The Secretary's Advisory Committee on

Infant Mortality,

US Department of Health and Human Services

Virtual Meeting

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Attended Via Webinar

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Reported by Gary Euell

Committee Members

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Committee Members - continued

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Paul H. Wise, M.D., M.P.H., Richard E. Behrman Professor of Child Health Policy and Society, Stanford University

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Ronald T. Ashford
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Ex-Officio Members - continued

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

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Ex-Officio Members - continued

Cheryl S. Broussard, Ph.D., Associate Director for Science, Division of Congenital and Developmental Disorders, National Center of Birth Defects and Developmental Disabilities, Centers for Disease Control and Prevention

Kristen Zycherman, Coordinator for the CMS, Maternal and Infant Health Initiatives, Center of Medicaid and CHIP Services, Centers for Medicare and Medicaid Services

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Michelle Loh, Division of Healthy Start and Perinatal Services, Maternal and Child Health Bureau, Health Resources and Services Administration

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Voices from the Community

Merlin Marrain-Jackson, M.P.H.

Doula/Certified Lactation Counselor, Syracuse Healthy Start

Efua Ansah-Eleazu

Healthy Start Case Manager/Doula Mentor, Community Health Center of Richmond, Staten Island, NY

C O N T E N T S

P R O C E E D I N G S

WELCOME, CALL TO ORDER, AND INTRODUCTIONS

LEE WILSON: All rightly. Good morning, folks. My name is Lee Wilson, and I'll be acting as the Designated Federal Official under the rules of the Federal Advisory Committee Act. I would like to officially open day one of the Secretary's Advisory Committee on Infant Mortality for the U.S. Department of Health and Human Services. The meeting will run April 19 and 20, and I'd first like to thank the chair and the committee for their participation and attendance in this meeting. I'd also like to thank the Ex-officio members for attending, the speakers, the guests, and the staff from both the agency and the contractors who are providing support for this advisory committee meeting.

It will be a two-day meeting, and there will be an opportunity for public comment at the meeting. We have had a call through the Federal Register to allow for individuals to submit in writing or verbally their

recommendations or input that they would like to provide to the committee, and we will -- we generally provide an opportunity for those who may have not met the deadline, if time is sufficient, to provide public comment separate from those who may have registered previously.

The meeting is virtual. It is a public and open meeting and it will be recorded and transcribed, and we will be making the notes public. So, thank you all for coming, and meeting is officially open. Dr. Ehlinger.

EDWARD EHLINGER: Thank you, Lee, and good morning, good afternoon, good evening, not knowing where Jeanne Conry is at this point in time. So, to all of those various time zones, welcome to our virtual SACIM meeting. If you are like me, the previous virtual meetings that really lasted all day were really difficult for me to sit on my butt for that long and stay concentrated. So, we're trying something a little bit new this meeting to have two half-day meetings. And so, I hope tomorrow afternoon, we can get a little

feedback on whether this works because we've got a lot of work to do in this -- these two half days. So, I'm hoping that we can get it done and we'll get to that in a second.

But first off all, Happy Patriot's Day. This is the day that we, you know, commemorate, particularly in New England, the Lexington and Concord, the first skirmishes of the Revolutionary War. And previously, this day was called Fast Day before it turned into Patriot's Day, and it was a day of public fasting and prayer, traditionally observed in New England to -- for prayer and repentance proclaimed by the British colonies to avoid such things as calamities, plagues, natural disasters, and crop failures.

And I'm thinking, given what's going on, maybe we should have a fast day because we need a lot of prayers repentance because in the last thirty days, we've had forty-five mass shootings, just even one yesterday in my home state of Wisconsin. I know Tara probably is very

aware of that. COVID continues to be a threat throughout the county, and here in Minnesota, we're increasing cases again with variants being a major part of that.

And as we speak, we are having the closing arguments in the trial of Derek Chauvin for the murder of George Floyd, and one week ago yesterday, we had in our -- just ten miles from here, the killing of Daunte Wright. And so, in our community, we've had demonstrations every day and every evening for the last week. There are Humvees in my neighborhood and there are National Guard and law enforcement officials all throughout the Twin Cities. All of the church services over the weekend really focused on racial injustice. I see chain link fences almost everywhere downtown and boarded-up buildings. And the Minneapolis schools have gone virtual for this week in anticipation that something might happen if the -- when the decision on the Chauvin trial comes down, and we've had curfews for three of the last seven nights. So, obviously the racial injustice, the

racial unrest is affecting everybody in our community and my guess is that Minneapolis and St. Paul are no different than anyplace else. There's a lot of tension, there's a lot of concern, a lot of nervousness.

And that harkens back to a statement that Frederick Douglas made probably 150 years ago. He said, "Where justice is denied, where poverty is enforced, where ignorance prevails, and where any one class is made to feel that society is an organized conspiracy to oppress, rob, and degrade them, neither persons nor property will be safe." That's why I argue that inequities are one of the existential threats to our society, you know, along with nuclear war and pandemics and climate change because we're all affected by inequities in huge ways.

But at the same time that we have all of this stuff going on, there's just lots of action, lots of things particularly being proposed at the federal level. It's almost that there's something new coming out every day. It's almost

like an avalanche of issues and actions coming out. And just last week, CDC declared, you know, racism as a serious public health threat. So, there's lots of stuff going on. It's either the best of the times or the worst of times. So, this is really an important time for us to be coming together. Things are moving so fast that we really want to get ahead of the curve that if we don't act fairly quickly, what we do may be irrelevant, and I certainly don't want SACIM to be irrelevant.

So, we've spent the last couple of years getting lots of testimony, hearing lots of things, and now is the time for us to act, and I'm hoping that this meeting and leading up to June where we can finalize some recommendations.

So, as we do our little introductions, I just -- I know to keep it brief, you know, introduce yourself members of SACIM and do you come in here in this best of times/worst of times with optimism or dread, hope or fear, enthusiasm or resignation? You know, introduce

yourself and kind of give a sense of where you are. So, let's -- I'll just on my screen. Steve -- Steve Calvin.

STEVE CALVIN: Hi. Steve Calvin. I'm a maternal and fetal medicine physician here in Minneapolis as well and I share many of the experiences and concerns that Ed has articulated. Our birth center -- we have two birth centers, I work with midwives -- is just a mile north of where George Floyd died and so, it's been, you know, a very, very traumatic year for not, you know, not so much for us, but for the people we serve. So, I'm just hoping that our work with SACIM can advance care for mothers, babies, and families in ways that really benefit -- benefit everyone, and I think we have a lot of great opportunities. So, actually, I am hopeful.

EDWARD EHLINGER: Good. Janelle.

JANELLE PALACIOS: I'm Janelle Palacios. I'm a nurse midwife. I live and work in the Bay area in Northern California, and I do a little bit of research consulting on the side and

I'm also a practicing nurse midwife on the floor in a hospital. I'm optimistic. At one of the very earliest SACIM calls that we've had and meetings, I suggested that something almost catastrophic had to happen in order for us to have like a national attention to maternal and infant outcomes that we have in our country, and we had COVID. And I was thinking that we would pull together as a community, but we saw the exact opposite in our country. We saw just glaring disparities. So, I'm optimistic because we have a chance to really have change and it is painful to have change, but it's much needed. So, I'm optimistic and excited.

EDWARD EHLINGER: Great. Before we go to Jeanne, can we taken down the share screen so we can have a broader view of the gallery? Jeanne.

JEANNE CONRY: Good day. Jeanne Conry, I'm a retired physician from the Permanent Medical Group in California, past president of the American College of Obstetricians and

Gynecologists, and current president elect for the International Federal of Gynecology and Obstetrics. So, my life focus has been on improving the health and well-being of women with the goal of improving the health and well-being of newborn children and our families. So, I am cautiously optimistic. I see change coming about and certainly the meetings that we've had with this group are very enlightening and exciting because I believe we can invest in the health and well-being of women, and we are investing in the health of future generations, and I think that's where we've got to be looking. We've done a lot for this generation. We've got so much more work to go, and I see a global movement that's very exciting.

EDWARD EHLINGER: Thank you. Belinda.

