THE ADVISORY COMMITTEE ON INFANT AND MATERNAL MORTALITY (ACIMM)

Hybrid MEETING

AMEREN COMMUNITY ROOM

DELMAR DIVINE

5501 DELMAR BLVD.

ST. LOUIS, MO 63112

9:00 am -- 4:00 pm CST

Tuesday, April 2, 2024

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- COMMITTEE MEMBERS -

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CDC Act Early Ambassador to Oregon
Help Me Grow Physician Champion

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M. Kathryn Menard, M.D., M.P.H.
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Phyllis W. Sharps, Ph.D., R.N., FAAN

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Johns Hopkins School of Nursing

ShaRhonda Thompson

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P R O C E E D I N G S

Welcome and Call to Order

BELINDA PETTIFORD: Good morning, everyone. I am Belinda Pettiford, and I am so happy to see each of you today. I have the pleasure of chairing this awesome team and getting to work with them. I am at this point going to call the meeting to order, and turn it over to Vanessa.

VANESSA LEE: Welcome. As Belinda said, this is a meeting of the Secretary's Advisory Committee on Infant and Maternal Mortality. We call the meeting to order. I'm the Designated Federal Official for the Committee, which is administered by HRSA, the Health Resources and Services Administration, and I work specifically in the Maternal and Child Health Bureau.

I want to welcome our Chair, and Committee members, our federal ex-officio members, those online, our speakers and presenters and members of the public who have both dialed in and joined us here in the room to start the meeting. Thank you all so much for being here. We're- thrilled to be conducting the Committee meeting here in St. Louis.

Many of you may not know, but this is only the second time in the history of the Committee that we've met outside of Rockville, Maryland, where HRSA is located, so it's a really special meeting, and we're just excited to be here to learn from the communities, the service organizations in the area, and those-

-our grantees--as well as others.

I know we have a lot to cover in the next two and a half days, so I'm just going to turn the meeting right back over to our Chair, Belinda.

BELINDA PETTIFORD: Thank you so much, Vanessa, and I'm gonna work having my back to—going back and forth. Again, we are so pleased to be here in St. Louis. As I've been talking to the Committee for the last several months, one of the reasons we wanted to come to St. Louis was to listen. You know, if we weren't willing to come, and wanting to listen and hear the wonderful work you're doing here, but also what else needs to get done.

What else should we be doing to do try to improve infant and maternal health here in this state and around the country, with the specific focus on improving our Black and African American rates. So we are again, very pleased to be here. I must first of all thank one of our Committee members, ShaRhonda Thompson because this is home for her, and it has been----and she has welcomed us with open arms right from the beginning, and said, Yeah. Sure I could come to St. Louis, and we are feeling welcome and ShaRhonda has done an awesome job in making sure that's going to happen. Again, we want to hear from you all. Even though our backs may be turned, or maybe it's Vanessa, and our backs may be turned, it's not because we don't want to hear and we don't want to listen, and we will spend time doing that today.

Because we want to be able to give an opportunity for everyone to introduce themselves. We're going to do a shorter

introduction than normal. So today I'm just going to first ask the ACIMM members themselves to just give your name, and if you're representing someone besides yourself, let us know who that is. But let's start with the ACIMM members. We really want to make sure we reach out to everyone that's here with us today as well.

So, again, if you'll just give your name. Let them know if you're on ACIMM, and if you're representing someone besides yourself just say who that is, and we'll start with you, Joy.

Introductions of ACIMM Members: Appointed and Ex-Officio

JOY NEYHART: Hi, I'm Joy. And I am a board certified pediatrician who has been practicing in the last 24 years. I'm now currently between work, and I'm starting a master's in public health program in September with the University of Washington, so I'm currently representing myself and serving on the ACIMM Committee.

BELINDA PETTIFORD: Thank you, Joy.

JACOB WARREN: Hi, I'm Jacob Warren, I'm a Health Equity Epidemiologist, and on faculty at the University of Wyoming.

BELINDA PETTIFORD: Thank you.

PHYLLIS SHARPS: Hi. I am Phyllis Sharps. I'm a Professor Emerita at John Hopkins School of Nursing.

MICHAEL WARREN: Good morning, Michael Warren. I'm the Associate Administrator of the Maternal and Child Health

Bureau. At HRSA I serve as the Executive Secretary for the Committee.

SARAH MEYERHOLZ: Good morning everyone. My name is Sarah Meyerholz. I'm the Program Lead for ACIMM, also with HRSA and MCHB.

BELINDA PETTIFORD: Introduce yourself again.

VANESSA LEE: Okay. I'm Vanessa Lee, I'm the Designated Federal Official for the Committee, also with HRSA and Maternal and Child Health Bureau.

BELINDA PETTIFORD: We'll go down to Charlan.

CHARLAN KROELINGER: Good morning everybody. I'm Charlan Kroelinger. I'm the Chief of the Maternal and Infant Health Branch in the Division of Reproductive Health for the Centers for Disease Control and Prevention. Good to see you.

STEVEN CALVIN: And I'm Steve Calvin. I'm a Maternal Fetal Medicine Physician. Actually, I went to medical school here and did rotations right at this hospital about 40 plus years ago. And I'm representing myself, but also representing Midwifery Care generally everywhere throughout the United States in my own way.

LEE WILSON: Good morning. My name is Lee Wilson. I direct the Division of Healthy Start and Perinatal Services, which is in the Material and Child Health Bureau. Our division is where the Advisory Committee is lodged, and we also oversee the Healthy Start Program, which is one of the programs that ACIMM is charged with providing recommendations on.

SHERRI ALDERMAN: I'm Sherri Alderman. I am a Board Certified Developmental Behavioral Pediatrician. I represent

myself and babies. I am a voice for babies with special interest in infant and early childhood mental health.

KATHRYN MENARD: My name is Kate Menard. I'm a Maternal Fetal Medicine Specialist based at the University of North Carolina and a Committee Member representing- myself.

SHARHONDA THOMPSON: I am ShaRhonda Thompson, and I'm from St. Louis, Missouri, and I'm a community member trying to represent the voices all across the United States.

BELINDA PETTIFORD: Thank you, ShaRhonda. We're going to go to the rest of the room. Carolyn, you want to start.

CAROLYN DAVIS: Good morning everybody. My name is Carolyn Davis. I'm the Case Manager Supervisor of Missouri Healthy Start. I've been around for 20 years. 10 of them I volunteered and 10 of them I've been a voice for infants, women, and children and fathers.

(Audio garbled.)

CYNTHIA DEAN: Good morning. My name is Cynthia Dean. I'm the CEO of the Missouri Bootheel Regional Consortium, and I also serve as a Project Director for Healthy Start. I've been around a long time, and I'm happy to be here in my own Missouri.

RONDA SMITH: Good morning. I am Ronda Smith, and I am the Maternal Director for the State of Missouri, representing the Department of Health and Senior Services.

KENDRA COPANAS: Good morning. Kendra Copanas. I'm the Executive Director of Generate Health. We're a maternal and infant health coach in St. Louis.

LORA GULLEY: Good morning. I am Lora Gulley. I'm the

Director of Community Mobilization and Advocacy with Generate Health. Good morning everyone.

JESSE DAVIS: Good morning. I'm Dr. Jesse Davis. I'm a Pediatrician by training, Chief Medical Officer and Vice President of Strategy at the St. Louis Integrated Health Network. We are a health care intermediary, and we focus on the best quality and improving access to quality care.

KARLA DUNCAN: Good morning. I'm Karla Duncan. I'm representing the Mourning Project, M-O-U-R-N-I-N-G, which will be coming to St. Louis this summer, with 20,000 baby booties -to - the- infant mortality rate that this country has.

GWENDOLYN SIMPSON: Good morning. My name is Gwendolyn Simpson. I'm with the City of St. Louis Department of Health, and I am the Manager of the Title V MCH block grant.

UNIDENTIFIED PARTICIPANT: I'm an gene otologist in the division of Newborn Medicine at St. Louis Children's Hospital and Washington University, and I'm proud to be here and provide information-- .

ROSE ANDERSON: Good morning. I'm Rose Anderson Rice. I'm Deputy Director at Generate Health.

TISHAURA JONES: Good morning. I am Tishaura Jones, Mayor of the City of St. Louis. Good morning.

ADRIAN WILLIAMS: Good morning. I'm Adrian Williams. I am the Board Member of Generate Health.

NICOLE WOOD: Good morning. My name is Nicole Wood, and I am one of two Program Managers for the Maternal Health Access Project.

ELENA HORVIT: Good morning. My name is Elena Horvit, and I am the other Program Manager

TERRI PLAIN: Good morning. I am Terri Plain, and I'm from the Missouri Foundation for Health. I lead a couple of maternal child programs for the Foundation.

SHARISE BAKER: Good morning. My name is Sharise Baker, and I'm with the Department of Mental Health. I oversee clinical coordinated leadership for the state. I am also representing the MO-CPAP -project. -

Tayniya BUDDS: Good morning. My name is Taniya Buggs, and I'm currently a senior attending SIUE and I'm getting my bachelor's in public health, and I'm currently interning at St. Louis City Department of Health and Maternal Child.

BELINDA PETTIFORD: Did we miss anyone? So wonderful to have a student here with us. Thank you all. Did we leave anyone out? You don't want to introduce yourself? You need to introduce yourself.

UNKNOWN SPEAKER: (Inaudible.)

BELINDA PETTIFORD: Thank you. Do you think we have everyone? I know we have some people that are virtual, but I know there are issues. We have some ex-officios that are virtual, so we're going to take the time for our ex-officio members that are joining us virtually today. -You will take a moment to introduce yourself as well.

DEBORAH KILDAY: Good morning. This is Deborah Kilday. I'm with the Office of the Assistant Secretary for Health in the Office of Women's Health, and I'm a Senior Advisor, supporting

from the-- --

BELINDA PETTIFORD: I know we have some ex-officio members on. Can you all hear us? -

ALICKA AMPRY-SAMUEL: Can you hear me? This is Alicka. Okay. I will try and turn on my camera, but it says that I'm- unable to turn on my camera, so good morning everyone. It's Alicka Ampry-Samual-, the Regional Administrator at HUD.

MARIE-ELIZABETH RAMAS: Good morning. This is Marie Ramas. I am a Committee member, a family physician by trade, and representing myself.

BELINDA PETTIFORD: And Marie, we cannot actually hear you well, so we're going to come back. We're going to work on the audio, and we'll come back to you because actually Marie is one of our members. We'll work on the audio and come back.

MARIE-ELIZABETH RAMAS: All right.

BELINDA PETTIFORD: So everyone should have a copy of the Agenda. If not, they do have copies out in the lobby area if you would like to grab one. At this time we are very fortunate to have the Mayor with us today. Mayor Tishaura Jones is with us, representing St. Louis. I saw her picture when I got off at the airport. Thank you so much for joining us today. Wherever you are comfortable. The microphone is over there.

Welcome from the Mayor of St. Louis

TISHAURA JONES: Good morning. So I want to thank Chair Belinda Pettiford and my new friend, and the Health Resources and

Services Administration for facilitating today's meeting. It's exciting to work to get more resources into more communities to help take care of mothers and babies.

I may be Mayor, but my most important title is mom. I am the single mom of the most adorable and tall 16-year-old. Rose from Generate Health, our sons actually play on the same basketball team, and I've got to say our sons just won their state championship.

But when I was pregnant with my son it was a reminder about the access to health care. I worked in public health for many, many years at People's Health Centers, which is just two blocks down the street from here. And while my pregnancy was pretty uneventful, it was still a reminder, even though I work in public health, and I knew the barriers to access to the health care that our people deserve when they are pregnant.

And a lot of times I would hear, you know, not necessarily horror stories, but just really surprising stories of women not accessing maternal health until they were three, four, or five months into their pregnancies. And our public health nurses, you know, activated and got them care immediately. But it just made me think about others in the community who didn't have that kind of access.

And I also said that I was a single mom, so that means that, -and I can totally say that my pregnancy was not planned. It was with a guy I was seeing, you know, but I was very fiscally responsible at the time, so I had all the questions about oh Lord, babies are expensive, and how am I going to take care of daycare,

health care, all of- these things.

And I know that those are the questions that many of our moms have, whether they are single or not whether the pregnancies are planned or not. And we know that in this country there is a stark difference between the type of health care you have access to if you come from a community that has the money to take care of it versus if you don't.

And we want to make sure that we get rid of those health care disparities, especially when it comes to our moms and babies. Also, welcome to the Delmar DivINe. I know that you've seen all of the pictures along the walls. This used to be a hospital. And here's a fun fact. I was born in this hospital back in 1972.

