orderly and reasonable operations of an advisory committee, but we will be going through the bureaucracy in the process of getting approval for the plans. That's all.

DR. EDWARD EHLINGER: And also, I know that the charter needs to be renewed, and we would -- I would like to strengthen the charter and, you

know, enhance it a little bit and also, I know independent of that, is also to try to get more resources for this committee so we would have more dedicated staff for this. I know those are two separate things, but just be aware, and I know one has to go through your budget process and whatever else and the other has to go through whatever you do to get the charter. Any comments on those two items?

DR. MICHAEL WARREN: Well, we'll certainly be working on the charter piece sooner rather than later. I think the current charter expires in September, if memory serves correct, and so, we will be working through that. Again, we're coming on the time where there's a change in administration, and so, we will sequence that and work with folks in the department to move that through.

The budget conversation is not appropriate for us to discuss as federal employees. So, I won't -- won't touch that.

DR. EDWARD EHLINGER: Okay. Magda.

DR. MAGDA PECK: First of all, thank you for bringing this whole kind of interior piece to light. One of the things that has been most extraordinary is the level of engagement at workgroups. There was a question posed today like who's on it, and so, I did answer that in the chat.

I was wondering as we always look to strengthen our workgroups, is it possible for us to know what you're working list is so that we can engage individuals who are on that list already in the work potentially at the role of level of a workgroup that would make our work more robust, regardless of what the ultimate decisions are about appointment? I'm not sure if we can put those two things together because it's been a really wonderful opportunity to tap people's time and expertise from diverse perspectives.

DR. MICHAEL WARREN: Let us explore that and see if there are issues with sharing that. I don't -- to be honest, I don't know, but we can explore that and see.

DR. MAGDA PECK: We'll appreciate it. It will help us to better work in the interim for as long as our terms, you know, remain.

DR. EDWARD EHLINGER: One last thing from an organizational thing is I got an E-mail from David during the course of this meeting that a couple of potential dates for the next meeting -- we hadn't had a chance to discuss it -- but he proposed April 6th and 7th and June 29th and 30th. That seems like three meetings in six months. That seems like a lot for that short period of time. What was your thinking about in scheduling those two times?

DR. DAVID DE LA CRUZ: Yeah. So, part of that is also just because of the logistics contract and, you know, the length of the logistic contract and the delays we had in the earlier meetings this year and then, you know, September to January sort of seemed like a short period of time. We have two more after this one in the current contract.

So, we want to make sure that we get them

both in and then also with enough time that the contractor can finalize the minutes before their contract period ends. So, that's how we came up with those two dates. They are absolutely flexible. We did have to have some tentative dates as we wrote the contract and we can play around with schedules a little bit. We always do find that the sooner we try to get on your calendars, the better, considering how busy you all are.

The April one will for sure be virtual. When we wrote the contract last year, we were hopeful that the June one would be in person, but that is also subject to change for sure.

DR. EDWARD EHLINGER: When does the contract end?

DR. DAVID DE LA CRUZ: The end of July. That would give them a month to turn around the meeting minutes.

DR. EDWARD EHLINGER: Okay. Now it makes sense. All right.

DR. COLLEEN MALLOY: What happens if you

only do one meeting before the contract, then you lose budgetary expectations or?

DR. DAVID DE LA CRUZ: Yeah, we'd have to look into that with our contracting folks and see if we can do a no-cost extension. But the preference would definitely be not to -- would be to end the contract on time without any non-deliverables.

DR. COLLEN MALLOY: So, April -- is that April date is two days after -- for some people, it would be a holiday. It's Easter, so, I mean. I don't know how many other people have children on this committee, but especially for people presenting, I mean, that's like a spring break for a lot of people. So, that would be difficult.

DR. MAGDA PECK: Is it possible to do one day, not two-day meetings? I mean, for example, being able to have one day as -- the reason I like the earlier dates is that if we are going to be action-oriented and if there's work to come out that is substantive, that will influence this time of transition, by the time we get something

approved in June, it means it's not going to make it someplace until August and perhaps our window of influence may be diminished.

So, if there was a one-day to try to build consensus among us and it was more of a working meeting and our committees -- our workgroups did the kind of consolidation and cross work in between, I could imagine then by the middle of and certainly before May and April, we would have actions to recommend in a time of opportunity and then we could look at whether or not or how to use a late June, even if again, it was one day, not two.

I want us to see momentum, and I am with all that got put on our table, I am highly doubtful that if we wait until near the first of July, that we will consolidate just logistically enough to seize this moment to influence policy with recommendations that are sound.

DR. EDWARD EHLINGER: I concur. I think that was one of -- I was also thinking about a one-day meeting as opposed to two-day meetings

because these are difficult meetings to hold and move as quickly as possible.

So, why don't we tentatively, you know, just mark on your calendar tentatively. We won't make any decision about the 6th and 7th of April and the 29th and 30th of June just to have them there while I talk with David and Michael about how we want to proceed with this.

DR. TARA SANDER LEE: I agree with Colleen. I mean, it's really close to a holiday. I mean, that Monday, my son is actually on vacation the week before, but it's immediately after. So, it would be hard to prep for the meeting. So, I would definitely support if we could postpone it a week. That would definitely be helpful for preparation purposes.

DR. EDWARD EHLINGER: Then, my guess is we can look at that for sure. All right. That's sort of the objective business.