BELINDA PETTIFORD: Hello, everyone. I am Belinda Pettiford. I'm in North Carolina with the Division of Public Health. I'm head of Women's Health here. I have been working in this

arena for 30+ years like some of you all have and have worked at the community level and at the state level. In my own state of North Carolina, we are also having marches for many reasons, but mainly for racial equality.

I am hopeful because I have no place else to be but hopeful because I think once we lose our hope, we are all in deeper trouble than we could ever get out of. So, I remain hopeful even in the midst of the challenges, even in the midst of the inequities. And the fact that CDC comes out and acknowledges what man of us already knew, that racism is a public health threat helps me remain hopeful, and I think that hope moves into optimism. So, I am always excited about this meeting and the opportunity to share and to hear from others, but especially those that are not on the committee. We like to hear from you all as well. So, I remain hopeful.

EDWARD EHLINGER: Great. Thanks, Belinda. Paul -- Paul Wise.

PAUL WISE: Hi. I'm Paul Wise,

Pediatrics Health Policy and International Studies at Stanford University. I'm also working for the federal court overseeing the detention of migrant children in US immigration systems. I've been spending a lot of time on the border, particularly over the last month.

But I remain optimistic. But justice always implies and requires struggle. So, I'm also pragmatic and I bring both optimism and pragmatism to this committee as we address the issues that have been laid out by it.

EDWARD EHLINGER: I appreciate that and Paul and I have had a relationship for many, many years, and it's nice to have somebody who's been in the field for a long time remain optimistic and the pragmatism of lived experience is really important. Tara.

TARA SANDER LEE: Hi, everybody. My name is Tara Sander Lee. I am a scientist with the Charlotte Lozier Institute, which is based just outside of Washington, DC in Arlington, Virginia. I reside in the state of Wisconsin.

So, thank you, Ed, I appreciate your acknowledgement of what happened. Yes, it's been happening in Wisconsin. I know it's nothing and it's happening in the rest of the nation as well. It's just depending on the week, it's who is -- who is getting hurt that week.

But, yes, I am very hopeful. I think just given -- I was very happy to hear, Ed, that you mentioned that there is definitely a need for prayer and repentance. I think, you know, we are all -- we are all in that place and there's where my hope lies. I think my hopes lies in the prayer that we need to see going forward in how to deal with these very challenging issues, which I believe that we can if we really listen to each other and that we hear all the voices that are speaking. So, thank you.

EDWARD EHLINGER: Good. Colleen, glad you could make it on. We're just going around introducing ourselves and whether you come to this meeting with optimism or dread, hope or fear, enthusiasm or resignation.

COLLEEN MALLOY: Yes. I heard your opening. So, thank you. Yeah. My name is Colleen Malloy. I'm a neonatologist at Northwestern in Chicago, also finishing up my Master's in Health Informatics. I feel like I am hopeful even though, you know, I live in a city where I think in 2020 there were 769 shootings and in March alone, I think we're at 278 shootings. So, you know, obviously there are issues that need to be addressed. But I feel like because I have interface with the families, I feel like that's what gives me hope because, you know, if you meet a family having a baby or dealing with issues where their baby is sick, like that's where the real, I think, spirit of America lies because, you know, that's where we all share common ground and every parent feels the same way about taking care of the health of their families. So, that's where I think it's -- we have good reason to be hopeful because I think even though maybe the press likes to do otherwise, I think we have so much more in common than you see on the news every day. I've

kind of even stopped watching the news because it's like overwhelming how much I think people try to divide us when in reality, I think we're just all the same in our humanity and our desire to make the best lives for our families.

EDWARD EHLINGER: Thank you. Now, I know Magda Peck will not be with us for the next couple of days. She's dealing with some medical issues and I don't see Paul Jarris yet on. So, otherwise, we have all of our members. And I would like to have Michael introduce himself and share his perspective. Dr. Warren, excuse me.

MICHAEL WARREN: Good afternoon. No, Michael is fine. Good to see you all and good morning or afternoon or evening, wherever you're joining us from. I'm always hopeful when I'm on these calls because I am so grateful for your time and expertise in helping to advise us on how to move forward.

I'm also particularly hopeful because we've been talking a lot and we've shared with you our interest in having this goal of eliminating

inequity in infant mortality by 2030, well ahead of the Healthy People 2030 goal, which would generate improvement but not equity. I'm excited about the energy around that and the commitment that we see from the administration and from the department and to really dive in and think about equity and the roots of inequities and to think about how we approach our work to really get at those inequities and to support states and communities in doing the work that they need to do with our support to move this along. So, excited and again grateful for you all's expertise and time and look forward to the conversation over the next couple of days.

EDWARD EHLINGER: Thank you. And Lee, I know you introduced yourself earlier, but reintroduce yourself.

LEE WILSON: Thank you. This is Lee Wilson. I'm the Director of the Division of Healthy Start and Perinatal Services. Again, thank you all for being here. I'd have to say that my emotions go back and forth, and so, I

would -- I would choose the words committed to change because my -- my level of hope, my level of satisfaction with where we are, and the pace that we're moving goes up and down. But I do feel committed to this issue. I feel committed to the work that all of you are doing and on top of that, I feel very thankful for the willingness that you all have put into the issue, not only with being at this meeting, but with your lives and the work that you choose to do. So, thank you all.

EDWARD EHLINGER: And Vanessa Lee. Vanessa, I want you to introduce yourself because I've been working with her most closely on getting this meeting together and on other issues related to infant mortality.

VANESSA LEE: Yes. Good afternoon, everyone. I'm Vanessa Lee. I'm a project officer and support the work of the committee in the Division of Healthy Start and Perinatal Services at MCHB and, like my colleagues, I'm also just thankful and grateful for all of you and the work that you're going to put over the next few days.

I look forward to helping in any way I can. Thank you.

EDWARD EHLINGER: Thank you. And thank you for all your assistance, Vanessa, as we move this forward. I know there are many other people on this Zoom, and I'd love to be able to go around and have people introduce themselves with their voices and their images, but that's not possible. So, if you could, could you just introduce yourself in the chat, particularly if you're an Ex-Officio member, you know, let us know that you're an Ex-Officio and, you know, give us an upside or the downside or something in terms of your, you know, best of times/worst of times, glass half full/glass half empty kind of person so we can get a sense -- read the Zoom room on the -- the atmosphere that's going on.

REVIEW AND APPROVE MINUTES FROM JANUARY MEETING AND OBJECTIVES THE FOR APRIL MEETING

All right. So, the next item is approving of the minutes. They came out in the board book. I'm sure everybody read the 48 pages,

whatever. But I have gone through them and I made a couple of changes that they included. But does anybody have any -- would somebody like to move approval of the minutes?

JEANNE CONRY: Jeanne. I move that we approve the minutes.

EDWARD EHLINGER: Okay. Is there a second to that motion?

BELINDA PETTIFORD: This is Belinda. I second it.

EDWARD EHLINGER: All right. So, any discussion on the minutes? All right. And so, I'm going to say since I see most people, just if you approve, raise your hand. All right. Any -- any objections? All right. So moved.

While I'm thinking about it, when we get into discussion, I'm hoping to use the raise hand function. If you show the list of participants on the right-hand part of your screen, there's a little raise hand thing and I'll try to use that as we go forward in our discussion.

VOICES FROM THE COMMUNITY

All right. So, next, we've, you know, I really like to hear the voices of people who are not on our committee, particularly voices of people who are receiving -- who are in the midst of dealing with some of the issues that we're concerned about with our SACIM committee. And so, we've labeled this section Voices of the Community, and we have two people here who are going to be sharing their stories with us briefly, and I really appreciate it. The first is Efua Ansah-Eleazu, who is the Healthy Start Case Manager and Doula Mentor for the Community Health Center of Richmond in Staten Island, part of the Staten Island Healthy Start. So, Efua, I'm really appreciative of you being here. So, if you could -- you are unmuted so, you know, introduce yourself and tell us the story that you bring to this committee. So, take it away.

EFUA ANSAH-ELEAZU: Thank you so much, sir. Thank you, Mr. Edward and everyone that is here. Thank you for the opportunity to be

part of this forum. I'm honored to just be part of this.