And after I had my son, I had my son right before I declared that I was running for office. So when he was three months old that's when I launched my campaign. But he became my why. No offense to the men in the room, but sometimes men run for office to be somebody, but women run for office to do something.

And my son was the why behind why I was running for office because I wanted to make this state and city better for children like him, and that's still unresolved as I leave office. And I'm just thankful that you've chosen St. Louis to have your meeting here because -unfortunately, Missouri runs 44th in the nation when it comes to maternal mortality, I would say the 44th- worst rate for maternal mortality in the United States.

And that's unacceptable. That's unacceptable. And I

am just over the moon and our federal government and state government are here to have a robust discussion about how to change that. And I will provide more resources in our community to make sure that we decrease the disparities and get Missouri out of filing the list of any more maternal mortality.

So again, I'm just super pleased that you're here. I hope that your discussions today are robust. I know that you've been here for a couple of days. I hope you enjoyed St. Louis. We have an excellent food scene, excellent arts and culture. I don't know if you've been able to get out and explore all the places, and again thank you and thank you and thank you. God bless.

BELINDA PETTIFORD: Thank you so much, Mayor Jones, for being able to join with us today. And it would be really nice of you to be able to share your story with us, but I think you also made the clear point that a lot of times when we're talking about maternal and infant health, we're talking about the clinical components.

But if you think about all of the determinants of health, and fortunately for us, we have one of our work groups that's focused on social determinants of health. So in reality today, even though you can't stay with us all day long it will still feel like you did. And you've got an awesome team here in St. Louis and beyond in the state that's working to try to make sure we're elevating these issues, and trying to move them to improvement.

So again, thank you so much for joining us. Okay. So we're going to follow on with the agenda. Do you have the online

introductions? Is the volume working for online now? Thank you. So at this time we're going to go to the approval of our minutes. Everyone should have received---the Committee members should have received the minutes from the December meeting. -

Approval of Minutes

BELINDA PETTIFORD: Everyone has hopefully had a chance to review them. I know some of you were reviewing them on the plane yesterday because you told me. At this time do we have a motion to approve those minutes?

SHARHONDA THOMPSON: Motion to approve.

BELINDA PETTIFORD: Thank you, ShaRhonda. And we have a second from Kate Menard. Those in favor of this motion if you'll say aye?

(Chorus of ayes.)

BELINDA PETTIFORD: Any opposers likewise?

(No response.)

BELINDA PETTIFORD: And the minutes are approved. Thank you all. Okay let's see how long that lasts. I now turn it over and we're happy to have Dr. Warren with us here today.

Maternal and Child Health Bureau (MCHB) Welcome and Updates

MICHAEL WARREN: Thank you so much Belinda. You said that about timing just before I started, so I'll try to keep it

short.

BELINDA PETTIFORD: If you need it.

MICHAEL WARREN: Good morning again. It's so good to be here with you all. I really appreciate the warm welcome we've gotten in St. Louis. I think this is now the second time we've had these Committee meetings, as you heard, outside of Rockville, Maryland, outside of federal office space, and these are far and away the richest meetings we have in terms of hearing community voices and understanding what we need to do to better support state and community partners.

So, thank you all for so graciously hosting us, and thank you to all of our Committee who are appearing online, who have joined us. I'm going to share a few updates from the Maternal and Child Health Bureau, and if we can advance to the next slide, I will start with the budget. So, we are six months into federal fiscal year '24. We're about a week and a half into fiscal year '24 budget, as you all know that just got passed. I guess a week and a half ago now.

(Audio dropped out)

BELINDA PETTIFORD: It's coming.

MICHAEL WARREN: While we're doing that, I will share overall about a 1.7 billion- dollar budget for the nation's mothers, children and families in our Bureau. A couple of highlights. -One, if we can get back one slide please. As you all know in the initial House versions of the budget there was a proposal to eliminate the Healthy Start Program. That's 145 million dollar program that is focused solely on improving the

health of mothers and babies, particularly in communities with high rates of infant mortality.

That funding was restored fully, and so Healthy Start was funded at 145 (Audio dropped out.) ---pool of money. -The other budget item I will highlight for this year, we did get a 2 million dollar reduction in our special projects line.

This is the line where we fund a variety of emerging issues, projects, it's where many of our maternal health projects have been funded from the last year, so our AIM program with the safety bundles got its start as a special project.

Our State Maternal Health Innovation Funds are funded as special projects. Technical assistance that we provide to state and communities, all of our workforce and research and training programs are funded out of that. (Audio dropped out.) - (-Audio inaudible.)

--an opportunity for states, there is a proposal to double the funding for our Family to Family Health Information Centers. These are located in all the states and serve families of kids who have special health care needs. They do things like connect families to other families who have a similar diagnosis. They help families navigate what are often complex and challenging and confusing health care systems.

And those organizations have been running on a shoestring budget for a long time, about $90,000.00 to set up a whole state system to do that work that's in most cases not enough to afford a whole FTE and the things that go along with that. And so, the President's budget proposes doubling that program, and

continuing it into the future.

On the next slide, this slide actually, the other items that are in the budget, a 15 million dollar increase for our AIM Program. So most folks know AIM is the safety bundle programs that have started helping folks develop safety bundles for things like reducing hemorrhage and primary C-section-, and addressing severe hypertension in pregnancy.

We've since grown that to have state capacity grants that go out to states to be able to support their ability to enroll every birthing facility in the state to participate in an AIM. I'm really excited that the President's budget has 15 million dollars in new funding to be able to support OB readiness.

So we know in many rural parts of our country, and in some places not so rural, there's a growing number of maternity care deserts, and that doesn't mean that we don't have still a shortage of need for those services. We just don't have the folks to provide the care in those situations. We also know that if you are having an obstetric emergency, or if you're in labor, the closest hospital is the one with the blue H sign that you see while driving, and that's probably where you're going to go. And we need to make sure that all of those facilities are ready to take care of whatever obstetric emergency presents, both acutely in terms of stabilizing that individual, providing immediate care, transporting where appropriate, but all that work in planning and training needs to happen in advance, and so there's funding in the budget to support that.

There's money to expand our state maternal health

innovation awards. Currently we're at 35 states. We want to continue to grow that. And then there are some new investments. Five million dollars to support community-based grants to address social determinants of health, as you've- heard already several times this morning, we know those factors in communities where people live, learn, work and play are very important to their overall health and well-being.

And so these grants would be demonstration projects to show what we can do to influence maternal health. And then there's 5 million dollars in new funds to grow and diversify the doula work force. We know that doulas are a vital part of that perinatal workforce, particularly in elevating the voices of moms, and improving their experience during pregnancy and labor and delivery and the post-partum period.

And this would be funding to recruit and train and then employ and create a pathway to employment for community-based doulas. There are a couple of funding opportunities that are,- -actually one funding opportunity we have that's still open. You'll see that on the next slide, and there's- a QR code in case you would like to visit that.

And that's our maternal health training and resource center. And this is a national center that provides technical assistance across a variety of our maternal health grants, and that is open until early May. And then we have a couple of funding opportunities on the next slide that we will post between now and the end of the fiscal year.

One for a policy innovation program, and one for a

fetal alcohol spectrum disorder screening and intervention program. So, quickly moving on to the next slide. We are here in St. Louis for our ACIMM Meeting. We are also holding a meeting tomorrow for purposes of enhancing maternal health initiatives. We will be meeting with our colleagues from the Missouri State Health Department, as well as other HRSA funded partners in the state, to look at where we've got opportunities to work across HRSA grants.

So before coming to federal government, I spent about a decade in state government in Tennessee. And one of the things that we were able to do was to leverage our various federal funding in ways that helped amplify any one of our particular programs. We were a very resource poor state, but we found that when we came together there were synergies that happened.

Some of the parts, or the whole was greater than the sum of the parts, individually with what we were doing. And so, it was so helpful for us to come together, and we are excited to be visiting 12 states over the next few months to be able to look at what they're doing, to learn from them, and to think about how to support them in flexible ways to be able to improve maternal health.

The next slide gives you a sense of the states that are participating, so you can see the states highlighted there in red that we'll be visiting on the map. On the next slide I want to,- I remind you, as I do every time I talk to you about our national Maternal Mental Health Hotline. -We know that maternal mental health conditions are the leading cause nationally of

pregnancy related deaths.

They are incredibly common, and often resources aren't available. So this 24/7 hotline is available to help meet the needs of folks in communities across the country. That number is 833-TLC-MAMA, and the QR code that we have there will take you to the website that not only has more information about the hotline, but also a link to order promotional materials.

So if you want, well cards, magnets, posters, flyers, if you're in a clinic or a hospital, or a community-based setting, or if you know people who would benefit and you just want to give them out, they're available for free, and we will ship those to you. And when you run out we will ship you some more.

And so, I encourage you to visit that and help us spread the word about the hotline. We're over 30,000 calls now that have been received by the hotline since its inception. I know there are materials in your packet around congenital syphilis. We always, on the next slide, want to take the opportunity to encourage our community partners to help us address this emerging maternal and child health crisis.

We know the rates of congenital syphilis have increased more than ten fold over the last decade. And what is striking, and is unfortunately common among many of the challenges we face in maternal health is that most of these cases are preventable. The estimation is about 90% of those cases are preventable. And we also know from work that's been done by our colleagues, that about 40% of those cases involved moms who didn't get any prenatal care.

So, as we think about the continuum of care and our approach to health, there's a great opportunity there to think about connecting people, making sure they have access. And when they do, making sure that testing and treatment happens.

On the next slide, you'll see there are a number of ways that folks can help. Organizations in cities and countries, and states across the country are thinking about these opportunities for community-based- organizations, to partner with public health and community health organizations.

An opportunity to share information about the importance of this challenge. I was talking to an OB colleague recently who said they were talking to a patient, and they said that's not a real thing anymore is it? And yes it is, very real, and very problematic for many folks across the country.

And so there's a great opportunity for education and awareness, and for our clinical partners, opportunities to think about testing, screening, testing and treatment. There is a link here, our partners at CDC do tremendous work in this space, and there are resources available to help you understand what county rates are, and where you need to focus your efforts. And so I would encourage you to check out that link.

Lastly, trying to move through quickly for the Chair, we are excited to be celebrating in another week, Black Maternal Health Week. Our public affairs team has put together a toolkit that we hope you all will use and share and amplify with your partners. This QR code will take you there.

There are graphics that are available for websites and

publications. There's copy or text that can be placed into newsletters, and messages that go out. There are also a variety of videos featuring people with lived experience that remind us all about why this work is so important.

And so with that, I will hand it back over to the Chair, and look forward to the next couple of days.

BELINDA PETTIFORD: Thank you so very much, Michael. We appreciate you always providing great updates. But does anyone have any questions for him at this time?

UNIDENTIFIED PARTICIPANT: You mentioned near the end of your remarks what history with states, and varying funding to leverage dollars better. Do you have any thoughts at the opening and some of the agencies here that they might think about. And are there any preconditions that are unique to Tennessee, that as you look at these other states and other regions you feel like, you know, that was really important, and that was a differentiator?

I just want to mention what you think are some precursors as we go forward?

MICHAEL WARREN: Thank you for that question. So for folks online who may not have been able to hear, there was a question in the room about are there any precursors or conditions to sort of facilitating this engagement with partners? I think the first thing is awareness.

So we used our bully pulpit at the State MCH Program to say who else is HRSA funding for maternal and child health funding, and we're going to convene those folks and pull them

together. We didn't necessarily have any authority to do that, but it was just a goodwill gathering of folks to say let's talk about the various funding streams that we have.

And we were a fairly resources poor state with great need. And so folks were very motivated to say how can we do more when we aren't necessarily getting new resources in. And so we started at the standpoint of sharing information, and doing some trust building. I'm not here to try and come after your money. You're not here to try to come after mine.

But we started talking about what we were doing. And even over the course of that first meeting, what we saw is that folks were saying oh, we're doing something similar. I can share this information with my participants, for example, or my providers. I can share information about your program. And so it started that way with let's share information about each other's programs.

It then evolved to there are ways that I can help you. So as a concrete example, we had an autism training program in our state, and we had county health departments who were saying our nurses don't have the training to be able to understand how to best care for children with autism and their families, and to think about how to approach, for example, a clinical exam.

And so that autism training program had never worked with the health departments before, but they said we can do a curriculum for you. And they worked and trained every public health nurse in 95 of our county health departments on that.

We similarly pulled folks from the Hospital Association

together who had some federal money working on quality improvement projects. They had become very interested in some of our work to reduce early elective delivery, and said we're trying to get hospitals engaged, but we've had some difficulty in doing that. Do you have any money to do any kind of incentive?

