SACIM THE SECRETARY'S ADVISORY COMMITTEE ON INFANT MORTALITY U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

SECRETARY'S ADVISORY COMMITTEE ON INFANT MORTALITY

Meeting Minutes of September 23-24, 2020

Virtual Meeting via Adobe Connect

Please note that the meeting minutes follow the order of events of the meeting, which differed slightly from the final meeting agenda that was posted on the Committee's website

Table of Contents

IN ATTENDANCE ... 3
- Committee Members ... 3
- Ex-Officio Members ... 3
- Committee Staff ... 4
- Presenters and Speakers ... 4
- Voices from the Community ... 5

Wednesday, September 23, 2020 ... 6
- CALL TO ORDER ... 6
- SACIM WELCOME & INTRODUCTIONS ... 6
- APPROVAL OF MINUTES ... 7
- VOICES FROM THE COMMUNITY ... 7
- RACISM AND BIRTH DISPARITIES ... 9
- MATERNAL AND CHILD HEALTH BUREAU UPDATE ... 13
- FOLLOW-UP ON JUNE COVID-19 Recommendations ... 15
- MCH ORGANIZATIONS RESPOND TO RACISM ... 15
- RACISM AND THE POWER OF QUESTIONS ... 19
- WORKGROUP PRAXES ... 21
- WORKGROUPS ... 21

Thursday, September 24, 2020 ... 22
- WELCOME BACK ... 22
- BYLAWS REVIEW ... 22
- VOICES FROM THE COMMUNITY ... 22
- MATERNAL HEALTH, TELEHEALTH, COVID-19 AND EQUITY ... 24
- CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC) UPDATE AND HEAR HER CAMPAIGN ... 26
- WORKGROUP REPORT OUTS ... 28
  - DATA AND RESEARCH TO ACTION WORKGROUP REPORT OUT ... 28
  - CARE QUALITY AND ACCESS WORKGROUP REPORT OUT ... 28
  - HEALTH EQUITY WORKGROUP REPORT OUT ... 29
- PUBLIC COMMENT ... 30
- COMMITTEE DISCUSSION AND PLANNING FOR NEXT MEETING ... 30
- WRAP-UP AND ADJOURN ... 31

IN ATTENDANCE

Committee Members

Jeanne A. Conry, M.D., Ph.D., President, Environmental Health Leadership Foundation

Steven E. Calvin, M.D., Obstetrician-Gynecologist

Edward P. Ehlinger, M.D., M.S.P.H., Acting Chairperson of SACIM

Paul E. Jarris, M.D., M.B.A., Senior Principal Health Policy Adviser, Health Transformation Center, The MITRE Corporation

Tara Sander Lee, Ph.D., Senior Fellow, and Director of Life Sciences, Charlotte Lozier Institute

Colleen A. Malloy, M.D., Assistant Professor of Pediatrics (Neonatology), Ann & Robert H. Lurie Children's Hospital of Chicago

Janelle F. Palacios, Ph.D., C.N.M., R.N., Nurse Midwife, Kaiser Permanente

Magda G. Peck, Sc.D., Founder/Principal, MP3 Health; Founder and Senior Advisor, CityMatch; Adjunct Professor of Pediatrics and Public Health, University of Nebraska Medical Center

Belinda D. Pettiford, M.P.H., B.S., B.A., Head, Women's Health Branch, North Carolina Division of Public Health, Women's and Children's Health Section.

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

Ex-Officio Members

In Attendance at the Meeting

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

Alison Cernich, Ph.D., ABPP-Cn, Deputy Director, Eunice Kennedy Shriver National Institute of Child Health and Human Development

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

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

Danielle Ely, Ph.D., Division of Vital Statistics, National Center for Health Statistics, Centers for Disease Control and Prevention

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

Not Present at the Meeting

Ronald T. Ashford, Office of the Secretary, U.S. Department of Housing and Urban Development

Suzanne England, D.N.P., A.P.R.N., Great Plains Area Women's Health Service, Great Plains Area Indian Health Service, Office of Clinical and Preventative Services

Wendy DeCourcey, Ph.D., Social Science Research Analyst, Office of Planning, Research and Evaluation, Administration for Children and Families

Dianne Rucinski, Ph.D., for CAPT Felicia Collins, Deputy Assistant Secretary for Minority Health and Director, Office of Minority Health, U.S. Department of Health and Human Services

Karen Matsuoka, Ph.D., Chief Quality Officer for Medicaid and CHIP, Director, Division of Quality and Health Outcomes, Centers for Medicare and Medicaid Services

Iris R. Mabry-Hernandez, M.D., M.P.H., Medical Officer, Senior Advisor for Obesity Initiatives, Center for Primary Care, Prevention, and Clinical Partnership, Agency for Healthcare Research and Quality

Elizabeth Schumacher, J.D., Health Law Specialist, Employee Benefit Security Administration, U.S. Department of Labor

Diana Bianchi, M.D., Director, Eunice Kennedy Shriver National Institute of Child Health and Human Development, National Institutes of Health

Dexter Willis, Special Assistant, Food and Nutrition Service, U.S. Department of Agriculture

Committee Staff

Michael D. Warren, M.D., M.P.H., FAAP, Executive Secretary, SACIM; Associate Administrator, Maternal and Child Health Bureau, Health Resources and Services Administration

Lee Wilson, Acting Designated Federal Official, SACIM (on behalf of David S. de la Cruz, Ph.D., M.P.H.); Acting Division Director, Maternal and Child Health Bureau, Health Resources and Services Administration

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

Presenters and Speakers

Dorothy Cilenti, DrPH, Principal Investigator, Maternal Health Learning and Innovation Center at Maternal Telehealth Assessment Project, University of North Carolina at Chapel Hill

Joia Crear-Perry, M.D., FACOG, Founder and President, National Birth Equity Collaborative

Glenda H. Eoyang, Ph.D., Executive Director, Human Systems Dynamics Institute

Michael R. Fraser, Ph.D., M.S., CAE, FCPP, Chief Executive Officer, Association of State and Territorial Health Officials (ASTHO)

Lori Freeman, M.B.A., Chief Executive Officer, National Association of County and City Health Officials (NACCHO)

Rahul Gupta, M.D., M.P.H., M.B.A., FACP, Senior Vice President, Chief Medical and Health Officer, and Interim Chief Scientific Officer, March of Dimes

Zea Malawa, M.D., M.P.H., Director, Expecting Justice, San Francisco Public Health Department

Aunchalee Palmquist, Ph.D., IBCLC, Assistant Professor, Department of Maternal and Child Health, Gillings School of Global Public Health, the University of North Carolina at Chapel Hill

Andrea Serano, CLC, IBCLC, President and Chief Executive Officer, Reaching our Sisters Everywhere, Inc. (ROSE)

Sarah Verbiest, Dr.P.H., M.S.W., M.P.H., Co-Principal Investigator, Maternal Health Learning and Innovation Center and Maternal Telehealth Assessment Project, the University of North Carolina at Chapel Hill

Jonathan Webb, M.P.H., M.B.A., Chief Executive Officer, Association of Maternal and Child Health Programs

Voices from the Community

Latoshia Rouse, Birth Sisters Doula Services

Schyneida Williams, University of California-San Francisco

Dakisha Mitchell, Mother speaking on experience with Maternal & Child Programs (Healthy Start) in her community in Chicago

Kimarie Bugg, D.N.P., FNP-BC, M.P.H., IBCLC, Reaching Our Sisters Everywhere, Inc. (ROSE)

Wednesday, September 23, 2020

CALL TO ORDER

Lee Wilson
Acting Division Director, MCHB/Division of Healthy Start and Perinatal Services
Health Resources and Services Administration
(acting on behalf of David S. de la Cruz, Ph.D., M.P.H., Principal Staff and Designated Federal Official, MCHB/Division of Healthy Start and Perinatal Services, Health Resources and Services Administration)

Edward P. Ehlinger, M.D., M.S.P.H.
Acting Chairperson, SACIM

Mr. Wilson called the meeting to order as the acting Designated Federal Official in the absence of Dr. David de la Cruz. Appreciation was given to everyone for their participation. Dr. Ehlinger greeted the participants and expressed thanks for their participation, dedication, and support.

SACIM WELCOME & INTRODUCTIONS

Edward P. Ehlinger, M.D., M.S.P.H.
Acting Chairperson, SACIM

Dr. Ehlinger welcomed SACIM with notes about the United States' current socio-political climate, also highlighting SACIM's journey since 2018 with understanding health inequity and disparities. Dr. Ehlinger gave condolences to the 200,000 plus lives lost in the COVID-19 pandemic, which has illustrated these inequities and disparities, as there has been a disproportionate number of deaths among persons of color.

Introduction of SACIM & Ex-Officio Members

Dr. Ehlinger asked the Committee to introduce themselves and answer: What is the question that needs to be asked if we are to improve the health outcomes for mothers and babies?

- Ms. Belinda Pettiford addressed the question with "are we prepared and ready to truly address racism as a public health issue?"
- Dr. Colleen Malloy asked whether we are willing to recognize the sacredness, the importance of humanity of babies in this country, if we recognize it in all people to realize the value of infants and children of all races, all genders in America?
- Dr. Janelle Palacios asked if the nation is brave enough to face the changes needed to make improvements in infant health?
- Dr. Magda Peck queried how to strategically translate what we already know, in terms of data and research, into the actions that will lead to dismantling structural racism and promoting health equity for all to reduce maternal and infant mortality?
- Dr. Paul Jarris asked if we are willing to create the conditions needed to enable every woman, child, and family to be healthy, noting the opportunities needed for healthy women, children, and families throughout the lifecycle, which is far beyond pregnancy care, beyond healthcare and takes much larger environmental policy to look at the construction of society.
- Dr. Steve Calvin noted that changes within the system of maternity and newborn care needed to be made both from provider and payer perspectives. Dr. Calvin asked what the core barriers are that we need to either go around or knock over to provide better care?