So, once again, my name is Efua Ansah-Eleazu, and I am one of the case managers for the Healthy Start Program in Staten Island. I am also a doula, which is a birth and postpartum doula and also currently certified lactation counselor.

So, I'll just tell you a brief journey about how I became a doula. I got this information from an agency in Staten Island when I just had my second child. I was really surprised that there was even support out there for women, especially women of color at no cost to me and, you know, I was blessed to have a really, really compassionate supportive doula come to my home to assist me with breastfeeding education, safe sleep, just, you know, being there for me emotionally, mentally, helping me with my first child, which I didn't have the support with and therefore, I lacked a lot of knowledge and education about breastfeeding and all that I knew

now that I had a doula.

I would say, you know, that really impacted me my whole life, you know. I felt like I had a mission and a purpose to give back to my community. Therefore, I decided to become a doula myself even though my daughter at the time was 5 months. I was able to get a scholarship at no cost to me. I went for the training, I became a doula, and from that, I was able to support, you know, over 50 women during their births. I became a part of the Healthy Start Program at the Community Health Center of Richmond. They, you know, supported me with my education. I became a lactation counselor and after that, I decided to reach out to more women in my community and tell them about our doula services and they became trained as well. They wanted to do more for their community. And it's been really impactful. It's been great. It's been such a blessing.

Our mission is to reduce maternal and infant mortality amongst African American women, to support them during their pregnancy, just

letting them know what to expect. In the hospital, we serve different, you know, status. You know, women who don't have the ability to afford a doula, especially immigrants who have no idea how to navigate the system in this country, and we've made a big difference from, you know, them having a doula now versus when they didn't have a doula and just being there for their partners, being there for their families, letting them understand the process and what to expect. We have been able to reduce the anxiety, you know, their stress levels. A lot of times, they might not have their partner with them. You know, helping single mothers, helping, you know, people who don't have the resources to even have what you need to have for this kind of birth, you know, having a birth plan with them, sitting down with them, just a lot of bedside manners and letting them understand that people are out there who actually care. You know, a lot of times we work closely with midwives and the OB/GYN. We do counseling with them, childbirth education, safe

sleep, and a really important one is breastfeeding education and letting them understand what to expect, you know. We've also been able to reduce the risk of postpartum depression with women because we've seen that when they have support during their pregnancy, it does impact them after their pregnancy.

We also help with other resources, even with their first children, with childcare, with, you know, applications to different programs, you know, talking to them about the education, what is your goal, what are you doing from here, and we're seeing a big, great big, you know, difference from, you know, someone who was scared to even go into, you know, the labor room and after their baby is born and how strong they are, how, you know, how much desire they have to continue fighting for themselves and their children and just -- just stronger, you know, just stronger and bolder and to be able to impact their community as well.

So, I'm just honored to be a doula,

and I hope that, you know, many, many more people in the communities know that there is support out there and you can come to us for this help. Thank you so much for the questions.

EDWARD EHLINGER: Oh, thank you. I hope you can stick around for a little bit because I want to hear next from another doula, and then we can open it up for questions from -- or comments from the SACIM members. So, hang on for a little bit, and we'll now go to Merlin Marrain-Jackson, who is a doula and a certified lactation consultant from the Syracuse Health -- Healthy Start in Onondaga County Health Department.

MERLIN MARRAIN-JACKSON: Yes, hi. Good afternoon, everyone. Thank you for having me. Outside of being a doula and a lactation consultant -- counselor, sorry, I want to say that my perspective is really unique because I used to work in the hospital. My last place of work was in the Perinatal Unit of one of the hospital in Onondaga County, and I've seen disparities inside and outside of the hospital where mothers, if you

do not know them or if they don't know them, they really are given a type of laissez-faire treatment. And so, this is what encouraged me as a mother and a friend to leave the hospital, to come out into the community, to serve as someone who has had, even in my own lifetime, seen disparities where with my last child, who is 5 years old, you know, I knew stuff, but I didn't know a whole lot about the -- hour -- that -- that golden hour. And so, for me, as I learned, I was realizing how much I, myself, have experienced health disparities and just having people feel as if well, you're supposed to know. And so, this is what spurred me on to become a doula. Everything that my sister said before, you know, it's that and then some because I have walked into patient's rooms where doctors don't promote breastfeeding with black mothers -- black- and brown-skinned mothers, but then they go to another room and then it's no, you want to breastfeed the child. And so, I've seen that firsthand and coming out into the community, being able to connect with the

Healthy Start Program at the county level as a contracted doula with Syracuse Community Connections, I see mothers crying out for help.

My most recent experience, we have mother and baby class that happens in the community and one mother, she wanted to breastfeed. The doctor she went to -- the pediatrician -- ended up telling her the baby was losing weight. This baby is 3 weeks old, the baby was losing weight, it's best to give her a bottle. Now, this is a mother who wanted to breastfeed exclusively and in that class, we learned that, you know, what her wishes were weren't taken into consideration.

In addition, what was not said is let me connect you with a lactation counselor or someone that can help you evaluate the latch because she complained of nipple pain.

So, some of these things, you hear often with the clients that they are not being heard.

I had another mother, even though she

was going to a methadone clinic, she was being treated at one of the local prenatal centers and they talked down to her. They made her feel guilty. They made her feel, instead of empowering her that she was connected to the methadone clinic, that she was connected to services in the community, she was made to feel less than a person. This is her words exactly. So much so to the point that when the baby was born, she had an experience where the -- she wanted to breastfeed. We understand that there are contraindications sometimes to doing that, but as opposed to suggesting, you know, let's listen to her, let's hear what her story is, how can we help this mother, that is not the case.

A lot of times with the clients that I've seen, they're sent home and there are no support systems in place. Now, one of the hospitals, they do have a group session that happens -- a support group session that happens centered around PMAD, but black- and brown-skinned mothers, the reality is that the trust is not

there. And not only that, the means to get to some of these support groups is not there because there's more than one child in the home, there's transportation issues, there is the issue of cultural competency that if you don't walk in my shoes, you don't fully understand what I'm going through. So, all of those things cause a risk to mothers who are in the community and experience disparities.

I remember one time as a person in the hospital working in the health care, I've seen mothers die and most times it's the black- and brown-skinned mothers that pass away during or after childbirth. One particular scenario, this mother passed away, but before she was brought down to the Prenatal Unit, she was complaining of pain, but no one took her seriously and she came down as a transfer to the unit and later on ended up passing away because what she complained of, we later learned that she was complaining of leg pains, she had a blood clot, you know. So, these are some of the things that I would like to see

addressed in the community when we talk about mothers -- black- and brown-skinned mothers, especially, they face so many challenges -- challenges with housing. I have one particular client right now who was waiting on housing and, you know, it's like they are living in conditions that we would not put ourselves in. And so, it's a slow turnover. It's a very slow process to get things happening in the community.

So, I would love to see from this meeting that some of these issues are really addressed: cultural competency and connectivity from the hospital to the transfer home where mothers feel supported and they are heard, that they are listened to, that they're not made to feel less than, because their voices are so powerful.

And I just want to say thank you for having me on and I look forward to what comes out of this meeting.

EDWARD EHLINGER: Well, thank you very much. Thank you for your story. Thank you

both of you.

So, are there some comments or questions that members have, and if you do, raise your hand and ask some questions. Steve Calvin.

STEVEN CALVIN: Yeah, hi. Merlin and Efua, thank you very much for your work and for sharing your perspectives. I work with midwives in a practice that cares for about 450 mothers per year and about 15 percent of our mothers are mothers from black or indigenous women of color and do you have any advise in how we can, I don't know, kind of how we can educate the community about the availability of doula services; that would be question number one. And then the other, do you feel like the larger team actually incorporates your perspectives and views? I mean, we're working toward a team approach for maternity and newborn care, and I wonder about your experiences and if you have any advise on how we might kind of bridge some of the gaps and educate some of our colleagues.

MERLIN MARRAIN-JACKSON: Definitely.