We had a little bit, and we spent I think $5,000.00, which is pretty meager as a state on these banners that sort of recognize hospitals that met their early elective delivery targets. And you would not believe the hospital's sort of excitement and energy over getting one of those banners, and having a visit from the State Health Commissioner, the lead of the Hospital Association.

And so, it didn't necessarily require a lot of money or effort, but those were ways, and the Hospital Association said we couldn't have done that on our own. We couldn't have done that and to have the health department come in was helpful. So, I think to your precursor is a willingness to come together, an open mind to think about how partnerships might look, and folks may connect.

Humility to know that we can't solve this all on our own, and we can work together. And then to patience to see it through. It won't happen overnight, but it's a really important opportunity. We work closely with your colleagues and Missouri State Department of Health, and know that they've got a long tradition of partnership with Title V.

And so I think you've got some great work to build on here.

BELINDA PETTIFORD: And I'll add to that, if Michael doesn't mind, because we did something similar in my State of North Carolina. I realized when I introduced myself I never told you all where I'm from. But I am from North Carolina, and we're in the middle of basketball season, so there's a lot going on there.

But one of the things that we did early on was trying to figure out in coming together we needed to come together around the issue. And so what we started was in developing what we called our statewide Perinatal Health Strategic Plan, because of incentives we were all focused on the trauma infant health, but we were all going in our own silos and in our own different directions.

And what we felt like we needed to do is if we came together and developed a plan together, then we could all see ourselves in the plan, and people when they're writing for grants, when they're applying for other funding sources, when they're developing new programs we were encouraging people to go back to the plan.

Is there a part of the plan that you want to implement, that you would value that it's right in line with your work. And that's what has helped us. I mean one of the first things we had in our plan in 2016 was to expand Medicaid. We are in a very purple state that's got a little red, and they're still purple right now. But this past year we finally expanded Medicaid, but because we kept it on our list.

We included things like we wanted 12 months

post-partum extension. We wanted to enhance the work of our Healthy Start Programs by applying for different additional funding. So those things were in our plan, and it wasn't that the State Health Department was leading it, it was anyone that wanted to be at the table could come, take the lead, and just kind of report back when we meet every other month, and just let us know what you're thinking.

You know, no one is holding you accountable, but you're holding yourself accountable by saying this is the part of the plan that we agreed to report. Other questions?

UNIDENTIFIED SPEAKER: The MIECHV supplemental funding, will it have to be the current MIECHV grantee that applies for that, or could someone else apply for that?

MICHAEL WARREN: So the funding will come down through our awardees, but states can partner with folks on the implementation. So for example, if you want to bring a new partner to the table, to think about implementing a model in a community where there is need, but the current grantee doesn't have capacity, you can do that.

And we can connect you back with program folks, but they'll just need to do some sort of like MOU to be able to show the relationship between those entities and how they're going to do it. But we're trying to be as flexible as we can be for the states to be able to meet the need because we know the need is great.

BELINDA PETTIFORD: Great questions. Anyone else?

VANESSA LEE: I just want to add in while we have all

of you here, Dr. Warren talked about many of the funding opportunities you have available, but I'd be remiss if I didn't make a plug for we always need more grant reviewers in HRSA, and we want people from the community. We want people who actually do this work and in states and communities to be reviewing the applications that we receive, so we can hear from the committee maybe you know, who we should fund or not fund, what score you know, we receive.

So we do rely on an objective review committee of external reviewers, and we are always open to applications for that. So if anyone is interested in becoming a HRSA grant reviewer, we need more reviewers.

MICHAEL WARREN: And there's a stipend for participation.

VANESSA LEE: Yes, you get paid for it. We'll clarify that. So we could put information about where to go on the website if you're interested.

BELINDA PETTIFORD: Or if you know others that might be interested. Okay. We're going to continue on with our agenda. And I think our next two presenters, and thank you Michael, for bringing up the whole emerging issue of congenital syphilis. I think many providers and individuals will think syphilis had been taken care of years ago, but I think in my own state, and I think around the country we're quickly seeing that we did not take care of it because it has definitely come back.

And we're seeing the impact on the maternal and infant health, which is why I wanted to make sure we had a presentation

on it today. So are our two virtual presenters ready because I know we're a little ahead of schedule?

UNIDENTIFIED SPEAKER: We should be able to do ex-officio- introductions for the virtual folks.

BELINDA PETTIFORD: Okay. So we have some other ex-officio members and members, so I think Marie is one of our Committee members, and Marie has been joining us virtually-. So Marie, can you introduce yourself now?

MARIE-ELIZABETH RAMOS: Yes, good morning. Is that better for everyone?

BELINDA PETTIFORD: Still cannot hear you. We have a microphone? Give us one moment, Marie.

MARIE-ELIZABETH RAMOS: Sure, no problem.

(Audio check.)

BELINDA PETTIFORD: Thank you everyone for your patience. We just want everyone to know who else is joining us. Why don't we do this. Why don't we just take a quick ten minute break so we can work out the technology. If there are people in the room who have not introduced, please take this time to go up and meet them and just introduce yourself, and we're going to work on the technology quickly. We'll be back together at 10 o'clock, in ten minutes.

Additional Introductions of ACIMM Members: Appointed and Ex-Officio

BELINDA PETTIFORD: So we're going to get ready to get started again. Everyone can take their seats. Yes, I'm going to

go stand in the back. So I think now we have the rest of, -I know we have Marie on, who is one of our active members that is joining us virtually, and then we also have some other -ex-officios that are virtual, and we're going to give them a moment to introduce themselves.

And in case you didn't hear earlier, we're doing very short introductions, just your name, and if you're representing somebody other than yourself let us know who that is. And Marie, we're going to start with you.

MARIE-ELIZABETH RAMOS: Thanks. Good morning. Marie Ramos, family physician. I'm representing myself. I'm on the Committee and am Co-Chair for the SDOH Subcommittee. I'm also an alma mater of Washington University in St. Louis, so it's nice to see everyone virtually in this space. -Thank you.

BELINDA PETTIFORD: Thank you Marie for joining us. We know that you're here in person in spirit at least, okay. Because I know you definitely wanted to be back here. And I know we also have other ex-officio members. I don't- have the list in front of me. So let's who is ex-officio-, Caroline Dunn, do you want to introduce yourself?

CAROLINE DUNN: I'm Caroline Dunn. I am a Senior Technical Advisor with USDA, and I specifically work with the WIC Program, or the Special Supplemental Nutrition Program for Women, Infants and Children.

BELINDA PETTIFORD: Thank you, Caroline. Alicka, I see your name.

ALICKA AMPRY-SAMUEL: Hi everyone. It's Alicka Ampry--

Samuel-, and I am the Regional Administrator here at HUD for Region 2 in the Field Policy and Management Office.

BELINDA PETTIFORD: Thank you. I see Kristen?

KRISTEN ZYCHERMAN: Hi. I'm Kristen Zycherman from CMS. I'm a Qualify Improvement Technical Director, and the Lead on Maternal, Infant Health Initiative for the Center for Medicaid and CHIP Services, happy to be here.

BELINDA PETTIFORD: Wonderful. Allison?

ALLISON CERNICH: Hi all. Allison Cernich. I'm the Deputy Director of the National Institute of Child Health and Human Development, joining you virtually, and apologies my camera is not on. I am driving.

BELINDA PETTIFORD: Thank you. Be careful. Deb?

DEB KILDAY: Hello everyone. Deb Kilday. I am a Senior Advisor within the Office of the Assistant Secretary for Health in the Office on Women's Health, and it's great to be with you today.

BELINDA PETTIFORD: I see Danielle?

DANIELLE ELY: Hi. I'm Danielle Ely. I'm with the National Center for Health Statistics, and I manage the Birth and Infant Death File, which is used to provide the national infant mortality statistics.

BELINDA PETTIFORD: Thanks. Did we miss anyone? Wendy, thank you.

WENDY DECOURCEY: Hello. This is Wendy DeCourcey from the Administration for Children and Families. I work with the office that does the research and evaluation for ACF, which

includes for Office of Head Start, Office of Child Care and the home visiting program for tribal and general populations.

BELINDA PETTIFORD: Thanks Wendy. I think we've got everyone. So we're going to continue on in our agenda. Again, our next topic area, which is an emerging issue that we've discussed briefly earlier, is around infant and maternal health specifically congenital syphilis, and needless to say I was a little surprised when I found out who one of our speakers were, Shannon, because up until a few months ago Shannon and I were hanging out together in North Carolina.

So, I'm pleased to have with us this morning---oh gosh, let's see whose name I'm -going to mess up, Babak Yaghmaei I know I messed it up, so let me go and apologize, the Deputy Director for Region 3 and 4 on the engagement team, coming out of the Office of the Secretary, as well as Shannon Dowler, who is a Sexually Transmitted and Infection Consultant, also coming out of the Office of the Assistant Secretary.

So we're going to turn it over to the two of you all to give us an update on congenital syphilis, and it's impact on maternal and infant health in our country. Thanks.

Emerging Issues in Infant and Maternal Health: Congenital Syphilis

SHANNON DOWLER: Great. Thank you so much for having us on today. We'll just introduce ourselves as we do our different sections. And it is great to see you Belinda and Kate. It's nice to see two familiar faces from North Carolina. I'm

excited to be here in the role of working on the syphilis and congenital syphilis task force, so this is one of my passion areas, and so it's great to tie that into work.

The first thing I want to do is tell the story, so if we can go to the next slide I'm going to briefly tee us off with the data, and where we are right now in the data, related to syphilis and congenital syphilis. And then Babak is going to tell you more about the task force, and then hand it back over to me.

So, do I have the power to advance the slides, or are you guys doing it? Oh, they went away, now they're back. Can you advance to the next slide?

BELINDA PETTIFORD: Let me try - they're working on making sure that they can advance then Shannon.

-UNIDENTIFIED PARTICIPANT: Hold on one second, let me try...

BELINDA PETTIFORD: They’re working on making sure they can advance them, Shannon.

SHANNON DOWLER: That's great. I appreciate it. And so, I'll just,- I'll kill time until I see the first data slide, and just say that syphilis has been around for hundreds and hundreds of years. -It is not new to us, and has actually been a public health crisis repeatedly in our country. And due to public health efforts in a variety of ways, over 100 years we've seen really dramatic improvements in syphilis.

I think back in the 1920's as many as 25% of the socioeconomically challenged people living in the United States were impacted by syphilis, or congenital syphilis. And so, we're

certainly in a better position than we were 100 years ago. But we're not where we want to be, especially right now.

And then while we're waiting for the slide to come up, Babak, do you want to introduce yourself? All right. No. It worked perfect. Murphy's Law. Okay. So what you see is that the rates were super high when we started measuring this in the early 1940's, and then there was a sudden improvement. I would like to say that's because of the prowess of public health, but it's actually more about penicillin.

But there have since been some small, what looked like relative small, increases is because the rates were so very, very high before we had penicillin as an effective treatment for syphilis. But we saw in the 90's there was another significant increase, and then over the last ten years we've been in another increase, actually surpassing the one that we saw in the 90's.

And so, if you go to the next slide, this is a visual of us taking you from 2013 to 2022, thanks to the CDC, and their amazing ability to capture data. And you see the rates of syphilis, primary and secondary syphilis across the country as it spreads and becomes an increasing problem everywhere within the country.

If you go to the next slide. One of the things that's notable about this particular rise in syphilis we've seen in the last decade is that until the last few years it's been a very high male to female ratio, and that's because the population most impacted were men who had sex with men.

And so, the number of men infected were significantly

higher than women. And part of that is, - means, that there wasn't congenital syphilis for us to worry about. But what you see over the last five years is that ratios dropping down, and you're seeing the rate in women climb significantly. -If you'll go to the next slide.

One of the other things we've seen along with that is, not surprisingly, congenital syphilis. So as women were becoming more infected with syphilis, they were getting pregnant and having babies, and so there was a comported rise in congenital syphilis cases. And what I would say is a devastating rise.

There are many people who train in medicine. Anyone who trains since the mid-90's probably never saw congenital syphilis at all clinically. People that trained up until 2010 probably never even saw primary or secondary syphilis, so there's this opportunity where a lot of your physicians and advanced practitioners and clinicians actually haven't- seen a lot of syphilis cases, which adds to the challenge of the rising rates now.

So if you go to the next slide you will see that in addition to the increasing rates of congenital syphilis, there is an unsurprisingly, a significant health inequity that we see in who is getting congenital syphilis as a function of its total number of live births.