- Dr. Tara Lee asked if we are ready to look seriously at the deficiencies in maternal mortality data collection, and the role that racial disparity plays in induced abortion, and the contribution that it plays to maternal and infant mortality?
- Dr. Wanda Barfield noted the importance of data and research and understanding these issues.
- Dr. Danielle Ely asked about the most important stakeholders that we would need to contact.
- Dr. Cheryl Broussard wondered what the evidence says that moms and babies need?
- Dr. Michael Warren asked how do we engage, support, and partner with states and communities to create optimal health across the life course to achieve equity in both infant and maternal health?
- Mr. Lee Wilson noted what can be done personally to listen to the needs of those individuals within the target population and those we are working with daily?
- Dr. Alison Cernich asked how can she improve real-world data to inform the way that we build the evidence to improve the health of infants and their mothers, especially through data solutions that are available to us to fix through health and human services?

APPROVAL OF MINUTES

Lee Wilson
Acting Division Director, MCHB/Division of Healthy Start and Perinatal Services
Health Resources and Services Administration

The minutes from the June 2020 meeting were reviewed and approved by the Committee.

VOICES FROM THE COMMUNITY

Latoshia Rouse
Birth Sisters Doula Services

Schyneida Williams
University of California-San Francisco

Background on Latoshia Rouse

To begin the opening of "Voices from the Community" Dr. Ehlinger welcomed Mrs. Latoshia Rouse, who is the owner of Birth Sisters Doula Services, where she is a birth and postpartum doula. She is the mother of a 10-year-old who was born at 36 weeks, and 7-year-old triplets born at 26 weeks. Her work has been at the hospital, state, and national level on progress relating to patient and family engagement and policy, research, measurement development, equity in pediatric and maternal and infant health area. Her passion is helping parents find their voice and helping clinicians learn from their experiences.

Latoshia's Experience

Mrs. Rouse shared that she is a mother of triplets that were born via emergency delivery. She described herself as a Black woman who was dismissed when seeking a doctor who understood her high-risk case. Without warning, she was told by her doctor's office, "We've done everything we can," allowing her only one last appointment with the doctor she wanted to deliver her. Mrs. Rouse recalled having a feeling her babies were coming early, and she rushed to find a new doctor in her county. She found a doctor, and

after one appointment, had beautiful triplets at 26 weeks, 6 days. However, 20 days later, Mrs. Rouse experienced a postpartum hemorrhage at home. On that evening, she awoke to a large pool of blood in her bed and called for an ambulance. She shared the lack of compassion she felt from the Emergency Medical Team that showed up. Rather than examining her bed to see how much blood she had lost or whisking her to the hospital, Mrs. Rouse said she was asked by the EMT what she did that day, what she took, along with other questions that further delayed her care. Mrs. Rouse expressed feeling upset by the questioning but feeling helpless and unable to get upset at the EMTs who were her only way out of there. She remembered her head dropping at times and when asked if she could stand up and saying she could not, the EMTs did not believe her and took her by the arm to stand her up. She then fell, and that was when she was taken out of the house. Mrs. Rouse said she never felt like she was a priority to the EMTs, possibly due to the neighborhood she lived in. Mrs. Rouse reminded the Committee that it is important for providers to see people as someone that needs help and not as a stereotype of the neighborhood they live in.

Committee Questions and Discussion

Dr. Ehlinger opened to Committee the discussion of Mrs. Rouse's experience:

- Ms. Belinda Pettiford stated that she was fortunate to work with Mrs. Rouse in North Carolina and that she is one of the Co-Chairs of the recent perinatal systems of care task force. She noted that it was important to know that Mrs. Rouse's husband was not at home during her emergency, because he had to work that night – many assume she has no partner. Ms. Pettiford felt it was important to address any bias people may have when listening to Mrs. Rouse's story. Ms. Pettiford also highlighted the importance of continued dialogue with providers as many providers are indoctrinated in terms of a certain attitude and perspective of certain groups of women.
- Dr. Steve Calvin stated that as a high-risk obstetrician who works with midwives, the story that Mrs. Rouse told was not unusual, unfortunately. Dr. Calvin noted the importance of a postpartum doula whose presence could help to offset and act as an intermediary in the problem Mrs. Rouse described.
- Dr. Magda Peck appreciated Mrs. Rouse's story, noting her strength during that tumultuous time and that emergency medical technicians were a part of the continuum of care. Dr. Peck asked Mrs. Rouse what care she needed that day.
    - Mrs. Rouse believed the need for her that day was for the service providers to walk into the home and say, "We are here to help. We've got you. We are going to get you to the hospital."

Background on Schyneida Williams

Dr. Ehlinger then introduced Ms. Schyneida Williams - a certified community health worker and the mother of a preterm low birth weight baby born at 35 weeks. Ms. Williams' professional development was furthered by her work as a case manager at New Beginnings, a homeless prenatal program where she is working intensively with pregnant women at risk for preterm birth. She became a member of the University of California-San Francisco (UCSF) preterm birth community advisory board in 2016 and recently started her journey as a community engagement coordinator across three initiatives under the UCSF OB/GYN department.

Schyneida's Experience

Ms. Williams described her experience of having her own preterm low birth weight baby at 35 weeks. Although she attended all of her prenatal care visits and had private insurance, Ms. Williams remembered

her experience of pregnancy as one that was misinformed, misguided, and miseducated. She shared how care providers did not take time to discuss or address the various social determinants of health that were impacting her life and her pregnancy (e.g., a sewage plant in her backyard, only one grocery store in the area, trauma from a family member's recent murder) or prepare her for the process of being induced (due to preeclampsia) and having a baby preterm. Providers used terminology and language that she did not understand and did not explain that having a baby at 35 weeks would require a stay in the Neonatal Intensive Care Unit (NICU). Ms. Williams recalls how hard it was to leave the hospital without her baby and was not prepared for that. She also had difficulty breastfeeding and pumping breastmilk while her baby was in the NICU. She felt heavy judgment was being directed toward her and toward the amount of time she was in the facility. She said it took an hour to get to the hospital, and she was trying her best to travel there and to feed her baby enough, so that she could be released from the NICU. Ms. Williams noted that she was left with little to build on, as she left and tried to begin a healthy journey with her preterm baby. Ms. Williams indicated that this lack of connection and education was what led to her making poorly informed health choices. She felt her care providers lacked context. Ms. Williams provided suggestions for SACIM including:

- Doula-midwife integration into the healthcare system
- Cultural awareness and sensitivity training
- Authentic community-based research
- Patient education at all pregnancy stages

Committee Questions and Discussion

Dr. Ehlinger opened to Committee the discussion of Ms. Williams' experience:

- Dr. Janelle Palacios noted how much power and privilege providers have, and how they can discount women, where they come from, and what their lived experience is. She said with this power and privilege, providers think that they know what is best for you, for your baby, and they disregard other things going on in a woman's life - it is important to note that women need time to process what is going on and space to think about choices, and allowed some time to take care of other things in preparation for having a baby.
- Dr. Wanda Barfield noted that as a neonatologist by training, she understood Ms. Williams' story and sees an expectation by hospital systems for women to conform to the culture of that particular place, which was incredibly frustrating and unfortunate. She said Ms. Williams' story resonated with her, in terms of the expectation that women needed to be visible to care. She noted that there are so many things going on in the postpartum period for women in terms of their needs, and additionally for self-care. Dr. Barfield highlighted we know all too often that women are suffering from postpartum complications that are leading to maternal morbidity and mortality.
- Several Committee members thanked Ms. Williams for sharing her story and agreeing to speak.

RACISM AND BIRTH DISPARITIES

Zea Malawa, M.D., M.P.H.
Director, Expecting Justice

Dr. Ehlinger welcomed Dr. Zea Malawa, Director of Expecting Justice at the San Francisco Department of Public Health, who introduced her presentation on "Racism and Birth Disparities" by highlighting that the project she leads takes an upstream approach to addressing racial health disparities in birth outcomes.

Dr. Malawa presented on the root causes of birth disparities, noting that when we talk about Black disparities a common belief is that pregnant Black people are engaging in problematic behaviors that lead to adverse birth outcomes. However, literature indicated that there is a correlation between structural and interpersonal racism in the medical setting. Dr. Malawa provided examples such as the mass incarceration of Blacks, and how Blacks and Whites use illegal substances at the same rate, however, Blacks are more likely to be arrested and convicted. Black men's arrests lead to disruption of family, and families are central to supporting birthing people.[1] In 2019, the lifetime risk of being killed by police if you're a Black man is one in 1000. [2]

Dr. Malawa noted that race determines your environmental exposure as well. Communities of color are much more likely to be exposed to pollution in their neighborhood than White communities. She described this as one legacy of the great migration - a majority of Black people have settled in highly industrialized areas and although the industrial jobs have since disappeared, the pollution sticks around and continues to impact Blacks disproportionately. A study from 2019 showed that on average, Black people inhale 56 percent more pollution than they create. White people are breathing in 17 percent less pollution than they create on average. [3] "From environmental gaps to educational disparities, noted is the implicit bias and "pull yourself up by your bootstraps" mentality, when many are given no boots."