Now, we're going to talk about the letter that I drafted that I sent to all of the committee members, and I want to give a little bit of

background to this, because I think I've actually been looking forward to this conversation. Because my role as acting chair, I believe, is to organize and channel the energy and the ideas of all the committee members that we have into a strategic effort to address the goals and priorities of the committee. So, my goal is to listen to you and get your information, get your energy, see what's there, and try to organize it and channel that energy.

And you know in our charter, it says, "Provide guidance and focus attention on policies and resources required to address the reduction in infant mortality and the improvement of the health status of pregnant women and infants. The committee addresses disparities and provides advise on how to best coordinate the myriad of federal, state, and local private programs and efforts that are designed to deal with the health and social problems affecting infant mortality and maternal health." So, that's what our charge is.

And then, I had discussions with each one

of you. I had one-on-one interviews with each of you and we went through a whole series of questions, and I found that you want to make a difference, you know, across the board. Everybody wants to make a difference. You want to be strategic and I specifically asked are you willing to take some risks and not everybody, but most people said yes, I'm willing to take risks.

And here are just some of the quotes that came from my discussion. I wanted to be on this committee because it has the potential to make an impact. We must create a difference. We need to talk about uncomfortable things, especially racism. There is an urgency, preventable deaths aren't acceptable. We must be strategic, pragmatic, and act with urgency. I worry that we won't get anything done. I question whether or not SACIM is a waste of time. Will our efforts be futile? I wonder if anyone in the federal government sees SACIM as a priority. We have a bad system that needs change. We need to disrupt the system. We need to confront the

administration -- whatever administration -- to make a commitment to prevention in healthy babies and mothers. Stick to the science. Be data-driven. Use science as a force for change. Pay attention to the politics, even if there is an administration change. Stick to the science. This is a historic moment. The country needs guidance. We need to break ground, but breaking ground is scary. SACIM needs to be bold, but smart and pragmatic. That's what I heard from each of you.

And so then, in our meetings over the last, you know, two years, we've decided we want to center on equity. We want to make it our North Star, and we recognize that systemic racism is the basis for most of the inequities that we have, and so, we wanted to address that and we decided -- and we've said many times, we wanted to seize the opportunity to make a difference.

I've also learned that it is difficult to move things quickly in an agency or an organization like this because of the rules that

we have to follow, the fact of how often we meet. So, you know, we have to see the advantage of how we do that is really kind of interesting. So, as it relates to this -- so, that's just the background.

So, back in the fall, several members of two of the working groups came forward and advocated that SACIM respond to the executive order from the last administration related to the critical race theory and they drafted a letter and sent it to me, and I said that I would rather be advocating for something that we should be doing rather than not doing and reminded people that we were going to have an election and there might be an administration change. So, we'd see how that was going. Yes, we did have an election. There is an administration change, but some still wanted to move forward with that letter in some fashion. And so, I, you know, I thought all right, how do we do this.

Then, on Inauguration Day, when the new President issued an executive order on racial

equity, it seemed like that might be an opportunity, one of those things to seize an opportunity to make a difference, to move forward. And so, that was what prompted me to take the information that I had received from several people who are interested in responding to this whole issue of racism, given our background history, and that's why I put it into the letter and why you didn't get it farther in advance is because I didn't know what the President was going to be writing about on January 20th, and our meeting was the 25th.

So, really, I was putting together to do a couple of things. I want to try to raise and put it forward to the President to raise the visibility of SACIM -- enhance the power potentially of SACIM, and reinforce the idea in this administration that addressing racism is essential to the work of advocating equity and advancing equity for moms and babies. So, that's what prompted all of this.

So, the question is -- the first

question, is the strategy, you know, is the letter to the President the most strategic thing to do at this point in time. Independent of the content of the letter, is -- yes, we are officially advisory to the HHS Secretary, but in this opportunity -- and just today I just saw an article that the President is doing something related to health equity -- signing something today, I don't know exactly what it is. But is this the strategic moment to actually try to connect with the President on what we're doing?

So, that's the question -- the first question.

DR. TARA SANDER LEE: I would say no. I would say no.

I would say no, I don't think this is the right time to do it. We don't have a Secretary in place. When I look at the letter -- and I appreciate the efforts you put in, Ed, I really do, and I appreciate the history behind leading up to this, because I feel like there's a lot of that that wasn't know, so I appreciate that. But just

when I look at the letter and I look at statements like we're poised to make recommendations, I don't believe as a committee we are poised to make recommendations right now. I know we've heard a lot of information and we're all digesting it, but I don't think it's the right time, and I think we need to wait for a Secretary to be in place.

DR. EDWARD EHLINGER: Other thoughts?

DR. COLLEEN MALLOY: I mean, I'd be interested to hear from maybe the Ex-Officio members because like from my perspective, it seemed like a very political letter, and I know there was -- we talked about this yesterday -- it seemed very political, and from a committee that's bipartisan, I think Ed even said non-partisan committee, it seems like we wanted to write a letter saying how much we disagreed with the other administration and we didn't get to do that, so now we're going to write this letter applauding the new administration. To me, it seemed very political, and that's not the scope of this committee.

People can have whatever political beliefs they want. I have no problem with that. You can write letters on your behalf. But then, when you're asking the committee to write a letter supporting one administration over another, and that's really the gist of this whole thing, I think. Like, you know, the purpose in our charter and the scope of this committee is to be advising the HHS.

And so, now, we're trying to make a bigger political statement, and that's the part that I don't really feel comfortable with in the same regard as, you know, if this administration changes again in the future. I don't think, you know, this committee should make another statement saying well now, we support this new administration or we don't.

