The Secretary's Advisory Committee on Infant Mortality, US Department of Health and Human Services

Virtual Meeting

Tuesday, June 22, 2021

12:02 p.m.

Attended Via Zoom Webinar

Job #41947

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Reported by Garrett Lorman

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P R O C E E D I N G S

WELCOME, CALL TO ORDER, AND INTRODUCTIONS

LEE WILSON: Let's begin the meeting of the Advisory Committee on Infant Mortality this morning/afternoon, depending on where you're located. It is June 22nd and 23rd, 2021. My name is Lee Wilson. I'm the Director of the Division of Healthy Start and Perinatal Services in the Maternal and Child Health Bureau at HRSA, and I am acting as the Designated Federal Official in the absence of David de la Cruz, who is deployed as part of the Commission Corp work with the border.

First, I want to thank your committee members, our chair, and our ex-officio members for logging into this -- this meeting this morning/afternoon. We appreciate your willingness to attend and participate as experts advising the Secretary of Health and Human Services on infant and maternal health. Thanks also to our invited guests. We look forward to hearing your expertise and insights on these important issues. And finally, I want to thank the staff of HRSA and

other staff who have and are working hard to ensure that this meeting achieves its objectives and runs smoothly. We appreciate the many tasks and details, both big and small, that you attend to. So, thank you very much.

We have a full agenda today, for the next two days actually, with some great content planned as well as roll-up-your-sleeve types of work when it comes to recommendations and for future directions. So, I'm going to turn it over to Dr. Ed Ehlinger, our chair, to begin the meeting. Ed.

ED EHLINGER: Thank you, Lee, and good afternoon and good morning to everyone. I reiterate all of the thanks that Lee had to all of the folks for all the work that you've done.

We have three -- I have three major objectives in this meeting and one is just to finalize the recommendations that we've been working on over the last year and particularly since the last meeting. So, I've dedicated a lot of time to discussing that to make sure that we

get through and come to consensus or at least general agreement on the recommendations. So, I put a lot of time on the agenda for that. If we get through them quicker than that, we have lots of other things we can fill up the time with because the other couple of objectives are to really look at what is going on with some of the data issues that are coming forward and also the issues of racism. We have two sessions that are planned for that.

But the third agenda item is really trying to think, we've got one more year left or 18 months left for many of on this committee, and -- and I want to use our introductory time not just to introduce yourself but actually to think about how we want to use the next 12 to 18 months, so that the introductions are going to be more than just sort of a superficial hi, this is who I am, and this is where I'm from. I really want you to tell us, you know, what you bring to this committee, what the issue is that you think is most important that we should address and why.

And it comes out of the fact that -- that out of the 332 million people in the United States and the dozens of people who want to be on this committee, we have 10 people who are on this committee. We are a select group. For whatever reason -- as I mentioned in an E-mail that I sent out -- for whatever reason, this group -- this unique group is together for this period of time to do the work, and we have an opportunity as 10 people out of 332 million to really have -- make a statement to the HHS Secretary about what needs to happen about a couple of really important issues -- infant and maternal mortality -- two of the three leading indicators for sort of international health comparisons. And we bring a group together that has really a varied background. We have different skills and experiences and expertise and passions and then various geographic areas. So, I really want to really focus on some of those as we introduce ourselves.

And so, this is a good time to do that. We've come together really, we've had

summer solstice, where it's really celebrating life. We've got the longest days of the year. So, we want to shed light on what's going on in our world. We're following the pride weekend, where we really got to celebrate diversity and all its complexities and all its colors and how much we benefit from the diversity in our community. And we come together shortly after the first celebration -- national celebration -- national holiday of Juneteenth, where again, where we acknowledge our history, both our positive and negative parts of our history. We honor our stories. We honor our ancestors. We honor this -- - all of the work that we do collectively and certainly, I really honor, as I always start meetings, really honoring the indigenous folks who were here before here in Minnesota where we're on the land of the Dakota and the Anishinaabe or Ojibwa and wherever you are, honor the ancestors that have really laid the foundation for our work.

So, what I want to do now is take a bit of time, at least five minutes for each of

you, to introduce yourselves, to say what do you bring to SACIM, you know, what skills, expertise, passion, connections, whatever, and then what issue do you want to address. Because this is going to help me set the agenda for the next 12 to 18 months. I don't want to miss the opportunity that we have with this unique group of folks to actually make a difference on these issues, and we have an opportunity that very few people have. And so, I want you to say what is the issue that you would like SACIM to address and then why is that important so we know the context.

So, let's start. Tara, why don't you start. You're sort of the top of my list here.

TARA SANDER LEE: Okay. Sorry for the delay. Just had to get my mute off. Thank you for this opportunity, Ed. I think this is a great idea and I'm excited to tell you what I've been thinking about actually ever since I started this committee.

So, what do I bring to SACIM? Well, let me introduce myself first. My name is Tara

Sander Lee. I'm the Senior Fellow and Director of Life Sciences at the Charlotte Mosier Institute and we do a lot of science and statistics that help babies.

So, what do I bring to SACIM? I am a Ph.D. scientist. I have 20 years' experience in academic research and clinical medicine related to childhood disease. I bring to the table expertise and knowledge about fetal development, congenital disease, diagnostic testing. I directed a lab that did a bunch of diagnostic testing on kids. This -- my expertise covers both the prenatal period, newborn, as well as adult. I also have knowledge about fetal interventions that can increase survival of babies after birth. I bring to the table experience in state and federal policy related to health care and I have a passion for protecting the life of every child both inside and outside the womb.

So, what issue do I think that SACIM should address in the next 12 to 18 months? Well, our charge, going back to our charter, is to

advise the Secretary on policies and practices that reduce infant mortality and improve the health of pregnant women and their infants. Our focus and advice must be objective and rooted in scientific, evidenced-based methods.

So, let me start with according to the CDC, birth defects are the leading cause of infant deaths affecting approximately 1 in every 33 live births in the United States each year and accounting for 20 percent of all infant deaths.

So, what's the issue? I think one of the issues we need to focus on is increasing access to medical treatment and care before and after birth for families facing a poor prenatal diagnosis or a poor prognosis when born extremely premature.

So, let me talk about birth defects first and diagnosis. So, some of these birth defects are treatable before birth and scientific evidence proves their effectiveness in reducing infant deaths. Almost monthly, we hear about another story in the news about how a baby was

diagnosed inside the womb with, for example, like spina bifida, who received lifesaving fetal surgery or babies diagnosed with twin-to-twin transfusion syndrome that both survived after given the chance of life with advanced fetoscopic techniques that helped to reduce maternal mortality and morbidity.

So, with spina bifida, for example, the management of myelomeningocele study or MOM study found that fetal surgery on fetuses with spina bifida before 26 weeks gestation was associated with a decreased risk of death or shunting before postnatal age at 12 months as well as improved mental and motor function including independent walking, which is amazing at 30 months of age. These benefits continue into childhood up to 10 years after birth.

In another example, as I mentioned earlier, twin-to-twin transfusion syndrome, when minimally invasive surgery is performed between 16 and 26 weeks gestation, it can save the lives of both twins at all stages of disease. High-volume

fetal therapy centers such as Children's Hospital of Philadelphia, as well as Cincinnati Children's are reporting extremely high success rates, higher than 90 percent survival rate of at least one twin and higher than 80 percent survival rate of both twins after this fetal surgery. However, not all women who face a prenatal diagnosis of severe birth defect have access to fetal therapy and several improvements can be made to increase the quality of prenatal surgical care in the United States.

I've outlined several recommendations that I have presented in our small group, Quality Care, and I'm just going to say real quick that a couple of these include providing just maternal and fetal therapy awareness. Many women don't even know that these options exist. Providing financial assistance and child care support for families that decide to undergo this treatment and, for example, a lot of information is coming out that this service remains an essential service, especially during health emergencies such

as COVID and unfortunately, it did not remain an essential service in some cases. So, there's been a lot of reports coming out about this.

Regarding extremely premature babies, we need to insure that babies born extremely premature and treated are given access to active intervention. Advanced technology is moving back the clock of viability to as early as 21 weeks gestation. So, we need to make sure that families have this care when they need it most.

I'm going to tell you two quick stories that have been in the news. Story one of Jamarius Jake Harbor [phonetic] born at Emory Decatur Hospital in Georgia at only 21 weeks young, weighing only 13 ounces, smaller than the size of a hand, on Friday, December 20th, 2019. This little baby boy had extremely low odds of survival. The mother had lost two previous preemies at 22 weeks each. As she reported to the local news station, and I quote, "We looked at each other in the eye and I told him, the doctor, just give it a try. I just want you to try. As

long as you try, that's all that matters to me. Don't just up and say that you can't do it. Just because you haven't done it doesn't mean it can't be done." And her little baby boy was treated and he survived.

Second story, just yesterday, there was a story all over the news about another premature baby, Richard Scott William Hutchinson, born at 21 weeks gestation last year during the pandemic shutdown, weighing less than a can of soda at Children's Minnesota -- so, maybe I should say pop actually since he was born Minnesota -- who celebrated his first birthday last month -- or this month actually, and his parents were told that he had a 0 percent chance of survival but received the advanced care then that he needed to survive.

So, we need to seriously talk about recommendations so that all parents know that they have these options and advanced care available to them.

So, final question. Thank you for

giving me the time. So, why is this issue of most importance to me? Because babies are dying and because these babies are dying because the health care system is preventing some parents from receiving the medical information and advanced care that they need after receiving a poor diagnosis or prognosis when born extremely premature. So, some of these deaths are preventable and we need to make sure that these babies are given the care that they need to survive.

So, thank you very much for giving me the time, Ed. I appreciate it and I'll turn it over to whoever you think is next.

ED EHLINGER: Good. Thank you, Tara. Thank you both for the information and for good modeling about why -- why we have a diverse group of folks on this to bring different backgrounds, different issues. And so, thank you for bringing up an issue that really needs some further discussion.

All right, Steve.

STEVE CALVIN: Great. Hi. Steve Calvin here. I'm in Minnesota along with Ed. I am an OB/GYN who specialized in maternal and fetal medicine after serving three years at the National Health Service Corps at an FQHC down in Tucson, Arizona. So, I have a heart for that -- that kind of care and the population served. I served mostly Spanish-speaking mothers and mothers from the what used to be called Papago Tribe, but Tohono O'odham now. Clinical practice really has been my focus throughout my career, but I've also been involved in teaching, research, and advocacy for system reform. For more than a decade, those reform efforts have been made with colleagues in an independent accredited birth center practice that provides primary midwifery care that is integrated with a strong perinatal safety net. I tell moms and families that I see that I know every bad thing that can possibly happen, but I'm also aware, because of the experiences of my daughters and daughter-in-law in just seeing moms with normal pregnancies that pregnancy is a

physiologic process with the potential for -- for major complications. So, you really have to do both -- have a safety net and honor physiologic birth.

During 40+ years in maternity care, I've seen the advent of incredible medical advances that benefit mothers and babies. What Tara mentions is true. I've watched that. Early in my career, I did some fetal transfusions for babies that were anemic. Those things deserve celebration, but over the decades, I've also seen the persistence and worsening of endemic problems and barriers that prevent optimal care for all pregnancies, and the most dramatic problem is the persistence of racial outcome disparities. The causes of those disparities are complex, but there are proven care model remedies that are available.

Eighteen months now into a 4-year SACIM term, I've learned a great deal from committee colleagues, ex-officio members, HRSA staff, and all those who participate in our meetings. During this time of deep political

division, we just must remember that the care of babies and mothers is a bipartisan priority, and I've seen that to be the case. It's something everyone can agree on. It's a privilege to be part of SACIM and to have the opportunity to help provide significant focused recommendations to the HHS Secretary Becerra.

So, what issue to I think SACIM should address in the next 12 to 18 months? My number one issue really is implementation of Medicaid payment reform for maternity and newborn care. I believe that reform will provide much higher value care for the nearly 50 percent of mothers and babies who receive care through Medicaid each year. I know it's a complicated issue, but I think it's incredibly important.

And why is this issue of most importance to me? Through my clinical career, I really was focused on high-tech solutions to complicated maternal and fetal problems, and those are important. I mean, I -- I got a graduation announcement from a family where the little girl

was born at under a pound -- graduation from high school. And so, I know those things are really important and they need to be part of our decisions and our recommendations.

But support for comprehensive primary perinatal care and doula services has been neglected by the current payor and provider systems, and this neglect has negative consequences that would be immediately addressed by implementing a primary midwifery model of care with the option of birth center care described within the ACA-supported Centers for Medicare and Medicaid Innovation Strong Start Study, which, I think, most of the people on this of the 71 people of us are -- are familiar with that.

More than $40 billion of state and federal funds are currently spent for maternity and newborn care each year in the United States, and much of it right now is funneled through Medicaid Managed Care Organizations that with some exceptions, so far, do not really support beneficial care models. The federal and state

leadership in this area would really immediately address persistent racial outcome disparities and would encourage similar changes in the commercial market. And the problem really is not lack of money. There's a lot of money in the system right now. It is really how it is spent. And the broken fee-for-service payment model, I believe, must be abandoned and exchanged for something new that really looks like a single comprehensive bundle of services that is risk-tiered for this comprehensive package then for a single amount of payment and that amount could be distributed over a period of time. And we'll have more to talk about a little bit later this afternoon.

So, I appreciate the opportunity to be on this committee. I've learned a lot from everyone and I'm excited for this next couple of days.

EDWARD EHLINGER: Thank you, Steve. Thank you very much. We appreciate that perspective.

Next, Magda.

MAGDA PECK: Good morning, Ed. Good morning, colleagues. I want to thank you for the opportunity to continue to serve the nation's mothers, babies, families, and fathers. I have been working for the well-being of all women and children and families for a while. And so, I bring initially a clinical perspective, and I think it's important to remember how we start the work that we do. So, as one of the first physician's assistants in the country working for the National Health Service Corps at the US-Mexico border, having a firsthand experience to be able to lay hands on and be an advocate for women, children, families, and fathers has informed my work. And as I have moved into the role as a public health scientist from the numerator to the denominator, if you will, I have come to understand that the way that we make a difference has to be both at the individual level and at the system's level. So, I bring to SACIM a capacity to know maternal and child health science and to bring a public health perspective strongly to the

table.

I want to add that my passion around that content knowledge is around the use of data -- the strategic and effective use of data, the translation of our numbers into evidence-informed practice and policy. And I think we have a myriad of information, but it is not always being used most effectively, and in that midwifery of data to action is where my sweet pot can play.

As a systems thinker, I am undaunted by the complexity of infant and maternal mortality, and it requires us on this esteemed body to be able to see multiple perspectives and multiple altitudes of a given challenge so that we can have solutions that are not quick fixes.

I bring an unwavering commitment to equity and justice. It is why I wake in the morning. And I bring some particular skills that are, I think, have been proven useful in the last two years about strategic collaboration, the ability to engage diverse voices and perspectives and to help us collaborate in a way that leads to

consensus, a respect for difference, and an ability to shape comprehensive solutions.

Last, what I bring in my newest portfolio on my third half of car talk, as I become active in the field of story-telling for social change, that I would like us to bring forward voices that will lead not to only inform but to engage and ignite our work. So, story-telling is something that I have been working and mastering and particularly story-telling for social change.

So, what's the issue? Well, I want to first start with what we have to do before we take on another issue and that is that we have to sustain the work that we've already done and not jump to the next hot thing that needs to happen. And so, sustainability, tracking what recommendations we've made because we have done short-term work to be able to inform now two Secretaries of Health and Human Services. So, let's make sure that what we say goes somewhere, that we move from word to deed and look to how we

can institutionalize the work that we are recommending going forward. That is in particular not only on specific clinical and public health recommendations, but centering the work on health equity, racial equity, birth equity, and our work in an anti-racist space with courage and accountability. So, let's sustain what we're going before we take on the next issue.

If there is to be the next issue, then I want to borrow from a colleague, Mark Freeman, who talks about three powers that whatever we take on should have. Mark would talk about it needs to have data power. As Tara mentioned, this needs to be backed by evidence. So, we want to have this data power that can inform our work.

Second is we need to have proxy power in this thing that we choose to do together. If we choose this, it will being along other issues. So, let's make sure that we cluster and not compete among our striving issues.

And third, communication power,

especially at this time. It can help inform a narrative that can change the minds and mindsets of how we understand who lives and who dies and why. So, I'd like us to be thinking about those three powers.

One issue for me that satisfies data power, proxy power, and communication power is the issue of women of reproductive age and particularly pregnant and parenting, breastfeeding, and early moms who are experiencing homelessness and housing insecurity. Homelessness is social nutrition -- sorry, housing security is social nutrition. We need to be able to assure that not a single woman in this nation is evicted while she is pregnant and while she is parenting a child in the first year of life, and there's an urgency post-COVID, as the CDC ban on eviction wanes and fades. Shall we argue and advocate that the most vulnerable will not experience homelessness on our watch?

I would like us to also understand why this is most important to me. I have been

steeped in the city of Milwaukee and when I served as founding Dean of the School of Public Health at the University of Wisconsin, Milwaukee, and noticing and learning from Matthew Desmond, who did his doctoral thesis at the University of Wisconsin on the toxicity of eviction using Milwaukee as a case study, has ignited in me an awareness that if we can assure that the experience of housing security is universal for pregnant and parenting mothers, then babies will survive and thrive.

My name is Magda Peck. I am the head of MP3 Health, which is an independent consulting collaboration. I have an academic affiliation at the University of Nebraska Medical Center, where I am an Adjunct Professor of Pediatrics and Public Health, and I am the proud founder, former CEO, and continued senior advisor to City Match, and I want to thank you for the opportunity to use this space to bring my unwavering passions and purpose. Thank you, Ed.

EDWARD EHLINGER: Thank you, Magda.

As always, very articulate in your statement about what the issues are. Those three individuals -- I had asked all of the SACIM members to send me ahead of time what -- what their issues were. I got three from the group. So, I don't know what the issues are that the others are going to bring forward, but I'm going to go Jeanne Conry, you're next.

JEANNE CONRY: Thanks so much, Ed, and I'm very delighted to be part of this noteworthy group with the perspective of maternal and infant health when we're looking at infant mortality. So, I very much appreciate being part of this.

I'm, as you said, Jeanne Conry. I practiced obstetrics and gynecology for 30 years with the Permanent Medical Group -- Kaiser Permanente in California. I have a Ph.D. in biology, research scientist, went to medical school, and then decided that I was most passionate about preventative health care and thought the best niche for me was taking care of

women in the largest health maintenance organization in the United States that puts a focus on the health and well-being of patients and outcomes -- the outcomes first. And I look back at my 30 years with Kaiser Permanente and believe that that's the way we should practice medicine around the United States, and I'm retired, so I'm plugging them surely in my retired position, but I appreciate all the time that I had there.

I've also been a leader in obstetrics and gynecology in the United States. I had the good fortune to lead the state of California with the 5,000 OB/GYNs in the state in half a million deliveries, was Chair of Obstetrics and Gynecology for the California Region District, and then went on to be elected the President of the American College of Obstetricians and Gynecologists, an organization that represents 60,000 practicing physicians around the United States and puts again a vision for the health and well-being of women first and foremost. I'm now fortunate enough to sit as the President Elect for the International

Federation of Gynecology and Obstetrics and have brought to that the same passion that I brought to ACOG and to California and to every practicing moment.