Disparities in wealth exist as well – Dr. Malawa described historical policies like redlining and urban renewal which negatively affected Black families and caused them to have fewer assets. This meant many Black families did not have a safety net when they experienced the challenges that many families experience, such as job loss, divorce, or sudden illness.

Dr. Malawa continued by explaining that college was not a cure for wealth gaps. Many believed that if people could get a higher education, they could overcome other forms of structural racism. However, Dr. Malawa pointed out that a Black woman with a bachelor's degree earns less than a White woman without a degree, and the same is true for Latinx. She then described hiring bias that still exists in this country. For example, the Harvard Business Review reviewed 25 years of studies looking at hiring bias. Often in the studies, identical resumes were sent out to a variety of employers, one with a White-sounding name and one with a Black-sounding name. They evaluated how many of these resumes were invited for a call back interview. In the last 25 years, dozens of studies show there hasn't been a significant improvement in racial hiring biases.

Dr. Malawa then introduced the "Risk Factors for Preterm Birth" IOM report 2006 – 2011, which listed acute stress, racism, neighborhood conditions, anxiety, socioeconomic status, chronic stress, and work conditions as risk factors for preterm birth.[4] Mainly correlated by racism and stress, few met criteria of causality for preterm birth. She pointed out that downstream clinical interventions therefore were not as effective because at the root of the disparities was racism.

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[1] Human Rights Watch (2009), http://www.hrw.org/en/node/81105/section/4

[2] Edwards F, Lee H, Esposito M. Risk of being killed by police use of force in the United States by age, race–ethnicity, and sex. Proc Natl Acad Sci USA. 2019;116(34):16793. doi:10.1073/pnas.1821204116

[3] Tessum CW, Apte JS, Goodkind AL, et al. Inequity in consumption of goods and services adds to racial–ethnic disparities in air pollution exposure. *Proc Natl Acad Sci USA*. 2019;116(13):6001. doi:10.1073/pnas.1818859116

[4] www.nap.edu › resource › Preterm Birth 2006 Report Brief

Dr. Malawa highlighted the question, “How do we dismantle structural racism?” Expecting Justice, her organization that generated the Abundance Birth Project, gave light to a framework called “Racism as a Root Cause (RRC)”, which is not a “band-aid” approach. She explained the following criteria for the framework:

- The intervention or approach has to be long-term and sustainable. Racism and the sequelae of racism were not created overnight, and so interventions needed a lasting impact. She noted that when piloting an innovative solution, we should be simultaneously trying to identify a long-term sustainability plan for the intervention.
- The intervention must have a precise impact. When using the RRC approach, the precise impact on the prioritized population is important. She explained that a global approach did not acknowledge the fact that people were not starting at the same place. Centuries of historic racism and ongoing racism have deeply impacted Black, indigenous, and Latinx people and so they required a different kind of intervention than people who were not facing racialized barriers. A “colorblind” approach would lead to inequitable outcomes. She recommended local members of the priority population or community be at the table to inform the decision-making and development of programs to have an approach that addresses racism as a root cause. Last, to have a precise impact, Dr. Malawa said we must understand the specific racial barriers that a community is facing and not assume it looks the same from one community to another.
- The third criterion Dr. Malawa shared was to change systems. She said an assumption we make is that changing the mothers will lead to a change in health outcomes; therefore, many of our programs are about building resilience, building self-efficacy, motivational interviewing for individual mothers, etc. Dr. Malawa shared, as a Black woman, there is nothing wrong with us, and as her colleague reminds us - there is nothing inherent in our melanin that would lead to adverse birth outcomes. Rather than trying to change Black women who are trying to negotiate a problematic system, she said we should focus on changing the problematic system.
- The fourth criterion of the RRC framework is taking a reparations approach. For the RRC framework, Dr. Malawa explained reparations means a shift in resources, power, and opportunity into the hands of people who are facing racial marginalization. She noted that racism was created in this country to make it easier to extract wealth from racially marginalized groups. A 2017 study she cited indicated that in today’s dollars, Black people – just from slavery alone – would probably be owed around $17.3 trillion for their unpaid labor. Dr. Malawa said when we think about trying to heal communities that have experienced racism, it’s important to recognize that we have to restore some of what has been torn apart, taken away, or extracted if we want to see better outcomes.

Dr. Malawa then showed an example of what the Racism as a Root Cause Approach does not look like and an example of the correct use of the RRC Approach to dismantle systemic racism by presenting the Abundant Birth Project in San Francisco (an RRC Intervention), [5] which is the first-ever cash supplement program for pregnant women in the country. Dr. Malawa described a study from 2017 in Manitoba, Canada that showed that a modest increase in income for pregnant people led to a decrease of preterm birth by 17 percent. Low birth weight was reduced by 20 percent. Dr. Malawa said there was data that showed increased cash could reduce stress and improve birth outcomes. She shared the Abundant Birth Project would be awarding Black and Pacific Islander pregnant women with $1,000 a month for a year,

[5] www.expectingjustice.org › Abundant-Birth-Project-Fact-Sheet-11.19.pdf

and the study was addressing the difficulties for moms to bond with their babies due to financial circumstances post-partum, and she would be analyzing financial and birth outcomes.

Dr. Malawa said she believes the use of cash will cause a reduction of stress, and stress is one of the few preterm birth risk factors that meet the criteria of causality. She believes it may also help with financial planning and internal loss of control, financial stability and security, reducing exposures that lead to risk factors related to adverse birth outcomes, and help to rebuild trust with government programs. Within the first two years of the study, Dr. Malawa enrolled 150 Black and Pacific Islander women and was working with partners from UC Berkeley and UCSF as a community-academic project to help with evaluations.

Dr. Malawa then explained how her project trained four Black and/or Pacific Islander mothers from the community in qualitative research methods and interviewing. There were 21 interviews conducted to understand unmet financial needs and expectations from the program. The 21 interviewees were placed in a human-centered, design-thinking sprint by delivering Wi-Fi-enabled iPads across the city to ensure the "digital divide" didn't keep moms from participating during COVID-19. Dr. Malawa pointed out that this portion of the study was "designed by mamas for mamas", and the consumer experts were paid because their expertise was essential to high-quality programming. The consumer experts or "mamas" were given $100 per hour for community engagement, and funding was primarily through private philanthropy. She shared the city and county of San Francisco were also going to contribute money.

In closing, Dr. Malawa explained how the Abundant Birth Project addresses the following questions of the RRC framework or approach:

- Is it long-term? Yes, Dr. Malawa said she was working with funders to develop a policy opportunity, such as having the earned income tax credit potentially be a pathway for sustainability.
- Does it have a precise impact? Yes, Dr. Malawa explained that for this program, the focus was on the two groups of mothers at highest risk for adverse birth outcomes in San Francisco – which was Black and Pacific Islander people.
- Does it focus on systems change? Yes, she noted that rather than asking moms to work harder or save more, the program was trying to change the environment by giving cash, so it was easier for them to meet their financial needs.
- Does it have a reparations component? Yes, she reiterated that she and her team have been working hard to shift the resources and decision-making power into the community. She shared that they were also working hard to make sure that community members had the opportunity to apply and successfully compete for jobs that were associated with this program.

Committee Questions and Discussion

Dr. Ehlinger posed a question to Committee members and Dr. Malawa regarding "racism as a public health crisis". Does that change our discussion, thinking of it as a crisis? He stated that when he thinks of a crisis it is something that we deal with right now and get over and move on to something else. He asked Dr. Malawa, "How do you talk about racism? Do you talk about it as a crisis or use some other language?"

- Dr. Malawa responded that she talked about racism the way the audience needed to hear about it to produce change. Dr. Malawa noted that if it was as simple as changing our definition of crisis or how we are describing racism it may be easier.

- Dr. Tara Lee asked Dr. Malawa what outcomes she was going to measure and if she hypothesized that the cash will lead to seeing a reduction in preterm birth?
    - Dr. Malawa noted that this is a feasibility pilot and that her team would need further studies to make definitive assertions about birth outcomes because adverse birth outcomes are relatively infrequent. The focus areas for statistics are trends in birth outcomes, healthcare engagement, lactation postnatal, preterm birth, low birth weight, infant mortality, and maternal mortality. Qualitative work will be conducted to understand what people's experiences of pregnancy and birth were. In conclusion, Dr. Malawa stated the need to understand if food security and housing security were achievable with this intervention, and decreasing economic volatility and people's sense of financial well-being.
- Dr. Peck recalled the four criteria of Dr. Malawa's framework and noted the Pacific Islander communities in her city, and why she chose to specifically focus on Black women without incorporating the PI community. Dr. Malawa noted that her health department, the San Francisco Health Department, disaggregates Asians from Pacific Islanders which allows for more specificity to understand the issues this community is particularly facing.

Committee members and Dr. Ehlinger thanked Dr. Malawa for her time and for sharing this with the committee.

MATERNAL AND CHILD HEALTH BUREAU UPDATE

Michael D. Warren, M.D., M.P.H., F.A.A.P.
Associate Administrator, Maternal and Child Health Bureau
Health Resources and Services Administration

Dr. Warren provided the Committee with updates on the following items: MCHB Strategic Plan, Title V Program, and Healthy People 2030 Infant Mortality Goals. Dr. Warren shared that the Maternal and Child Health Bureau is focused on a strategic plan with about three to five focus areas where Committee input is welcomed. He also described the estimated timeline for MCHB's strategic planning process with "Planning the Plan" completed in May 2020, "Information Gathering & Synthesis" through the Summer of 2021, "Plan Finalized and Disseminated" through 2021, and "Plan Implementation and Evaluation" through 2022.

