Advisory Committee on Infant and Maternal Mortality

Virtual Meeting

10:00 a.m. until 5:00 p.m.

Tuesday, June 13, 2023

Health Resources & Services Administration (HRSA) Headquarters

5600 Fishers Lane, Pavilion B Rockville, MD 20857

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1 - **COMMITTEE MEMBERS** -

2

3 **Sherri L. Alderman, MD, MPH, IMH-E, FAAP**

4 Developmental Behavioral Pediatrician

5 CDC Act Early Ambassador to Oregon

6 Help Me Grow Physician Champion

7

8 **Steven E. Calvin, MD**

9 Obstetrician-Gynecologist

10

11 **Tara S. Lee, PhD**

12 Senior Fellow and Director of Life Sciences

13 Charlotte Lozier Institute

14

15 **M. Kathryn Menard, MD, MPH**

16 Upjohn Distinguished Professor

17 Department of Obstetrics and Gynecology

18 Division of Maternal-Fetal Medicine

19 University of North Carolina at Chapel Hill

20

21

1 - COMMITTEE MEMBERS, CONTINUED -

2

3 **Joy M. Neyhart, DO, FAAP**

4 Pediatrician

5 Rainforest Pediatric Care

6

7 **Belinda D. Pettiford, MPH, BS, BA** *(Chairperson)*

8 Women's Health Branch Head

9 Women, Infant, and Community Wellness Section

10 North Carolina Department of Health and Human Services

11

12 **ShaRhonda Thompson**

13 Consumer/Community Member

14

15 **Marie-Elizabeth Ramas, MD, FAAFP**

16 Family Practice Physician

17

18 **Phyllis W. Sharps, PhD, RN, FAAN**

19 Professor Emerita

20 Johns Hopkins School of Nursing

21

1 - COMMITTEE MEMBERS, CONTINUED -

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3 **Jacob C. Warren, PhD, MBA, CRA**

4 Dean, College of Health Sciences

5 University of Wyoming

6

7 **- EXECUTIVE SECRETARY -**

8

9 **Michael D. Warren, MD, MPH, FAAP**

10 *Health Resources and Services Administration*

11 *Maternal and Child Health Bureau*

12 Associate Administrator

13

14 **- DESIGNATED FEDERAL OFFICIAL -**

15

16 **Vanessa Lee, MPH**

17 *Health Resources and Services Administration*

18 *Maternal and Child Health Bureau*

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20

21

1 **- PROGRAM LEAD -**

2

3 **Sarah Meyerholz, MPH**

4 *Health Resources and Services Administration*

5 *Maternal and Child Health Bureau*

6

7 **- EX-OFFICIO MEMBERS -**

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9 **Wendy DeCourcey, PhD**

10 *Administration for Children and Families*

11 Social Science Research Analyst

12 Office of Planning, Research and Evaluation

13 U.S. Department of Health and Human Services

14

15 **Kamila Mistry, PhD, MPH**

16 *Agency for Healthcare Research and Quality*

17 Associate Director, Office of Extramural Research, Education & Priority

18 Populations

19 AHRQ Lead, Health Equity

20 Senior Advisor, Child Health and Quality Improvement

21 U.S. Department of Health and Human Services

1 - EX-OFFICIO MEMBERS, CONTINUED -

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3 **Amanda Cohn, MD**

4 *National Center on Birth Defects & Developmental Disabilities, Centers*

5 *for Disease Control & Prevention*

6 Director, Division of Birth Defects & Infant Disorders

7 CAPTAIN, United States Public Health Services

8 U.S. Department of Health and Human Services

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10 **Charlan Day Kroelinger, PhD, MA**

11 *National Center for Chronic Disease Prevention & Health*

12 *Promotion, Division of Reproductive Health, Centers for Disease Control*

13 *and Prevention*

14 Chief, Maternal and Infant Health Branch

15 U.S. Department of Health and Human Services

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17 **Danielle Ely, PhD**

18 *National Center for Health Statistics, Centers for Disease Control and*

19 *Prevention*

20 Health Statistician, Division of Vital Statistics

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1 - EX-OFFICIO MEMBERS, CONTINUED -

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3 **Karen Remley, MD, MBA, MPH, FAAP**

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9 **Kristen Zycherman, RN, BSN**

10 *Center for Medicaid and CHIP Services, Centers for Medicare and Medicaid*

11 *Services*

12 Coordinator for the CMS Maternal and Infant Health Initiative

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15 **Suzanne England, DNP, APRN**

16 *Indian Health Service, Great Plains Area Indian Health Service*

17 MCH Nurse Consultant, Office of Clinical & Preventive Services

18 U.S. Department of Health and Human Services

19

20

21

1 - EX-OFFICIO MEMBERS, CONTINUED -

2

3 **Alison Cernich, PhD, ABPP-CN**

4 *National Institute of Child Health and Human Development, National*

5 *Institutes of Health*

6 Deputy Director

7 U.S. Department of Health and Human Services

8

9 **Yanique M. Edmond, PhD, MPA, CTRP-C**

10 *Office of Minority Health*

11 Lead Public Health Advisor, Division of Program Operations

12 U.S. Department of Health and Human Services

13

14 **Dorothy Fink, MD**

15 *Office of Women's Health*

16 Deputy Assistant Secretary, Women's Health Director

17 U.S. Department of Health and Human Services

18

19 **Caroline Dunn, PhD, RDN**

20 Senior Analyst, Food and Nutrition Services

21 U.S. Department of Agriculture

1 - EX-OFFICIO MEMBERS, CONTINUED -

2

3 **Alicka Ampry-Samuel**

4 Regional Administrator

5 Region II—New York and New Jersey

6 U.S. Department of Housing and Urban Development

7

1 P R O C E E D I N G S

2

3 **Welcome and Call to Order**

4

5 MS. VANESSA LEE: All right. I think we'll get started.
6 Again, good morning and welcome. This is our meeting of the Advisory
7 Committee on Infant and Maternal Mortality, or ACIMM for short as we
8 like to call it.
9 I'm Vanessa Lee and the designated Federal Official for the
10 committee. Before I turn it over to our Chair, Belinda Pettiford, I
11 just want to again welcome our members, our federal ex-officio members
12 who are here, our speakers, presenters. Also, members of the public
13 who have joined either online or in person.
14 It's been four years since we've been able to hold a
15 committee meeting here in HRSA in the building, so we're all very
16 excited. Just, yeah, it's a great day so welcome all of you. I'm
17 officially opening the meeting and calling it to order. I'll now pass
18 it over to our Chair.
19 Oh, let me do some housekeeping first. Thank you, Belinda.
20 So, for those of you here with us in the building, this is Pavilion B
21 as in boy and you're on the fifth floor. So, if you venture to other
22 floors in the building just remember to come back down to fifth.
23 Again, this is the Pavilion B room that we're in. For
24 restrooms, if you just exit the front door here behind me. We pretty
25 much have restrooms in every corner of the fifth floor atrium, so if

1 you step out there's restrooms to the right around the corner. I've
2 been using one if you just go left around the corner. But if you want
3 to venture towards the cafeteria which is straight ahead as you leave
4 the room, there's also restrooms on each side of the cafeteria.
5 When we break for lunch, there's a full-service cafeteria
6 as I mentioned for breaks or for lunch. There's also a little snack
7 shop as you exit the room and walk diagonally to your left.
8 Well again, welcome everyone. I'm now going to turn it over
9 to our Committee Chair, Belinda Pettiford.
10 MS. BELINDA PETTIFORD: Good morning, everyone, and it is so
11 great to be in person. I know every place that I've been, maybe in the
12 last year, people are getting really excited about coming back
13 together. More and more people are coming out, so it is really nice to
14 have some of you in person.
15 We also know that some of you tried to get here and be in
16 person. We know that there were some challenges with some flights, and
17 we know that people have other lives, you know. ACIMM is not always
18 first in their lives, so we understand that but we're just excited to
19 have so many of you here today.
20 As you look at the agenda, and everyone should have a copy,
21 you will see we have a full two days. We try to use this time very
22 wisely but also build in a little time so you can connect a little bit
23 offline. As a Committee, we don't get to meet in person often so when
24 we do, we do like to have that chance to just check in with each other
25 and get to know each other a little bit better.

1 As you can see in the agenda today, you can see we have
2 quite a few federal updates, and we're grateful for those. We're going
3 to also take a few moments to share updates about some of our ongoing
4 efforts based on our last group of recommendations to the Secretary,
5 what we prioritize, American Indian and Native Alaskan challenges. So,
6 we will get some updates on what all of us around this table and others
7 have been doing to move that work for.
8 Then we will delve further into a specific area around
9 social determinants of health. You will quickly hear as I have been
10 meeting with various committee members that social determinants of
11 health or social drivers of health is one of the priorities that many
12 of you in this room are interested in and many on the committee.
13 So today we will get to hear about housing so I'm very
14 excited about housing highlighted on our agenda. We'll also as always
15 we try to make sure on the agenda that we are centered and remember the
16 importance of our work is based on our community voices so today as
17 well as some I think of tomorrow, we'll have a couple of community
18 people, consumers, participants that will be able to join us in their
19 experiences, their challenges and their concerns and also give us
20 recommendations if they like.
21 We also have a federal update on the Federal Healthy Start
22 Program that many of you who don't know my background has always been
23 near and dear to me. In North Carolina, we received our first site in
24 1997 and I was the first project director so it is--Healthy Start has
25 been near and dear to me for quite some time now.

1 And also, to remind our committee that we are the advisory
2 group for Healthy Start for this federal program, so just keep that in
3 mind and we are the ones making recommendations so it's always nice
4 that we get to hear some background on it. We're very fortunate to have
5 a very specific Healthy Start Project here today to share their
6 experience.
7 We have so many public comments that have come in that are
8 on our schedule that we've scheduled two times for public comments.
9 We've got a long list. We will see how many show up. We think a number
10 of them will so it's always nice to have people come and share their
11 thoughts and challenges and concerns with us and as a committee we have
12 an opportunity to respond.
13 We will also take time during today and tomorrow to
14 consider what do we want to truly prioritize as a committee and what
15 will we focus on next. So, we will start that conversation today. We
16 will think a little bit about it tonight. Not a real homework
17 assignment but just something to be thinking about and then we will try
18 to move it forward tomorrow.
19 And then tomorrow afternoon and tomorrow day I guess, we
20 have two panels that we're really looking at, what are our Federal --
21 excuse me -- our National partners doing to address issues around
22 infant and maternal health and that is important to us so that we can
23 try to make sure that wherever we can that our efforts are aligned and
24 we can develop more synergy to our work for.
25 And then we'll always wrap up with any updates anyone wants

1 to share as well as our next steps. So, as we get started this morning,
2 we want to start by asking our committee members to introduce
3 themselves. And because we have quite a few people in virtual land we
4 want them to introduce themselves as well. We want our committee
5 members to introduce themselves, our ex-officio and then others that
6 are, that are in the room that we'll get them to introduce themselves.
7 As a committee member, just to keep it as brief as possible
8 because we can go on and on and I know Belinda can, we could go ---if
9 you'd just give your name, your role and kind of where you're from and
10 we'll keep it that simple and then I'll take personal privilege to just
11 let everyone know on Saturday we celebrated my mother's ninetieth
12 birthday so I feel like I need to let the whole public know that
13 because--
14 [Applause]
15 MS. BELINDA PETTIFORD: And she had the best time in the
16 world. Any of you that are connected with me also maybe you could
17 identify in the picture so just give me a break.
18 [Side chatter].
19

20 **Introductions**

21

22 MS. BELINDA PETTIFORD: So, I am Belinda Pettiford and I
23 have the privilege of serving as your Chair. I hail from the wonderful
24 state of North Carolina and in North Carolina I am as part of the State
25 Title V, I head up the Women, Infant and Community Wellness section.

1 And we will just go around ---well we will just go this way. You want
2 to go?
3 DR. MICHAEL WARREN: Sure. Good morning. Michael Warren I'm
4 the associate Administrator of the Maternal and Child Health Bureau
5 here at HRSA and it's so great to welcome you all to our headquarters,
6 thanks.
7 DR. ALISON CERNICH: Good morning, I'm Alison Cernich. I am
8 the Deputy Director of the Eunice Kennedy Shriver National Institute of
9 Child Health and Human Development at the National Institutes of
10 Health. I'm an ex-officio on this committee and thanks so much for
11 having me.
12 DR. KAREN REMLEY: Karen Remley at the CDC National Center
13 for Birth Defects and Developmental Disabilities. I'm the Center
14 Director.
15 DR. DANIELLE ELY: I'm Danielle Ely. I'm from the National
16 Center for Health Statistics and I manage the Linked Birth and Infant
17 Death file.
18 MS. ALICKA AMPRY-SAMUEL: Good morning. I'm Alicka Ampry-
19 Samuel and I serve as the regional administrator in Region-Two for HUD.
20 DR. Kate Menard: Good morning. My name's Kate Menard. I'm a
21 maternal fetal medicine specialist, hailing from North Carolina and
22 faculty member at the University of North Carolina in Chapel Hill.
23 I feel like I should give a little more information because
24 I feel like I work for all of you. I have, -I have-, --I do. I have
25 HRSA funding for the MHLIC work that is leading maternal health work

1 and our maternal health innovations program locally.
2 I have an Indian Preference Act with CDC. I'm consulting
3 with them particularly related to levels of maternal care and most of
4 our funding right now is coming from the NHLBI for the work I'm doing
5 in implementation science of hypertension treatment. I just felt like
6 that was kind of disclosure stuff.
7 DR. STEVEN CALVIN: Steve Calvin. Hi. I am a maternal fetal
8 medicine physician from Minnesota, and I am a big fan and work with
9 midwives and community birth with birth-centered care as well.
10 DR. CAROLINE DUNN: I'm Caroline Dunn. I'm an ex-officio
11 member from the U.S. Department of Agriculture, specifically Food and
12 Nutrition Service where I work with the WIC Program.
13 DR. PHYLLIS SHARPS: Good morning. I'm Phyllis Sharps. I'm
14 Professor Emeritus of John Hopkins School of Nursing and I'm a clinical
15 nurse specialist in maternal child health.
16 MS. SARAH MEYERHOLZ: Good morning, everyone. My name is
17 Sarah Meyerholz, and I am a program lead, -the program lead for ACIMM
18 as well as a project officer so nice to meet everyone in person.
19 I'm- also going to pass it around the room, is that what you want,
20 Belinda? Perfect.
21 Lashelle, let's start with you since you have your personal
22 mic there and then I'll walk this around.
23 MS. LASHELLE STEWART: Good morning, everyone. I'm Lashelle
24 Stewart. I'm the Executive Director for Baltimore Healthy Start and
25 I'll be presenting about us later.

1 DR. LUD ABIGAIL DUCHATELIER-JEUDY: Thanks Sarah. Good
2 morning. I'm the snack person.
3 [Laughter]
4 No, so we have snacks at the table. My name is Abigail
5 Duchatelier-Jeudy. I serve as the contract representative that supports
6 the logistics for this meeting and other duties.
7 DR. MONIQUE HANNA: Good morning, everyone. My name is
8 Monique Fountain Hanna. I serve as our chief medical officer here in
9 our Division of Home Visiting and Early Childhood Systems and I also
10 serve as currently detail to the Office of the Administrator serving as
11 liaison for perinatal health equity.
12 MS. DAWN Levinson: Okay, sure, yes. Hi. Good morning. My
13 name is Dawn Levinson. I'm the Deputy Director in the Division of
14 Healthy Start and Perinatal Services and I bring greetings from our
15 director Lee Wilson. He's sorry he couldn't be with us today but says
16 hello to all.
17 MS. LOGAN: Good morning, everyone. My name is Rochelle Logan.
18 I'm the supervisory public health analyst for the Division of Healthy
19 Start and Perinatal Services. I've met a lot of you all via Zoom so
20 good to see you in person.
21 MS. MIA MORRISON: Hi, good morning. My name is Mia
22 Morrison and I'm also a supervisory public health analyst and team lead
23 in the Healthy Start Branch in the Division of Healthy Start and
24 Perinatal Services. So nice to meet all of you.
25 MS. Sonsy Fermin: Good morning, I'm Sonsy Fermin, and I

1 work in the same division with all of these wonderful ladies, and I
2 work in the Women's Health Branch with MDRBD, soon to be Maternal
3 Mental Health and Substance Use and FASD.
4 MS. KIMBERLY SHERMAN: Good morning, everyone. My name is
5 Kimberly Sherman. I serve as the branch chief for the Maternal Women's
6 Health Branch here in the Division of Perinatal Services. Welcome.
7 MS. LIVE HOYNES: Hi. My name is Live Hoynes and I'm here
8 today on behalf of the National Indian Health Board in our Maternal and
9 Child Health Team. We work on indigenous maternal health projects and
10 I'm also a public health associate with the Centers for Disease
11 Control. I'm really excited to be here.
12 DR. ANDRE CHAPPEL: Good morning, everybody. My name's Andre
13 Chappel, I'm the director of the Public Health Services Division and
14 the Office of the Assistant Secretary for planning and evaluation. I'm
15 going to be talking a little bit today about maternal health and social
16 determinants of maternal health, a couple of topics that I've been
17 dabbling with for a few years so very much looking forward to the
18 conversation. Thank you.
19 MS. EMMA KELLY: Hi, I'm Emma Kelly. I'm the logistics for
20 this committee along with my colleagues Emma Allen and Kelsey Judd, who
21 you've probably gotten a million emails from in the past two weeks
22 from.
23 MS. BELINDA PETTIFORD: Okay, so I know we have some members
24 who are joining us via Zoom so as I call your name if you'll come off
25 mute and introduce yourself that would be helpful. ShaRhonda, I see

1 your name so would you come off of mute ShaRhonda and introduce
2 yourself? We may have to come back to ShaRhonda. Oh, there you are.
3 MS. SHARHONDA THOMPSON: Hello, yes. First it wouldn't let
4 me come off mute. I don't know what was happening. My name is
5 ShaRhonda Thompson, and I am the community -- that's on the ACIMM
6 council and want to get as much information as I can from the
7 communities so that I can be the spokesperson for them.
8 MS. BELINDA PETTIFORD: Thank you, ShaRhonda. Sherri, I
9 think you're on, Sherri Alderman.
10 DR. SHERRI ALDERMAN: Yeah, yes, my name is Sherri Alderman.
11 I am a developmental and behavioral pediatrician in Oregon, and I come
12 with a deep passion for infant and maternal mortality.
13 MS. BELINDA PETTIFORD: Thank you, Sherri. As I was sharing
14 earlier, she was trying to get here today so thank you very much.
15 Trying to see if Jacob is on. Jacob are you on? He may be joining us
16 later. Or Tara? Don't see Tara's name. If either of you are on, if
17 you'd just come off of mute. Otherwise, I'll catch you later in the
18 day.
19 And then we have a few ex-officio members that are on. I
20 think Tina is on. Tina?
21 DR. TINA PATTARA-LAU: Hi. It's Tina Pattara-Lau, maternal
22 and child health consultant from the Indian Health Service, giving care
23 to Indigenous communities in the Phoenix area. Thank you for the
24 opportunity to join today.
25 MS. BELINDA PETTIFORD: Thank you, Tina. And Wendy?

1 DR. WENDY DECOURCEY: Hello. Wendy DeCourcy from the
2 Administration for Children and Families. We are a program service arm
3 at HHS providing Office of Head Start, Office of Refugee Resettlement,
4 Office of Family Assistance Administration for Native Americans, and
5 the Office of Child Care among any other programs that we support.
6 MS. BELINDA PETTIFORD: Thank you so much, Wendy and
7 Charlan, I think we see you on?
8 DR. CHARLAN KROELINGER: Good morning. This is Charlan
9 Kroelinger, I'm the Chief of the Infant and Maternal Health Branch,
10 Division of Reproductive Health of the CDC. I'm happy to be here.
11 MS. BELINDA PETTIFORD: Thank you, Charlan. Did we miss any
12 ex-officio members? So please just come off and introduce yourself.
13 Okay, if you're there and you can't come off of mute, just drop a note
14 in the chat and Sarah will let us know you are there. So, thanks
15 everyone.
16
17 **Review and Approve Minutes**

18
19 MS. BELINDA PETTIFORD: We will continue to follow our
20 agenda as noted. And next we will have a review and approval of our
21 minutes from our March meeting so hopefully you've had a chance to look
22 at them. I'll give you a moment. They're in your briefing book. And
23 once you have reviewed them, if I could get a motion to approve the
24 minutes.
25 DR. KATHRYN MENARD: I motion.

1 MS. BELINDA PETTIFORD: Thank you, Kate. Do we have a
2 second?
3 DR. STEVEN CALVIN: Second.
4 MS. BELINDA PETTIFORD: Thank you, Steve. Those in favor of
5 the motion, if you'll say aye.
6 [Chorus of ayes.]
7 MS. BELINDA PETTIFORD: Any opposers, likewise.
8 [Silence]
9 MS. BELINDA PETTIFORD: And the motion passes. Thank you
10 all.
11 And let me back up a moment because I did not share one critical
12 piece of information. Everyone, many of you know, probably all of our
13 committee members, that we have had one resignation of a committee
14 member. -So- Charlene Collier in Mississippi, we are sad that Charlene
15 has decided to step down.
16 As I tell people, there's a lot going on in Mississippi,
17 just like there's a lot going on in North Carolina. She's doing okay,
18 but she has made a decision to step down. As a committee member if you
19 want to reach out to her, I'm sure she will appreciate a note from any
20 of us because we think she does amazing work and will continue to do
21 that even beyond ACIMM so excited about that.
22 I also want to give a special welcome this morning to our
23 new ex-officio members. They introduced themselves even though I didn't
24 make sure everybody knew that they were new so I'm so happy to have
25 Alicka Ampry-Samuel with us with HUD. We've been wanting someone from

1 HUD so thank you for being with us today.
2 As well as Caroline Dunn with the Department of
3 Agriculture. And she and I had a whole conversation about another
4 Caroline Dunn that I know in North Carolina so, that she knows as well
5 so it's all good. Who also works in the nutrition field. We're going to
6 have to get them together.
7
8 **Federal Updates**
9
10 MS. BELINDA PETTIFORD: All right. So now we're going to
11 continue on. We went through the minutes, and we have a couple of
12 federal updates this morning so I'm going to--we'll start off with Dr.
13 Michael Warren to give us an update. I'm turning it over to you.
14 DR. MICHAEL WARREN: Thank you, Belinda. Good morning again,
15 folks. I'm just going to share a few updates from the Maternal and
16 Child Health Bureau to give you a sense of some of the things we've
17 been working on over the last few months.
18 All right, next slide please. So, you'll remember about a
19 year ago when on Mother's Day in 2022 we launched the National Maternal
20 Mental Health Hotline. This was a new authorization and appropriation
21 from the Congress. We were really excited to get that off the ground.
22 Really, really incredible response, about 13,000 calls in
23 the first twelve months and I should say calls or texts because you can
24 either do a voice call or text the hotline. What we found is about
25 seventy percent of the incoming conversations are via phone about

1 thirty percent via text, so a substantial number of folks using that.
2 It is free. It is 24/7. It is confidential. Folks are able
3 to answer the lines in English or Spanish and sixty-plus additional
4 languages are available via translation service and we get calls from
5 all over the country.
6 As we have gone through the first year of the hotline, a
7 lot of lessons learned when you stand at something new like this. One
8 of them is that the number was difficult to remember, and it was longer
9 than a traditional toll-free number and some folks were actually having
10 trouble with calls going through so we did some engagement with
11 stakeholders to think about a new number, something that would be
12 easier to remember.
13 And so, where we landed on with a lot of excitement from
14 stakeholders was 1-833-TLC-MAMA and so that is the new hotline number.
15 The QR code that is there on the screen will take you to a web page
16 with information about the hotline and I'll talk a little bit more in a
17 minute about some of the exciting things that are there. Next slide
18 please.
19 You all know really better than everybody why this matters.
20 We know that maternal mental health conditions are common, really
21 across the perinatal period if we look for example, a postpartum
22 period, one in eight women report depressive symptoms, that is self-
23 report.
24 And interestingly in converse of that, one in eight women
25 report that they weren't asked about symptoms of depression during a

1 postpartum visit. And so, anything we can do to increase the
2 availability of resources and make them easier to obtain is really
3 important. Next slide please.
4 I should also add we know from our maternal mortality
5 review committees that our colleagues at CDC lead and partnership with
6 folks in the state that maternal mental health conditions contribute
7 substantially to maternal morbidity and mortality across the country.
8 So, as we think back to the first year of services, I
9 mentioned over 13,000 calls or conversations coming in. the wait time
10 for these is just remarkable, so well under thirty seconds in terms of
11 both calls and texts in terms of when folks are getting response.
12 And we do this, -we operate this hotline in collaboration
13 of Postpartum Support International or PSI. They've got a network of
14 trained folks across the country representing a variety of disciplines
15 who are specially trained in perinatal mental health on the other end
16 of the line. Next slide.
17 Just to give you a sense of who is calling, the vast
18 majority of folks, about three quarters are calling for themselves but
19 you'll see we've got providers calling, folks who are calling on behalf
20 of another person, maybe a partner or a parent, a friend and of those
21 who are calling for themselves you can see about a little over a third
22 are in the postpartum period, about one in five are pregnant and in
23 that grey wedge of the pie are folks who are not reported.
24 As you can imagine the primary focus of this line is to
25 provide support and assistance and while the data collection is a nice

1 piece of that we don't hold up the service on behalf of the data
2 collection and so we have some missing data and we will work to refine
3 that over time but the primary goal of this is really around service
4 delivery. Next slide.
5 If you look at why people are calling the hotline, probably
6 not surprising to you the top three reasons for people calling are
7 depression, anxiety, and feeling overwhelmed. You will notice these
8 numbers add up to more than 100 percent because these are folks can
9 often report multiple reasons for calling the line and you can see the
10 top five that are there represented on this chart. Next slide, please.
11 I mentioned that I would share with you some exciting news.
12 So, we had on the hotline for a while, materials that can be downloaded
13 for print, so we've got posters, we've got flyers, we've got wallet
14 cards. We've got texts that you can insert in newsletters or emails or
15 web postings, but we also got some additional funding from the Congress
16 to be able to support additional promotion.
17 And so, on the website now, in addition to being able to
18 access any of those things for free, you can also request to have
19 materials shipped to you for free. We are able to do that in limited
20 quantities. Magnets, wallet cards, posters. So, the response has just
21 been incredible today. I think we're over four hundred entities across
22 the country had requested promotional materials.
23 If folks need to order in larger quantities, they can reach
24 out to us at the bureau, and we can have conversations about what's
25 possible there but really excited that these materials are available.

1 This is a good way to put those precious funds from the Congress to use
2 and to be able to make more folks aware of the hotline.
3 We have seen a bump in calls to the hotline since the
4 launch of the new number and since the availability of the promotional
5 materials and as those materials get out into the community, only
6 expect that that call volume is going to continue to increase. Next
7 slide please.
8 So just a few other updates. Belinda mentioned Healthy
9 Start. We were excited in the fiscal year '23 budget to get funding
10 increase for our Health Start Program and the Congress specifically
11 called out additional funding to support an enhanced version of Healthy
12 Start with a focus on communities with high number of excess infant
13 deaths and we talked with this committee about that before, those
14 deaths that are due to disparity and the deaths that we need to prevent
15 in order to be able to achieve equity in this country.
16 So, with the additional funding, we plan to make up to ten
17 awards. That funding opportunity is currently on the street and
18 applications are due in mid-July, so if you are interested in that,
19 please take note of that. If you know folks who may be interested,
20 please let them know.
21 These are for new communities that aren't currently served
22 by a Healthy Start Program and so we really want to make sure we are
23 getting to those communities where the need is great. That has always
24 been a criteria for Healthy Start. You have to have an infant mortality
25 rate at least 1.5 times the national average and we really also want to

1 make sure we get to those communities where those excess infant deaths
2 are the highest.
3 I'm so proud of the team that has worked on this. Many of
4 them are in this room. They were very deliberate to engage folks
5 through a number of listening sessions and the public requests for
6 information that are influencing not only this funding opportunity but
7 also our Healthy Start competition which will happen in 2024.
8 So, the entire cohort of Healthy Start Grantees, 101
9 communities, will recompete in fiscal year 2024. So later this calendar
10 year, those--those NOFO's will likely be available. So, we're excited
11 to be able to use the information that we've gathered.
12 Just an example of the kinds of things we've heard. One of
13 the hallmarks of the Healthy Start Program since its beginning has been
14 this notion of a community consortium. Folks who are from the
15 community who know the community well, who can help guide and direct
16 that work.
17 In previous iterations of Healthy Start, we called those
18 community action networks. We also have made the participation by
19 community members aspirational, so it was a goal that was worked toward
20 over the course of their Healthy Start Project.
21 We've now put in a floor of participation as a baseline
22 expectation for community engagement. Along with expectations for the
23 percentage of community members that should be a part of that
24 consortium. We've also put in strong recommendations that those
25 community consortiums should be led, or co-led, by folks who are from

1 that community.
2 I think this was a consistent listening or theme from the
3 listening sessions we heard that folks don't want people coming in,
4 sort of swooping in to help the community. These efforts really need to
5 be of, for, by the community and I think this is one example of how
6 that work is going to move forward. Next slide, please.
7 Also, really excited that there was additional funding in
8 the fiscal year '23 budget for a research network for minority serving
9 institutions. This was originally part of an omnibus, that package of
10 bills related to addressing the maternal health crisis and this was one
11 of the pieces of that that passed.
12 We will be able later this year to make sixteen awards for
13 research centers as well as one national coordinating center and again
14 this was a NOFO that the team did an amazing job gathering input from
15 the field as we were thinking about and drafting the funding
16 opportunity.
17 A number of themes came up in those sessions that reflected
18 in that NOFO. One of them is really about meaningful community
19 partnerships and this I think builds on that theme we talked about with
20 Healthy Start. And so not just having members of the community
21 participating in your research but having members of the community help
22 you develop the research questions, think about what those research
23 protocols look like, think about how you update community members
24 periodically and then involve community members in dissemination of
25 your findings, so that's reflected in the NOFO.