I mean, that's not -- when you kind of look at how this plays out, I know people might like that it's one way now, it might not be that way forever, and like at the heart of hearts, like, what do you really want this committee to

do? Do you want it to be a political animal or do you want it to make good policy recommendations to help mothers and babies and advance health equity, and I think we can do all those things without trying to get a face in front of the new President?

Like, I -- so that's, you know, I don't know, like officially there seems to be a lot of governmental regulation about how this is supposed to go, and we're an advisory committee to the Secretary of HHS, like, that's what we are. Beyond that, I'm not super comfortable with that, so I don't know what the official response would be.

DR. EDWARD EHLINGER: And I didn't share it with the Ex-Officio members because they are government employees and it would inappropriate, I think, for them to comment on a letter to the President. That's why I didn't share it with them. I don't mind them having a copy of it, but I just didn't ask for their input because I didn't want to put them on the spot.

And certainly, I, you know, my intention, I think I focused on the issue of racism, addressing racism, not on, you know, I tried to avoid the politics of it. But it was really the issue that we want, because that's what I -- because I framed it in terms of that's what we said we wanted to do, and we signed onto the letter to the HHS Secretary back in June saying that racism is front and center at issue and we need to address it. And so, I want --

DR. COLLEEN MALLOY: Right. But I guess just to play the other side of that, and this is not that I really don't want to get into, but other administrations would also argue that they wanted to fight racism and that they wanted to promote health equity -- and I'm not here to make those arguments for them -- but the fact that we don't send a letter to a different administration saying I know that you join us in fighting racism and I know that you join us in wanting to promote health equity because I think I can't, like, that's what they would say. Like, I don't think

any administration would sit here and say, oh, it's great to have disparities in health care. No one would say that. So, we all have the same goal here, but different sides perceive it differently.

So, like I said, I'm not going to -- I don't want to get into debate about that, but that's what we end up looking like that we're saying well, this administration, they really want to fight for decreased health disparities and this one didn't really want to, but there's no one from the other one to state their argument and to give you examples of what they were doing to help improve like structural racism and to help improve situations for people in like minority populations. And there are arguments to be made for that. I'm not the one to make them, but so that's -- like, if we're just going to say well, I wanted to say congratulations for someone trying to advance these issues that are important for us, we didn't do that before, so we're doing it now. So, that's what makes me feel like it's more of a political thing.

DR. EDWARD EHLINGER: Okay.

DR. PAUL JARRIS: This is Paul. I think we do need to remain apolitical; I agree. But when a strong statement is made about racism and the multiple impacts of it, including on health, and I think we've heard so clearly the impact of racism in all form on disparate birth outcomes. So, I think the science is there. And so, we have an opportunity to basically reinforce an approach, making this a central approach, which is what our committee set out to do. So, in that regard, I think it's acceptable.

A strong statement was released, very consistent with the approach we're trying to take. And so, to say we support that and here's, you know, why it's important for infant mortality is perfectly acceptable. I mean, these -- and I think it would probably be appreciated by our community is that we, you know, to our health professionals as well as others. So, I'm okay with it and, you know, if another administration had done it or released some other statement that

was an important statement about a critical foundational approach to infant mortality, we should also commend that and say we're on board with that.

DR. EDWARD EHLINGER: Well, Paul, do you think the strategy of sending a letter to the President is an appropriate strategy at this point in time?

DR. PAUL JARRIS: I think that you always have to be cautious when you send a letter to the President because it's bypassing several steps -- HRSA, HHS, whatever. But this is such a fundamental step, I think it would be okay. And it's also a way of reinforcing that that is the view among HHS and HRSA.

Now, writing a letter that was critical of any level would not be appropriate. We also have to look at it very carefully to make sure we follow all potential protocol there, like I was thinking well we should ask the President to direct HHS to do something, and I actually now think that's not appropriate because then we are

going around the person we report to.

I think it's acceptable and you just, you know, you have to be really careful when you do it.

DR. EDWARD EHLINGER: Jeanne.

DR. JEANNE CONRY: Yeah, and I will confess to not even looking at the letter from a political viewpoint. I felt like we've come up with a really strong statement and suddenly, there was an executive order voicing exactly what we had concerns about. So, when the suggestion was made should we write a letter to the President, I just thought wow, that's a great idea. It's not a critique of the whole committee. It was just wow, what a great opportunity to just say this coincides with what we were saying. In no way did I view it as slighting Xavier Becerra. He's appointed head of Health and Human Services, and if people perceive that that's a slight, then I'm all for not sending the letter. But I don't view it as a political we're saying one thing to this administration, we are slighting another

administration. It was we had come up with a set of recommendations around disparities and this was signed, and it was like wow, thank you, we're supporting -- we support that. So, probably my naivety about the politics.

DR. EDWARD EHLINGER: And Magda, you have your hand up.

DR. MAGDA PECK: I see this as an and, not an or. So, let me first start with the what is our responsibility to SACIM and how I view it. We are on record as a full advisory committee. In our closing paragraph of the June 29th, 2020 letter sent by our acting chair on all of our behalf saying that we affirm that institutional and structural racism is core to driving the disparities that we are charged with addressing with policy and we said we will be sending you recommendations soon. We've not done that. It is not January, February, and by the time we get something out, it will have been an entire gestation since making that declaration.