Dr. Warren then gave a brief history of Title V and its connection with infant mortality reduction efforts. He showed the correlation with Title V and the contributions to the public health system for mothers, children, and families in the country. Dr. Warren noted that the Title V Program does not sunset.

Dr. Warren then talked about the early years of Title V in action, where Title V funds supported prenatal care, well-baby clinics, school health services, immunizations, direct services, core public health services, public health nursing, nutrition services, and health education. He then noted if there were hospital or physician charges that an individual didn't have other sources of coverage for, these funds could be used for those purposes ("payer of last resort"). In 1939, Dr. Warren highlighted special projects for hospital care, premature infants, or for the care of women who had complications during pregnancy. Over the years as there were specific elevations in the incidence of disease or elevations in interest around a particular area, there were additional funds appropriated. There were funds to support training programs which were some of the earliest training programs in maternal and child health, specifically supporting nurse-midwife' social worker positions and public health practitioners. Dr. Warren continued with the history of The Emergency Maternity and Infant Care (EMIC) program developed during World War II,

and the other focus areas of Title V including the 1980s, Omnibus Budget Reconciliation Act of 1981 (OBRA) and 1989. In closing, Dr. Warren highlighted the 2000s with the most recent appropriation of $687 million in FY20, and the gap between where we are authorized to function and where we are appropriated or funded to function.

Dr. Warren then displayed the intricacies of the MCH Block Grant to States which is a federal-state partnership. The MCH Block Grant is a mandatory formula block grant that determines the amount that states get, and states must do a Five-Year Needs Assessment across the MCH population (Dr. Warren explained some members may be in touch with the process as some states just submitted their needs assessments on September 15 to the MCHB.) When the needs assessments are done, states develop an action plan and every year report not only on what they have been able to accomplish on the action plan but what their plan is for the year ahead. For the federal portion of the Block Grant funds, states must spend at least 30 percent of their block grant funds on primary and preventative services for children, spend at least 30 percent on services for children and youth with special healthcare needs, show maintenance of effort based on 1989 expenditures on maternal and child health (OBRA), and provide a match of $3 for every $4 of federal dollars that states get through their block grant.

Dr. Warren then highlighted the "FY 2018 Percentage Served by Title V: Direct, Enabling, and Public Health Services and Systems" [6]: where for FY 18, the block grant reached 91 percent of all pregnant women in this country and almost 99 percent of all infants. The reach indicated the flexibility and the accountability piece of the block grant that is noted by Dr. Warren as important. Utilization of the performance measurement framework helped with understanding national outcome measures, where national performance and state outcome measures track direction. Title V Funds also included: special projects of regional and national significance (SPRANS): ~ $119M in FY20; community integrated service systems (CISS) ~$10M in FY20 for early childhood comprehensive systems, child health, and children with medical complexity; family-to-family (F2F) health information centers ~ $6M in FY 20; and maternal, infant, and childhood home visiting (MIECHV) program ~ $400M in FY 20. Dr. Warren finalized the overview with the "Infant Mortality CoIIN". He showed high-level results from the national phase (2014-2017), which had more of a focus on SDOH and preconception health/pre-pregnancy care, such as 81% of the participating states and jurisdictions reporting declines in their infant mortality rate.

In closing, Dr. Warren discussed infant mortality and Healthy People 2030, which he reminded the Committee had launched. He said for the Bureau, it had raised the question of "what would it take to achieve equity in infant mortality rates by 2030?" He showed the target for Healthy People 2030, which was 5.0 infant deaths per one thousand live births by 2030. He then shared the most recent data available from CDC WONDER for broad or bridged race/ethnic groups. The figure showed Non- Hispanic Whites, Hispanics, and Non-Hispanic Asian/Pacific Islanders had already surpassed the HP2030 goal, while Non-Hispanic Black and Non-Hispanic American Indian/Alaska Native infants have not. Dr. Warren noted that they have not even made the original HP 2000 target (7.0) 30 years after it was set. He further explained that even if Non-Hispanic Black and Non-Hispanic American Indian/Alaska Native infants met the 2030 target, they would not achieve equity with the Non-Hispanic White majority group. Using the same target setting projection for the overall IMR, Non-Hispanic White infants were projected to reach 4.0 by 2030. Dr. Warren proposed this as the true target for equity – that all racial groups achieve a rate of 4.0 infant deaths per 1,000 live births by 2030.

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[6] Health Resources and Service Administration, Maternal and Child Health Bureau. Title V Information System. Available at https://mchb.tvisdata.hrsa.gov/.

Through additional data analyses by MCHB staff (Dr. Ashley Hirai), Dr. Warren explained what that would require - we would need to prevent an estimated additional 4,000 deaths every year for Non-Hispanic Black infants, and about 160 additional Non-Hispanic American Indian/Alaska Native infant deaths every year. In total, he said we would need to save an additional 4,186 babies/year, which is fewer than 12 babies/day given there are about 10,500 babies born each day in the United States. In closing, Dr. Warren shared more data at the state and county level that showed the "lift" at the county and state levels to achieve Black-White equity or reach a 4.0 IMR for Black and AI/AN infants.

FOLLOW-UP ON JUNE COVID-19 Recommendations

Edward P. Ehlinger, M.D., M.S.P.H.
Acting Chairperson, SACIM

Dr. Ehlinger reiterated to the Committee the importance of providing updated and continued recommendations to the Department of Health and Human Services Secretary and noted that recommendations on COVID-19 were made in June through a letter sent to the Secretary. There was a response back from the Secretary, and the next phase of action was to continuously gather updates or review new data/evidence and to generate recommendations based on this information.

Recommendations to the Secretary from June SACIM Meeting:

- Stand-up hospitals, non-hospital-based labor and delivery units, and expanding the capacity in freestanding birth centers
- Expanding the use of licensed and/or certified midwives within them to practice under their certification
- Expanding access to health with telehealth broadly defined
- Support for community-based postpartum and newborn care
- Support for broad financing, including Medicaid, for telehealth
- The continuation of state eligibility for Medicaid for a full year after delivery
- Expanding some of the federal financing for home visits
- Providing professional liability insurance
- Expanding the data and surveillance systems

FOLLOW-UP:
Dr. Ehlinger posed a question to the Committee: Have there been any changes since the recommendations in June or anything not spoken about?

Members made mention of: telehealth, expanding Medicaid a year postpartum, loosening of restrictions of who can attend births, and the COVID impact on moms and babies, particularly populations of color, including indigenous populations, and highlighted the equity issue.

Dr. Steve Calvin noted that currently more mothers are accessing maternity care by midwives and are more interested in the flexibility of care, however there are noted barriers.

Dr. Magda Peck mentioned that SACIM should advise more, practice in creating more visibility, and know who the new generation of leaders are at the local, state, national, and tribal levels. Dr. Peck also noted that every word that is official from SACIM, even those beyond recommendations to the Secretary, might be used as a tool for change.

MCH ORGANIZATIONS RESPOND TO RACISM

Jonathan Webb, M.P.H., M.B.A.
Chief Executive Officer
Association of Maternal & Child Health Programs (AMCHP)

Lori Freeman, M.B.A.
Chief Executive Officer
National Association of County and City Health Officials (NACCHO)

Rahul Gupta, M.D., M.P.H., M.B.A., FACP
Chief Medical and Health Officer
March of Dimes

Mary Ann Cooney, M.P.H., MSN (On behalf of Michael R. Fraser, Ph.D., MS, CAE, FCPP Chief Executive Officer)
Chief Program Officer from ASTHO
Association of State and Territorial Health Officials (ASTHO)

Additional Organizations Represented:
CityMatCH
National Healthy Start Association
National Institute for Children's Health Quality (NICHQ)
Arthur James, M.D.

Leading the presentation on organizational responses to racism, Mr. Jonathan Webb introduced the panel members and noted, "Why Are We Here?" To answer this question, Mr. Webb listed the current statistics, climate, and history of public health. Mr. Webb indicated that in the early 2000s, the field of public health has focused on inequities and the social determinants of health, and understanding life course theory. There were "Guiding Principles" which were listed by Mr. Webb. One was the importance of noting that racism is the underlying factor for a lot of public health issues and the need to align on a shared statement of accountability so that advancement could occur in respective spaces of an anti-racist movement. Second, health equity has been the topic of conversation and important in the community, as well as racial equity vs. health equity. Third, public health institutions have tremendous power and influence in disrupting structural inequities, and it was important to dismantle systems and build programs. He said it was important to note how to thoughtfully partner with impacted communities? Mr. Webb suggested seeing community members as assets versus some of the language and the framing in our work that puts them in a deficit, such as "vulnerable population" and "low income" being synonymous with race or an ethnic group. A final guiding principle listed by Mr. Webb is that meaningful impact requires specificity. We must move with urgency, celebrate upstream together, build trust and rapport, approach communities with humility, and repair partnerships as we move forward.

Next, Mr. Webb welcomed the MCH organizations present to explain the present statement on racism and perspectives from the field at the state, city or local, and community levels. (For state perspective: AMCHP/ ASTHO, for City/Local Perspective: CityMatCH, NACCHO, NHSA, and for Community Perspective: March of Dimes/NICHQ). From Mr. Webb, representing AMCHP, the notes of accountability internally and externally were explained, and the effort to communicate effectively with what is being done and how to engage with partners and relationships that are building. In particular, in June, AMCHP addressed racism as a public health crisis and the process to move the issue forward. Mr. Webb noted that building actionable solutions around how to make changes and operationalize the changes are important, and Title V and Medicaid directors and communities are understanding

reimbursement of services, how that impacts the field. How to support, share expand the learnings about the services.