1 We also heard from a number of minority serving
2 institutions about institutional challenges and barriers to applying
3 for our funds and so we have done a couple of things to address that.
4 One is that we have built in a funding preference for
5 minority serving institutions in this application process. We've also
6 built in a planning year, recognizing that you get grant funds, it's
7 not like you just flip a switch and boom, your program is up and
8 running but it takes some time, especially if you're working to build
9 capacity-.
10 And so, we've built in that expectation that the first year
11 will be a planning year here. So real excited. That NOFO again
12 will--or those grants will also be awarded later this year.
13 If we could go back one slide. One thing I failed to
14 mention on the Healthy Start NOFO, we are making ten of those awards.
15 Our hope is to be able to fund at least one project in a tribal
16 community and at least one project in a rural community.
17 I think back to what this committee heard at our meeting in
18 Minnesota and thinking about how we can support tribal populations in
19 particular, so we were able to put a special funding consideration in
20 that application process to be able to do that.
21 So, if we can go forward a couple of slides now, thank you.
22 We would be remiss if we didn't take the opportunity to
23 talk about work that is active and ongoing across the department and
24 with many of our partners and that is making sure that folks are
25 connected to health insurance. I think that everyone knows that during

1 the pandemic there were a number of wavers in place that allowed people
2 to continue coverage with Medicaid and CHIP without going through that
3 sort of regular redetermination process.
4 Those waivers have now ended, and states are going through
5 the redetermination process. Nationally, there are about fifteen
6 million people who are at risk of losing coverage. About seven million
7 of those are eligible to continue to receive coverage and overall, we
8 know that about five million of those fifteen are children.
9 And so as we think about the needs of MCH populations we
10 know that insurance doesn't solve all of your problems but it is a big
11 start in helping you get connected to care and so we want to make sure
12 that folks who are eligible for Medicaid and CHIP stay connected and go
13 through that redetermination process successfully.
14 We have been supporting a number of our grantees to be able
15 to do that. Our colleagues across HHS are working on this. There are
16 materials that are available through our colleagues at CMS in a variety
17 of languages.
18 We've got a number of materials available in a tool kit
19 that you can use to be able to do this work and so we would ask that in
20 your networks and in your program efforts that you take any opportunity
21 you can to be able to connect people to care.
22 If they, for some reason are not eligible for Medicaid or
23 CHIP and they have been covered, we always want to think about what's
24 the opportunity to make a warm hand-off and so Healthcare.gov is a
25 great resource to think about connecting people to care that they may

1 qualify for.
2 And I think that is my last slight maybe, yup. And
3 certainly, happy to answer any questions. I'll be around for the next
4 couple of days.
5 MS. BELINDA PETTIFORD: Any questions for Dr. Warren at this
6 time? Any questions?
7 Well, fortunately, as he said he'll be around for a little
8 while. So great.
9 So now we're going to turn it over to Caroline Dunn with
10 the Department of Agriculture for her to share some updates.
11 DR. CAROLINE DUNN: Thank you so much. I feel like Dr.
12 Warren is always a tough act to follow but I appreciate it.
13 So again, good morning. My name is Caroline Dunn, and I am
14 with the United States Department of Agriculture's Food and Nutrition
15 Services, specifically in the Office of Policy Support where I am a
16 senior analyst with the Supplemental Nutrition and Safety Programs,
17 research and analysis division.
18 So, among the suite of nutrition assistance programs, SNS
19 administers the supplemental nutrition program for women, infants and
20 children. We're WIC, which is one of my main programs and what I'll
21 focus on today.
22 So, WIC is an important program that provides services to
23 families across the country and I'm so excited to be here to represent
24 USDA's important work.
25 Since it's my first time, I'll do just a quick overview of

1 the WIC program and also highlight some of our efforts to modernize the
2 program in ways that we hope will continue to allow us to improve the
3 lives and protect the maternal and child health.
4 I'll also give a brief overview of two upcoming efforts
5 that we have related to addressing WIC's role in maternal morbidity and
6 mortality. Next slide please.
7 The USDA's Food and Nutrition Service--our mission is to
8 increase food security and reduce hunger by providing children and low-
9 income people with access to food, a healthful diet, nutrition
10 education in a way that supports American agriculture and inspires
11 public confidence. Next slide please.
12 I'm going to start off by giving a quick overview and
13 overarching description of some of our efforts intended to guide the
14 work for the next coming years. The first is USDA's emphasis on
15 addressing nutrition security which Secretary Vilsak announced last
16 year.
17 And this extends again beyond the work the FNS does across
18 the US Department of Agriculture and really builds on USDA's work to
19 promote food security by increasing the focus on emphasizing the
20 coexistence of food insecurity and diet-related diseases and also by
21 applying an equity lens to our efforts and recognizing the role that
22 structural racism plays in increasing food insecurity and the risk of
23 diet-related diseases.
24 You may have also heard that President Biden recently
25 convened the first White House Conference on Hunger in over fifty years

1 and that conference brought together over six hundred key interested
2 parties in person and thousands more online and through listening
3 sessions and private sector commitments around the goals to ending
4 hunger and increasing healthy eating and physical activity by 2030.
5 Next slide please.
6 So, the Special Supplemental Nutrition Program for Women,
7 Infants and Children--better known as WIC, has been serving families
8 since 1974, during critical periods of growth and development including
9 pregnancy, the postpartum period, breastfeeding, infancy and early
10 childhood.
11 And in its fifty-year history, WIC has been proven to be
12 one of the most powerful and evidence-based public health programs
13 available. WIC is a tailored assortment of healthy foods, nutrition
14 education and importantly referrals to other health, community and
15 social services that families may need.
16 The program currently serves just over six million people
17 per month including almost half of all infants born in the United
18 States, all through D.C., and thirty-three tribes as well as five
19 territories. Services are provided at a variety of clinic locations
20 including but not limited to health departments, hospitals, schools,
21 nonprofits and other healthcare facilities.
22 And WIC also plays a key role in the USDA's nutrition
23 security efforts. Although eligibility criteria are slightly different,
24 many families receiving WIC are also eligible for programs like SNAP
25 and are already eligible for programs like free and reduced school

1 meals.
2 Because WIC provides certain foods rich in nutrients that
3 are important in pregnancy, infancy and early childhood, it really
4 ensures that families can include these foods in their diet and allows
5 them to stretch their food dollars, including those through SNAP. Next
6 slide please.
7 So, some examples of the foods available in the WIC package
8 include dairy such as milk, cheese, yogurt, eggs, canned fish, peanut
9 butter, tofu, whole grains, fruits and vegetables and WIC participants
10 receive food benefits on an EBT card which works similarly to a debit
11 card.
12 Participants can also shop at a variety of stores approved
13 by their state agencies. Next slide please.
14 However, despite the proven impacts of the program and the
15 great benefits, right now we know that only about half of all eligible
16 women, infants, and children participate. And we believe strongly that
17 to maximize our program's impact and to make families across the
18 country in territories healthier we have to close this gap.
19 So, the American Rescue Act of 2021 provided about 390
20 million dollars for the USDA to invest in WIC outreach, innovation and
21 modernization. The USDA engaged interested parties to identify
22 investment priorities including making sure that all eligible families
23 know about it, making work easier to access, ensuring that WIC shopping
24 is convenient, Connecting WIC families to farmers markets and providing
25 culturally responsive care.

1 Next slide please. So, our overall quick modernization
2 rules really focus on enrolling all eligible families, making WIK
3 attractive so the families stay on the program the entire time they're
4 eligible, making shopping simple and convenient, so that families can
5 use all of their benefits and making it quick, equitable, and
6 accessible for all. Next slide please.
7 First, we know that today's families need services to be
8 simple and convenient in order to fit them into their busy lives.
9 Before 2020 WIC was only available in person. WIC state agencies have
10 been able to use a variety of flexibilities since then as a result of
11 the public health emergency, to provide services in different ways.
12 And today's families also rely on digital communication and
13 tech forward interactions in their daily lives Including interactions
14 with their health care providers. So, we're working to make remote and
15 digital services, including Telehealth a key and permanent part of the
16 WIC program.
17 Providing options for families to choose how they want to
18 access WIC will help us reach more eligible families and provide the
19 services and support to families they need to live a healthy active
20 life. Next slide.
21 So, WIC is really uniquely positioned to improve families'
22 lives long-term and to reduce racial disparities in maternal and child
23 health outcomes. But again, to make an impact families must know that
24 they're eligible and enrolled in the program.
25 So, we've really been prioritizing outreach to ensure that

1 all eligible families know about WIC, especially in underserved
2 communities. We're investing in outreach in both the local and national
3 level to spread the word about how great WIC is, whether they hear
4 about it from a healthcare provider, from a community organization, or
5 from other forms of providing assistance to semination through family
6 members, friends or neighbors.
7 We're developing WIC national outreach campaign, which is
8 expected to launch in 2024 and that campaign is being developed under
9 contract using a measured approach, grounded in research and informed
10 strategic audience engagement.
11 The WIC campaign is really being developed to resonate with
12 a broad swath of populations, including historically underserved
13 communities and communities of color that have participated in WIC in
14 disproportionately low rates compared to white families. Next slide
15 please.
16 Overall, we want to make sure we deliver a modern WIC
17 experience that feels relevant and helpful to families. We envision a
18 WIC program that uses technology to make applying to the program,
19 scheduling appointments, receiving nutrition services and interacting
20 with WIC between appointments easy and carefree.
21 Moving in this direction will reduce many barriers to
22 participation for eligible families who may not want or be able to
23 attend in person appointments. For example, those without access to
24 reliable transportation, those in rural areas and those working during
25 WIC clinic hours.

1 So as part of our modernization portfolio we're really
2 working on strategies to simplify that enrollment process and make
3 quick easier for families to access. We really believe that these
4 strategies are important for bringing new participants in and keeping
5 the ones that we are currently serving. Next slide please.
6 WIC also is prioritizing and has been prioritizing
7 providing culturally relevant care and investing in efforts to support
8 and diversify the WIC workforce. We believe that providing culturally
9 competent care and ensuring that WIC's staff reflects the diversity of
10 their communities is the ideal way to implement WIC.
11 And to work towards this FNS Has partnered with the USDA's
12 national institute of food and agriculture to combine the expertise of
13 both agencies to tackle this critical component of our WIC
14 modernization strategy. We understand that retaining staff is just as
15 critical as recruitment and so this strategy will Address both
16 recruitment and retention. Next slide please.
17 So FNS's Office of policy support has also done
18 considerable work focused on maternal morbidity and mortality and
19 infant health and we're excited to continue expanding this portfolio as
20 we learn more about the impact of WIC On health outcomes and about the
21 role that WIC can play and identifying and addressing early warning
22 signs of maternal distress.
23 Since last year FNS has engaged in several activities
24 related to maternal health. And what we've learned from these
25 activities have provided us with direction for our future work in this

1 space. Two activities that have been incredibly impactful in shaping
2 our current understanding of WIC's research and evaluation efforts, are
3 supporting a stakeholder engagement session in April of 2022, which
4 included Presentations from key federal partners such as CDC, NIH, and
5 HRSA In addition to other academics and researchers in the maternal
6 health space.
7 FNS also supported and coordinated with the Agency for
8 Healthcare Research and Quality to conduct a review by the Hopkins
9 Evidence-based Research Practice Center. And the findings from that
10 report supported activities to determine that more evidence is really
11 needed in this space to understand the impact of WIC on maternal
12 health.
13 And based on findings from these preliminary activities,
14 FNS is determined that additional research and evaluations are needed
15 to better understand the relationship between WIC participation and
16 maternal health outcomes and also to evaluate how evidence-based
17 approaches to detect and address early warning signs of maternal
18 distress can best be implemented in a WIC setting. Next slide please.
19 So, building on this work the USDA is committed to
20 supporting research into the relationship between WIC and maternal
21 health, both understanding how WIC impacts maternal health and also
22 investing in research for understanding how WIC programs can be used to
23 grow our efforts to support maternal health and address health
24 disparities.
25 As such USDA intends to initiate two cooperative agreements

1 focused on maternal health and addressing health equity and the coming
2 year. At a high level the results of these cooperative agreements will
3 support rigorous academic research as the impact of WIC on maternal
4 health outcomes especially using available secondary data and also
5 building new evidence and data for public use.
6 With this work, USDA intends to continue building strong
7 cross-governmental research relationships and also to diversify the
8 existing research community by encouraging young researchers from
9 diverse backgrounds and institutions to participate.
10 Our second effort will really focus on understanding how
11 USDA can deploy and innovative approaches to addressing maternal
12 morbidity and mortality in the WIC setting. As we know, more than
13 eighty percent of maternal deaths are considered preventable and early
14 warning signs and interventions have been shown to improve maternal
15 health during this important period.
16 So, this project will find a cooperative agreement to an
17 entity that will subsequently award subgrants to WIC state and local
18 agencies who will implement and evaluate education, communication, and
19 other evidence-based activities and at assisting WIC clinic staff and
20 pregnant and postpartum people with recognizing early warning signs of
21 maternal morbidity and mortality. Next slide please.
22 So to summarize the USDA is committed to support research
23 the supports women and infants' health and in modernizing our programs
24 to ensure eligible families have the ability to easily enroll that
25 eligible participants remain in the program, to increase the redemption

1 of food benefits tailored to support optimal health, and to extend
2 program access and equity among diverse populations.
3 We're excited to be involved in efforts with this committee
4 to provide perspective and to learn from other agencies and advocates
5 who work tirelessly to support paternal and child health and I thank
6 you for the ability to be here this morning.
7 MS. BELINDA PETTIFORD: Thank you so much, Caroline. We
8 really appreciate you joining us. Questions?
9 MS. ALICKA AMPRY-SAMUEL: I have one question, and know you
10 talk about the outreach and their efforts because about half of the
11 participants that are eligible do not actually participate in the
12 program, do you have information on why they're not participating?
13 MS. BELINDA PETTIFORD: That's an interesting kind of
14 thought process. I know we've looked at it some in my own state, but I
15 would love to hear from a national perspective why.
16 DR. CAROLINE DUNN: Absolutely, that's a great question. I
17 would say there's a diverse set of reasons for non-participation
18 ranging from access to the program to consideration of benefits and
19 also feelings of you know--feelings of wanting to make sure that
20 benefits are available for others or not being considered a burden.
21 So, we see a very diverse set of reasons for
22 non-participation which I think, you know, we're able to address
23 throughout the campaign. So, a big part of the national outreach
24 campaign is making sure that people are aware of the WIC program and
25 their eligibility for the WIC program.

1 There's also a lot of confusion about who might be eligible
2 so we will be working very closely with federal partners and Medicaid
3 and SNAP to identify adjectively eligible families and to conduct
4 outreach to them as well. I would say, you know there's a great body of
5 research out there looking at this in different populations and it's
6 such diverse reasons for non-participation that it's really not a
7 one-size-fits-all approach to addressing it.
8 It's really a comprehensive approach across the entire
9 program.
10 MS. BELINDA PETTIFORD: Thank you I know one of the areas
11 that we started hearing a couple years ago was When some of the
12 legislation came out around if you are not legally in the U.S. you
13 shouldn't. And so, a lot of people did not, they kind of went back and
14 were a little nervous about coming to a program that they consider, you
15 know, ICE, and so they wanted to make sure to be honest with you.
16 And so, I think it's overcoming some of that barrier is
17 part of what we're hearing also.
18 DR. CAROLINE DUNN: Yeah.
19 MS. BELINDA PETTIFORD: Wonderful other questions? Anyone in
20 the virtual world with questions? Yes?
21 MS. ALICKA AMPRY-SAMUEL: I know I'm new.
22 MS. BELINDA PETTIFORD: Just jump right in.
23 MS. ALICKA AMPRY-SAMUEL: Have there ever been any
24 intentional collaborations with HUD to work with families that live in
25 HUD assisted properties? And I ask that question because there's been

1 some really direct work with HRSA Around the maternal mental health
2 hotline nationally and we got a lot of input and feedback from our team
3 so I'm just wondering.
4 DR. CAROLINE DUNN: So, I will not speak to the
5 comprehensive history of WIC collaboration, but I will say that I think
6 it is a very good and natural partnership, but I would love to continue
7 a conversation on how we can continue to partner on that.
8 MS. BELINDA PETTIFORD: Wonderful. We are about making
9 connections because we're all trying to support the same families in
10 many instances so great. I can't tell if there's anything in the chat.
11 SPEAKER: No questions in the chat box.
12 MS. BELINDA PETTIFORD: No chat? Okay. If you think of
13 questions later, eventually, Carolyn will be with us all day, or most
14 of it. We can track her down, we'll say that.
15 DR. KATHRYN MENARD: I don't really have a question, just a
16 comment. The modernization term that you're using is just really
17 resonating with me, you know there's so many of the programs at work
18 and so many of the social support programs that we have that require
19 this show up for it, you know signing up for Medicaid or signing up
20 for--you know just show up for it is so we just you know, there's so
21 many better ways to do it to allow women that you know go to work and
22 do this after hours and you know all this makes sense.
23 I'm really, really encouraged to hear that y'all are going
24 in that direction.
25 MS. BELINDA PETTIFORD: Thank you all. Now remember you can

1 ask the questions at any point. So, if no other questions and we want
2 to thank you again so much for coming and being with us and being an
3 ex-officio member.
4
5 **Follow up: AI/AN Recommendations**
6
7 MS. BELINDA PETTIFORD: So now we'll continue on the agenda
8 and follow up and get any updates if any member of the committee
9 members would like to share about any efforts that you've been focused
10 on or working in related to our last recommendations. Remember we
11 submitted I think it was fifty-nine recommendations to the secretary
12 around American Indian and Alaska Native.
13 So, there's a lot to choose from. You can pick anyone you
14 want. You don't have to go with all fifty-nine but any updates that
15 anyone would--would like to share that they've been working on in the
16 last little bit since we met in March? Any--oh yes please.
17 DR. KAREN REMLEY: Sure, one thing that isn't really
18 directly infant mortality but it is, and that we're working with--we
19 have PHA's, which are public health associates so there are people who
20 just graduated from college with a public health degree, two, who are
21 working with tribes in the southwest to better understand when children
22 have newborn screening, and in particular hearing loss detection at
23 birth they're not getting followed up well and why not and what can we
24 do to work with the states and with the tribes to better understand
25 what the

1 barriers are and then to fix those barriers.
2 What we've learned more than anything is that the PHA
3 experience of being embedded into the tribal health department rather
4 than the state health department makes a big difference in their
5 experience and you know--what they're going to be learning.
6 The two we have are staying in their tribal health
7 departments because they had such a wonderful mentoring experience. So
8 that you know I think what we learn would help with a lot of early
9 identification of children with developmental problems in tribes,
10 maternal health, you know just trying to really learn the culturally
11 competent way to be engaged, be involved, and participate.
12 MS. BELINDA PETTIFORD: Thank you so much for sharing. That
13 was a great example excellent. Thank you. Alison.
14 DR. ALISON CERNICH: Just another note and I will be
15 restarting this work coming up soon but NICHD collab-ed with a number
16 of our federal partners on a lot of work around stillbirth over the
17 past six months.
18 We've published the report and can get the link for you all
19 on the issue of stillbirth and the ways that we need to continue to
20 address this. Obviously, we led this through research, but we worked
21 with our federal partners and with a group across the country to think
22 about what issues we need to confront to better understand and prevent
23 stillbirth.
24 And so, we will be restarting this group again, as I said,
25 to talk about we made some recommendations about how to move this

1 forward and we'll be now working on the implementation of those
2 recommendations.
3 And so we do this through the Council, NICHD's council is
4 where we do the public reporting of this but we also open the meetings
5 that we have to the public so a number of my federal colleagues here
6 have been working with me on this and of course we invite you all to
7 track this information about this on our website.
8 MS. BELINDA PETTIFORD: Thank you for sharing, Alison.
9 DR. STEVEN CALVIN: I mentioned earlier the funding
10 considerations that are in the Healthy Start NOFO. One of the things we
11 heard during the tribal meeting in Minnesota and the recommendations
12 were to think about where there are opportunities to make more funding
13 available, specifically tribal communities.
14 So, we've been exploring where we got the authority to put
15 in those specialty funding considerations in our funding opportunities.
16 And the other thing to share is that where was this
17 overwhelming feedback that it is so important to have meetings in the
18 community. The meeting in Minnesota was the first time this committee
19 has ever met outside of a virtual space or federal space and so we are
20 continuing that in our December meeting which you will be hearing more
21 about is a community-based meeting in St. Louis so our travel meeting
22 in Minnesota really paved the way for that.
23 MS. BELINDA PETTIFORD: Thank you. And we'll thank ShaRhonda
24 later for letting us come to St. Louis with her. Others who want to
25 share any updates? I know we've got Tina Pattara-Lau with the Indian

1 Health Services. If you've got any updates you would like to share,
2 Tina, then please just come off of mute.
3 DR. TINA PATTARA-LAU: Thank you, Belinda. This is Tina and
4 good morning and thank you for the opportunity to provide some updates
5 from IHS.
6 As I mentioned, recommendations from our report on have
7 been incorporated into IHS's 2023 Agency Work Plan on specifically
8 focused on patient safety, quality of care, strengthen and diversify
9 the workforce, strengthen approach and needs to document social
10 determinants involved.
11 As you are aware, many sites are maternity care deserts
12 where housing, transportation and childcare are providing challenges in
13 access to care. And lastly, our communications with IHS tribal and
14 urban sites are somewhere with maternal care workers and including
15 nurses to the field to provide patient care.
16 We've got several programs to put the focus on quality
17 maternal care at IHS we have drafted for an emergency department in
18 order to provide training and technical support.
19 For sites that are maternity care deserts, IHS has 28
20 Federal and Tribal an additional forty-eight critical access sites and
21 so this training is critical to provide different with checklists,
22 emergency protocols and curriculum for training just to safely triage,
23 save lives and transfer pregnant patients and newborns.
24 Second, we're piloting maternity care coordinator and MCC
25 program, which will provide child health and support to maternal,

1 infant and beyond that twenty-minute clinic appointment. This is
2 modeled after a preexisting program in the VA to increase screening and
3 education intervention during pregnancy and postpartum.
4 And we are partnering with community health aide program in
5 to sponsor public health nurses, community health workers, as well as
6 nurse support workers. We have five IHS; areas interested in
7 participating in the pilot. Great Plains, Navajo Oklahoma and Phoenix.
8 So, we're really excited to get this off the ground and
9 we'll certainly keep this committee updated. To increase our
10 communication with the field always it's our goal to bring policies and
11 programs to the bedside. We continue our MCH newsletter as many of you
12 receive twice monthly.
13 Please let me know if you are interested in receiving this
14 carved out in the MCH space on the IHS website for launch later this
15 month and we've been invited to collaborate on several webinars
16 including responding to the rise in congenital syphilis in indigenous
17 communities, looking at maternal mental health and the Family Spirit
18 Home Visiting Program.
19 We've now been invited to develop curriculum with Northwest
20 Portland Areas Indian Health Board, Indian Country Echo on care and
21 access for the pregnant people from Indigenous communities. Our next
22 one will be on substance abuse disorder in pregnancy. That will be
23 August 16th at 9:00 in the morning Eastern time.
24 Thanks for the opportunity to provide updates and happy to
25 answer any questions. Thank you all for the work that you do.

1 MS. BELINDA PETTIFORD: Thank you, Tina. Can you repeat
2 again what the pilot sites are for your--I think you said the maternity
3 care first and a couple of other things?
4 DR. TINA PATTARA-LAU: Sure. So, five IHS; areas of the
5 twelve have expressed interest in starting this MCC program so
6 Albuquerque, Great Plains, Navajo, Oklahoma and Phoenix. And this is
7 very much again a pilot phase.
8 You know we want to of course make sure that this is
9 something that shows impact, but additional sites are interested as
10 well and hopefully we can ideally expand as the VA has, you know that
11 has an MCC at every site.
12 MS. BELINDA PETTIFORD: And the pilot is for a year? And
13 what's the timeframe? Excuse me.
14 DR. TINA PATTARA-LAU: Right now, we are actually able to
15 hire and so we intend to continue ongoing with these five areas and
16 certainly have the support to do so. We will certainly study outcomes
17 as we go, so we don't have time restriction.
18 MS. BELINDA PETTIFORD: Oh, wonderful. Thank you. We want
19 you in the building with us for our next in-person meeting because we
20 want to hear more about that. Thank you so much.
21 DR. TINA PATTARA-LAU: Thank you.
22 MS. BELINDA PETTIFORD: And I did reach out to--any
23 questions for Tina? Any questions or anyone who wants to share? I did
24 reach out to our former acting Chair, as well as Janelle Palacios to
25 see what efforts that they have been working on to move the

1 recommendations forward and as you can know, they've both been very
2 busy.
3 But they were able to share their spin on a U.S. World and
4 News Report webinar confronting the crisis of inequitable maternal and
5 infant health outcomes that I think Janelle participated in and was
6 part of that webinar.
7 Also, I know Janelle participated in and did a couple of
8 presentations at the AMCHP Conference Around Health Beginnings with
9 Title V building the racial equity competence through partnerships
10 between Title V and community-based organizations. She did a couple of
11 presentations during the AMCHP Conference.
12 I know Janelle also participated with a maternal health
13 tribal learning community health and wellbeing, reconnecting indigenous
14 lifeways. They did a webinar and so we can send that link out because
15 that webinar is actually now on YouTube so people can listen to it.
16 Janelle also participated in the National Healthy Start
17 2023 Conference. She did a plenary there on Rooted in Story,
18 Storytelling in Clinical Practice, Research and Policy that was very
19 well-received. They are also planning a podcast at--an incubator
20 podcast that her--Janelle and Ed are doing together with the University
21 of Illinois in Chicago.
22 It is planned for July the 27th. We can share information
23 on it. I think Ed had shared that there is some work going on in
24 Minnesota with their local PBS station and their doing some work in
25 this area and there's some ongoing conversations going on with the

1 Kellogg Foundation around ways that they could move some of the
2 recommendations into action.
3 As we know CDC has already released their "Hear Her"
4 campaign with a very specific American Indian Alaska Native focus as
5 well. There will be a fireside chat on Native American--around maternal
6 health. It's part--it was held actually in March, and it's now part of
7 the Policy Center for Maternal Mental Health.
8 ProPublica is looking at this area so this may be something
9 for those of you that have ever worked with ProPublica or seen articles
10 they released, they do a lot of background research and then they'll
11 release a series so this is an area they are looking at.
12 And they most recently--as the podcast will be released
13 soon, what they will be sharing this information so when we get that
14 podcast, we will share that back out with our committee members.
15 So, as you can see, they've been very busy and I'm sure
16 I've left something out, but those are the things that I'm aware of
17 that Janelle and Ed have been working on. So, any questions from
18 anyone? No questions? I can't believe we're right on time. Anyone in
19 the chat?
20 SPEAKER: No questions.
21 MS. BELINDA PETTIFORD: Everybody in the chat is fine and
22 quiet? Okay. We are going to move on with our agenda then.
23
24 **Social Determinants of Health**
25

1 MS. BELINDA PETTIFORD: Our next presenter we happen to have
2 with us are focused on social determinants of health and we're happy to
3 have Andre Chappel with us. He's the Director of the Division of Public
4 Health Services and Specifically the Office of Health Policy, the
5 Office of the Assistant Secretary for Planning and Evaluation.
6 I admit it when I did one on one conversations which each
7 of the appointed members of ACIMM, many of you mentioned that social
8 determinants of health, social drivers of health was one of the areas
9 that you wanted us to delve more into and look at ways that we could
10 elevate this work and so we are very fortunate to have with use today
11 who will share his work, specifically around social determinants of
12 health but I think it will also lean into some of our conversation on
13 housing.
14 So, turning it over to you, Andre.
15 DR. ANDRE CHAPPEL: Thank you very much. I'm delighted to be
16 here today to talk about a couple of different topics that I've spent
17 quite a bit of time working on over the last few years. I spend a great
18 deal of my attention on these topics. I feel very strongly about them,
19 and I just want to note that I think it's terrific that you've got two
20 new members from other departments around the federal government.
21 It can be really challenging. There's so much going on in
22 the federal government for us to collaborate closely on some types of
23 initiatives. I think we do a pretty good job within HHS but especially
24 when you're crossing boundaries, not just across departments but across
25 topics, it's one of the things that's been really challenging what I'm

1 about to talk about which is social determinants of health.
2 You know, at Health and Human Services we have health and
3 human services, and they often operate along the paths and we're trying
4 to get them to cross over more and more and that's terrific that we've
5 got these two new members so moving on to the next slide.
6 So, I'd like to start off some of my talks with just saying
7 who are we at ASPE because a lot of people don't know it's the office
8 of the Assistant Secretary for Planning and Evaluation.
9 We go by ASPE. A lot of folks don't know who we are because
10 we don't deliver services to the public. We are located in the Office
11 of the Secretary. We're considered a staffing division and so people
12 who are in, in sort of the health policy community know of us but
13 others outside don't always know who we are.
14 We service the principal advisors in office to the
15 Secretary. The Secretary has many different advisors across the
16 department. I'd like to think that one of the value-adds that we bring
17 as an organization is our cross-cutting view of what's going on across
18 the department.
19 We have somebody at ASPE that touches every part of the
20 Department of Health and Human Services. It's kind of a fun place to
21 work because if I want to know about what's going on over at FDA, I can
22 walk down the hallway and talk to one of my colleagues about that.
23 Within the ASPE we have a few bread-and-butter sort of
24 activities that we do. We are a research and evaluation shop, that's
25 one of the main activities that we undertake. We always undertake

1 activities--one of the--so when we're going through our research
2 planning phase each year, one of the most important criteria that we
3 judge when we're trying to figure out what we're going to work on in
4 the next year is what are the policy implications of the work that we
5 can be doing?
6 We want to make sure that we have policy levers, that we
7 have somebody in the department that's going to uptake our work, that
8 they can do something with it that can inform decision-making.
9 We do both quantitative and qualitative types of research.
10 We have access to pretty much all the data across the department
11 including all CMS, Medicaid, Medicare claims data. There's survey data.
12 We buy private claims data, surveys, what have you to be able to inform
13 the work that we do.
14 We also do a lot of qualitative work, with especially some
15 of our agency partners where we'll go out and do case studies. We'll
16 convene and do expert panels on topics where we're looking to inform
17 the work that we're doing.
18 We co-chair the department's legislative development
19 process. For a lot of folks outside of the federal government when I
20 say legislative development, they're like "what is this about? You're
21 the Executive Branch. Why are you doing legislative development?"
22 Well, the President's got to budget every year and part of
23 the President's budget is a series of legislative proposals and so
24 those have to be developed somewhere and so each department has a
25 process whereby we develop these--these proposals each year.

1 And these are all where we need authorities that don't
2 currently exist and they're not for topics that we can address through
3 our existing administrative authority. So, it's we're telling Congress
4 that we see something that can be improved on one of our programs, but
5 in order to do that you have to give us additional authority.
6 And then we do provide input on a variety of different
7 clearances as I mentioned here. So, we'll move on to the next slide.
8 So, these are a few of the topics I'm going to be talking
9 with you today and I'm going to provide a little bit of context on
10 social determinants of health and another term that we use, health
11 related social needs.
12 We're going to talk a little bit about an action plan that
13 we developed at HHS as well as some follow up activity that we've been
14 doing with the White House and implications for all of this for
15 maternal and infant health. Next slide please, and we can keep moving.
16 Okay, so and I think for the members of this committee you
17 are very well aware of what I mean when I say social determinants of
18 health, health-related social needs. The primary distinction that I'll
19 mention here is social determinants of health are the underlying
20 factors that exist within a community where somebody lives that can
21 impact their wellbeing.
22 So, things like transportation, education, the neighborhood
23 and built environment, and social and community context. For
24 health-related social needs, it can be an expression of where somebody
25 lives, the impact that it has on them individually so social needs,

1 things like financial strain, housing stability, food insecure, food
2 security, access to transportation.
3 So, you can see there's a tie-in with social determinants
4 of health but there's not necessarily perfect overlap. Somebody could
5 be living in an area that has a solid sort of foundation of social
6 determinants of health but still be struggling. Somebody could be
7 living in an area that has got a lot of challenges, but they happen to
8 be in a stronger personal position. We'll move on to the next slide.
9 So, this is what we've been calling our social determinants
10 of health ecosystem. It's just sort of a fun diagram to explain how all
11 of this ties together. It's not intended to be perfect in any sense,
12 but it is intended to give sort of a conceptual view of how we view
13 the--view the situation.
14 So upstream you're looking at the social determinants of
15 health, underlying factors, public health has a role to play in
16 prevention. Here, multisector, public, private partnerships. You're
17 looking at whole of government types of initiative to try to address
18 the underlying factors in these communities.
19 If you move down the stream, you're moving into midstream,
20 which is human services and this is basically where if you have
21 challenges with social determinants of health they can express
22 themselves in terms of personal social needs and then moving then all
23 the way to the bottom of the stream, you're getting down to health
24 outcomes.
25 And this is where we really don't--you know, ideally, we're

1 trying to prevent things from getting all the way down the stream. We
2 want them to stay upstream and promote prevention at the earliest
3 possible point.
4 As you move down the stream though if somebody develops
5 social needs that can affect their health as well and that's why we
6 call those health-related social needs and we really want to have the
7 healthcare and social care sectors working closely together to do a
8 better job with coordination of needs.
9 So, we can move on to the next slide. On this slide, I
10 think the main point here is just to say that you know these factors
11 are really important. Up to fifty percent of country-level health
12 outcomes are affected by social determinants of health.
13 We've got a diagram that we show here that the Robert Wood
14 Johnson Foundation helped to prepare, and it just indicates that while
15 clinical care is extremely important once you develop a medical
16 condition, obviously vital to be able to address that successfully.
17 There's a lot more going on that determines health outcomes and it's
18 really important that we don't turn a blind eye to that.
19 We can move on to the next slide. And this slide is just
20 intended to say, you know, all of these disparities that we see in
21 social determinants of health and underlying structural factors are
22 also some of the contributors to the disparities that we see in health
23 outcomes for the reasons that I just mentioned so I just take a pause
24 here to just say that there's a number of different things that I've
25 listed that can affect people's health outcomes. We can move to the

1 next slide.
2 Okay, so the next few slides are not intended to be you
3 know, a thorough review of the literature but I did want to dig in a
4 little bit and say that social determinants of health and its related
5 social needs are not just factors that affect everything else, they
6 affect maternal health as well.
7 You know, there's a few studies that I've listed on this
8 slide and the next ones that talk about poverty and its impact on
9 maternal health and infant health. Educational attainment--again,
10 maternal health and infant health. We can move to the next slide.
11 Housing. So great that we have our friends from HUD here
12 joining us because it's incredibly important. Housing instability has
13 got a lot of really unfortunate implications for both maternal and
14 child health.
15 I was surprised when I was looking through the literature
16 to find that infancy is the time in somebody's life when they're most
17 likely to be having housing instability which is really, really
18 traumatic I would imagine.
19 Racial segregation, closely linked to housing. Where do
20 people live and the impact that that has and opportunities to be able
21 to access all kinds of things like healthcare, social services, what
22 have you.
23 Nutrition, this one I almost didn't list because it's like
24 how could nutrition not impact somebody's health and especially
25 maternal and infant health. I've got a little shout out to WIC there

1 because {laughs] and so I was glad when you were talking about that
2 because I thought Jeez, there it is. Having participation in WIC can
3 really make a difference in somebody's health.
4 And the environment as well. So, you know the environment
5 often gets skipped over because it's sort of challenging and like it's
6 this big issue that we have to deal with that spans more than just like
7 health and social care but it's also incredibly important.
8 You know, every day we're seeing the implications of the
9 environment and I take a pretty broad lens on what I mean by that. Air
10 pollution here is what I've listed but there's all kinds of things like
11 lead and safety issues and everything and so we can move onto the next
12 slide.
13 These are just some of the citations just for peoples'
14 reference, but we can keep moving. Okay so now I'm going to switch
15 gears and talk about what we have been doing here in HHS to try and
16 address social determinants of health and we can move to the next
17 slide.
18 So early on in the Administration, ASPE and CMS met with
19 the Chief of Staff to present some work that we had been doing on
20 socioeconomic status and social determinants of health. The Chief of
21 Staff was quite enthusiastic about the topic. Said he'd be interested
22 in finding out what else had been going on around the department on
23 this topic.
24 Expressed that it was something certainly of interest to
25 the Secretary and so we said, well, we can develop an action plan.