And so, we have an obligation independent

for the moment, or at least aligned with a letter of affirmation or a letter of alignment with the new President in the context of an unprecedented executive order -- forget the rescinding -- it's about the affirmation of advancing racial equity and communities.

And so, I think that I would encourage us to not talk about should we send a letter to the President or not, and I would engage Paul Wise in this if he's still around --

DR. EDWARD EHLINGER: He had to go to another hearing.

DR. MAGDA PECK: But I -- our conversation in the DRAW group yesterday was strategy comes first. What is the impact that we want to have, on whom, by when, with what results? So, one is that we have a theme that is core -- our North Star -- and I would encourage us to be shaping a letter to the incoming Secretary or the appointed Secretary as our mandate specific to racism, as a driver of public health crisis manifest in egregious and persistent disparities

in maternal and infant mortality based on the data that we've heard, affirmed by goals set by 2030 by Dr. Warren and others, and informed by what we heard today.

And I think there is urgency for that letter to follow our letter of the 29th, and I could imagine a tandem letter to the President responsive to the executive order of January 20th about advancing racial equity informing about the work of SACIM, copying the new Secretary, so it goes at both levels and that we align them. This is the strategy piece that I need to imagine, and then after that, what do we produce? Jeanne, you asked me that yesterday. We had agreed last year we're not going for the landmark report on acts but a series of shorter-term letters to inform and encourage and advise that are very specific so that we are sustaining momentum.

So, I could also imagine that by June, we have environmental health policies recommended, border health policies recommended, if not sooner. So, I see a suite of communications of which this

should not be discussed in isolation but rather what is the repertoire of communications that we will sign on that interface with each other, seize opportunity, work at different levels, stay within our boundaries of what is protocol, and bring our consensus forward in a nonpolitical bipartisan way at best, not looking back, looking forward because that's what moms and babies demand of us. My two cents.

DR. EDWARD EHLINGER: Yeah. My intention was to get a letter to the President and then have a follow-up letter to the Secretary when the Secretary gets confirmed. The letter to the Secretary would be a little bit different because there's a whole bunch of other issues that we need to work with the Secretary on. But the one to the President was basically affirming that racism is our North Star and we support the administration's effort to advance health equity and address racism.

For the MCHB folks, any history of communications from the committee when there is

difference of opinion?

DR. MICHAEL WARREN: I'm not aware. I'd have to go back and look. I don't know if David or Lee would have guidance there.

DR. DAVID DE LA CRUZ: Hi, this is David. So, it would -- it would -- you could clearly state in the letter that this is not the consensus of the committee but, you know, and you can be as specific as you want and say how many do agree, how many don't agree, and you could decide if you want to, you know, list names in each one of those categories. So, it is possible to send something that is not consensus.

DR. PAUL WISE: It's also possible -- and this may be a way of sort of making the instrument less blunt -- but I have seen committees in the past say this is the opinion of a group or a significant group. There is a dissenting view and to like articulate what the dissent might be. The sticking point might not be what the general message is. The sticking point might be the audience or the approach and therefore, it may be

a way of better reflecting what the discourse is so that it --

DR. PAUL JARRIS: Yeah, because I don't know if we determined whether the lack of consensus is due to the fact that we're sending a letter to the President or is the content of the letter.

DR. TARA SANDER LEE: Well, and that's kind of the point that I wanted to bring up. So, I think there is the issue one of whether the letter should be sent or not. The second issue is the content of the letter. I've been hearing a lot of statements made that our recommendations are sound. We have recommendations. I don't recall us meeting as a committee yet about the recommendations. I've heard a lot of presentations. I've heard a lot of presentations and information given. We in no way are prepared as a committee, in my opinion, to make recommendations based on what we've heard.

So, I think that some of the statements that are made in this letter are too far reaching.

So, for example, you know, just that, you know, we are poised to make recommendations related to, and then there's a list. I would say where is that? What -- what recommendations have we discussed or made? I've heard people make recommendations to us, but we haven't as a committee decided. And so, I think that's just -- I think that's overreaching and that in no way have we given -- it's just not true.

DR. COLLEEN MALLOY: I mean, I guess for me it's not -- it's more the method than the message. Like I said before, I mean, say take the huge opioid initiative [inaudible -- audio cut out.] We didn't come out and have some big statement and write a letter say oh, thank you for making this initiative to focus on the health of mothers and babies. So, it just -- if we were doing this all along and like watching different -- and there's going to be many executive orders to come out of any presidency, and we haven't responded to any of those. And like, I think that's why I think we turned a corner [inaudible]

criticizing different executive orders coming out of the executive branch. That's what made me uncomfortable because I think it's -- there's a political -- it seems political to me.

And, you know, [inaudible] people voice their opinions against DACA and this and that. Like, there's been things along that people have feelings and emotions and opinions and that's totally fine. But when we end up then putting it all together on paper and saying as a committee, we want to stand up and applaud you, it seems political to me because it's -- it hasn't been done before, and it's not necessary, and we have statements saying that we want to advance health equity. We all wholeheartedly signed that and we all were part of that. We have no problem with that.

But now, I feel like we're trying to raise it a little bit and say we're applauding this new administration for coming on board, and that's what it feels like to me and I've shown it to a couple of other people, and that seems like

the tone of it. And so, I, you know, I feel like there were many good things that came out of the previous administration that we didn't say one thing about, but we're saying something about this. And so, that's why I feel like it's too political for me, and I have no problem, like I fully signed a statement that we put together last fall because we were all on the same page with that. But this is taking it a different direction in my mind.