As I said, I practiced, I was on labor and delivery for those 30 years seeing patients in my clinic, holding the hands of patients as they delivered a premature infant or as they delivered the most wonderful special baby they ever had, holding the hands of patients as they had to make very heart-wrenching decisions about their health care. I support universal health coverage and believe that that should be a basic tenet of every country around the globe, United States included. Universal health coverage, which means preventative health care, it means emergency health care, and it means surgical health care, and that should be an absolutely given with a country that spends more on medical care than any other country in the world. Universal health coverage should be a right, not a privilege, and I believe fundamentally that until

we grasp that and until we understand all of the elements of universal health coverage, we won't do what we need to do.

The Affordable Care Act did that and does it, but it's not as broad as it needs to be, and that's a political discussion I can't go into. But it did, for the first time in the history of the United States, put well-woman health care first and foremost saying a woman had the right to have access for mental health screening, access to prenatal care, access to contraceptives, access to all the choices she needs to make in order to make sure her health and well being are cared for.

I appreciate Dr. Tara Lee's comments about recognizing how much our practice of medicine has evolved and will continue to evolve. We saw that with COVID. We know that will continue. I also believe passionately that the care that I provide for a woman -- that anybody provides for a woman -- happens between that provider in the exam room with that patient and I believe fundamentally in a woman's choice. A

woman has a choice to make decisions. I have been there as a woman sees the defects -- her child has cardiac defects that are not compatible with life and decides that she's going to terminate the pregnancy. I've been there as a patient says she knows that she's got a child that has -- is carrying defects that are not compatible with life and she cares to continue that. My duty is to be there with my patients, and I did that and believe passionately that that's where we need to be. We need to provide patients with what they need.

In terms of what I bring or I brought, it's that I look -- I can speak for my ACOG presidency. There were three important elements that I brought and they still are resounding in what we're doing.

Number one, the National Maternal Health Initiative that was sponsored with HRSA. The National Maternal Health Initiative looked at maternal morbidity and mortality and what we needed to do. We proposed ten bundles of care that needed to be implemented.

The second was well-woman health care, that we need to invest in the health and well-being of women before, between, and beyond pregnancy if we're going to impact the health and well-being of our families in our country.

And the third was the focus on the environment. And again, as Tara Lee has said, there are environmental exposures that impact the health of an infant that can be contributing to birth defects, and we need to make sure that our environment is clean and healthy so that those exposures don't happen.

With VIGO [phonetic], I'm continuing to bring those same three focuses in to fruition. I do want to say that my issue is the systematic approach to maternity care with the implementation of what I would call safety bundles. We know what it takes. It is a matter of implementing those safety bundles to effect change, and the best example we have of that is the California Maternal Quality Care Collaborative. The United States currently ranks about 40 to 43rd in the world in

terms of maternal morbidity and mortality. We're comparable to a low- to middle-income country rather than being up there with the European Union. If you look at California and what California implemented, we brought maternal mortality down to the level of the European Union. How? Systematic approach to care, recognizing what we need to do, and involving all of the hospitals -- ever since -- 94 percent of the hospitals within the state of California.

I agree with what Steve said. It doesn't have to be high tech. High tech is wonderful. I do love electronic records. I'd love to bring that everywhere. But making sure that we follow some of what we know is basic. We, in the United States, should be able to lead and to learn. Leading, we have the ability to do, but we don't always need to, and yet, we need to learn from other countries on what they do well and what we can do better.

So, I thank everybody for allowing me to be part of this, and mine is really a

systematic approach to care. Thank you.

EDWARD EHLINGER: Thank you, Jeanne, and for the rest of the committee, Jeanne is a poster child of what I'm really hoping because of her we have a set of environmental recommendations coming forward what we're going to be working on because of her pushing that issue. And so, I'm raising -- asking you to raise the issues because I want you to take a lead to really show your activism, your passion, your energy to -- to move these issues forward. I'm always asked, you know, what's the one issue that we should focus on if we're just going to just focus on one. I say all of the issues are important, but it's where are the opportunities and where do we have the energy to move things forward, and that's what I'm hoping to get from you is where is the energy so that we can move something forward because all of the issues are important. So, Jeanne, thank you for being the poster person for that related to environmental health issues.

Janelle -- Janelle Palacio.

JANELLE PALACIOS: Good morning, everyone. Thank you, Ed. I am Janella Palacios. I am the most junior committee member here. I am Salish and Kootenai. I grew up on the Flathead Indian Reservation, and I currently am in the Bay Area sitting in historical Pomo and Coast Miwok land, and I'm coming to you with a few different roles. I am a nurse midwife. I'm currently just coming off two night shifts that were about sixteen hours long each and delivered over eight babies each night. So, it's been a little busy post-COVID and entering the summer baby season.

As a midwife, I have direct clinical experience and philosophically, I view labor and pregnancy from a very normal perspective and we often deal with the after effects of manipulations of a person's experience across their lifespan, which manifests in their high blood pressure, which manifests in preeclampsia, which manifests in the number of diseases that affect people while they're in labor or they're pregnant, and I'm interested in understanding how we can change

life, change our environment, change the social environment that we live in in our nation so that we don't have these issues anymore, and this comes from the experience of having grown up on a reservation with most of my family members having diabetes and always learning from a young age that oh, Indian people will always have diabetes and they're just prone to it. But the research is not understanding that there's like a historical context for this, that our lands were taken away, there is a great amount of stress that was impacted on our generations of lives, children that were taken from their homes and their families and kept on residential schools with Canada recently finding over 215 bodies of dead children that were buried in unnamed mass graves, and this has happened, I believe, also throughout our nation. So, understanding that diabetes is not just something that Indian people have a problem with, but it's an affect -- a traumatic effect from trauma and intergenerational pain. Also, understanding that a lot of people on

reservations had access to commodity foods and if anyone knows commodity foods has been in the military, received any kind of food assistance, a 5- to 10-block of cheese is just largely fat -- flavored fat. It's very delicious, but it comprises a lot of our diet growing up. And so, to me growing up and going to college and understanding research, it was not a big jump for me to understand why these people had such high rates of diabetes. Similarly, it's not a big jump for me to understand why we have such poor maternal infant health outcomes among the Black, indigenous, women of color in our nation and it largely rests upon how our nation has treated these people, and it's not just women and children, it is the fathers too. It's the entire family, it's the community.

So, as the junior -- the most junior committee member, I had a little bit of experience also as a past president of the largest Native American health research organization called Native Research Network and as a practicing

clinician, as a nurse midwife, combining that with a little bit of my background experience of when I did my Ph.D. at UCSF over ten years ago where my expertise was in maternal and infant health among native women in tribal communities, I helped reform our current thoughts on the formation of motherhood. The research I did challenged the long-held view of where motherhood formation began. Everyone believed it began with pregnancy or sorry, no with the delivery of a baby, and my research showed that it actually begins when we're children. It actually begins when we are young people and we are learning through our family members and we have real needs that we have to take care of that we start beginning to form our motherhood formation.

So, my qualitative experience and the experience of working with stories and being a story-teller and doing story work is a strength that I bring to this committee.

And more recently, something that I have tried to help inform Kaiser Permanente

through presentations that I've done multiple times across the Bay Area and has now reached into a national form where I'm being invited to give story-work presentations that specifically link historic effects and the -- the effects on people directly, especially maternal and infant health and how it manifests through our outcomes.

So, when you ask me what I can see myself helping with SACIM during the next 18 months, like Magda has shared, that I would love to see that the foundation that this iteration of SACIM has brought together continues to move forward and we actually have actionable items that are put into action. So, we're no longer speaking in code. We're no longer speaking and just dreaming of different things and talking to a multitude of people to just get ideas. We've kind of done that segment for a number of years, and now it's time to take action. And knowing that this is just the beginning, that if we're trying to really affect maternal and infant health, it's going to take as many years probably, or hopefully

less, as it has done to take to create these outcomes that we have, and I personally believe that it starts with a massive transformation across our nation with regard to truth and reconciliation of our nation's history and it is a social consciousness and a social awareness that I am really -- social change that I'm really interested in helping.

So, thank you again, and I take pleasure in helping in any way I can.

EDWARD EHLINGER: Thank you, Janelle. I got some feedback that I wasn't coming through. Lee, is this sounding better? No?

JEANNE CONRY: Worse.

EDWARD EHLINGER: All right. I'll go back to the microphone. How is that?

MAGDA PECK: Better.

EDWARD EHLINGER: All right. Janelle, thank you, and all perspectives are needed. It's not a matter of experience, being senior or junior. All of those perspectives -- the more experience you have sometimes can be

good, but sometimes it can put you into a certain mode that you don't think about new ideas. And so, we need all people from all different ages and all different parts of the country and all different perspectives. So, being junior is a good thing. You bring a lot.

And I know that we have other members, but I don't see them on the line or on our list right now. Are there any of the SACIM members that I'm not seeing that are dialed in and not on our participant list?

MAGDA PECK: Ed, would you speak their names so that people who are listening in can understand the complement in its entirety?

EDWARD EHLINGER: So, Collen Malloy, Paul Jarris -- I think Paul Jarris is biking, so he won't be here, but Paul Wise, and Belinda Pettiford, she has a budget hearing that goes on at noon, so she's going to come in later, but I didn't know if she had gotten on yet. So, I don't see them.

TARA SANDER LEE: Ed, sorry to

interrupt, but Colleen texted me. She wants us to tell you that her line isn't muted, but nobody can hear her talk. She's definitely on.

MAGDA PECK: Some technical issues.

TARA SANDER LEE: So, some kind of technical issue is preventing her from speaking right now. But she -- she's been -- she's here.

EDWARD EHLINGER: All right. So, Vincent, see if you -- see if you can facilitate getting her voice heard.

LEE WILSON: If Colleen is there and she can look in the E-mail, there should be a telephone call-in number as well, which may be able to provide some assistance. She may be able to speak through that line, if possible. I'm not sure, Vincent, if you can help with that as well.

VINCENT LEVINE: Yeah. Colleen, if you'd go ahead and raise your hand if you're in the audience so I'll be able to promote you. But I don't see her in the panelist listing here, which would -- she would need to be in order to speak.

EDWARD EHLINGER: While we're working on that, I would like to quickly run through our ex-officio members and have them introduce themselves, certainly not to the length of time that we've had the SACIM members, but I do want you to introduce yourself, the agency you're from, and just what, from your agency's perspective, what would you like SACIM to be focusing on over the next 12 to 18 months. So, I'll just start at the top of my list. Wanda Barfield.

WANDA BARFIELD: Yes, hello everyone. I'm Wanda Barfield, and I direct the Division of Reproductive Health at CDC. I'm a neonatologist by training and I've had the joy and opportunity to see many babies be born and cared for and I appreciate all the comments of the clinicians here. And also, as a mother, I have recently celebrated the 20-year anniversary of my premature son who was born at 34 weeks on Juneteenth 20 years ago, and I know that, you know, it is so important that we do care for our infants, and this committee is so important, but we also

understand and realize how critically important it is to address the health of women and mothers before pregnancy and throughout the life course as well as Janelle put so gracefully, also men and families. And I think that this committee has been so committed to doing that work, and I'm honored to be a part of the work that you're doing and I just want to note that as an ex-officio, my role is to try as best as possible to help to support the committee's work and you guys have been so active in terms of the work that you're doing and what CDC and my colleagues from CDC bring is the opportunity to continue to support the work and to move things forward so that you're able to make the best recommendations for all of us. And I appreciate the opportunity not only to work with my colleagues at CDC but also those who are supporting this through HRSA and our colleagues at NIH as well as other federal officials. So, thank you for the opportunity and I just look forward to sharing information later in this meeting, particularly from the pregnancy

risk assessment monitoring system and hearing from all of you about ways that we can improve that surveillance system to better serve, particularly women, and address disparities, and improve health equity. Thank you.

EDWARD EHLINGER: Alison Cernich.

ALISON CERNICH: Good afternoon and good morning to all of you. I'm Alison Cernich. I'm the Deputy Director of the Eunice Kennedy Shriver National Institute of Child Health and Human Development, and we're just one of many institutes at NIH that works on issues related to maternal health and infant health. I think that the NIH community at large has been very invested in trying to transform really the evidence base around both pre-pregnancy, pregnancy, and postpartum risks for mothers and then also to better understand and many of you are aware that NICHD has the largest portfolio of projects related to birth defects, to preterm birth, to sudden infant death, and sudden unexplained infant death. And so, this is something that is very

near and dear to our institute's heart.

And I think just to echo some of what has been said by other speakers and not to belabor it, one, I think working with our interagency colleagues, I think we are trying very hard to build the evidence base to support the things, like Jeanne mentioned, related to safety bundles or care practices that we can institute at large that will be transformative for pregnancy and for neonatal outcomes.

But I think the other thing that we really have to do and that we have concentrated on this year is make sure that we are looking at this with an equity lens and that we are engaging the community to the greatest extent possible because what we prescribe may not be the thing that engages the community and leads them where they are to have them participate fully in whatever it is that we think might be better for their outcome.

So, we are really trying to be more engaged in having community partners in all of the

research that we do in this area, and whether that's through partnerships with HRSA, the requirements to have community partners is part of our research activities and/or to really look with a health equity lens as specific populations who have been understudied and not included in the evidence base that informs what we do today.

So, I just want to thank all of you and all of my interagency colleagues for all your efforts. I think, you know, we can -- we can go alone and fill that evidence base, and I think hearing the conversations here and really understanding the perspectives that you all bring helps to inform what we bring back to our agency and what we can implement. And so, I want to thank you all for sharing that with candor and bringing these really valuable community voices to bear.

EDWARD EHLINGER: Thank you. Cheryl Broussard.

CHERYL BROUSSARD: Hello everyone. Wonderful to see you again. I'm Cheryl Broussard,

and I am from CDC's Division of Birth Defects and Infant Disorders, and like Wanda said, our role as ex-officio members is to support the committee. So, as an epidemiologist in particular, I'm here to support the committee related to data, so helping you understand what data we have and what data we need and especially what data we can link together between mothers and infants to both better understand and improve maternal and infant health. So, thank you for all you do.

EDWARD EHLINGER: Thank you.

Danielle Ely.

DANIELLE ELY: Hi, I'm Danielle Ely. I am from the Division of Vital Statistics at the National Center for Health Statistics and I manage the Linked Infant Mortality File, which is the file that links the birth certificate information with the death certificate information for infants.

Pretty much to reiterate what Wanda and Cheryl have said, we spent a lot of time trying to offer the support to the committee in

any way we can. In my role, I do my best to provide data as needed to the committee, and I am so very grateful to the committee for all of the work that they have done to try to press forward in creating more equitable outcomes for infants and their mothers.

EDWARD EHLINGER: Thank you, Danielle.

Joya Chowdry.

JOYA CHOWDRY: Hi, thank you. I am from the HHS Office of Minority Health representing OMH and I am so honored to be able to listen to this committee and support any of the recommendations that you come up with.

The Office of Minority Health is dedicated to improving the health of racial and ethnic minority populations through the development of health policies and programs that will help eliminate health disparities. We have some exciting programs with the CDC in supporting the MMRC programs and initiative and then also helping to develop a -- helping to develop the

Hear Her program specifically for those populations. So, we're really excited about that and those projects are starting soon.

OMH recently also released an E-Maternal Health Planning program related to class -- culturally and linguistically appropriate class services, and I encourage everybody to access that. It's free. You get two CLPs for any practitioner. So, that's great.

But, OMH is really excited to work with our partners and with SACIM and others to help encourage the use of disaggregated data for both maternal and infant mortality. As many of you have already said, without the data, we can't really assess the issues that are coming up and also get to the outcomes that we need to get to. So, thank you so much.

EDWARD EHLINGER: Thank you. And I know, Karen Remley, you're not -- I don't think you're officially an ex-officio member and you're going to be talking tomorrow but introduce yourself.

KAREN REMLEY: Sure. I'm partnering with Cheryl. I am the relatively new Director of the Center on Birth Defects and Developmental Disabilities at the CDC and probably the most important thing about me is I'm a pediatrician -- pediatric ER doctor for the first part of my career. So, I took care of a lot of children who came in either at the end of life or near the end of life with complex problems or sudden infant death, and you know, I've just been passionate about this.

Very quickly, I was State Health Official with Ed Ehlinger. I was in Virginia when he was in Minnesota. I was hired by the then Governor Tim Kaine with the specific job of lowering the infant mortality disparities in Virginia. Met Wanda at that time and what the governor said to me was four governors have tried to do this. We had an infant mortality rate in people of color that was three times that of Asians and whites and he said I do not want to be the fifth governor who can't fix this problem.

And I said to him we're not going to fix it during your tenure because he was 2-1/2 more years left, but we will get there, and I was really proud when we came in. We got a D- from March of Dimes for our infant mortality rates and it took until 2014 -- so 2008 to 2014 -- we had a B+, and that means there's a lot more work to be done. I'm honored to just be kind of a co-member, not an ex-officio member -- with Cheryl, and I think the important thing I learned as State Health Official was humility and targeted interventions really listening to each community about what works well for them and I worry that we can talk about the best quality care, but if you don't have access to that care, it doesn't matter. So, every woman before they are childbearing, but every woman of childbearing age, deserves to have the information they need so that every child has the best opportunity. So, thank you. Thanks, Ed.

EDWARD EHLINGER: You're welcome.

Kristen Zycherman.

KRISTEN ZYCHERMAN: Hi, I'm Kristen

Zycherman. I am in from CMS in the Centers for Medicare and Medicaid Services in the Division of Quality and Health Outcomes.

So, in our division, we house the Medicaid and CHIP core quality measures, which include the Maternity Core Set as well as the CMS Maternity and Infant Health Initiative. So, we are kind of on the measurement -- the measurement side as well as the quality improvement side. So, we are thrilled to be a part of this. We're, as I'm sure you guys all know, we cover 40, 42 percent of births, much higher in some states, and cover 40 percent of children in even higher percentage in that first year of life for any mom that gives birth in Medicaid. So, as a payor and measuring -- measuring quality, we are really excited to be a part of this work group, kind of as a -- it struck me what Magda was saying about -- about using the data to then enact quality improvement because you can't fatten a calf by weighing it. So, it's good that we're doing something with all of this data -- with all these

data people we have. So, thank you.

EDWARD EHLINGER: I see that Paul Wise is on. Paul, we've been going through the introductions, and I asked all of the SACIM members to answer the three questions that I sent out earlier, you know, what do you bring to SACIM, what do you think the issue is that we should be dealing with for the next 12 to 18 months, and why.

PAUL WISE: Thanks very much. Thank you all. I'm a pediatrician at Stanford with a long history of working with Ed and others and Magda and others on the call on addressing disparities in maternal, infant, and child health in the United States. I've also been working heavily on improving child health in areas of armed conflicts and politic instability with a long history of working in Highland Guatemala. You can see behind me virtually Lake Atitlan, where I've been working for more than forty-five years. And most recently, I've been working for the federal court in the United States overseeing

the treatment of children in US Immigration custody, Border Patrol, ICE, and ORR, the Office of Refugee Resettlement in HHS, and in that capacity, I've spent quite a bit of time in detention facilities talking with families and unaccompanied children as well as officials from all these different agencies and have strong feelings about the role of HHS, both the opportunities, the expertise that HHS brings to these issues, but also the opportunity to do a lot more, particularly in providing leadership for major reforms in how migrant children are cared for and reunited with families and sponsors in the United States. So, thank you.