1 That's one way to sort of operationalize learning what we're doing
2 across the department and starting to think strategically about what do
3 we think are our sensible next steps to try to address this topic.
4 We convened a group of folks from across our 130+ folks to
5 help us develop this action plan, including I think pretty much most of
6 the operating divisions and staff divisions in HHS and I've listed a
7 few of the materials that came out of this process.
8 So, this was back in April when we developed this plan. We
9 didn't make it all publicly available because as I mentioned a big part
10 of the plan was to try to think strategically about what we wanted to
11 do next. It was a deliberative type of process and there's things in
12 there that we're talking about, potential next steps, things that we
13 hadn't finalized that we were going to do yet.
14 But we did release a summary of what we are doing, both in
15 a JAMA health forum article as well as a two-page summary on our action
16 plan on ASPE's website and we also did a review on evidence-based
17 strategies and federal efforts so it's just sort of a review about what
18 do we know about what's working out there for social determinants of
19 health.
20 So, you can find all that at the link that you see on this,
21 on this slide. And you can move to the next slide.
22 These are the three goals that we had in the action plan.
23 The first one was an ANC data infrastructure and utilization of data,
24 something we love at ASPE. We love working with data. So, but it's not
25 just about doing research. It's about trying to improve quality. It's

1 about trying to share data to make sure we have good coordination
2 across sectors, interoperability, what have you.
3 Goal two, which was improving the affordability of
4 healthcare services and support partnerships between healthcare
5 providers and community-based organizations. I'll be talking a little
6 more about this as we move forward.
7 And Goal Three. This is our whole of government approach
8 trying to tackle the underlying social determinants of health,
9 something we found as, you know, for us just within HHS is a little
10 challenging to do because many of the levers that exist--exist
11 elsewhere in the federal government.
12 There was something that developed a little bit later which
13 I'll talk about in a few moments that allowed us to do more of that, so
14 move to the next slide.
15 Okay, so following up as to when we developed our action
16 plan. We coordinated four different priority groups, and this is where
17 I was talking about where we had some deliberation during the process
18 of developing the action plan.
19 People sort of circled around various topics where we found
20 multiple people in different agencies wanting to do additional work on
21 them and there's four of them listed here on the screen.
22 I'm going to talk a little bit more about the first one.
23 It's something that I was personally a little bit more involved with,
24 and it's sort of informed other things that we're doing as a federal
25 government but all of them equally important and they're all

1 contributing to strengthening our efforts. So, move to the next slide.
2 For this first group, health and social care coordination.
3 You can see our vision statement here. We had a vision of developing a
4 newer agency approach to coordinating key HHS policies and programs
5 that can drive alignment of health and social care.
6 We really believe that it's not only important. We've done
7 lots of things as a federal government to try to expand access to
8 healthcare services but it's really important as we have more and more
9 people to be able to access healthcare that there's venues to have
10 their other needs addressed, their social needs addressed.
11 You can see on the slide here there's a number of different
12 policies. The ones I've listed here I think are all from CMS and
13 they're all intended to try to improve access to health-related social
14 needs in different ways.
15 There's new screening measures that are being implemented
16 through regulations at CMS that are incentivizing providers to engage
17 in the screening of health-related social needs but that's not the end
18 of the story, right? So, you screen somebody for health-related social
19 need and then it's just like medical care.
20 If you just screen it and if you don't follow up what's the
21 point in doing that? That actually can be not helpful. So, you know,
22 we're trying to find ways that we can expand what we're doing within
23 our current existing authorities to be able to support access to these
24 services.
25 And you can see here that CMS is actually doing quite a bit

1 through Medicaid program as well as through Medicare Advantage for
2 older Americans. They are opening up opportunities to be able to pay
3 for social services. On a limited basis, but nonetheless able to pay
4 for them under certain circumstances, particularly when it's been
5 demonstrated in the literature in the evidence base that addressing a
6 social need could result in savings and improvements in quality for
7 outcomes, health outcomes.
8 Then there's some new measures that in terms of maternal
9 health that CMS is putting out which I'm sure all of you are aware of
10 already but severe obstetrical complications, sort of similar to severe
11 maternal morbidity measure, a birthing-friendly designation and
12 cesarean deliveries and we think that all of these have tie-ins to
13 social determinants of health and trying to improve on all of these
14 metrics means that there's probably going to--it's probably going to
15 help drive the agenda for moving forward and addressing social
16 determinants of health.
17 Okay, next slide please. And I think it might be the slide
18 before this one--thank you, this one.
19 Okay, so how do we go about doing this? None of us are
20 blind to the fact that being able to adequately fund social services is
21 vitally important and you know, that can be a challenge at times. I did
22 mention on the last slide, some of the actions that CMS has taken to
23 try to open up new opportunities to be able to fund this.
24 You know, funding is one piece but actually being able to
25 connect people to care is the next piece and so if we're successful in

1 being able to have people screened for social determinants of health we
2 want to create an environment at the local level that encourages
3 coordination across the social care sector and the healthcare sector.
4 One promising approach that we've identified is community
5 care hubs. They are a type of backbone organization. They represent a
6 network of community-based organizations that come together to--for a
7 number of different functions. We've got a blog post that's here and I
8 think one of the--one of the things that they're doing is trying to
9 come together to establish contracts with healthcare providers and
10 manage that process.
11 Because it's really difficult for any given community-based
12 organization to figure out how they're going to engage with the
13 healthcare sector and manage, you know, there's a lot of conflicts,
14 processes and things in terms of managing referrals and so on and so
15 forth. So, they sort of serve as the backbone administrative
16 organization for a group of CPOs to come together.
17 And I've listed a number of different functions so that
18 they can, they can engage in. They integrate sources of funding across
19 mobile funding streams, something that's incredibly challenging, as
20 many of you already know and they can develop that sort of intellectual
21 capacity to know what grants are out there and how to grade and blend
22 them together appropriately.
23 They can help with managing referrals and payments ensuring
24 that deliverability and fidelity and compliance and that's just to say
25 that the whole process they can try to standardize so that people can

1 have the same experience coming in from different healthcare providers
2 and going to different areas of network to have their needs met.
3 IT implementation and maintenance. This is an incredibly
4 important one. You know, it's getting at the whole idea of the silos in
5 electronic health records and trying to break those down but also the
6 communication between social care and healthcare and information
7 sharing and that can be incredibly challenging as well.
8 And there's you know, a number of different vendors out
9 there that have ventured into this space. The systems don't always talk
10 to each other, so we're trying to support having communication between
11 systems to improve coordination.
12 Data collection and quality improvement reporting. That all
13 comes from trying to improve these data sharing mechanisms. Fostering
14 the community-based workforce development. Something that CDC has been
15 doing quite a bit with as well as others around the department and we
16 can, I think, move on to the next slide.
17 And this diagram is just intended to be sort of one way to
18 see what kind of functions does this community care hub engage in and
19 how does it all fit together. So, some people can come in through
20 screening, it could be through a healthcare provider, it could be
21 through this community care hub organization as a whole, it could be
22 through an individual community-based organization.
23 You're connecting them with other services. You're having a
24 referral sort of feedback loop. We call it the closed loop referral to
25 make sure that not only was the person referred but they received

1 services, and this was the outcome of it. and then you're tracking
2 outcomes to try to get that quality improvement piece over time.
3 Next slide. I've listed a number of related efforts that
4 are going on across the department to try to support this type of
5 environment. ACL and CDC have been partnering on trying to support
6 community care hubs. They have developed a National Learning Community
7 and Center of Excellence Programs to support the continued development
8 expansion of hubs.
9 ACL directly supports a number of hubs across the country.
10 The Office of National Coordinator for Health IT, this is getting at
11 interoperability of STOH and health-related social needs data, so they
12 have a few different programs that operate through developed standards
13 and try to promote an option of those standards.
14 There's a partnership that's outside of HHS per se, outside
15 of the federal government but something that we're engaged in
16 nonetheless, a partnership to align social care which is really
17 bringing together all of these organizations that are involved in these
18 hubs and trying to develop strategies to encourage partnerships at the
19 local level.
20 The CDC's community health worker says it's getting back to
21 the community-based workforce topic that I was talking about. These are
22 all kinds of different folks that fall underneath this umbrella.
23 It's intended to be a broad terminology, community health
24 worker, doulas could fit under this. A number of different sorts of
25 supports that aren't necessarily clinician based.

1 And then of course HRSA's community health worker training
2 program as well so they also have a community health worker training
3 program and these are the types of folks that often get engaged in
4 community care hubs that are all about trying to coordinate services,
5 engagement with the community and so on and so forth.
6 Okay, we can move to the next slide. The CDC also has
7 something they call accelerator grants, and these are all planning
8 grants and also implementation grants. They've moved onto
9 implementation now to try to develop approaches to trying to address
10 social determinants of health at the local level.
11 They go out to a variety of different kinds of
12 organizations. Everything from tribes to local communities, different
13 organizations.
14 And then there's complimentary efforts. I've listed these.
15 These aren't you know, quite as directly related to supporting hubs or
16 supporting local communication but they have implications nonetheless
17 for the operations of hubs and trying to coordinate services.
18 So, there's HUD we speak to here and then the CDC has a few
19 cooperative agreements that they fill social determinants in as a focus
20 on. Okay, we can move on to the next slide.
21 Okay, so these now are switching over to maternal health a
22 little bit more again and these are different programs. Again, not all
23 of them are about "social determinants of health" but social
24 determinants of health is implications for all of these.
25 The NIH has the IMPROVE initiative, which is really trying

1 to get at what are the underlying factors that are affecting maternal
2 health outcomes and you see here that I've highlighted in blue
3 structural factors and that gets a little bit as the underlying social
4 determinants of health and they're really building in a focus on having
5 community identify needs and community first participation and research
6 planning.
7 And then for CDC we have MMRC's PQCs and I think they just
8 could really benefit a lot from having community engagement to
9 understand what are some of the nonmedical risk factors that are
10 contributing to maternal health outcomes, and I know they're doing work
11 in this space to try to bolster community engagement.
12 Mentioned here, going back to some of the discussion here a
13 little bit earlier about facilitation across enrollment across
14 different benefit programs, Medicaid programs working with WIC. There's
15 a lot of different programs that are going into this and trying to
16 figure out how do we best get more eligible folks enrolled and all the
17 different programs that could be benefiting them.
18 And then there's other efforts like the White House
19 Conference on Hunger, Nutrition and Health that have obvious
20 implications with social determinants of health for maternal health.
21 Okay, so we can move to the next slide.
22 Okay, so, on this slide this is like "what are you all
23 about here? Why are we meeting here today and how can you help us?
24 Because we need help."
25 [Laughing]

1 You know, that's saying maternal health has obviously
2 proven to be very challenging. I think there's lots of wonderful things
3 going on that I hope we're going to you know, turn the situation around
4 in the next few years but we will wait to see.
5 Social determinants of health, as I mentioned at the
6 beginning of the talk, also very, very challenging for its own set of
7 reasons but you know, maternal health is affected by many different
8 things as I had mentioned a little bit earlier, social determinants of
9 health and health related social needs are certainly some important
10 factors that figure into this.
11 I think dealing with social determinants of health is
12 probably a little bit challenging because it really gets at some of
13 those underlying factors. I mean they're incredibly important but
14 probably a bit of a longer-term proposition prospect to be able to
15 address.
16 Health-related social needs also are challenging to address
17 but with some of the recent policies that we are putting out by the
18 department I'm really hopeful that we're able to do more and more in
19 terms of trying to meet the needs of our beneficiaries in more ways
20 than just health care or just social care but the full picture of
21 wellbeing holistically.
22 So, you know, in this environment of limited resources that
23 we're moving into, obviously with the recent legislation we all know
24 that we're going to be living in an environment of limited resources.
25 What types of things could we be working on within that

1 environment that will make the most different? What are the things that
2 are going to push the needle the most? I've put some food for thought
3 on this slide and the slides that have come before this, but we really
4 are looking forward to hearing your advice on what we could be doing as
5 a federal government to make further gains here.
6 So, thank you so much for your time today. I’m happy to
7 take any questions that you might have.
8 MS. BELINDA PETTIFORD: Thank you so much, Andre. We'll take
9 a moment for maybe one or two questions if anyone in the committee,
10 anyone has--including the people in virtual land. You can ask questions
11 as well.
12 DR. STEVEN CALVIN: I think I'll go ahead. Thanks for the
13 presentation and the outlining of all the possible solutions. I know, I
14 quickly looked, and your background is a lot in healthcare financing
15 and kind of just how to drive things.
16 A number of years ago I tried to just kind of look to the
17 fact that we in the U.S. pay about 140 billion dollars for pregnancy
18 care, about fifty-sixty billion are public funds and we've got this
19 scattered thing of Medicaid all around the country and Medicaid managed
20 care.
21 Do you have any thoughts on how kind of just paying for
22 care in a different way would drive a lot of this? I--you know--I see
23 we have an interest in coordinating and community hubs and if you also
24 maybe just added one quick question, do you have any thoughts on the
25 health bond idea?

1 I'm not sure how I feel about that either but a general
2 kind of providing incentives to address social determinants. I think
3 that might also get into a problematic approach with just you know, the
4 profit motive just sort of drives that too.
5 So, I don't know if I--clarity of question.
6 DR. ANDRE CHAPPEL: Yeah, and I'm not as familiar with the
7 bond issue but I can say that you know, so one of the interesting
8 spaces in HHS over the last you know ten years or so has been over at
9 the Centers for Medicare and Medicaid Innovation where they have been
10 testing out a lot of different types of models to be able to cover
11 different services.
12 They recently completed work on the accountable care
13 community model. You know wanted to challenges they did run into even
14 though they were trying to coordinate services, you know they weren't
15 able to provide some of these--these financing for social needs and
16 when they're trying to coordinate having people go to get social care
17 they were finding that--that not only that was the issue but more so
18 was just trying to have enough capacity in the social sector to be able
19 to meet the needs of people who were going to them. So that's something
20 that we're continuing to think you know, more about.
21 How can we try to bolster the sector and do what we can to
22 try to trade efficiencies as much as possible? To try to make sure that
23 people can get these needs met but I think it's a chicken and egg
24 situation that you're always dealing with. If you don't have the
25 finances and then you build the financing and then you don't have the

1 capacity, so I think it's going to take a number of years for us to
2 figure this out.
3 But it is certainly something that we'd be interested in
4 hearing more about from you all if you have thoughts on this.
5 DR. STEVEN CALVIN: I have a follow-up on this. I agree the
6 CMMI work is really interesting, and I've just become passionate over
7 the last decade seeing kind of the chaotic way that cares paid for you
8 know fee for service, it's a big problem just in general in the system.
9 Pregnancy is such an ideal episode. It's time limited, it's
10 pretty definable and the more we can do it that way and then also
11 provide transparency about how the money is spent and the
12 accountability about the outcomes. And of course, there will be
13 clinical entities that will say well we really can't fix this housing
14 problem but this we can connect with people that can.
15 So somehow starting with pregnancy is an episode; it's
16 something where we all started basically.
17 DR. ANDRE CHAPPEL: That's right.
18 MS. BELINDA PETTIFORD: Thank you so very much. I don't see
19 any other questions but if we could get a copy of that, I think you had
20 a two-page summary on your action plan. That would be helpful if we
21 could share it with the rest of the committee.
22 But thank you for your time and coming to be with us today.
23 DR. ANDRE CHAPPEL: You're welcome. Thank you everybody.
24
25 **Social Determinants of Health**

1 **Focus: The Impact of Housing on Birth Outcomes**

2

3 MS. BELINDA PETTIFORD: Thanks. We're going to continue on
4 with our agenda and if you need to just stand up and move around a
5 little bit, take care of your personal needs because we are going all
6 the way to lunch, okay?
7 We happen to have our next panel with us and we're focusing
8 on the social determinants of health and the impact of housing on birth
9 outcomes. So, we are fortunate to have three panelists with us today.
10 We'll start with Veronica Helms and Veronica is with HUD
11 the US Department of Housing and Urban Development And specifically in
12 the office of policy development and research. After Veronica joins us
13 virtually will then have Adam Mueller.
14 Adam is the executive director for Indiana Justice Project
15 which is one of the catalysts for infant health equity Programs funded
16 out of the division. And then we're fortunate enough to have in person
17 Lashelle Stewart with us. She is the Baltimore Healthy Start executive
18 director, also one of the catalysts for infant health equity.
19 So, we will go in that order and start with Veronica.
20 MS. VERONICA HELMS: Awesome, thank you, and when I tried to
21 start the video it says, you cannot start your video because the host
22 has stopped it. I am happy to move on without the video, but I just
23 wanted to make sure we are all good.
24 MS. BELINDA PETTIFORD: Okay we see talking up in the
25 corner. We will get a message to you. Why don't you go on and present

1 and we'll see you at some point for real, Veronica. Thanks.
2 MS. VERONICA HELMS: All right, great. Can y'all see me now?
3 MS. BELINDA PETTIFORD: We can see your slides. We cannot
4 actually see you.
5 MS. VERONICA HELMS: All right let me try again.
6 MS. BELINDA PETTIFORD: If you start so she has control of
7 her own slides? [Side chatter]. I think you have control of your own
8 slides if you'd like to try to start.
9 MS. VERONICA HELMS: Perfect.
10 MS. BELINDA PETTIFORD: Some people can see you. We just
11 can't see you in the room.
12 MS. VERONICA HELMS: I got you. Well thank you guys so much
13 for having me. I'm going to be filling in today for Solomon Greene who
14 is the political appointee that oversees the office that I sit in, the
15 Office of Policy Development and Research. I know that this is really
16 important to him and a really important cause, but he's actually
17 representing Secretary -- fudge at the UN this week.
18 So, he is out, and you guys get me. I'm sorry. I'm really
19 passionate about this too and was excited to talk to you all about this
20 topic.
21 All right let me see if I can get my slides. There we go,
22 and so as I'm sure all of y'all know HUD mission is to create strong,
23 sustainable, inclusive communities and quality affordable homes for
24 all. And our most recent strategic plan which is from fiscal years 2022
25 to 2026 has five core goals, which are listed here on this slide.

1 Most of the work I think that is in this maternal and
2 childhood space, solves under goal three, which is to advance
3 sustainable communities and the reason--sorry, I was trying to--okay.
4 And the reason I bring this up is because we're in goal
5 four, we have three sub-rules. The first one is 4A--guide investment
6 and climate resilience. This is where we focus on climate change,
7 renewable energy, what HUD is doing in this space.
8 4B is strengthen environmental justice. This again is in
9 the climate resilient space. Focuses on healthy homes, reduce
10 inequities, environmental hazards but what I really want to draw
11 attention to in this group is 4C, which is integrate health and housing
12 and the office that I sit in, the office of Policy Development actually
13 leads this particular strategic plan goal which is to integrate health
14 and housing.
15 For the first time in the agency's history, we have a
16 specific mild-marker or goal that is improve maternal and child health,
17 which I think is really exciting when I started at HUD about ten years
18 ago that's something I wouldn't have imagined but I'm so happy to see.
19 So, we've heard a lot from other speakers about housing
20 insecurity and I know a lot of folks are familiar with the concept.
21 What's interesting about housing insecurity is that in the--on the
22 research side, the data side, there's not necessarily an agreed upon
23 metric or measure for what housing insecurity means from a measurement
24 perspective.
25 But when you think about persons of reproductive age and

1 are infants, we really want housing that is safe, physically adequate,
2 affordable, based on choice and certain.
3 And this can really--again, it really depends on who is
4 talking about housing insecurity and how it's being defined, who the
5 research community is or if it's a program. It can tend to really span
6 a really large gamut, so it can be everything from rent burdened, are
7 you paying more than thirty percent of your income for housing?
8 To are you facing eviction? Whether it's formal or informal
9 we know that's a pretty big issue following the pandemic and even pre-
10 pandemic. Are you facing violence in your home? Are you living in your
11 car? We also think that if you live in poor housing quality, we would
12 also consider that to be housing insecure.
13 So, on a broad perspective, on the HUD side I'd say that
14 we--we tend to be pretty inclusive in what we believe housing
15 insecurity really entails.
16 So, this graph here shows housing insecurity during the
17 COVID-19 pandemic. I don't know if you're familiar with the census
18 household pulse survey, but it's a really great survey that was
19 deployed in April of 2020, so about a month after lockdowns started
20 happening and the survey started out weekly, now it's monthly but it
21 was one of the first times the government, I'm sure all the data people
22 know that we actually had data in a timely fashion.
23 So, we're getting data about a week after it was being
24 fielded which was really exciting. And we were kind of able to assess
25 how many folks were confident in their ability to pay rent. How many

1 folks were fearful of an eviction. How many folks were behind on rent.
2 And I think that this graph does a really good job of
3 showing from times of April 2020 when the Pandemic first started, we
4 see about 5.4 million renter households that say they're not confident
5 in their ability to pay rent, but you see that it really tends to ebb
6 and flow based on what's going on in the larger political environment.
7 We see peaks around May of 2020 when Dr. Fauci testified
8 before the Senate and they were talking about mortality numbers but
9 then we also see in December of 2020 once the FDA approved the vaccine,
10 numbers started to go down.
11 So, we're continuing to track housing insecurity
12 post-pandemic. We see that numbers are a little lower than they were in
13 April of 2020, but we know that this is a problem that's not going
14 anywhere, and we really just want to continue to track it.
15 So, what is the current state of housing insecurity for
16 woman and children? I believe the colleague before me underscored a few
17 of the points that I'm also going to underscore.
18 So first we wanted to think about women and children that
19 live in public and assisted housing. Women represent about seventy
20 percent of all HUD-assisted adults and over three quarters of them
21 identify with a racial or ethnic minority group.
22 We estimate that approximately 50,000 new babies are born
23 every year to HUD-assisted woman and children comprise about forty-six
24 percent of all HUD-assisted children. An interesting statistic about
25 these 50,000 new babies, we're working on some research now where we

1 were trying to look at the timing where someone gets on a wait list
2 versus when their homeless when they get on a waitlist and then when
3 they actually enter the program.
4 We're seeing that what often happens is that women will
5 find out they're pregnant. They'll get on the waitlist; they'll have
6 the baby and then will be admitted to housing. We would love to see
7 there be a shorter window between when--we would like to see that baby
8 born when housing assisted--when they are housing assisted versus while
9 they're still on the waitlist because there is an emerging body of
10 evidence that suggests folks without a voucher versus folks with a
11 voucher tend to have better FCH outcomes.
12 We'll talk about that a little bit more in a few slides but
13 one thing I just want to underscore about HUD-assisted women and
14 children is that they tend to be high utilizers of the public
15 healthcare system. For example, about a quarter of woman report having
16 two or more emergency room visits during the prior year.
17 Self-reported health is not that great and for children we
18 see high rates of some ailments such as asthma and learning
19 disabilities. So again, I want to underscore what my last colleague
20 said about infancy is the period of life where a person is most likely
21 to live in a homeless shelter.
22 And approximately ten percent of homeless families have an
23 infant under twelve months of age. And this goes back to the point I
24 just made about really trying to understand that trajectory of
25 pregnancy waitlist and homelessness. We're really trying to understand

1 what that timing looks like and how we can decrease that timing to
2 better serve special populations.
3 We also see that there is a strong link between housing
4 stability and MCH. Prenatal homelessness is associated with higher odds
5 of low birth weight, preterm delivery. Again, in this group I know I'm
6 now saying anything that's new or astounding but just to underscore
7 some of the statistics in this space.
8 So, we wanted to quickly highlight some promising MCH and
9 housing efforts that we're really trying to think about as we move
10 forward with our strategic plan and move forward with thinking about
11 how we can address this goal of improving maternal and child health.
12 We see that there's an emerging "small but robust" is what
13 we've been calling it, emerging body of research that shows that when
14 housing assistance is paired with health services there can be striking
15 results for maternal and child health outcomes.
16 I'm going to break up a few studies. So, the first is the
17 Ohio Healthy Beginnings at home study, where we did do a joint briefing
18 on this, I want to say a couple years ago but I feel like I have no
19 concept of time anymore, with ASPE.
20 We brought together these researchers and they did a
21 presentation to HUD and the HHS staff which was really great. There are
22 some issues with just because they didn't have a very large sample
23 size, but the results are still pretty astounding.
24 We saw that babies in an intervention group were less
25 likely to be admitted to the NICU, when NICU was required, the average

1 days spent was lower. And then we also saw difference in terms of
2 full-term and healthy weight.
3 The Family Options study is another study I just wanted to
4 quickly underscore. It is a large-scale RCT where essentially homeless
5 families with young children were given four interventions, one of
6 which being a voucher.
7 We saw that families who were given vouchers had less child
8 separations, decreased maternal psychological distress, fewer child
9 behavioral problems. We later saw that those results were pretty
10 outstanding.
11 We have--that study is continuing on, we're continuing to
12 track these families, but this study really does, gives us some of the
13 best statistics in terms of what can vouchers do for families that are
14 facing homelessness.
15 And lastly, I'll bring up Boston's Healthy Start and
16 Housing Program. This program was in Boston. It was similar to the Ohio
17 one in the sense that they had a -- of vouchers for pregnant women and
18 then they also used home visiting and their evaluation really showed
19 that there was improved mental health status and reduced stress for
20 women in the program.
21 So, what are we doing moving forward? HUD as I mentioned
22 really has a commitment to improving outcomes for women, children and
23 families. I think Alicka might be in the room. We're so happy to have
24 her represent HUD and help move the ball forward.
25 We're really thinking strategically about what is this

1 emerging body of evidence and how can housing really improve maternal
2 child health, how can we facilitate cross-agency research, and how can
3 we build partners with MCH stakeholders so there are a few studies, two
4 specific studies we're working on with the National Center for Health
5 Statistics to really quantify some of these MCH outcomes using
6 sub-linked data sources that I can get into another time but we wanted
7 to ask.
8 And I know Richard said this when he did this meeting in
9 2021, is really to include HUD at the table, to consider how we can
10 incorporate housing screening into existing programs, to really help
11 build stronger partnerships at the state and local level and explore
12 shared program funding opportunities.
13 I will underscore that we did have a large influx of money
14 to prevent eviction and as those grants start to go out the door, I
15 think there is also opportunity to incorporate that into MCH programs.
16 So here are some resources but I just want to thank
17 everyone for their time. I don't know if we are having questions now or
18 at the end, but I appreciate having the opportunity to chat, I
19 appreciate Alicka being in the room, and thanks for helping me.
20 MS. BELINDA PETTIFORD: Thank you, Veronica. We're going to
21 go on to Adam if you could hang around and we'll do questions at the
22 end. Thank you.
23 MR. ADAM MUELLER: Can you hear me okay?
24 MS. BELINDA PETTIFORD: We can hear you, Adam and apparently
25 you may be able to turn your camera on if you want to.

1 MR. ADAM MUELLER: I think it's on. I can see myself, so I
2 think we're good.
3 MS. BELINDA PETTIFORD: Perfect.
4 MR. ADAM MUELLER: Okay, well thank you everybody for having
5 me here today. I will be brief in my comments and my slides, knowing
6 that we're hitting up against lunchtime.
7 A little bit about me. So, I'm the Executive director of
8 the Indiana Justice Project, we're essentially a law policy/legal aid
9 organization in Indiana. Prior to that I had sixteen years of
10 experience as a legal aid attorney at Indi Legal Services working on a
11 variety of housing-related cases, Medicaid-related cases, those sorts
12 of things.
13 And I'm here to represent a team of folks from the Housing
14 Equity for Infant Health initiative which is the project that is HRSA
15 funded, Catalyst funded, and we're really excited about it. Next slide
16 please.
17 So, as I mentioned before, Indiana Justice Project is a
18 statewide law and policy program. We're focused on health and economic
19 justice, sort of the areas where we look specifically at and our
20 mission statement is "equal justice and opportunity for all Hoosiers".
21 Go ahead, next slide please.
22 So, this is a bit of a reiteration of what we've already
23 heard today but the overview and sort of the premise behind this
24 project is to show that there's a consistent relationship between
25 housing instability and average pregnancy outcomes. If we can address

1 housing, we can address that social determinant. Next slide please.
2 The project itself has several partners. I listed a few but
3 I also mentioned a few others. So, the lead partner is the Glassers
4 Maternal and Child Health Initiative, which is a project out of Indiana
5 University, the actual grantee of that.
6 The recipient of the Catalyst Funding is the Indiana
7 University Trustees. Then through that there are several different
8 buckets of work that are being done and I will talk about those in a
9 second but some of the partners include the City of Indianapolis, state
10 agencies, Caresource, the Manish Ketter organization, the Indiana
11 Justice Project which is us as well as several sort of affordable
12 housing related organizations.
13 Next slide please. There are essentially two interventions
14 to the--to the project. The first is the Healthy Beginnings at home
15 and the previous speaker did a really good job of describing the model
16 that's being done in Ohio. We're simply replicating part of that in
17 Indiana with our Caresource, who is also involved in the project in
18 Ohio so we're really excited to have them on board with that.
19 And the issue that I'm going to talk about today is the
20 intervention is the Health Justice Intervention. So, we're sort of the
21 lead organization working on this, this particular intervention. Next
22 slide please.
23 The simple premise--uh go back to the last slide please.
24 The simple premise between the health justice intervention is that we
25 use all available legal tools to improve housing, health, and security

1 for pregnant moms and babies on a systems' wide level.
2 So that's sort of where we started with our premise, and
3 we'll talk about how we do that with the next slide please. There are
4 essentially three buckets of work being done in this area. The first is
5 education. Know your rights materials and presentations.
6 So, this is going to consist of a periodic bimonthly
7 presentation given either in person or virtually to folks who may be
8 housing insecure, facing housing insecurity. What are their rights?
9 What are their rights when it comes to being--facing eviction or the
10 rights to--to healthy--healthy housing, a housing free of environmental
11 hazards, that sort of thing.
12 The second one is a strategic court advocacy intervention
13 and this has lots to do with sort of thinking about that engagement
14 with folks who are housing insecure and where that actually translates
15 to legal action so oftentimes it's talking about people who are facing
16 evictions in court cases that are sort of moving through the system.
17 That's also about a dialog with the judicial system. One of
18 the things I like to think about with this is if you, if you think
19 about how this -- talked about starting with health is the core and
20 then moving out to sort of looking at those social determinants of
21 health, in one way we're sort of looking at the legal sphere, the legal
22 judicial ecosystem and how we bring health considerations into that
23 conversation and what does that actually look like.
24 And finally legal analysis. So, helping both housing
25 related advocates as well as health-related advocates, understanding

1 how laws are currently written in Indiana affect housing insecurity and
2 affect health outcomes and then helping to sort of do that analysis if
3 there are proposed laws or regulations that would affect them.
4 That also includes looking at amending court rules when it
5 comes to how evictions are processed and seeing what that--how those
6 things may be changed as well. Next slide please.
7 All of this work we do in the health justice intervention
8 is also informed by--by what we call a health justice intervention
9 workgroup, and this is a group that meets monthly that consists of
10 housing law experts, licensed community leaders and other folks that
11 are interested.
12 We sort of talk about what are the goals of the--how are
13 the goals being achieved. What strategies should we tweak to achieving
14 interventions and that sort of thing. It's a really great place for,
15 for us to get sort of dialog and feedback. Next slide please.
16 So, within our first year we've sort of hit several
17 different--tackled several different objectives and feel really good
18 about sort of where we stand about the project. We are approved on our
19 IRB for our "know your rights" sessions.
20 We're actually having our first session tomorrow night
21 virtually. We're having thirty-three participants. We're really
22 excited. Part of this I should say, go just a step back. The theory
23 behind the "know your rights" is creating--giving rights--rights
24 bearers, giving them the sense of what rights they have, either
25 affected individuals or community partners so that they can become sort