DR. PAUL JARRIS: Colleen, can I reflect and see if I can understand? So, you're saying there's many priorities of which we could address, why are we addressing this one priority?

DR. COLLEEN MALLOY: No, I mean, I just, you know, without looking back and -- there were different issues for minorities and people of color made by the other -- that's the only thing that sticks in my mind because it's more of a definitely -- it's different than infant mortality, that's why I thought of the opioids.

So, I'm just kind of speaking off the

cuff that that was a huge initiative with millions of dollars put forth in a statement to help. Like, so I mean, I could go back and do some research and tell you, okay, well, here's another initiative that came out of HHS or came out of like the administration, we didn't say anything about that, so, I mean, there were millions of dollars given to historically black colleges, we didn't say anything about that. That's obviously advancing equity and disparities.

I mean, there's things that -- you don't have to agree with that, but there's things that other administrations will tell you, well, we did this for this group of people and we thought we were trying to improve their lives. So, I'm not making that argument for them, I'm just saying like, you know, I hate speaking for another group, but that's what I feel like this is.

So, like there's other things that they did -- the other administration -- the last one before that, Obama, whatever -- every administration wants to improve problems with

racism and prejudice in this country, and every administration would like to accomplish that. So, has this committee, even under Obama, come out and said we want to voice our support for this action that you've taken? I don't think they have. [Inaudible.]

DR. PAUL JARRIS: Yeah, this committee didn't exist then. But so, would you --

DR. COLLEEN MALLOY: The scope of this committee [inaudible.]

DR. PAUL JARRIS: Would you be more comfortable rather than -- because I can't remember the letter right now -- rather than commending -- it sounds like in fact, you are commending the President or the administration.

What if we actually reinforced the importance of the issue rather than commending the administration?

Is that more comfortable?

DR. STEVEN CALVIN: Maybe could I -- I could jump in too. You know, at the very end, I think it was even after the election, the HHS

Secretary released 184-page Healthy Women/Healthy Pregnancies/Healthy Future, and it was an action plan, and it was explicit in the first paragraph regarding the racial disparities and the need to address them.

You know, they specifically said three and a half times maternal mortality for black women, three and a half times the average. So, in that instance, I mean, you know, if we're going to write anything, and maybe reaffirm what we already wrote, it would be really important, I think, to say as the previous administration focused on this, we would, you know, I agree with the concerns. I know -- I know that we have a range of political views on the committee and that it had -- it had the impression that this was like a congratulatory kind of a valentine saying now we have somebody who will really listen to these problems, and that -- I think that we just don't want SACIM to become that.

And I think -- I think we do great work, so that would just be my addition is that this --

this report that came from Alex Azar, and I think it was released in early December, so it was after the election, but I think there was work on that for about probably a year in advance. If we're going to be sending anything, we should say look at what has been done previously. We need to continue this work in the new administration.

DR. PAUL JARRIS: Well, that's -- that's a valid point. I don't -- I'm not familiar with this report, I don't know who's going to write it.

But if it actually addressed this as a central issue, we should -- as in this released report, an addition, you know, as to the argument here. That's fine. Because what we're trying to promote, as you say, is not an administration but an approach to racial equity. So, I think that's a fine way of looking at it.

DR. EDWARD EHLINGER: Magda, you had your hand up.

DR. MAGDA PECK: Thank you, colleagues, for the robust conversation and the agreement in finding space with dissent with each other. I

think it's very healthy. So, thank you for that integrity that you bring to this space.

I'm not hearing anything that says that the part B strategy, if you will, that Ed articulates about sooner than later and preparing now in anticipation of a confirmed Secretary, likely to be Becerra, that we be ready with a follow-up letter to our June 29th letter to the Secretary in the context of our bedrock commitment to health equity and racial justice, so and acknowledging what we've learned including the maternal health initiative, which has come in the past administration that we heard a remarkable report on at this particular meeting.

So, I would encourage us to have affirmation that we should be working on that communication collectively and with consensus that affirms our commitments and introduce ourselves to the Secretary coming in as soon as this individual is in office. And so, that takes time to do, and I would encourage us to be using that deadline that we set for ourselves and that product as a

way to incorporate much of the content of what we've said here.

Separate from that is the question about whether SACIM acknowledges -- take the word affirm out -- acknowledges the Presidential level commitment to racial equity and elevates our visibility as being a partner in that work at this time looking forward.

And so, I see there's a way that both could happen in a way that is not political, but frankly positions us to do our job even better. And I encourage us to think about this in a strategic, nonpartisan way. This current President, who is all of ours, has made an executive order to advance racial equity in the whole of government, and we serve as limited government employees who serve here on SACIM, that's us too, and I think affirming alignment to that without congratulations, without inference, without -- just saying that, which is now law, we are on board with that because we've always been on board with that and we would be working with

the Secretary on that, and another letter that is actually substantive as the first of a suite to come out in regular order between now and September, and I think there's a place for both, which reflects the tone that you're looking for, the strategy that we want, and the alignment with what's happening.

DR. EDWARD EHLINGER: Yeah. Well, I look forward to this conversation, and I'm going to cut if off here because, you know, we -- I want to be done by 3:30.

But, I mean, it raises the issue, how do we -- how do we move quickly? You know, I just don't think we're going to be able to get a letter out because, from what I understand, in order to get signoff from the full committee, we have to have a public meeting. We just can't do it by E-mail, you know, from the rules that, you know HRSA has or the federal government has. So, I -- but it really influences how we move forward.