EDWARD EHLINGER: So, what are the -- what is the issue that -- that we should focus on in the next 12 to 18 months, because you've been really helpful in bringing forth a set of recommendations on this that we're going to be talking about in about a half hour about migrant and immigrant health. Any particular issue that you would like to have us look at?

PAUL WISE: Well, I think HHS, I mean, all of the issues that are coming out our recommendations are important, and I strongly support them. But we have an unprecedented challenge on our southern border and HHS can do a lot more than it's been doing to change, to reform the systems of care that hundreds of thousands of children every year are coming into the United States, coming into US custody engage. And this is the time, particularly for dramatic exploration, and I would suggest significant reforms in the systems that have been in place for decades that are failing, and we have the capability to dramatically improve the humanitarian conditions for children and families and HHS, in my view, has a strong leadership role to play.

EDWARD EHLINGER: Good. Thank you.

And you -- you've heard from Lee Wilson, and you will be hearing shortly from Dr. Michael Warren, but let's hear from Vanessa Lee. Introduce yourself, Vanessa, please.

VANESSA LEE: Hey, everyone. I'm Vanessa Lee. I'm a project officer in the Division of Healthy Start and Perinatal Services at MCHB in HRSA. More and more I've been working to support the committee. I've been slowly more of my time on this work, and I'm just honored and always inspired to be at these meetings and looking for any way I can help support the committee and move your work forward.

Prior to working with SACIM, I was leading the Infant Mortality COIIN Initiative, which was a national collaborative looking at quality improvement and innovation to support states and communities in lowering their infant mortality rates. So, happy to be with all of you today and look forward to the next two days together.

EDWARD EHLINGER: Good. And Juliann DeStefano. Juliann, are you there? Maybe she stepped away. All right. Did we -- were we able to get Colleen on the line?

VINCENT LEVINE: She should be

joining within the next five minutes, but she was driving before.

EDWARD EHLINGER: Okay, all right. Well, we've introduced everybody. I haven't introduced myself. I'm Ed Ehlinger. I'm the acting Chair of this committee and I've been, you know, on the opposite end of what Janelle mentioned. I'm, you know, I'm the senior, and, you know, Paul and I have worked -- Paul Wise and I have worked together for a long, long time. I worked at the local level, the state level, and the university level with a background in medical care and public health and I recognize that we've got -- we provide great medical care and we provide great public health care and that those, as good as they are, have not moved the needle on the disparities and on the -- on the issues that really impact health so that we have to change how we do our work. We need to find a new way of doing medical care, a new way of doing public health, whether it's improving access and how we do it and how we address the issues that -- that

really affect our communities, and I've come to the conclusion that it's really not about individuals; it's about communities. How do we change life in communities? How do we change, as the Institute of Medicine said, the conditions in which people can be healthy? And that's the work that we have to do.

And in order to do that, we have to change public sentiment. We have to change the political will. And as Abraham Lincoln said, "Without public sentiment, nothing can get done. With public sentiment, everything is possible." And so, I think the work that SACIM has to do is really raise the issue of the importance of mothers and babies in our society. You know, we all say yeah, they're important, but we don't really put our money where our mouth is. We don't -- our actions don't reflect that. Not having paid maternity leave, paid family leave, not having child benefits, not having child care, not having affordable housing, not having stable and secure housing. All of those things that -- that

really impact the lives of mothers and families and babies, we don't support. That means that we don't really have mothers and babies as a high priority.

So, my goal is to raise this and change the narrative. Change the narrative about moms and babies and that they should be a center point of everything that we do, and you'll see those in the recommendations that are coming forward that we're going to be talking about today that our recommendation is that the health of moms and babies and families should be the priority focus on all of the decisions that are made. And so, that's the issue that I bring forward, and as Chair, I get to set the agenda. So, that's why you see some of those things in here.

But also, as Chair, that's why I also wanted to hear from you, because you also have passion about a whole variety of things that I've heard today, and I want to bring those forward because that's where the energy is. Where you've got the passion, that's where the energy is, and

that's when we can get things done both to sustain things that we've started and evaluate the things that we've started and take the next step, whatever that might.

So, welcome to everybody. We're going to have a great meeting. Let's now get down to the official business and first of all, do I hear a motion to support our minutes -- to approve the minutes of our last meeting?

STEVE CALVIN: So moved. This is Steve.

UNIDENTIFIED FEMALE SPEAKER: Second.

EDWARD EHLINGER: All right. Any discussion? All right. All in favor, say aye.

[Chorus of ayes.]

EDWARD EHLINGER: All opposed, say nay. All right. And before we get to our -- I do see Colleen is finally on. Good. Colleen, welcome, welcome.

COLLEEN MALLOY: Oh my gosh.

EDWARD EHLINGER: A long way of getting here. So, really do take the time. I

think you've heard some of the introductions, I hope. So, introduce --

COLLEEN MALLOY: Yes.

EDWARD EHLINGER: -- introduce yourself and what you bring and the issue that you think is important for SACIM to address over the next 12 to 18 months.

COLLEEN MALLOY: I'm trying to figure out where I can best hear you. Say something. Can you hear me?

EDWARD EHLINGER: I can hear you.

COLLEEN MALLOY: Okay. Yeah, I've heard everyone's discussions. I really appreciate them and this is a really fantastic group. Especially even listening to what Ed just had to say, I mean, I think that motherhood and babies should be celebrated and that's actually why I was late because I had to pick up my daughter in another state. So, I knew this date was always going to be difficult for me. I think, even looking back, I think one of the first SACIM meetings, we were talking about breastfeeding and

someone on the committee said, well, what would you know about trying to hold a job and breastfeeding, and I said, I used to breast -- I used to pump in my car to and from work going to work, I mean, every working mother knows this -- this balance of whether you work in the home or outside of the home and I really do think that, you know, we used to respect motherhood and babies, and I think -- how many times do you hear a pregnant lady standing on a subway and everyone her is sitting down. Like, that happens all the time. It happened to me. I would take the train downtown to work and I would say half the time someone offered me a seat when I was like nine months pregnant. So, I do think that things have changed in that regard.

I don't have your list of questions in front of me. But what I bring to the -- what my background is, I'm a neonatologist. I feel like I am a fervent supporter of pregnant women and people in difficult pregnancies, people who have difficult deliveries, difficult situations.

I think, you know, looking at the constellation of options that are offered to people, you know, babies who have issues, these congenital difficulties have been since the dawn of time, and we, you know, Mother Nature kind of has a way to deal with that, and I think that from my perspective, we do a really bad job of offering people alternatives like perinatal hospice, to give people who want more closure and a more smooth transition if you have a baby that has, you know, multiple issues and may or may survive much beyond life. I've seen perinatal hospice be such a wonderful things for families in a difficult situation because termination doesn't really fix the problem; it just kind of gives them another problem.

So, I do agree with what people said, you know, it's not all about high tech, but I think that we have to be fair and that the standard of care in the middle of Chicago is one thing for babies, it should be that same standard of care in other parts of the country, whether you

live in a rural environment, whether you live in a disadvantaged economic situation.

I also do think that although we talk a lot about social determinants of health, we do need to realize that one of the very strong driving factors for infant mortality is prematurity as a result of often times preeclampsia and chronic hypertension. So, there's obviously some issues that we could, I feel, like address within the pregnant woman's journey through pregnancy. So, you know, what is her state of nutrition? What is her state of just general health? Because if you already have chronic hypertension, you're definitely going to have gestational hypertension. You're definitely going to be at way higher odds of delivering early and even, you know, by the CDC data that's well published out there, prematurity is a huge driving force to infant mortality because, let's be honest, most infants don't die, and this committee is a committee for infant mortality. So, if we're going to focus on infant mortality, preemies in

any group are the most likely to not survive infancy.

And the other thing I think that we haven't really talked about too much is -- I think I just looked at the video the other day -- but it's like 6 percent of babies due from violence. Well, that's, I think, something that we could definitely have an influence on because that -- these are specific things where we could intervene.

And so, I agree with everything everyone has said and I think there's -- if we look at concrete issues, from my perspective, that would be, you know, prematurity, which, yes, I'd like to drive myself out of business. It won't ever happen, but there are so many babies that, you know, are delivered early because of the mom's health status. So, how can we then maybe improve upon mom's health status so she doesn't have to be induced at, you know, 26 weeks, 27 weeks, 28 weeks, and I think there are things we could offer from that.

And then also, just general conditions of when you hear of, you know, in Chicago, I feel like it's every week there, you know, like a 5-year-old that's been shot and also there's, oh by the way a 2-month-old, a mom holding a baby and they're sitting in Burger King, and, I mean, a lot of those, it's, you know, I hate to say it, but what we say in Chicago is it's -- they're like business transactions. Not with those people, but they're like innocent bystanders in the business transactions that go on in the city, and I really think that that's horrible and I think that we -- I feel like we're so desensitized to it. What, like 300 people are shot in the month of May and like nobody's really -- I mean, that should be something that we should all be protesting in the streets for, right?

So, I would like to focus on prematurity prevention and also violence and, you know, I support everything that you guys have spoken to, and I appreciate all the different perspectives, and I also appreciate when I know

sometimes, you know, I've had to turn off my camera, run to get a kid, come back, I am -- I feel like, you know, like any parent on this group, like I'm always running difficult balance between work, family, and also this is a volunteer position basically. So, like, you know, I have -- I feel like I have two full-time jobs, so I don't want anyone to think like, yes, Ed, I didn't answer your E-mail with the list of things, but honestly, I was like up one night at 2 in the morning and I was like, oh I should write that list, and I was like, I'm just going to go to bed. So, it's nothing that I don't prioritize SACIM. I do, but I have like ten other things before that, as everybody does on this committee. But I think sometimes we talk a lot about motherhood and we forget a lot of the people on this group are mothers too, and, you know, [inaudible] it's just something to remember because it's like we're all parents probably in some way. So, congratulations to all of you for maybe balancing better than I do, but I do my best. So, thank you.

EDWARD EHLINGER: Thank you, Colleen, and that's what we expect, everybody to do the best they can, recognizing that life is much broader than just this meeting on SACIM. So, thanks for all you do.

All right. Let's now move on to an update from Dr. Michael Warren. Michael, thank you for being with us today and I look forward to your conversation.

UPDATES FROM THE MATERNAL AND CHILD HEALTH BUREAU

MICHAEL WARREN: Thank you, Ed. Good afternoon everyone or good morning, depending on where you're joining from. I'm Michael Warren. I'm the Associate Administrator of the Maternal and Child Health Bureau. Just by way of quick introduction, I'm a general pediatrician by training. I spent about ten years in state government public health in Tennessee prior to coming here, and I've been at HRSA for about 2-1/2 years now. I'm really excited and honored to be a part of a bureau that has, since its creation in 1912, been focused on issues of infant and

maternal health, and just to go back to the conversation a little bit earlier around data, one of the very first activities of the Children's Bureau in the 19-teens was to go around the country and to gather data because there wasn't a standard birth and death registration. And so, just to get a sense of how many babies were dying, why they were dying, and where there were opportunities. And one of the telling things is if you look at a report from 1916, my predecessor ten predecessors ago, Julia Lathrop, who was the first Chief of the Children's Bureau, wrote about maternal mortality that deaths are on the rise, deaths are higher in the United States than in other countries around the world, and the majority of these cases are preventable. And if I hadn't told you that was written in 1916, you would have thought that one of us wrote that today.

And so, my ask is that our colleagues who come 105 years after us are not having these same conversations, that we accelerate the work that we've been engaged in for so long, but in

particular we accelerate the work around elimination of inequities. And I -- I so appreciate the wisdom of this group, the diverse perspectives that you all bring.

One of the things that I learned very early on in state government in Tennessee was what we were doing in Memphis was not going to be the same thing we were doing in Nashville or Chattanooga. Every community is different. The constituencies are different, the solutions are different, and that's true at the federal level. What's going to work in Vermont to address infant mortality is probably not going to be the same as what works in Texas or California or Massachusetts. And so, really thinking about how we meet states where they are and support them to move all the states and jurisdictions along in this journey toward equity, and it's something that our team is thinking about quite a lot.

I just want to share some high-level updates with you, and I'll try to move quickly through these to get you back on time. If we can

advance to the next slide, please.

So, we are currently in fiscal year 21. We will be here until the end of September. Some updates that have happened since the last time we spoke with you all that I wanted to share. We've released two new competitive funding opportunities within our Healthy Start Program. One is for a supplement to support community-based doulas. We've heard in this committee about the importance of doulas and availability of doulas. So, we'll be awarding twenty Healthy Start grantees with awards to expand that work. And then, we are also going to be giving out thirty -- approximately thirty awards to support the development of infant health equity plans. So, this is building on the existing community action networks that are within the Healthy Start Grantee Sites, looking at opportunities to think upstream about social and structural determinants of health and particularly as those relate to infant mortality and inequities in infant mortality so that those plans can then service the foundation

for later work. So, those will -- both sets of supplements will be awarded before the end of the fiscal year, which is September 30th.

We've also talked a little bit about our budding Infant Mortality Initiative, and I'll talk a little bit more on that on a subsequent slide. We are currently procuring a contract that will help us with some of the planning for that work and looking at strategies that we need to pursue.

With additional funding that came in the FY21 budget, you may remember the FY21 budget was officially approved at the end of December 2020, and so, our team has been working on implementing those items that were new or different. One of those was some additional funding for AIM, the Alliance for Innovation on Maternal Health, and with those additional funds, we are engaging in a supplement to ACOG, who is the current grantee for the AIM work. We are also embarking on a contract that will support an evaluation of AIM. So, we have state level data

that tells us about improvements that have been made in states that have implemented various AIM bundles. It's important for us to understand as we move forward with continued interest in AIM, what have the -- the larger outcomes been across states, what are there -- are there outcomes that we can compare, but also, what are those essential ingredients that make AIM work. And so, what are those core parts of the program or initiative that we need to continue to support. Are there pieces that are missing that we need to fill in and all of this will help inform our work moving forward.

Finally, in terms of new funding, we are anticipating making fifteen awards to states to enhance their capacity to have better data around maternal health. So, we already have existing investments called the State Systems Development Initiative or SSDI that's funded through our Title V Block Grant Program. This will allow us to support additional states that may have some difficulty collecting data to do reporting for AIM or other maternal health work

that they're doing. And so, we'll be awarding those by the end of the fiscal year as well. Next slide, please.

So, I mentioned the Infant Mortality Initiative, and I've talked to you all a couple of times about this work where we have looked at the Healthy People 2030 targets, which are important and they are not sufficient if we're going to get to equity. So, we know that many populations have already achieved the Healthy People 2030 target. We anticipate that those populations will continue to improve and by the time we reach 2030 be well below that target. But we know that for non-Hispanic Black and non-Hispanic American Indian and Alaska Native infants, they have persistently been above the Healthy People targets. They have not met the targets that have been set, and even if they meet the Healthy People 2030 target, we won't achieve equity. And so, we're very interested in how we can accelerate improvement across populations to get to equity.

There are some existing activities

that are supporting that, things that we shared with you all before, our Block Grant, which really funds the public health system for mothers, children, and families in this country, Healthy Start which in 101 sites across the country focused on improving infant and maternal health and reducing disparities, the MIECHV, Maternal Infant and Early Childhood Home Visiting Program, so voluntary evidence-based home visiting in communities with high rates of adverse outcomes. We also support some core public health activities to help us better understand the causes of death. So, we support Child Death Review and Fetal Infant Mortality Review work across the country as well as a national center that provides technical assistant and support to states and communities. We support a National Safe Sleep Partnership, looking at translating the science behind safe sleep into action and working with communities to prevent SIDS and SUID deaths and then I just mentioned the new funding opportunities we currently have on the street for FY21.

We are looking broadly at ways that we can again accelerate this work toward surpassing the Healthy People 2030 target and getting to equity. We're doing some very localized work in Region 5. So, states that have historically had not only high infant mortality rates but some of the highest Black infant mortality disparity rates in the country. So, the six states in Region 5 have been coming together for the last few months with virtual learning sessions that will culminate in a meeting likely both in-person and virtual some time in the late fall where we bring together state teams and outline plans for moving forward based on their learnings to date.

We also continue to explore where we've got opportunities to really hone in on infant mortality and equity in our funding opportunities that will be coming up next year in fiscal year 22 and beyond. So, as those solidify, we will certainly keep you all posted. I also want to put in a plug. The conversations that you

all have are so informative for us as we're thinking about the needs and the opportunities. And so, as we think about with our teams where do we go with these future funding opportunities, to the extent that we have flexibility, the recommendations that you all make and the conversations you all make are so incredibly helpful.

I mentioned the contractor that we're currently pursuing. That contractor will be doing a literature review of national, state, and local interventions to help us understand the menu of options that are available as we support states and jurisdictions moving forward.

They'll also be looking at activities that are currently underway by our federal partner agencies and national non-governmental agencies that are engaged in this work. There are a lot of folks who are already working on infant mortality, have been working on infant mortality just like we at the Bureau have, and so rather than reinvent the wheel or duplicate something, we want to

better understand what is that spread of activity and where are there opportunities to fill in gaps or expand word that's already ongoing.

So, we've started engaging our federal partners. We actually had a kickoff meeting with federal partners a couple of weeks ago. A very robust conversation. We are engaging external partners as well. As I mentioned, there are external entities who are and have been in this space. So, we're talking with them, and that includes private funders. There are a number of private funders who are in this space either working very locally, sometimes in substate region, or with a collection of states and some working nationally. So, we're trying to better understand what they're doing, what their interests are, and how this work might align and be synergistic with that. Next slide, please.

So, I talked a little bit about the new additions for FY21. Many of you may also have seen the President's FY22 budget was recently released. I wanted to give you a quick update on

that as it pertains to the Bureau. So, our total proposed budget is $1.5 billion. The largest budget item that we have historically and in this proposed budget is the Maternal and Child Health Block Grant at $822 million proposed followed by the Maternal, Infant, and Early Childhood Home Visiting or MIECHV Program, and then Healthy Start rounding out top three.

I will walk through the increases specifically that are related to maternal and infant health on the subsequent slides. But just for completeness, there are a couple of other ones. There's a $4 million proposed increase for Autism and Other Developmental Disabilities and then a $5.8 million proposed increase for the Emergency Medical Services for Children Program.

On the next slide, we'll talk specifically about some of the maternal and infant health investments. So, our MCH Block Grant is proposed to have $110 million increase; $29 million of that increase would go into the formula awards for block grants to states. If you know

the block grant legislation, it has multiple parts. So, part of it is the block grant to states, part of it supports Special Projects of Regional and National Significance or SPRANS. And so, there's an $81 million increase proposed in the SPRANS budget and many of those items are listed below related to the HHS Improving Maternal Health Initiative.

So, as an example, there's a $30 million increase proposed for the State Maternal Health Innovation Program that would get us up to $53 million. There's a $5 million proposed increase for AIM, the Alliance for Innovation on Maternal Health, and $1 million increase for -- being established as we speak -- Maternal Mental Health Hotline. So, this was an item in the FY21 budget and there was funding proposed for that in the amount of $3 million. This budget would propose an additional million to add onto that.