Next, Ms. Mary Ann Cooney from ASTHO (additional State Level perspective), indicated a statement of impact from ASTHO, illustrating that the statement was curated from their current president Rachel Levine and now past president Smith, who worked with the organization and the board on releasing the statement. Read in the organization's voice their position is as follows: "Racism is an issue that contributes greatly to disparities. We need a shared agenda and a shared goal among many of our public health partners. We also believe that our work is important to develop the leadership of state health officials to develop their capacity to be able to also lead in this area. And to be representatives of the public health community within their states to then bring to light the policies that would address structural racism." ASTHO acknowledged the disparities, especially amongst African American women. Ms. Cooney shared that ASTHO is using resources to develop the leadership at the health official level, senior deputy level, and the directors of maternal child health to assist them in leading and listening to the communities in which they serve. In closing, Ms. Cooney listed the major challenges such as differing perspectives in leadership.

Ms. Lori Freeman, CEO of NACCHO, provided the city or local perspective, noting contributions from the National Healthy Start Association lead by Deborah Frasier. Their organizations cover the crucial landscape of local health departments and communities across the country. Ms. Freeman noted that in the NACCHO 2019 National profile, the majority of local health departments provide services to support the health of mothers and children, 68% provide WIC services, 70% do active surveillance and epidemiology for maternal and child health populations, 35% provide direct services and a third provide prenatal care and well-child clinics. Ms. Freeman noted that the strong community partnerships allow them the ability to address the inequities in birth outcomes, particularly among Black populations. Ms. Freeman highlighted the inner workings of the federal Healthy Start programs which have a community consortium or community action network that facilitates intimate community involvement in all levels of local Healthy Start programs. Furthermore, staff are hired within the communities they serve to represent the unique and diverse voices of program participants.

Ms. Freeman noted the importance of fathers. In the last four years, a significant transformation of the American family structure has occurred. In 1960, 8% of children younger than 18 had nonresident fathers. The rate increased to nearly one in four in 2014. Research demonstrates that fathers play a critical role in children's development and life outcomes but also in the role of the support for mom before, during, and after pregnancy. Ms. Freeman shared that NACCHO and NHSA support the development of federal, state, local, community infrastructure that provides support and systems of services for men that will reduce barriers to male involvement and inclusion in the family unit. She closed by stating the patterns of inequality and the distribution of disease and illness correspond to the patterns of political, social, and economic inequality.

In the closing of recommendations, Dr. Rahul Gupta provided insight from the community level perspective on access and collective impact. Dr. Gupta illustrated the importance of maternity "deserts", which is linked to equity, and how 40% of women have reported not receiving information about the coronavirus from their provider or hospital. Dr, Gupta also spoke of implicit bias training where his organization is working to train 10,000 healthcare professionals in the Southeast area of the US with maternity case studies around implicit bias.

The overall recommendations from each level are indicated as follows:

- Developing, tracking, regularly presenting indicators that measure social health and well-being including inequities in population health status similar to the national presentation of economic indicators
- Identifying the institutional sources of decision making cumulatively generating health inequities, examples include: uneven investment in local infrastructure, inequitable city distribution of resources by neighborhood, discriminatory lending practices, foreclosures by neighborhood, discriminatory law enforcement policies for offenses, and political influence.
- Actively recruit a racially, ethnically diverse workforce at all levels including leadership and boards of directors, and develop metrics to monitor.
- Identify and require antiracism training and dialogue with the public health workforce and contractors.
- Support local policies that address root causes such as paid sick leave, land use, living wage.
- Support health equity impact assessments for all policies and embed equity across all agencies and in decision making so it becomes a core value and one criterion to be weighed in all decisions.
- Develop long-term relationships with communities, based on mutual trust and recognition of each other's strengths, leadership capacity, and common interests in confronting the social inequity and inequality at the root of social injustice.
- Support research that explores the generation of social and economic inequality and explores the power dynamics that enable decisions that increase social and economic inequality.
- Be prepared to shift our power in organizational power dynamics to support equity and social justice. Work with social movements, build arc alliances with a constituent, community organizers, and relative institutions as a means towards changing the structures and processes that generate health inequity, and develop a public narrative that articulates the relationship between health inequities and reclaims the legacy of social justice.
- Utilizing appointments to assess and document the personal experiences of Black, indigenous, and other persons of color as people in their prenatal and postpartum journey.
- Identify gaps and foster improvement with documented metrics for accountability.
- Link community members to health services with internal metrics to ensure adequate culturally responsive healthcare is accessible and delivered.
- Partner with community members, social movements, and community-based organizations to develop educational resources on healthy birthing specific to Black, Native, and Latina people to increase self-advocacy and knowledge.
- Expand infant and maternal mortality review boards. Collaborate and act on the information that comes from the boards to create change in the community.
- Collaborate to create and disseminate materials on Black maternal health, facilitate culturally responsive training, training in racial bias, and training in providing quality care to Black people, Indigenous people, and people of color.
- Identify a birthing advocate to liaison between the local Health Department to coordinate and stipulate the needs of the birthing person and the provider to ensure that the patient's needs are met.

In closing, Mr. Webb noted that a clear explanation of social determinants is needed to understand adverse maternal health outcomes, and public or elected officials and many others are often not aware of the systems that create and reinforce the racial inequity.

Mr. Webb thanked the Committee for their time and emphasized the major importance this has on all communities.

Committee Discussion and Questions

Dr. Ehlinger opened discussion period with the following question to the Committee, "What is the theory of change and where is the energy to move this agenda?

- Mr. Jonathan Webb noted that the energy from AMCHP's perspective is the energy from various historic moments, such as COVID and the inequities that COVID created. Another example noted by Mr. Webb is historic moments such as the murder of George Floyd on film - although not the only time or first time, Mr. Webb noted the perfect storm to push. There is a groundswell and movement around these things. In closing, Mr. Webb said the energy is building among team members, and among the membership within AMCHP specifically. Mr. Webb noted the creation of recommendations and frameworks that are aligned with members of his organization as a part of the statement on action forward.
- Mr. Scott Berns of NICHQ answered by noting that his organization agreed upon the guiding principles with the idea of accountability. Mr. Berns noted the importance of holding each other accountable to enact action items and hence, the theory of change.

RACISM AND THE POWER OF QUESTIONS

Glenda H. Eoyang, Ph.D.
Executive Director
Human Systems Dynamics Institute

Dr. Glenda H. Eoyang received a welcome from Dr. Ehlinger who then began by posing a question of how do we address structural racism as a Committee and how do we formulate the necessary recommendations?

Dr. Eoyang began by asking how we, as professionals, work across systems and between institutions, how are we looking at larger patterns, and how do we see these patterns? What is the world of what we call pattern-based action?

She argued that addressing patterns is not a matter of moving A moving B moving C, but by exploring patterns as a whole. There is power in the questions and process of exploring the questioning. Dr. Eoyang indicated that, at the Human Systems Dynamics Institute, their vision was for people everywhere to thrive by seeing patterns clearly. We seek to understand, and we act with courage to transform turbulence and uncertainty into the possibility for all. Dr. Eoyang showed the difference between "Formal Logic: Problems to Solve vs Pattern Logic: Patterns to Unstick." Pattern logic is about asking questions rather than giving answers, giving credence to the theme of asking questions to unravel complex systems. In the "Complex Adaptive System" there is a need for an adaptive capacity, rather than work in silos, with adaptive work rather than consistency. Dr. Eoyang discussed three parts to the system, which are: Part One, Group of Agents that are different and interact (Ex.: Pregnant women's health process, institutions partnering to come together in conversation, or cultures); Part Two, System-wide Patterns that are an interaction of agents resulting in a consistent pattern (Ex.: Healthy pregnancy, good collaborative, systemic racism, or anti-racism); and Part Three, Patterns Settle and Influence Future Interactions Amongst Agents.

Dr. Eoyang then described “Complex Change” which usually consists of a system with some consistent stability, then a breakthrough. She provided an example in this system of health inequities present, COVID-19, George Floyd’s Murder, a breakthrough where the tension accumulated leading to a release. Complex change is unpredictable, uncontrollable, examples include falling in love, an avalanche, innovation, learning. It includes many interdependent levels at the same time, such as institutions, communities, governmental levels, and all of those different systems levels are interacting and they are driven by tension and then they release.

Next, Dr. Eoyang discussed “Sticky Problems” which she described as having: “lots of causes, many stakeholders, various descriptions, they challenge assumptions, and they cannot be solved.” Dr. Eoyang then explained inquiry and adaptive action, where inquiry is asking questions, and adaptive action is an iterative decision-making cycle, like the scientific method. Questions provide different answers that help to operationalize this idea. She then illustrated examples of questions within adaptive action and the steps towards “Inquiry and Adaptive Action”, which are: “What do you see? What do you think? What do others see? What is happening? How is it happening? What is happening now? What are my emotional responses, my personal biases?”

1st step: Get a good overall picture, although not complete because it's a complex system.

2nd step: Cohort, understanding work dynamics, tensions, feasibility, risks, allies, antagonists

3rd step: Accountability and action for change, the pattern does not shift unless some action is taken.

Inquiry & Adaptive Action Workshop

Dr. Eoyang gave an example of how the more complex the problem is, the simpler our tools need to be.