And so there are a couple of populations I'll just highlight. In the dark blue you see that the Black African American population was 14% of the births, but almost a third, 29.9% of the congenital syphilis cases you see a slight increase

in the Hispanic and Latino population, but you see a significant increase in the American Indian and Alaskan Native population, and also the Native Hawaiian and Pacific Islander populations.

So as a rate of rise, those are the populations that we're seeing the most disparities in. If you go to the next slide, this looks at the actual reported stillbirth and infant deaths. And what we suspect is that we're actually missing probably a significant number of these because it wasn't on clinician's radars, they weren't really attuned to it. But you see there was a significant rise, so hundreds of babies in 2022 died as a result of congenital syphilis infection.

And I will say, a completely preventable infection, with appropriate testing and treatment during pregnancy. Next slide. All right, I'm going to turn it over to my colleague now.

BABAK YAGHMAEI: Hi everyone. My name is Babak Yaghmaei. I'm from the Office of the Assistant Secretary of Health. Part of my role is to be part of the engagement teams here in the Office of Infectious Disease and HIV/AIDS Policy, but I've also been having the fortunate---humble- fortune to be part of this Federal Task Force, along with Dr. Dowler and many of our other ones.

So the Federal Task Force, next slide please, came to be a cross cutting across the federal government, more than 200 members as you see here. And really the HHS agencies, there is numerous individuals working on this. We do this every week. But we do realize that working with the Federal Bureau of Prisons, USDA, Veteran Affairs, the Office of National AIDS Policy at the

White House, these are all critical areas.

We're lucky to be able to be led by Admiral Levine, who is the Assistant Secretary for Health. Our efforts have been ongoing. We meet weekly, and what we really focus on, next slide please, is ensuring that health equity is part of everything we do. So we set up three pillars when this task force was created to work around that framework, data surveillance, prevent, screen and diagnose and treat.

And these six subcommittees drive the work of these three pillars. Again, social determinants of health, health equity, these are all in the lens. While we are looking at it from a cross cutting federal government perspective, we do ensure that, as you can see from our community engagement piece to all the way to our data team, and everything in between, we do ensure that we can get as much as the ground level work from the communities to inform what we do, whether it's challenges, best practice, or the asks of the federal government.

Next slide please. The task force identified 14 jurisdictions and states, 13 states and 1 jurisdiction, District of Columbia, and this was chosen from the data that we saw regarding reported cases counts, or report case rates. And as you see just jumping off the page right here to build off of what Dr. Dowler was talking about, we've got primary and secondary syphilis, as well as congenital syphilis rates increasing.

These 14 areas were identified as a primary focus for the task force efforts currently, with hopeful plans to scale it out. And so that's where these 14 priority jurisdictions, if you

hear that that from the task force, that's how we selected them. Next slide please.

What I want to do is hand it off to Dr. Dowler to talk about some of the actions, and to give you a little bit more of an insight into what we are continuing to do here at the task force. Dr. Dowler?

SHANNON DOWLER: Great. Thanks so much. So if you want to move on to the next slide, you'll see that in the summer of last year the work really began with the task force with issuing letters to grantees, and starting to bring information out there.

In October the CDC published guidelines for Doxycycline use, that's because it was increasingly difficult to get Bicillin in some places and we wanted to make sure that pregnant women could access that because Doxy is not appropriate in pregnancy.

The IHS got involved with their STI treatment guidance. HHS generated really impressive heat maps for the priority jurisdictions so that they could dig deeper into their resources and cases. If you'll go to the next slide you'll see that the momentum just continued into early 2024, where Extencilline was announced by the FDA to address the Bicillin shortage. Equity workshops began to be held led by HHS.

And then NIH became working on workshops on syphilis treatment with researchers. There was a congenital syphilis provider roundtable where representative organizations around the country came together with Admiral Levine to start talking about this.

And then the meetings have continued with the priority jurisdictions, really powerful meetings where we're hearing about what's happening on the ground in those states, and what sort of improvements and progress they've been able to make, and how they can learn from each other.

I want to highlight there's going to be a webinar next week on syphilis substitutes and child welfare, which is going to be I think an exceptional conversation. And there are going to be ongoing regional summits for the native populations. In addition to some of these big high-level achievements, if you go to the next slide there are some areas that we are focused on.

In looking at the access to Bicillin and Extencilline, we want to understand if Medicaid programs are paying for Extencilline. Also looking at pointed peer testing. It's recently FDA approved where you can actually in the field, or in certain environments do a rapid test to diagnose syphilis. It's not a perfect test. It is not as easy as a strep throat rapid test, so it's going to require some investment and understanding on the ground to make sure we use it appropriately.

There's a document that will be coming out to the public soon talking about the best populations to use the point of care testing, but it's going to be really important that it's paid for. So our commercial payers covering it are public payers covering it. That's going to be an important piece of this.

We're also working to get a little more harmonization of testing recommendations on pregnant persons. I think if you look at the guidelines you have state statutes, which are wildly

different in every state. But then you also have big national organizations that everyone looks to, ACOG, AAFP, USPSTF, and all the guidelines are just a little bit different, and a lot of them actually focus on risk-based- screening, which is a challenge when it comes to overcoming health inequities.

So we're also looking at other specific areas, like around substance use, and stigma is a barrier to prevention and treatment. Lots of ongoing work in the task force across all the different partners. So I think that's the end, is that the end of our slides?

So, just some additional things that are going on in the background. Lots of provider awareness and training on diagnostic and treatment guidelines. I will just say as a physician that's worked in the sexual health space for a lot of years, congenital syphilis is tough, syphilis is tough, it's very challenging to diagnose and treat.

It is just not a clear cut, there's a positive test and you do something. It really ties back that you have to look at a lot of historical documentation and history, and understand their staging, which is a real challenge in the exam room, and there are many, many providers out there who have never seen syphilis.

So there's a lot of opportunity for provider education, and I will say our new syphilis shows up a little differently than what was in the textbooks when I went to medical school. We won't say when. And so, helping providers understand what syphilis looks like, and how to look for it.

Also, public awareness. Getting the public aware, and

up to date on what they need to be doing, lots of other ways that we're reaching out to the public, and then sharing best practices, what's happened in different areas, where they've actually made a dent, made an impact, so that we don't have to recreate the wheel everywhere, and we can all benefit from each other's successes.

So, I think with that, Belinda, we wanted to open it up for just some conversation. First of all, any questions about the task force, or the work that has been going on in the task force? Any other? We'd love to engage in any discussion that this think tank would like to provide.

BELINDA PETTIFORD: Thank you, Shannon and Babak. We will open it up for questions, and does anyone have questions? Yes?

STEVEN CALVIN: Sure. Thanks so much for your work. You brought to mind, just two weeks ago I started a recent role as a faculty person down at the University of Arizona's College of Medicine in Phoenix, and I saw a Native American lady who three years ago lost a child to congenital syphilis.

And she was, I mean she is obviously any loss of a child is devastating. She was devastated because she just carries a burden of guilt, and it was just undiagnosed. She's now newly pregnant, and everything is fine this time, but so it just points out. Thank you for your work.

BELINDA PETTIFORD: Questions? Shannon and Babak, you know, as part of ACIMM, you know, what we do is we are fortunate to be able to make recommendations back to the Secretary on ways to improve maternal and infant health. And I know a lot of the

work that you all have done around congenital syphilis, are there one or two recommendations that you think that with this iteration of ACIMM that we should consider that we move forward to the Secretary as well?

Right now we're operating under three work groups, and our primary focus is on improving Black infant and maternal health. And our work groups are around social determinants of health. We've got one on preconception and interconception care that we also focused on what is happening in rural communities. So any thoughts there?

SHANNON DOWLER: I would throw a couple things out there, and then one of the areas we're really focused on is where can public payers help in this space where they're getting federal dollars. We know a lot of local health departments and state public health is grossly underfunded, and so how can we capture the existing resources of public payers?

And so, looking at the family planning benefit, making sure that states have a family planning benefit. Not all states do. But encouraging states to have family planning benefit that gets into your preconception health. It's for, you know, all people that have reproductive potential, and really important that STI testing.

I just made the assumption because North Carolina has a very robust family planning benefit, but everyone did. But in fact there are some states that don't include STI testing as part of their family planning benefit. And that seems that that would be a natural step to make sure that one, what could we do to

encourage states to have this family planning benefit, and then to include SCI testing as part of that benefit for folks that have limited resources, and don't qualify for full Medicaid coverage, or in states that have an expanded Medicaid.

I think also the reimbursement for Extencilline for those folks that are needing to use that, and then reimbursement for point of care testing is important. And then the alignment around recommendations I think is probably the most key thing that we hear from providers on the ground is how do we even know what we're supposed to be doing because everybody has something different.

The state statute in North Carolina is very rigorous. We're not one of the priority jurisdictions, and maybe that's part of it because we have a really rigorous state statute around it. But if you go to your organization, let's say you're an OB/GYN and you look to ACOG, they have very specific risk-based screening, and so we're going to miss people when we're asking for individual judgements to happen at the point of care. So as much as we can standardize testing in pregnancy to take away that.

A great example of this is the most recent stillbirth that we had in North Carolina was a woman who did have prenatal care, and she entered prenatal care in her second trimester. And her baby had congenital syphilis and died, and she was never tested, even though she showed up with symptoms of a sexually transmitted infection in her first visit.

So, we're leaving too much to human error when we need to standardize the testing. Babak, do you want to add anything to

that?

BABAK YAGHMAEI: Nothing. You did it perfectly. I think Dr. Dowler has just summed up a lot of what the task force has been keying on, and one of the other reasons why she was brought on as another expert at the task force. And we do appreciate that you all are asking us this question.

The conversations are helpful, but we do realize that there's a so what behind it. It's nice to present here, but we do want to encourage you to be a voice as much as we are going to do our best to pledge that we will do a so what with this. For example, those priority jurisdictions are teaching us a lot about these challenges that you're also bringing up and voicing out. So these are being done all in parallel to a common goal.

BELINDA PETTIFORD: Thank you both so much. Questions?

KATHRYN MENARD: Hi Shannon and Babak, this is a really important presentation. This is Kate Menard, and for those who don't know, I'm an obstetrician and fetal medicine specialist. We tend to, when we think about congenital syphilis, we think about, you know, screening individuals, you know.
And I think what you showed us that there is 40% of these that the congenital syphilis cases are in people that never make it to care sites.

But I think we in our committee structure and the work groups that we're talking about where this belongs, it's in preconception, which starts when someone is born, and the screening strategies from the nonpregnant individuals. So that's one, I think, really important way we can incorporate into our

plans for, you know, allocating these.-

The other thing is about education. I don't mind revealing when I trained, which was a long time ago, it was just before, so I saw syphilis in my career, and some cases of congenital syphilis.

But in recent years have not. But Shannon has taught me is that it presents very differently now. And so, even as someone who did train, it presents in a different way in mice. And certainly we have people who, you know, have trained in 2010 and beyond, you know, they thought it was not a thing anymore.

So, Shannon, my question is how can you get to people? You know, nobody has the time, you know, the different ways we can get information out to our professionals at all levels, you know, and how can we do that?

SHANNON DOWLER: And that is a great question. And that has been a recent point of conversation. I mean everyone has webinar fatigue. You know, we made it through the pandemic with webinars, which was great, and we were able to accomplish a lot during that, but now everyone is back to their regular life and having layered on webinars on top of it, it's just people are exhausted with it.

And so that's not just the best way. And then it's also a lot of, -it's very time intensive, and resource intensive to get 50 people, or 100 people in a virtual room, and so it's not as effective, so I think using our associations that are representative, you know, large nursing associations, physician associations, to provide those resources. -

We've heard the recommendation that, you know, substance abuse for people that are prescribers is a required part of their licensing now that you have to go through a certain amount of substance abuse training. Is there some way to leverage, you know, training around syphilis and congenital syphilis?

You know, there's I think a lot of creative ways that we could get more broad information out there. But I think brevity is important. We have to figure out how to tell the story quickly, and for our current demographic of folks who access technology in a way that they want to be taught, maybe a little entertained at the same time, and have it done in a really quick and efficient fashion.

And so we have to think about how we do it differently.

BABAK YAGHMAEI: And, the other parts so we're seeing in the best practices areas is as slowly we try to scale that out from the ground level to outreach groups. So, whether it's these associations or just a health center that does really good outreach, there's that piece when it comes to the public part, and breaking down and understanding that the stigma is a reality.

So, using those groups as much as you can to leverage the messaging to get it out there, and Dr. Dowler already mentioned about how to reach the providers.