1 of go to the community to help sort of explain and sort of be empowered
2 to sort of exercise those rights.
3 We have represented about four or five individuals in
4 eviction proceedings. I'm really excited to make sure that one of the
5 sort of the early successes that we'll be writing up is we recognize
6 the way that evictions in a particular court were being issued.
7 They need to be tweaked a little bit and for folks to be
8 able to apply for certain kinds of rental assistance. It was through
9 our advocates that we established that so you know, individual client
10 representation but obviously working with a judge to figure that out,
11 all of the folks who don't have representation in court, this is now
12 something that could be applied to them.
13 We've had two written products. One of those was a
14 commissioned product from the University of Notre Dame's Law School
15 Clinic that looks at Indiana's eviction laws and compares them to the
16 American Bar Associations sort of ten guidelines for stopping or
17 avoiding evictions and sort of says "how does Indiana compare"--and
18 this is useful for policymakers, useful for decision makers, judges,
19 that sort of thing as well.
20 Last week--excuse me, this month we had a piece published
21 in the Indiana Bar Association's Magazine that essentially said judges
22 and the courts and the laws should recognize the impact of evictions on
23 pregnant moms and babies in doing their legal analysis that went out to
24 over 8,500 members of the Indiana Bar Association.
25 We're really excited about that and the dialog that that's

1 going to be generating. We sat on the staff of the Housing Needs
2 Coalition Steering Committee which allows us to help inform the legal
3 implications or the health implications of some of the law and policy
4 that's being proposed in Indiana.
5 We sit on the Indiana's Core Superior Court Access which is
6 essentially the body Commission of the Supreme Court that looks at
7 tweaks to rules and court rule changes and how--and how can we sort of
8 look at equity as sort of being a reason to say--them to say this is
9 what we tweak this way and that way all with sort of the goal of
10 avoiding eviction and eviction trauma.
11 And the next week we're hosting our first annual Housing
12 Justice Conference where we're going to bring together a lot of legal
13 aid practitioners as well as community members, v research and analysis
14 folks to sort of say how do we sort of melt these fears in a way that
15 really does bring the health MCH issues to the legal sphere, to the
16 Judicial process and whatnot.
17 Next slide please. Well, that's the end of my presentation.
18 It's really exciting work. It's a lot of fun and we're glad to develop
19 partnerships for this. I'll be glad to take questions at the end and
20 thank you for your time.
21 MS. BELINDA PETTIFORD: Thank you so much, Adam, and again
22 we will take questions at the end. We're going to transition now
23 because Lashelle is in the room here with us and so we'll turn it over
24 to Lashelle.
25 MS. LASHELLE STEWART: Okay, well good morning again

1 everyone and I just want to thank you so much for having me here today
2 and so much of what has went forth for Healthy Start is actually doing
3 in the community.
4 And I feel like my presentations are out of order because
5 later on this afternoon I'm going to talk about who Healthy
6 Start--Baltimore Healthy Start is and what we do.
7 So, this Catalyst for Infant Health Equity Grant is just a
8 piece of what we do at Baltimore Healthy Start and I will say that
9 everything about this grant came out of our Community Action Network,
10 which Dr. Warren mentioned earlier. All Healthy Starts have those.
11 Our Community Action Network is made up of people from our
12 community, agencies, nonprofits, for-profits, businesses and our most
13 important members are members of our Healthy Start program, our parents
14 and so our parents at Baltimore Healthy Start are very vocal on our
15 Community Action Network.
16 We actually have what we call a Parent Leadership Group
17 which trains and helps them to have the confidence to speak in rooms
18 like this with people who have all these letters behind their names and
19 talk about what's important to them.
20 So, I'm very proud of our Catalyst for Infant Health Equity
21 Grant and you can go to the next slide. So, the Catalyst for Infant
22 Health Equity Grant's purpose is to support the implementation of
23 existing action plans that apply data driven policy and innovative
24 system strategies to reduce infant mortality.
25 Disparities in specific counties in jurisdictions and I

1 will say that our Catalyst Grant was funded by way of a planning grant
2 that we initially had because Community Action Networks have to have
3 action plans each year and so we received that grant initially to do
4 our action plan and we have all these big, hairy, audacious goals from
5 the Action Plan with no idea that funding was going to come about to be
6 able to do it.
7 And so, when the Catalyst Grant came about, we were like
8 "yes" and then we applied for it, and we got it, and we were like
9 "praise the Lord." So, all these things we thought were like pie in the
10 sky things, we were able to start implementing. So, we are so excited
11 to have this grant. Can you go to the next slide, please?
12 So, our Catalyst Grant will address housing for pregnant
13 women and families as it relates to the social determinants of health
14 and birth outcomes. Overarching goal of our project is to reduce infant
15 mortality and the disparities in infant mortality between the various
16 racial groups.
17 Next slide please. So, the social determinant is our focus
18 and I'm glad Andre talked about the social determinants of health. We
19 talked about social determinants of health since 1991, right and so the
20 focuses that this catalyst grant addresses is economic stability
21 through our university courses, through our housing affordability and
22 through our workforce development component.
23 The social and community context is addressed through
24 improving capacity, stability and engaging and strengthening our
25 residents. And the neighborhood and built environment is addressed

1 through working with our landlords to develop healthy housing, walkable
2 communities and greenspaces within our communities. Next slide please.
3 So, what we will actually do, our strategies, we have
4 housing navigators that will work with forty tenants per year to secure
5 affordable and healthy housing within our communities. We are asking
6 landlords or housing providers to commit to twenty-four-to-thirty-six-
7 month contracts because oftentimes our moms get into housing and it's a
8 year and then they are left to find housing again, which is very
9 stressful, you can imagine during the pregnancy and the postpartum
10 period.
11 So, we are asking people to do more long-term housing
12 commitments with our families. And I will say that this grant is
13 addressing housing not just with the tenants. We are engaging the
14 landlords to see what it is that they need to help them have healthy
15 housing for our families as well as educating our families about the
16 opportunities that they have for housing through public housing and HUD
17 and those opportunities as well.
18 The next thing is the education piece. So, the presenter
19 before me talked about educating our parents and we do have, within the
20 housing university we have courses, so we have 101 series and 201
21 series, where they are talking about their rights.
22 They learn about their rights. They have people come in
23 from the housing department to tell them about opportunities that are
24 available to them through the voucher program that they may not have
25 known.

1 We've talked about escrow and evictions and so all those
2 things our families are getting educated on, so they are better
3 informed as they go out and try to achieve housing as well.
4 We also are very happy to say are developing green spaces
5 within our communities with canopies and trees and just safe
6 environments for our moms to go out and enjoy as families.
7 And then we will be hosting landlord and developer
8 symposiums to provide information and support to landlords because a
9 lot of times it's not that landlords don't want to do well; they don't
10 know all of the resources that are available to them just as moms don't
11 know the resources that are available to them. So, we are engaging and
12 supporting them as well. Next slide please.
13 We are also advocating to make tenant assistance resources
14 more available to our moms. We're working with landlords, like I said,
15 to find out about exiting programs. We are equipping pregnant women
16 with knowledge and resources through workshops.
17 We are individualizing counseling and eviction grants
18 through our housing navigators. We do have funds to help people not get
19 evicted. We have funds to help people get their homes organized. We
20 have funds to do pest prevention because that's a big thing as far as
21 having safe and healthy housing for our moms as well too.
22 And then we have media campaigns that will amplify and
23 raise awareness to the sensitivity and the connection between safe
24 housing and infant health equity. Next slide please.
25 So, as I mentioned before, all of our strategies will

1 develop based on the planning grant that we received. During the
2 planning process the community was engaged through surveys, one on one
3 interviews and meetings to determine what they needed because a lot of,
4 we talk a lot about what everybody thinks people need but we went to
5 the community.
6 We're grassroots, we have boots on the ground. We are from
7 the community. I'm actually from one of the communities we serve as a
8 director, and many of our staff are as well.
9 So, we went to the community to find out what it is that
10 they thought they needed, what they wanted. Our moms were very vocal
11 and that's how the strategies came about. Next slide please.
12 So, some of our strategic partners, we wanted to bring
13 unlikely partners to the table because infant health and maternal
14 mortality and morbidity are important to us all and so people don't
15 often see the connection.
16 When we first chose housing as our priority in 2015, people
17 were like "housing? I mean, housing? How's that going to help the
18 baby?" and we were like "what? That's fundamental to everything else,
19 right?" And so now we're getting a lot of support around it but some of
20 our strategic partners are the Center for Urban Families, the Family
21 Survivor Network.
22 We have other partnerships that are right in the community
23 where our green space is being developed. The Family Survivor Network
24 is right on the corner of one of the green spaces so when we talk about
25 community base, it's definitely driven.

1 One of the young ladies that works with us, like the
2 community space backs up to her back yard. And so, this is--so I can
3 tell you those names, you won't know those people. They're from
4 Baltimore when I say that it really is community-driven and community
5 based, it really is community-driven and community based. Next slide.
6 So, I talked about and everybody else has talked about how
7 important housing is to infant mortality reduction and improving birth
8 outcomes. When we talk about Maslow's hierarchy of needs it's at the
9 base of the hierarchy of needs. You can't do anything else effectively
10 if you don't have a safe place to lay your head at night.
11 And so, that's what I want to drill home to everyone is
12 fundamental, it's fundamental, it's fundamental. We can't have moms
13 that have healthy babies if they don't have safe, healthy and
14 affordable housing and a thing that we would like and I see that Boston
15 I think he said is doing it, they have set-asides -- dedicated to
16 pregnant and recently postpartum women, just there are other
17 governmental set-asides for housing.
18 We're taking it to the landlords. We're taking it to the
19 private developers but if there were such a thing as a set-aside for a
20 pregnant woman during that pregnancy period to get into housing quickly
21 and not do the waiting list, just in a general population I think that
22 would be very helpful.
23 That's something that we're trying to advocate for in our
24 city and that's something if it were just on a national level available
25 to pregnant women it would definitely result in improved birth outcomes

1 and reducing infant mortality.
2 Next slide please. So, we're almost one year into our
3 Catalyst for Infant Health Equity Grant and we have had so many
4 successes. We have all of our staff on board. Our staff were trained
5 in tenant rights and everything prior to us opening the doors. We
6 opened the doors on April 11, 2023.
7 We did not have a kickoff until May 11th because April 11th
8 was during Black Maternal Health Week and we had a big event there
9 where we recognized some leaders in Black Maternal Health and I see Dr.
10 Joia, you came into the room.
11 So, we did, we wanted to give it its due, and so we had a
12 press release and a ribbon cutting and a launch on May 11th. We
13 currently have forty-four women in the program. Now mind you, we were
14 supposed to serve forty a year, but we have forty-four women in the
15 program already participating services being served by navigators who
16 are going to help them find housing, reduce all of those other
17 barriers.
18 I will talk about all the other things Healthy Start does
19 in concert with this to make sure that the women are getting everything
20 that they need in order to get into that stable, safe, and affordable
21 housing. Next slide please.
22 We do have the planning committee established for the
23 housing provider symposium, which is going to happen September 16th and
24 like I said that symposium is aimed at developers. We want to engage
25 them. We want to engage landlords. We want to engage all those people

1 who provide housing to our families and not just look to HUD.
2 Nothing against HUD. We love HUD but we want everyone to
3 come to the table and be a concerted effort to improve housing for our
4 moms in Baltimore. We have identified our plots for our green space,
5 and it just so happens that the community had the same vision that we
6 had so we have an oasis in mind of several blocks, and it's coordinated
7 through many community organizations that are going to make this
8 happen. I think that's it. Next slide.
9 Yes, that's it. So as everybody was talking, I had so much
10 to say. I know we had fifteen minutes. There's a lot I left out, but I
11 can answer questions just like everyone else. Thank you.
12 [Applause].
13 MS. BELINDA PETTIFORD: Thank you, Lashelle and thank you to
14 all of our panelists for this session. I have been waiting on this
15 session so I'm really excited to be able to--Vanessa and Sarah, I've
16 been warning them I'm probably about this session.
17 So, I wanted to take time to see if you have any questions
18 that anyone has, anyone on the committee or our appointed or ex-officio
19 members, any questions that you all may have? Yes.
20 DR. KAREN REMLEY: I would just make a comment to say how
21 incredibly important this is and it kind of connects with the social
22 determinants of health conversation. I'm biased of course being a
23 pediatrician, but social determinants of health starts when you are
24 conceived.
25 Not when you are an adult and even in my own agency, people

1 think of it as being a very--services are still very adult-focused or
2 mother and infant and we know that, you know, if you graduate from high
3 school, your opportunities to have better social determinants of health
4 increase.
5 And so, I think for this group the more we can talk beyond
6 even infant and maternal mortality but that really having the best
7 opportunity for you know pregnant women and babies is the cheapest way
8 to impact social determinants of health and our country still doesn't
9 get that, but you know, yeah--but the work you all are doing is so
10 important so thank you.
11 MS. BELINDA PETTIFORD: No, thank you. Others? Yes Kate.
12 DR. KATHRYN MENARD: Very naive question. This might be for
13 Andre, or it might be for others that, I don’t know, very naive
14 question.
15 You know, we know, and we learn more a lot about how
16 services support individuals, right, that are--that are in need. And
17 I'm thinking about agriculture, you know, we do a lot to support our
18 farmers and that's the thing.
19 I'm just wondering if there's any programs at the federal
20 level to support those who are landlords, who kind of know--who support
21 affordable housing so that it makes it easier to you know, to serve
22 that clientele in a way that's sustainable?
23 [Off mic chatter]
24 DR. KATHRYN MENARD: Sorry, so in my understanding what HUD
25 does or other to support the landlords who support affordable housing

1 but if we can support that infrastructure in a more robust way then it
2 makes it easier for clients to--you know, for individuals to seek
3 affordable housing and stay in affordable housing and meet the rent
4 obligation, etc. and not face eviction notices. You know, it's more
5 upstream I guess is what I'm thinking.
6 MS. VERONICA HELMS: I guess--you can go ahead, Alicka. No,
7 no, go ahead. I'll follow you.
8 MS. ALICKA AMPRY-SAMUEL: And that's, so just, just the
9 start of it, we do--so my role as a regional administrator is in the
10 field and so we have ten regional administrators. One of the reasons
11 why I'm actually here and the Secretary wanted to appoint me to this
12 particular committee is because it's moving away from HQ, right?
13 We love the smart folks in headquarters in DC but this is
14 to make sure that we are on the ground and so when you're--Lashelle
15 when you were talking about landlords and having a symposium for the
16 landlords, that's the work we do every day as connecting to make sure
17 that landlords understand the programs that we have available so we're
18 intentional about landlord outreach.
19 And just for a quick example. If we have a landlord that's
20 deciding to come out of our program, we're going to do everything that
21 we possibly can to make sure that they stay within it and figure out
22 other resources or other programs to keep the units affordable.
23 So that's the work that we do every single day on the
24 ground outside of you know, all the smart people at headquarters. Does
25 that answer your question?

1 DR. KATHRYN MENARD: Yeah, in part.
2 MS. VERONICA HELMS: And just to piggyback off of hat
3 answer, which I think is so--rings so true of like when you think of
4 the folks on the ground, it's FPN, it's like building these
5 relationships because we have the same ten regions and I think those
6 opportunities are there I would say at headquarter level because they
7 sit in policy development and research, we tend to be very research
8 focused obviously and less programmatic.
9 There is a large focus, particularly with the last
10 administration on why landlord participation was so low because we
11 realized there's a huge issue when we give vouchers that the act of
12 getting a voucher and then actually "leasing up" is the phrase we use,
13 leasing up for voucher success, is not that great right.
14 Sometimes folks will get vouchers and not be able to use
15 them and there has been a lot of focus on interviewing landlords and
16 understanding why don't you participate in the program and if you do,
17 how can we better fill that program. I think that research has been
18 published but let me see if I can find it and drop it in the link.
19 But we certainly do realize that there's an issue just from
20 a research perspective.
21 MS. ALICKA AMPRY-SAMUEL: And just one last thing. We also
22 provide a lot of incentives to get more folks interested in our
23 programs and then when you look at our voucher programs across the
24 table, we're doing more direct financial funding and support for things
25 like security deposits and just other ways to make it more attractive

1 to be a landlord.
2 MS. BELINDA PETTIFORD: Adam, can we get you to a
3 microphone? Thank you. And then we'll go to Lashelle.
4 MR. ADAM MUELLER: Sorry about that. Are you able to direct
5 some of your vouchers and things like that directly to pregnant people
6 because I remember that was something that we had talked about a year
7 or so ago and it was a real challenge, so it still remains a challenge
8 because I think that kind of gets developer to--
9 MS. ALICKA AMPRY-SAMUEL: And so, for us that's working
10 directly with our Continuance of Care, our COCs in addition to our
11 public housing authority but with our COCs they all come from different
12 backgrounds. They work with and cater to certain populations and so the
13 funding will go towards, or the vouchers will go towards, those
14 programs and there are some that work exclusively with certain
15 populations.
16 MS. LASHELLE STEWART: I was just going to give some
17 information about one of our surveys. Only thirty percent of the
18 landlords that we survey accepted Section 8, housing projects at
19 eighty-four percent indicated that they would be willing to accept and
20 earmark units for pregnant women if the women were participating in a
21 program that helped support them, educate them and help them with the
22 housing. So like you said, the need is there and so that's why we
23 wanted to extent the hand to the landlords because a lot of them are
24 not participating in the programs that can help them as well as our
25 families and they just need the help, just like our families need the

1 help so--
2 MS. BELINDA PETTIFORD: Thank you for keep bringing up
3 that--
4 MS. LASHELLE STEWART: That voucher program for pregnant
5 women.
6 MS. VERONICA HELMS: One thing that we've been talking about
7 at headquarters that I think has been kind of an issue is we would love
8 to nationally see a carve out of vouchers for pregnant women, however
9 the issue is a fair housing issue because it actually discriminates
10 based on family status and gender which are both protected classes.
11 So, it's kind of one of those things where the Fair Housing
12 Rule tends to you know, make these positive changes but then there's
13 unforeseen consequences so we're trying to figure out, like, how we can
14 work around that, but we haven't had much success. Sorry, I didn't
15 need to interrupt. Go ahead. [side chatter].
16 At a national level we would love to see a buildout of the
17 program, but we just haven't gotten here yet unfortunately.
18 MS. BELINDA PETTIFORD: Thank you, and ShaRhonda I see
19 you've put a note in the chat. Do you want to read your question, or
20 I'll read it?
21 Chair reads question. "Are there ramifications if a
22 property owner or landlord is not providing or maintaining the property
23 appropriately?"
24 So, I don't know what the ramifications are. Alicka looks
25 like she's getting ready to answer it. I'm thinking Adam the Attorney

1 might also be trying to answer it.
2 MS. ALICKA AMPRY-SAMUEL. I'll put the lawyer part of me on
3 the other side. But yeah, we do have enforcement departments. We have
4 departments where you can file a complaint, I work out of the field
5 policy and management.
6 We're like the first eyes and ears to the community so you
7 can reach out to our office and then there's a division, our
8 multifamily division, asset management division that will be the ones
9 to connect with our contractors who work directly with our vendors, our
10 landlords if there's a problem.
11 I usually find myself and other regional administrators at
12 these buildings talking to property managers and the residents to make
13 sure that our families have the support and decent housing that they
14 deserve.
15 MS. BELINDA PETTIFORD: And when you're talking to them do
16 you also let them know about other resources? Just trying to close up.
17 Of course, okay.
18 Adam, I see maybe you're going to chime in?
19 MR. ADAM MUELLER: In addition to what was from a tenant's
20 perspective there are rights under--every state law has a code that
21 could be enforced and there's also local law enforcement can enforce
22 codes for, irrespective of what apartment is subsidized or whatnot. The
23 problem from a tenant's perspective is that it's difficult. It's just
24 very difficult to enforce these things.
25 You know if you're not caught up on the rent you're

1 essentially, your arguments are dead in the water but you know, finding
2 an attorney that would help represent you during the process, taking
3 the time off of work to go to court, taking pictures, there are all
4 sorts of hurdles.
5 Not like we're trying to give you an art project, it's to
6 reduce those hurdles and barriers as much as possible so that folks
7 know their rights and enforce them in as easy a way as possible.
8 MS. BELINDA PETTIFORD: Thank you, Adam. And Lashelle?
9 MS. LASHELLE STEWART: I just, as far as Baltimore locally,
10 talking about our parents again, in 2018 our parents helped to
11 influence a law for Baltimore because it had not existed previously
12 that landlords, all landlords in Baltimore had to have a checklist
13 before renting and so now our moms, they talked about what they needed
14 to have in the homes in order for them to be safe and healthy and so
15 that law passed in 2018 that all landlords, even individual property
16 owners.
17 Before it was multi property owners and a lot of our moms
18 live in single family homes and so now they do have that checklist,
19 they do have to get that inspection before they are able to rent and we
20 did a big campaign in concert with a lot of other agencies in Baltimore
21 to make sure that people are aware of that law so that if they move
22 into a place that has not been inspected then they have that recourse
23 to make sure that it is up to code and up to standards for the city.
24 MS. BELINDA PETTIFORD: Good to hear, thank you. Other
25 questions? We have a few more minutes. No other questions. We want to

1 thank this awesome panel. Thank you all for taking time to be with us
2 and sharing your perspectives and your expertise and again we are
3 excited to have Alicka to hang around with us to stay on as an ex-
4 officio member because I just think this is one of those topic areas
5 that's not getting ready to go away.
6 So, thank you all so very much and we appreciate you all.
7 [Applause]
8
9 **Public Comment**
10
11 MS. BELINDA PETTIFORD: So now I'm going to turn it over to
12 Vanessa because we're going into the public comment period though we're
13 a minute or two early so we will see where we are with public comment.
14 MS. VANESSA LEE: Thank you, Belinda. As Belinda mentioned,
15 all of our advisory committee meetings we spend a portion of the agenda
16 on providing the opportunity for comments from the public and people
17 are able to submit them in writing.
18 We received some written public comments that the
19 Committee--you should have received in your briefing book and then we
20 had a number of people sign up to provide their comments orally and we
21 actually had to split the group up between the two days.
22 So I have a list of those that are prepared to provide
23 their comments today, on Tuesday and I'm just going to state the names
24 in the order that we received them so that you sort of know when you
25 are up, but we are going to start with Candi Cornelius from Oneida

1 Community Health.
2 Candi, I'll let you get yourself teed up and you can be
3 sure you can unmute yourself. After Candi will be Dr. Joia Crear-Perry
4 who is here in the room with us from the National Birth Equity
5 collaborative and then I've been scanning online to see if Christine
6 Farmer is on. You would be on third.
7 Sosie Love Thurman from Seattle Health Board, if you're in
8 the Zoom we'll keep an eye out for you and then John Mueller. If you're
9 online again we'll look out for you on the Zoom as well.
10 But why don't we first start with Candi Cornelius online.
11 Are you able to unmute, Candi?
12 MS. CANDI CORNELIUS: Yes, can you hear me?
13 MS. VANESSA LEE: Perfect, thank you. Thanks for being here.
14 MS. CANDI CORNELIUS: Yes, thanks for having me. My name is
15 Candi Cornelius. I am from the Oneida Nations. I work here in Oneida,
16 Wisconsin as the Prenatal Care Coordinator, which is key benefit, which
17 is where I provide support and education to first time moms.
18 We have a contract with a nearby Prevea where we have the
19 OBs come in and see our clients. This is very rare. Most other tribes,
20 there -- is probably an LCH nurse. Do not have OBs and I believe one of
21 the reasons is HS funding.
22 I noted this earlier that LHS is severely underfunded.
23 There was an article stating when some of the facilities had to close
24 there was people who actually died because they had lost their care
25 provider. A proposal in the '23 budget was possible for more funding

1 but it -- versus sustainability.
2 I see somebody else in the comment section where they also
3 noted in tribal communities that they have one person doing all
4 maternal health work. That's me. I have no assistant. There's other
5 community health workers but their focus is elders, which you'll find
6 pretty common in tribal communities. Elders come first. So additional
7 funding obviously is a need and a concern here in Oneida and probably
8 all tribal facilities throughout Wisconsin.
9 I also wanted to note, I've done a lot of presentations on
10 maternal and child health, specifically on Native Americans and I
11 wondered often all of the research has pointed out specifically and
12 this is Native American-specific past research has noted the timing of
13 maternal mortality.
14 They know it's over forty years old. They give you a
15 timeframe. It's due to pregnancy and they give you the causes, you know
16 they list see cardio and hypertension. Where are the treatments? What
17 are the solutions? What are the next step to finding some remedies for
18 this?
19 I've been here twelve years and I've not seen really any
20 change in OB practice, as far as tests, care, increase visits, increase
21 tests, anything like that. The only thing I remember was March of Dimes
22 when they would tell us to stop inductions. There was a toolkit
23 encouraging hospitals without medical conditions at thirty-nine weeks,
24 a week from now no changes and we've stopped many preterm births so
25 that's my wish, my goal, my concern is we already have the research.

1 Where are the actions taking place?
2 Another thing is I had seen, and I was really--it was nice
3 to listen in on all of the updates because one of my concerns was WIC
4 since COVID, majority of my patients are not even willing. I just
5 reached out to the WIC supervisor, and she said there's no in-person
6 visits until August.
7 So even though our state of emergency within our tribal
8 reservation has ended, WIC and I don't know if it's according to the
9 FDA or who's giving them but their doors are still closed and for
10 people from minority groups, it is so important to walk through a door,
11 meet the person, you know develop that trusting relationship, hear it
12 from somebody about what the programs involved.
13 So, I really think within my population it's a lack of
14 information. Some people thought, well new moms--"I don't want to get
15 the dad in trouble." They think it's kind of like child support so
16 super -- education. They don't feel it, I mean I give them a to-do list
17 and they don't feel it is a priority probably because of that lack of
18 information, that lack of trust.
19 And like I said, the lack of actually in person. So that is
20 also a big concern and I hope for change for that and I hope with the
21 recruitment there will be a big turnaround, once I was able. Because
22 before I was able to walk my patients right down there, have them talk
23 to somebody and enroll and that would be that.
24 But you know, over half of my clients that I follow are not
25 enrolling so definitely there I see a need for that so there is going

1 to be more recruitment and awareness, but I just wanted to tell you a
2 little bit what I think with the population.
3 And lastly is to note in the research that I did I found a
4 rate of severe maternal morbidity, how old they were before they're
5 pregnant, while they're pregnant and within the last 20 years there was
6 a study between 1993 and 2014. The maternal morbidity rates increased
7 200 percent. So, for me this is prevention.
8 We need to step back and talk about well women visits; do
9 you have a primary? Getting further going into high school. We're just
10 having a lot of women enter pregnancy unhealthy, obviously leading to
11 complications and leading to that high risk of morbidity and
12 unfortunately mortality. So, I just wanted to note that.
13 The method of delivery. It was also nice to hear that more
14 research projects are going to be done. I’m also involved with a
15 research project with UW Madison, a Native American medical student. We
16 are going to look at the change in method of delivery. I'm in Brown
17 County right now and when I started in 2011 within two to three years,
18 I noticed a big change from a vaginal to a primary cesarean and then
19 just repeat, repeat, repeat.
20 Where's the VBACs? Where's the vaginal birth after
21 delivery. And medical student dove into the data and proved that to be
22 true. The rates of VBAC increase on a very small rate for all races,
23 Black, Asian, Hispanic, White; Native American--none.
24 So, we're looking on right now interviewing patients who
25 received care here who have a primary and then a repeat and they are

1 given education. Was it a personal choice? Did you feel persuaded? All
2 those types of things. Or is it something medical that once again
3 prevention before pregnancy may be the solution? So, method of delivery
4 is also a big concern here.
5 And obviously we talk about expenses. It’s twice as much to
6 have a cesarean and then all the complications that go around with it.
7 Well, I guess that's it for me. Any questions you may have or
8 references that I need.
9 Another one I see is Healthy Start. I did mention this last
10 time. We did qualify for the Healthy Start I want to say in 2015 and at
11 that time it was due to infant mortality rates we qualified. Had an
12 excellent program coming and then we did not re-qualify.
13 So, I don't know if that meant we met the goals and then
14 didn't requalify but that was a real disappointment because that was
15 additional staff into our tribal clinic that was focusing on moms and
16 babies.
17 So just interested to see what the qualifications are for
18 that grant and with the three years possible extension we have probably
19 a full year for our staff just to get trained here on automation,
20 policies, procedure having to do with Healthy Start so they really got
21 maybe a year and a half in of true Healthy Start so we always have a
22 problem with those two year grants and so just looking at
23 recommendations to qualify and extending the grant cycle. Thank you.
24 MS. VANESSA LEE: Thank you so much, Candi. We've taken all
25 of that feedback. I know in the room I see lots of note-taking by the

1 members. We will try to save some time at the end for any reactions or
2 comments by the committee members but for now thank you again, Candi.
3 I'm going to move to Dr. Joia Crear-Perry in the room.
4 DR. JOIA CREAR-PERRY: Hey Vanessa, hey y'all. It's been a
5 crazy couple years, huh? How are you feeling? I'm just happy to be back
6 here with y'all. Let's just say that to begin with.
7 So, I am Joia Crear-Perry. I'm an OB-GYN by training and
8 the Founder and President of the National Birthday Equity Collaborative
9 and I can note out on every single presentation, as I've actually
10 worked with almost all of those groups from Boston to--I guess, you
11 know, we can have a whole conversation about Baltimore, but I really
12 want to just pull us back a little bit.
13 Because back when Kimberly walked in with me earlier, I
14 remember that in 2019 we were really on a path to undo the root causes
15 of racism, classism and gender oppression that are deeply engirded
16 inside these institutions and we were having a robust conversation
17 about that and I think between the pandemic and all of our lives we
18 just haven't been able to go back to that.
19 I was working with her in housing back in 2016. So, we've
20 been having these conversations, you know for a while, so it feels big,
21 and it feels hard because it's everywhere but if you remember that at
22 the founding of this country was a belief of a hierarchy of human value
23 based upon race, based upon gender, based upon geography.
24 So, the reason that your work feels really hard and heavy
25 is because you're undoing a fundamental basic understanding of how we

1 treated all of your institutions, right. So, like if know that HUD was
2 created and people were put in big housing, I can use New Orleans where
3 I'm from. So put in big housing facilities where they didn't--because
4 they were housed and basically quarantined in a part of the city, and
5 now you're putting them across the city.
6 You made no infrastructure for that because your basic
7 assumption was we've got to put them all together to keep them away
8 from others. Once you undo that assumption, it changes fundamentally
9 how you do your work.
10 If you believe the reason women have c-sections or
11 hysterectomies is because they're hysterical, then all of your work is
12 how do we make these women start acting better versus how do we ensure
13 they have the social supports they need across the community?
14 So, the framework, we have in fact, we have created a thing
15 with ACOG called the "Cycle to respect for maternity care." It's
16 research-y and nerdy as the people at HUD were talking about but the
17 point was when we actually talked to women what they wanted first was
18 for us to unlearn the harmful things that we were taught.
19 I speak in the eye. I was taught in medical school that
20 there were three biological races. In the 1990's. This is not--I'm not
21 talking about sharecropping, I'm talking about 1990's. I'm not that
22 old, right? So, my embryology teacher said there were three types of
23 skin: Mongoloid, Caucasoid and Negroid.
24 That means that there are people who are my age, fifty-
25 years-old across the state of Louisiana who were taught the same thing

1 in their nursing classes and their--so they believe the reason people
2 have--don't feel, don't need a c-section.
3 All these things y'all were talking about comes from our
4 basic understanding of how we were taught and trained so we have to
5 unlearn those things. We have to know that race, gender is a social
6 construct. Girls are not better at cooking and sewing and boys are
7 better at sports. All of those things were made up for power and
8 control.
9 So, the more that we can work on in each of our
10 institutions and learning that what Baltimore has started doing works
11 because they are working with landlords to unlearn bad habits. They
12 learned that all the tenants are going to be awful and so they have to
13 unlearn that guess what? Pregnant people are not actually awful.
14 Just as the tenants have to learn that if you were always
15 in a place where all your bills were paid and you have to pay a light
16 bill for the first time, it is a big to do. Like we have not even
17 accounted for that so when you talk to patients, you talk to clients,
18 and they move from big housing to being somebody's tenant they
19 obviously have never done that before.
20 So just to blame them for not paying their light bill when
21 you have not accounted for--you've not even accounted for it and now
22 they have to pay one, it makes no logical sense. Like it really--so
23 this is what the people on the ground have to do right now. It has
24 moved from kind of centralized.
25 So, the beauty of HRSA, this is my last thing I have to