Dr. Eoyang followed with a prompt for the Committee: “How can we as SACIM interrupt the patterns of racism, past, present, and future that cause disparities in maternal and infant health outcomes?” Dr. Eoyang noted the importance of turning judgment into curiosity, conflict into shared exploration, defensiveness into self-reflection, and assumptions into questions.

The Committee generated questions addressing Dr. Eoyang’s concept. Examples of questions were:

- Ms. Pettiford asked what do we know about racism and its impact on maternal and infant health?
- Dr. Ehlinger asked what metaphor should we use in addressing a sticky issue?
- Dr. Palacios noted how can we operationalize community in this question, when reviewing maternal and infant outcomes.
- Dr. Magda Peck said we must render objective science and noted who has power, who has authority, and what are the different questions that will drive systems to change?
- Dr. Paul Wise asked to what extent can we limit racism in the provision of efficacious health and social services to reduce racial disparities in maternal and infant outcomes?
- Dr. Ehlinger asked why the data are overpowering that racism has impacted health outcomes and yet why does this pattern persist? why does discrimination persist?
- Dr. Barfield noted medical outcomes and mortality as an endpoint of complex factors and processes and wondered what are those complex processes? Dr. Barfield also asked how would we measure what we need? How do we define success, how does a mother define success? How does the community, a neighborhood, define success?

Dr. Eoyang concluded the workshop with a transition into the Workgroup Praxes stating the following:

"Now what will your workgroup do to interrupt these patterns and create new ones of health and equity?" Dr. Ehlinger thanked Dr. Eoyang for her time and closed with the premise that this technology breeds interesting questions that help to broaden the focus and expand perspective.

WORKGROUP PRAXES

Edward P. Ehlinger, M.D., M.S.P.H.
Acting Chairperson, SACIM

Dr. Ehlinger encouraged the data and research to action workgroup, the care quality and access workgroup, and the health equity workgroup to think of patterns, and how to change those patterns.

WORKGROUPS

Day one of the meeting concluded with breakout groups for each of the Committee workgroups: Data and Research to Action; Care Quality and Access; and Health Equity.

Thursday, September 24, 2020

WELCOME BACK

Edward P. Ehlinger, M.D., M.S.P.H.
Acting Chairperson, SACIM

Dr. Ehlinger welcomed the Committee for Day Two. Dr. Ehlinger began with history on this day, including in 1957, President Eisenhower ordered US Troops to desegregate the Little Rock Schools, in Arkansas, and also on this same day, 1789, the Post Office and the Supreme Court was also established by Congress during that time, both in the news. Dr. Ehlinger also noted the birth of Francis Watson Harper, an African-American US poet, who speaks of anti-slavery in her verses: "Mothers are the lovers who move in education. The true aim of female education should not be the development of one or two but all of the faculties of the human soul because no perfect womanhood is developed by imperfect culture."

BYLAWS REVIEW

Lee Wilson
Acting Division Director, MCHB/Division of Healthy Start and Perinatal Services
Health Resources and Services Administration
(acting on behalf of David S. de la Cruz, Ph.D., M.P.H., Principal Staff and Designated Federal Official, MCHB/Division of Healthy Start and Perinatal Services, Health Resources and Services Administration)

Dr. Ehlinger said that in SACIM's 31 years of existence, there have not been any official by-laws, only a statement from the Secretary on what the Committee does. Mr. Wilson clarified that the current operations of the Advisory Committee on Infant Mortality provide the committee the authority to advise the Secretary, HHS. Establishing additional rules, through bylaws, should reflect the requirements and protocols of the Advisory Committee's authority without unnecessarily restricting or inhibiting its deliberations

Mr. Wilson shared that the HHS Office of General Counsel will provide input on the draft bylaws as they relate to the Federal Advisory Committee Act provisions. Discussion of the bylaws and their elements will be ongoing and should be led by the committee and its members.

VOICES FROM THE COMMUNITY

Dakisha Mitchell
Mother speaking on experience with Maternal & Child Programs (Healthy Start) in her community in Chicago

Kimarie Bugg, D.N.P., F.N.P.-BC, M.P.H., IBCLC,
Reaching Our Sisters Everywhere, Inc. (ROSE)

Background on Dakisha Mitchell

Dr. Ehlinger introduced Ms. Dakisha Mitchell to members of the committee, stating she had lived in Chicago all of her life and was a mother of three. She is a participant in a Chicago Area Healthy Start Program. He said Ms. Mitchell had experienced many of the barriers that women in our community face - problems with housing, childcare, transportation, among many others.

Dakisha's Experience:

Ms. Mitchell described some of the barriers and challenges that she and women in her community faced as mothers such as lack of housing, childcare, transportation, and jobs. She recalled leaving the hospital after giving birth and not having a place to live. She said many community programs exist and tell you to call, but when she would try to reach them, it was difficult to speak with someone, or no one called back. Ms. Mitchell also noted that many assistance programs had requirements that were hard to meet, unreasonable, or not feasible given where a person was starting from. She gave the example of the public aid office, which required you to have a job to get assistance – however, people needing public aid were also needing assistance with finding employment. Ms. Mitchell noted the Healthy Start program helped her get diapers, job training and alleviated her questions about beginning motherhood, among other things. However, many mothers don't know where to begin she said, or how to navigate systems.

Committee Follow-Up & Questions:

Ms. Mitchell's discussion with Committee members illuminated additional examples of challenges/barriers that mothers experience:

- Job resources are listed but the qualifications cannot be met
- Lack of follow-through by programs offering assistance with housing, employment, or other community resources
- Available resources may have waiting lists (e.g., shelters for new mothers) or strict requirements such as no kids allowed

Committee members and Dr. Ehlinger thanked Ms. Mitchell for her time and for sharing with the committee.

Background on Kimarie Bugg

Dr. Ehlinger then introduced Dr. Kimarie Bugg, a doctorate in nursing practice and president and CEO of Reaching Our Sisters Everywhere or ROSE which focuses on breastfeeding inequities in African American communities. Dr. Ehlinger shared Dr. Bugg was a perinatal and neonatal nurse professional who had spent about four decades in the Atlanta metropolitan area promoting perinatal health, breastfeeding, and community-based impact solutions. He said she had broad experience as a nurse practitioner, a perinatal nurse consultant and had also worked on hospital inpatient floors and in emergency rooms. Dr. Bugg was known internationally for her work in lactation, antiracism, and health equity strategies and in the nonprofit world, and marginalized community empowerment. Dr. Ehlinger said Dr. Bugg lived in Atlanta with her husband, a neonatologist, and her 87-year-old beautiful mother; and they were the parents of five adult children.

Kimarie's Experience:

Dr. Bugg expressed deep concern for communities that were Black, Indigenous, and People of Color (BIPOC) and highlighted for the Committee examples of how racism was making these groups sick. She noted that disparities in infant and maternal outcomes continue, even among college-educated women, citing a study done in Atlanta in the 90s comparing infant mortality rates among graduates from Spelman College (a historically Black college/university) and Agnes Scott, which was a predominantly White college. She explained many in the BIPOC community lived in a constant state of "fight or flight"- when they apply for a job, when they walk into a mall, when being stopped by the police, going home daily to substandard housing, and when they go for prenatal care. These daily "fight or flight" situations caused a high allostatic load which was detrimental to health over time. Dr. Bugg also shared how birth work

changed for her, from watching her grandmother (a lay midwife) deliver babies at her home to what she learned in nursing school. From her work in the Atlanta metropolitan area and nationally focused on African American communities, Dr. Bugg commented that there seems to be a lack of empathy from society and a feeling of hopelessness in BIPOC communities – which is exacerbated by recent events such as the pandemic, floods, hurricanes, and societal unrest.

Committee Follow-Up and Questions

- Dr. Steve Calvin asked Dr. Bugg for her thoughts on why there was not the availability of midwife-led primary maternity care that was integrated into the larger obstetrical system in every community, which could help eliminate racial disparities. Dr. Bugg replied that the expansion of Medicaid would help tremendously and that women, who have just given birth, lose their insurance after about 2 months in the states without Medicaid expansion. She also believed there was a hierarchy of human value in some places and that we fund what we care for and what we value. She expressed a hope that mothers and babies were more valued, and that wraparound services/resources that would have a collective impact would be provided such as parenting skills, therapy, access to food, etc.
- Dr. Janelle Palacios asked if Dr. Bugg had any ideas in addition to meeting the basic needs of people - were there any policies or larger-scope issues that SACIM should consider? Dr. Bugg said she wished we could put caring, love, and empathy into policy and gave the example of Baby-Friendly Hospitals as something that more people could access if it became policy. She stressed the need for empathy and to focus on improving the stressors that cause higher allostatic load, which lead to physiological damage and poor health.

Dr. Ehlinger thanked Dr. Bugg for speaking with the Committee and was reminded by her talk of work he did with Louisville, KY to get payment for doulas. He said they were really struggling right now and acknowledged that there were so many traumas going on in the world – nationally and locally.