I would love to take a stab and thank you for that question. At Syracuse Community Connections, which is the organization that I am contracted with, they have -- and before I did that, let me tell you I used to oversee the Healthy Start Program, and it was through overseeing that program that I decided no, I need to do the doula -- learn or do the doula certification -- and what we started doing was lunch and learn with the doctors. Then we did lunch and learn with the nurses. And some hospitals, they were really rigid in terms of who is going to be in that -- in that labor room when mother is giving birth. Some still say we still have individuals who kick back or hospitals that kick back on wanting to have doulas in the room. They count them -- and I understand COVID -- but in those hospitals where the doctors and they were really understanding the role of the doula, that we're not there to give medical advice but we really are there to help those patients understand what is happening and help them ask the right questions as well. So, I

would definitely say lunch and learn would be a great place to start for re-educating the medical staff about the role of the doula.

EDWARD EHLINGER: Efua, do you have any comment?

EFUA ANSAH-ELEAZU: Yes, please. I do. Thank you. Thank you Merlin for that. Just like you, I've seen a lot of kickback in hospitals in Staten Island. It hasn't been easy with this journey. Especially now with COVID, I know that, you know, there are protocols that have been in place and it's the right thing to do.

But it just really hurts me to know that some of these moms and their partners just lack that support, you know, what to expect, the anxiety, you know, just thinking about, you know, how it's going to be, especially for their first time -- first-time parents not having that someone that you've been with, who you've bonded with through the whole journey, the whole pregnancy, and just to find out that she's not going to be there. It -- it hurts me as a person, as a doula,

as a mother, you know, because they trust us, you know, to -- to be their guide, you know, to hold their hand through the process, and I would love for there to be more of an understanding, you know, with the team and the hospital just to let them know that we just -- we are just there to support, you know, and we have created a huge impact, you know, in terms of lowering infant -- maternity and infant mortality, lowering the risk of c-sections, you know, being able to increase the chances of mothers having VBACs. I, myself, have supported over ten women, you know, with their VBACs, okay, and having non-medicated births, okay, first-time moms no epidural, no -- like, I mean, that's just amazing, like for them to just have that empowerment, you know, just to let them know that you can do it. You can do it. You, you know, it's going to be difficult, but just having that person who has been through that journey, who -- who can tell you how it's going to be, it's important to have that.

So, we need to collaborate more, use

technology, media, I don't know what Facebook, Instagram, you know, talk more about these things, more forums like this. Thank God for Zoom and all these platforms. I think we need to have more awareness, okay, more Healthy -- Healthy Start Centers all over the world need to promote this. And what's so unique about Community Health Center and Richmond Healthy Start Staten Island is that we have, you know, our pediatricians supporting us. We have our midwives supporting us. We have, you know, other case managers who have all been trained -- 99 percent of our case managers are doulas now. I'm talking about birth and postpartum and lactation counselors. So, we take our -- our work and our support into society really, really serious. You know, we transition from case management, childbirth education classes, lactation classes, and we've seen over 80 percent, 90 percent of our women are exclusively breastfeeding. I mean, how -- how amazing is that?

So, I've seen -- I've seen that.

I've seen the journey. I've seen the impact of doulas and I think that hopefully in a couple of years, it would get better and better and better and I think that that will -- that will impact our society and this country, and the world, you know. Thank you so much.

EDWARD EHLINGER: We've got a couple more questions. One from Belinda and then Jeanne Conry. Belinda.

BELINDA PETTIFORD: Thank you, and I appreciate Steve's questions today because I do know that in the midst of the pandemic, one of the things we were hearing around our state from our hospital is that doulas were not allowed in the hospital. So, we definitely need to make sure they're integrated with the system.

But for Merlin and Efua, thank you so much for your presentation and your wonderful experience and the great work you're doing. Can you share briefly your training that you received to become a doula because we -- we're looking at it in our own state and we're, you know, doing a

landscape analysis. So, I'd love to hear what you actually go through for your training.

MERLIN MARRAIN-JACKSON: So, for myself, we've been trained by a group called Ancient Song, which is out in Brooklyn, New York, and we did a four-day -- full four-day training, but we also had books that we had to read. We had three book reports that we had to do. We have reports that we had to shadow another doula on and then we had reports that we had to do as well. So, in all, it's about a year with going through the process from the theory to the practical.

BELINDA PETTIFORD: Thank you, Merlin.

EDWARD EHLINGER: Efua.

EFUA ANSAH-ELEAZU: Yes, please. Thank you. Yes. So, I was trained by Healthy Women, Healthy Futures, and this is a citywide scholarship by the city, and I was one of the first doulas that were trained that went to Borough Hall and we matched and we were able to get the funding and if you don't know Debbie Rose,

she is one. Yeah, so I training is by DONA. DONA is international. So, anywhere you are in the world, DONA is recognized, okay? So, our training is pretty much -- so, a couple of days in the week, I believe it was five days, and then after that, you went through continuous training. So, continued education with breastfeeding, safe sleep, you know, professional development, just everything, okay, and we also had opportunity recently to train doulas to be lactation counselors.

So, after that, you'll get certified with DONA and you are recognized on their website in the hospitals, especially now with COVID, you are able to be looked up in the system to see if you are certified. Most of our hospitals in -- the two hospitals in Staten Island prefer that you were trained by DONA. So, that's the training we got.

EDWARD EHLINGER: Good. One last question.

BELINDA PETTIFORD: Thank you so

much.

EDWARD EHLINGER: One last question from Jeanne Conry.

JEANNE CONRY: Thank you, Merlin and Efua, for an excellent summary of what you are able to provide -- the support that you provide for women, and I think actually the fear that many of us have seen with this last year and COVID, fear from the patients, fear from the health care providers, and certainly fear from everybody, which just influences things in a very negative fashion. So, I appreciate you describing how difficult this last year has been.

As we look forward to the coming year, hopefully putting much of COVID behind us, what would you say are the next steps we need to do to be able to embrace? I heard social media in terms of embracing support for women in labor. But we've certainly seen that much of women's health has been marginalized in the COVID pandemic. What do you think we need to do going forward to put support for women, support for

women's health, first and foremost?

MERLIN MARRAIN-JACKSON: I believe that one, it would definitely be more financial supports because as a doula, even though you may follow that person from -- you may get them when they're almost due, so they're one month or they're a couple weeks sometimes before their delivery date and that relationship that the doula builds isn't just limited to six weeks after delivery.

Sometimes, I have clients now that I've been following for over six months to ensure that they are following up and to ensure that the housing that they are seeking, that they are getting that type of services. So, I would definitely think that funding needs to happen because with the funding comes the availability to open up the -- the platform for more doulas to be trained, for longer services to be provided to these doulas or to these clients.

Then I want to say that definitely reaching into the hospital settings and building a

bridge. There has to be a way for the hospital to know what's in the community. So, definitely connecting the hospitals with the resources that the community has in that no client or no patient leaves the hospital without being connected to someone in the community, be it a lactation counselor or consultant and that should happen visa versa in the community, in those antenatal and prenatal clinics. Those clinics need to know what is happening in the community level so that if you spot a mother who needs additional supports, you know what's happening in the community and this way, there is a full circle where from the community, the community knows what resources there are so that they know where to go find doula assistance whether or not they can afford it, yes or no, to connect with those classes happening and then from the doctor's office visit, they know to connect the hospitals and the community to each other to the services being provided. So, definitely more promotion, not just on social media, but I think this has to

happen on a managerial level so that it's very intentional that we know that when you go to the hospital, you're going to be referred back to us so that we can follow up with what's happening with you and connecting you with the primary care services that you need as a mother to ensure that you have good health.

JEANNE CONRY: Thank you. So, I'm hearing that important term is that connection is probably the most important -- communication and connection and more than just labor. It's that connection, you know, whether we -- the [indiscernible] or the support that we see for women across that lifespan. Thank you.

MERLIN MARRAIN-JACKSON: Yes.

EDWARD EHLINGER: Efua.