1 talk to Dr. Warren about this. So, CDC has a brand. People know CDC.
2 NIH has a brand. People don't--nobody has heard of HRSA. Y'all do so
3 much work. You are the Health Resources and Services Association.
4 You're supposed to be--so when I think about Title X, Title V,
5 midwifery, all the stuff that I do, it start with you all.
6 So how do we ensure that HRSA understands it's role, sees
7 itself as a big boy. You're as big as CDC and NIH. What are you doing?
8 How are you unlearning the things that created you to be in these
9 silos? Why do we keep having to re-up the need for title money for
10 maternal and child health? It makes no sense.
11 We're begging for money for moms and babies in a country
12 that has the worst outcomes for maternal and child health in the world,
13 in the industrialized world. This is what I--the reason I get to go to
14 Geneva all the time is because y'all aren't branded well [laughs].
15 Okay? I get invited to the UN because we have the worst
16 outcomes in the world and the world looks at us and thinks we look
17 crazy. We spend a lot of money on a bunch of things that don't make a
18 lot of sense. So, I'm offering and asking, not that you have to hire
19 and beg for our respect for maternity care.
20 There's a lot of other people who are doing--my colleague
21 Karen Scott has "Undoing Obstetric Racism". This is not about me
22 promoting my product. This is me asking for us to re-think and re-learn
23 how we do our work, all of us. No matter where you sit.
24 If you are at a research, at a university. If you are
25 running public policy for HHS. If you fundamentally believe we are

1 broken and your job is to fix us, I don't need you to do your job
2 anymore.
3 If you understand none of us are broken but there have been
4 systems and structures and policies that have been trying to break us,
5 and you have the power either through your vote or through your work or
6 through your policy making to undo that then you enter your job every
7 day very differently. You show up very differently and you show up for
8 the patients and the clients very differently.
9 So that is my request for this committee to really rethink
10 and unlearn the harm of white supremacy because it is killing all of
11 us, so that is it.
12 MS. VANESSA LEE: Thank you, Dr. Joia. Always a pleasure to
13 hear from you and it has been a long time. Thank you, thank you for
14 coming in person too. I am going to move us along. I know we have lunch
15 in a little bit.
16 Kristen Farmer, I've been looking out in the Zoom. I don't
17 see you but if you are here online and want to raise your hand we'll
18 circle back. I do see Cecile--oh, thank you Christian. Nice to see you.
19 And then after Kristen we're going to have Socia Love-Thurman in the
20 Zoom, just to tee that up and then John Mueller last.
21 Thank you for being with us Kristen, you're on.
22 MS. KRISTEN FARMER: Thank you and good afternoon. So, we
23 have enjoyed this session. My name is Kristen Farmer and I've been
24 working in maternal and child health for the last eight years. I'm the
25 founder of a nonprofit organization in Cleveland and Akron Ohio called

1 Birthing Beautiful Communities.
2 It's where we are working to preserve the sanctity of
3 birth, that was why I was interested in birth in the first place and
4 I'm a big advocate of midwifery.
5 So about two years ago, over two years ago after having a
6 ton of success with the organization that I founded as a perinatal
7 support agency, a doula agency to be able to train women to become
8 doulas and provide services free of charge to women in the Cleveland
9 and Akron Communities of those doula services.
10 I got to this place where I sort of had this breaking point
11 to where I was seeing some improvement in outcomes in the work that we
12 were doing but I was not seeing the impact that I really wanted to see
13 across the spectrum of birth work itself. I took a sabbatical and it's
14 been over two years and I sort of went on this sort of spiritual
15 journey because I wanted to find out and understand deeper as to why
16 were we seeing the outcomes, the poor outcomes that we were seeing.
17 Because at first my question was why are Black babies dying
18 at the rate they are? But my question became a deeper question when I
19 started to ask why is it that Black people have the worst outcomes of
20 pretty much everything, across education and all systemic issues.
21 And I wasn't satisfied with the answer just being systemic
22 racisms because that's one factor but that's an external factor and so
23 what can we do internally, empowering ourselves in order to overcome
24 any barriers that have come up against us.
25 And so, I created sort of this outline of strategies so to

1 speak, as to what I believed anyway that will help to improve birth
2 outcomes and the first thing is that most of the programs that we have
3 are very systems focused.
4 We have to incentivize women to participate into them and I
5 think that a part of us don't really think about the fact that systems
6 are created or made up of communities and they communities are made up
7 of families and families are made up of individuals.
8 And so, if we want to see communities change then we have
9 to change first. Our external chaos that we see within our society and
10 communities is just a reflection of our own internal chaos and so what
11 do we do about that? And how do we empower ourselves and how do we
12 empower the people around us so that we all feel empowered to advocate
13 for ourselves in whatever spaces were are in.
14 And so I put the part of the program in that I had been
15 developing under Birthing Beautiful Communities and since have been
16 around empowerment and because if a women does not feel empowered
17 within herself, if she has a negative self-image about herself so then
18 it's going to be hard for her to advocate for herself which is why
19 doulas are so powerful and so important because even if the mother
20 can't advocate for herself there is someone who can advocate for
21 ourselves.
22 But are we creating spaces for women to be able to gain
23 that positive self-image and look at themselves as powerful beings on
24 this planet who have the capability and ability to empower themselves.
25 The second thing is that according to March of Dimes, we

1 have close to 1,100 perinatal deserts across the United States and a
2 part of that is because we don't have a traditional birth worker
3 pipeline. For a long time, I have been thinking about how do we get
4 younger women into the profession of birth work by even teaching middle
5 schoolers and high schoolers about birth because we don't really learn
6 about our bodies.
7 And there are women that want to have babies and those that
8 don't have babies so a lot of times women are just finding out about
9 their bodies when they become pregnant and so by that time the
10 education curve is, I don't want to say necessarily too late but it's
11 definitely a curve and so you know we can do a better job at educating
12 and normalizing birth in our younger years, in middle school and high
13 school years.
14 And it's also a way for us to recruit more women or just
15 people in general who would become a part of the birth work pipeline
16 that would include doulas and midwife assistants and midwives and also
17 those who want to become OB-GYNs.
18 Another point is that the United States is not "home birth"
19 friendly. And not as either to midwives because considering that most
20 of the developed world primarily those births are attended by midwives
21 but here in the United States about ninety-five percent of births are
22 attended by physicians.
23 And we love physicians but midwives absolutely do serve a
24 purpose because close to eighty-five percent of women can birth without
25 complications and so I would like to see an increase in midwives, even

1 in this committee.
2 I have heard the term midwifery a few times since I've been
3 in here, but I looked at the list and I didn't see any midwives who are
4 a part of this advisory committee and I think that those are very
5 important voices that absolutely should be at the table.
6 I think that we also should work on earmarking funding for
7 traditional midwifery and given more opportunities for women or for
8 people to just become midwives as well because again, and I cannot
9 stress enough the importance of midwives and women having options to
10 birth in hospital and birth outside of hospital and birth without fear
11 that they may get in trouble if they want to get--they want to give
12 birth at home.
13 And I think that mothers and fathers and families overall
14 just need more financial support and flexibility because two things
15 certainly can be true at the same time. On one end there is a very
16 basic need, the housing, the shelter, the food.
17 Those things are very important but that self-actualization
18 part is also important to us so whatever we're doing to give the
19 support in that space to those people, those individuals and those
20 families that they develop a positive self-image about themselves
21 because if they have a positive self-image about themselves they can
22 empower in any spaces, even beyond the maternal child health space.
23 And lastly, I absolutely believe in the power of doulas and
24 so I would like to see more support and there has been. When I first
25 started this work in 2014 in my city nobody had even heard of what a

1 doula is. Or what a doula did so that was like a completely new concept
2 and so I think overall I just would like to see a lot more innovation.
3 Because I know that there's been a hiatus and there was
4 COVID and we have been sort of on a break but this is the first
5 maternal and child health meeting that I've been to in over two years
6 and you know a lot of the same conversations are still happening around
7 social determinants of health and equity. So, we have to survive those
8 challenges to get back into our creative genius and think about these
9 things in a very innovative way.
10 Think about it outside of the box, forget, you know, the
11 rules that we could really challenge ourselves to solve this issue.
12 Thank you.
13 MS. VANESSA LEE: Thank you so much, Christian for your time
14 and your comments. Dr. Socia Love-Thurman is on next, and I want to
15 thank the committee members for letting us drift a little into your
16 lunch break. Dr. Socia Love-Thurman are you on?
17 DR. SOCIA LOVE-THURMAN: Well, I won't take too much of your
18 time since I know that you're going to lunch but thanks for having me.
19 My name is Socia Love-Thurman and I'm a resident of
20 Cherokee Nation of Oklahoma. I'm also UT in Delaware and I serve as our
21 Chief Health Officer for the Seattle Indian Health Board. And I would
22 just say I got to speak with this committee not too long ago in
23 September when you had your meeting at -- so hello again.
24 I want to just kind of bring the voice to urban Indians as
25 I always want to just because the funding isn't always in our favor to

1 be able to do the work that we need to do.
2 So, we are a qualified health center, Urban Indian
3 Organization as well as a Tribal Epidemiology Center, the only in the
4 country that does the actually for all Indian programs.
5 We've been in operation for about fifty-two years now,
6 providing care primarily for our American Indian and Alaskan Native
7 population but we're for all people in what would we call "the Native
8 Way". And so, I work here in our clinic providing direct clinical care
9 and care as well.
10 One thing I always want to reiterate is that seventy-six
11 percent of American Indian Alaskan Native people are in areas and so we
12 are a really valued part of the IHS continuum of care -- we need to do
13 this work.
14 And so, one of the things that we have been really striving
15 for is really thinking about how we can create more culturally attuned
16 community-based programming and I just want to piggy-back on that, on
17 what Christine just mentioned. As a direct care practitioner, what I'm
18 seeing a lot of is that as Urban Indians we don't always have access to
19 IHS Hospitals or places or people to feel like they get culturally
20 taken care of.
21 And of course, as we all talked about the racism and just
22 active genocide that our people feel when they enter hospitals is
23 really traumatic. So what I'm hearing from a lot of folks lately is
24 we're losing prenatal patients because they don't want to deliver in
25 the hospital and we don't have really a place for them to deliver and

1 so I do want to piggyback because what I hear a lot of our patients
2 wanting is more committed midwifery services.
3 And so that isn't something that we have offered in our
4 clinic just yet, but it is something that we're really looking forward
5 to bringing because one thing that people need is options. People just
6 want to be able to know whether they can have a stay at home birth and
7 we can do everything that we can so they can feel safe.
8 We realize those fears, births that could happen and we
9 work really closely with hospitals so that there isn't this stigma or
10 shame that happens when you need a transport to the hospital from the
11 home birth that needs higher level care.
12 And midwives may be a really good bridge for this. So, it's
13 actually something I've been thinking about a lot for the people that
14 we serve here is what can we do that is different? We do have to think
15 outside of the box because I continually hear about the harm that is
16 happening and I've seen it when I worked in OB at the local hospital.
17 That it's just really, really harming our patients but it's
18 actually harming the brown and Black providers as well in the hospital.
19 And so, it's become very difficult to be able to really advocate for
20 real, rural intervention, delivery assistance. So, I just want to put
21 that out there.
22 The other thing I've been really seeing a lot of is you
23 know so many of the things that have happened to our people, of course
24 we are seeing higher rates of suicide, violence, substance use and more
25 being talked about is interpersonal violence at home that is directly

1 affecting the health of moms and babies.
2 And so what I really want to advocate for is the funding
3 for more of our community space programming that can help, whether it
4 be doulas, workforce development to get more doulas, more midwives,
5 more advocates for the people in the community because we really need
6 to bring back that village of people who are around women during this
7 sacred time and be able to lay witness to some of the harms that they
8 can see when women aren't able to have that right now.
9 So, I'm really just highlighting because they mentioned
10 this, and I feel like we're just trying to play catch-up at this point
11 to create safe places for our women.
12 One of the things at SHB that we're working on is we just
13 purchased some property to reinstate our inpatient treatment program.
14 We're really excited about this. It will be a ninety-two-bed treatment
15 center in Washington state here that will also offer in-patient
16 treatment for pregnant and parenting people and provide onsite child
17 care for kids up to five.
18 And there is, you know, I think every early Indian program,
19 every child in Washington could create inpatient programming if we
20 wanted so we're going to be able to offer ten beds and that's something
21 that I'm really excited about but I hope that we'll continue to see
22 more funding to create more culturally attuned, innovative treatment
23 because studies have shown that our cultural like talking circles,
24 groups, candle board making and really teaching face-to-face can be a
25 really great way to bring pregnant people, especially if they've been

1 gone for a long time and suffering from addiction so they're back in
2 around.
3 Everything that I just piggy-backed on is important so are
4 doulas. Washington state just really copied that they were passed, and
5 more states need to follow suit and see doulas as--as important as
6 funding for our hospitals. And workforce development is a big part of
7 this.
8 More funding for bringing people up. I've heard all the way
9 down to middle school, I think is one thing that we don't talk about,
10 but we have the junior medicine program. We would love to have a nurse
11 practitioner program. A midwife program eventually, just the ability to
12 train more people of color to this work.
13 And lastly one thing that we're really excited about is we
14 did quality and we're calling for sovereignty which is very about
15 revitalizing these certain communities and so what we're going to be
16 focusing on with this funding is introducing indigenous focused
17 prenatal care.
18 But being able to create a curriculum that will take care
19 of women from conception up until at least one year postpartum, will be
20 able to bring their baby into the circle as well. Because one thing
21 that we often forget about is the postpartum period and how important
22 that is for women but also just the high rates of infant mortality.
23 So we're excited to be able to really bring people together
24 with a holistic approach with -- really at the heart of that with
25 teaching about ways and really try to revitalize a lot of the teaching

1 that has been lost in the groups and really take away some of the
2 Western purposed care and bring back more of our part.
3 So that's what I'm really excited about, and I can just
4 hope that we can share that with other women and tribal country. None
5 of that would happen if we didn't have amazing partnerships with our
6 community, including Hummingbird and the which is a group that
7 programming, and even tonight they are having a town hall that's
8 focused on mainly maternal mortality and community, and they're
9 bringing together tons of people to talk about it.
10 And so what I hope to see is that more of these town halls
11 are happening or actually mostly to the people in community groups who
12 are most affected by these terrible rates of mortality and so what's
13 happening is those community groups are stepping up to do that work and
14 I hope that other people can follow suite, that we years and we will
15 start to host and hear what the community really wants. Because
16 ultimately, they will have the answers that we need.
17 MS. VANESSA LEE: Thank you. Sorry, didn't mean to interrupt
18 there. We're starting to wrap up. Thank you so much. We've taken up all
19 of those comments and we just have one person following who's been
20 waiting patiently and thank you again to committee members.
21 John Mueller, could you unmute please?
22 MR. JOHN MUELLER: Yes. Can you hear me?
23 MS. VANESSA LEE: Yes, thank you.
24 MR. JOHN MUELLER: Yes. Thank you for accommodating me. My
25 name is John Mueller and I'm a retired public works engineer and former

1 water treatment professional and I thank you for this opportunity to
2 continue advocating for the end of artificial water fluoridation.
3 Last week I emailed materials to this committee, which
4 hopefully you have reviewed as they pertain directly to infant and
5 maternal mental health, respecting the AT THIS POINT's report on the
6 science and the current TSCA lawsuit to end fluoridation.
7 I am now going to read to you the brief closing statements
8 in an article published in this framed 1990 edition, twenty-four years
9 ago, of the Florida State University Journal of Land Use and
10 Environmental Law. The Title of the article is 'Highlights in North
11 American Litigation During the 20th Century on Artificial Fluoridation
12 of Public Water Supplies". And I quote "the end of fluoridation will
13 take time, but not because time is necessary to develop essential
14 scientific information. We already know and appreciate the enormity of
15 the risk. We knew enough many years ago, but the end will finally
16 arrive because as Aristotle said at the beginning of the Metaphysics,
17 "all men by nature desire to know"".
18 The article then finishes by telling us "ignorance cannot
19 be perpetuated forever. The necessary legal and scientific reforms will
20 come in the 21st century. Our descendants will look back on us and
21 they will be amazed." I pray that you will agree that the fluoridation
22 controversy has now reached critical mass, favoring the end of the
23 practice and that the time is now for ending dental treatment with our
24 tap water.
25 The current administration is telling us the time is now as

1 directed in President Biden's highest priority initiatives on
2 environmental justice and listening to the science spelled out in
3 multiple executive orders including 13985, 13990, 14008 and further
4 reiterating and promoting those in the more recent Executive Order
5 14091.
6 The rapidly increasing public awareness of this issue also
7 tells us the time is now. An article was recently published by an
8 online business news service about the current TSCA lawsuit. The
9 article has over a 120,000 views, just in its first few weeks.
10 In summary, it is time to apply the precautionary principle
11 and first do no harm. Current and emerging science tells us,
12 fluoridation is harmful to prenatal and early life brain development.
13 The precautionary principal can be embraced and applied most
14 judiciously and with integrity by the EPA conceding in the TSCA lawsuit
15 with coordination through the White House Environmental Justice
16 Interagency Council established an Executive Order 14008 Section 220.
17 Thank you again for this special opportunity to help
18 promote public health and especially the future brain trust of our
19 great nation. Thank you.
20 MS. VANESSA LEE: Thank you, John. And I apologize for
21 mispronouncing your last name and thank you again for waiting
22 patiently. I know we couldn't get to you at the March meeting so thank
23 you to the committee members as well for staying active and I'm going
24 to turn it back to our Chair and again I just want to thank all of
25 those that took the time to give public comments to the committee

1 members.
2 We have another set tomorrow but Belinda, I'll turn it back
3 to you.
4 MS. BELINDA PETTIFORD: Thank you, Vanessa and thank you all
5 for all of your public comments. I think if you stay around or have
6 time to stay around either today or tomorrow to start hearing the
7 recommendations that we may be trying to move forward in the future.
8 You may hear some of your comments again.
9
10 **Lunch Break**
11
12 MS. BELINDA PETTIFORD: So, thank you again for your time.
13 Now I'm going to ask the committee and apologize to them because we
14 still need to start back at 1:45 because we have a very--we don't want
15 to take any time away from our community voices session that is
16 scheduled to start at 1:45 so thank you all and everybody have a quick
17 but wonderful lunch.
18 Lunch Break 1:05 p.m.
19
20 **Community Voices**
21
22 Start 1:47 p.m.
23 MS. BELINDA PETTIFORD: So, we're coming back from lunch. I
24 hope everyone had a wonderful lunch no matter the length of time, as
25 long as you had a time to step away. We're grateful for those of you

1 who came back and appreciate it and if you're still eating lunch, feel
2 free to keep doing so. We are good with that.
3 And we're going to follow our agenda and we're moving now
4 into our community voices section of our agenda, and we specifically
5 asked these two individuals to come join us today. They are both
6 virtual but they're going to be talking about more on the social
7 determinants of health and specifically the work that they've been
8 doing in their engagement around the catalyst grants.
9 So, we will start with Taylor. Hi Taylor.
10 MS. TAYLOR THOMPSON: Hello.
11 MS. BELINDA PETTIFORD: We're going to let you get started
12 then. So, we have Taylor Thompson with us. She's of the Indiana Healthy
13 Beginnings at Home program, so we will start with Taylor.
14 MS. TAYLOR THOMPSON: Okay. So, I've been with the program
15 for I want to say for about two months maybe, give or take. I was real
16 skeptical about the program though because nobody ever calls and wants
17 to help you out. So [coughs], excuse me. I was first of all skeptical
18 about even doing the program. I didn't know if it was real and then I
19 ended up meeting with the individual that is--I guess you want to say
20 my case manager and she had talked me and guides me like through a lot
21 of stuff that I needed help with.
22 Because I was homeless with three of my kids, I was kind of
23 living with my mom and just like around with people I was cool with.
24 Even though, like I was working full time I had a steady income that
25 was not bad, I just couldn't not--one really afford to move and it

1 wasn't working in my favor. So, we were kind of homeless bouncing
2 around and then they came around and asked me if I wanted to
3 participate in the program and here I am two months later [laughs].
4 MS. BELINDA PETTIFORD: So Taylor can you tell us a little
5 bit about--I know you said you were skeptical so we understand the
6 whole issue of trust and trying to make sure that you're engaged with
7 people you already have a relationship with, That will help you move to
8 trust, but can you talk a little bit I know you've been in the program
9 two months but how do you think the program has been beneficial to you?
10 MS. TAYLOR THOMPSON: Well first of all they got me into an
11 apartment, pretty--pretty quickly. So now I have my own space. My
12 children are a lot happier. They're in their own space. So, it's a nice
13 relief that I don't have to worry about where they're going to sleep at
14 or, you know, what we're going to do for the next couple days. So
15 that's how it's been beneficial for me. So as far as like everything
16 else if I reach out to my case manager asking her for resources or
17 anything, she has you know made progress with getting me those
18 resources. When we have our weekly visit, she will look stuff up on her
19 computer to help me out.
20 MS. BELINDA PETTIFORD: Thank you Taylor Do you mind sharing
21 the ages of your children?
22 MS. TAYLOR. THOMPSON: Oh yes, the oldest is fifteen and I
23 have an eight- and nine-year-old and I'm currently twenty-nine weeks
24 pregnant with my last. My baby girl.
25 [Laughter]

1 MS. BELINDA PETTIFORD: We hear you, dear. If there's
2 anything you know if you think about the program that you've been in,
3 and you think about the efforts that have been to support you with this
4 because again we understand that you had to get comfortable with it
5 first.
6 MS. TAYLOR THOMPSON: Uh-huh.
7 MS. BELINDA PETTIFORD: Is there anything that you would
8 like to recommend or share with the committee as to how a program like
9 this or similar program could be supportive to families?
10 MS. TAYLOR THOMPSON: Yeah because, I'm from Indiana and I
11 feel like Indiana has very limited resources for one--single parents.
12 You know, we have the basic stuff like the foods stamps, the SNAP,
13 state insurance stuff like that. Some people get Section 8. But I feel
14 like we're very limited.
15 So that's why people who like really need the help, who's
16 trying, I feel like it would really benefit. Especially pregnant women
17 I feel like it's hard on pregnant women. At least I know for me because
18 I'm a high-risk pregnancy. So, my work schedule is way different than
19 it was before when I was pregnant. So, the program, like having a
20 program to try to guide you. It's nice because I don't have to worry
21 about if I'm able to make rent, if I'm able to pay bill, like it's
22 stress free.
23 MS. BELINDA PETTIFORD: That is good to hear that it is
24 removing a lot of stress from your life which we know the impact of
25 that on your health as well as the health of your family.

1 MS. TAYLOR THOMPSON: Yes.
2 MS. BELINDA PETTIFORD: I would like to open it up to other
3 members in the room or who are virtual if you would like to ask Taylor
4 any questions, or Taylor, we can let Drena speak and then come back.
5 Maybe we'll go there.
6 MS. TAYLOR THOMPSON: Okay.
7 MS. BELINDA PETTIFORD: So, Taylor, will you be around for a
8 little while?
9 MS. TAYLOR THOMPSON: Okay.
10 MS. BELINDA PETTIFORD: Thank you for holding on for a
11 little while Taylor so we're going to now switch to Drena Plummer.
12 Drena is with the Baltimore Healthy Start Program. And she's also
13 participating in their housing effort. Yes Drena.
14 MS. DRENA PLUMMER: Yes, hello.
15 MS. BELINDA PETTIFORD: Hi there.
16 MS. DRENA PLUMMER: Hello.
17 MS. BELINDA PETTIFORD: Can you hear me, Drena? This is
18 Belinda.
19 MS. DRENA PLUMMER: Yes, I can hear you.
20 MS. BELINDA PETTIFORD: Do you want to share a little bit
21 about yourself and your connection to the program there with Baltimore
22 Healthy Start?
23 MS. DRENA PLUMMER: Yes. I joined Healthy Start last year
24 when I was pregnant, and they helped me through a lot. They help me get
25 the things that I need. The housing program and everything else, yes.

1 MS. BELINDA PETTIFORD: So, can you go into a little bit
2 more detailed, Drena, about the type of support that you received with
3 Baltimore Program?
4 MS. DRENA PLUMMER: They helped me to keep my blood pressure
5 down when I was pregnant because I was--because I was returning for
6 high risk of pregnancy, so they helped me with that. They help me with
7 clothing, resources for housing or how to get it. And they're about to
8 help me with job opportunities as well because right now I'm currently
9 not working and I'm looking for employment.
10 MS. BELINDA PETTIFORD: Okay. Thank you, Drena. Anything
11 with the Committee any recommendations that you would have or anything
12 that you want to share with us around the program that you're
13 participating in or any program that supports pregnant individuals and
14 parents?
15 MS. DRENA PLUMMER: Oh yes, I would recommend this program
16 to them if they need help; they will help you, come out for you. You
17 can call them whatever you need.
18 MS. BELINDA PETTIFORD: Thank you Drena. Are there any
19 specific parts of the program that you like that you kind of elevate?
20 That you think this is the most exciting part and I'm glad that one
21 piece of the program that's there?
22 MS. DRENA PLUMMER: Oh, yes. There's one piece of the
23 program called "The Belly Buddies" and they help with, like, some
24 breathing exercises or how to sleep and all that stuff. Yes.
25 MS. BELINDA PETTIFORD: Oh, we'll have to ask Lashelle About

1 that program. Apparently, Lashelle's going to chime in on that one as
2 well. No go, on Drena don't let me cut you off.
3 MS. DRENA PLUMMER: No, you're fine, sorry.
4 MS. BELINDA PETTIFORD: I was going to open it up to other
5 committee members to see if they have questions. We really appreciate
6 both of you all joining us today to kind of show your perspective. And
7 we do want you to think about in the next few minutes to see if there's
8 something if you were thinking about designing a program in this
9 country or in your community to support pregnant individuals and their
10 children and families what would you want the components of that
11 program to be?
12 And while you're doing that I'll see if there's any
13 questions. Anyone have a question? Yes, yes, we have a question in the
14 room. Kate.
15 DR. KATHRYN MENARD: So first I want to thank both of you
16 for being here with us today. Thanks for teaching us. My name is Kate
17 Menard. I'm a physician who does prenatal care and my question for you
18 is I hear that sometimes getting into these programs, that trust is
19 needed to engage, and that sort of thing is a hurdle. Can you tell us a
20 little bit more about what we, what that's about? And what we as
21 providers can kind of do to help overcome those hurdles make it
22 more--you know help connect folks to services like this?
23 MS. TAYLOR THOMPSON: I would say maybe just having the
24 knowledge of it. Because I actually heard of the program through my
25 insurance CareSource. So, it wasn't through my provider or anything

1 like that. But I think that if the provider has the knowledge that's
2 the one that we trust obviously because you're looking after our kid.
3 So, if you had that knowledge to say "hey this is a program that I
4 recommend" I feel that we won't be as skeptical to join or maybe listen
5 to what this person has to say.
6 But some random person just calling you saying, "hey I'm
7 from CareSource and I'm going to transfer you over to so-and-so because
8 they have this program", it's kind of like you're not calling, are you
9 really calling to help me or are you calling because you have my social
10 security number and banking information.
11 So, I guess it's having that knowledge between the provider
12 and the patient, I guess it would help everything smooth over.
13 DR. KATHRYN MENARD: Thank you. I think that's really
14 actionable. Thank you.
15 MS. BELINDA PETTIFORD: And Drena I don't want to cut you
16 off if there's anything that you want to add to that.
17 MS. DRENA PLUMMER: Yes, that's how I learned about Healthy
18 Start--through my OBGYN; she told me about the program. They gave me a
19 call within like two to three days, and I thought it was the perfect
20 opportunity to see what the program was about.
21 MS. BELINDA PETTIFORD: Thank you, Drena. I think Sherri, I
22 think your hand is up if you want to come off of mute Sherri, Sherri
23 Alderman.
24 DR. SHERRI ALDERMAN: Yes. Yes, thank you very much. And
25 thank both of you very much for sharing with us your story. Your

1 perspective is so valuable to help us make recommendations that are
2 meaningful for families so thank you very much for that.
3 My question is again in that mindset up how we can make the
4 very best recommendations? I would like to ask you especially Taylor
5 because you are so new to the program, and you did talk about--you were
6 you were understandably a little apprehensive about entering the
7 program initially. And in this period of time the last two months you
8 are saying now that you trust the program and you see the benefits for
9 yourself and your family.
10 When you think back to those, that first connection, or the
11 first couple of times that you met with somebody from the program could
12 you share with us what helped you begin to trust the program? What
13 happened in that internet action that helped you to be able to see that
14 it was okay, safe for you to participate in this program?
15 MS. DRENA PLUMMER: I would say that it will probably have
16 to be my case manager. I feel that if she wasn't so relating and down
17 to earth and so willing I probably wouldn't have went ahead with it.
18 And she wasn't pushy You know how some people are like oh you have to
19 do it right now, right now.
20 She gave me the option. She told me the details of the
21 program and she gave me, like, a folder that had like the details of
22 it. And she was like you know, why don't you just read over it. Take it
23 home and sleep on it. She's like if you want to do it, you're going to
24 do it. If you don't, you don't.
25 So, it wasn't forced. The ball was in my court at that

1 time. She, I don't know, she was a very trusting person and I know that
2 sounds so crazy because I just met her for like, you could tell that
3 she was there to help. And that she wasn't there for anything else
4 other than being my benefit. Like she wanted to see my best interests.
5 And I think by her doing that and as far as like what I
6 went tours she was there. If I texted her and asked her a question
7 about the program. She answered. It wasn't like there was no
8 hesitation. She knew it. She was all in. So that's what made me go
9 ahead and go with the program because of the case managers that I had.
10 DR. KATHRYN MENARD: Well, thank you for sharing that
11 insight with us. What I'm hearing is that you reluctantly, with some
12 caution engaged with a person who gave you control and put you in the
13 driver's seat. Providing that other person with what would be
14 meaningful for you.
15 And that it was not a checklist, that that person had to
16 accomplish it was being---giving it the time and space to allow you to
17 become more comfortable and to know that you would be the one that
18 would be making the decisions on your life for yourself and your
19 children in the program.
20 MS. DRENA PLUMMER: Yes.
21 DR. KATHRYN MENARD: Thank you.
22 MS. DRENA PLUMMER: You're welcome.
23 MS. BELINDA PETTIFORD: Thank you Sherri for that question,
24 but Drena, I don't know if you want to respond to it as well. It's your
25 call, dear.

1 MS. DRENA PLUMMER: She said everything on point.
2 MS. BELINDA PETTIFORD: So, you just know it's the person
3 that you really developed a relationship with. You feel like you can
4 trust them and that's an important piece.
5 Anyone else in the committee have any questions that they
6 would like to ask or any comments that they want to make?
7 To us this is always one of the most important parts of our
8 meeting is actually getting to hear from community representatives,
9 because people are actually utilizing this service that live in the
10 community. And because we learn a lot from you all I mean you are truly
11 the subject matter experts on your own care and your ability to
12 participate in some of these programs, so we appreciate your time.
13 I think--do we have any other questions? I don't want to
14 leave anybody. I think we have one other question here.
15 MS. ALICKA AMPRY-SAMUEL: Hi, my name is Alicka. I just
16 wanted to know if there's anything that you think can be done
17 different, or you might have felt was a waste of time, or should
18 change? Because I know the programs are great, but I just want to know
19 if there are like lessons learned that you would want to change or do
20 different?
21 MS. DRENA PLUMMER: To me I don't think nothing really needs
22 to be changed. Everything is just perfect to me. Like the way they do
23 stuff. How they call to see if you're okay and etc.
24 MS. TAYLOR THOMPSON: As far as my end I'm going to say no
25 because I don't---maybe it's because I'm still new to the program. I

1 haven't witnessed Anything that's "out of place" yet. And everything
2 for me I felt like it went pretty quickly. From me meeting them, to me
3 making my decision and to me moving and everything else that they've
4 done so I really can't say anything bad. [Laughs]
5 MS. ALICKA AMPRY-SAMUEL: Thank you and I wish you all the
6 best.
7 MS. TAYLOR THOMPSON: Thank you.
8 MS. BELINDA PETTIFORD: ShaRhonda, I see that you've got
9 your hand up. You want to come off of mute and ask a question?
10 MS. SHARHONDA THOMPSON: Yes, before your case manager
11 mentioned the program, did you have any knowledge of the program? That
12 you noticed was advertised or that you saw any literature about?
13 MS. DRENA PLUMMER: No, I hadn't heard of this program until
14 when I got pregnant and when my OBGYN told me about it. I had no
15 knowledge or anything.
16 MS. TAYLOR THOMPSON: Yes, ma'am I didn't know anything
17 about the program until CareSource reached out to me about it.
18 MS. SHARHONDA THOMPSON: Do you think if you would have
19 known about the program or heard about it or other people maybe heard
20 about it and who had participated in it, if you would have had more
21 knowledge of it do you think it would have eased your willingness to
22 participate in it?
23 MS. DRENA PLUMMER: Oh yeah, of course.
24 MS. TAYLOR THOMPSON: Yeah, if it was advertised then yeah.
25 If I would have known about it, then I definitely would have joined.