Can we ever do anything really quickly? Can we move something rapidly in making some

suggestions?

As I look at it, I can see over the years why SACIM seldom puts out any documents. They wait three years, four years, to get some comprehensive document that nobody acts on. And I think we just need to keep trying to figure out. That's why I was so impressed with the fact that we got something out last June relatively quickly related to some recommendations. If we're going to be strategic, if we're going to be addressing issues that are facing our country and our moms and babies right now, we need to be able to find some way to move it quickly, and this is just, you know, I think a part of a conversation that we have to think about how do we move things more quickly.

So, what I'm going to do is I'm going to put a hold on a letter to the President, but I think we need to work on a letter to the HHS Secretary when he gets confirmed, and that will probably align with our meeting in April. I mean, I hope he gets confirmed then, but you know, we

could then have a consensus meeting as part of our discussion in April to send off a letter that everybody can sign off on.

All right. Last -- we have five minutes, and this is where I put the work on our chairs. I heard a lot of things that came in our meeting today -- yesterday and today that the workgroups have been looking at that really do -- there's some synergy, that they overlap, that they complement each other, and I think that I would ask that the chairs of our workgroups meet with me within the next few weeks to kind of review what we've heard, what we've learned, how we might be able to package those into a package of recommendations that we can work on between now and April to bring forward in April to really have some robust discussion with the entire group with the idea of either making a recommendation at that time or setting the stage for additional work that we could, you know, add the recommendations in June.

So, putting the work of pulling out what

we've heard over the last two days, some really deep, deep data dives, deep thought into policy approaches, series of recommendations that, you know, most of which were really relevant to what we're doing, pull together and be able to make something at our next two meetings to bring those forward and move them forward.

Any thoughts from the chairs of the committees?

DR. STEVEN CALVIN: I think that's great, Ed, and, I mean, some of these presentations, I appreciate that you brought in Darryl Hood. I mean, I think there are some cross connections now here that are going to be really valuable. We're going to be connecting with people that will really help us advance this work.

MS. BELINDA PETTIFORD: I think it will be helpful also as the committee chairs if we can get together and have that discussion around where the crossover is and we could probably [inaudible] that are in line with the recommendations coming from all three of the workgroups.

DR. MAGDA PECK: I concur with that. I think that I heard in particular between equity and the DRAW group on a couple of pieces even before the environmental health presentation, lots of synergy and overlap. I think that it will be -- a number of our DRAW members were with us for the last two days, and so, I will want to go back and solicit from them what they heard.

I also think that Janelle Palacios' not being with us today will be a useful role for her to hear it freshly and to tape her leadership with you, Belinda, and as a member of our liaison's group, sometimes the person who is not there can be particular helpful to at least make sure it makes sense. So, we will bring her back into the loop on that and I look forward to meeting with the other liaisons in short order. And I appreciate the depth of content, the passion of heart, and the collaboration of my colleagues. Thank you.

DR. EDWARD EHLINGER: All right. Let's just go around once and just get just a comment

about your reflections of these last two days. On my screen, I'm going to go around and I'll call you. Tara, your reflections of these last two days.

DR. TARA SANDER LEE: I might sound like an echo of kind of what was said earlier, but I too, I mean, just as a -- I know I've been saying at a lot of these meetings how much I want to see more data, and I really, really feel like this meeting, I saw more data. So, I appreciated that. I felt like it was very engaging. There were some fantastic presentations, a lot to process.

I just -- I think that some of these issues are really hard. I mean, you know, I didn't sleep well last night because, you know, you so desperately want to do all of this. You want to help all of these women and their babies, and these stories are hard to hear. And so, for me, as a woman of faith really praying where are we, where am I as a member of this committee supposed to direct their efforts?

I think there's a desire to want to do it

all. And God knows, I would love to. I would love to help every baby and ensure that every baby makes it. I would love to ensure that every woman -- every woman survives and doesn't have to go through the heartache of what you hear.

And so, that's going to be, I think, my task, is to really seriously -- and that's why I think my comments that I made earlier that I'm not -- I don't feel comfortable yet making recommendations because as a scientist, I really want to look carefully at this. I want to look at more research. I want to -- I want to, you know, as a scientist, you don't always just accept what people tell you. You want to go and you want to compare what you've heard other people say, you want to read some papers.

So, I really just in my role, you know, I look forward to working with everybody to really decide where do we think we should put our efforts because we can't do it all. Where do we think it's going to be the biggest impact, and I'm hearing people? I'm hearing people. I know that

there are inequities, and I know we need to address those, and I think that there are so many inequities.

So, let's work together and try to identify the most important ones. Thank you.

DR. EDWARD EHLINGER: Steve.

DR. STEVEN CALVIN: I'm grateful for the work of the HRSA folks and the MCHB. I mean, that was very impressive, and I am grateful for all the information, and I'm going to do a lot more digesting of that.

DR. EDWARD EHLINGER: Colleen. Unmute and give us your reflection.

DR. COLLEEN MALLOY: I'm sorry, me?

DR. EDWARD EHLINGER: Yes.

DR. COLLEEN MALLOY: Oh, I'm sorry. I have three kids learning from home today because we had a snow day.

DR. EDWARD EHLINGER: So, your quick reflection on the two days of meetings.

DR. COLLEEN MALLOY: Yes. [Inaudible -- audio cut out.]

DR. EDWARD EHLINGER: You're -- you're --

DR. COLLEEN MALLOY: I thought that was really good what Tara just said. I think it [inaudible] what?