There are also some new items that are proposed to be funded in the FY22 budget. There's $25 million for Pregnancy Medical Home

Demonstration, $10 million for Early Childhood Development Expert Grants that would put developmental specialists in pediatric practices in cities. There's a $5 million increase to establish Training Grants for Health Providers on Implicit Bias, and then $1 million proposed for a National Academy Study, which would look at recognizing bias in clinical skills, training courses in allopathic and osteopathic medical schools.

So, all of this has been proposed again. We are in that time of the year where the President's budget has been released. The Congress will now act on that as we head toward the end of the fiscal year, which will again be September 30th. So, we will keep you all posted as the budget moves forward and once it is final, we can let you know which, if any, of these things are included. Next slide, please.

Other items -- there are some other items that are related to maternal health that aren't -- that are in other parts of HRSA or

aren't in the SPRANS budget that I mentioned. So, within MCHB, there's an additional $5 million that is proposed for the Screening and Treatment for Maternal Depression Program. This is a program that increases access, whether virtually or in person, to mental and behavioral health services for women. Right now, we fund seven states. This would allow us to double that program. Also in HRSA's Federal Office of Rural Health Policy, there's a $5 million increase for Rural Maternity and Obstetrics Management Strategies or the RMOMS Program. This looks at creating networks of care, particularly in rural areas to improve access and quality of care and this would add $5 million to that program. And then, within HRSA's Bureau of Health Workforce, there is a proposal to add $5 million to support Maternity Care Target Area Implementation. So, you may remember that several years ago, there was legislation specifically talking about how maternal care needs can be incorporated into like HPSA planning and this work -- this funding would go to support that work.

Next slide, please.

I wanted to circle back with you all. We got input from -- from you all as members and through various stakeholder groups on the development of our strategic plan. We officially launched that at the AMCHP meeting, which was held recently. And so, we wanted to share that with you all. Our mission and vision have not changed. Our mission is to improve the health and well-being of America's mothers, children, and families, and we envision an America where all mothers, children, and families are thriving and reach their full potential.

We have four key goals that have been set out to help us accomplish that mission and reach that vision. The goals are around access, equity, public health capacity and workforce, and impact. So, just to give you a sense of the work, each of these goals has a series of objectives that fall underneath them, and our team will now begin the work of developing specific strategies, activities, and measures to carry out that plan

across our programs. But, this plan will really serve as the North Star for our work for the next ten to fifteen years. As I think I've mentioned to you before, most organizations do strategic plans in the three-to-five-year timeframe. Because we are a grantmaking organization, most of our grants are given out for five years. And so, if we develop a three-to-five-year strategic plan, much of that work has already been accounted for in the grants that are already on the street. And so, we wanted to have a longer window to really be able to think about where we want to go, whether we need to make changes to any of our existing programs to help us accomplish our -- our mission.

So, these four goals are going to guide that work -- again, access, equity, public health capacity and workforce, and impact.

And on the next slide, you'll see an example of what those objectives look like. So, specifically, we wanted to share with you the equity goal and the objectives that fall under that.

So, the first objective is to advance health equity across all of our programs and investments. There is not one equity program in MCHB. All of our programs should be focused on equity, and we want that to be baked into the very fabric of what we do.

We also want to look internally. So, with the second objective, strengthen our effectiveness by increasing our own organizational diversity, equity, and inclusion.

Number three, we want to invest resources to improve the health of all populations and communities that are marginalized including those that have been affected by racism and ablism.

And then four, this follows a theme that we've heard in this committee to collect and use data on a number of stratifiers that can help us to understand disparities and to be able to advance equity in our work moving forward.

So, these are the four objectives that line up under the equity goal. Again, each

of the goals has specific objectives. We'll put the link in the chat box for where you can find the strategic plan goals and objectives on our website and encourage you to take a look at those. Next slide, please.

And that's it, four minutes over. Thank you.

EDWARD EHLINGER: Well, you got a little late start. Thank you, Michael.

Any comments or questions from the SACIM members? If you have some questions, raise your hand. I see Jeanne. Jeanne, why don't you start?

JEANNE CONRY: Thank you, Dr. Warren. Great summary and always great information and a lot of projects that you guys have going on. It's always impressive. I'm intrigued with the AIM analysis. I think those data will really be valuable. What kind of time frame are you looking at there?

MICHAEL WARREN: So, that funding has to be allocated by the end of this fiscal year.

We're doing that through a contract. So, the contract will have to start by September 30th and we'll move forward from there. And Lee, I don't know if there are any more specifics that we're able to share since we're in the middle of an active procurement.

LEE WILSON: So, yeah, we can share that the contract award period, it's a one-year contract. So, we're expecting the work to be accomplished -- most of the work within six to eight months with a report then from there. That's not to say that the work might not be extended or if there another stage to build off of that, we could potentially go beyond that.

JEANNE CONRY: That's welcome, very welcome. Thank you.

LEE WILSON: Um-hum.

EDWARD EHLINGER: Magda.

MAGDA PECK: Thank you, Dr. Warren. I just want to note that the way that you've integrated what you've learned particularly and committed to around Equity Into Action. So, first

of all, thank you to Maternal and Child Health Bureau for evolving with us and modeling how policy can reflect changes in the narrative about what drives who lives and who dies. So, thank you first. And a question.

I really appreciate your endeavor around the scan across broader HHS, which is what we do. We're trying to inform our Health and Human Services Secretary. The purview of what we're wanting to address goes outside those boundaries into EPA and the environment or in the housing security, into Homeland Security. So, I was wondering, when you use the language about, you know, who is in our space, how do we know, or is this part of your scan to know, are we in their space? In other words, how do we get maternal and infant mortality -- the narrative around it -- to be so compelling that the agencies that are not seeing this as their main value would begin to see it as essential to their impact on the most vulnerable of Americans? So, I was wondering about how do you get them to shift their view in

your inventory and your stand. And then, how do you -- can we benefit from your scan so that the SACIM work truly engages folks outside of our immediate departmental policy influence so that there is no other eviction of pregnant women, so that the borders issues that Paul talked about are front and center, so that the environmental passions and purpose that Jeanne brings is something we can directly influence because we are in their spaces because they see it as important. How does that happen?

MICHAEL WARREN: So, I think you're exactly right. The scan that we're pursuing is to really understand where are all of these things occurring across the federal government. So, when we pulled federal partners together recently, as an example, we had partners from HUD there and they are fantastic partners and have a history of work actually in this space of maternal and infant health. And so, I have no doubt that we will find other partners who are already working on this and that care about this and there may be others that

-- that we bring along. But I'm under no assumption that we already know who all of those folks are, and that scan will help build that work out.

We can certainly share with you all as we continue to move forward with that work what those findings are, what we're learning, and how those folks might contribute to this moving forward.

I think to your point, you know, as we think about social and structural determinants of health, HHS is big. There are lots of agencies working on lots of different things, but we don't touch all of those social and structural determinants of health and to really be able to -- to get to equity, we're going to have to engage those partners outside of the department but also remembering to engage those partners outside of the federal government and those national organizations that are doing this work and partners who are working in states and communities.

EDWARD EHLINGER: Any other questions, if you do and you haven't raised your hand? Michael, as you were listening to all of those introductions and the people talking about what they bring and the issues that they see, do you see places where we can leverage each other -- that MCHB can leverage the energy and passion that we have of SACIM members and vice versa that we can link with you on some of your strategic initiatives?

MICHAEL WARREN: I do, and I wanted to note real quick, I saw Dr. Wise waving his hand, so I don't want us to miss the opportunity to call on him. So, I'll answer that and then maybe we'll go to Dr. Wise.

I think the feedback that you give us is so incredibly helpful. It is really easy sometimes to get sucked into the DC bubble and to -- to know from all of you what's going on in yours states and in your communities and with your constituent organizations about how programs actually look on the ground is incredibly helpful.

And so, we very much welcome that feedback, that input to help us really make sure that we are moving in the direction that we want to go in, and I would also say the thing that's really helpful from this group is your accountability. We've laid out our strategic plan with our mission and vision. We are public servants and we want to hear from you about how you think we're doing on that as we move forward. So, we will welcome the opportunity to hear from you all moving forward.

EDWARD EHLINGER: Thanks. Paul, did you have a question?

PAUL WISE: Yes. Thank you, Michael. Clearly, MCHB has embarked on a number of very important initiatives, but what specifically is MCHB doing to address migrant children and families, particularly those recently released into the United States and even more particularly, those with special health care needs?

MICHAEL WARREN: So, thank you for that question. I think there are a number of ways that we're working, and I will not speak for --

for colleagues and ACF and other parts of HHS. But I can tell you some of the things that are happening here within our most recently infant mortality COIIN, the Collaborative Improvement and Innovation Network. There has been one of the COIINS that's been focused on preconception and prenatal care in border states. That's not a new need that has come up, but that's something that was recognized previously and that the Bureau has worked on with a number of states along the US/Mexico border.

I think a number of our grantees who are community-based, whether they're Healthy Start or MIECHV are providing support in communities to help connect families to services, children who may be living in communities, connect them to services, and then I think the other thing I would add is that our state block grant recipients, particularly those who are in border states are providing leadership in those states to help address those needs. Certainly, if there are specific concerns or additional needs, I'm happy

to have further conversations around those, but those are some things that come to mind. Again, specifically speaking for MCHB. I don't want to speak more broadly for the department.

EDWARD EHLINGER: Okay, thank you. All right. Well, thank you, Michael. Good summary, a lot of stuff going on. I'm glad we're in partnership with you on this.

Let's now -- we're going to move into our review of our recommendations.

DISCUSSION OF SACIM RECOMMENDATIONS TO HHS SECRETARY

EDWARD EHLINGER: As you probably know, we -- the recommendations really evolved over the last couple of years from all of the content information, the briefings that we got from a variety of experts over the last couple of years on a variety of issues and were then put together in a series -- set of recommendations that we talked about at our last meeting and did a lot of editing at that point in time with input from the committee and redrafted these

recommendations, put them out particularly to the work group folks who have looked at these recommendations and made some additional edits and additional recommendations. And so, they are now -- the ones I sent to you this morning are sort of the most recent updates. I did even get a couple of additions subsequent to my mailing it out earlier this morning. But we're going to go through the draft of these recommendations and finalize them so that we can vote on them tomorrow and have them ready to send to the Secretary. So, I appreciate all of the input that people have given to this set of recommendations, to the work group folks, and to myself, and Vanessa is going to share her screen, and we're going to talk about basically the recommendations. But, as part of the recommendations, I did put together a background piece sort of to provide context for the recommendations so they don't just stand out as here are the recommendations and come out of nowhere.

So, as we think about the

recommendations, also think about the background, the context, and the context is not to give a comprehensive view of the issue, but to raise why this is important, why these, you know, why the terror and workforce and migrant issues are important. And so, be thinking about does this make the case of why this is really important. Are there things that we could put into that background piece that really makes the case that this is important.

And Vanessa, if you put up the recommendations, the share screen, the very first part. Just like, you know, all of the work, as Michael said, equity is embedded in everything that we do. Really, our overwhelming recommendation that we start off this series with is that SACIM recommends that all investment and policy decisions at all levels and sectors of government be made with special consideration to their impact on infants, mothers, women throughout their life course and that immediate increase in policy recommendations both on mothers and infants

in our nation who are more likely to suffer optimal -- suboptimal birth outcomes for a variety of reasons. So, we say that all efforts throughout the government at all levels should really embed a perspective of women and children or infants and mothers, and I know that we will have some -- some wording conversations, and I always usually start with infants and mothers as opposed to mothers and infants because our -- our charter is we're the Secretary's Advisory Committee on Infant Mortality. So, I want to make sure that we start with infants, but that's an editorial thing.

So, this is going to basically be the basis of our overwhelming, overall, overriding recommendation. Any comments on that before we get into this -- this special -- the subsections of that? Any comments on this sort of general recommendation?

JEANNE CONRY: Just -- Jeanne -- just like the comment that I shared with you later with what I understood instead of saying preconception,

use the term pre-pregnancy.

EDWARD EHLINGER: Yeah. Okay, yes.

JEANNE CONRY: Yeah.

EDWARD EHLINGER: There's -- there is -- wording is -- is evolving and people are using different words, and we're also going to probably have to some consensus about how do we talk about BIPOC, Black, indigenous, people of color. How do we -- we need some consistency in that.

JEANNE CONRY: Yeah.

EDWARD EHLINGER: And what I would probably do is try to work with our work group leaders to try to come to some consensus when it comes to that language. And so, does anybody have some concerns about using pre-pregnancy as opposed to pre-conception?

MAGDA PECK: Ed, I just want to underscore what you just said about having common language. If our -- if one of our priorities -- and I heard it from you, articulated as well by Janelle and myself -- about narrative and story. SACIM has the opportunity as a leading entity of

expertise to -- to generate a common set of language, particularly around equity, birth equity, racial equity, and other concepts, and I don't know if there is right now a consensus within and across maternal and child health on what is the power of words that we will all agree to use and who decides that and how is it decided, because words are about power.

So, I want to note that it's not just we can wordsmith but that we should, as SACIM, endeavor, and particularly with the Equity Work Group, to -- to build that common knowledge understanding and language so that our story is clear, and we should do that in a way that acknowledges that differentials of power.

EDWARD EHLINGER: All right. So, as we go through this document and if people have some recommendations in terms of wording and if we get a sense of consensus on the wording that we can use, that's why I raised the question does anybody have any concerns about using the term pre-pregnancy as opposed to pre-conception. It

may be one small starting point for how to -- how to start to put together that glossary of words that we use.

WANDA BARFIED: Hi, Ed. In terms of talking about issues of race ethnicity, there is some language from the Commonwealth Fund that might be helpful. I'll put the reference in the chat.

EDWARD EHLINGER: That would be great.

MAGDA PECK: Thanks, Wanda.

EDWARD EHLINGER: That would be great. That would be great. All right. With no other comments about this, I'm going to now have us go to -- because Paul has some other commitments that may take him away from us for a while. I really do want to start with the Migrant and Border Health Recommendations, which are the end of or close to the end of this document, and I'll let Paul Wise sort of lead us through this conversation.

PAUL WISE: Thanks much, Ed, and

thanks everybody for the flexibility. I apologize that I won't be able to stay on for the whole set of meetings.

Basically, Border Patrol apprehended 180,000 individuals in the month of May on our southern border. Half are families and unaccompanied children. More than 1,000 unaccompanied children a week are apprehended on the southern border. Back in March and April, it was closer to 2 to 3,000 a day were being apprehended. The vast majority of families have been turned away -- turned back to Mexico because of the COVID protocols. It's called Title 42. However, tens of thousands of children and families have been released into the United States. There are approximately 15 to 20,000 unaccompanied children who are in emergency intake shelters run by HHS, who are going to be reunited with their families.

Our recommendations are response not only to the current challenges for families and children apprehended and released into the United

States but recognizing that the COVID protocols that permit the expulsion of virtually all the families are going to come to an end likely sometime over the next few months. And when that happens, we're likely to see a dramatic increase in families who are released into the United States.

The six recommendations begin with enhancing border community capabilities. Even though MCHB and other HHS programs have provided traditionally support to border communities, the needs are dramatically outpacing the resources that are available. There needs to be recognition that when children are and families are released in these border communities, there's an urgent humanitarian requirement to take care of them and basically to get them on their way as they move throughout the United States. And those border community capabilities are not being met currently in HHS should and could play a leadership role in addressing those needs.

Second, the medical, social, and

mental health services for families and unaccompanied children released into the United States are a kind of hodge podge of programs and often these families do not have access either because of restricted state programs or because access for these families are just difficult because of their recently arrived migrant status.

The third is that there are pregnant women and children being released into the United States with special health care needs, and these kids almost always are set adrift. And despite the fact that there are several networks that have been formed, at times informally, at times more formally, of special health care providers for children that fall into this category, there's no organized HHS or MCHB support for meeting the special requirements of children entering the United States.

We've had orthopedic issues, we've had neurologic issues, we've had cardiac issues for these children and it's only been through informal networks that any of these kids have

found their way to appropriate places around the country. This needs to be addressed in my view immediately. It doesn't require a lot of money, but it does require leadership and organization.

The fourth area is something that I have been acutely aware of. It's the lack of integrated capabilities to take care of children and families as they are apprehended by Border Patrol and Homeland Security agencies and unaccompanied children transferred to HHS capabilities and facilities. There is an urgent need for some new thinking to create integrated capabilities, facilities that bring together the law enforcement requirements of Homeland Security with the caretaking medical capabilities of HHS.

The distinct silos and big gaps -- seams between Homeland Security and HHS need to end. There is an opportunity now. HHS has the experience, the expertise, the leadership, and just spectacular people who can help broker these kinds of new innovative approaches that are desperately required and now we actually have a

moment when we have opportunity to explore and innovate and experiment with integrated services. We don't want kids sitting in overcrowded Border Patrol facilities when across the parking lot, HHS has very well run, much more expanded medical and custodial care facilities able to take off Border Patrol's hands children with -- who are unaccompanied on their own.

There are also children who under the zero tolerance program 2017/2018 were separated at the border from their families. They're still -- best estimate was almost 1,000 children who have not yet been reunited with their families. The Biden administration is making special efforts to reunite these families, but there are also thousands of families who were separated at the border who have now been reunited but are in desperate need of support services, mental health services, and particularly to address the needs of young children who were separated from their families and are still experiencing the sequela of emotional and mental trauma at that time. HHS can

play a special role.

And the last recommendation speaks to the opportunities to provide COVID vaccines as appropriate based on CDC recommendations for adolescents, children, and families as they enter the United States.

And I just want to thank your working group for putting these together and the full group for giving us good feedback and special attention.

Number 7 and 8 speak to the requirements for data and the integration of medical records from Border Patrol to ORR to health providers around the country that these should be portable and function as a seamless system.

Last, the research requirements. Particularly, as the number of migrant families and children continue to grow as they come into the United States, that we need better ways of serving their needs, better ways of supporting the practitioners, better ways of understanding where

advocacy could make the greatest difference. Let me stop there and seek comments from other working group members and everybody else on the call.

EDWARD EHLINGER: Any questions or comments that people have? One of the things that -- Paul, if you're looking at our background piece, which is very generic, your introduction to your presentation today really highlighted some numbers and the urgency. To me, it would seem like we should probably put some of that urgency in that little -- short little background piece that we have to make it much more compelling that this is something that needs to be done now. So, I would -- I would appreciate a little help with you trying to sort of frame that urgency in that background piece.

PAUL WISE: Happy to do that. With the termination of the Title 42 COVID Expulsion Protocols, we expect an 80 percent increase in families released into the United States or something close to that.

EDWARD EHLINGER: Jeanne, you have a

question.

JEANNE CONRY: Yeah. Paul, very moving and very persuasive and very factual summary. So, thank you for all that background information. The only -- two comments for the COVID-19. I would just be more assertive and say support for rather than consider some more support -- just say support for it so it's a little typo.

And then for the integrated facilities, you might highlight that this is an opportunity for Health and Human Services to support administration's reinstatement of ICE's Presumptive Release Policy that is applied to pregnancy detainees and was discontinued in the previous administration. So, I think just an affirmation there that this policy is one that's helpful for pregnant women. Thank you.