MATERNAL HEALTH, TELEHEALTH, COVID-19 AND EQUITY

Sarah Verbiest, DrPH, MSW, M.P.H.
Co-Principal Investigator, Maternal Health Learning and Innovation Center and Maternal Telehealth Assessment Project
University of North Carolina at Chapel Hill

Aunchalee Palmquist, Ph.D., IBCLC
Assistant Professor, Department of Maternal and Child Health
Gillings School of Global Public Health
University of North Carolina at Chapel Hill

Joia Crear-Perry, M.D., FACOG
Founder and President
National Birth Equity Collaborative

Andrea Serano, CLC, IBCLC
President and Chief Executive Officer
Reaching Our Sisters Everywhere, Inc. (ROSE)

Dorothy Cilenti, DrPH
Principal Investigator, Maternal Health Learning and Innovation Center and Maternal

Telehealth Assessment Project
The University of North Carolina at Chapel Hill

Dr. Sarah Verbiest introduced the Maternal Health Learning and Innovation Center which has partnered with Georgia Health Policy Center, the American College of Obstetricians and Gynecologists (ACOG), the Association of Maternal and Child Health Programs (AMCHP), R.A.C.E. for Equity, Reaching Our Sisters Everywhere (ROSE), University of North Carolina's School of Medicine, School of Social Work and School of Public Health, and has partnerships with the National Perinatal Association, the National Birth Equity Collaborative and the Morehouse School of Medicine with Dr. Natalie Hernandez.

Dr. Verbiest gave an overview of the Maternal Health Learning and Innovation Center, stating its purpose was to accelerate evidence-informed interventions and advance equitable maternal health outcomes. She stated the goals were to build a nationally prominent resource center to help with training materials, online resources, and support communities. Dr. Verbiest described the "Maternal Health Innovation Symposium Event" which had a tremendous response. The event held a spark session and had over 20 prerecorded sessions, where organizations shared innovative ideas to illicit collaboration. Dr. Verbiest encouraged the Committee to listen.

Dr. Dorothy Cilenti led the discussion on the Maternal Telehealth Access Project, which was funded by the CARES Act through a $4 million award. Dr. Cilenti shared the project purpose, which was to increase access to perinatal services and support through telehealth, including clinical care coordination, support doulas, and community health workers. The project was also responsible for dissemination of what is learned through various channels, and public service announcements. Dr. Cilenti noted the deliverables of the project showing the need for awareness around COVID-19 trauma-informed care for frontline pediatrics providers during the pandemic and an assessment to better understand the barriers related to telehealth.

Dr. Aunchalee Palmquist gave an overview of the assessment work for the project, which was to inform the implementation of the project and ensure that all of the funding decisions and technical support and training were aligned with those goals. Dr. Palmquist indicated that there were various stakeholder perspectives of telehealth and distant care services for critically underserved and marginalized populations, to ensure that the program implementation was aligned with the stakeholder's concerns, needs, and priorities. Dr. Palmquist showed how the assessment team had representatives of many different partners, and explained there were two kinds of assessments - a provider assessment of obstetric care providers primarily in hospitals and other clinical settings, and then a community assessment. Dr. Palmquist shared the structure of the assessment - a mixed-methods, multi-layered assessment, with a review of the literature on telehealth, as it relates to health disparities among pregnancy and in the first year postpartum. The secondary assessment was of online stories from perinatal entities such as the United States Breastfeeding Committee (USBC) and many others across various platforms. In conclusion, Dr. Palmquist showed the analyses portion of the assessment, where ROSE held a series of listening sessions. A comparison of findings from the provider assessment and with ROSE was a way to inform the recommendations. These stories from the field were shared online with USBC and Mom's Rising with 245 submissions about how the COVID-19 pandemic has been affecting people during pregnancy and postpartum. The listening sessions had a total of 102 participants across about 12 or 13 listening sessions, along with representatives from 28 states and Puerto Rico.

Ms. Andrea Serano led the discussion around the listening sessions and highlighted the main areas. Ms. Serano highlighted Health Connect One, and the indigenous practicing counselors in the Appalachian breastfeeding network as a collective during the listening session. There were seven listening sessions

with community support providers, for a total of 48 participants. The listening sessions with Health Connect One were hosted in Spanish. Ms. Serano noted the Appalachian Rescue Network serves 13 states along the Appalachian Mountains and the team connected with their community support providers to find out the impact of COVID-19 and telehealth. She shared indigenous breastfeeding counselors and native families across various tribes participated to give further insight. In closing, Ms. Serano listed some major learning points from these sessions including the convenience aspect of telehealth (access, check-ins, childcare visits).

- Flexibility (in-between hours and navigating children with a stay at home order)
  - Challenges: Technology, a low-quality camera which may affect the ability to see and create a good assessment, connectivity with a phone, cell towers, reservation location, new providers are not aware of past patient history, language barriers, lack of understanding, feeling rushed, esp. with bereavement, lack of privacy and giving info via telehealth, families are home birthing out of fear, access to referrals
  - Solutions: Home healthcare addresses many of the needs that were brought up quite a bit. More homes visiting would impact and at least serve as a way to connect between a telehealth visit and being able to see your primary care provider.

Ms. Serano shared that through the CARES Act they were able to provide mini-grants to 68 applicants out of the 142 applications received, and ensured all 10 of the HRSA regions were represented and 62% of states were represented in the selection choices.

Dr. Joia Crear-Perry reinforced many of the topics addressed by Ms. Serano, noting that some of the key findings from their workgroup and ROSE included black birthing individuals experiencing impersonal care that diminished in quality during telehealth visits, lack of medical equipment, and digital redlining (a lack of access to internet in certain areas). Dr. Crear-Perry called for more investment in telehealth, and stressed the importance of trust in telehealth, specifically trusting and valuing patients. She gave the following recommendations: allocate funding for home visiting and remote monitoring; scale up navigation; improve systems and referral coordination; provide birth workers with a livable wage; invest in black birth workers and community based, black women-led organizations; have health care navigators teach first time patients the logistics of telehealth sessions; arranging for interpreters if needed, and: making sure that patients are seen regularly.

CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC) UPDATE AND HEAR HER CAMPAIGN

Wanda D. Barfield, M.D., M.P.H., RADM USPHS (ret.)
SACIM Ex-Officio Member

Dr. Wanda Barfield provided an update on the "Hear Her Campaign" and the Division of Reproductive Health which is addressing maternal morbidity and mortality. Dr. Barfield noted the decision to have a communication campaign to raise awareness and support the work of the Division of Reproductive Health.

Dr. Barfield indicated there was an environmental scan conducted in early 2019 to create this campaign and the partnerships initiated. Partners of the Hear Her Campaign included ACOG (American College of Obstetricians and Gynecologists) and the Council on Patient Safety and Women's Health to develop a list of urgent maternal warning signs that are featured in the campaign. Dr. Barfield indicated that the environmental scan included conversations with experts in the field, and the idea of raising awareness of

warning signs, and listening to women and hearing their concerns. Feedback from women in focus groups to generate Hear Her stories is in English and Spanish on the website. The website shares information on pregnancy-related death in the United States, personal stories from the women who have experienced pregnancy-related complications captured in a video, as well as important information about the urgency of maternal warning signs from the council on patient safety and women's healthcare.

Next, Dr. Barfield provided an update on the Maternal Mortality Review Committees (MMRCs) which are a multidisciplinary process where a committee at the state or city level identifies and reviews maternal deaths that occur within one year of pregnancy regardless of the outcome of pregnancy. The MMRCs began in Fiscal Year 2019, and the CDC is directly supporting maternal review committees through enhancing reviews and surveillance to eliminate maternal mortality, also called the "ERASE MM" program. MMRCs are one component of an interconnected system that includes; HRSA's Title V program, Maternal Health innovation project, AIM safety bundles, and CDC's perinatal quality collaboratives and efforts in risk-appropriate care. CDC also supports the Maternal Mortality Review Information Application (MMRIA), called "Maria" which is their standardized data system. Dr. Barfield indicated that CDC is continuing to strengthen Maria's ability to capture information on social determinants of health, utilize geocoded data to help bring information about the community a woman lived in based on SDOH, access community vital signs into the discussion of her death by the MMRC, and allow communities to document how discrimination and racism contribute to a death based on common definitions defined by a workgroup. Dr. Barfield noted by the year-end all MMRCs will be able to collect these data and that these efforts are helping us to collect data that can then translate into programs that address the factors that are contributing to maternal deaths. Another overview Dr. Barfield shared was on the Rapid Maternal Overdose Review (RMOR) which is an initiative leveraging the MMRC infrastructure to comprehensively review all pregnancy-associated overdose deaths. RMOR supported state-level MMRCs in Massachusetts, North Carolina, Ohio, Tennessee, Utah, and Wisconsin.

Next, Dr. Barfield highlighted the Pregnancy Risk Assessment Monitoring System (PRAMS) that collects the specific population-based data on maternal attitudes and experiences before, during, and after pregnancy. The PRAMS team has created a database to track all indicators related to social determinants of health from 2012 to the present. Dr. Barfield noted that the team is working on analysis and publication so that they may share insights from this unique source of data. She also stated that a social determinant of health questionnaire supplement for PRAMS sites was available to adopt in the spring of 2021. PRAMS had also developed a COVID-19 questionnaire supplement for sites that began in October 2020. The COVID-19 supplement showed barriers to attending prenatal care appointments, the use of prevention measures to prevent COVID-19 during pregnancy, barriers in using prevention measures, the presence of a support person in the hospital during delivery, hospital practices to protect moms and infants from COVID-19 transmission, barriers to receiving infant care services, and social and economic hardship experienced during the pandemic. Dr. Barfield highlighted that "better data = better practice."

Dr. Barfield discussed how the Perinatal Quality Collaboratives (PQCs) are working hard with HRSA's Alliance for Innovation on Maternal Health (AIM) initiative to support dissemination and implementation of the AIM bundles. In July, she said CDC and HRSA held the first joint AIM and PQC annual conference. The meeting was an excellent opportunity for continued collaboration, connecting colleagues committed to improving perinatal care across states and offering an opportunity to share best practices and practical strategies. Dr. Barfield described how PQCs were also working to develop key strategies for promoting birth equity including providing respectful care, addressing social determinants of health, engaging patient communities and birth partners, as well as engaging in educating providers with the incorporation of implicit bias training. PQCs have also served important roles in the COVID-19 pandemic

response, she reported. Dr. Barfield noted the pandemic response had also provided an opportunity for newer PQCs to establish themselves as leaders in perinatal quality improvement and dissemination of best practices.