BELINDA PETTIFORD: We have two more questions.

JOY NEYHART: I'm a pediatrician who trained in the late 90's, then I tested for one case of congenital syphilis. So the question is if I'm being a bit an elite, two questions. One

is as a pediatrician when I screen at adolescents, we're used to just screening for GC, Chlamydia and HIV, so should we be adding syphilis for all of our adolescents now, no matter who they are?

And then also in terms of pregnancy, when I admit a newborn, I always checked for the VDRL--, and the RPR. What else should be happening during pregnancy, and again this might be too much in the weeds, but these are the questions that come to my mind.

SHANNON DOWLER: Yeah, so I don't think the data is there yet for universal screening recommendations on adolescents based on the age of the majority of the people who have congenital syphilis. I would have to defer to my CDC colleagues on that, but that is not a universal recommendation at this time.

But certainly risk-based. You know taking a sexual history and really understanding who is at risk. There are certain populations that are more at risk than others, and that does need to be top of mind for folks.

I think one of the biggest challenges we've seen is moms get sent home from the hospital before their test results are on the chart. And so that's particularly true in rural areas where they're batching the tests. They're not doing them as often as you might be in a big teaching hospital.

And then once mom and baby are gone, it is very difficult to track them down and to bring them back in. And so, really important that we are holding moms and babies until we have the test results.

There could be an opportunity for that point of care

test to be used really strategically in those rural communities where it's going to take four or five days to get a test result back, and we obviously don't want to keep moms and babies in the hospital that long if we don't have to.

So it's going to take a lot of sort of individual approach. I do think though that providers that are taking care of the newborns need to have this fresh on their mind again to be looking for those test results on the chart, and then we want pregnant women to be getting tested at their first prenatal visit. And that doesn't mean necessarily the big one. It could be the first time they encounter someone with a positive pregnancy test.

We would rather over test than under test right now, so how can our Urgent Cares, our primary care offices, our emergency departments when they're diagnosing a pregnancy, also go on and get into the habit of testing for syphilis, and then also incorporating it at 28 to 30 week period in pregnancy, and then at delivery. Those are the sort of hallmark times.

And to Kate's earlier point, a lot of people aren't getting access to prenatal care, particularly if there's substance use involved, fear of retribution, fear of losing their baby might keep them -- just fear of, you know, government. It might be keeping them out of offices and getting the care that they need.

So, how can we get the care to the people? How can we make sure that we're doing testing in pregnant populations in non-traditional ways, and that might be an important step at getting ahead of this.

BELINDA PETTIFORD: ShaRhonda and then Dr. Davis.

SHARONDA THOMPSON: Hello. My name is ShaRhonda Thompson. And as far as the public awareness and whatever or no of any states that might be utilizing their home health care workers, or their community health workers, you know, whatever they call them, that may be incorporating some teaching in their visits when they go to visit them at home.

SHANNON DOWLER: Absolutely. And I think probably the best demonstration of this has been with the Indian Health Services where they are really engaging community health workers and others.

Unfortunately, a lot of states Medicaid is not reimbursing for community health workers, and so it can be a tricky place to bring people in, but they're really important partners in this. So getting out into the helm is just critically important.

We know public health does it all the time. One of our nurses came over from clinic the other day having given someone a Bicillin shot on the trunk of her car because she wasn't comfortable letting anybody in her house. And so, you know, public health is used to this, but we need to be thinking about paramedics, and who are our other partners in the health care space that are going into people's homes that can help with this.

BELINDA PETTIFORD: We have one more question.

JESSE DAVIS: Jesse Davis. I agree that the preconceptive space is vital for education, and I appreciate the emphasis on provider education, babies, and providers and patients. -My question is how can we support and activate our

community organizations who are on the ground, because health literacy is a big issue.

And so, prior to pregnancy making sure that there's an understanding of the importance of this. Understanding, you know, of the stigma, in like what comes behind tested, and treatment, or resources, and utilizing the public health department resources as well.

So, I really liked what you said about leveraging payer resources as well, but there is a huge access issue from needing to actually receiving treatments, standardizing what that looks like, standardizing, you know, the recommendations, but also standardizing even simple things like notification to privacy.

We know it's not pre-standardized or automated, you know. So there's a lot of resources that are available that are not necessarily being utilized by communities. So how can the task force sort of form organizations that are on the ground that are already on the ground.

SHANNON DOWLER: That's a fantastic flag, and I think we learned in COVID, more than anywhere else in our history that community-based organizations are critical to our shared success. I think the difference is with COVID there is a lot of federal money raining down into communities, and into community--based organizations to do that work, and we're- not seeing that happen right now with syphilis and congenital syphilis.

And that's sort of the plug to me of why we need to use our public payers as much as possible because that at least is some money that exists to cover things, but there's still a large

uninsured population that I have to think about, and then that doesn't help our community based organizations who really are the boots on the ground folks that have the trusted relationships, and will help drive this work forward.

BABAK YAGHMAEI: We're also seeing that in some states they are able to finally create a way to leverage bright white dollars for example, to make up a deficit where DIS dollars were taken away, or something like that. But then we have a state, for example, that does syphilis home observed treatment program, which you know, many of the other states don't.

So sharing these best practices came out of almost very locally them getting together and having these, I don't know, monthly, quarterly, however you want to make it feasible to have these conversations because no one wants to reinvent the wheel. How do we just improve on what we've already done that works well?

And one of the things us at the federal level are doing is taking those 14 priority jurisdictions during a learning collaborative to spread these best practices, identify the additional asks where we can with the federal government, but also the vision is -- and it's in development with ASTO as our partner, is how do we make it so it's available.

So when we scale it out outside the 14 priority jurisdictions it can be available to the states that weren't in that, and then keep it going.

However, on the local level we do encourage as much as possible to get together whether it's the HIV Planning Councils, whether it's a consumer board, many different community based

organizations to get together and talk about what they're already doing, and kind of pooling those resources to Dr. Dowler's point of leveraging those.

SHANNON DOWLER: One other place that we're looking at is incentives. How can we use incentives, not just for patients, but for providers to do the right thing and every time. So one of those creative levers we can use to support people, we're looking at contingency management programs which are very effective in substance use disorders, and thinking about is there some way to match that up with syphilis treatment, particularly in pregnancy.

Bicillin does not feel good. It is a painful shot. And especially if you get that one big dose, people then have to come back for two or three shots. That is not fun for anyone. And so, how can we think about incentives?

At the same time, I think we have to honor our history, and syphilis of all the sexually transmitted infections has been marked with a really terrible history in our country, between the syphilis study at Tuskegee, the Guatemala inoculation study, we know some bad things have happened related to syphilis.

And so, that happened from a federal government perspective into the local, so we have to be really mindful about those levers, and making sure that we don't actually create more anxiety or distrust.

BELINDA PETTIFORD: Thank you.

MICHAEL WARREN: This is Michael Warren from the Maternal and Child Health Bureau at HRSA. So, we've done some outreach to our state Title V programs, those advanced grant

programs in states reminding them of the possibility that they have them in the block grant, to be able to address emerging issues like primary and congenital syphilis.

We also have done some very focused work with our Healthy Start grantees, so those are in communities across the country, and they provide not only clinical services, but also see that community help outreach that ShaRhonda was talking about, and so we've done that.

In listening to you all talk today though, I think we've got an opportunity, we're going to take back our team to cross sort of reference the 14 priority jurisdictions, and those jurisdictions where we have other federal investments, to maybe do a little bit of a deeper dive, and we'd love to follow-up- with our colleagues to think about some of those flexibilities that you're seeing in states.

One of the things we've heard, for example, was the state Title V program is connected with the state and STI program, often they're in the same building. Sometimes on the same floor, but different federal funding streams, different projects, different stakeholders, and so they don't always connect.

But if we can get some of those best practices from you all, we'll admit to looking at our investments and figuring out where there may be some opportunity to really leverage the resources that we do have in states.

BELINDA PETTIFORD : Thank you. And please join me in thanking Babak and Shannon. We appreciate you. We will continue with this conversation, but we do have an agenda. Okay. So at

this time I think we have Maxine. Thank you, Maxine. Maxine Clark is joining us today, and she is going to give us the history of Delmar DivINe, and I guess we can call you Ms. Delmar DivINe.

The Delmar DivINe: Turning the Delmar Divide Around

MAXINE CLARK: That would be an honor. Well, welcome everyone. Thank you so much for being here and choosing our site as a place for this important meeting. I cannot tell you how much that means to me walking around the building every day and seeing how many convenings happen here that help us be better citizens, help us be healthier, help us be more mindful of our fellow human beings, and what might be occurring in their lives so we can be more sensitive.

The Delmar DivINe - I might be better known for being the founder of Build--a--Bear Workshop. How many of you have been to a Build--a--Bear Store? Okay, that's good. I see some hands down, so that is more business to be had. But I just know that those hugs, the business that you gave us actually turned into what you're sitting in today.-

That personal wealth that I was able to achieve in that work, and it is thanks to millions and zillions of people. Prior to me starting Build-a--Bear-, as well as the community that customers that come to us every day. But I felt a responsibility, and every day is a learning day.

So, sitting here listening to this conversation I don't think I've heard the word syphilis since I was in college, which

was quite a long time ago. So I was thinking, of course, when I hear something, I think about how I can go to work to help solve the problem. And I do think, because I work with so many young people, that the education for young teenagers is really, really important.

And we have an organization here called Girls In the Know that works with young teenagers to do just that, and their mothers to help them be better educated in all things related to sexual and human relations, so I think that's something that I hadn't heard. I thought we had figured out how to resolve it, but clearly we haven't, so thank you for informing me on such an important health issue in our community.

So, thank you for informing me on such an important health issue in our communities. So, Delmar DivINe is a really wonderful, you're sitting in a 100 plus year old hospital. This was the former St. Louis Hospital. It was built in 1904, right around the time of the World's Fair. And it was a state of the art hospital at the time.

It is a campus made up of about nine buildings. This is a semi-original- building because this was it caught fire, so they had to rebuild half of it, but it was the doctors and nurses cafeteria, so you can see pictures of it in the back, you can kind of see what it once was. It was a very segregated hospital, which we own.

We own that part of the history of St. Louis as well, but it no longer is. This is a place that brings people from all backgrounds, all ages, all nationalities to here to solve the

problems that are caused here in St. Louis by the social determinants of health.

If we know them, that's my philosophy. If we know what they are, we know how they work against us, how do we work to help people mitigate and have access? Not just a door that says this is a health care place, but it really takes them inside and welcomes them, and teaches them what they need to know.

They may not need to know everything, but we get to know them as a person. And this is also what I call there's think tanks out there. This is an action tank here, Delmar DivINe. We are in the business of solving problems. Our tenants, about 35 nonprofits are a third health care, a third health care and mental health, a third education, and a third community development.

And all those things, when you turn over the rock of poverty in most cities, but certainly in St. Louis, there's housing, health, mental health, homelessness, education, access to health care being accessible. There's so many things. And so we really worked hard to bring the tenants together.

And actually, I have to say Kendra was probably one of the very first people I met when I started on this project. Kendra Copanas of Generate Health, and she really educated me in some of the important issues. Most of our tenants like Generate Health, have hundreds of partners, so this is not just a building of 35 nonprofits, because there's 26,000 in St. Louis. This is a building of thousands because of all their partners added up together, and they're all welcome here to be part of our community, and we see them here often.

But my goal was, and actually it started----this project started in 2014, about in 2014 a doctor of public health at Washington University School of Social Work, Jason Purnell, issued a report in March and spring of 2014, called the For Sake of All, which was a report that identified in very easy terms for all of us to understand the social inequities that exist in St. Louis.

And he used two zip codes, 63105 and 63106. 63105 happens to be just a little bit east of us, and south of us, and 63106 just happens to be a little bit west, and slightly north of us. They weren't next to each other, but they had huge differences in, -they weren't very far- away, not even 10 miles away, and had huge differences in maternal health, particularly.

That just shocked me. How could we be so close to a hospital that was very close to a Barnes Jewish Hospital. How can we be so close to a hospital and have so many mothers and children not making it through to year one, let alone past birth. I just couldn't even fathom it, and it really started me thinking about all the things that we could do to change that.

I went to lots of those sessions, and seeing the intersection of all of the problems and health care problems that we have in any community, but particularly in St. Louis. And then summer of 2014 Michael Brown was killed just about six miles from here in Ferguson, Missouri.

And that report that Jason had issued earlier took on a whole new meaning because most people in St. Louis had no idea. They just live in their little neighborhood like all of us do

wherever we're from. And we didn't know what was going on in the neighborhood next to us.