PAUL WISE: Great. I think we should do that.

JEANNE CONRY: Okay, thank you. Awesome work.

EDWARD EHLINGER: Any other comments

from anyone or questions? All right. Good. Paul, thank you for the work that you've done both, you know, putting this together, but particularly your work on the border. You've brought a really good perspective to the needs, and I hope that our recommendations here can actually move the needle a little bit.

All right. If there's no other questions, then we can move on to Care Systems and Financing of Care.

STEVEN CALVIN: Yep, here I am. Vanessa -- I sent Vanessa something that may actually get there, and if not, that's okay too. It's -- I just put another list of things together. So, the Care Systems and Financing of Care. I should preface it by saying that through most of my 40+ years of doing this, I just tried to do the best thing I could do with evidence-based care and, you know, just understanding the disease processes and the normal physiology and trying to do my best. I had very little understanding of coding, billing, insurance. I

mean, it was a big puzzle. So, yeah, I guess -- yeah, Vanessa. Maybe what we can do -- let's start with just the Care -- the list that we had before and then I was just going to maybe hit this secondary.

VANESSA LEE: Okay, sure. Let me get that back up.

STEVEN CALVIN: Thank you very much for doing it on short -- short notice. So, I spent the last-- I've spent the last decade educating myself about how care is paid for and how that works, and it's been -- it's been an eye opener; let's just put it that way.

So, we're going to go here to the Care Systems and Financing of Care. I think that, number one here, is -- it really addresses something that's important and it really looks -- just yesterday, I think, CMS released information that I think there are 80 million Americans or citizens and people in the country currently on coverage with Medicaid, and I think some of our colleagues from HRSA and from other agencies can

attest to that. So, it looks like Medicaid coverage, except maybe for some exceptions in some states where there is still resistance, the -- the access to and the provision of coverage by Medicaid is expanding.

So, our -- the inequalities that we face -- and I'll just maybe cover that here with a little summary at the end. So, number one, the extension of Medicaid coverage for -- for mothers in the postpartum period for a year, I think that's coming -- we see it coming here in the state of Minnesota and I think on a national level, there's going to be more support of that because everyone has recognized that -- that -- that whole first year is incredibly important and when a child from birth to the first year of life has coverage but her or his mother does not, that's a bad thing.

The, you know, 1115 waiver, is these demonstration projects that are -- that are being encouraged. I think that sort of dovetails with that and I know that both on the state and federal

level, there's a lot of -- a lot of interest in that.

Number three, we do recommend that CMS should issue timely and comprehensive guidance regarding the opportunity for this option from the American Rescue Plan Act so that it really does have the intended impact that -- that those who voted for it in Congress and signed into law, that those things happen. So, there are a number of those kinds of things happening. We also believe strongly that -- that birthplace options, the National Academy of Sciences had a panel. Some of us were involved in that in presenting to that panel. It was a really -- they produced a very helpful document. But pregnant women really do, as they consider their options of where to give birth, especially those in underserved communities, they should have access to -- to really accurate, culturally appropriate care.

Someone -- I don't if Patricia Loftman is attending the meeting today -- however, she has an incredible experience and perspective.

She is a midwife of color who is a national leader and she has really -- I've learned a lot just by listening to her and understanding that -- that it really is important to have -- I think Janelle will also address in the workforce issues -- but to have options that are culturally appropriate. And so, that -- those options do include things like birth centers, and I'll talk about in a minute.

Care teams, the redesign of the system to support -- to support mothers who are in the situation where sometimes they have very few options besides kind of local clinics, sometimes feeders into public hospitals that can do a really good job, and sometimes things don't go so well. So, the care team support is really important. The more that teams can be developed -- and that's what's been leading me toward understanding it -- that an episode of care is an important approach.

So, we do definitely include, I mean, I am very transparent in my disclosure that I work with midwives. I also work with physician

colleagues. But midwives are crucial to this -- to getting access to better care.

Doula services, we'll probably have some more discussion about that, but there is an awful lot of evidence that doula services are very helpful in decreasing interventions and increasing engagement and providing much better outcomes.

So, those kinds of care teams and community setups are really important for -- for women as they choose both their location of birth and then they go through the process.

Number six, again full disclosure, I work with midwives. I own the Minnesota Birth Center with two locations here in the Twin Cities doing about 450 births per year both at the birth centers -- one in St. Paul, one in Minneapolis. Our birth center in Minneapolis is just over one mile to the north of where George Floyd lost his life and was murdered. And so we -- it's our neighborhood basically. Birth centers are a real great option and they're recognized -- I'll show in just a minute both the American College of

OB/GYNs and SMFM, Society for Maternal Fetal Medicine -- have a level of care document that includes birth centers as a basic -- a basic option. And this also, I think, we can talk some about meeting the rural health issue with pregnancy care because a lot of places, including in Minnesota, up in Grand Marais and Two Harbors, they closed down labor and delivery and said well, there's no care up here, and so, some mothers are giving birth in an ambulance driving down the north shore of Lake Superior to Duluth. Birth centers would be an option for that.

So, we should have a comprehensive system that includes expansion of accredited birth centers -- I'm just making a personal argument for accreditation because I think it's -- it's a way of assuring the care.

We also have a focus on telehealth for access, especially in rural areas, the expansion of access to telehealth for things like imaging and consultation and intrapartum consultation, prenatal consultation to include

physicians and certified nurse midwives that there are -- there are a lot of opportunities for this. Colleen has -- has done some looking into this as well for neonatal services. After babies are born, they sometimes can have a better care pathway if they have access to telehealth.

Healthy Start expansion is also something we're recommending so that every -- Belinda Pettiford has been really focused on this and a leader in this -- that every jurisdiction that has an infant mortality racial disparity ratio of greater than 1.5 will have adequate resources to implement a Healthy Start Initiative.

That we should prioritize pregnant women and infants to -- I know that there's work -- we've already heard it from colleagues that are ex-officio members, that this work is ongoing. The COVID crisis did show a lot of gaps in the system and things that we really need to work on.

Crisis communication. We really -- during things like COVID, you know, I -- it's hard to even think back on it, but back during the

beginning of the crisis, there was a fear. Some mothers were calling birth centers trying to arrange out-of-hospital births because of the fear of an overwhelmed hospital system, and I think that this just gave us an opportunity recognize something like this could happen again and we should have a plan for it.

Home visiting is also important. The midwife-led maternity model of care and the nursing home visiting and also just home health workers. That's -- that's very useful and there is even some ability maybe to do some monitoring -- blood pressure monitoring and things in particular. It's been pointed out that preeclampsia and hypertension has really increased in its incidence. We have to kind of work on -- work on that too.

So, Vanessa, if you, let's see, could just put up what I just -- what I sent you too, that would be really helpful. All right.

This is just the case for CMS and CMII for an episode of bundled payment. I just

wanted -- I'll go over this briefly. We can have more discussion as well. Thanks for making it a little larger.

Just a background, you know, that women make up a majority of our population and do require higher health care expenditures, and 85 percent of American women give birth at some time in their life, and the current system really from -- and you know, obviously I'm coming at this from a perspective of a male, but someone who is around pregnant women and those who care for pregnant women all the time and have had that and also just the experience of fatherhood and grandfatherhood.

The current system really ignores maternal self-agency and it interferes with the positive familial impact of physiologic birth. And the significant racial disparities that are persisting, in many instances, they're -- the more I've thought about it -- of trying to define the notion of systemic racism within care, and I went to medical school in St. Louis in the late '70s and there was clear segregation in those

instances. But in many instances, still there is overt segregation that exists between Medicaid and private pay care delivery. I worked at an FQHC. Sometimes, however, mothers who are on Medicaid, particularly in major metropolitan areas, are just shunted through a system, and I understand totally the importance of teaching, but there's a difference and there's a segregation that I think we have to pay attention to.

Pregnancy, birth, and the postpartum period really are an ideal and arguably the most important episode of care. Health care reform should start where we all did with pregnancy and birth. The current maternity and newborn care system, it's fragmented, poorly performing when compared to other countries. As Jeanne has pointed out, this is largely due to fee-for-service-payment incentives that reward cesarean sections and NICU admissions, and I am not denying the need for cesarean section and NICU admission. But it rewards -- it rewards that.

Very low Medicaid payments are a

major problem nationwide. And an example is -- I know, because I've looked at the contracts -- in Minnesota, the Department of Human Services provides monthly prepaid medical assistance payments to the managed care organizations that win the contracts in each county, and that amount is more than $20,000. Now, that seems overwhelming like oh my gosh, that's a lot of money, and it is, and it also has to cover NICU care and the baby's care for the first year of life. However, all in-MCO payments for primary midwifery birth center care for the other birth centers and the birth center I'm involved with is approximately $4,000.

And so, Medicaid payments in other states are significantly lower. Some are a little bit higher. And so, the question has arisen, what is being managed?

Many of the health care outcome measures that health plans use in early prenatal care and postpartum are -- excuse me -- are early prenatal care and postpartum visits. So, it's

really not outcomes. So, there's no incentives for plans, hospitals, and obstetricians sometimes -- not always -- to support birth centers and midwifery care, and I think there is an opportunity to create a state plan amendment template for state adoption of some sort of a Medicaid e-maternity episode of care.

And then, this flows into the commercial market too, and if you look at the amounts, the -- those -- those who run companies and the employees of those companies are paying a lot of money and the current commercial insurance plan design shifts birth cost to families, and it probably increases all kinds of problems because of that.

A very important issue is the lack of or the recent lack and then just being priced out of the market for malpractice insurance for small providers like this and rural providers, and there's really no legal option at all or any feasible option. So, many -- many places do well clinically with outcomes, and then they just close

or they say well, I only take -- we only take cash only. Inclusion in federal torts claims protections could be a potential solution. And then, I think, as many of our colleagues have pointed out, the epigenetics and life course issues are generally ignored.

So, this is just my pitch again that the current payment-of-fee-for-service-system can't support the higher value that's provided to maximize the chance of physiologic birth in a different model. So, payment for a pregnancy episode, whether it's to a large health system or to some other convener of care including a birth center, will provide better outcomes for mother and baby with significantly reduced cost increases. I wouldn't claim that it's going to cost a lot less, but it is not going to keep skyrocketing, and the outcomes, as demonstrated in Strong Start, will be better.

So, I have to say I have been very appreciative of Tara Sander Lee and Colleen as members of the committee who have worked with us

on this as well as Patricia Loftman and Lisa Satterfield and Wendy DeCourcy. I think Amy Cole was involved. Janelle has been involved in this as well, and I know she'll have more to say about workforce. So, I think I've talked a little long, but any comments from the work group members or others?

EDWARD EHLINGER: Steve, do you see that the recommendations that we have embracing some of these points that you've made on your second slide, or is there a need for additional recommendations?

STEVEN CALVIN: Yeah, I would just say that we do need to recommend that CMS and state Medical agencies need -- need to -- to really encourage and to implement bundled payment because without it, all we're doing -- I read through the list. That's why I'm sorry I ended up just adding sort of this really strong pitch for bundled payment with the option of. I mean, some mothers will choose to go the hospital. They want an epidural the minute they get there, and that is

just fine. But this kind of additional thing on the end really is my pitch for the committee to consider and hopefully agree that a definition of the bundle and what it involves -- and it can include hospital care, it can really expand and include the baby's first year of life, it's a whole, that's a lot of work -- but I think that -- that's something that needs to be a definitive recommendation. Otherwise, we're just kind of back in eight -- seven or eight or nine years' worth of great white papers. The Aspen Institute, I know we're going to be hearing from Secretary Sebelius, in this meeting. There have been a lot of entities that have recognized the need for change, and I think the only way to do it, if you want to change something, just change the way you pay for it.

EDWARD EHLINGER: Jeanne has her hand up.

JEANNE CONRY: Thank you. And I will confess to not being an economist, not having a lifelong familiarity with fee-for-service

medicine. As I said, I practiced my entire life in a health maintenance organization where the focus is on preventive health care and making sure your outcomes are good. So, I -- I -- I appreciate Dr. Calvin's very passionate discussion here, but I would need some economist to come and help me understand this much, much more than discussing it here and coming up with any agreement today. I -- I will say -- plead ignorance or plead lack of understanding, but I need some economist to help me. I know that I led the medical group and looked at economic basis of the care that we provided doing 5,000 deliveries, 6,000 deliveries a year and know the budget and everything that we did and the type of care we provided. I certainly cannot compare that to the fee-for-service world or anything else. So, I just would say before I signed on to any of these points, I would need a lot of assistance analyzing it.

EDWARD EHLINGER: Thank you, Jeanne. Let's talk about recommendations that

were on the draft, you know, without adding another one right now. We can talk about how we might want to proceed with that. Any comments about the -- what do we have -- eleven recommendations that we have, you know, that we have evaluated over the course of the last six months?

JANELLE PALACIOS: Hi, it's Janelle. One -- thank you -- and thank you, Steven, for that information that you did a deep dive on a little bit more about reimbursement and the models that we have in place.

Consistently, one of the issues that health equity has talked about when we're looking at all of these recommendations is just attention to the language, again, as Magda has shared, and I believe our partner from Office of Minority Health, Joya, has given her feedback that anytime that we're talking about culturally appropriate care or to that effect -- so, example, in point number four, we should also include the term linguistically appropriate. So, it's culturally

and linguistically appropriate, just to be consistent and to follow form. And that's a term that Office of Minority Health is using and has been in the published research. So, it is a term that we should be using.

STEVEN CALVIN: Yeah. Thank you for pointing that out.

JEANNE CONRY: I do have two comments about this document if there's nobody else who is commenting.

MAGDA PECK: Go ahead, Jeanne. I'll come in later.

JEANNE CONRY: Oh, no, no, that's okay. Go ahead.

MAGDA PECK: Thank you. This is Magda for those without visual. I very much appreciate the specificity of these recommendations and I will put on my Data and Research for Action hat and say how do we know what the impact will be if these are accepted, enacted, and operationalized. What is the data, surveillance, evaluation, and research necessary,

a, to document these recommendations, and I think we will have that in our background document. But what are your recommendations specific to the data side of this from a health services research perspective or from a surveillance and monitoring? How will we know that doing this is going to make a difference and the difference we want and by when?

STEVEN CALVIN: I would say too, thank you, Magda, if -- if Wanda Barfield is on, I would be interested in thoughts from the CDC and the monitoring because currently what we have -- currently being in the midst of some research just on looking at things, it's hard to tease out what a really happens, especially it's more from billing things than clinical episodes, and I agree with Jeanne that having -- having electronic health records is incredibly important, and there are -- there are ways to pull it out of the health record.

Wanda, are you around?

WANDA BARFIELD: Yes, hi. I'm here.

So, thank you. I think that, you know, this list is really very thoughtful. I think there are opportunities to sort of assess and evaluate these sort of things. I think in terms of looking at utilization as well evaluating the programs and some of the specific areas can be done internally in terms of at the, you know, in terms of at the state level. There is an opportunity to, I think, monitor these things, and I do appreciate what Magda is saying in terms of making sure that that is noted so that we can see what the progress is.

You know, another area that I don't think is elucidated as well here is the identification of risk-appropriate care so that women and infants can deliver at the right place, the right time. And so that means also that healthy moms and babies should receive, you know, quality yet less invasive care and those who are at higher risk -- particularly when we think about, you know, rural, tribal areas, where there are systems set in place so that women and infants have access to risk-appropriate care, and that is

something that does vary considerably by state and each facility in many states just decide for themselves.

EDWARD EHLINGER: Yeah.

MAGDA PECK: Thank you for that, Wanda. I just want to encourage perhaps an additional recommendation -- much as Paul modeled in the migrant and border health and Jeanne models in the environmental conditions -- that specific data, evaluation, research, recommendations be attached to each of these specific sections. So, with investment and capacity, because states have varying capacity to do this, and so, it has to be both -- so, I would just put it there. And we have not, Steve, had the opportunity to have any cross talk between the Data and Research for Action Work Group and your recommendations. But I -- we would be remiss if we put forth recommendations without corresponding investment in the quantitative and qualitative data that will come to inform us about the impact of the recommendations that we are making.

COLLEEN MALLOY: I don't feel like we had that same request for say for when Paul was talking about the border, I don't think we had that same -- I guess I'm not sure what you're asking Steve for, to be honest, because I don't think other sections had an economist commenting on the financial part of it or the possible outcomes. I guess I'm missing what you're looking for.

MAGDA PECK: I -- what I'm looking for, and I will say that it was there under Paul's summarized recommendations from the perspective of border and migrant health -- he had a specific research recommendation, he had a specific electronic medical record, so informatic recommendation, and I -- I think that the question will be -- and I come to my -- particularly my federal colleagues -- do we have adequate data and surveillance systems in place that we have access to that will help us to evaluate and monitor the impact of these recommendations on outcomes and Wanda, what I hear you saying is, perhaps calling

out that need to invest in those systems and to strengthen existing systems and to use those data in this health services research area might be of use.

STEVEN CALVIN: Yeah. My only addition to that too is that, you know, the Strong Start Study ran from, I don't know, 2012 to 2016 or '17, and there's an infrastructure there to measure those kinds of things as well. So, you know, to try -- and I agree with you too, Magda, that we do need to set up a measurement mechanism, and then we also have to -- have to use an electronic health record and obviously, that has its challenges of the various types, but there are ways for them to talk to each other, that's for sure.

EDWARD EHLINGER: I agree. I think we should add another --

STEVEN CALVIN: Yeah.

EDWARD EHLINGER: -- you know, objective or recommendation at the end related to that. I think we also have to be really concerned

though that sometimes the request for evaluation before you do something negates all of the work that has been previously done. Sometimes it's a way of blocking movement forward by saying well, we need more data. We have lots of studies that really support lots of these recommendations that are already three. That has been documented in many cases, not all, but some of those. And we need to then say all right, for things where we don't have evaluation, we need to develop a mechanism to do that.

MAGDA PECK: Wanda?

WANDA BARFIELD: So, just to add to that, Ed, I mean, there are existing data systems that can be used. I mean, we don't necessarily have to reinvent the wheel in terms of new data systems. So, for example, in terms of thinking about home visiting, I mean, there are states that are assessing that through their Title 5 evaluation work. There's also the opportunity to utilize surveillance systems such as PRAMS, which you'll hear about tomorrow, in terms of thinking

about questions that could address that.

Method of -- and mode of delivery, you know, unfortunately, MCHS, because of limited resources, has not been able to revise the questionnaire to maybe ask a question like planned home births. I mean, we know that -- we know out-of-facility births and, of course, colleagues at MCHS can add more. But the ability to be more flexible is challenging. So, some of those issues in terms of resources it not necessarily for new things but for strengthening existing systems.

MAGDA PECK: That is my intent is to invest in sustaining and strengthening and we will get to this specifically later in the interoperability and harmonizing across without -- without -- I just -- I would encourage us to think about what the implications might be for strengthening data systems.

COLLEEN MALLOY: Then, wouldn't Medicaid have a pretty extensive data collection network, I would think? I don't -- I imagine they're not without their data collection.