EFUA ANSAH-ELEAZU: Yes. I think I agree with you, Merlin. Thank you so much for that. I also think that Medicaid should promote -- - Medicaid and the insurance companies should promote doula services and support. I think that, you know, just like when you find out you're

pregnant and Medicaid is able to cover your insurance through the pregnancy, it should be part of it. It should be part of the -- it's just, you know, basic support that you're giving to the mothers, you know, having a lactation counselor, breastfeeding support. All this can be included.

I remember, I believe, two years ago that was something that was being looked into, which is doulas being, you know, we were going to be part of Medicaid. I was one of the two doulas who were participating in this in Staten Island. Unfortunately, not too many people -- not too many doulas signed up because they complained about how much they were going to be reimbursed. So, I think that that's a really important factor from the prenatal support, you know, just knowing that it's part of what they are eligible for, and if their income, you know, doesn't take care of that, then maybe they can get some kind of, you know, reduction in their payments or, you know, just how -- how can I pay for this, you know, what's out there, what are my chances, you know. And I think

that at the end of the day, it will all come together. This way the doctors, the providers, the OB/GYN, the nurses know what okay, this is what she's qualified for and we don't have to go through all of this chaos, you know, when they get to the hospital. Thank you.

EDWARD EHLINGER: Thank you both of you Efua and Merlin. You had great presentations, lots of good information. The more I learn about doulas and the impact they have on reducing disparities and improving birth outcomes, particularly engaging in populations of color in American Indians in the health care system in a really effective way and the need to really have that connection with that helper throughout pregnancy and postpartum, not just right at the time of labor and delivery is so important. The data to me are becoming increasingly powerful and yet there are so many barriers in terms of reimbursement. It's hard to have a profession being a doula and make a living on it with the reimbursement that's there. And so, we have a

whole bunch of recommendations that we will be discussing today and tomorrow related to doulas and others that I hope will help move us forward. So, thank you very much for your presentation. It was really a wonderful addition to our meeting.

MERLIN MARRAIN-JACKSON: You're welcome. Thank you for having us.

EFUA ANSAH-ELEAZU: Thank you so much for the opportunity.

MERLIN MARRAIN-JACKSON: Would you like us to stick around or --

EDWARD EHLINGER: You're welcome -- you're welcome to be part of the meeting. It's an open meeting. So, you can, you know, join in as like all of the other participants on this committee.

EFUA ANSAH-ELEAZU: Okay, thank you.

EDWARD EHLINGER: Thank you.

MERLIN MARRAIN-JACKSON: Thank you.

LETTER TO SECRETARY

EDWARD EHLINGER: All right. Next on our agenda is the letter to the Secretary. The

three things that I really wanted to do on this meeting is, you know, one, finalize the letter to the Secretary, second is come up with some -- some draft recommendations that we can work on over the next couple of months to finalize in June, and then to have some conversations just about some of the organizational issues related to SACIM in terms of our charter and bylaws and things like that.

So, now let's -- let's talk about the Secretary's letter. My -- my goal was -- it was just to have an introductory letter. Can we stop the shared screen so I can see faces other than -- all right, good. The purpose of the letter was just introductory to say: Dear Secretary Becerra, Congratulations on your appointment. This is who SACIM is. We've had an impact over the 30 years and we will pledge to work with you on advancing health equity and optimal health for all, particularly related to kids. I tried not to put in any recommendations because I think that -- at this point in time -- because that's what we're

here today to really discuss about some of those recommendations and have, you know, get input from the committee. And I wanted to keep it as short as possible so that the Secretary would read it and have some -- know that we're here.

So, I sent copies to everybody on the committee, and so, I'm wondering if anybody has any comments or concerns or things that they would like to do to make it a better letter.

And Jeanne, you have your hand up. I don't know if that's from the previous or for here. Okay, Jeanne.

JEANNE CONRY: Yeah. No, it's for this. I -- I'm very supportive of the letter. I thought it had the right tone that we're introducing ourselves and we're welcoming Javier Becerra to his position. So, I liked what it stated and how you stated it. So, thank you very much for a very reflective letter.

EDWARD EHLINGER: Yeah. I also had, you know, one to introduce ourselves but I also wanted to put us on -- give us a little challenge

that we're going to come forward with some recommendations. So, now if we say it, maybe we'll get it done.

Any other comments? Tara.

TARA SANDER LEE: Yeah. The one question I have, and I know that Secretary Becerra is very interested in getting better data, and that's been one of the focuses of our -- of our workgroups. So, I was wondering if we could, in the statement where we say that SACIM is poised to make recommendations, you know, regarding, and then we have a list of things, and also data has come up many times as far as like in just improved data in general, especially regarding maternal mortality to make sure that no -- no data is missing, especially when it comes to the underrepresented members of our country.

So, I was wondering if we could add just maternal mortality data. So, you know, SACIM is poised to make recommendations related to and then just add maternal mortality or maternal mortality and infant mortality data.

EDWARD EHLINGER: Yeah. That would be -- I think that's a good -- good addition. We will make -- because we will be adding that into some of our recommendations from what I've seen from the draft. So, yeah, I will do that.

TARA SANDER LEE: Thank you.

EDWARD EHLINGER: Data related to maternal and infant mortality.

TARA SANDER LEE: Exactly.

EDWARD EHLINGER: All right. Does anybody have any -- I'd like to send the letter out from the committee, not just from me. I'd like to say, you know, here's the Secretary's Advisory Committee. Does anybody have any concerns with, you know, just that blanket here's from the members of the committee?

JEANNE CONRY: No, I think, I mean, I'll be completely honest. I don't agree with all of Secretary Becerra's policies that I think are coming or have already come. But I -- I -- I do believe that it's worth a congratulatory letter, and so my only ask is that going forward that this

-- this same form be applied to whatever Secretary is -- is hired into this position moving forward regardless of their position.

EDWARD EHLINGER: Yeah. I tried to keep it as neutral as I possibly could and as honest as I possibly could. So, thank you for that. I recognize that. All right. So, seeing no issues or concerns of anybody being part of that from the Secretary or from the whole committee, I will take that as -- Colleen.

COLLEEN MALLOY: No, I'm fine with sending the letter. I think that I was wondering do you know if SACIM has done that in the past like with Secretary Azar to have been sent a similar congratulatory letter before?

EDWARD EHLINGER: I don't know that. I wasn't -- I've only been around for, you know, a couple of years, and so, I --

LEE WILSON: That is not the case. There was not a letter sent.

EDWARD EHLINGER: Okay. So, this is a new thing. The reason -- you know, I think the

reason we want -- I really want to send a letter is just because I don't think SACIM is very well known, and I really do want to be proactive in saying we're here. We've done -- we've really done some good work over the years, and so, we want to be on your radar so that when we -- when our recommendations come, they're not coming out of the blue and he will say oh, I've got to pay attention to this.

PAUL JARRIS: It's a nice courtesy. I can't see any downside to a polite letter of congratulations to raise awareness.

JANELLE PALACIOS: Hi. It's Janelle. I -- Ed, this is a timely letter. This is reflective of the times that we're living in. It's the tone, I felt also, was -- was thoughtful and it's really reflecting like what our country is dealing with right now, like in the city that you are living in right now, you are living some of these experiences. You're seeing what is coming from some of the racial inequities that we have in our country. So, it's a one-page easy

read and Javier knows that more is going to come from this group.

EDWARD EHLINGER: Good. All right. Any other comments? All right. Then, I will -- I will finalize this letter. I will add what Tara suggested related to data -- related to maternal and infant death as part of our forthcoming recommendations and then get this out as quickly as I can and I'll work with Lee and Vanessa to make that happen. Excellent, excellent. All right. All right.

SACIM RECOMMENDATIONS (COMMITTEE DISCUSSION)

EDWARD EHLINGER: So then, the next thing is really getting into the -- the core of our work for these couple of days. As I mentioned in my introductory comments, there's so much going on. Things are happening really, really quickly and almost every day, something new comes out and changes are being made and policies are being implemented and executive orders are being issued and it's hard to keep up. And if we don't act quickly, some of our recommendations may be

irrelevant. And just -- but there's an opportunity, I think to weigh in on what we've been doing -- what we've learned over the last couple of years.