1 MS. DRENA PLUMMER: Well, this is my first child so If I
2 didn't have a child, I probably wouldn't have even known about it until
3 last year so, and I would recommend it to any first time parents, or
4 any parents that's having like a second or third child. Do the program.
5 MS. BELINDA PETTIFORD: Thank you, ShaRhonda. Did I get to
6 your questions?
7 MS. SHARHONDA THOMPSON: Yes, thank you.
8 MS. BELINDA PETTIFORD: Thanks, ShaRhonda. Others? Yes,
9 Lashelle.
10 MS. LASHELLE STEWART: I don't have a question, but I do
11 have a comment and that's been one of my issues since I came to Healthy
12 Start. That all these things happen in a community with Healthy Start
13 around the nation and people don't really know about it.
14 So, we don't really have a national platform. And I'm not
15 taking away from any other health concerns like heart disease or
16 cancer. But we don't have that big national concerted voice to reduce
17 infant mortality. And yet in our communities and I'll speak for myself
18 personally most people that I know have either lost a child or know
19 someone who has lost a child.
20 So why don't we get that huge national platform like
21 everything else does because these are our babies that are dying? So
22 it's sad to hear them say, and we try to promote Baltimore Healthy
23 Start as much as we can but we begin in Baltimore and we do need a
24 national platform to let people know that babies are dying and we need
25 the support on a national, on a big time level like cancer, like heart

1 disease, and other things like that.
2 MS. BELINDA PETTIFORD: Thank you, Lashelle. Are there
3 others in the room, maybe shaking their head saying, yes, maybe you're
4 right.
5 [Speaking off mic]
6 DR. LUD ABIGAIL DUCHATELIER-JEUDY: CareSource is a partner
7 in the Catalyst Grant, so that's how all the connections happen.
8 MS. BELINDA PETTIFORD: Thank you. Well, I don't want to cut
9 anyone off, but please join me in thanking Taylor and Drena for joining
10 us this afternoon.
11 [Applause]
12 MS. TAYLOR THOMPSON: Thank you.
13 MS. DRENA PLUMMER: Thank you.
14 MS. BELINDA PETTIFORD: You are both welcome to stay on as
15 long as you would like. Again, thank you so much for joining us and we
16 look forward to maybe at some point meeting you in person, okay.
17 MS. DRENA PLUMMER: All right, sounds good.
18 MS. BELINDA PETTIFORD: Take care of both of you.
19

20 **Federal Healthy Start Program**

21

22 MS. BELINDA PETTIFORD: So now we're going to continue on in
23 our agenda. We may be a minute or two ahead of schedule. We will see
24 how long that lasts. Hopefully, I didn't just jinx us.
25 So now we're going to move into presentations and

1 conversations around the Federal Healthy Start Program. I think
2 Lashelle kicked it off About reminding us. Healthy start is a federal
3 program that focuses on improving birth outcomes and specifically
4 looking at perinatal disparities.
5 But this is also an opportunity for us to really delve
6 deeper into the Healthy Start program. And I reminded you earlier that
7 we are the advisory group for this federal program and so they do look
8 to us for you know recommendations at times, or just to make sure that
9 we are aware of the program.
10 So, we will start with Lashelle who you already know is the
11 project director excuse me the executive director of Baltimore Healthy
12 Start.
13 And then after Lashelle we will have Ada Determan who is
14 here in the division, and she is one of the project officers --is she a
15 project officer? Oh, she is not a project officer. She is a data person
16 she is our data lead for Healthy Start.
17 And then we will go to Mia Morrison who is one of the
18 project officers. Team lead. Well, I will find out who. Apparently, I
19 don't know anyone working in the program anymore.
20 MS. VANESSA LEE: You did say that.
21 MS. BELINDA PETTIFORD: I did say that yesterday, didn't I?
22 I should just follow with my desk and read my notes. Okay so now we're
23 going to turn it over to you, Lashelle.
24 MS. LASHELLE STEWART: Okay, so hello again everybody. So,
25 this presentation is going to be all about who Baltimore Healthy Start

1 is. And we can advance the slide.
2 So, Baltimore Healthy Start was established in 1991 just
3 like this committee was established in 1991. We are one of the original
4 fifteen Healthy Start projects. We are the only federally-funded
5 program of its kind in the state of Maryland.
6 We are a member of Maryland non-profits, and we work in
7 partnership with B-More for Healthy Babies, which many of you may have
8 heard of. It's a city-wide strategy in Baltimore to reduce infant
9 mortality. Next slide please.
10 What we do we work with our families in their residences
11 and in the communities to make sure that every child has a safe,
12 nurturing, thriving environment every day for the first few years of
13 life and beyond.
14 Our mission is to reduce infant and maternal mortality and
15 morbidity by utilizing the life core perspective, Andre's gone but he
16 mentioned the life core perspective, by improving the health and
17 well-being of women and their families through the provision of
18 comprehensive supportive social services offered in the communities
19 where they live.
20 So, we don't just focus on the health part of the maternal
21 health because it is about the whole life of the woman.
22 So, Maxine Revance who's been at our Healthy Start since it
23 came about pretty much, she always says health is in the community. So,
24 it's not just what's happening at the healthcare provider but it's all
25 those other things that influence a woman's life and that's how we

1 approach our help with families. Next slide please.
2 So, the Healthy Start initiative, I think I'm preaching to
3 the choir here because it's a lot of Healthy Start people in the room,
4 but it's designed to reduce disparities in prenatal health outcomes.
5 Next slide.
6 So, where we are we work in communities. We're in Baltimore
7 City And we work in communities with infant mortality at least one- and
8 one-half times the US national average and high rates of other adverse
9 perinatal and of all kinds such as low birth weight, preterm birth,
10 maternal morbidity, and maternal mortality.
11 And so, in Baltimore we have thirty-eight census tracks
12 that we serve in the city. Baltimore is really a city of sides but
13 we're on both sides of the city so we tried to capture as many people
14 as we can in the underserved areas of Baltimore City. Next slide.
15 So, these are some stats for Baltimore City in 2019. This
16 was like the most comprehensive stats I could get across the board. Sad
17 to say up to date. But as far as low birth weight for African Americans
18 is 15.7, as far as whites it's about 7.5 and you could just go on down
19 the list and see that we are still at least double that of whites in
20 Baltimore City for the adverse birth outcomes. Next slide please.
21 Our target areas are the most marginalized areas in the
22 city. We've recruit pregnant and postpartum women regardless of their
23 risk. So, some other programs you hear about they tier families in
24 order to come in and they tier families in order to receive services.
25 We believe at Baltimore Healthy Start that if you live in

1 our area then you are at risk and so if you live in one of our areas
2 you automatically are eligible for the program. We do have a ninety to
3 ninety-five percent penetration rate in our target areas.
4 We actually have what we call recruiters who go out and
5 canvas our areas and so they knock on doors, they go in stores. They go
6 everywhere to look for pregnant women. They approach people at the bus
7 stop, and I've actually seen them do it. And I'm like "I would not give
8 you all my information if I were her" but they give it to them. And so
9 that's how we get that ninety to ninety-five percent penetration rate
10 in our areas. Next slide please.
11 And so, this talks about the 2020 infant mortality rate for
12 African Americans in Baltimore City, it's fourteen out of a thousand
13 live births and of course COVID negatively impacted our infant
14 mortality rates. We were on a good trajectory for years in the city and
15 when COVID came we witnessed a lot more infant deaths. Unfortunately,
16 the infant death rates began to rise again.
17 We attribute a lot of it in our Healthy Start area to the
18 fact that we weren't able to access our families in the ways that we
19 have many years and so we went to virtual visits, we went to virtual
20 groups and we weren't actually laying a finger on the families or going
21 into the homes and actually seeing what was going on. So unfortunately,
22 we have had an increase in infant deaths in recent years. Next slide
23 please.
24 We have a lot of benchmarks, Dr. Warren. We have a lot of
25 benchmarks but I just thought that this one was so extraordinary that I

1 wanted--[laughs] I wanted to point out just one just to kind of give a
2 little bit of the impact of what Baltimore Healthy Start, and what
3 Healthy Starts across the nation do with our work with families.
4 And when we started the breastfeeding initiation rate in
5 our project area was eight percent. In 2022 we pulled the numbers, and
6 it was sixty-six percent breastfeeding initiation rate and although
7 that's not the target, that's a lot of work that has been done.
8 And then when we look at our Baltimore Healthy Start as a
9 whole because we have other programs, not just our HRSA-funded
10 programs, 73.45 percent of our families all across our Healthy Start
11 programs have initiated breastfeeding. So, we're just wanting to show
12 just a snapshot of the impact of the work that we're doing. Next slide
13 please.
14 We serve over a thousand families in Baltimore City every
15 year. Those are our numbers for 2021 and our numbers for 2022 for
16 families served. Next slide please.
17 The four approaches, improve women's health, improve family
18 health and wellness, promote systems change and assure impact and
19 effectiveness through workforce development, data collection, quality
20 improvement, performance monitoring and evaluation. Next slide.
21 So, who we serve? In order to be eligible for our program,
22 a person must be either pregnant, be a woman with a child six months or
23 younger, be the father of an expectant woman or have the child in your
24 care and live within our service areas.
25 And then once families are enrolled, we serve them until

1 the baby has turned eighteen months old. At that point--well, prior to
2 that point we begin working with Early Head Start daycare providers and
3 other programs in our area to do a warm handoff so that once they age
4 out of Healthy Start services, they are not just left with no safety
5 net to continue services.
6 So Early Head Start and the Judy Center in Baltimore has
7 been really helpful with us transitioning our families as well. Next
8 slide.
9 So, this is the good part [laughs]. What we do, we have
10 core client services and population health. We do outreach and
11 participant recruitment, which I mentioned the recruiters canvassing
12 the neighborhoods. We also go anywhere people ask us to come. We go to
13 health fairs. We go to community events. We are out and about to let
14 people know who Healthy Start is and what we do.
15 We also in recent years have become more active with social
16 media and now we have a young person on our team who has even gotten us
17 on TikTok. So, I'm excited about that. We're on Facebook, we're on
18 Instagram, we're on Twitter. But now we're on TikTok too. So that's
19 part of our reach as well.
20 We do case management and care coordination. Home visiting
21 is part of that comprehensive approach that we take to care
22 coordination. I do always say we're not just a home visiting program.
23 That's one of the strategies that we use to engage and help families.
24 We also have a certified registered nurse practitioner who
25 goes out and she does postpartum home visits and she's the only person

1 on our team who is still going out into the community during COVID. So,
2 everything else became virtual but she still went out postpartum-ly to
3 meet with the moms.
4 We have what is called a maternal health intervention
5 program where we talk to moms about post-birth warning signs and stuff,
6 so she was very instrumental in getting that message out. We do health
7 education through groups and special events. We do maternal depression
8 screening and referrals.
9 We do inter-conception care; we do developmental screenings
10 and referrals for our babies. We work closely with our infants and
11 toddlers' program. If our babies do not screen developmentally
12 appropriate to do referrals and coordination of services.
13 We do STI screening, and we do pregnancy testing. Another
14 great program that I'm very excited that we have is our DIAC care. We
15 partnered with Total Health Care, and we recently have gotten funds to
16 partner with another federally qualified health center in our area to
17 provide mother baby visits.
18 One of our benchmarks that we have trouble with a lot is
19 moms going back for their postpartum visits and going back within a
20 timeframe that's specified. So, we did realize though that moms take
21 babies to their appointments right, they take the babies with.
22 So, we, Maxine--I keep saying her name. Dr. Joia knows her
23 well, she a long time ago had this idea. If we had the mom's
24 appointment at the same time that we have the baby's appointment, then
25 we guarantee that mom comes.

1 And so if the DIAC care, and it's a supplement through HRSA
2 that we got in 2019 with the DIAC care when our moms go in they are
3 seen and we have one of our community health workers that is in doing
4 the social determinants of health questions, but they are also doing
5 the medical checks at two weeks, two months, four months, six months,
6 nine months and twelve months so that mom is seen and all her needs are
7 taken care of as well as the baby being seen.
8 So that has of course increased our postpartum return
9 rates, right? so excited about that. We also have our Merck's Safer
10 Childbirth Cities Project -- which has, we have partnership with the
11 Preeclampsia Foundation, which is called Patients as Partners, where we
12 train moms to talk about their birth stories and talk to hospital
13 administration and hospital providers about what it is they need. How
14 they were treated and how they can make things better for moms in the
15 birthing process.
16 Also with Merck we are working to develop a severe maternal
17 morbidity review in Baltimore City because we sit on the Maternal
18 Mortality Review and we sit on the Child Fatality Review but we want to
19 review cases and talk to moms and talk to people before the deaths
20 occur and so that's part of our Merck's Safer Childbirth Cities Project
21 as well.
22 We also talked earlier about our Community Action Network.
23 The whole purpose of that group is to make life better for Baltimoreans
24 and so it's comprised of our moms, other organizations in the community
25 for-profit, non-profit, anyone who wants to make life better for people

1 in Baltimore is welcome to join our Community Action Network.
2 And then we also have the doula training and mentoring
3 where we are training people from our community to be doulas and then
4 act as doulas for people within the Baltimore Healthy Start Program and
5 other moms in Baltimore city and we're also mentoring them to be able
6 to get, now in Maryland they're able to request reimbursement for
7 Medicaid for their doula services and so once our grant project is
8 over, they will have the ability to request reimbursement for their
9 services to families.
10 I talked about our Housing University and how Catalyst for
11 Infant Health Equity initiative already so next slide please.
12 So, there's Belly Buddies under our Family Engagement and
13 Wellness Activities. So, Drena talked about Belly Buddies. Belly
14 Buddies was established in 2012 by Baltimore Healthy Start. It's a
15 prenatal stress reduction program for moms. So, with Belly Buddies they
16 go through eight weeks with people who they were close delivery date
17 with them, and they actually become bely buddies.
18 They do a lot of stress reducing techniques. They do yoga;
19 they do knitting; they do parenting classes and at the end we have a
20 blessing away ceremony where they actually connect and so that is a big
21 draw with our Healthy Start program and it does work. We do see the
22 outcomes. The moms have healthy weight babies. Most of the moms doing
23 the Belly Buddies Program initiate breastfeeding. And I didn't bring
24 the stats for Belly Buddies, but the stats are, the stats are out
25 there.

1 We also have breastfeeding education. We did at one time
2 work with WIC to get some of our moms trained to be peer counselors and
3 so they checked in with moms and helped them along their breastfeeding
4 journeys as well.
5 We partnered with a local community college to do GED
6 classes. We have a food pantry with the food bank. Emergency diapers,
7 formula, cribs. We have a Healthy Start Store where we created our own
8 dollars and moms can use those dollars to shop in our store to purchase
9 things that they can't get on SNAP, but they might run out of towards
10 the end of the month. So, they can get like baby supplies, cleaning
11 supplies.
12 Pretty much anything you name and if it's not in the store
13 and they have a special request we can get it based on their bucks. We
14 do have an Early Childhood Development Program because a lot of times
15 we have groups in session. The children are in the center and so we
16 have programming to address their needs as well.
17 We have fatherhood services. We have a phenomenal
18 fatherhood engagement specialist, pregnancy testing. I talked about the
19 nurse. We do have a teen group because we feel like if you engage not
20 only the young women but the young men as well before they get to the
21 childbearing age, they are more likely to have better outcomes when
22 they get to that time.
23 We do circle security parenting classes. We do have a van
24 and we use Lyft now and Uber to get moms to where they need to do, like
25 doctor's appointment and in to see us. I talked about the parent

1 leadership group, which I'm very proud to say I brought to our
2 Baltimore Healthy Start because when I came they didn't have the parent
3 leadership group and I'm like "hey, we need to hear directly from them
4 about what they want to do, how they want to do it, how we can best
5 help.
6 And so, I will say that the community voice is one of the
7 most important things that we have implemented. Next slide please.
8 Those are some of the moms that are in the housing. You saw
9 Drena. She's there with the Housing Troops project. But those are some
10 of the moms that are in the Housing University right now and that's at
11 our kickoff. That happened a few weeks ago. They brought the babies. So
12 that's it. Thank you.
13 [Applause]
14 MS. BELINDA PETTIFORD: Thank you, Lashelle. Can you hang
15 around so we can ask some questions later? Thank you.
16 And we'll go to Ada.
17 DR. ADA DETERMAN: Hi everyone. Thank you for having us
18 here. I'm with Healthy Start, I'm actually the Division State and
19 Violation team lead but you know, we're very happy to be here to
20 present on Healthy Start today.
21 And then also I just wanted to not only thank you for the
22 invitation but also just note how hard all of our information is due to
23 the hard work of the grantees. We have a 101 Healthy Start grantees
24 that report a lot of information to us and so I just wanted to say that
25 this is due to all of their commitment and hard work that we have this

1 to present today. Next slide please.
2 Okay, so I have a short agenda. I'm just going to review
3 the data, talk about the data source and also a little bit about next
4 steps. I'm going to go quickly through the data, just really a bunch of
5 charts on the performance measures and benchmarks that Lashelle
6 mentioned and also, I would just like to say that we can have links
7 available if you want to see details about how these measures are
8 defined. Okay, next slide.
9 All right. With relation to the data sources, we have the
10 two sources primarily that we've been using for this data presentation.
11 One is our discretionary grants information system, the DGIS we call
12 it. It's MCHB's performance measurement system. All of the programs
13 report here. It collects information on like financial, quality
14 improvement, health equity, grant impact, demographics and some program
15 specific measures.
16 Healthy Start has nineteen benchmark measures that our
17 grantees report on and I'm happy to say that the grantees are doing
18 well across the board on most of these performance measures and this
19 data comes to us in aggregate form annually.
20 At the bottom we have a birth and death indicators
21 template, and this is where we capture the birth/death outcomes and so
22 the number of live births by singleton status and birth to multiples,
23 preterm birth, low birth weight and number of infant deaths.
24 We also have a few other data sources, like a narrative
25 progress report and we have a newer data system that I will talk about

1 a little bit later. Next slide.
2 Okay, so first I wanted to say that again, we have a 101
3 grantees and they, we're in the middle of our five year project period,
4 which runs from 2019 through 2024. So, the presentation today will
5 capture information from 2019 through 2021 and you can't see the legend
6 here but in grey is 2019, blue is 2020 and gold is 2021.
7 So, I just wanted to note that the number--despite the
8 pandemic, we've seen a number--increasing numbers--participant numbers
9 over the course of the project period so far. Starting with, you can
10 see all participants there. In 2019 it was just below 60,000 to in 2021
11 hitting about 77,000 and so they've been doing a lot of work despite
12 the challenges in the environment.
13 We also have a good mix of participant types. As you can
14 see here, you know they serve pregnant women, non-pregnant meaning to
15 be their post-natal or preconception and so pregnant women annually
16 comprise about thirty percent of our total population for participants
17 served.
18 Infants and children ranged annually from thirty to almost
19 fifty percent and then we also have a focus to serve men. Our goal is
20 to try to get about 10,000 men per year and you can see, we get about
21 half of that. Okay, next slide please.
22 With regard to race and ethnicity, let's see we serve
23 about--the participants are about sixty percent Black every year and we
24 also have about twenty percent that are white. A good number are
25 unknown and then the rest sort of fall across the racial categories or

1 multi-race.
2 And also and one of the things that Lashelle mentioned is
3 that we do focus on the Black/White infant mortality disparity, however
4 the Healthy Start grantees do, anyone who lives within their catchment
5 area is eligible for the services so anyone that comes to their door
6 they will assist because you're given high risk status or eligibility
7 status if you live in that neighborhood and the other criteria being
8 reproductive age and such.
9 Okay, in terms of ethnicity of the participants, we've been
10 increasing form about 20 percent to about twenty-five percent between
11 2019 and 2021 that are Hispanic. Okay, next slide.
12 Okay, with regard to healthcare access. First I wanted to
13 orient you to the chart so the pink bars that you see here provide
14 national data and I tried to find comparisons that, you know, that
15 closely matched our measure as much as possible and then the lines that
16 you see going across, the red lines in the charts, those are the
17 Healthy Start benchmark targets which often range from like eighty or
18 ninety percent or 100 percent but they vary based on the measure.
19 Okay, so I'm happy to report that Healthy Start has
20 consistently met and/or exceeded targets related to healthcare access.
21 As you can see, the large majority of our participants report having
22 insurance likely due to Healthy Start's assistance linking them to
23 Medicaid.
24 It's comparable to the healthy people 2030's most recent
25 data report of ninety percent and also nearly all Healthy Start women

1 and children report having the usual source of care by 2021, which is
2 also likely associated with their insurance status and the fact that
3 Healthy Start programs link participants to healthcare providers.
4 And you can see with the usual source of care we actually
5 surpassed the National Data Equivalence reported in the CDC's
6 Behavioral Risk Factor Surveillance System for Children within MCHB's
7 National Survey of Children's Health. Okay, next slide.
8 This slide really should be titled women's healthcare
9 utilization, forgot to change this one. I just wanted to share that
10 with regard to early prenatal care, we measure whether the participants
11 have had a prenatal care visit in their first trimester and so you can
12 see that we've had a steady increase since the start of our program
13 period and surpassing the target in 2021. Not quite matching that of
14 what was reported in CDC PRAMS in 2020 but you know, it's getting
15 pretty good.
16 This is really not an official Healthy Start benchmark, but
17 we do report this to our Congressional Budget Justification so it's one
18 of our priority measures.
19 Postpartum visit. Currently we assess postpartum visit as
20 having a visit within four-six weeks post-delivery. So, you can see
21 we've fallen short of our eighty percent target. And we are aware that
22 this might be due partly because we do have a short window for
23 postpartum. You know, ACIMM recommends going out in the first twelve
24 weeks and so you can see with CDC PRAMS they also do the four-six weeks
25 so we're a bit behind on that piece.

1 Well-woman visit. We are exceeding the target and doing
2 better than the national data element so outperforming what we see with
3 the BRFS, the Behavior Risk Factor Surveillance System, and that's
4 having a preventive visit in the last year.
5 Okay, next slide. So, we also assess reproductive life plan
6 which also means that they--it measures their, well if they have one,
7 it has if they have an intent to have children, you know, using
8 contraception and also using condoms to prevent STDs. The majority of
9 our participants report having a reproductive life plan and you can see
10 we surpassed the high ninety percent benchmark in 2021.
11 Inter-conception spacing. We measure the percent that did
12 not conceive within eighteen months of their previous birth and again
13 we met the target all three years and it will beat out what we see for
14 healthy people 20/30 which has the same measure exactly.
15 Okay and then lastly for this slide, no tobacco use in the
16 third trimester is another important measure and you can see that we
17 exceeded the target set in 2021 although we're not quite as high as the
18 national comparison. All right, next slide.
19 Okay, so I do have to note with this personal well-beings
20 trends, is that we have very high benchmarks here. They're all 100
21 percent so you know, it's almost hard--it's impossible really to ever
22 really get that when you're working at this scale, but you can see I
23 think attending to a person's wellbeing is one of Healthy Start's
24 strong suites.
25 We have nearly universal depression screening of Healthy

1 Start women participants and I wanted to--you can see the national
2 comparison is very low. It's not exactly a 1:1 match. Our rate is about
3 the participants screened and that one is really more about the number
4 of primary care visits or the percent of primary care visits where
5 depression screening has occurred and so that's based on healthy people
6 20/30.

7 And again, you, now for referral we had a pretty high
8 percentage in 2021. Of the people who screened positive, eighty-five
9 percent have been referred for additional follow-up for treatment,
10 which is you know a really great outcome since mental health is--you
11 know, a higher priority for primary care visits.

12 And then again, we have good screening of intimate
13 partner--of participants for intimate partner violence on our women
14 participants with the last of this data set being eighty-five percent
15 of women screened. Next slide.

16 Okay, so we can see that overall Healthy Start participants
17 are following important guidelines and caring for their children, which
18 is likely associated with the program's efforts to engage and given
19 them all the educational programs that Lashelle just mentioned.

20 We have a number of measures here. Safe Sleep we base on
21 three criteria. A firm surface without soft bedding. Being put to sleep
22 on their back and also sleeping alone in their bedding in their bed.
23 And you can see we exceeded the target in 2021 as compared to the CDC
24 PRAMS where you know, it's close to the same, the national data but
25 they're really only assessing back to sleep here and their other

1 criteria here are actually much lower.
2 Okay so Healthy Start is just under the benchmark for
3 breastfeeding like ever. For initiation we have a benchmark of eighty-
4 two percent. You can see we're slowly increasing towards that. We're
5 below the eighty-eight percent outcome reported by PRAMS.
6 Breastfeeding at six months though, remains a challenging
7 target for our population and we understand that this might be due to a
8 number of factors. You know, cultural or racial differences,
9 unsupportive work policies, you know age. Sometimes younger
10 participants just don't breastfeed as frequently and so there are a
11 number of factors and just like the general environments in which they
12 live.
13 So that's one of the measures we are wanting to work on
14 moving forward. And then in terms of well-child visit, we have
15 excellent results for children receiving their well-child visits per
16 the American Academy of Pediatrics recommended schedule as you can see
17 here as compared to the National Health Interview Survey for Children
18 0-4. We're right at the same level.
19 Next slide. And I'm sorry about that, there's a highlight
20 here and we kept deleting it, but it somehow keeps popping up for some
21 reason so. Okay, these measures for home life trends are intended to
22 show the program's influence on participants' parenting practices and
23 involvement with their children. We have a daily reading measure for
24 you know, reading to their children at least three or more days per
25 week.

1 You can see we exceed our targets with that and it's you
2 know, similar to what's reported in the national data set although that
3 one's a bit more, that one's four or more days per week.
4 In terms of father/partner involvement in both of these
5 categories, this is really like the mother's report of, it's not an
6 assessment of the father's, you know, behaviors. So, women participants
7 reported increasing levels of father or partner involvement during
8 their pregnancy. You can see over the past from the start to 2021,
9 which is you know, it's pretty high considering, almost hitting the
10 target, considering when you think about the different types of
11 relationship status.
12 So, you know, they may not be together but maybe still
13 involved so I think that has a lot to do with the Healthy Start, really
14 trying to focus on family.
15 And then the father/partner involvement with children
16 who--in the program who are less than twenty-four months old. You can
17 see that's also increasing and exceeding the target that we set at
18 eighty percent and of course that's an important issue for child
19 development.
20 Next slide. All right. Lashelle talked about the Community
21 Action Network and this is something every Healthy Start grantee is
22 required to participate in. they are supposed to have a network of you
23 know, members of the community, business leaders, people with lived
24 experiences, you know a range of partnership, to work together to
25 improve more of the social structure and environment in which the

1 people live.
2 So, we have three measures, well two but one has two-step
3 parts, that assess our what we call the CANS. The first is collected
4 impact and this measures the CANS ability to collectively apply their
5 resources, to implementing one or more strategies, to achieve common
6 goals among the partners and these questions--there are five questions
7 that we use.
8 They each have two points. It's about a common agenda,
9 sharing measurement systems, mutually reinforcing activities,
10 continuous communication and having a backbone infrastructure in place.
11 And here you can see I pulled out the ones, the grantees that scored
12 between eight and ten and so you can see that they've increased over
13 the years to almost eighty percent in 2021 meeting those criteria.
14 The one in the center, the CAN components, it's based on
15 three measures, whether or not they have regularly scheduled meetings,
16 if they had membership from three or more community sectors and then
17 having a twelve -month work plan. And they have to have all of these to
18 be successful and you can see that in the last year, 2021, eighty-seven
19 percent of our grantees met these criteria.
20 And then lastly an important part is the CAN participation
21 and you can see three quarters of our grantees met this participation
22 threshold and basically this is having CANS where at least twenty-five
23 percent of the members--of the membership of the CAN are Healthy Start
24 participants or other community members with similarly lived
25 experiences. So, it's to make sure that they inform the CAN, you know,

1 with real life information and experience.
2 All right. Next slide. Okay so now these are our outcomes
3 for the birth and death indicators. And so, in gold we have Healthy
4 Start and then in blue are the national outcomes as reported by CDC.
5 And as you know, by design Healthy Start serves areas where
6 disparities are greatest so we would never expect really that our data
7 will match the national data just because we have that built in
8 disparity. But we do hope to see improvements over time or at least
9 sort of be aligned with the direction that CDC is going.
10 And then also I just wanted to note that the 2019 data is
11 not as comparable because in 2020 we started using singleton births
12 only to assess low birth weight and pre-term birth.
13 Well for both between 2020 and 2021 the preterm birth and
14 low birth weight both in the US and within Healthy Start there were
15 slight increases in the preterm birth and low birth weight, but then
16 you can see the different mortality rates.
17 We have a different experience. Healthy Start grantees have
18 been showing a decrease in their IMR in 2019 starting with 8.05 deaths
19 per 1,000 live births and dropping down the 6.67. Whereas nationally
20 it's a bit more steady. There was a bit of a drop in 2020 and a steady
21 increase in 2021.
22 And our next step really is to determine you know whether
23 these differences are significant and we're in the middle of doing that
24 now. Okay next slide. Okay and we try not to mention that we do use our
25 Healthy Start data not to inform us and for reporting compliance, but

1 we really use it to share the information with others.
2 As I shared, we use our data in the Congressional Budget
3 Justification. Another example is a report to Congress that we submit.
4 This is like to the Office of Minority Health, but we are highlighted
5 in there. And then also sometimes we have you know some supplements
6 Within the maternal child and health journal where we highlight
7 activities of the Healthy Start program. So, we do try to share the
8 story widely. Next slide.
9 Okay I just wanted to quickly touch on one more data system
10 that we have. This is the Healthy Start monitoring and evaluation data
11 system. We call this HSMED. And it was launched at the end of 2020. Our
12 first full year of data was 2021. Our grantees submit client-level data
13 that's deidentified based on three Healthy Start forms.
14 The data team right now is in the process. We have a lot of
15 data to go through on this and we're in the process of doing data
16 cleanup and creating our data-sets and prepping it for analysis, so our
17 goal is to have HSMED be the primary data source beginning in 2024. And
18 I'll get why that's important in the next slide.
19 So, with HSMED what we're really excited about is the fact
20 that again we have deidentified client level data particularly for race
21 and ethnicity, and this is where we can really start to explore while
22 we address the disparities. We weren't able to do that as well when you
23 get the data in aggregate because you particularly get the race and
24 ethnicities in separate pools from the outcomes and this way, we can
25 actually track things, you know, on a client level.