MAGDA PECK: Yes and your primary care has and community health centers and PRAMS and -- but it's not necessarily being used in a consistent and integrated way. And so, if we're going to raise these up, I just would like to encourage us to maximize the current data, strengthen the systems of those data, and support the linkage and interoperability of those data, and to be able to answer important questions. So, it's a yes and.

EDWARD EHLINGER: Yeah. So, I suggest that we hold on to, you know, sort of developing another recommendation here until after we hear from the Data and Research to Action Work Group to see how their recommendations might fill this gap and if there is still a gap, then develop a recommendation coming from Steve --

MAGDA PECK: That's right.

EDWARD EHLINGER: -- and Magda and Wanda, if possible.

STEVEN CALVIN: Sure. Thank you.

MAGDA PECK: That's fine.

EDWARD EHLINGER: And I think related to the -- Jeanne had her hand up -- relative to the financing, I -- I personally don't think that we've done enough evaluation as a committee to actually make some statement about financing at this point. I think it's important and maybe -- and Steve, you raised that as one of the issues that you really want us to address in the next 12 to 18 months.

STEVEN CALVIN: Yeah. That's fine with me. That -- that's just fine. I understand the hesitancy.

EDWARD EHLINGER: Yeah. All right. Any other questions or comments on this?

JEANNE CONRY: I have a couple comments, Ed. This is Jeanne.

EDWARD EHLINGER: Okay, yeah.

JEANNE CONRY: Yeah and thank you so much for that. I just -- Colleen, I understand your questions, but I'm just -- from my own background with economics and coding and all of that, I need a lot more help and it takes a lot of

analysis and more than what we've had. But I appreciate all that went into it.

And I appreciate Magda for bringing up very, very important points on where we need to look at the research and some of the recommendations. I'm very happy with the levels of care that we have come up with. It was a lot of -- a joint project between ACOG and SMFM, and it's a very important statement based on a lot of information. So, I think that's very important.

Under the first step, just to comment, we had talked about this, I think at our last meeting, extending Medicaid coverage for at least one year after delivery, I thought was the agreement. I wanted to clarify that. Wasn't it one year after -- one year after delivery rather than one year after pregnancy?

EDWARD EHLINGER: There -- there was the question of not every pregnancy ends with a delivery. We want people to be cared for after the pregnancy. That was what I had gotten, not --

JEANNE CONRY: So, if somebody

miscarries at 6 weeks -- so, this is where you get back to my original comment. We need universal health coverage and universal access because then we wouldn't be quibbling about these would be my -- my point there. But if somebody miscarries after 6 weeks, are we saying then they should have that extended care?

EDWARD EHLINGER: I would -- I would think yes personally.

TARA SANDER LEE: Well, but I don't know if that makes sense though, because we're not including, you know, a delivery just makes sense to me because we're not currently collecting data on all pregnancies. So, I mean, you know, when we talked before about there being some need for maybe better improvement or collecting like maternal mortality data and stuff, the argument has always been given that we don't -- we don't know all of the -- we don't know every time that a woman is pregnant and has a miscarriage. So, I actually think that delivery just is a better fit.

JEANNE CONRY: Or at least maybe

bring that back to the three of you and have another discussion.

UNIDENTIFIED FEMALE SPEAKER: Certainly, okay.

JEANNE CONRY: And then the other one is care teams should include physicians and they're left out every time we talk about care teams or care. So, this includes use of physicians, midwives, doulas, and other community based. I would put physicians in when we talk about a care team.

EDWARD EHLINGER: Great point.

JANELLE PALACIOS: That was one of the questions that we had when we discussed this in Health Equity. We were unsure if this was supposed to be like targeted kind of like public. Was there one recommendation that was specific to public health and so not clinically -- not like in a clinic setting, that this would be someone that would be making home visits or that was community based versus the -- because, you know, like a nurse midwife also may not be in that community

setting, but a lactation person or consultant or a doula going to someone's home might be more in that realm. So, we were kind of wondering also, was there intention of trying to just locate specific -- because I believe in one of our -- in our workforce area, we have a specific recommendation related to public health care -- care received in public health versus clinical health.

EDWARD EHLINGER: Thoughts?

JANELLE PALACIOS: And then, Vanessa, also just to add the culturally and linguistically appropriate to the care teams for 5. Thank you.

We can maybe come back to this one as well as care teams. I mean, if we talk about care teams in terms of every type of provider that cares for pregnant or a peripartum person, an infant, or fetus, it's a very large, large care team versus if we're trying to really be specific and intentional about, you know, are we talking community in terms of outreach, home visiting, clinic? So, again, we can maybe come back to this

because it's -- some of this might be reflected in the workforce recommendations as well.

JEANNE CONRY: It's just that it says to provide support, pregnancy, labor, delivery, and recovery -- education support during pregnancy, labor, delivery, and recovery, so.

EDWARD EHLINGER: Yeah, because I think this recommendation really was more about the clinical care around the birth itself.

MAGDA PECK: I would also wonder, as was in a previous set of comments, about before, between, and beyond pregnancy. This is -- the preconception period is not reflected here, and that is a flag to me or interconception. But that -- recovery is seen as interconception, but it's more than recovery. And so, I'd be curious if this is truly focused on surrounding end of pregnancy or whether or not it is around a broader perinatal, which would include preconception and interconception. And I just was not part of the conversation. So, I'll be curious with what your aspiration is to have impact.

EDWARD EHLINGER: Steve, any thoughts on that?

STEVEN CALVIN: Yeah, I think, I mean, some of this, you know, goes into the environmental, I mean, yeah.

MAGDA PECK: I'm just curious if you would invite, you know, community-based, preconception, prenatal, and the amount of work we have been doing in life course approaches to bring in preconception would be -- would allow their preconception to be both before and interconception. And I just think if we -- if we only look at the care team in terms of immediate clinical and specific to delivery, we have again missed an upstream approach beyond environmental conditions.

STEVEN CALVIN: Sure, yep. And I mean, sure, all those things are going to have their own economic impact too. I mean, you know, our list can be long.

EDWARD EHLINGER: I just wonder if a separate recommendation needs to come related to

that, you know, pre-pregnancy, interpregnancy period and separate out sort of the single episode of pregnancy and the care that goes with that and then the broader life course. If it needs -- I don't know if we can do it all within one recommendation, if it should really be two recommendations.

JANELLE PALACIOS: And the other issue I see too is that it has the word reimburse and I know in the past, we've talked about reimbursement in terms of like equitable reimbursement for same work done, and that's not always the case. So, I'm -- in this iteration, the reimbursement part is in it versus an older version that I saw. But I do know that we have talked at length as a group and especially in Health Equity about equal, equitable reimbursement for the same work done. So, I would support a recommendation for equitable reimbursement for work -- the same work done amongst providers.

STEVEN CALVIN: Right, and that -- that eventually too is what comes of a bundle,

because those who are administering a bundle will say wow, a midwife can do the same work for, you know, for 50 percent of these moms. There's an incentive to just provide better care. But currently, when it's RVU-based situation, it's -- there -- there are incentives. So, I appreciate that comment though, Janelle. It's really important. I think a midwife should be paid the same for doing the same thing that a physician does.

EDWARD EHLINGER: Well, the reimbursement actually brings back to the fee-for-service model. That's the terminology that supports fee-for-service kind of thing. So, we really want equitable funding or resourcing of the care. So, we may need to think about --

UNIDENTIFIED FEMALE SPEAKER: Or salaried, which is a different concept altogether from what you all are talking about.

EDWARD EHLINGER: Yeah, so sort of funding. How do we find it?

UNIDENTIFIED FEMALE SPEAKER:

Exactly. There's a lot more to the discussion than fee-for-service or bundles.

EDWARD EHLINGER: Yep. All right. Thank you for all of this input. I do think we need to do a couple of things. We need to take a little biology break for about ten minutes and then I think this was enough -- I hope, Steve, to give you some thoughts of maybe sort of editing some of these things --

STEVEN CALVIN: Sure.

EDWARD EHLINGER: -- and we can come back to it. I put some time tomorrow morning -- I think I have an hour tomorrow morning where we can kind of go back and review that, and if you give me something tonight, I can actually sort of finalize it with those -- with those inputs.

STEVEN CALVIN: Okay.

EDWARD EHLINGER: Any other burning issues before we take a break? All right. Let's take a ten-minute break. So, we'll be back at five minutes to three Eastern Daylight time.

[Off the record at 2:45 p.m.]

[On the record at 2:55 p.m.]

EDWARD EHLINGER: All right. Welcome back, everyone. We have three more groups to go through -- sections to go through. Like I said, I did build in an hour tomorrow. So, if we, you know, don't get through as much as we wanted today, we can continue on tomorrow. What I'm hoping is that from these comments, from the input we've gotten, the people who have sort of led the area will do a little bit of editing of those recommendations along with what Vanessa is doing and get those to me as early as possible this evening, and I can go through and get another updated draft to people by tomorrow morning so that we can get as close to final as we want.

I also recognize that we have a lot of recommendations and there's going to be working issues and trying to get everybody to be on the same page on every word and every phrase is going to be impossible. So, I'm hoping that we get to a point that people say I can't live with this at all or, you know, I have some concerns about it,

but I can live with it. It can -- I'm okay with it moving forward even though I may not be in total agreement about a specific word. But if there's something that you really cannot support, I want to know about that so that we can address that because I don't think, you know, a lot of it is -- some of it is editorial, some of it is wording that we will have a difficult time getting through it and getting 100 percent consensus about every word.

So, with that background, let's move on to the workforce recommendations.

JANELLE PALACIOS: Yes, perfect. I'm trying to put my video on, but it's -- it says the host has to allow me to put my video on. Oh, perfect, thank you.

There is one issue and I'd be remiss if I did not bring this up. But -- and this came through Health Equity. Our revisions didn't get into this version, and we had just a few different changes. But one of the issues that we had regarding Steven's recommendations was to include

-- and this was more recent -- was to consider -- was to consider support for increased funding for Indian Health Service, just recognizing that Indian Health Service has historically and consistently been underfunded, and I have some word that I can -- let me see if I can put it in the chat -- but I have some language that was written regarding this. But it's something for us to think about and consider it. And I do have a link to a report that was done -- that was done by a bipartisan joint commission addressing kind of any civil rights issues and this report was done specifically on the funding status of Indian Health Service, and they found it to be underfunded. So, in the chat, I will write the potential wording we can use. Let's see if that's it. And then I will also --

EDWARD EHLINGER: Isn't that part of Treaty rights that they're supposed to fund it and they're not doing it, so just have them follow the law.

JANELLE PALACIOS: Yes. Right,

right. If it was that easy, and it would probably be another hundred years of litigation.

EDWARD EHLINGER: Yea.

JANELLE PALACIOS: Because we just recently had, you know, rights about water rights and issues that have taken about forty years. And at the end -- let's see, I can get you -- let's see, here is the citation just for that if anyone wanted to read this report. It was very interesting and it was aptly titled *Broken Promises.* All right, here we go.

All right. So, for workforce recommendations, thank you, Ed, for just being thoughtful about the language and, you know, understanding that we may not all agree on it. One of the issues that Health Equity has discussed is in light of just when we talk about racism -- specifically structural racism -- to name it and to use that term throughout our documents rather than to dance around it, and we have that in our background and we have that in our cover letter. So, it's great that we have that.

And included in the other issue is Pat reminded me to think about when he use the terms like vulnerable and minority that those are somewhat negatively -- they're negatively charged, and it kinds of sheds a -- it takes away from the -- the thriving part that we really want to focus on and when we're really talking about vulnerable people, what do we really mean, to be very specific. We mean Black, indigenous, people of color, whatever term that we decide to come about, whether it's Black, you know, Hispanic, Latin-X, or something else. So, just being very specific about that is something to be thoughtful of.

All right. Expanding the workforce. We had a number of -- Health Equity was able to kind of parse out our work and people joined different work groups to kind of come up with -- to help shape recommendations and to help make sure that there was health equity. And Jeanne, I think this is where we're going to have a lot of our discussion about what we're talking about specific to what kind of provider type or kind of

space that we're talking about care for -- perinatal, postpartum time.

So, the first recommendation to expand resources, to establish, expand, and sustain public health workforce, development of a community workforce including community health workers, home visitors, public health nurses, doulas, navigators, neonatal practitioners, and others who care and are trained to serve for maternal and child health populations.

In this issue, this is specific to our understanding -- this was specific to kind of like a public health realm, and so not necessarily clinic-specific. And so, midwives were not included specifically in this language as well with physicians. But we thought that we would also take out neonatal nurse practitioners. We don't have -- I don't know if neonatal nurse practitioners do home visits or they're in that space. My understanding is that they're an advanced practice nurse and would be more like in a clinic setting or in a hospital. So, if was

truly to try to get community involvement, community engagement, we would take out that and leave it in the hands of the force of the workforce in the community.

Are there any thoughts on changes to this recommendation?

JEANNE CONRY: No, I'm good with that if you pull out physicians. Pull out -- because otherwise it's the family practice nurse practitioners, nurse practitioners for women's health, and then it gets complicated. Okay.

JANELLE PALACIOS: Yeah. All right. Moving on to midwives. Expand the use of certified nurse midwives and/or certified midwives and allow them to practice to the full extent of their certification in all states and in all facilities. Earlier versions had licensed, and we took that out to reflect certification since it was -- that was tied to their licensing anyway.

And for those of you who may not know, midwives -- there is an issue across the states on the scope of practice for midwives. If

there are no comments on this --

Oh, the article I mentioned, I thought I put in the chat. It's the *Broken Promises government* -- it's like 1158 I put that link in.

Number three, fund midwifery training, commit sustained resources to support certified nurse midwives and/or certified midwife education, funds for midwifery training should be specifically directed to communities of color, low-income communities, and rural areas to increase the diversity of the midwife workforce and improve its capacity to meet the needs of Medicaid beneficiaries and better reflect the population served. This was about expanding the pipeline for a diverse midwifery -- sorry -- this was -- this was specifically just increasing midwifery training and availability to midwifery services. Later on, we have one that's directed to increasing the diverse pipeline about the workforce. Are there any issues with increasing midwifery training?

EDWARD EHLINGER: As you know, I took out the -- the previous document had the commensurate funding with OB/GYN, and I took that out because that was problematic.

JANELLE PALACIOS: Okay, good. Good, thank you. The next one is to -- let's see -- oh, you know what? We -- I will also have another one. At the very end, I'll add the diverse perinatal workforce. That's the pipeline one that is missing from this version.

But, liability protection is number four. Provide professional liability protections for the evolving reconfigured maternity care team specifically for integration of non-hospital community based care with hospital-based care and the expanding perinatal workforce. The liability protection seemed like an easy recommendation.

EDWARD EHLINGER: We'll get pushback, but it is -- it makes sense.

JANELLE PALACIOS: And -- go ahead.

STEVEN CALVIN: I was going to say, Janelle, we -- we can then figure out whether we

should put it in the funding and financing or the workforce. But it is important and, you know, those who work at FQHCs are covered by the Federal Tort Claims Coverage and, you know, the Indian Health Service as well, and it's not a cost-free thing, but if we're going to have anything change, there has to be that kind of protection. I'm aware of, you know, folks who are going to have to just close down because they -- they don't have the ability to -- to get malpractice coverage.

JANELLE PALACIOS: And on that same coin, you want nurse midwives who are practicing to be covered. You want them to have professional liability. You want all practitioners to have this.

STEVEN CALVIN: Yes, yeah, yep.

JANELLE PALACIOS: Yes. Number five, doulas as a preventative service. Now, I specifically reached out to DONA, which is a national -- an international doula training organization, and the National Black Doula Association and the National Black Doula

Association, a representative from them, reached out to me and responded with some very strong words about our recommendations regarding doulas.

We were thinking of how could -- the basis for this recommendation came into like how could we try to ensure that every person who wanted a doula or had some sort of -- met some sort of criteria where they were -- their pregnancy or birth or labor was gong to be at risk, that they would be able to receive this care. And so, this recommendation came towards that end to look at how we can encourage the United States Preventative Services Task Force and WPSI to evaluate doula services as a preventative service. And Dr. -- well, Jeanne, you've shared with us -- you've shared an E-mail that this is not necessarily a recommendation that would be appropriate for WPSI at this time, correct? That this is -- I mean, and this is different from something like a screening, a tool, or a breastfeeding lactation. But I think that we need to challenge ourselves to think about how we can

package this differently so that we can have this embedded, that there is -- we know we have foundational research of that doula that, you know, a constant labor support is really -- it impacts maternal and infant outcomes. And then, how do we move that into recommending that women have access to this and not just women at risk, but women who may be middle class as well.

So, that is something for us to think about. Are there any immediate thoughts as to how to help this, knowing that with embedding it in Medicaid, that states have -- they can decide whether or not they will reimburse or pay for doulas?

JEANNE CONRY: So, you agree with deleting the WPSI and US Preventive Services Task Force?

JANELLE PALACIOS: After reading your exchange with Ed, yes.

JEANNE CONRY: Yeah.

JANELLE PALACIOS: I see that -- I could see how it would not be appropriate to go

there and so, that's just, you know, a feat to help us to strategize to where it should go.

EDWARD EHLINGER: Well, I added the, you know, like HRSA has Women's Preventive Services Guidelines. It would be appropriate for us to recommend to HRSA to do something. How they then follow up is up to them. So, I'd be curious from Lee or Michael, what -- how that recommendation would fly. What I'm trying to do is I'm trying to get doulas to be paid for. They're underpaid --

JEANNE CONRY: Yes.

EDWARD EHLINGER: -- and actually enhance this as a professional service that actually leads to a whole variety of good things.

JEANNE CONRY: So, I guess -- so, Women's Preventive Services Initiative makes recommendations based on the evidence regarding the service and then any implementation -- we may put together implementation, how to implement it most effectively or where research needs to take place. If you are saying that you want doula part

of the implementation, you would then need the service evaluated. So, is there evidence to show support during labor is -- reduces cesarean section or something like that? So, it's the service you're focusing on and that -- and that's not something that this committee should be doing. So, there are two elements to it. Any individual on this committee -- any individual in the United States -- can send a note to WPSI. There's a form at the WPSI website saying what you want investigated or what you want considered. But Secretary Xavier Becerra is not going to tell us what to do. We're telling him -- we're making recommendations. So, there are two different issues. One is WPSI would never say doulas specify which type of care you have to do. We would never say doulas. We would just say this service should be covered.

EDWARD EHLINGER: So, how do we get doulas paid for? That's the bottom line. How do we assure they get paid?

JEANNE CONRY: I don't know. That

gets into the economics of things that I don't understand.

JANELLE PALACIOS: So, we have, you know, we have a number of, you know, Oregon, for example, passed a law that Oregon -- that doula services would be reimbursed and there was a number of criteria like six or seven criteria for this. And I just posted the link to the cost-benefit analysis of this study -- of this report that was done and I believe this was done like in 2016 and this report was maybe done in 2018.

But, so, you know, definitely one route is that each state passes a bill -- passes a law that Medicaid then or some funding is then shifted to doula services.

We're kind of getting in to the weeds of this, but, you know, when we think about doulas, there are different services of doulas. A doula is not a doula is not a doula.

JEANNE CONRY: Kim put the -- Kim put the -- thank you, Kim -- put the nomination form for topics.