We didn't really go there, or if we met somebody from there we didn't know exactly where it was. If they said they were from Ferguson, we didn't really know where that was. And so it was near the airport, so that's how we knew where we were. But unfortunately, Michael Brown's death brought it to full center court.

And I tell his parents that he did not die in vain because all of us learned a lot, and this building is here because of what I learned sitting next to young people, sitting on a hill right across from in Canfield Green, where he was killed.

Young people telling me what was on their mind, but what they missed, what was not open to them, but what they didn't think was opened to them, and I learned a lot, and I went to work at that problem in our family foundation.

And then I was working on our KIPP School, a charter school right around the corner here, and one of the neighbors said to me, Maxine, you always go right, why don't you turn left and see the neighborhood. And if you see a house you want to buy we'll help you remodel it. That was my friends, Rodney and Juanita Norman, and said yeah, that's a good idea. I love history. I love historic houses.

I didn't need another house actually, but I loved history. So I turned right, and I turned right again, and I saw the sign in this building for sale. And I wondered, oh my gosh, we just opened up a school. I didn't even know what this was,

honestly. I just saw the sign and I called the number, and I was connected to the City of St. Louis who owned the building.

And they said well, it's for sale, and they told me the price, and they said it's a large building, Maxine, do you really want to take this on? It's 500,000 square feet. I said so that's half a mall, I can do that. You know, I know about malls.

And I started calling people to see how to help me, but I knew that this was the place when I found out the history of the hospital, when I found out that it had always been a place of caring.

That it could still be a place of caring even in a 21st Century way. But I could bring all of these nonprofits that I was meeting in my retirement all around St. Louis. I could spend half my day in a car because nobody was really together. And there wasn't easy ways to go knock on somebody's door.

In fact, recently I'm working on a project to bring the health care providers in breast cancer research together with the community that has a disproportionate number of people who die of breast cancer. And I said why is this happening when we have all these brilliant surgeons and doctors over here at Washington University and St. Louis University, and we have all these people in the vicinity dying?

And I found out that there are so many more organizations that I still didn't even know about, all working towards the same problem. If we were all working together we would have one plus one equals 1,000, and we would have cured this problem by now.

And so, that's what we're here for. We're an action tank. So take that home with you. When you think about you're working with people, or visiting people who are doing things like this, building spaces to bring community together, know that there is a way that people can work together.

I am just astounded by what we've been able to accomplish in actually only being here. We moved in in the spring of '22, most of us, and we are 100% full. We haven't had a vacancy. We have 670 people that have a badge like me. That's a lot of people in an office building, but because they built this so solidly, you can't hear a peep.

You can be walking in the hall, and you don't hear anything. And you wonder, is there anybody here? There are a lot of people here, and thank you today, for bringing so many people to our space. But we work together. Fortunately for me, I've been on the Board of Barnes Jewish Hospital, and the Board Chair of Goldfarb School of Nursing, and all these things are related, you know.

If we have all these relationships, how could we bring people to the table to work positively towards the solutions that we need. I mean they're not any different in St. Louis. I can take it from listening to your conversations, than they are in many, many cities around the country. So could we set an example, rather than be the example?

Can we set an example for how we can make people -we can help people, we can't make people, but on how we can bring people to a healthier place in their life.- I just finished

reading a book called Well by Dr. Sandro Galea, who is the Dean of the School of Public Health at Boston University, and somebody recommended the book to me, and I thought I read it in like a day. It was all that Jason had written about, but it told it more a prose like story.

And I thought to myself this is - it's not about health care, it's about health. How do we get people to be aware of the things they can control about their health, and how can we be a place for that to happen? -So, one of the fun things that we have here is a group of citizens, senior citizens, called the Wisdom Cafe, and they come together multiple times during a month, but they asked us for certain programing.

And I knew that they trusted us when they asked us to please have a class on sex after 60 because they live in communal living spaces. They live in, --there's more women than men, and they aren't worried about having children, so they're, you know, if they're having a sexual relationship they aren't getting in trouble with some disease issues that I had no idea. I said I'm over 60, can I come?

And I was really curious about we brought people to the table, the experts in this in St. Louis, and we've now had --I think we're on our 10th class. They started with about six people, five men and one woman, but now they're very diverse, and they're not talking about STDs, we're talking about relationships and positive relationships, and respect for each other. And these are all people over 55. 55 -- I think the oldest person is like 98 in the group, and they're coming for joy, for community, for

all of the things that make for a healthier, longer life.

And I've done a lot of personal interviews, and you may all know about this. I don't know if I told Kendra and anybody else in the room here that's working at Delmar DivINe, but we're working, I came to this realization from these senior citizens that if they're 80, and 90, in St. Louis and they're Black, and they're health and walking without a cane, without a walker, they have a secret. And how do we maximize that secret? How do we share that knowledge what they've done in their lives? And they gave me all the answers, by the way. And when I looked at it, and I happened to see the Netflix special on blue zones, I realized that those are the exact same nine things, points that the blue zones.

So we contacted the blue zone people. We're working on making this zip code that you're sitting in, 63112, and the adjacent zip code, 63108, which also includes the 9th and 10th political wards of St. Louis. It's not a political discussion, but it takes in about 45, close to 50,000 people to start working on converting this neighborhood into a healthier place for everyone to live and thrive.

And I'm so excited about it because I can't do,- I'm not a doctor. I am not going to build another hospital. We're in one already. I don't think it's- going to be easy to build a hospital in the future, but how do we build internally for people, the opportunity to learn and be knowledgeable, and to help themselves get to the place that they want to be.

So there's lots of parts of that, but one of them I

know we're going to be really successful is a glass of wine every day. One a day, not six on Saturday or anything like that. We're working on that one will be a good one. Everybody reads the brochure, and they say oh, I like that. But they actually -- we have tremendous parks in this neighborhood.

We have all the sidewalks that are -- need some repair, but we have the sidewalks that roll down to the wheelchair or a bicycle can easily go through. We have gardens. We have all kinds of things, but we're putting a new emphasis on it because in this particular neighborhood we have a plan, it's called the We Collab West End, but it also stands for neighborhood plan that was developed from the bottom up.

And while they concluded a lot of buildings and restaurants, and things like that, economic development. They didn't actually think about the health. They wanted to have Urgent Cares, and things like that around here, but they didn't really think about this. And when I told them they said this is just exactly what we want to have here. How do we do this? How do we?

And so, I can be a conduit, but I can't do all the work. But I can bring the people together to do the work, and that's what we're doing here. That's what this place is about. Bringing people together to work together, so that one plus one actually doesn't equal two. I'm really bad at math. My math is at least 100 and maybe 1,000.

So thank you for being here today. Thank you for being part of our information base to change our community, to turn our

community around, and to help us be healthier from the time we start walking, to the time we can't walk around so easily anymore. And I appreciate all that you bring to the table, and if there's anything else and any other conference we can bring here that will help us, and our community know more about what's going on, and how government can engage with us to find open doors.

Not necessarily can you all solve everything, but open the doors for more information to be shared across more lines with more people that talk to people every day, that can - even if we're not a doctor, or we're not a health care- provider, we can provide information when we see something that is not working right.

We can connect that person to something that will get them in the right direction at the very least. So thank you again, and if there's any questions I can answer for you about Delmar DivINe I'd be glad to. Does anybody have a question or two they want to ask? No questions?

BELINDA PETTIFORD: I think most of us are trying to figure out how we find a Maxine Clark. Any questions?

KATHRYN MENARD: It's just a comment, and this is fine truly, we all want you everywhere. A book to recommend? It's by our Shannon Dowler, it's entitled Never Too Late, Your Guide to Safer Sex After 50. It's a happy go, and it's very fun.

MAXINE CLARK: I think we'll make that available for that group, you know, that they would really probably like the book. I mean that's what we're also doing is exposing them to they have a book club, all kinds of things, a different subject

matter in different times that people bring up.

And I want to tell this one story because it was really important. One of the ladies that lives in this neighborhood, she worked at Anheuser Busch for 20 years, a Black woman, she was a typist. She was -- loved what she did, and she had sort of sat over here, and she worked there.

And there were other secretaries that worked in the executive office that were more, they were all white, and they were secretaries. They sat over there. And she could hear them talk about the books they were reading, and she'd say I've read that book, or I have it, I'm going to go get it at the library.

And but they never talked. They never really just joined in. The white people didn't ask her to join, and she didn't say can I join your group. And about two years before retirement, before Anheuser Busch was sold, and they retired most of the people, she heard them talking about a book she read, and she didn't agree with the premise.

And she jumped out of her chair, and she said you know, I don't agree with you. And she said they looked at her, and her first response was did they not know I can read? That's what I thought. And she knew they knew that, and then they said oh, you read the book? Do you want to join our book club? And now, 20 years later, maybe it's 15 years later, they're all good friends.

They travel on cruises together, they retired at the same time, and they all have developed a friendship. And she said don’t, she said -tell as many people as you want the story because I don't want people to miss the opportunity to reach out to each

other, Black to white, white to Black, Black- to Hispanic, white to Hispanic, to all the people that can add value to your life because that's what's made my life longer.

She said we go on these trips. We talk about the trip for months before we plan it. She says it's a whole industry onto itself. And I said I think that, and I really appreciate you sharing that with me, so I think that's one of the things that, you know, community brings, but you have to jump into it, you know. And not everybody is -- some people are afraid that they might get in deeper than they intended.

And she says I definitely got in deeper, but I am so glad I did because I've gone to places I never would have gone before, and I wouldn't have gone because I would have gone alone. And she says now I get to go with friends that we've made. Now we have 15 years of togetherness. But I thank you all.

Oh, Kendra do you have a question?

KENDRA COPANAS: If you can quickly say the genesis of the name, Delmar DivINe?

MAXINE CLARK: Oh yes. Thank you. So Delmar, you may have heard about it, or read about it, has been designated the Divide in St. Louis. The separation into white and Black, rich and poor in St. Louis was always more middle class and lower income north, and Philadelphia or south of Delmar.
And that became even more popular by the BBC after Michael Brown was killed, it just became sort of an infamous name.

It just made me crazy. And one day I was looking at the name. I was working on a branding for this project, and the

case to go out and raise the money to redo this hospital, and I just looked at the warden and I said that shouldn't be a D, it should be an N, and it should be DivINe, and the IN just sort of popped out at me, so I made it bigger, and I started thinking of all the words that start with I-N, inspiration, innovation, investment, all kinds of things.

And I was really, it was a working title. But when I shared it with the community over and over and over again, and I was getting ready. I said we're going to have a contest for a naming contest, for the branding of the building. He said well, isn't the brand the Delmar DivINe? And I said well, do you want it to be? And he said absolutely. Don't you know that we're all members of the Divine 9 sororities and fraternities.

You know, God brought you to -- all kinds of spiritual things that people were saying. And so we kept it, and it's been a great name for us. No one calls it the Delmar Divide anymore, and in a very short window of time we've been able to change the perspective, and it's beginning to look at lot better as you go down Delmar, as you go east down Delmar.

70 restaurants are opening on Delmar in the Maker District by the fall, and we're creating a really wonderful event to celebrate all that, that will be our taste of St. Louis so to speak, but we're not calling it that. We're calling it D is for Delicious on Delmar.

I'm a branding person, Build-a--Bear and these things, and it's fun to get everybody involved, and so we're working on that. And we're working on the many, many other things that are

part and parcel- of creating our community. So for me it is absolutely divine to work with all these incredible people in a place that every day brings joy to so many people, but a lot of joy to me, and gives me purpose to keep doing this work, and making sure that we can hug more people.

It's similar to Build-a---Bear. We hug this neighborhood broadly, and we count everybody who walks in here as part of our neighborhood, so you're in it now, and I hope that you'll stay here and enjoy and come back many times to share with us in what we're doing to make you proud of us, and to show that that better is possible, healthier is possible.

BELINDA PETTIFORD: Thank you so much.

MAXINE CLARK: You're welcome.

BELINDA PETTIFORD: Okay. And so we just went - we- were ahead of schedule, and now we're not. I'm going to actually still take a quick five minute break, just so people can run out, and then we'll get started back at 11:00, well, we'll say 11:10.

Improving the Health of Black and African American Birthing People and Their Infants in St. Louis

BELINDA PETTIFORD: All ready to tee up? And I am going to try to pronounce these names. Okay. So we are fortunate to have with us on our session on Improving the Health of Black and African American Birthing People and their Infants here in St. Louis. We're very fortunate to have with us a representative from

St. Louis County Department of Health.