1 We can use this information to tell then a more complete,
2 compelling, and accurate Healthy Start story. Again, like I said, think
3 about how is Healthy Start addressing the disparities within the
4 populations because you can look at things by race and ethnicity.
5 Also being able to stratify this data across a number of
6 different data types again thinking about the participant grants
7 between levels and investigating whether participant demographics,
8 healthcare utilization, and everything are associated with improved
9 outcomes. And so, we hope to share this data with y'all in the near
10 future.
11 Okay and next slide. And then the next three slides are
12 just references for all the national data so that you can look into
13 that if you like. And I just want to thank you all for letting us be
14 here and if you have any questions my contact' at the end thank you.
15 [Applause]
16 MS. BELINDA PETTIFORD: Thank you Ada We may have some
17 questions before you leave today. Thanks.
18 MS. MIA MORRISON: Hi, good afternoon. My name is Mia
19 Morrison and I'm a supervisory public health analyst and team lead in
20 the division Of Healthy Start and perinatal services in the Healthy
21 Start brand and today I'm presenting on behalf of our branch chief
22 Bonita Baker who unfortunately is unable to attend.
23 And I'm pleased to be able to talk on the topic around
24 three key engagement activities that took place over the calendar year
25 2022 and 2023 and how these activities will inform our future Healthy

1 Start priorities. Next slide please.
2 So, the three engagement activities that I'm going to touch
3 on today are one the infant health equity convenings. And this was a
4 series of four meetings that took place over calendar year 2022 where
5 we invited over thirty key partners, subject matter experts,
6 individuals with lived experience from around the nation to speak about
7 their recommendations and action steps for the bureau and for the field
8 on how we can work to achieve infant health equity.
9 The second engagement activity that I'll talk about today
10 is our grantee listening sessions. That was a series of two
11 conversations that took place in October of 2022. All of the current
12 Healthy Start grantees were invited to participate and the majority of
13 them attended.
14 We talked to them about lessons learned from the current
15 grants cycle. What were the strengths, what were the challenges and
16 what were their recommendations for continuing to improve our Healthy
17 Start programming that we can take with us into further grant cycles.
18 And the last engagement activity that I'm going to draw
19 upon today was our request for information that was released to our
20 federally registered notice from January to February of 2023. We asked
21 the field for input on a series of questions ranging from program
22 design and implementation and also touching upon data and evaluation.
23 We received over 100 responses to our request for
24 information. Many of the respondents were students citing research and
25 studies that that they had learned about in their classes. And we also

1 got a sizeable amount of response from current grantees, clinical
2 providers, and advocacy organizations. Next slide.
3 So, across all three engagement activities we received
4 three broad categories of feedback. We heard a lot about the importance
5 of flexibility and our programming, of addressing social and structural
6 determinants of health within our Healthy Start grant design and also
7 considerations around identifying ways that we can reduce grantee
8 burden. Next slide.
9 So, as I go through these subsequent slides, I'm going to
10 drill down on four main takeaways. One was increasing the emphasis of
11 addressing upstream factors in social and structural determinants of
12 health which impact perinatal health in the communities that Healthy
13 Start grants work.
14 The second is identifying ways to increase the emphasis on
15 strengthening family and community engagement from program design to
16 implementation to evaluation. The third is identifying mechanisms that
17 we can use to continue to support grantees and implementing strategies
18 that are flexible and are customized to addressing the key drivers of
19 infant mortality within their communities.
20 And lastly, I'll talk about the considerations that we
21 received around reducing grantee burden. Next slide. So this next slide
22 is quite dense as are the subsequent four slides but I'm going to walk
23 through them and talk about the recommendations that we received from
24 our engagement activities and then highlight how we've been immediately
25 able to address them in our FY23 Healthy Start initiative enhanced NOFO

1 and how we're also considering them in terms of future priorities for
2 Healthy Start program design.
3 So, in the interim recommendation that we received around
4 increasing the emphasis around upstream factors in social and
5 structural determinants and how it is impacting perinatal health. We
6 received recommendations around thinking about bringing together
7 non-traditional partners.
8 I think this room is very well versed in how social and
9 structural determinants impact the health of mothers and infants
10 throughout the life course. But on action stuff that was called out to
11 us in the infant health equity convenings charged us to find ways to
12 convene partners from both the clinical setting and also from social
13 service settings and from organizations that are uniquely poised to
14 address the social and structural determinants of health needs in their
15 community.
16 From our grantee listening sessions they charged us to
17 identify increased ways to design programs that affect the root causes
18 of health disparities at the upstream level. We also heard about how
19 many of our Healthy Start grantees are working to address mental health
20 needs in their community and that access to mental health services
21 remains a huge challenge in many of the communities that Healthy Starts
22 are working in.
23 And again, from the request for information we heard about
24 the need for increased flexibility to address social and structural
25 determinants of health and particularly housing transportation and the

1 built environment was called out. In terms of our FY23 NOFO we've been
2 able to address some of these recommendations immediately.
3 We've emphasized in our program requirements and
4 expectations that Healthy Start projects are expected to provide
5 referrals, support navigation, and linkages to not only clinical care
6 but also services and organizations addressing social determinants of
7 health within the community.
8 With the work with respect to the community consortia which
9 is also known as the Community Action Networks, the work is really
10 guided by a plan that the community develops to address social
11 determinants of health within the community. There's a measurement
12 around progress to attain those goals.
13 And also, we have activities built in so that members of
14 the community consortia including the coordinator participate in
15 technical assistance activities around addressing social determinants
16 of health. Next slide.
17 So with respect to family and community engagement we heard
18 a call to really prioritize and amplify the lived experience of
19 mothers, fathers, birthing people, and community members, in fact not
20 only a call to value this feedback and this perspective but also to
21 ensure that there's a pipeline from an advocacy role to a career in MCH
22 should families and participants choose to pursue that.
23 We also heard the importance around compensating people
24 with lived experience for their participation in activities like the
25 CAN or the community consortia. And we heard great suggestions from our

1 grantees around increasing the availability of incentives to engage
2 families in activities and in leadership activities as well as
3 opportunities for the community to hear updates and feedback on how the
4 grant is performing.
5 In FY23 we've been able to address some of these
6 recommendations in a few ways. One, we've stipulated in the NOFO that
7 the community consortia acts as an advisor and advises and performs the
8 planning development and implementation of the direct and enabling
9 services that Healthy Start projects implement.
10 We've added language to emphasize that as a best practice
11 the community consortia coordinator should be representative of and
12 from the project area. And we've also added suggestions that the
13 community consortia chair or co-chair should be a current or former
14 Healthy Start participant.
15 In terms of leadership development opportunities, I'm
16 really excited to briefly touch upon a recent activity that was led by
17 our technical assistant center at the end of May. They had a national
18 consumer convening in Chicago where they brought together families
19 community health workers, and other community members to build a
20 network of family voices that can advocate and provide leadership
21 around topics pertaining to Healthy Start.
22 This community convening, consumer convening also provided
23 participants with opportunities for training and strengthening their
24 leadership development skills. Next slide please.
25 So, on this next slide I'll talk a little bit about what we

1 heard around increasing flexibility to customize the approaches, to
2 addressing the key drivers in infant mortality within the community. I
3 want to say first and foremost throughout our engagement activities
4 we've really heard about the strengths that organizations, families,
5 and communities bring to the work that we do.
6 And so, it's with that basis that basis that understanding
7 of those strengths that we heard, recommendations around strategies
8 that were particularly work in their communities. And I think that much
9 of what Lashelle talked about earlier highlights how each Healthy Start
10 brings a unique perspective on how they'll address the key challenges
11 to perinatal health in their communities.
12 One recommendation that we heard from the infant health
13 equity convenings is fostering a cultural shift to honoring cultural
14 knowledge, tradition, and expertise as evidence. And from the request
15 for information, we heard about the need to customize strategies based
16 upon the unique needs of the target population within the project area.
17 We also heard very specific suggestions, some of which we were able to
18 immediately coordinate into our FY23 NOFO.
19 So, for example the ability to develop, if two applicants
20 are proposing an overlapping project area, thinking about a way that we
21 can give them an opportunity to develop MOUs or MOAs after applying if
22 they propose to serve an overlapping geographic area in certain
23 instances.
24 And so, within the FY23 NOFO we're definitely--we're
25 calling out the increased flexibility to customize interventions to

1 meet the unique needs of the target population. We're also providing
2 more flexibility around the leadership opportunities that Healthy Start
3 projects participate in. So, we are calling out to them to identify
4 which leadership opportunity of the state, local, or community level
5 would be most impactful for their target population.
6 In terms of direct and enabling services, we're offering
7 more range in the types of services that are offered to families. So,
8 for example not only our projects expected to provide case management
9 and care coordination, but we also want them to focus on group-based
10 health and parenting education as well.
11 Applicants will also have the ability to use part of their
12 funding for a clinical provider. And whether that's a nurse
13 practitioner, behavioral health specialist, or a nurse midwife we want
14 them to select that clinical provider based on the needs of their
15 target population.
16 In addition, with respect to flexibility the community
17 consortia works with the community in order to develop a plan that
18 addresses the needs of their community specifically and the social
19 determinant of health that they would like to target. Next slide
20 please.
21 So lastly, I'll talk about what we heard regarding grantee
22 burden. I think throughout all three engagement sessions we heard about
23 the importance of ensuring that frontline staff like community health
24 workers, doulas, and midwives that their role is respected as equal to
25 that of clinical providers.

1 We heard a lot about the burnout that many of the front
2 lines staffers are experiencing specifically in the wake of the peak of
3 the COVID pandemic. We heard a call to prioritize recruitment and
4 retention strategies so that Healthy Start projects can maintain their
5 community health workers that build those lasting that lasting rapport
6 with families.
7 We heard a call to consider quality over quantity in terms
8 of numbers served. And we also heard that it's important to understand
9 that many of the community health workers are experiencing the same
10 stressors that are faced by the families in their own caseloads.
11 In the FY23 NOFO, we specifically highlighted that
12 applicants should consider strategies to support staff for attention.
13 And we linked to resources developed by the Bureau to help applicants
14 think through some of the strategies. In terms of the data and
15 reporting burden we did an internal analysis, and we definitely heard
16 the call that while grantees are committed to demonstrating their
17 impact, they challenged us to find ways that we could reduce the
18 reporting burden for them.
19 We examined what our program priorities are. We examine
20 potential areas of redundancies in information that we're capturing,
21 and through that analysis we were able to remove nine of the
22 benchmarks. And so, the FY23 grantees will see a reduction in the data
23 for the benchmarks that they're collecting.
24 Additionally, we have reduced the number for members served
25 in the FY23 NOFO for the case managed participants. Healthy Start

1 programs are expected to work with 450 participants and 200 through
2 group-based education.
3 Additionally, moving forward we're examining our own
4 internal monitoring protocols to identify ways that we can further
5 reduce grantee burden. Next slide please.
6 So, this is my contact information. If you have any
7 questions about the information that I presented I'm happy to answer
8 questions today. If you have questions about the FY23 NOFO I'm also
9 happy to take those via email today as well. Thank you so much for your
10 time.
11 [Applause]
12 MS. BELINDA PETTIFORD: Thank you so much. So now we're
13 going to open it up for questions. So, any questions from any other
14 committee members? Either ex-officio or appointed? Yes.
15 DR. DOROTHY FINK: I just have a quick question for Ada. I
16 don't know if you've gotten any provisional 2022 numbers yet but I know
17 at the national level what we're seeing is there is a significant
18 increase in infant mortality overall so I guess more of a comment to
19 you might be prepared to see something like that.
20 DR. ADA DETERMAN: Sorry, it looks like it was red, so I
21 wasn't sure it was on. Yes, we don't have the '22 data. We do have the
22 inputs from the grantees. I have to compile them still so that's
23 something we're working on. The 2022 data with regard to measures we
24 don't yet have that, we get those at the end of the month but yes, we
25 are currently about to switch '22 data analysis so yeah, thank you for

1 the heads up.
2 MS. LASHELLE STEWART: WE did notice that at the city level
3 in Baltimore, which I mentioned in my presentation.
4 MS. BELINDA PETTIFORD: And I wonder, are we tracking any
5 impact from COVID? Because we were seeing that in other areas and I
6 know 2022 could be Something to look at and maybe not. So, I don't know
7 if you all are looking at it that way.
8 DR. DANIELLE ELY: So, we have not officially put anything
9 out on COVID, but we have been kind of tracking numbers. And one of the
10 issues that we run into is just how it is listed on the death
11 certificates in terms--and we're just not seeing many COVID cases for
12 infants in general so it may not be necessarily COVID-19 directly.
13 MS. BELINDA PETTIFORD: Yeah, I'm thinking more about access
14 to prenatal care.
15 DR. DOROTHY FINK: So it could be more related to that but I
16 don't--We don't have the link data yet up for 22 to check into that and
17 so I can't speak in terms of access or how people are getting care but
18 we just know that overall we're seeing that in the professional
19 numbers.
20 DR. MARIE RAMAS: Great presentations. Just curious, both
21 ACOG and the Academy of Pediatrics on the Academy of Family Physicians
22 have all recommended this concept of fourth trimester care. You had
23 mentioned in your presentation that twelve weeks postpartum and that
24 one year postpartum how having expanded access and routine follow-up
25 can help prevent consequences both in a perinatal standpoint but also

1 capturing some of the highest causes of Morbidity and mortality for
2 their black birthing parents.
3 So, can you explain to me how that's being incorporated if
4 it's being incorporated? And how you can see that scaling in a more
5 ready fashion?
6 DR. ADA DETERMAN: Sure, I don't--Dr. Warren do you want me
7 to answer? It's okay. Yes. So, we have been--I was aware of the prior
8 2018 recommendation. And so, we've been working on this for about a
9 year trying to figure out how to do that measure to extend out the
10 twelve weeks. And I know I can mention both?
11 [Laughter]
12 Okay so within our Title V program they are moving towards
13 having the twelve -week postpartum visit, you know, measures as well
14 and Healthy Start will be online to that as well. We are also mindful
15 to the fact that a lot of states are moving towards having Medicaid
16 sort of cover the year of postpartum. So, it would be great if we can
17 really think beyond that because as you mentioned.
18 That's where a lot of the maternal mortality and one third
19 of the maternal deaths occur and the severe morbidities and the
20 follow-ups. So, we just want to make sure that we are on that and
21 tracking these issues and trying to move our programs into that
22 direction.
23 DR. MICHAEL WARREN: I was just going to say to what Ada
24 mentioned. So, Title V would be the CMCH block grant. We've just
25 published a draft guidance on that and so for the first time in many,

1 many years we've actually put in a required measure for states---states
2 to have a lot of flexibility to choose. But we actually, in a maternal
3 domain, are actually looking at a postpartum visit at which we are
4 required for all states to report given the current focus of the
5 department and the Administration.
6 MS. MIA MORRISON: And I was just going to add Just a
7 concrete strategy from our FY23 NOFO we've called out doulas as an
8 important component of clinical care team, if grantees select to use
9 their funding to hire doulas. And we know that doulas can work with
10 mothers in the postpartum, to help identify those maternal early
11 warning signs. And so, we're constantly thinking of strategies that we
12 can embed within our NOFO about that critical, early postpartum period.
13 DR. MARIE RAMAS: One last thing the Academy-- sure. Can you
14 hear me now?
15 SPEAKER: Yes.
16 DR. MARIE RAMAS: So okay, my apologies. So for the Academy
17 of Family Physicians, we're actually working on a project on fourth
18 trimester care specifically to identify what are the best practices for
19 primary care clinicians, not just maternity care clinicians but primary
20 care clinicians and that one year postpartum period to identify, screen
21 universally, and know how to manage it, treat and support birthing
22 individuals.
23 So that should be coming out actually in the coming months
24 as well.
25 MS. BELINDA PETTIFORD: Kate?

1 DR. KATHRYN MENARD: The question--really close-- to take us
2 back a little bit I think I learned this about a hundred and couple
3 programs funded. How many aren't? You know the applications that are
4 received and the need and that kind of thing that don't get funded?
5 DR. WARRREN: So, I don't know but we can find out that we
6 can share the exact number. We certainly get far more applications than
7 we do---then we have the ability to fund, that we have resources to
8 fund. So let me see if we can give an exact number in terms of the last
9 application cycle.
10 One of the things that we do have that we published, I
11 believe at the Healthy Start 2023, the enhance NOFO was a list of the
12 communities with excess infant deaths of fifteen or more. And just that
13 list alone takes up about half--would take up about half of the
14 available slots for Healthy Start. But let me see if we can get you an
15 exact number.
16 MS. BELINDA PETTIFORD: And I know that you're looking for
17 the number but at one point it was based on 300 communities in the
18 country qualifying for Healthy Start but it may not still be true. But
19 I know that at one point that was what the goal was and about one third
20 of the communities were funded. Based on the right, their infant
21 mortality rate was one and a half times. That was the data at one
22 point.
23 DR. MICHAEL WARREN: And we can pull that, I mean in
24 partnership at the folks in partnership with NCHS can look and see
25 because that's--That would be a simple analysis to see how many, if we

1 do it at a county level, to see how many counties. One of the aspects
2 of Healthy Start is that sometimes it's a single county, sometimes it's
3 part of the county, sometimes it's a group of counties.
4 So, what we could look to see how many counties have infant
5 mortality rates that high. One of--As you all know well one piece of
6 that is what's the number. So, you might have an area that's rural or
7 frontier just because the numbers are so small and have really wide
8 variations in their rates. We can do some digging on that.
9 MS. BELINDA PETTIFORD: Were you going to ask another
10 question? Okay.
11 DR. KATHRYN MENARD: Just--I've got some knowledge gaps. How
12 do you define--I mean is it depending on the community, the size of the
13 community, it's not county? Is it a certain number of births? I don't
14 know how you define a Healthy Start community.
15 MS. BELINDA PETTIFORD: Ma'am.
16 MS. MIA MORRISON: Oh sure. So Healthy Start communities can
17 define their project area using county ZIP codes or portions of county
18 zip codes. But they must meet the requirement for the infant mortality
19 right which is 1.5 times the national average and a specific number of
20 infant dads in the three-year period. If they don't meet the number of
21 infant deaths, then they can qualify using low birth weight rates or
22 pre-term birth rates.
23 DR. KATHRYN MENARD: So, you're really thinking about rural
24 areas, they have potentially a big geographic area but could define
25 themselves as a healthy star community to get the number of births per

1 year, or average outcome?
2 MS. MIA MORRISON: So, many of our rural project areas are
3 larger geographically.
4 MS. BELINDA PETTIFORD: Other questions? Yes Steve.
5 DR. STEVEN CALVIN: So maybe it's Ada that can answer this
6 one. The stillbirth rates?
7 MS. BELINDA PETTIFORD: A little closer to the mic, thank
8 you.
9 DR. STEVEN CALVN: Stillbirth rates? Maybe I'd missed it
10 because there are certainly disparities in that area as well. Is that
11 part of your measurement?
12 DR. ADA DETERMAN: No, we currently don't track that. We do
13 have questions related to other outcomes in the HSN media that I sent.
14 That's where we're analyzing the participant level data. But we haven't
15 actually pulled that information at this time. But you know in the
16 future we might be able to report on that. We do have other outcomes
17 that we can track.
18 DR. MICHAEL WARREN: I think there has been a growing
19 interest in that certainly across the department and colleagues At
20 NICHD and CDC have been engaged in network. A number of our state Title
21 V programs are doing work related to stillbirth and many of the Healthy
22 Start sites participate in their local fetal and infant mortality
23 review. So, you know it's not reported as a benchmark measure for them
24 they're engaged in those fetal deaths at the local level. And the
25 review of those.

1 DR. KAREN REMLEY: And we at the CDC are starting, lucky to
2 have funding from NICHD we're hoping.
3 MS. BELINDA PETTIFORD: Move closer to the mic.
4 DR. KAREN REMLEY: And to use our program MAT-LINK. I don't
5 know if anybody here is familiar with MAT-LINK which looks at mothers
6 that have had exposures to opioids and babies.
7 We're also going to have a pilot stillbirth modules and
8 some of those entities so that we can gather more, first find out like
9 what information is not being gathered and what those disparities are
10 to be able to start to look at causation and other issues.
11 MS. BELINDA PETTIFORD: Ada I have one question, well first
12 a comment. So, thank you very much for sharing this data. I think many
13 people have been wondering where the Healthy Start data is and for you
14 to do such an excellent job and sharing it and pulling it together, we
15 really appreciate it. I was also very pleased because I hear from
16 Healthy Start sites at different points in time.
17 Not just in my state but in others, that the benchmarks
18 were going to come down because there was concern about, I think it's
19 like thirty-six pages' worth of information you have to complete on one
20 participant which did seem a bit much. not just to me but for people
21 that I'm hearing from, and I see Lashelle shaking her head as well.
22 And so I'm grateful to see that that is being Revisited
23 because-- you know in my mindset and it could just be mine my mindset
24 is don't ask for anything you're not going to get a lot, because that's
25 time that could be spent doing having some direct engagement and

1 actually working on the program versus capturing information so I'm
2 very happy to see that so thank you for doing that component.
3 I wonder if there have been any conversation around and I
4 hear this from Healthy Start sites, around the numbers served. Because
5 the numbers served is the same no matter whether you are a frontier, a
6 rural, or an urban area and realizing that when you're dealing with a
7 transportation issues or just the size of the population it's a
8 different type of way that you have to serve them.
9 So, have there been any conversations around, and I don't
10 know if they came out in the RFI or the listening sessions around if
11 you are a rural area or a frontier area do you still qualify if you
12 serve fewer people? Has any of that been in any of your conversations?
13 MS. MIA MORRISON: Yes, so thank you for bringing that up
14 that is something that has been noted through the RFI And that's
15 something that the team put some thought into considering how to
16 approach. For the FY23 grant cycle we tried to dig in a little bit of
17 flexibility around the numbers served in terms of breaking up the
18 intensity of services into those receiving case management care
19 coordination and those receiving the group-based education.
20 We've lowered slightly the number receiving case management
21 care coordination and we've realized that depending on the geography of
22 the project area it still may be a wide area that projects are serving.
23 I do think that one silver lining that's coming out of the pandemic is
24 the use of Telehealth tools to connect with families and that's part of
25 the flexibility that we'd like to see and how applicants are proposing

1 to serve their families.
2 We definitely understand that virtual can't replace that
3 face-to-face human contact but for some families that may feel more
4 comfortable or it's a great burden to come to a Healthy Start site or
5 it's not feasible for Community Health worker to drive to a remote area
6 on a weekly basis we do appreciate seeing those strategies that
7 applicants and current grantees are using.
8 I know that that's not an immediate fix for that comment
9 that's been raised but I do want to assure that the bureau is
10 continuing to put thought into it.
11 MS. BELINDA PETTIFORD: Thank you so much. I appreciate
12 that thought process. I think that one of the challenges with frontier
13 and rural communities is still access to broadband internet. So, when
14 you're doing that telehealth, it sounds good until you actually try to
15 make the connection. So yes. I see Lashelle your hand went up?
16 MS. LASHELLE STEWART: Yes, I had, I guess it's one question
17 but it's twofold. Is there consideration to not have it be level
18 funding for the five years? Because what happens and that Healthy Start
19 program is that we have the same amount to serve families and the price
20 of everything increases each year, but our grant level is the same for
21 five years.
22 So, it makes it difficult to attract and maintain staff,
23 especially since everyone now is into community health workers whereas
24 Healthy Start was based on community based for thirty years and now
25 everybody else is catching up. So, we compete against hospitals and big

1 organizations who can better compensate their teams and also grow each
2 year in the compensation and benefits and that's something that we
3 don't have the luxury of at our level. So, I'm just wondering if that's
4 considered?
5 DR. MICHAEL WARREN: I will say there was feedback from the
6 field because one of the questions had to do with like funding and
7 funding strategies so two cycles ago there was a tiered approach where
8 everybody got the same amount so one of the things, we're interested in
9 is there a preferred strategy. And it was mixed in terms of what folks
10 want.
11 I think that just very practically the challenges that we
12 have what you talked about is what we get from the Congress stays flat.
13 So, we don't have the ability to ramp up the funding over time. What
14 that would mean if we would have to fund fewer programs. and I think we
15 have really wrestled with that internally to try to serve as many
16 communities as you can with some money-- or do you, you know, if we
17 were to get more money we could find more communities so with the
18 Healthy Start Enhance we got twenty-three more funding ten more
19 communities.
20 But when the size of the pot Remains the Same that's the
21 constraint unfortunately that we've been working under.
22 DR. MARIE RAMAS: Yes, just to that point there's something
23 I know that is an increasing area of concern in the medical community
24 is how do you get the right level service to those in the population
25 that are in highest need and have Downstream highest impact as far as

1 cost utilization and poor outcomes?
2 And so, I think if I may reframe the approach, it's not
3 necessarily losing any of the services it's been getting better at
4 identifying who absolutely needs those services and who can have a
5 greater impact from the interventions because we have limited
6 resources.
7 And to that point I'm curious in the CDC or with our
8 partnerships has there been any movement towards identifying not just
9 specific, because we all know the segregate populations are the highest
10 risk. So, we all know that but how do we identify the actual people,
11 areas, populations that would most highly benefit from a public health
12 standpoint from the interventions that are available because then we
13 can create margin to bring people up to the rural spaces right.
14 So, I think that would be while we want everyone to have
15 universal access that would be with limited means and Congress at that
16 point, they're interested in how do we save, you know how do we save
17 unnecessary expenses.
18 DR. ADA DETERMAN: This is not really a direct answer to
19 your question, but we've had conversations, like I'm mostly talking
20 about part of the evaluation team and working with our contractor. We
21 did pull together they have sort of like this expert panel that works
22 behind the scenes with them.
23 So we have pulled our extra panel and we kind of think
24 about how do you sort of do the rest assessment profile for the you
25 know within the participant group so that way maybe you can have more

1 targeted interventions or more intensive interventions going to that
2 ones at highest risk if they had you know like prior adverse outcomes.
3 There are a whole host of things that we've discussed at
4 some of these meetings to try to figure out what what's a way that we
5 can use especially our data that we have collected to try to figure out
6 how to kind of like maybe do tiered approach in that manner and have
7 more frequent visits with those and maybe you know have a quarterly
8 visit with those that may be a little bit over risk but still at a high
9 risk because they live in our communities.
10 DR. MARIE RAMAS: and I would hope that the expert panel
11 reflects the demographic populations that are most adversely affected
12 as well. because it helps to identify blind sides too but that's
13 wonderful thank you.
14 DR. MICHAEL WARREN: I think one other change we introduced
15 in the most recent NOFO was the addition of the group education option
16 recognizing that there might be some economy of scale in a lighter
17 touch intervention. At the same time, we were very clear like I don't
18 count a health fair as a group, like a one-time health fair as a group
19 educational event in terms of having some-- some sort of more involved
20 touch.
21 So that's a new thing for this cycle. We'll see where that
22 goes but that may be a way that will help folks sort of triage
23 resources to be able to focus more intensive resources on a more
24 sustained basis on a smaller group and be able to reach broader folks
25 at the community level through those group sessions.

1 MS. BELINDA PETTIFORD: And when you asked your question
2 Marie, I quickly looked at Kate Menard because she and I were thinking
3 about I think the same thing. In North Carolina we didn't do it as part
4 of a Healthy Start but we did do it as part of our pregnancy medical
5 home where is part of our pregnancy medical home we actually develop a
6 maternal and infant impact ability score so we can determine which
7 population or which individual actually would benefit the most from
8 getting care management services.
9 So, there's been some work that's been done with that. I
10 don't think that we can just share because I don't know if I have it,
11 but I think that we can connect you with the people that did it in
12 North Carolina and have some conversations if that's something. Kate.
13 DR. KATHRYN MENARD: I just know there's some more to be
14 published on that, with the works that we published on that program it
15 showed a narrowing, that the low birth weight was an outcome of a
16 narrow ring of the disparities and low birth weight of that change and
17 stratifying who received care and I think a lot of---and this is just
18 stimulating me to think more and more about whether---
19 Baltimore has done this beautiful work at the community
20 level and you've made the great case that you're--you know, working
21 with the community on so much individuals whereas certain communities
22 that are benefiting from that are like "man, wouldn't it be great if
23 everybody could be a Healthy Start Community" right because everybody
24 needs it.
25 But the pregnancy medical home program which was the

1 managed care-- it was the care management program for the entire
2 population before we split into five Managed Care programs. But it was
3 for the entire population and entire and everyone got screened, well
4 not everyone but as many as we could, and that data was used to find
5 out who would benefit most from care management.
6 But is it better to use these funds for these targeted
7 community populations or is it better to use these funds to-- at the
8 population age where you'll find more people? Your thoughts Dr. Warren.
9 on that or is it a blend I don't know?
10 DR. MICHAEL WARREN: I think probably it will be a blend of
11 both. The reality is, since we're talking about relatively small
12 dollars, so right now the Healthy Start Grants are a million dollars a
13 year for the community so to do both of those things might be a toll
14 order.
15 We could also go back to just authorizing legislation and
16 the instruction and then watching the Congressional Budget to tell us
17 what to do and I think you're seeing that across multiple of our
18 programs that approach of their sort of a population level certainly a
19 targeted universalism approach and then thinking about okay for folks
20 who either screen or identify through those efforts getting a much more
21 focused service home visiting follows a similar kind of model in some
22 communities so it's good for us to continue to think about.
23 MS. BELINDA PETTIFORD: And I will just acknowledge now,
24 Lashelle did an awesome job with her presentation but when you see one
25 Healthy Start site you've seen one Healthy Start site. And Lashelle

1 could probably talk about other resources that she has leveraged to be
2 able to do all the work that they do in Baltimore. She's not able to do
3 this with a million dollars she needs smaller than that.
4 And so, I don't want people to walk away saying oh it looks
5 like every Healthy Start site looks exactly like that. They do not. But
6 Lashelle, I don't know if you were going to say something.
7 MS. LASHELLE STEWART: Yeah, that's what I was just about
8 to say, Belinda. A lot of the things I mentioned are not funded by HRSA
9 because we only get nine hundred and something thousand per year, which
10 was cut we used to get two million per year to do the work and so it is
11 a collaboration between a lot of funding sources at Healthy Start
12 programs.
13 Mine is not unique. We find ourselves kind of like in a
14 hamster wheel of always trying to find funding to keep the work going,
15 to do what the families need. So, it's not, I know I probably made it
16 sound easy but it's not easy at all. And Andre's gone now but earlier
17 he talked about hubs, and I said to myself that's what Healthy Starts
18 really are.
19 We are hubs in the community. There's a lot of things that
20 come under our umbrellas. And so if it was just not HRSA to fund these
21 initiatives that are supposed to be reducing maternal health but if it
22 came together of a bunch of federal programs that really looked at all
23 of the work that Healthy Starts do in the communities to meet the needs
24 of families then we probably could get enough and it not just come
25 solely from the maternal Health Bureau and HRSA but other programs as

1 well.
2 MS. BELINDA PETTIFORD: I see another question from
3 ShaRhonda and ShaRhonda do you want to come off mute and ask your
4 question?
5 MS. S. THOMPSON: Yes, I do. So I know it's mostly a lower
6 income individuals that's the focus but I noticed that in our area and
7 maybe more areas but, there's been a huge cry for help for median
8 income households because they kind of fall into that whole not low
9 enough to be eligible for assistance but not enough to execute
10 everything to flow as well.
11 Is there anything in place to address the help for those
12 pregnant mothers?
13 MS. MIA MORRISON: That's a great question and I can begin
14 to address that. So Healthy Start and I can speak directly to the
15 guidance that's in the FY23 Healthy Start enhanced initiative.
16 Project funded projects are intended to serve families
17 within the project area. Over fifty percent should be from the target
18 population and the target population is the population with the highest
19 infant mortality rates living within the project area. However, any
20 pregnant women, interconception women, father whose interested in
21 Healthy Start Services living in the project area should be able to
22 receive them.
23 MS. BELINDA PETTIFORD: So ShaRhonda, it's really not
24 specifically based on income.
25 MS. SHARHONDA THOMPSON: Okay good to know.