DR. EDWARD EHLINGER: You're frozen. You're freezing in and out. We'll come back to you when you get a little more stable connection. So, Magda.

DR. MAGDA PECK: I am drowning a bit in the content of research and data and perspective and stories from today in the best of ways. I have a snorkel, so I think I'm okay. Still breathing.

I actually think we do have enough research for some of the recommendations that we want to make. We maybe just don't know it. And that our primary work is to be translators to make the complex be clearer and to focus and be strategic and make a difference. And so, I think we have an opportunity to digest and reflect and ask what is enough now to lead to action, and I think we have ample opportunity for that at this

time.

DR. EDWARD EHLINGER: Thank you. Paul Wise, reflection on these two days.

DR. PAUL WISE: Thank you. It's been very impressive, and I think it's fair to say that we are a highly functioning efferent organ, but we need to work harder on our afferent capability and impact. We're very good at listening and appreciating data and stories.

But I do think we need to recognize that we do not have a good feel for what our strategic contribution should or can actually be. What is our incremental contribution to these issues and I think that was reflected in the conversation about the letter? But I do think and perhaps the chairs of the working groups can pursue this or Ed offline with members of the committee, to identify the highest priority for us for the next six months and to align our work to create products and contributions that are strategic in intent and the mechanisms by which the contribution is made.

I think that's going to be an important

challenge for us in the coming months.

DR. EDWARD EHLINGER: Thank you. I appreciate the afferent and efferent. I hadn't really thought about those words in a long time, but it's very appropriate. Paul Jarris.

DR. PAUL JARRIS: Thanks, Ed. I'm feeling very hopeful. I'm feeling like we may have a historic opportunity now to truly address in a very mainstream way equity.

That would be, of course, racial equity or geographic equity, equity in many different ways, and I hope we can take advantage of it. I hope that SACIM can continue to stress the vital importance of that if we want to achieve the infant mortality race that we possibly can achieve because we simply can't do it without looking at equity.

So, I'm hoping that we continue to push that and take advantage of a more welcoming environment and not be too passive.

DR. EDWARD EHLINGER: Good. Thank you. Jeanne.

DR. JEANNE CONRY: Thank you. I want to echo Magda's term the translation, because I think what we have heard time and time again is that there is a lot of research, there is a lot of science, but it's how do we translate and then amplify, because I think we're here to amplify some of these messages. I certainly know in the area in environmental sciences, Dr. Woodruff clearly pointed out it's very difficult to do double-blind case-controlled studies when no one has controlled a release of a chemical or any toxic substance, and that's a consistent message.

So, you've got to look and interpret the science differently. So, as Magda said, there is a great deal of science about any number of areas, whether we're talking about preterm delivery or we're talking about air pollution, or we're talking about racial disparities. There is a great deal of science. So, it's how do we amplify those messages and put it into a cohesive and, as Paul was saying, strategical. I think that will be the challenge.

DR. EDWARD EHLINGER: Thank you. Belinda.

MS. BELINDA PETTIFORD: I've actually enjoyed it yesterday and today. It was a lot of information to digest at once. But I thought it flowed very well. It was really good to hear, you know, the next steps with the maternal health plan that was released in December, I think. I can't remember exactly when, but I remember the webinar.

And so, to see how it was going to continue because even in the early release, you know, we were getting questions around so what does this mean and having spoken with some folks to know that they started working on it. You know, I had planned to release it Mother's Day weekend and everything got delayed. I thought all of the presentations were good.

I still think we have to think through actionable recommendations to address equity, because I think taskforce -- as a taskforce committee, as a committee workgroup talks about the issue, and we've not seen the improvement.

What we keep seeing is our data shows that we're getting worse. So, we need to use this as an opportunity to make true change, to recommend to whoever we need to recommend -- this Secretary or whoever we recommend to -- how we can move this work forward and give people suggestions and recommendations of things that they can do to support the work.

I think the voice of the community is always critical in these discussions and in these conversations. I think we did a really good job yesterday with community voices. I also think that the nurse midwife that presented with Paul was another voice of the community, and I thought that was important to hear, but I also think that about the two individuals that spoke about Michigan.

We need to make sure that we don't just feel how they feel and, you know, be empathetic but to truly come up with a way to show that we can work and come up with recommendations to improve the situations that they're in, because

it's impacting all of our families and it's impacting our community. And I truly believe that this is our opportunity to do that. I think if we're going to ever truly be able to move forward with equity, we have to seize this opportunity now, and we can't just keep talking about it.

I enjoy working with this group and look forward to us coming up with truly actionable recommendations sooner versus later. Thank you.

DR. EDWARD EHLINGER: Thank you. All right, Colleen, let's come back to you. Let's see if we can get your voice this time.

DR. COLLEEN MALLOY: I'll try. Let me know. I honestly have every child in my house doing virtual school today, so I think we're all overloading the Wi-Fi, but is it working?

DR. EDWARD EHLINGER: It is working right now.

DR. COLLEEN MALLOY: Okay. So, yeah -- no, I -- I'm looking at the pages and pages of notes that I have taken on the presentations, and I feel like I did the same thing last time, and I

think that, you know, we do -- we're pushing the boulder up the hill, I think, a little bit, and I think that we just have to be more concise about our recommendations.