MAGDA PECK: As -- as I listen, you know, at number five, what you're -- what I hear you saying is establish doulas as a covered essential preventive service and in doing so and having served on the former IOM -- Women's Preventive Services Initiative that led to what WPSI is doing now -- there was a recommendation from the 2010 IOM report that we would update based on practice and literature and evidence what would be the covered services. And so, I think the more than you can put this in the context, if you were going to put it in the Patient Protection Affordable Care Act and you look at the Women's Health Amendment and the work of the IOM, it was USPSTF and what came from the recommendations. And so, which is institutionalized through the work of WPSI.

So, I just think that we can work on the language here, but I want to encourage us to -- - to focus on coverage -- as covered essential preventive services for women, and that would give it particular historical context and it is part of

what the mandate is, which is to update what are those essential services.

EDWARD EHLINGER: Good addition, good addition. Thank you.

JANELLE PALACIOS: And certainly, I'll have to get --

JEANNE CONRY: It still gets -- yeah. But it still gets at the point that you can fill out the form and nominate right now. But SACIM should not be telling WPSI what to do because we're in consultation the other direction. So, if people -- if you believe it and if you people want it, then it should be -- put the form through and we're going through -- actually, Magda, we're evaluating the IOM recommendations over again right now this year, so.

MAGDA PECK: Exactly, it's time.

JEANNE CONRY: Yeah, yeah.

JANELLE PALACIOS: So, as a way to fast track this, if we can work on the language, then I am -- I -- so, we may not all -- so, Ed, are we to do these recommendations, do we need 100

percent consensus for every single recommendation?

EDWARD EHLINGER: I don't think we need 100 percent consensus. If there's something that people can't live with, then we'll have to take it out. If they can live with it but they're not -- I mean, if they agree with the concept but they have some issues with the wording, we -- I hope we can move forward that way. So, we have to figure out some way that -- I think everybody wants to support doulas, the work that doulas do for a whole variety of reasons. How do we best move that forward? They don't have a whole lot of advocates for them, and there have been so many blockages and we've not made very much progress over the last several years in moving it forward. So, how do we take advantage of our -- the power that we have to move it forward?

MAGDA PACK: Right. And I would encourage us to label this not only as a preventive service but as a covered preventive service. The more than you can say upfront in the recommendations that this is about coverage,

getting it paid for. And Steve, your point earlier, you know, the way that you get policy to change is somebody will pay for it. Somebody will demand it. Somebody will pay for it.

JANELLE PALACIOS: Great. I like the addition, the covered -- a covered service -- a covered benefit.

LEE WILSON: So, this is Lee. I have a quick question. I'm sorry, I had to step away for a second, so I'm not sure if it was covered in your discussion, Janelle, or not. When you're talking about doula services, we have spent some time looking at the range of doula services that are provided. Is there a category that you're talking about.

JANELLE PALACIOS: Right.

LEE WILSON: Entering from a political standpoint, the more extended services tend to be seen as more of a social support than as a health support.

JANELLE PALACIOS: Ah. So, I made it very astutely that it is a -- we are getting into

the weeds when we talk about the different levels of doulas because there are -- there's a spectrum. Do we talk about just the preconception and pregnancy?

LEE WILSON: I think the term that they've been using is birthing doula.

JANELLE PALACIOS: Versus a full spectrum doula versus a postpartum doula, yes, exactly. So, and there's some arguments that, you know, we have such high rate -- I don't know what the current rate in the nation is for postpartum readmission for women who have preeclampsia or who are hemorrhaging, but there's a fair amount that I see on a day-to-day basis just in the Bay Area. And so, there's this lack of knowledge of just like normal things postpartum, right? So, the social support, you know, postpartum versus social support while you are pregnant or something. It's contested because we don't have -- they aren't licensed. It's a certification process, and we don't have a whole -- I don't know all the ins and outs of the standards, and I know that it's a

developing -- it's a developing field. So, being intentional and careful about what kind of doula support is mentioned, I totally understand. I -- I can't say at this moment I have the language to share what would be the best. But if were to probably support something, it would -- we would have to look to the literature. A lot of the doula support has been about specifically birth and not necessarily postpartum or preconception.

EDWARD EHLINGER: If anybody has wording that, I mean, the -- from when I look at the data, the services that are provided by doulas -- however they're defined -- it seems to be very powerful on reducing disparities and improving birth outcomes. So, I really don't want to leave this out because we're dealing with not having the right definitions, because you're missing an opportunity. Because of all the things that we can do, getting doulas covered however they're defined would be a real step forward. And so, if you have wording that you can send me, anybody that has some thoughts about this, I'll work on

this tonight and see what we can come up with.

JEANNE CONRY: Just don't way WPSI and US Preventive Services Task Force. When you're focusing on those two areas, they've got very specific roles in how they work.

EDWARD EHLINGER: Now, let's take that off the table.

JEANNE CONRY: Take those out and then you can look at doula services separately. But when you're -- WPSI has a very specific role in how -- and US Preventive Services Task Force in terms of the evidence and what the recommendations are, and you guys can already put something in that on your own, but I would take those two out.

EDWARD EHLINGER: Yeah. Let's just take it out. That will simplify the conversation. They were put in there only as a way of -- because if they get approved by them, they get funded. But let's find other ways for it.

JEANNE CONRY: It's not that simple.

MAGDA PECK: And there could be some language in the background that gives that as an

example and some context, but not put it as a specific recommendation. So, I think there's a way to -- to perhaps add some language into the context that would be in the background piece.

JANELLE PALACIOS: Okay.

EDWARD EHLINGER: All right. Let's move on.

JANELLE PALACIOS: All right. Licensing doulas. Again, I think we should take this one out altogether because they're not licensed, they're certified. So, I know we were trying to get to some sort of like consensus on the standard, but they're not licensed at all. They're just certified.

Let's see, funding doula training, establish a grant program to support doula training to increase the available doula workforce to support pregnant Medicaid benefits. Funds for doula training should be specifically directed to communities of color, low-income communities, and rural areas to increase diversity of the doula workforce and improve its capacity to meet the

needs of Medicaid benefit series.

This -- so, this is actually the funding doula training. I know we were trying to get specifically on trying to help increase the doula workforce. But we were also intentionally trying to, I believe, this is where the culturally concordant, linguistically concordant, race concordant care was trying to step in. We were thinking about a pipeline also of trying to expand the workforce for a diverse workforce. So, we can either keep the funding doula training solely by itself as just a way to increase doulas nationwide, or we can roll it into a recommendation that Health Equity came up with, which I will put in the comment box, which was specific to diversifying the workforce.

EDWARD EHLINGER: The number seven, invest between the maternal and child workforce added that race concordance here.

JANELLE PALACIOS: Augmenting people of color, okay. We were -- yes, I think we were trying to be specific on how to -- what kinds of

programs advocate for financial support that would lead to this increased diversity. So --

MAGDA PECK: Wanda?

WANDA BARFIELD: So, I was just -- there was actually a recent publication in Pediatrics that talked about the lack of diversity in pediatric and subspecialty pediatric providers. And, you know, the thought just came to me, yes, it is important that we're talking also about doulas but what other parts of the workforce in maternal and perinatal health are we forgetting? So, you know, nursing as well as other supports, lactation consultants, I mean, there are existing systems that may also -- we also may need to consider as well.

JANELLE PALACIOS: Vanessa, if you're able to copy and paste the -- my chat comment and maybe just add it as a number eight as a recommendation.

VANESSA LEE: Sure.

JANELLE PALACIOS: Thank you.

VANESSA LEE: Sure.

JANELLE PALACIOS: Are there any issues with expanding the diversity of the workforce? We'll just begin there as something standing alone, and this would be the entire workforce encapsulating the maternal and infant population. Okay? If not, then is there any -- are there any issues related specifically to funding doula training, understanding that this is typically -- this is an accessible -- typically an accessible side hustle or career pathway that people of color -- Black, indigenous, people of color can usually obtain in a short amount of time with few funds.

WANDA BARFIELD: Your point is well taken. I want to resonate on that. Particularly over recent years, the cost of a nursing education has skyrocketed.

JANELLE PALACIOS: Yes, yep. And I don't even want to have the nightmare of what doctors leave medical school with today.

MAGDA PECK: I would also speak to advocating and I want to be careful this is not

through a lens of privilege. But I think that there is a notion about what constitutes quality doula training and that there is an implicit bias if medicalized and institutionalized within a frame of privilege about what that would be. And so, I just want to raise the question about not only expanding quantity, but assuring that the quality is, in fact, community grounded and informed and driven by wisdom and voices of people of color. And so, I'm just a little yellow flag about more would solve it versus challenging the nature of what is the quality and essential nature of that training and who provides that training in a way that grounds it and assures that it works from the heart and the head.

JANELLE PALACIOS: Um-hum. Thank you, Magda. This is -- your comment reminds me a lot of the -- the strong words I received from the doula participant who gave her insight into the recommendations, and her comment was that we should not be looking at doulas as the panacea to maternal and infant outcomes, that we really have

to address the systemic or racial structural racism that is ongoing in our country and we're trying to reach that by increasing the diversity of the workforce and trying to expand services and access to care. But we have to take also, I think, a look at possibly recommendations that are -- and tomorrow, we'll talk about this -- but other recommendations to specifically address racism and anti-racist work.

MAGDA PECK: Thank you for listening.

EDWARD EHLINGER: All right. Janelle, so if you could do whatever edits you think are appropriate, and if anybody else could send me additional edits, we'll work on this tonight and see what we can come up with for tomorrow.

JANELLE PALACIOS: Okay. Thank you.

EDWARD EHLINGER: All right. Jeanne, are you ready for the Environmental Conditions?

JEANNE CONRY: I am. Okay. Long day so far for everybody, so thank you for everybody's attention still.

Our condition -- Environmental Condition recommendations, Health and Human Services should play a larger leadership and coordinative role in protecting infants and women prior to and during pregnancy from toxic environmental exposures.

Number one, prioritize pregnant women and infants, commit and implement a major and sustained increase in research, funding, and policies aimed at protecting pregnant women and infants from toxic and harmful environmental exposures in the air, water, food, and various consumer products especially for Black, indigenous -- and this is where we can reframe the wording according to being consistent -- pregnant women and infants most burdened by cumulative impacts. Any comments?

Okay. Next one, data and monitoring collaboration. Invest in, strengthen, and expanded CDC collaboration with EPA to implement, house, and maintain the most up-to-date data to better identify communities at risk and invest and

build upon the American's children and the environment indicator series.

MAGDA PECK: Is it -- I was going to say, both of these falling -- and I really appreciate the clustering of the data at research and monitoring specifics. So, thank you for putting these front and center. I'm curious about if it's just CDC collaborations.

JEANNE CONRY: No. Down further --

MAGDA PECK: And so, whenever we've been specific because we are embedded within HRSA, we are more broadly across Health and Human Services, and I'm wondering why the specific specificity of CDC, what we're building on. That, I'm sure, appears in the background that I may have missed. I'm just wondering if it's a missed opportunity to use this as a leading edge but leave an open door for the stronger collaboration, frankly, between HHS and EPA.

JEANNE CONRY: Good point. I think we a little bit later will mention NIEHS and NIEHS is kind of one of the major groups that ties it

all together. If Wanda's on, I can defer to her to see if we should just expand and include CDC, NIEHS collaborations may be a better way to word it.

WANDA BARFIELD: Yes, I don't -- sorry, I didn't remember it being that specific.

JEANNE CONRY: Okay.

WANDA BARFIELD: Can you just scroll down a little bit?

JEANNE CONRY: Because I think we called NIEHS out later. Research collaborations partner with foundations and others to fund a science-based initiative that would address the environmental contributions to maternal and infant health and advance racial equity.

Where is NIEHS? Did we -- we pulled out --

MAGDA PECK: Alison, are you still on? Perhaps you have a comment here.

ALISON CERNICH: I -- I am. I was just going to make the suggestion that if we go back up to the point that you were making, I think

there is an ongoing effort to -- and Wanda, you can probably also comment on this -- EPA is convening some interagency working groups in this area already. So, it may just be better to day encourage HHS and agencies to collaborate with EPA.

JEANNE CONRY: Okay.

ALISON CERNICH: Because I think they are looping in not only NIH, CDC, but also other agencies for data languages. So, I think it would be better here --

WANDA BARFIELD: Just keep it broad. Yeah, I would agree with Alison.

JEANNE CONRY: Okay, okay. Thank you.

MAGDA PECK: And -- and I would add here, going back to Dr. Warren's comments up front, as the scan is done, we may want to encourage not in the recommendations but that he be listening for -- I know he's away for 30 minutes -- the notice of how do -- how do these recommendations inform the scan that will be done

across the agencies, because that would be a way to immediately implement and down the road.

JEANNE CONRY: Yeah. And we don't even have the list of the dirty dozen or dirty one hundred that we should be focusing on. We're working on that one now. Those are good suggestions. I think, keep it broad, okay.

Number three -- or after you finish typing. Research club. Okay, that one's done. Biomonitoring. Biomonitoring is kind of a funny word because biomonitoring captures a lot of it, but toxic measurements also will significantly expand and improve CDC's biomonitoring programs, especially monitoring of pregnant women, infants, and children with an emphasis on pregnant women, infants, and children who are Black, indigenous, or Hispanic.

So, again, would you want to change the wording there?

MAGDA PECK: I could imagine -- go ahead.

TARA SANDER LEE: Oh, my only thought

is that if you're going to be collecting data, I mean, don't you want to monitor all races to make sure that there isn't any bias? I mean, you want to, I mean, in any study you want to try to get a broad expanse of population.

JEANNE CONRY: Good point, Tara. The observation of many is that it's the underserved in some of these populations are at higher risk simply because of the areas that they're living. They're higher exposure to pesticides, higher exposure to certain chemicals. So, they are at increased -- much increased risk.

TARA SANDER LEE: Totally agree. I just think -- I just think by only focusing on that group, I mean -- I mean, you could be confirming the hypothesis as well or confirming those studies, and I just think it would definitely behoove you if you're going to be doing any data collection to get, you know, to make sure that all races are represented so you can actually make that claim.

JEANNE CONRY: Um-hum.

WANDA BARFIELD: Yeah, I would agree, and I think the emphasis is the important aspect there in terms of again because we know that there are disparities.

Going back to the issue of, you know, calling out the specific biomonitoring programs, I think is, you know, is important. If there are areas that we've left out in other components of HHS, we should include them. But, you know, this is a broad brush in terms of, you know, the current work, for example, that going on in Environmental Health.

MAGDA PECK: And it can be improved in CDC and other federal biomonitoring programs. It allows there to be some breathing room that acknowledges -- I'm not wordsmithing, it's more of a nuance around interoperability --

WANDA BARFIELD: Yeah.

MAGDA PECK: -- of data. And I would also strongly encourage us to go back to the background section that supports this so that the structural racism component is well articulated

and therefore, there is a justification based on data about why we are putting this emphasis on not only the population of pregnant women and infants, and this is the first time that we notice children -- I just want to pull that out -- because it's a life course approach to not have children mentioned much in any of the recommendations 2 through 4. So, I'll raise that as a question. But without, you know, given structural racism, given what has been well documented, it is -- it would be essential for us to call out Black, indigenous, and Hispanic or -- and other people of color in this. I just feel strongly about this.

JEANNE CONRY: And good point. We included children simply because of the continuum. We see certainly stillbirths, we see birth defects, we see that, but then we go on to see ADHD, autism, and others. So, it is a spectrum. But you're right, given the nature of this committee, it would not be unreasonable then to just say women and infants if we wanted to do something like that. But we continue it because

it is a continuum.

MAGDA PECK: Well, we mention our pregnant women and infants through their life course.

JEANNE CONRY: Okay.

MAGDA PECK: And that -- it brings life course back and I'm trying to reflect Dr. Warren's strategic plan and emphasis on our work in SACIM being grounded in equity and across the life course from generation to generation, and that's the last piece I want to say is that often times, it's the intergenerational component of toxic exposure, which I think it what you're meaning by cumulative effect.

JEANNE CONRY: Yep.

MAGDA PECK: But you might want to put something about intergenerational in this language.

JEANNE CONRY: Inter and transgenerational, I hate to say.

MAGDA PECK: It is transgenerational -- certainly transgenerational in terms of the

epigenetics. Thank you for even that augmentation. I appreciate that.

JEANNE CONRY: Okay. The next one, we've already had one meeting with the lead for the EPA -- oh, this one is FDA. Eliminate lead in consume products, direct FDA to identify and eliminate all sources of lead in food, cosmetics, and personal care products with lead and other toxic metals, and baby food is a top priority. And honestly, a study just came out of Canada, but looking at all prenatal vitamins, showing 50/50 were contaminated. So, that was a very worrisome study. So, we can even throw prenatal vitamins in there when you look at the toxics. But eliminating lead from consumer products is zero tolerance for children's health. And then eliminate lead -- oh, are there any comments about that one? And it goes hand and hand with the next one, eliminate lead.

This is HUD and EPA. Coordinate with other agencies including HUD and EPA to swiftly implement a multiprong nationwide strategy to

eliminate all sources of lead, to protect the lives and health of pregnant women, infants, and children, especially those disproportionately exposed and impacted.

We did have a meeting with the new EPA lead for children's health and talked with her about this is a priority. We already know, I mean, the science is clear. CDC's recommendations are very clear, zero tolerance, zero lead, but achieving that has been extremely slow.

MAGDA PECK: Jeanne, I want to appreciate the voices and stories we've heard in Flint. So, I just want to acknowledge that as part of our antecedent of this work in the qualitative side of stories and reform.

And the other is just recognizing the money side of this.

JEANNE CONRY: Yep.

MAGDA PECK: So, this is -- I appreciate multipronged nationwide strategy to eliminate. I am -- will be curious about how that is executed given particularly in urban areas and

[indiscernible] areas and others, what that will take to actually do and how that will be in coordination with local and state and tribal strategies as well.

JEANNE CONRY: You're right. You come to the point where the cost of a child's life is balanced against the cost of changing a pipe.

MAGDA PECK: Yes and thank you for bring up Dr. [?] book. I think that this is an opportunity being specific in the background to make sure that we are listening and calling in the work that needs to happen for zero tolerance for lead and that if is zero tolerance, then we can say zero tolerance.

JEANNE CONRY: Yeah, okay. The next one is Infrastructure Equity Impacts. Assure that all infrastructure projects be implemented, do so with a focus on equity and improving individual and community health. Again, we're talking about some of the -- the deserts that are in populations in some of the large cities where they don't have the resources we're talking about, changing

elements of the community, make sure that we aren't contaminating those population while we're trying to change the infrastructure.

EDWARD EHLINGER: Yeah, this is particularly important now since Congress is debating what infrastructure projects to fund. So, they're going to fund, I hope, something and in the past, the funding has often been at the expense of people of color, indigenous communities. And so, I wanted to make sure that anything that goes on really needs to have that equity lens.

MAGDA PECK: And do we want to weigh in on how we define infrastructure or do we allow it to be fluid with the qualifying word all? And I just think this is a bit squeaky at the moment.

JEANNE CONRY: It is squeaky.

EDWARD EHLINGER: If we start to define infrastructure, I would -- I would -- because that's at a date that's going on at a different level.