Dr. Barfield suggested the following action items to the Committee:

- Review the Centers for Disease Control website for messaging or to connect to the Hear Her campaign team, there may be a person of interest who has experienced a serious pregnancy-related complication that would like to share their story. Contact information is hearher@cdc.gov.
- Review new publications such as the second edition of Data to Action which is CDC's public health surveillance for women, infants, and children, and the July MMWR with new data on prescription opioid use during pregnancy which highlights the importance of screening all pregnant women for substance use or misuse and connecting them to treatment if needed
- Findings from the CDC's Pregnancy Risk Assessment Monitoring System indicated that 4% of women reported marijuana use during pregnancy. Dr. Barfield noted the findings reveal a need for healthcare providers to conduct evidence-based substance use screens for marijuana use.

WORKGROUP REPORT OUTS

DATA AND RESEARCH TO ACTION WORKGROUP REPORT OUT

Magda G. Peck, Sc.D.
Workgroup Chair, SACIM Member'

Dr. Magda Peck introduced the major theme for the Data and Research to Action Workgroup (DRAW) report out, which was "Data Linkage." Dr. Peck alluded to the powerful questions that began the brainstorming session of the DRAW workgroup. Many of the DRAW workgroup members highlighted questions around who owns data, having Whites as a reference group in data, and how current data can fully address racism, for example. In the follow-up to COVID-19, DRAW expressed major challenges with data are: data architecture, low capacity, timeliness, and lack of interoperability and linking of data systems. For example, there is no linkage between pregnant women and infants, and electronic health record details for the mother is an upstream issue where it is hard to address the social determinants of health.

Dr. Peck then indicated how much more useful data could be with the linkage of data systems to show environmental systems, geographic information (maternity deserts), and other regional data information. Ideas raised in the workgroup were to create more specification and a standard across systems, looking at diagnostics, reference ranges, and monitoring protocols for maternal and infant health and social determinants of health. She shared thought concepts for more deliberation were integrated outcomes across countries to share data, environmental factors influencing women's health outcomes (pesticides, toxic exposures), surveys and data in place to better understand patient-centered care, and better fiber-optic networks and better connectivity to provide services.

CARE QUALITY AND ACCESS WORKGROUP REPORT OUT

Steven E. Calvin, M.D.
Workgroup Chair, SACIM Member

Dr. Steve Calvin led the Care Quality and Access Workgroup report out indicating there was discussion and updates on COVID-19, vaccinations and infant mortality, rural perinatal care, and access to high-

quality perinatal care for vulnerable populations. For the COVID-19 update and discussion, the workgroup felt that overall maternity and newborn outcomes have been good, however they acknowledged mothers whose lives had been lost related to complications due to COVID. Dr. Calvin highlighted an important Washington Post article showing some good outcomes, despite the unprecedented challenging times. Dr. Calvin noted that COVID has disrupted an already dysfunctional system with major inequities.

Dr. Calvin then highlighted the issue of decreasing vaccination rates and infant mortality, showing that "In Michigan, fewer than half of infants age 5 months and younger recently were up-to-date on recommended vaccinations, and families are hesitant to take children in because of fears of transmission." The recommendation from the workgroup was to pay close attention to vaccination rates as this will become more important as the pandemic persists. Next Dr. Calvin highlighted common themes in rural perinatal care including distance to care and disjointed care, how social determinants are more impactful in rural settings, creative new delivery models, telehealth and telemedicine, devices and connection (Broadband Internet) to improve access.

In his concluding remarks, Dr. Calvin spoke about access to high quality perinatal care for vulnerable populations, and encouraged the Committee to review the Milbank Quarterly article by the Urban Institute and Institute for Medicaid Innovation [7]: "Midwifery and Birth Centers Under State Medicaid Programs: Current Limits to Beneficiary Access to a High-Value Model of Care." He thought the following policy points were of value; birth center services must be covered under Medicaid per federal mandate, but reimbursement and other policy barriers prevent birth centers from serving more Medicaid patients; midwifery care provided through birth centers improves maternal and infant outcomes and lower costs for Medicaid beneficiaries; and birth centers offer an array of birth options and have resources to care for patients with medical and psychosocial risks; and addressing the barriers identified in this study would promote birth centers' participation in Medicaid, leading to better outcomes for Medicaid-covered mothers and newborns and significant savings for the Medicaid program. Dr. Calvin noted that it is important to investigate beneficial models with a focus on coordination, continuity of care, food security, and housing.

HEALTH EQUITY WORKGROUP REPORT OUT

Janelle F. Palacios, Ph.D., C.N.M., R.N.
Workgroup Co-Chair, SACIM Member

Belinda Pettiford, M.P.H.
Workgroup Co-Chair, SACIM Member

Dr. Palacios began the report out with the Health Equity Workgroup's praxis history, stating that "Everyone has an equal and just opportunity to live their healthiest lives across the nation and that strives to a common understanding, to identify gaps in plans, and take actions to ensure policy recommendations to improve maternal and infant health are grounded in health equity and a commitment to health equity." The Health Equity Workgroup looked at key factors, issues, and frameworks related to maternal-infant health that could inform health equity practice. Dr. Palacios highlighted the health equity framework based on the life course model, the social justice and birth justice, and human rights frameworks, and

[7] https://www.milbank.org/quarterly/articles/midwifery-and-birth-centers-under-state-medicaid-programs-current-limits-to-beneficiary-access-to-a-high%E2%80%90value-model-of-care/

concepts such as intersectionality, social determinants of health, and intergenerational transmission. She stated structural racism would be a focal point to the workgroup's centering on health equity.

Dr. Palacios concluded with thoughts moving forward which were to connect with others to ensure synergy and alignment as they advance this work, that health equity will continue to center the discussion of structural racism and its effects on maternal-infant health, how questions will continue to be asked as we search for agents of change to shift the current patterns of maternal-infant mortality, and how we recognize that an individual's lived experience is essential in identifying problems and solutions.

PUBLIC COMMENT

Lee Wilson
Acting Division Director, MCHB/Division of Healthy Start and Perinatal Services
Health Resources and Services Administration

Mr. Wilson opened the platform for public comment from persons who registered to make a public comment. One of the registered callers came to the line, Ms. Patricia Loftman. She was representing the New York City Midwives, and was a midwife of 38 years who was newly retired. Ms. Loftman indicated the issue of race concordance in midwifery care, and noted there was minimal investment in increasing the numbers of Black and indigenous midwives. She shared that race concordance increases adherence to appointments, with treatment plans, increases connectedness, comfort, respect, trust, and patients report the highest level of satisfaction.

Mr. Wilson called on others by name who had requested to make a public comment. No other comments were offered. He acknowledged a written comment that had been submitted to the Committee by Sophie Skop, M.D. of the Charlotte Lozier Institute.

COMMITTEE DISCUSSION AND PLANNING FOR NEXT MEETING

Edward P. Ehlinger, M.D., M.S.P.H.
Acting Chairperson, SACIM

Looking forward, Dr. Ehlinger introduced to the Committee the prospect of having the next meeting in person, however we would have to consider if the COVID pandemic restrictions have changed. Dr. Ehlinger asked if there were any further recommendations from the Committee in the totality of SACIM Day One and Two.

- Ms. Pettiford asked for ways to gather data consistently from the community voices and individuals with lived experience. Ms. Pettiford suggested to connect more with the Healthy Start Program, and actively listen to community engagement feedback.
- Dr. Peck mentioned doing an inventory created with a scan and upkeep of community voices, and noted how do we do this both soundly, methodologically, ethically, and non-exploitatively?

Other recommendations from the Committee were to pay close attention to vaccinations for infants in the next coming months, better understand interoperability and intersectionality with data systems as it related to mothers and infants, and have increased access to telehealth technology to improve access in rural (highly critical) and urban areas. Other themes from SACIM include: valuing patients and building trust, providers need to learn how to practice medicine in telehealth and digital literacy, invest in Black women-led organizations and expand the provision of maternity care services, ensuring digestibility of patient education, how to ensure patients are learning and understanding?

WRAP-UP AND ADJOURN

Edward P. Ehlinger, M.D., M.S.P.H.
Acting Chairperson, SACIM

Lee Wilson
Acting Division Director, MCHB/Division of Healthy Start and Perinatal Services
Health Resources and Services Administration

Dr. Ehlinger thanked the Committee, Guest Speakers, and Voices from the Community, for their profound contribution to the lives of mothers, infants, and children. Dr. Ehlinger concluded with a reminder following the quotation of Edgar Lee Masters, "Did I follow truth wherever she led and stand against the whole world for a cause and uphold the weak against the strong? And if I did, I would be remembered among all people. So, did we follow the truth? Are we following the truth? Are we standing against the world for a cause of maternal and infants' survival and health and being able to thrive? And particularly, are we upholding the weak against the strong, people who have been disadvantaged by policies and systems because of their race, because of their disability, because of their gender, and because of their location, because of the geography, because of their history. Have we done that? And if we did, we're doing our job, we're doing our job as individuals, as professionals, and as members of SACIM."

Motion to adjourn was made at 3:30 p.m. EST and was passed unanimously.