1 MS. BELINDA PETTIFORD: That is a good question, thank you.
2 Yes, Karen, I'm sorry.
3 DR. KAREN REMLEY: This makes me think about centering
4 pregnancy models and I don't know, I'm wearing my old state health
5 official hat more than I am my CDC hat because that's not where we are.
6 But CMS has never really done, in my mind, you may know more than me
7 about this Michael, really push state Medicaid organizations to think
8 about better ways to fund centering pregnancy models.
9 You know when I was seeing your belly buddies and thinking
10 still it's Healthy Start light but it's better than nothing and if it
11 was fun to appropriately you know, because there's so much evidence to
12 show that a decrease in maternal and infant morbidity and mortality.
13 DR. MICHAEL WARREN: I would just say that's-- and we didn't
14 specifically call out centering since it is a proprietary model, but we
15 did reference group prenatal care to that point in the FY23 NOFO as a
16 strategy that folks can use their money to do. Because prior we really
17 didn't focus on individual case management and opening that up to group
18 that's one of the allowable uses there.
19 But to your point there's not enough money in Healthy Start
20 to do that. And so, thinking about other strategies, Title V comes to
21 mind. Some of the state title V programs have done group prenatal care
22 pilots. I think more of what I've seen with working with individual
23 managed care organizations within States, that's certainly something
24 that we can take back.
25 [off mic]

1 DR. MICHAEL WARREN: I mean there was a strong start a
2 number of years ago and so there is some evaluation that would lean in
3 that direction both for that, pregnancy medical homes, birthing
4 centers. I'm sure there's something I'm leaving out but yeah.
5 [Off mic]
6 MS. BELINDA PETTIFORD: There are some states that
7 incentivize group prenatal care. South Carolina does it. I think
8 Georgia. We just got funding from our general assembly in North
9 Carolina that we will be incentivizing so CMS is engaged in it, it may
10 not be elevating it yet. But I know there's a handful of states. Yes
11 Allison, that actually does, Medicaid does incentivize it.
12 DR. ALISON CERNICH: They are looking I think also and
13 want-- you may even want to think about CMS. I think CMS has been
14 trying very hard to modernize and extend benefit as well as
15 measurement. And so, I think they also have the birthing friendly
16 hospital designations that they've rolled out that have parameters that
17 have to be measured in order to meet sort of that bundle.
18 So, I think they are doing probably about right-size some
19 of their reimbursement. I don't know if it's everything that you all
20 are talking about, but I think they have tried quite a bit over the
21 past
22 year.
23 MS. BELINDA PETTIFORD: Thank you. Any other questions?
24 Before you get to go on break. Any questions? Yes Marie.
25 DR. MARIE RAMAS: I'm going to just reiterate. the United

1 States still has the highest Black maternal infant mortality rate in
2 the world and so while it is important that everyone get equal access
3 to these amazing resources, at the end of the day we still are in a
4 maternal Health crisis in our country and so I would-- I would be very
5 interested in seeing how CMS addresses that specifically if there are
6 specific geographic areas, rural remote, or urban that are serving a
7 particular population that is literally dying by the second in the
8 country.
9 Then that is what we need in addition to generalized
10 expansion. We don't have the luxury of time to--to keep pontificating
11 on things we already know exist which is Black birthing people are
12 dying, Black babies are dying, and it could be prevented. We had a
13 recent Olympiad who died in childbirth at home. Young, healthy Olympiad
14 with suspicion of preeclampsia.
15 And so, while it's our job, it's our job to create
16 additional urgency in the things that aren't working and then expanding
17 programs that we know are working to the populations that needed the
18 most.
19 MS. BELINDA PETTIFORD: Thank you Marie. I will say our CMS
20 representative was not able to join us today, but we'll make sure that
21 we pass this information on but it's a good segue to our conversation
22 after lunch--I mean after break. You did have lunch. I know you did.
23
24 **Break**

25

1 MS. BELINDA PETTIFORD: We will take a fifteen-minute break
2 now and if we could get everyone to come back at 3:48 you get to have
3 your whole fifteen minutes, thanks.
4
5 **Open Discussion**
6
7 MS. BELINDA PETTIFORD: We're going to be starting back on
8 our agenda next. We have time for just some open discussion from the
9 committee and we wanted to use this as an opportunity to First think
10 about the presentations that we've heard today. See what resonates with
11 people. I know we've had some really awesome presentations. Good
12 discussion.
13 And then we're going to roll over into thinking about some
14 of the recommendations or priority areas that we can consider to
15 develop recommendations for. But before we go into those priority
16 areas, I do want to open it up to see if anyone has anything that they
17 want to share based on the conversations and the discussions and the
18 great presentations that we've had today.
19 We have spent a great deal of time focusing on social
20 determinants of health or social drivers of health. We specifically
21 narrowed the focus down for this meeting to housing. And then we wanted
22 to have some time to really delve into the Federal Healthy Start
23 program so that all of us will be aware of it. So, any thoughts,
24 questions, concerns as we think about our next steps?
25 Because I shared earlier our last round of recommendations,

1 we submitted fifty-nine recommendations. And the Secretary, we
2 anticipate we'll get a response at some point but fifty-nine is a lot
3 so we may want to narrow it down. Maybe not fifty-nine. let's go round.
4 I have enjoyed the conversation I've had with each of you
5 because I did reach out to all of the appointed members. I haven't
6 gotten to the ex-officios yet but the appointed members I did reach out
7 and do one-on-one conversations with each of you. Just to get a thought
8 about priorities that will come into your mind that you're thinking
9 about that we should move forward with.
10 So within this next, you know, when we have our meeting in
11 December we will use that as an opportunity to figure out exactly some
12 specific presentations that we may want to be around those areas so
13 that we can make sure that we're following and looking at the latest
14 evidence or any promising strategies that may be going on in that area.
15 And y'all are just going to let me keep talking, right?
16 Yes, thank you, Phyllis. If you'll get close to the
17 microphone, you can pull the whole thing forward.
18 DR. PHYLLIS SHARPS: I think it was very great to have the
19 housing and health presentation. They were awesome. I would also
20 suggest that we think about housing in I-N health. We pilot test in
21 Baltimore-- pilot tested through our own nurse clinics in John Hopkins
22 School of Nursing, we pilot tested a couple of pilots where we set up
23 nurse-led centers in housing.
24 One was an elder housing, and one was in a shelter for
25 abused women of which at any time a fourth of the sixty residents that

1 were there were childbearing or had babies recently. and we got some
2 promising results and I think because of the combination of federal
3 agencies HUD, HRSA, the focus on workforce diversity preparing
4 other-- you know like you could have these projects staffed by
5 midwives, doulas and other community health workers and I think it
6 would have some of the very important outcomes that we see as a result
7 of home visiting.
8 You could even probably do some centering pregnancy
9 situations if they were in housing settings or women are. Or if there
10 are federally located or subsidized housing in the areas where you
11 might have a high proportion. Or maybe even in some of the Healthy
12 Start programs. Just testing innovations for doing that bring
13 healthcare to where women are because it decreases transportation
14 barriers and all the other kind of things that sometimes women have in
15 terms of and other parents, fathers, kids. You could do well-child care
16 there and accessing barriers.
17 We also had some health care in our childcare centers that
18 the School of Nursing staffed. So just the thought of thinking about
19 innovations and kind of bringing effective activities together in one
20 place that makes it easier for women to access care.
21 And then I wanted to follow up on something Marie was
22 talking about, and I think it's the struggle we have around just
23 allocation of federal resources. The question of equality versus
24 equity. And we know that there are some communities that, you know
25 we've all seen that diagram of little boys at different heights and

1 what happens if you give them a stool to stand on that's the same or
2 you give them a stool that's based on their height so they can see over
3 the wall. I think everybody's seen that.
4 It's the same thing here that I think probably certainly
5 the mood of the country and that kind of thing, but we know that there
6 are Populations that need more resources. We know that some of it
7 comes from where Joia said in terms of institutional racism, how we put
8 agencies together that have created these disparities and unequal
9 outcomes in healthcare.
10 So, it--it's something that I think will take a lot of
11 courage but it's something that I think we need to continue to think
12 about and whether or not how we could get resources where they are most
13 needed.
14 MS. BELINDA PETTIFORD: Thank you Phyllis. Others want to
15 chime in? If someone wanted to say something virtually, then you're
16 welcome to just come off or you're already unmuted.
17 DR. MICHAEL WARREN: So, one quick thing in response to Dr.
18 Sharps' comments. I think we've been trying for a few years now to
19 think how do we like laser focus on inequities. And how do we target--I
20 think it goes back to that conversation we were having before when you
21 try to do something really broadly focused.
22 And so, we did the first analysis looking at the excess
23 infant deaths and the distribution of those. We know the states those
24 are in. We know the counties those are in. Those deaths due to
25 disparity inequity. In the most recent Healthy Start competition not

1 only did we call that out, but we've given those priority points.
2 So that the communities with the highest number of excess
3 infant deaths actually get an additional points in the scoring and so
4 that doesn't completely get us there but I think it's a step moving in
5 that direction. To use your example the stools. It's the stool to be
6 able to move. It's more to do but it's a step in that direction.
7 MS. BELINDA PETTIFORD: Thank you. Others?
8 MS. S. THOMPSON: That goes right in line with what I was
9 working off earlier about the income. We do know that for
10 African-American women disparity is there regardless of their income so
11 for focusing just on lower income moms we miss a whole group of women
12 that still need, or birthing parents that still need that type of
13 assistance. Because they are still experiencing the same inequities.
14 MS. BELINDA PETTIFORD: Thank you ShaRhonda. Yes Steve.
15 DR. STEVEN CALVIN: Sure, I'm really happy to know we're
16 going to St Louis in December to visit ShaRhonda because having gone to
17 medical school there about forty-three years ago, you know at that
18 point there was a very, it was a segregated city. The medical system
19 was totally segregated, and I think ShaRhonda could probably also tell
20 you that things haven't improved a lot despite the fact that there
21 is-- there's been efforts. So, I'm excited about doing that.
22 I wanted to say how much I appreciated what Marie said too.
23 That it's our job to point out the urgency. I mean what we're hearing
24 about all these things I think all the work with Healthy Start is great
25 because what it does is it proves what works. strong start proved what

1 worked the problem just has been we face barriers.
2 I think tomorrow we're going to hear from what Medicaid
3 Managed Care carriers. I think that's what Jennifer Moore and her
4 colleagues are going to bring to us and that'll be great.
5 But I just know from the experience that we have in
6 Minnesota some states are under resourced as far as Medicaid. Louisiana
7 probably for sure I know that. For sure Minnesota is not. If you add up
8 the monthly payments for mother and baby through the course of a
9 pregnancy episode is $28,000. and I think in Louisiana last time I
10 checked with some of your colleagues it might have been 7 or 8,000 so I
11 mean it's not much.
12 And so that $28,000 was currently given to entities that
13 were supposedly managing care but entities that we know work, midwife
14 care birth center care are either underfunded by the management-- those
15 who are managing funds.
16 Because you just go back to, you know, most states have
17 data reporting or actually financial reporting of how much is spent and
18 you know it's obviously federal and state funding. Which is probably
19 why CMS has such a hard time doing anything because the Feds will point
20 to the States and say they're doing their own thing and they've got the
21 politics and the States will point to the CMS and say CMS won't let us
22 do this. So, it's kind of, it's a cover. It's a fig leaf for both to
23 say we can't do anything.
24 I think it's really going to take leadership and a
25 bipartisan way of leaders saying enough of this. We've been talking

1 about it for so long so I know for sure in Minnesota we're trying we're
2 trying to test things that would work better, putting in the hands the
3 management of the care in those that are managing the care as a team
4 and it is includes all the way from doulas to midwives, physicians,
5 hospital systems. So, I'm looking forward to tomorrow to continue
6 pushing on that.
7 MS. BELINDA PETTIFORD: Yes, Marie?
8 DR. MARIE RAMAS: Thank you Belinda. Something that I know
9 you and I talked about was one, a desire to have some implementable
10 recommendations in the near future, mid-future, and late future right
11 so getting some contacts as far as chronicity is concerned with some of
12 the recommendations.
13 Something I think might be interesting to explore is how
14 can we encourage and how can programs like HHSC for instance encourage
15 pathways for clinician extenders to maternal infant care? So, we talked
16 about community health workers as being a vetted, evidence-based
17 intervention, an extension that can not only bring return on investment
18 but also help to reduce downstream outcomes.
19 But then also we have potentially other healthcare
20 professionals or healthcare proxies that can help support the work. In
21 the substance use side, we have behavioral health technicians and so
22 they're not necessarily behavioral health specialists, they can't
23 prescribe medication, but they know just enough to do the screening,
24 and they know their community just enough so that they can be a Gateway
25 into access to care.

1 And so, I would be interested in identifying what are some
2 novel approaches to expanding access to care to communities that need
3 it and considering are there paraprofessionals? Just like we have para-
4 teachers, para-education. do we have paraprofessionals that can help be
5 extensions within this collaborative maternity care model? and so
6 that's something I would like to look into a little bit more. Do we
7 have best practices?
8 The other thing that I think that is interesting is doing a
9 deeper dive into what diversity means from a federal definition
10 standpoint and then what diversity might mean from a state standpoint
11 because that is very different.
12 So, in Massachusetts, for instance there are about, I think
13 we're at twenty-eight different ethnicities that are listed when you
14 are describing race and ethnicity in their general data. That's not the
15 case in the federal standpoint when we're getting funding. However, we
16 do know that there is a diverse experience within those who identify as
17 Black or Hispanic, right. And with that context comes different
18 expectations and different approaches to those populations.
19 And the third thing I don't think we've done enough, and
20 I'd be interested in looking into is this concept of rurality but
21 taking a sub context of different cultures within the rural experience
22 in America for our birthing parents and the families that take care of
23 them. I think we have an opportunity to go just a little bit deeper and
24 understanding the complexity of rural health care and access in
25 understanding what that means.

1 I can tell you the New Hampshire Policy Institute has done
2 robust research regarding how do you define rurality, how that
3 contributes to disparities in a unique way and just about every state
4 in the United States has rural pockets. So, I think that might be
5 interesting to-- for us to look into and then that could give the
6 secretary hopefully some additional insight and nuance as they're
7 considering approaches to this topic.
8 MS. BELINDA PETTIFORD: Thank you, Marie, I'm going to
9 switch us a little bit. Keep those thoughts coming because I did again
10 meet with each one of you individually. And so, I pulled together at a
11 high level some of the recommendations that were coming from you all as
12 to areas that we should prioritize. So, can you pull up those slides?
13 Thank you.
14 And I didn't associate any name with it so if you see
15 yourself in it that is great. Hopefully everybody saw themselves since
16 I was merging them all together from multiple conversations.
17 And I wanted you all to just kind of see the various
18 priority areas that we have that based on the interest around the tape
19 and that includes the virtual table. This is just part of them.
20 So, one of our potential priority areas is several of you
21 mentioned was the focus around our wraparound service and thinking
22 about the models of prenatal care looking at things like social
23 workers, community health workers, doulas, what is going on with
24 lactation specialists, all of those are an area that some of you were
25 interested in.

1 Another area of interest was the impact of social
2 determinants of health or the social drivers of health. This included
3 transportation, rural access, housing, job training, childcare, a
4 livable wage, even legal justice. These are just some of the priority
5 areas.
6 Another area was reproductive justice. What's the impact of
7 unwanted pregnancies, the impact of reproductive health restrictions
8 that we are seeing around our country?
9 A fourth area was systems challenges. So, if you look at an
10 unwanted pregnancy what is going on with the systems that individuals
11 may need to utilize. With our adoption system. With our foster care
12 system for example.
13 The next slide please, because I don't want you to think
14 it's just four. The next area, the systems of care to support rural
15 hospitals. So, we think around our country rural hospitals are closing.
16 And also issues around levels of care.
17 And some of the conversations I heard around levels of care
18 were some of it is related to the rurality of our country, but some of
19 it is related to hospitals that have been bought by larger entities.
20 So, you might could look in your state and most of the
21 hospitals are owned by three or four different entities or one or two
22 and how does that impact our regionalization process?
23 There was also interest in data. Data around preterm birth,
24 around maternal mortality, around maternal morbidity. I probably should
25 have put stillbirths there as well because that was another area where

1 they were priority-focused.
2 And then there were some that were interested in the root
3 causes of disparities or inequities, or racial discrimination, or bias.
4 and what's going on with our political climate and how do we address
5 those areas.
6 Another area is impactful opportunity. So, what is working
7 in our communities? What does the evidence say? Most importantly, what
8 is working around the country? Some communities are doing a really good
9 job in addressing these issues. So, what is working? What are those
10 promising strategies or those evidence-based? And what can we learn
11 from them to be able to utilize it more broadly and to help it spread?
12 And then one more slide: How does the money flow with the
13 payors? And this is the private dollars and the public dollars, what
14 is going on with the money? As they say, follow the money.
15 There was also interesting preconception and
16 interconception health and healthcare in general. Some of this was
17 fourth trimester but a lot of the conversation was around what is
18 happening to individuals before they get pregnant. And what are those
19 symptoms that are in place to support them? And how do you reach them?
20 There was also interest in looking specifically at extreme
21 preterm births as well as birth defects.
22 And then last but definitely not least is accountability.
23 So how are all of these things, depending on which direction we choose
24 to go, how is it measured? So, there are twelve buckets right now, and
25 that doesn't include probably our conversations from today.

1 There are twelve buckets based on individual conversations
2 that we've been able to have. I do appreciate your time that you gave
3 me to have these individual conversations, but it is trying to figure
4 out-- we do not want-- I don't think the secretary even wants us to
5 give him fifty-nine more recommendations. I think we've got a narrow
6 down our focus and really think through what is actionable.
7 So, some of the questions I started thinking about that
8 attempts to narrow it down is what resonates with the majority of us.
9 Is there anything else on this list that can be merged? And if we go
10 down this road what are the implications of trying to do some of it in
11 smaller work groups? realizing right now or not a full capacity.
12 We have ten members—no, nine members that we've lost--so,
13 we have ten members. We have ten members to participate. Hopefully
14 we'll have some more members on board by December, that is the hope,
15 and we know that it is trying to be elevated. But right now, it is us
16 and so how do we--I'll send the ex-officios-- we do have wonderful
17 staff to support us, but we do need to think about that.
18 So again, I want us to really think through. We can go in a
19 lot of different directions, or we can pick a couple of directions and
20 try to get more information about them, learn about them and then kind
21 of make recommendations from them. What is your pleasure? And ex-
22 officios please feel free to speak up as well because even though I
23 didn't do one-on-ones with you all we still have time between then and
24 December. Yes Kate.
25 DR. KATHRYN MENARD: When I look at this wonderful list, I

1 can, I see some people.
2 MS. BELINDA PETTIFORD: All the names have been left off.
3 DR. KATHRYN MENARD: Everything's deserving right, and
4 important. I'm thinking, “how would I do it?" I like the idea of seeing
5 what resonates the most. We need passion right behind these to get to
6 work done.
7 But how do you-- how do you decide? Like decide by one of
8 those 4x4s by what's possible, you know what's high impact. what's
9 possible in this environment, this political environment even to impact
10 what's impactable. I think if we could almost have a framework for
11 rating them and the decision making that might be helpful.
12 MS. BELINDA PETTIFORD: We can come up with a way to rate
13 them if need because you know we can turn this and we can put up some
14 flip charts in a minute and put some dots around. But there are other
15 ways we can do it as well but that's an excellent point. Marie.
16 DR. MARIE RAMAS: Yeah, just to expand on that a little bit.
17 What are the areas of focus for our Secretary as well? Like what are
18 his, what's on his agenda and how can we potentially amplify and
19 address in a more strategic and actionable way? Would we be able to
20 have somewhat of an insight into that?
21 MS. BELINDA PETTIFORD: Well and I think that, Alison, I'll
22 let Alison speak. Because I think there's a way for us to do that. We
23 talked yesterday to Carole Johnson, the host administrator to try to
24 find out some of those same things and really try to figure out how do
25 we narrow this down. Because part of the reason that we've asked all of

1 these National Partners to come and present in our meetings is to
2 really think through synergy. So, what are the National Partners
3 focused on as well?
4 As you recall, our March meeting, we had several of them
5 are quite a few of them actually present and let us know what their
6 priorities were tomorrow. We have two other groups that's going to
7 share priorities so maybe connecting it to about where the synergy is
8 at this point in time. Yes, Alison?
9 DR. ALISON CERNICH: I was just going to suggest the other
10 thing, very similar. All of us are working on agency priority goals,
11 and we're also working on, if you're familiar with it, the Maternal
12 Health Blueprint that is issued by the White House that reflects the
13 Department's priorities.
14 And so, if you look at those areas we can, you know as the
15 ex-officios, we can tell you some of the places we're already working
16 to help you narrow your list. It's hard for you all to know all the
17 pieces, parts of the things that were already doing. And if that gives
18 you a way to identify gaps that's something that we can do as a group.
19 MS. BELINDA PETTIFORD: Yes Karen.
20 DR. KAREN REMLEY: I think the other thing, and I say this
21 probably not as the CDC right now, but as in my other lives, is maybe
22 looking at what can federal, what can advising the federal government
23 that the federal Government can actually make a difference? or is this
24 a real problem in our country but it's not going to get-- you know if
25 you're trying to prioritize.

1 Is it something that's in the purview of the federal
2 government? But if it's not then it means you have to go advocate the
3 Congress rather than you have to share with the Secretary. Some
4 thinking, maybe we're trying to prioritize like kind of what can the
5 Secretary with his divisions, agencies, and the President do and how
6 can we give him things that are actionable instead of this is a really,
7 really bad problem but you guys have absolutely no leverage to pull.
8 That doesn't mean it's not equally or even more important
9 but just not within this group's purview.
10 MS. BELINDA PETTIFORD: And I think that's great way that we
11 can think about it but a part of me also thinks about do we use that
12 also as an opportunity to even if it's not on someone's radar to move
13 it to the radar.
14 And so when you limit it to just what is already on
15 everyone's radar, again it may just be finding out what are the
16 priorities and it may work perfectly for this group but I wouldn't want
17 us to just limit ourselves there, if we really think there are issues
18 you know as I said if the house is on fire we need to be able to share
19 that now.
20 And those things may be on the radar, hopefully they are.
21 But I totally understand, and I think we've had several meetings where
22 the conversation has been around so what does the Secretary have the
23 ability to influence? and should our recommendations just follow there.
24 and so that's the direction we should go if that's where the majority
25 wants to go.

1 Sherri has her hand raised and then I'll come to Marie.
2 DR. SHERRI ALDERMAN: Yes, thank you very much. Sorry I
3 have a smattering of thoughts, so I'll try to organize them at least to
4 the extent that you'll be able to understand what it is I'm thinking
5 right now.
6 One is that I really think could be very informative for us
7 to be able to tackle this work that we're doing is to have a deep
8 understanding of what is involved in States who have Medicaid waiver.
9 Those are intended to be innovations and there's more emphasis on
10 social determinants of health or social drivers of health.
11 And that's if we could have an understanding of what has
12 come, what have we learned from those Medicaid waivers and how we might
13 be able to see the fit, the alignment with what it is that we wish to
14 learn about and make recommendations for. they go back a long ways and
15 I think there's a lot of--a wealth of information there that will be
16 able to inform our work.
17 I would also be really interested in learning how the CMS
18 bulletins are formulated. Where they come from. It appears to me as an
19 outsider that it does not require legislative action. That it's a
20 mandate coming from CMS and imposed on States who receive Medicaid
21 dollars. And whether or not that might be a way of advancing the work
22 that we're doing to be able to have an understanding and how we might
23 be able to communicate with those with CMS and create those mandates
24 that go out to states.
25 I also know that a social driver of health is zip code and

1 that is, that goes beyond the metropolitan areas and into the rural
2 areas as well. I spent ten years working in the NICU and an
3 ultra-premature baby coming in and being transported from a rural area
4 was always a very complicated medical presentation beyond that births
5 of premature babies within the hospital. And that's an important
6 consideration.
7 It's quality of education and literacy and health literacy
8 also is disproportionately impacting rural communities. I really think
9 that's supporting rural communities could have two major benefits.
10 One is it has the possibility of, and I hope to pull the
11 country together and that could be a perhaps even nonpartisan issue on
12 how we support rural communities and in supporting rural communities we
13 also are working toward National Security.
14 We know that military offenses found outside the country
15 are targeting populated areas and we know from World War II and Germany
16 that it was the rural communities that actually rescued society and all
17 of the operations there in and supporting our rural communities could
18 be framed as a national security.
19 And then when I think about literacy, I think about too
20 being incarcerated people. We currently have a strategy of
21 incarcerating illiteracy as a way of removing them from the general
22 population and we also know that babies are born in prison and I think
23 that we need to keep that on our radar as well, is what's going on in
24 our prisons and how that's impacting families, how that's impacting
25 pregnant individuals and babies. Those are my scattered thoughts.

1 MS. BELINDA PETTIFORD: Thank you Sherri, we appreciate your
2 thoughts, and I think Marie your hand was up?
3 DR. MARIE RAMAS: Yeah, I think those are great points
4 Sherri. I think it will be helpful just summarizing some of the
5 comments that we had. We just need to know what the current state is
6 so we know where we can impact at least I do and so having a list of
7 the objectives or the goals and seeing what is already in process there
8 might already be programs in synergies that can be amplified to the
9 Secretary's purview.
10 I also think it is extremely important for us to identify
11 what is the fiscal impact of whatever we decide to propose to the
12 Secretary. Either where's there a lack of information to identify
13 fiscal impact or what are some models and potential frameworks that
14 would be involved in clarifying and defining fiscal impact.
15 Because even if it may not be what we suggest, may not be
16 in the purview of the Secretary, if we have a tangible amount or dollar
17 requirement that might provide some creative resources with all the
18 stakeholders that we have access to I think also providing fiscal
19 impact would help to identify what is the longevity.
20 And again, timeline and what is, realistically can be
21 accomplished in this short-term versus long-term. So that to me seems
22 very important and whatever we decide to do.
23 MS. BELINDA PETTIFORD: Thank you, Marie. Anyone else?
24 So, if I'm hearing you all correctly, we want a little bit
25 more information on what the priorities are coming from the Secretary

1 and all of them as well as the offices that he has that he can
2 influence that he actually has purview over? Am I hearing that
3 correctly?
4 So, we want to know what those priorities are so we can see
5 if there's a way to, you know to help elevate those issues to maybe
6 provide more support for them.
7 But also, if I'm hearing correctly, or some of those
8 priorities can they be directed to looking at what is happening in
9 rural communities, what is happening communities of color, whether
10 there are specific communities of color where their outcomes may be far
11 worse than others? I just want to make sure I am hearing everyone
12 correctly so that when we start working on this December agenda, you
13 all won't come back and say well that's not what we talked about.
14 [Laughter]
15 So, we want to hear from the Secretary's priorities and
16 then we can get with the ex-officios. And I think Kristen is now on
17 with CMS and I'm not trying to put you on the spot Kristen, Kristen
18 Zuckerman, if you just want to come on and say hello. We won't ask you
19 to answer any questions right now. If you want to just come off of
20 mute and say hello.
21 MS. KRISTEN ZUCKERMAN: Hi. Thanks so much. Sorry, I wasn't
22 able to join earlier but I was very happy to see the priority slides
23 that you put on him from your meetings with the individual members that
24 was great to see.
25 MS. BELINDA PETTIFORD: Thank you Kristen. I've got a

1 feeling we're going to be asking you questions later we just won't be
2 asking them today.
3 MS. KRISTEN ZUCKERMAN: Happy to field them and or take
4 them back if I'm not able to answer on the spot but will definitely
5 follow up with the group.
6 MS. BELINDA PETTIFORD: Thank you, yes Kate.
7 DR. KATHRYN MENARD: What you said back to us, and I think
8 we heard, you put several questions up there that I think we could make
9 progress on now. Am I the only surgeon in the group? I may need to get
10 that going. You made that point.
11 If we wait to December and--and you know, wait for more
12 information to make a decision, at least my term on this committee will
13 be passed before we get going. And so, can we move forward at least
14 part way while we gather that more information?
15 MS. BELINDA PETTIFORD: We can. What we can do is tonight we
16 can email these twelve potential priority areas out. Everyone can look
17 at them tonight. We still have some time on the agenda in the morning
18 to kind of narrow this focus down.
19 So, you can look at them and if someone wants to make a
20 case for an area that we've already gotten some synergy and we want to
21 move forward, there's nothing that says we have to wait for the parties
22 of the Secretary to move on that. If we wanted to look for the parties
23 of the secretary and specifically the offices under his purview, it's
24 really just to see if there's an opportunity to collaborate or to try
25 to elevate something that is not already something that he wants to

1 work on and that we might could see some positive movement quicker than
2 delaying it.
3 So, we can go in that direction. It's a lot. This is not
4 the whole conversation from each of you all. This is just me pulling
5 together some of the highlights from the multiple conversations and
6 merging the areas because, like some of these areas, some of you all
7 said this is something I wanted to do.
8 And no one ever, and I was clear when we met, while you
9 can't come up with one thing. I said, what are your thoughts? What are
10 your priority areas?
11 So many people came with a whole long list and others
12 limited to two or three. So, there's no right or wrong way to do this.
13 I just want to make sure we're doing it in a way that we can all of us
14 feel comfortable about it or at least the vast majority of us feel
15 comfortable with it.
16 And so, for us to do something, because if we don't make a
17 decision today tomorrow then we basically we have to make a decision by
18 tomorrow. But if we don't make it decision today or tomorrow then what
19 we're going to be stuck thinking about is what happens in December.
20 Now there's a lot of time in between now and December and I
21 know it's busy but there's activity we could be doing between now and
22 December. We could be, you know people could be taking on the role of
23 "hey this is a specific area of interest for me. I want to try to pull
24 what research is available, what data is out there, what efforts are
25 already going on".

1 I'm sure Vanessa and Sarah will be willing to help us think
2 through that and to pull that information together and then you can
3 take it upon yourself to review it so that we can at least have a more
4 focused conversation in December about it or we can do smaller work
5 groups and do this.
6 So, we can go in any direction that we want to, and I think
7 the last iteration that many of you are familiar with are staying we
8 can divide it up into three work groups. And so, we had a work group on
9 equity, we had a work group on data and research, and we had a work
10 group that really looked at clinical care and things of that nature.
11 So, we can go down that road. We could throw all the work
12 groups out of the window and narrow the work groups down to where the
13 priorities are. It's totally up to us which direction we go.
14 Just realized that when we have a work group that means we
15 need somebody else besides one person to be working on it. Hence the
16 term group.
17 [Laughter]
18 MS. SARAH MEYERHOLZ: Belinda, can I just jump in? In
19 addition to the slides, tonight I will also send out the HHS SDOH
20 advance in equity two-pager that Dr. Chappel talked about as well as
21 the White House addressing the Maternal Health Blueprint for folks to
22 take a look at. It's like sixty-three pages but it does outline like,
23 you know objective 1.1, 1.2 etc. and I just did a quick search for
24 rural, that's in there like fifty times.
25 So yeah, something else just to inform. The other thing

1 just to keep in the back of your minds. One of my like pet projects,
2 the reason I took this job was to look at previous recommendations and
3 think about where they're going. Are they being implemented? Are they
4 what's feasible, what's not?
5 And so, it's thinking about how that can be cataloged to
6 share back with you and the public. And so, as we think about
7 priorities like think about what, you know what it might look like for
8 me to catalog that.
9 MS. VANESSA LEE: See this is why Sarah and I make such a
10 good team. I just pulled up the recommendations the committee pulled
11 forward in August of 2021. You probably have fresh in your mind the
12 American Indian and the Alaskan Native recommendations but prior to
13 that set, the Committee focused on maternity and infant care systems
14 and financing, workforce expanding and diversification, environmental
15 risks and border health.
16 So, if you want to take a look back at those, that set of
17 recommendations just to refresh on what you already gave to us that
18 were actively. Sarah's been trying to work on and log what's being
19 what's been implemented and adopted, and I just don't want you guys to
20 have to repeat an area that you already had some really good concrete--
21 MS. BELINDA PETTIFORD: And that's a really good idea. We
22 can go back to those recommendations and if we don't feel like we felt
23 movement on those recommendations we can recommend them again. because
24 again it just keeps some in that pipeline of making sure that the
25 Secretary realizes it's a priority for us.

1

2 **Wrap-Up, Overnight Considerations**

3

4 MS. BELINDA PETTIFORD: So, is everyone good with having a
5 little bit of work to do tonight to think about? You don't have to read
6 the whole sixty-three pages of the blueprint though a few of us have
7 read it over time. It's just been a minute so some of us might just be
8 going back doing a refresher course.
9 [Side chatter] [laughter]
10 So, Allison will walk us through tomorrow. Yeah, there's a
11 twelve -page version of the committee's recommendation right you can
12 also send that. Yes Kate.
13 DR. KATHRYN MENARD: Do we know--I mean, this committee's
14 been meeting since 1991. Do we have any history of what recommendations
15 were successful or not or you know? If that's what you're talking about
16 I'm just sort of thinking you know like what that track should move
17 forward like how do we think about strategy, right.
18 MS. BELINDA PETTIFORD: Well, I think when the committee
19 came together in 1991 it wasn't all at the same time when they were
20 coming out with Healthy Start because of the high infant mortality rate
21 in the high-risk severities but I'll let Sarah just chime in knowing
22 what the others are because Belinda does not know right off the top of
23 her head.
24 DR. KATHRYN MENARD: Yeah, thirty years of recommendation so
25 I'm just sort of wondering you know---

1 MS. SARAH MEYERHOLZ: Yeah Dr. Warren may want to speak as
2 well but thinking about what I've looked at in the most recent years
3 which I think it was like six years back?
4 MS. VANESSA LEE: Before 2020 when the committee made
5 COVID -when you all made COVID recommendations were last submitted to
6 HHS for 2013 and that reports also online. And we've taken a look at
7 those and they're pretty broad.
8 So, it would actually be quite easy to say of some movement
9 that's been done, because I think there's been a lot of work in those
10 areas, but we can also send that around. but it's posted online as
11 well.
12 MS. SARAH MEYERHOLZ: And I think the trends, there's very
13 obvious trends and recommendations that if you look back, I haven't
14 gone all the way back to the nineties yet but even just the last six
15 years you can see the obvious trends being recommended. these
16 priorities, they're all there. So, Dr. Warren, do you have anything
17 else to add?
18 DR. MICHAEL WARREN: Yeah, I know I think it's just an
19 important priority we've identified to go because the committee over
20 its course of existence has been very generative. And so, it's
21 important to us to be able to say what is out there so we're not
22 continually repeating the same thing over and over. and then what's the
23 progress that's been made on those.
24 I would say and the Administrator shared with Belinda this
25 example yesterday that she has been in federal government for a number

1 of years the first time she heard about Medicaid expansion to the
2 postpartum period was from this committee--clearly that was a number of
3 years ago but an idea that had roots in this group, among others, so
4 clearly there have been substantial policy changes and we don't yet, we
5 will have to granularity of the entirety of the recommendations and
6 what has come from them so stay tuned.
7 MS. BELINDA PETTIFORD: Thank you. Other thoughts,
8 questions, concerns for tonight before we move into what we've talked
9 about? We've sent out light reading. We will also send out these
10 twelve priority areas.
11 We will have about thirty, forty-five minutes in the
12 morning to narrow down our focus and really think about how we want to
13 move forward in the morning. I will be thinking about it with you all
14 tonight and I think those are the main things.
15 MS. MYERHOLZ: My only thing to add is very minor. We will
16 have this room tomorrow too and the door will be locked so if you want
17 to leave your like name badges and I wouldn't leave anything, like,
18 personal, but the name badges feel free to do so if you, like, really
19 want to sit in the same seat tomorrow.
20 [Laughter]
21 MS. BELINDA PETTIFORD: We'll get here early and just move
22 the name tags around to see if you remember, right? Okay we're going to
23 give you a few minutes back on your day.
24 I know some of you all were dying to get out of here by
25 5:00 but because you didn't get your whole lunch, we're going to thank

1 everybody that is in Zoom in the virtual land. Thank you for joining
2 us. You will get the same information to review tonight so don't think
3 because you're not here in the building that you can't take your email
4 as well and we will continue and move this conversation to a closure
5 tomorrow.
6 So, everyone, have a wonderful evening. Be safe. And think
7 about and walk--before you read, not while you read.
8
9 **Adjourn for the Day**
10
11 (Whereupon the meeting adjourned at 4:35 p.m.)