And what I wrote down last time -- I'm looking at my same notebook that I used -- and at the time, I had a number of ideas for presentations, and I feel like, you know, maybe it would be helpful if we knew what the route is to suggest -- maybe just to E-mail -- to suggest to you to have a different type of presentation that maybe people hadn't heard about before or a different -- something from the NICU or like I'm thinking to myself that piece probably should be in here in terms of like the perspective that maybe I would have as a neonatologist working in a rural hospital and inner city hospital and kind of, you know, those voices of those families I think would be. So, I wrote that down last time and then the agenda came out and it was obviously set, and I didn't do anything in the meantime between the last meeting and this meeting.

So, I will work on that for next time, because I think, you know, that the presentations are really the most important part of this. So, like, how do you set the agenda, how are you deciding who is giving the presentation, I think, it's like a huge cornerstone of the message that we're sending.

But I appreciate, you know, talking about the letter was difficult for me because I don't want to -- I don't like confrontation anyway -- but I also don't like anyone to think that I don't agree with the message of this committee, because I do. It was just the different slant of it. But I don't want, you know, I think of all of you as my friends and colleagues, and even the people that come to present and the larger community that's watching, like I don't -- that was difficult for me because it was -- I don't want to take away from the message of all the good work that we're doing. So, thank you for listening to me.

DR. EDWARD EHLINGER: All right, thank

you.

Just in response, I try to listen to the voices of the committee. As I led into my conversation about the letter, that came about because people in a couple of the workgroups came forward saying we want to move this forward. We had the agenda item today on the environment because Jeanne has made a point over and over again that we need to do this. I mean, I try to gather -- I think I said it -- as organized and channel the energy and ideas of the committee members.

So, you know, please let me know what you want to have on the agenda, what things are important to do. So, just as I do listen to what you're having to say.

Before I close, Michael Warren, do you have any reflections from these two days?

DR. MICHAEL WARREN: So, certainly lots for us to take back and think about. I am always so grateful when this group gathers for the collective wisdom and experience that you all

have, and I think you challenge us to think about what we're doing and the ways that we're doing that, and we appreciate the breadth of opinions on the committee.

I appreciate the space you all have created for dialogue and for being able to navigate difficult conversations and think through differing opinions. And so, I just continue to be grateful for all of you for your service to our country and the advice that you give us.

DR. EDWARD EHLINGER: And David, as our DFO, I think it's DFO, right?

DR. DAVID DE LA CRUZ: Yes, Designated Federal Official, for whatever that's worth.

So, I was actually -- at the end of every calendar year, we have to go back and update our CVs and when I was doing that, it occurred to me that this is my 17th year as being involved this committee and not always as the DFO, but in various roles, and I am struck by how committed and dedicated all of you are and how hopeful I am for our moms and babies and communities that need

the work that you all do because with your continued leadership and your continued fighting and your continued presence, I am hopeful that we will see some nice change in our country.

So, I just also want to echo Dr. Warren and thank you for everything you do, and it really is -- one of my favorite things I get to do as a federal employee is to work with you all and to be involved in this, and, you know, I have read many of your articles and studied a lot of the work that you've done over the years, so to be able to sit and listen to you and be more closely involved with you is really an honor, and I thank you for giving me that honor.

DR. EDWARD EHLINGER: Well, I appreciate the support from MCHB and I really do appreciate all of the work that everybody on this committee does, and I think that, you know, the easiest thing for me would have been to, you know, take the input from the folks about a letter responding to Trump's executive order and just put it aside and not bring something forward.

But that doesn't help. I mean, we need to bring forward issues. It was sort of a stress test recognizing that we probably couldn't come to consensus that quickly on a letter, but it is a stress test to say how do we bring up issues, are we comfortable raising issues, are we comfortable living in tension. I know people don't like tension. But I think tension is where the energy is. Tension is where we have to listen and have to speak our voice and have to come and do some kind of compromise or come together. So, this was a stress test, and I think it is -- it highlights the fact that we are all committed, we all want to do good things for moms and babies. We do have a commitment to racial justice, and we want to move to take advantage of opportunities. How exactly are we going to do this? How can we best do this? We're still struggling with that.

But I think we're committed to doing things more quickly than the committee has done in the past, but how we do that remains to be seen, and I think we're making it up as we go along, and

I hope that, you know, in working together, we can find some ways over the next six months to really come together with some strategic recommendations because now is the time.

There is so much change going on. The COVID epidemic has highlighted the fact that our medical care systems is in disarray. Our public health system is in disarray. It does some really good things, but it has some big gaps, particularly around equity. Our economic system is not meeting the needs of moms and babies. Our education system is also struggling. So, we can't live with that uncertainty as a society, so some action is going to happen. So, that action is an opportunity for us to intervene.

So, I think this is a good time. We've got a good group of folks. We've got a commitment from everybody, and we certainly have a lot of data to support whatever recommendations we want to make. We have the data to support it. Now, we just have to organize it and get it into the right hands.

So, thank you for your commitment over these last two days. Thank you for your commitment for your overall terms as SACIM members, and thanks to MCHB for hosting us and let us move forward, and we'll get back to you ASAP with sort of the next steps.

DR. JEANNE CONRY: And thank you, Ed, for doing a great job always.

DR. MAGDA PECK: Yes, thanks, Ed.

DR. EDWARD EHLINGER: All right. Take care, everyone.

DR. DAVID DE LA CRUZ: This meeting is adjourned.

[Whereupon the session was adjourned at at 3:49 p.m.]

REPORTER CERTIFICATE

I, GARY EUELL, 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 9th day of February 2021.

_____/S/_____

Gary Euell

Notary Public