We have with us Dr. Hlatshwayo-Davis, thank you. You gave me the phonetics to pronounce it. -

MATIFAZDA HLATSHWAYO-DAVIS: She did it. She killed it. This is the beginning of a beautiful relationship. Listen, secured the partnership right there.

BELINDA PETTIFORD: And after she speaks we also have Dr. Kanika Cunningham, so thank you. Turning it over to the two of you.

MATIFAZDA HLATSHWAYODAVIS: Thank you so much for having me. What an incredible day it's been already. I'm so excited by what this has meant. I want to just on a personal level, as a Black woman leader, with my twin, and one of my best friends, the County Health Director, because you don't- see that kind of regional partnership that often.

Just say how incredible it was to work with your team. And I have not in my time, and in my tenure have a team reach out early and say we want to do this right, please give us recommendations. It was important to these two women in the back, who I want them to get their flowers and wave right now.

It was so important to them to hear from us, and for us to really give them recommendations on the leaders in the room. So when I walked in the room and I saw the leadership that has led this charge for decades before Kanika and I were even conceived of, that's leadership. So I do want to honor you and your board for the intentional way that you showed up in our city.

I am Dr. Matifadza Hlatshwayo-Davis. I'm- the Director

of Health for the City. Buckle up, as my husband who is in the crowd will tell you, it's always going to be an experience when I take the podium, but you chose this. You came to me. Let's remember this. I didn't just show up, you all. You all asked me to be here today, all right.

So I am the Director of Health at the City, my partner, Dr. Kanika Cunningham will come up behind me. She's the Director of Health at the County. And we are passionate about this. This is our life's work. I'm glad I got to go first today because she actually does this for real, while I'm an infectious diseases doctor by training with the public health degree.

She is a family practice physician who has led federally qualified health centers and has birthed many of the babies in this region herself in her own hands, who currently has the most beautiful baby at home. She just came out of maternity. I don't know why I'm telling her business. I just love her like that.

She will right, I would say about cousins or men, we go through these presentations. So next slide please. Let's start with some data. My good friend Dr. Corry Bradley says data is justice, so we're going to talk about the data in a way that honors Black women, honors women who birth children, and honors this movement.

But we've got to talk about the data. And we're going to---oh, the fact that they're abysmal. You all wouldn't have flown- out her to sit in this room and be with us if we weren't part of the problem area, so we've got to discuss it. So let's

start with these March of Dimes statistics here. The United States, as you know, has some of the worst maternal and infant health outcomes amongst all nations in the world.

And according to the March of Dimes 2023 report that I'm sure all of you in this room are very well acquainted with, but because we are being joined by close to 80 people right now, it's important that we speak this out, and make people understand the urgency of the moment.

This data is alarming. In our state, Missouri, is graded as a D minus in pre-term birth. In 2022, one in nine. Let me say that again, one in nine babies in Missouri were born preterm compared to the national rates of 10.4%, we're up at 11.3. Infant mortality rates amongst Black birthing people have also increased nearly twice the rate of- overall states.

I'm so tired of saying this. I'm so tired that it's my community that shoulders the burden of trauma again and again and again across all metrics, but today we're talking about it in this space.

Interventions for equitable, preventable, and early prenatal care can reduce disparities. We know this in birth outcomes, such as pre-term births, low birth weight, and inadequate prenatal care and early prenatal care. Next slide please.

I'm going to take you through the data at the City. So before you are going to look at maternal deaths, which include deaths of women while pregnant or within 42 days of termination of pregnancy. So from 2020 - 2022 the material mortality rate was

52.93% for the City, which is higher, much higher than across the U.S. and state rates.

In Missouri, the leading cause of maternal mortality is mental health issues. Let's just pause there for a second because as a physician and a public health practitioners, one of the things that has held us back, because let me tell you something. You're going to be hard pressed to go to any states where the leadership is as strong as the leadership that has shown up in the back of this room.

They're so respectful that they have sat here and listened, but they lead. This is what they do, right? But one of the biggest issues we face is thinking this is a monolithic issue, thinking that we can only talk about this as a vacuum. So what is actually taking our Black women out, what is actually taking them to their graves, quite seriously, is mental and behavioral health.

We have crises within crises, and we're tackling that right now in the City of St. Louis, and next slide please. I was going to keep going, but I only have 15, if I could have you all here all day.

So let's talk more about infant mortality, which is defined as death during the first year of life.

Infant mortality is an indicator that reflects disparities in our city relating to social, structural and political factors, as well as the health care, delivery and medical outcomes as well.

Data shows that from 2020 to 2022 infant mortality among Black babies was two and a half to three times the rates of mortality among white babies. By using zip code data, and

indicators related to social and structural determinants of health, policy implementation, and improved clinical care, the city aims to decrease racial and ethnic disparities in infant mortality by 67.52% by 2027. That is our commitment. Next slide please.

Early prenatal care data aligns with objective number one. In the community health improvement plan that Dr. Cunningham and I will be sharing with the region tomorrow, which is to increase the percentage of Black and brown pregnant people who receive early prenatal care by 15% by 2027.

Early prenatal care is defined as pregnancy related care beginning in the first trimester, so that's one to three months gestation.

In the United States, 77% of live births went to women receiving early prenatal care. In the city, while birthing people - white birthing people, I beg your pardon, account for 77.46%, had the highest rates of early prenatal care compared to only 53.72% of Black- birthing people.

Both rates by race were lower than overall in Missouri. Next slide please. Another objective that aligns with that is to increase the percentage of Black and brown pregnant women who receive adequate prenatal care by 50% by 2027. We believe inadequate care is defined as care beginning in the third trimester, or four or fewer visits for a pregnancy of 34 or more weeks gestation.

While this may sound boring, it's important to define these things. It's important that this becomes common language

that is agreed upon by the leaders from the health care systems, the largest health care systems, our federally qualified health systems, but the community based organizations that have earned the trust of our community, and you'll be hearing from a lot of those leaders over the next couple of days, listen to them.

These are the folks that are the most under resourced with a community trust. So, it's important that our definitions align. It's important that we've all seen the data together and understand it in the same way. In the City of St. Louis during 2020 to 2022, we were three times more likely to receive inadequate prenatal care than white birthing people.

We've done this at a zip code level. We've tried to make our data accessible. So before I came on as Director of Health in October of 2021, we didn't really make this data publicly available. We now have a monthly report. Our website, which is now translated into 17 different languages to honor our migrant and immigrant communities, has maps that are heat coded and color coded because health illiteracy is another big part of the story.

We all understand this, but it's not changing what's happening out there, so we need to be thoughtful. I come up here and I crack jokes, and I make myself accessible because one thing I'm going to flex about and say is I don't see one person on Solitaire right now. One of the things that is important about my leadership and Kanika's leadership is connecting with people, so the gap is not in this room. Let's be very clear.

The gap is in making folks in the community understand

this in the same way. So are you making this information accessible? Visible in a way that people can understand? This has to be one of the recommendations that I think we need to talk about really education leadership in this space about communication and education, and innovation there within.

I was on an urban radio station this morning, 105.1 Streets with D.J. Tack. The whole city knows that they can catch Dr. Mati, they've dubbed me the community doctor, the biggest accolade that I've ever had. I want t-shirts- made when I leave, right. You can't take that away from you, you can take a lot, but you can't take away that.

But the city knows that every Tuesday at 9:00 they can log on and listen to their Health Director. What are we doing at a national level that's accessible? How are we making this known so that people understand it's clear? At a time when we have a congenital syphilis crisis that's 600% higher in metrics since 2016 in our region, a national crisis. I'm not seeing that talked about.

And we're all in this room. We're in the auntie and uncle eras, and that's okay, but we need to be hiring people who know how to connect with young people on Tik-Tok, Snapchat, Blue Face, whatever the new -- I can't keep up. I'm still on Facebook. You know, I'm back there with the dinosaurs. Next slide please.

Two more slides. This is preterm births, and I'm not going to belabor the points. You're going to see devastating statistics. You're going to see Black and brown people shouldering the burden more. Read it, weep, let's move on to

solutions. -

Next slide please. Same thing in low birth weight babies. The kind of gaps in these bar charts that you are seeing should not happen, and the reason I took this job, and left a hospital job that I was very passionate about is because we are tired.

The Black community is tired. We no longer want to hear our story being spoken about in trauma and sadness. We are a joyful, powerful, incredible community, diverse in everything we do, and this should no longer, and will no longer be our story. So what are we doing about this today other than showing off and checking off a checked box, and we made the meeting happen, and we showed up and we look cute, because we look cute now.

What are we doing to honor the lives of Black and brown women? Next slide please. So, we know what these social and structural determinates of health, and I'm here to tell you that what Black women are telling us in the city hasn't changed. In a survey that we did connecting directly with women who in this space, this is what they told us. They do not believe they have adequate access to health care.

There are still health care deserts across the city and county, and it should not shock anyone in this room that they are more predominant in the north. Newark City and Newark County are seeing a staggering lack of access, and with it valid mistrust and distrust for health care entities, for government entities.

Some of my most successful programs is when I say I refuse to make you come to me. I don't make people come downtown.

And when I teach in community, one of my first icebreaker questions is how many people can tell me the address of the City Health Department? I'm going to do it today.

Ooh, I want to see what happens in the back. Jesse, you don't count. You don't get to answer this question. Sometimes you drop me off of work when the babies are tripping. So how many people know the address of the City Health Department? Hands up high. That is appalling. These are---Jesse- I said put your hand down.

Jesse's trying to get bonus points, he's like right? So that's another issue. There is valid mistrust and distrust. They don't come to where we are. We have to take health care into community. So another recommendation is what are you all doing at the national level, understanding the overwhelming crisis there is in public health?

125,000 public health workers leaving the workforce in 2021. An estimated quarter of a million by next year. What are you doing to make sure that the frontline? Because please be clear, we are the frontline. Public health departments, we are the frontline, and yet we are the most underfunded, and the most under resourced. I have a health department a quarter the size of what it should be the city of this size.

My budget less than 1% of the City's budget when I inherited, 2% right now. Abysmal. You call countries like mine in Africa, low-income countries, but most African countries are doing way better by public health. Keep the -U.S. - nobody talks about it because we're- not going to cover that, but they did.

I'm here to tell you of the very proud Zimbabwean they did. Systemic bias and racism, I unapologetically will speak it out. We foster it. The Supreme Court said this, we are with intention rolling back programs to train public health and health workers in this space, while Black women are dying at higher rates, right?

So if you are not willing to say it, and it's scary for you all. You're all the government now, right? But systemic and structural racism is real, and it is one of the main reasons why Black women continue to trail. So what are you doing? At a time where the funding is drying up, and we're seeing DEI programs and training drying up across the country, what is your plan, strategically to make sure that that doesn't increase the gaps that we already have.

Economic stability, man, Dr. Cunningham and my teams were really upset with us for making this one of the priorities. They said public health is not equipped to take this on. Our answer is we don't have a choice because if we don't understand that economic mobility is one of the biggest determinants for Black women in this region, we are not understanding the needs of Black women.

Health care is a luxury for many in my community. They don't have it as the number one, two, three, four, or number five priority, even though it should be, because they have to figure out where their next meal will be, who is going to pay their bills, how are they going to get their babies to school, who's taking care of their babies before we even get to health care.

So these are some of the metrics here around the social and structural determinants of health. Let's end on a positive here. What has been successful in the city? We are centering -- I'm sorry, that means next slide. Centering pregnancy and rebuilding of the metaphorical village. This is personal for me. I grew up, I have been raised in a culture where there is no word in Shona for cousin, for aunt, for uncle.

The literal translation in my language is younger or older mother, younger or older father, and a cousin is just a brother or a sister. We have to bring those core values back into what we are doing. The metaphorical village. My husband's mom and dad, talk about when he was a kid in Saginaw, Michigan.

They could ride their bikes down the street, and if they were acting a fool, they could yell out from the door, the window, and it was multiple people who were across the line that they still are close to to this day, that would take their babies.

We are not equipped to reverse these numbers. But what we can do is empower communities to have a family and a village, a metaphorical village to support them along their way, until such a time as we can get our act together. So what we're doing in the City's Department of Health is trying to rebuild that metaphorical village, that's group sessions for maternal support, not just isolating folks, and talking to them individually, community based maternal and newborn care.

Patient centered care from health professionals and service providers. I'm so proud that so many people that I call partners and friends are in the room today, because we realize

that we can do this work together. I know that if I send someone through our referral to Dr. Kabele at VGC, that her team is going to take care of our folks. I know that Kendra can call me and let me know what she's doing around data and justice at Generate Health.