So just, for example, last week, which was Black Maternal Health Week, there was a meeting sponsored by Black Mamas Matter and they had a video conference with the Secretary and they came out with -- during this conference, they came out with some -- a lot of recommendations, you know, make Medicaid expansion sustainable beyond a year wanting the fourth trimester care, develop maternity homes, develop performance measures relating to the experience of receiving care, develop composite measures of good postpartum outcomes, enhance birth centers, establish maternal and infant mortality reviews in every state, mandate and fund fetal and infant mortality reviews in every state. They came out with lots of recommendations and a lot of people are coming out with those recommendations, and many of those are being implemented. So, I think we have an

opportunity or also then as part of that, AMCHP, the Association of Maternal and Child Health Programs talked about expanding Title V to deal with some of these issues and the March of Dimes also weighed in on the Momnibus Act and the Maternal Death Reviews.

So, the American Rescue Plan is providing lots and lots of opportunities for action and funding for a whole variety of things. So, things are going to happen. So, that's why I really want to take these couple of days to look at what our recommendations are and we've got to move those forward as quickly as we can given our bureaucratic responsibilities of, you know, having conversations and voting and getting consensus so that we can put something forward in June, which may be, you know, which can be implemented, I hope, by this administration.

So, what I've shared with you over the last couple of weeks are some draft recommendations that -- that came about from what we've learned over the last two years as a

committee. These are issues that have been raised by SACIM members or raised by people who testified with us -- before us and also by polls from other groups, particularly the ACOG, Jeanne Conry shared what ACOG -- a letter that that ACOG had sent to the Secretary using some of their language because it matched what we had talked about, putting forward into these recommendations in these areas that I mentioned here: COVID-19, migrant and border health, physical environment, and workforce and systems of care because those are sort of the areas that we've been looking at.

And so, what I would like to do -- and so, like in COVID, I would like to really have the -- the breakout sessions kind of look at the recommendations that we've already made, which are now -- which we made back on June 30th of 2020, see which ones are still relevant, are things -- do some of them need to be changed, are there new issues that need to be put forward in those recommendations related to COVID, are there ways that they can be targeted a little bit more to

maternal and infant health, migrant and border health, brand -- not a brand new issue, but an issue that certainly has become much more visible in the last year and much more urgent in terms of its needs. The physical environment, Jeanne Conry put together some recommendations from the presentation that they made, I think an important area that a lot of people aren't addressing -- this is one area that I've not seen a whole lot of action going on that's visible -- there might be a lot of action going on, but I just don't see it -- that we can actually have some stake in, and then the whole series of system and workforce development issues that really could be quite large in their scope.

So, that's why I wanted to have us break up into teams to look at these things and do several things, and I'm going to try to share my screen if I can and so this is what I'd like to have our groups break up and I've got -- I put together an hour each for discussions of two topics at a time. The first one, Session 1, would

look at COVID-19 and migrant and border health, and then Session 2, physical environment and workforce and systems of care. And this is what I'd like to have happen in there, that we look at these draft recommendations, recognizing where they came from -- from the input from our committee over the last two years, from people who have testified before us, and some of what we're seeing from other aligned organizations -- really to look at those recommendations and find out which ones are unique to SACIM that nobody else would be making, because I think those need to be brought forward. If nobody else is going to make these, somebody has to make them and those are things that would be particularly important.

And then also, since things are changing really rapidly, are there recommendations already being implemented that need to be reinforced or continued? Some of the things are going to last a year but there's no legislation to keep them moving beyond a year, or should they be modified -- current activities, should they be

modified.

And particularly, many recommendations are out there related to racial equity that -- that really don't specifically focus on infants and mothers, and are there ways to really target that a little bit more specifically in getting these recommendations in each of those areas. Is there anything important that is missing, and I did get a couple of comments from folks, you know, over the last day or so that I wasn't able to incorporate and get back out to you, and I hope those come up in our -- in our conversations in those smaller groups. Anything important that's missing that should be included.

And should there be things that are dropped? There's a lot of -- a lot of recommendations here. Some of them have already been made that don't need to be made again. Should we, you know, like particularly in the COVID area, are there things that we should not have to state again? We may say our

recommendations are still relevant but not highlight those.

And then are there things that we should prioritize that -- that -- because if we have a whole variety of things, are there things that we really want to make sure that this gets -- it's identified and moved forward as our recommendation.

And then obviously, as we put these recommendations together, we want to make sure that we have supporting data. Are there more things that we need to really support the recommendations? And my -- my hope is that what we will do is come up with some tighter recommendations that we can come to a consensus to and then over the next three to four weeks, actually have individuals of our committee work on honing those recommendations and getting them to final form that we can get to the committee and we can vote on and act on in June. And from there, I would like to again, like we did last year, put our recommendations in a letter that would go to

the Secretary with the recommendations. But also, I note MCHB is putting out a more -- a broader report with a little bit more background that the recommendations would also be part of a -- a more comprehensive report that will come out a little bit later in the summer so that we would get something gout to the Secretary shortly after our June meeting and then have a more comprehensive sort of background piece that would come up later in the summer.

So, that's what I'm hoping that will come out of these -- these groups that we're having. And so, what I would do now -- so, are there any questions with that and I can stop sharing the screen here. Any questions about that? All right.

And I've arbitrarily placed you in groups and people have agreed to -- some people have agreed to sort of facilitate the conversation. It's, you know, we're all in this together, but somebody's got to sort of facilitate the conversation. And so, in the COVID group,

I've put Paul Jarris, Steve Calvin, Tara Sander Lee, and Jeanne Conry and Paul has agreed to facilitate the conversation. In the migrant and border health, Paul Wise, Janelle Palacios, Belinda Pettiford, and Colleen Malloy, and Paul has agreed to kind of facilitate that conversation. And so, that would be the conversation for an hour on these two topics of, you know, are they -- what's unique in this area, what needs to be put forward, what are our priorities, are the things going on that we can support in this area, recognizing that when we put this together finally with a letter to the Secretary, it may be organized in a little different way than these four categories, but that still remains to be seen. So, any questions about that? And you know where you're going.

And then, in the second hour, I think what we'll do is we'll put something in the chat saying, you know, your time -- the first hour is done, let's go to our second breakout group. And so, the second breakout group is in the physical

environment area, Jeanne Conry, Tara Sander Lee, Paul Wise, and Jeanne has agreed to facilitate that one. And in the workforce and systems of care, Steve Calvin, Janelle Palacios, Colleen Malloy, Belinda Pettiford, and Paul Jarris, and Steve has agreed to facilitate that one. And then, when we're done with that, we'll come back and do a little debrief about what we learned with that.

So, any questions or comments? And other members, other people from Ex-Officio members can choose to go into any one of the breakouts that they choose. I know some have identified to me ahead of time that they were going to go into certain ones. But we enjoy having others join into these work breakout group discussions.

All right. So, whoever is driving the boat, can we put people into those discussion groups?

VINCENT LEVIN: Yep. Hi, everyone. This is Vincent. I'm with LRG, the meeting

contractor. So, if you were with us for our January meeting, hopefully you remember the process. To make this easier, we have everyone self-select their rooms. So, I just put a link in the chat, and it's also on the slide here. When you go to that web page, it lists the sessions that each room is covering and the Zoom link for you to click on so you can put yourself in the meeting.

EDWARD EHLINGER: And then, Vincent, will somebody send a note at the end of an hour to, you know, choose the second group?

VINCENT LEVIN: Yep. We'll make sure this link gets reposted and you have LRG's staff numbers in all rooms.

EDWARD EHLINGER: Okay. Very good. All right, everybody choose your corner to go in and the bell will ring, and we will work on the recommendations. I hope you all have copies that I sent to you that you can work from. If not, let me know and I'll quickly E-mail something to you.

[Off the record at 1:16 p.m.]

[On the record at 3:36 p.m.]

DEBRIEF OF BREAKOUT SESSIONS

EDWARD EHLINGER: All right. I think we should probably get started and hope that others will sign in pretty quickly because I do want to stick to the agenda and end by 4 Eastern Standard Time. I like to always stick to the agenda as best I can in terms of timeframe.