MAGDA PECK: Understood. I just want

to acknowledge that -- that there is some opportunity in leaving it as all infrastructure projects or it could be all infrastructure investments being made because it may not rise to the level of a project. It may be a policy and it could be --

JEANNE CONRY: That's probably better wording. Yeah, infrastructure -- yeah, infrastructure -- yeah. No, that's good wording, Magda.

MAGDA PECK: Yeah, I'm not looking to wordsmith. I want to make sure that we have room in our intent to have the greatest impact with these recommendations. So, thanks for listening.

JEANNE CONRY: Yeah. No, no, no, I like that.

Restorative justice. Develop and implement programs to justly compensate community members who have been harmed by environmental contaminants outside of their ability to control. That one is -- is a reflection of the love canals and other projects that are doing a lot of damage

to populations right now, whether it's contamination of fields or waterways or a number of different areas. That one's also probably squishy.

JANELLE PALACIOS: It's squishy, but, you know, much needed. Where else do we see restorative justice in terms of our environment? You know, we have the Dakota, you know, access pipeline that exploded in a few different places and contamination of water and fields and surrounding communities. I mean, it's ongoing. We have a number of issues happening. It's bold. Who knows how far it will go? But with our, you know, climate change and our greed for resources, it's going to be very important that we are very mindful of the impacts and take care of our nation -- our population of people who have been affected.

JEANNE CONRY: Okay, thank you. Oh, excuse me, go ahead.

MAGDA PECK: I'm sorry. Just saying, the notion of through SACIM, I want to make this

specific to our charge, and this is -- this is powerful and this, in my view, essential, and I want to make sure that it is tailored as being within the context of our mandate to inform or make recommendations to Secretary of Health and Human Services. So, this seems beyond just HHS, number one, and so, I'm wondering about development and implement programs, if there could also be consideration of language around, you know, support and encourage or -- because our locus of control around restorative justice through the lens of SACIM is fairly limited. So, I'm trying to figure out what is our fulcrum? What is our leverage? And it may be yes to develop and implement programs and policies, but it may also be to encourage and support, and I don't want to water it, I just want to make sure that it can be actionable and invite collaboration across agencies.

EDWARD EHLINGER: All right. I think this statement is pretty proactive and I think it gets at what you're trying to -- what you're

suggesting.

JEANNE CONRY: But with policies and programs.

MAGDA PECK: Yeah.

COLLEEN MALLOY: I think we're going to have to be consistent then when we, you know, think about impact to the environment if we're talking about moving to an in-person meeting and all the fossil fuels used up by all of us flying all over the place to have a meeting when we obviously could do it virtually. So, I think we have to, you know, when you talk about the economist giving their opinion about things, we have to remember that everything we do has an environmental cost. So, you might want to get some like models from Academy of Scale purpose because we're all going to be thinking that we're flying to DC in a couple months and maybe that's not the right thing to do because we'll be using a lot of resources.

EDWARD EHLINGER: Wouldn't it be nice to live in a simple world, but we don't.

COLLEEN MALLOY: I mean, there's a give and take to anything. So, I think that, you know, having a zero policy for lead is great. But I don't know, just like you said before, I don't know what the cost of all that replacing every pipe. I don't know what the cost is. Do we get rid of every number 2 pencil at school? Is there a different alternative for number 2 pencils? So, when you say get rid of lead, I don't know, is that a realistic goal? Is that --

JEANNE CONRY: Yeah, it is. It is, actually. The EPA has said it and they have meetings to lead to that. But I would say as scientists, when we've got the CDC, we've got American Academy of Pediatrics, we've got the Endocrine Society, and every major society saying zero lead --

COLLEEN MALLOY: Yeah, well, you kind of interrupted me, but what I was going to say is --

JEANNE CONRY: Pardon me.

COLLEN MALLOY: -- that I -- I think

that it would help to have some numbers in terms of what the cost of changing everything out is. I have no problem if we lived in a zero lead. I wish everyone would recycle. I think at the last meeting we went to, I went through the aluminum cans in the garbage. So, like I think that everybody needs to do their part. If we had zero lead, that's great, but we need some kind of -- some kind of perspective as to what -- what -- how much does that cost? Is it a billion dollars? Is it $20 billion? I have no idea. So, if it's important before, it should be important for this also, right?

JEANNE CONRY: We can get the data then for elimination of lead. I can put the data together on environmental toxics and show it's well researched the cost to population health. We don't have it here, but it's easy to get the data both US and global data on population health and the impact of environmental toxics.

EDWARD EHLINGER: I think we have some of that in the references in the background

document.

JEANNE CONRY: We do.

MAGDA PECK: Yes, we do.

EDWARD EHLINGER: Yeah.

MAGDA PECK: What I like about this is that it -- it echoes and supports what is already out there with an emphasis on -- and that's consistent with what you said upfront. We really want to augment the lens and focus on pregnant women and infant through that lens. So, this allows SACIM to add our voice to what is already happening.

JEANNE CONRY: And thank you, Pat Loftman, for mentioning glyphosate. We do have a position statement on glyphosate because it is neurotoxic and it is found -- that goes along with a number of the other chemicals that are being found in food. Thank you.

And then climate crisis. We heard the data -- the 33 million deliveries in the United States along where we saw increased preterm delivery and stillbirth related to PM2.5 and to

heat. So, I don't know if we should say evaluate the impact on human -- women's health and birth outcomes in all legislation or just support -- provide that data or make sure that the impact on women's health and birth outcomes in all legislation is addressed. Make sure that we're part of the discussions on it or the impact on health is --

EDWARD EHLINGER: We want to make it known that that's an issue. So, how do we magnify, manifest the impact, you know, educate people about the impact, just make it known because I think a lot of people don't recognize that there is that impact.

JEANNE CONRY: Yeah.

EDWARD EHLINGER: There's a word that I'm struggling for, but I don't have it.

JEANNE CONRY: I'll think of it.

EDWARD EHLINGER: All right, thanks.

TARA SANDER LEE: I just one quick comment and question. So, I remember in our last meeting, Jeanne, we had discussed adding to that

language regarding tobacco, drug, and alcohol. I mean, I know that, you know, lead is important, but I -- I just -- I know we had talked about adding that language in just since we know that there is so much information regarding, you know, especially women that are exposed to secondhand smoke during pregnancy. So, are we going to do that? Is that going to be included?

JEANNE CONRY: We don't -- we use that as a background as an example of what's being done. We didn't suggest that there needs to be more research on that because it's already very well documented in terms of alcohol and tobacco. I think if we go up a little bit more, it was in the introductory statement just saying that women are exposed to -- during pregnancy to toxic environmental exposures, and we gave a list of alcohol, tobacco, and other types of products.

EDWARD EHLINGER: It's in the background piece, and there are enough recommendations out there that I don't think if we added something, it wouldn't really add anything

to the recommendations that are already out there.

TARA SANDER LEE: No, that's fine. I'm just trying to understand like the biomonitoring. Like, are there going to be -- they'll be giving grants, right? We're not going to -- we're not going to restrict people to just focus on certain things. The idea is that people will put together research questions. Am I understanding this?

JEANNE CONRY: Correct.

TARA SANDER LEE: Okay. So, we're not going to limit like what they decide to look for.

JEANNE CONRY: No. In fact, I think a lot of the biomonitoring, I mean, they -- those are included. I can't speak for any particular research. Certainly the ones that we've done have drugs -- different drugs, alcohol, tobacco levels measured, but it would depend on the way -- I don't think we want to write anything so specifically to tell them what to do. But often the biomonitoring programs are using those in

addition to a pesticide or -- or other chemicals.

TARA SANDER LEE: Okay.

EDWARD EHLINGER: All right. And let's -- thank you, Jeanne. Thank you very much. Then, let's go to Magda to as best we can -- whatever we can with the Data and Research to Action, and then we'll continue whatever we can't get to today tomorrow morning -- tomorrow afternoon or whenever we get together tomorrow.

MAGDA PECK: Well, first of all, I want to thank you for the opportunity to work with an incredible DRAW group -- Data and Research to Action Work Group. Particular thanks to Wanda Barfield, Alison Cernich, Danielle Ely, and Cheryl Broussard, a good example of how we have our ex-officios help us be evidence based and use what's there. Thanks to Jeanne and Paul and Janelle and Ed for participating actively and then Ellen Tildon, Cheryl Clark, Rosemarie Fournier, Carol Goldberg and Andidi Omoutaw [phonetic.] And this is, you know, a 15-member working group who put a lot of effort into what I'm going to present to

you today. I always have time to express gratitude and appreciation first.

Second, we've organized this a little differently. We will harmonize it with the other ways the recommendations are done. But essentially, there is a broader statement about how can we take urgent steps. I mean, sometimes data doesn't have urgency, but it doesn't count if it's not counted, and this is the time to make sure we're counting right and well. And so, how can we make more effective use of available and potential data information research to inform policies? We see this through the life force of data, service access, quality, provision, inequities, and outcomes for women and infants. So, the preamble is to align the first preamble of the overall data and the overall recommendations that we've been doing this afternoon. We've retitled it to call General or Overall Data and Research for Action Recommendations as a way -- as opposed to Data and Assessment, reflecting the desire for the data where data don't speak for

themselves.

We have three basic areas to talk about and they nest from the larger to the more specific. The first is around strengthening data and research specifically for promoting equity. The second is around enhancing data systems and the interoperability of those systems across agencies and data sets and infrastructure for data and the sharing of that data. And then the third is a specific detail on morbidity and mortality sentinel event review, recognizing the flourishing nature of maternal mortality reviews, the longstanding nature of fetal and infant mortality review processes that have been out there, and that recognizing that a greater investment in and aligned and harmonized, just given we're talking about same families, same communities, will be helpful. So, that's the overall approach just to tell you a roadmap of where we're going. You can go back to the top, then I will take them one by one. But that's the general approach.

Second, we would like to frame the

strengthening in data and research specifically for equity -- racial equity, health equity, birth equity, and the reason we say this is that we do not have equity necessarily in a call out. It is our way of saying that is our North Star, that is what anchors us. And so, we have a series of recommendations -- three of them -- that we'd like to put forth for your consideration.

And so, strengthen data, sources, protocol, surveillance, evaluation, and research methods. And this is to call out specifically and document systemic and social inequalities that adversely impact the lives and well-being of mothers and children. Measure specifically the impact of structural racism, the social inequities, and unequal treatment. On health care, access, quality, delivery, and outcomes.

And so, we've put in here the life course approach of women of reproductive age or some might say women of reproductive potential, which encompasses preconception or includes it, pregnant and breastfeeding women -- I know I've

called out for folks who were putting that on the chat all along -- and their infants. And so, these are about strengthening our systems.

The third is the one that we would like to move some forward ground on in that there has been a longstanding conversation with our colleagues around the nation and informed by our conversation with our equity colleagues -- Equity Work Group colleagues around what constitutes evidence. And yes, evidence is absolutely hard quantitative data and analytic research. We would like to add to that and expand the traditional concepts and definition of evidence to include community voices and lived experience, particularly individuals from Black, indigenous, and other people of color communities. So, these are our three ways of working to strengthen data and research for equity.

I want to take this bundle first and to see if there are comments that you would like to -- or questions you would like to raise.

TARA SANDER LEE: Well, my one

question is just with the stories because that's all self-referral. So, there's always the question, you know, recall bias and everything. So, I guess I'm just a little confused by the word evidence to describe stories since there is going to be -- that's just known that they're just using recall bias.

MAGDA PECK: That's -- therein lies the challenge. I really appreciate your comment. Traditionally, evidence has been seen as "objective", "science" and I, as a scientist, I'm trained. I would have to revoke my Harvard credentials if I did not completely support that and there are calls from communities, particularly communities of color, that the qualitative data often expressed as story in a systematic way can contextualize and augment what the hard data and the quantitative data says. So, the power of story -- and this is something I've come to be in my scientific portfolio is something I feel strongly about -- allows there to be an information that is put forth and a stickiness to

the hard data when accompanied by the voices and stories of the people who we are describing in our more quantitative methodologies.

And so the hope is that SACIM will -- can begin to institutionalize how the valued voices and lived experiences counts as much as the bits of numbers of babies who die counts. That's my -- my background to you. And there is a neuroscience, if we want to have the use of data, because data don't speak for themselves, research papers don't speak for themselves. So, when stories are included in the translation of data into action, it can augment the uptake of what we have learned in a quantitative traditionally scientific way. Does that speak to you at all, Tara? That's my -- that's my explanation.

TARA SANDER LEE: I think -- no, I appreciate that explanation and further clarification. I think is just kind of a new -- new idea for me. So, I just had to ask the question and I'll -- I'll continue to process as you continue your presentation.

MAGDA PECK: Absolutely.

TARA SANDER LEE: Thank you.

MAGDA PECK: It is disruptive, I acknowledge that, and the neuroscience of story, for which there is a scientific basis, tells how people hear the data and understand the research can be lubricated and, in fact, augmented by the accompaniment of evidence that comes from lived experience, as we heard in the stories in Flint. It's not just opinion. It is a description in a qualitative way.

EDWARD EHLINGER: Magda, we're getting close to the --

MAGDA PECK: So, that -- I wanted to get that part done and then save right at one minute. I can continue or you can read it and I can pick it up first thing in the morning. I wanted to get past this first part, and then in the second part about interoperability and the specifics about sentinel event review methodology, I'm happy to spend five minutes at the beginning of tomorrow with the understanding that if people

have concerns, it would be really great for you to send me an E-mail or send me a chat so I can know that, but I don't think they're going to be perhaps taking a lot of our time, Ed.

EDWARD EHLINGER: Why don't -- if you could, you know, briefly go through the remaining points, you know, as rapidly as you can, I think that would be helpful, and then if people will acknowledge that we may go five to ten minutes over.

MAGDA PECK: With your permission, I would be glad to do so.

EDWARD EHLINGER: Thank you.

MAGDA PECK: So, the second area is that there are -- there's myriad data and myriad data systems. But they don't talk to each other and the data aren't shared across sectors let alone across agencies or let alone sometimes within a large agency. And so, the idea of being able to invest in robust and interoperability data and surveillance systems that will allow the sharing and analysis to happen. So, we suggest

some components of key data systems and their characteristics, and we also include what the measurement should include of that access, quality, and utilization of data.

And so, that is that section. It does speak specifically by example to include institutionalization, incarceration, border detention, people experiencing homelessness or eviction, or of questionable migrant citizen legal status or other forms of legal status. And so, these are the two that we would like to put forth in the data systems interoperability and sharing looking for ways to strengthen that recommendation of the mechanics.

And then third, we see, as I mentioned upfront, we see an opportunity with the rapid expansion of especially the maternal mortality, the MRIA system and the FMR system. It's come to our awareness that they have grown up somewhat separate from each other and now there is a call for a way to augment sentinel MCH-related morbidity and mortality including maternal

mortality review and FMR, and so how to do that with greater technical assistance, encourage collaboration, and in a way that these now somewhat independent systems can work in greater harmony with adequate support and investment.

And the second part under B is to call for the inclusion of the more qualitative lived experience and family perspectives in the sentinel event review approaches, which is moving in that direction now, but this would call that out for greater encouragement in an evidence-based way.

Now, of the last two that were added below, number 4 and number 5, I want to thank Alison Cernich for bringing number 4 and 5 to our table, recognizing this comes from an NIH perspective is to call for the inclusion and prioritization of the inclusion or to justify the exclusion of women of reproductive age, pregnant and breastfeeding women, and their infants in health services research often excluded. We found that in COVID and we had to call it out for it to

be included. And so, that's why saying including vaccine and medication studies is a way to talk about a post-COVID time for something we've learned through COVID.

And then last is to identify and document the systemic and social injustice about in a time of public health emergency, what do we learn from COVID? So, we'd like to put forth this recommendation that we pay specific attention in a public health emergency to what is happening in systemic and social injustice specific to women and infants.

Those are our five and did that in about four minutes, Ed, and I wanted to see how you would like to proceed with comments or concerns.

EDWARD EHLINGER: If there are any brief comments, otherwise we will start tomorrow morning with, you know, commenting on this. So, thank you for rapidly going through that and really setting the stage because I think -- I'm sure there are some comments and it may take

longer than ten or fifteen minutes. So, let's hold off until tomorrow for those comments.

What I would like to do -- first of all, thank you for everybody who made the, you know, walked us through all of these various recommendations -- really powerful group of recommendations and for all the comments that people have made. I would like the people from the various work groups to -- whatever edits you can make, get them to me as soon as you can this evening, and I will try to pull them into a single document. Vanessa, if you can send me what you've done from the share pages, I will try to synthesize all of those and get the sense of the committee and get things back to you that we can discuss after we initially talk about the data pieces.

Janelle, it sounds like you have some -- some recommendations that will be coming relative to health equity that are not reflected in the recommendations that are before us. Is that true?

JANELLE PALACIOS: So, I shared with you the recommendations Health Equity discussed and Vanessa wrote them -- she included them into the document that we have. I was just thinking about we may have -- just thinking about the people who are presenting tomorrow, we may have additional recommendations that may come forth from what we learn or what we discuss. So, I was leaving that possibility open specifically related to the work -- anti-racist work or just structural racism and what kind of recommendations we're going to hear from the team that comes tomorrow.

EDWARD EHLINGER: Yeah. We will -- we will keep that open. We don't have a lot of time after -- after that. Yeah, we don't have a lot of time built into the agenda. But it's like everything else, every time we get a presentation, there are some new things that we can come forward. So, at some point, we have to say this is it. So, I'm hoping if something really jumps out, we will get it in. We'll fix it in there. But I -- I don't want to postpone this for longer

than we have to to get something out to the Secretary.

MAGDA PECK: Ed, I just want to say given I didn't get any specific feedback yet, if you do have something you really wanted to make sure that we heard from Data and Research to Action, you know, you've got my E-mail, send it to me because I won't know what to edit tonight without having that more constructive feedback.

EDWARD EHLINGER: Yeah, that's good. Yeah, thank you because read through what Magda and their work group has put together. It's dense and it's really important. So, take a look at that and any feedback you can give to me or to the chairs from the work groups would really be helpful so that we can come up with a document tomorrow that we can come to some closure on.

All right. Thank you all for the work that you --

MAGDA PECK: Lee, did you have a comment, Lee?

LEE WILSON: Yes. Just one -- one

item. Ed, I wanted to let you know that the conversation or the discussion about the GAO report out on maternal health tomorrow and the data on that is not a lengthy discussion and I can provide references. So, it should only take about five minutes for me to cover the findings and the response from the department. So, that may free up ten or fifteen minutes for you.

EDWARD EHLINGER: That -- let me just look. Oh, good. Good, yes. That comes after the racism conversation, which I sort of timed certain recommendations. So, that may free up some time depending on -- and Magda will be coordinating that session. So, she'll -- I'm sure she will pull out of you all of the information that could possibly be wrong out of that GAO report for the sake of infants and babies and mothers and babies, so.

LEE WILSON: Be very brief.

EDWARD EHLINGER: All right. I'll see you tomorrow. Thank you for all of your work. Have a good night.

MAGDA PECK: Thank you.

[Whereupon the meeting was concluded.]

[Off the record at 4:08 p.m.]

REPORTER CERTIFICATE

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

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

IN WITNESS WHEREOF, I have hereunto set my hand, this 7th day of June, 2021.

/S/
_____
GARRETT LORMAN
Notary Public