What I wanted to do with this little half hour of debriefing is just to see from the various breakout groups if there was anything that, I mean, first of all, if there was a general agreement that most, if not all, of the recommendations were sort of -- that were in that draft form were still on target, if there are some that should be eliminated, if there are some gaps that we need to develop new things, a general sense of is this -- are they going in the right direction of where we want to go, recognizing that more work needs to be done and what I hope will happen is that any notes that people took during the sessions they could forward to me and then I

will also get some feedback from the notetakers that were at each of the sessions and then tonight and tomorrow morning, I will work to try to put them into another format to allow us to have a little bit more discussion tomorrow morning and then have the workgroups -- our data workgroup, our equity workgroup, and our health systems workgroup -- look at all of those recommendations from their specific perspective. Are we, you know, are there some overriding data issues, are there overriding equity issues, are there some overriding workforce or care systems issues that need to be addressed so that we slice the view of these recommendations from a couple of different things -- one from topic focus and then one more from the workgroup focus.

And so, I know that a couple of the sessions -- breakout groups had fewer recommendations, particularly the physical environment and the migrant health area and that the COVID and the health systems one had, you know, a lot more draft recommendations. So, why

don't we start with the physical environment, and I know that went fairly well. There was pretty general consensus there. So, maybe Jeanne, you could fill us in on just generally what you thought of that session and what you might suggest we think about moving forward with what was talked about there.

JEANNE CONRY: Sure. Did you want me to share the screen or just discuss broadly?

EDWARD EHLINGER: I think you can just talk because there wasn't -- I didn't see a whole lot of changes that were made from what was distributed earlier.

JEANNE CONRY: No, thank you very much. No, it was pretty straightforward. Everybody has the statements. We're going to rearrange it a little bit to make it look a little bit better. But Tara had a great recommendation that we provide the broad perspective. When we're talking about exposures to the environment, it's as important to realize and historically understand that exposures may be as broad as and

as inclusive as drugs, alcohol, tobacco, even, I think, from some of our perspectives, blood sugar for a woman with diabetes. So, those are forms of toxic exposures. Much of the time, it's a choice -- a personal choice about taking drugs, exposure to alcohol and tobacco, but it's also as expansive as toxic substances in the air we breathe, the water we drink, the food we eat, and the products that we're using. So, in those circumstances, there's less of a choice without regulatory -- strong regulatory influences.

So, with the latter, we've got a mother and infant having very little means of timing or limiting their exposure to toxic chemicals because of life circumstances, demographics, social determinants of health. So, we thought it was important to call out those -- to address all of them, but then call out some of the differences there. And then it's the regulatory agencies that will protect health.

And then we came up with, we decided to flip the descriptions around and provide

recommendations first and then background. So, for example, recommend that the Secretary of Health and Human Services commit and implement a major and sustained increase in research funding and policies aimed at protecting pregnant women and infants from harmful environmental exposures, and then we give the background based on the presentations that we had at our last visit.

Our second recommendation is that we recommend that Health and Human Services significantly expand and improve CDC's Biomonitoring Program, especially monitoring of pregnant women, infants, and children, and then we provide the background of where biomonitoring helps.

The third recommendation is that Health and Human Services invest in, strengthen, and expand CDC collaboration with the EPA. So, at this point, we're saying we've got our agencies that are important for regulatory and for research to implement, house, and maintain the most up-to-date data and better identify communities at risk

so that we can invest and build upon American children and environmental indicator series.

The next recommendation is that Health and Human Services direct the Food and Drug Administration to identify and eliminate all sources of lead in food, cosmetics, personal care products, with lead and other toxic metals in baby food as a top priority and coordinate with HUD and EPA to swiftly implement a multi-pronged nationwide strategy to eliminate all sources of lead. This one, I would say, I think is absolutely critical because we know that there is no safe level of lead. So, all of us should be able to voice that clearly without doubt and say this is from a public health policy. We should make this, we should enforce this strategy, we should have it in all of our documents and then say EPA, HUD, everybody, it's up to you to make this happen, and they can figure out the logistics to that.

And then, let's see, we had a great recommendation that the Kellogg Foundation and

others fund a science-based RFA that would complement the current Kellogg Racial Equity Program, and this came about that the Kellogg Foundation has a Racial Equity 2030 Initiative to invest $90 million to fund bold solutions to drive an equitable future. We believe that this should be built upon with Health and Human Services funding so that it can complement what's going on.

And then, the final recommendation is that we recommend that all infrastructure projects be implemented with a focus on equity and improving individual and community health. So again, all the things that we're hearing about, whether it's transportation, energy, sanitation, safe water, it gets back to the water we drink, the air we breathe, the food we consume, our life circumstances were all the factors that are involved in social determinants of health. Those are going to have an impact on these -- on our populations, so making sure that the infrastructure focuses on safe health outcomes. So, that's it in a nutshell.

EDWARD EHLINGER: All right. So, the one thing that we need to get a little bit of work on is some recommendations particularly related to alcohol, tobacco, and other drugs as environmental toxins. So, we, you know, need to work on -- because I agree, we need the broader physical environmental recommendations but also the -- those chemicals that impact moms and babies. So, that still needs to be worked on. Thanks.

Comments from anybody else? All right.

BELINDA PETTIFORD: Jeanne, on this one where you're talking about you're looking at substance use and also you're looking for something around screening and treatment or are you looking more broadly?

JEANNE CONRY: This is a broad, you know, I think what we say is that when it comes to drugs, alcohol, tobacco, we actually have much more robust information, and I always put it when I'm talking with people, clinicians know that those are areas of concern but having that be part

of this broader discussion helps them understand that these are all types of toxic substances. So, whether we're talking about drugs and alcohol or we're talking about PFOA and lead, those are all in the same boat of toxic substances. On one hand, we're pretty familiar with drugs, alcohol, and tobacco, and on the other hand, we're not so familiar with these. But we should put them all together.

UNIDENTIFIED FEMALE SPEAKER: And they might compound each other too. So, I think that's --

UNIDENTIFIED FEMALE SPEAKER: Clearly, yes.

UNIDENTIFIED FEMALE SPEAKER: -- I that's -- so hopefully, that will come out of the research as well.

EDWARD EHLINGER: So, we need to do a little bit of work because, Belinda, this is a big broad range of things that you can work on all the way from education to, you know, marketing techniques and public policy related to price and,

you know, all of those things. So, I think we need to narrow it somewhat and get -- so, we'll do some work. We need to do some work on trying to clarify that.

JEANNE CONRY: And there is good research out of California with the Early Start Program that shows you can decrease infant mortality and complications with a concerted effort on drug and alcohol and tobacco programs. So, we've got very good data on Early Start.

EDWARD EHLINGER: Okay, good.

JEANNE CONRY: Thank you.

EDWARD EHLINGER: All right. And I don't see Paul Wise on here. That was the other breakout group that had fewer number, but Janelle and Colleen and Belinda were on that one. Any -- what was the tone of the conversation there with the boarder health and migrant health?

JANELLE PALACIOS: Sorry, just before we move on, Jeanne, in your discussion, did anyone bring up just the safeguard and establishment of clean water throughout the US for all people?

JEANNE CONRY: Well, yes, in the sense that that's one of the four -- it's the air we breathe, the water we drink, and calling on the EPA. We focused in one sense on lead but clearly, the PFOAs and the information is coming out on our water systems is critical. So, yeah, air, water.

JANELLE PALACIOS: Right. So, some strong language about that just, you know, given that, you know, in ten or twenty years, you know, we could potentially look very different and disparities could be even greater then with access to clean water knowing that we have communities today that lack access to clean water -- clean, healthy water. So, it would be lovely to have stronger language on that safeguarding it.

As I've said before in other workgroups, water is a commodity that we can buy on the New York Stock Exchange. That just happened, you know, a few months ago. So, it shows you that it is a commodity that is -- that is being vetted against.

EDWARD EHLINGER: Not a public good

or a right.

JEANNE CONRY: Right. We've got such good research that's come out of Irvine, California that an investment of, I think, what is it, I think $32 per person, which is currently less than a lot of people spend on their water, you can have an absolutely clean and safe water supply. So, we've got research that shows the potential. It shows that that potential isn't realized.

EDWARD EHLINGER: All right. We've got to move along here. Paul, you are on, good. What was the feedback or the sense from your group?

PAUL WISE: I apologize.

EDWARD EHLINGER: Paul Wise, Paul Wise.

PAUL WISE: Sorry, Paul Jarris. You win again. Sorry for getting on late, a few technical issues getting into the room. While there was general agreement on the proposed recommendations; however, there were several

different areas suggested for expanding the recommendations, particularly to ensure that people recognize the social services, reunification services, and mental health services that are going to be required for the children and families, pregnant women coming through the system.

It was also important to recognize that services should be provided to all migrant families, not just those recently released at the border, that there is a broader need for provision of access to services to a wider community, that community partners and institutions should be engaged to help ensure access to these groups. There was also a suggestion that for those families who are caught up in the zero tolerance program in which children were separated from their parents, there are approximately 7,000 estimated to have been separated, that HHS addressed their needs by providing appropriate mental health and social services for families that were, in fact, separated by the US government

during zero tolerance.

And the last was to recognize the special challenge of COVID and particularly the provision of vaccines when the approval for vaccines for young adults and children are appropriate and embraced by local public health authorities.

Let me stop there and see if anybody in the group corrects my mistakes or makes additional comments.

EDWARD EHLINGER: All right. So, it sounds like there was a good -- good consensus of the direction that you're going in. So, if you could send me, you know, whatever notes you had from your group, then we -- I'll put those into a document tonight and then we can have a more exhaustive conversation tomorrow afternoon when we get together to have the extended conversation. So, thanks.

PAUL WISE: Thank you.

EDWARD EHLINGER: All right. Any other comments from the rest of the team or

questions? All right. Then, let's go to the other Paul Jarris.

PAUL JARRIS: Great. Happy to be here with Paul Wise. So, basically, with the COVID-19 recommendations, there's two general ways of looking at it. One are recommendations specific to COVID-19 and the other is to address those systemic gaps that we have in our system that were stressed by COVID-19 and became more apparent or quite apparent.

So, in particular, with regard to COVID-19, making sure that the -- asking the Secretary to pay particular attention to pregnant women, lactating women, and infants regarding harm to their well-being, and that would include making sure that there are -- that these populations are priority populations and are considered in all the policies going forward including educational materials, support materials that are culturally appropriate, and in particularly community based to reach groups that otherwise were at greatest risk or vulnerable, assuring that there's a full

workforce that is educated and capable to support these individuals through COVID-19 as well, of course, in many other areas.

The telehealth has become quite an apparent tool. We want to make sure that really the whole comprehensive health care public health and social support system is intact and that telehealth is looked at within this context to see where it can particularly enhance the care of other systems and providers during a challenge like infectious disease and COVID-19.

With regard to what we would say at any point but is even more clear now is that recommending that Medicaid finance birth for a minimum of one year after the end of pregnancy or we use the word -- yeah, end of pregnancy. And we used the term end of pregnancy rather than delivery to be a little more inclusive of women who might have a poor pregnancy outcome to assure that they had care as well as those who go to delivery and making sure that we have, as part of this comprehensive system, looking at enhancing

the telehealth services such as appropriate monitoring tools that can be used by pregnant women, infants, and others postpartum so that if they do receive their services remotely, they have other tools that are necessary.

A lot of conversation on data and surveillance systems and the challenge of setting these up with regard to COVID-19 and pregnancy as well as COVID-19 pregnancy and under-represented or disproportionately impacted groups and the need to strengthen those systems and the interoperability of the systems.

We also thought it was important, whenever possible, to be consistent with recommendations for the OMH COVID-19 Equity Task Force or the American Recovery and Expansion Act or ARRA spacing.

I think those were the major things, but I would like to ask the group for additions, subtractions, or corrections.

EDWARD EHLINGER: You seemed to cover it from the perspective because I was in that --

in that group. Yeah.

PAUL JARRIS: Thank you.

EDWARD EHLINGER: All right. And then, Steve Calvin, from the workforce and systems of care. You had a couple of different areas to focus on.

STEVEN CALVIN: Yeah, we did, and some of it overlapped with Paul Jarris' group. So, that was helpful. I'll just make the quick comments, and I sent you a copy with comments in red.

When addressing the accredited birth center option, it was pointed out that it should just be as an option within a comprehensive system of care, which makes a lot of sense. There were -- there were comments about expanding and sustaining the public health workforce. Michael Warren made a really good point that workforce development efforts should be really mindful of what happened about a hundred years ago when there was kind of like a care improvement initiative that essentially eradicated or ended up stopping

the practice of traditional midwives, especially in the south, mostly black. They were removed from their communities as a practitioner under the guise of improvement of care. So, I just think we have to be really mindful of that. Probably when we're even talking about doula services and, you know, trying to strike a balance between adequate training but not making things so rigid and so just kind of unthinking that we end up actually doing some harm.

Colleen also recommended that we spend some time looking at training and availability and support for neonatal nurse practitioners because for midwives and neonatal nurse practitioners, there aren't enough training programs and there is a shortage around the country.

Fast forwarding here -- related to doula services, and I know, Ed, you know, you have done a lot of work with Mina and you know putting together a bibliography. Rachel from ACOG asked that there be citations regarding, you know, the

outcomes under recommendations related to doula services about improvements of outcomes, and I know we have that. And I think there was some discomfort about specific recommendations, the ones listed below, about, you know, the USPSTF and I'd be interested and, you know, Jeanne, you have as kind of a founding leader of the WPSI, the Women's Preventive Services Initiative.

Anyway, I just wanted to pass along that I think from an official standpoint, ACOG is a little nervous about kind of a huge push to suddenly have doula services available in, I mean, with all these recommendations. I think we just need to talk about it more tomorrow.

And then finally, Belinda brought up a really good point that as we recommend expansion or expansion of services and have kind of wish lists of things, I think we saw this in listening or we listened to Merlin and to Efua that we should really focus on expanding the current Healthy Start Program since it really does address health equity and has all along. And with that,

that's all I have.

EDWARD EHLINGER: Other comments? Yeah, I anticipated that there might be some discomfort with doulas. That's why I didn't say -- that's why I said the United States Preventative Services Task Force should evaluate doulas in terms of a preventative service, you know, recognizing that they have their own process. The same thing with the WPSI, you know, evaluate them as a preventative service.

JEANNE CONRY: Do you want comment now or tomorrow?

EDWARD EHLINGER: Tomorrow. I think tomorrow will be good.

JEANNE CONRY: Okay.

EDWARD EHLINGER: Then we can put it in broader context.

JEANNE CONRY: Yeah. There's a difference between service and who is providing it.

EDWARD EHLINGER: Yeah.

JEANNE CONRY: Okay.

EDWARD EHLINGER: Yeah. So, yeah, we don't have time for it. It's a longer conversation. That's why I built it in for tomorrow. I figured there'd be some, you know, various perspectives on it and details that need to be worked out. Anything else from -- any questions from the other members of the team related to the workforce and health systems? All right.

So, what I would like is if the leads from those breakout groups, if you could send me -- and I think some of you have already done it -- the notes from that, I will try to over the next 12 hours put that into another format and another draft to get out to you so that we can have a conversation tomorrow and then -- I will then from that have the work groups look at each of those -- the total set of recommendations from their various perspectives from equity to make sure that we're centering on equity with all of that work, that we've got the right data, and that our systems approach and workforce is comprehensive

enough to meet those needs, and then we can figure out the next steps of how to move forward after that.

All right. Anything else that we need to talk about today before we take our break and come back tomorrow afternoon or morning, depending on your time zone? Vanessa, anything? Michael, Dr. Warren, or Lee?

VANESSA LEE: This is Vanessa. Nothing on my end.

EDWARD EHLINGER: All right. All right. Then, let's -- we'll meet again at noon Eastern Daylight Time tomorrow and we'll go from there.

[Whereupon the meeting was adjourned.]

[Off the record at 4:00 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 3rd day of May, 2021.

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GARY EUELL

Notary Public