I know that we have innovative leaders like Ronke, who you will hear from later, right around what it should look like to build this metaphorical village to address these mental and behavioral health issues. So I have built myself a metaphorical village, as a leader in order for that to translate to what happens in the city.

So we are now dealing with trauma and for training we have the first ever Behavioral Health Bureau in the city that we launched a year ago. They work closely with our maternal child health teams, universal screenings, but prioritizing Black mother's voices and care and pregnancy in this fashion is something that we have started to do. Next lesson? Next slide please - next lesson, I'm sorry I'm tired. I didn't- have coffee today.

Partnerships are important. You've heard me call out my partners by name, by first name. I think these collaborative partnerships are so important. Your team mirrored that by how they showed up, how respectful they were, how they didn't condescend, talk down to us, and tell us how things would happen at a national level.

How they really tried to be intentional about hearings. So I believe you have what it takes, but what more can you do to

help us foster those community partnerships? I'll tell you one thing you guys know how hard it is for us applying for a grant.

I hate applying for grants. I'm 52% grant funded, and if it was up to me I'd never apply for another grant again.

Do you want to know why? Because A, I don't have people who can write grants. B, grants come with reports and audits, right, so we're knee deep in business. Listen to the community partners in the back because you guys need to hear this. You guys are huge about sending us money. We can't do anything with it.

It's what happens after that though, when we put out calls for people to apply for the money that comes to us from the federal government, nobody applies because I don't have a grant manager, do you think they have? Do you think they have the capacity to collect all of the reporting that's necessary to keep the funding?

They need help. So what innovative strategies can we have, which is one of my third recommendations around caring, funding, with real support for community based organizations who are the trusted leaders, who need this money to stay alive and to grow in such a way that it doesn't overwhelm them, or prevent them from even engaging.

What about pairing money with grant writers, and business managers who they could then have to actually collect their reports, so they can focus on the work. You want them focusing on the work, not the business of the work. And small community based organizations who are the heartbeat of trust,

valid trust in our communities, are struggling.

I want to just put some in the next slide, and then I'm going to shut up so my sis can speak. Really just some quotes from actual Black women that we collected for you to see on the screen. You only see liquor stores, funeral homes, cemeteries and abandoned houses in our neighborhoods. Mental health, and by the way, we asked them to comment on maternal child health, but this is what they came up with first.

It wasn't directly linked to their pregnancy or their kid, this is what is important to them. Mental health is the first thing you need to take care of. You can put yourself into a depression and not want to come out, and you have a baby on the way. Having the ability to access to a doula, who made sure she was going to be safe at the hospital was one thing a dad said to us.

Providers need to establish relationships with their patients, and if you as a patient do not feel comfortable, it is okay to make a change. Our health department too, should be the number one priority from one of the people that has boots on the ground from our organization.

This is what people are actually talking about, so policy should reflect what people are actually talking about, not what we have deemed. I once led a community meeting, I just thought I did it. It was innovative, I looked at LeBron James as the shop. Have you ever watched him on HBO? He has people come to like a barbershop and they just talk shop, like we do in our community, it's beautiful.

I'm a sports fan, and I like to talk as you can tell, so it's both things I love, Jesus. We decided to do that in the city. We found a barbershop that's at the cornerstone on the community, right downtown. It had beautiful Black art. We brought community leaders together. Ooh, you can tell I didn't do it. One of the first things I said is data is justice, like I said earlier.

And I said we do data to inform our programming. We use data to make our programming better. Oh, I thought I did it. And a community leader laughed at me on camera. My little ego was offended, you all. I don't get laughed at a lot in my position. They laughed. They said you academics love your data, don't you? And they say your data means nothing to us.

And I'll never forget this. They said to me if you control the variables, then you control the outcomes. So sometimes the reasons why the policy don't hit from a national and state, and even local level is because we control the variables. We don't even talk to the community about what kind of research we need to be doing, what their issues are, what their priorities are.

So our variables are going to make outcomes that are actually not even accessible to them. So do you have a community participatory approach with local public health and community based organizations before you even start collecting your data? That is my final recommendation today. My staff put a lot of recommendations on the slides that I didn't say anything about that, but just look at them.

Please honor their work, here they are. Read through these things as well. I have two more slides, but I took up too much of my time, and Dr. Cunningham's time is valuable and important. I'm going to stop here and say thank you so much for having me. Sis, you up next.

KANIKA CUNNINGHAM: Okay.

BELINDA PETTIFORD: We'll have your whole presentation to look at all of your recommendations.

MATIFADZA HLATSHWAYOD-AVIS: Thank- you so much.

KANIKA CUNNINGHAM: All right. Thank you, Dr. Mati. I absolutely love listening to her. You should hear how our phone calls go. But I'm so excited about the opportunity to lead with her, just because we do share very similar values. And one thing I could say about both of us, we truly love the community.

We love accountability. I would say she definitely when I think about Dr. Mati, I think about accountability. Not only does she speak truth to different systems, but even to me to those around her, and I just actually love you and your leadership, you're doing phenomenal. I love you for that.

So as she stated in the intro, I'm Dr. Cunningham. I'm Director of St. Louis County Health Department. I have a little bit of data in there as well, but I feel like Dr. Mati definitely covered it pretty well. I'll speak to a few things in St. Louis Country, and then my recommendations are a little bit different, I think from my own lived experience, but then also just practical things that I want you all to take back.

Let's go to the next slide. So, this is a picture of

my newborn. So I have pictures in my slide deck. So my personal journey, local state data. I'm going to touch on a little bit of the community health improvement plan Dr. Mati had mentioned that they were going to do the official roll out tomorrow. I just have a few little snippets from that, and then again those recommendations.

And I will say last night when I was working on this, and of course when I got in bed and I was like, I don't like these recommendations. So I probably changed it up a little bit, but it still makes sense, go to the next slide. So my personal experience. I have an 18-year-old, and now I have a four-month-old.

And with my 18-year-old I was 20, and at that time of course not in medical, not a doctor at all, you know, just working at Value City shoe department, in an abusive relationship at that time, but I was so thrilled to, you know, be pregnant, and with my first child when I was 20.

The pregnancy was great. I do remember that it was multiple times where people thought I had Medicaid, so the treatment -- and I had private insurance because I was working full-time, but I just remember just different events that took place throughout.

And now, knowing what I know as an adult, as a physician, deeper I get involved in this, that it was assumptions and judgments made about me based on the color of my skin. At that time I thought it was a privilege to say I have private insurance.

But now realizing what they were really trying to imply was a judgment that oh, you don't have Medicaid?

And then for them it created this environment that now I was treated a little bit better because, oh, I didn't have Medicaid. But at that time I didn't know. I just felt like oh yes, I don't have Medicaid. I get to say I have private insurance. So that experience, I remember when I had my first daughter at one of the hospitals here, I remember the nurse checked me in. I remember her expression. She said oh, you don't have Medicaid?

And I was like no, I don't.

And you know, I had my baby, and the doctor came, and everything -- it was fine. I had my family there, so I had a lot of support. I've always had a lot of support from my family, but I remember on the day of discharge when I was leaving. It was a nurse that came in who was doing my discharge, and she said, now, I don't want to see you back here next year.

So, at that time no, you're not going to see me back, and you know, but I was young. I was 20, I didn't know. I know I felt offended, but I couldn't name, and I couldn't put to words what that feeling was, but I carried that. Like I remember exactly that moment when she said that to me. So fast forward. Now I'm a physician, County Health Director, I know the health care system. Did deliveries myself.

I know how to navigate inside this health care system, navigate the community. So I got a little bit more, I guess courageous, going into this next delivery. Go to my next slide

because my - oh go back, you took it out? You took out my other slide. -But with this one I remember going in.

I went in for decreased fetal movement. So of course, as a physician my mind went all the way to the far left. As this was taking place the last thing I wanted was I'm going to go to the hospital when I get off work and finish this little report I'm doing, you know, try to drink my apple juice, and then did my counts.

So I went directly over there, and I remember when the doctor came in again. I mean I always feel like I should never have to say who I am, what my position is, and I tell people that the letters behind my name have more value and power than who I am as a Black woman. And I remember, the doctor came in did an ultrasound, and you know, chit chatted, and talking and laughing.

And of course I was looking at my fetal monitor. I was very involved in all of my health care, you know, all of my testing because I wanted to know. I didn't completely trust the health care system. And my friend was actually by OB, but it was still that I didn't feel comfortable just only being a patient. I had to also be a doctor for my baby and myself as well.

And I remember we were going through and the doctor there she's like oh, are you a doctor? You have your medical degree? I said I sure do. And so she thought that when I was making my comments about my strip, my fetal strip that I was just you know, just casually talking, I had to let her know.

And then the whole demeanor changed. And I get asked what do you want to do? Do you want to stay and get induced?

Everything changed when she found out I was a doctor. And I say that because everyone don't have that same type of privilege to be able to speak the medical talk, to be able to advocate for yourself.

And for me, there's no way I want to go home how this strip looked. And it was if you strip all of my MFMLBs here, but I saw how my strip looked on Friday, and I felt like if I would have went home with decreased fetal movements, and if something would have happened, I would have never forgiven myself.

So I chose to get induced that night. Labor and everything was fine. I had a phenomenal experience this time around, but I remember my husband asking me. He's like why don't you just let them -- just be the patient. And I was like, no, I can't, and all the datapoints, no.

But I intentionally picked the hospital I did because that particular hospital show up in community. So I pay attention as the Health Director who is showing up in community, who is speaking the same language to both of us. Who will truly support me if I had any adverse, even at the hospitals?

So, everyone can't have that privilege, but that was something that I chose, and I had a great experience this time. Next slide please. So, I have a few recommendations at the end based on my personal experiences. So at the St. Louis County Health Department, we do a lot of surveillance monitoring. We do a lot of the data, so we do get a lot of it firsthand.

My team reports together. We issue those out as well. So for us internally I think of us as a health department, as Dr.

Mati explained, it's good for us to look at the data, and to identify those gaps in care. But the community, they don't care about the data. That's for us. That's for you all to look at that data.

So at different levels we assess data, directly from my Medical Examiner's Office, from Vital Records, a course work with the hospitals, we interpret this data. So this slide is just only saying that we use our data to inform our policies, inform our community programming, and I'm doing this for all of St. Louis County, and then partner with St. Louis City Health Department as well. Next slide.

So again, if we look at some of the surveillance indicators that monitor typical birth rates, maternal mortality, infant mortality, your bread-and-butter things that we monitor of course when it comes in to helping other communities, specifically material child health. Next slide.

I'm going through kind of fast so we can get to the Q and A part. So disparities in pregnancy associated deaths. So this data here, of course, it's we have across all age groups, people ages 20 to 24, at the highest rate of pregnancy associated deaths compared to any other age group. That where greater neighborhoods with higher poverty levels, rates among Black women was three times the rate for white women in St. Louis County.

Rates of pregnancy associated deaths were highest among those living in north and out of regions of certain areas in the St. Louis area which higher poverty, higher crime, low income, so a specific area in St. Louis County in which we see more poverty,

poverty rates. Next slide.

And it's the same thing, at the CDC that we're seeing around the region, so I'm not seeing anything that's too new. The five-year average for fetal death rates between 2018 and 2022 was 5.8 per 1,000 live births. So in St. Louis County the most prevalent risk factor for fetal death was previous pre-term birth, followed by pre-pregnancy hypertension and gestational hypertension, this is specific for St. Louis County. Next slide.

So we'll look at of course, disparities and fetal deaths. Mothers aged 40 and older have the highest fetal death followed by mothers between the age of 15 to 19, and mother's aged 20 to 29, all experience higher than average fetal death rates.

Of course, and unfortunately, Black mothers have the highest fetal death rate compared to other racial groups in St. Louis County. Fetal death rate was highest among mothers that are living in medium poverty neighborhoods, followed by those in high poverty neighborhoods, and then fetal deaths were higher among mothers living in those particular areas in our county. Next slide.

Same information here. What we see, the Black mortality rate is higher compared to whites and the general region as well. So white mortality rate decreased by 38%, overall 22%. But what we can see here is the same trend that we've been seeing in the region, as well as the national data. Next slide.

And in pregnancy related mortality, so Missouri witnessed more maternal deaths during an active pregnancy per capita between 2018 and 2020.

So nearly half of the pregnancy related deaths occurred between 43 days and one year post-partum, so I have a few comments with that.

84% of deaths were determined to be preventable, so a few things that Dr. Mati had mentioned. The intersection of mental health and behavioral health. One thing that I always speak on is the history of substance use.

I think we're doing a great job as a country talking about substance use now, but when we talk about substance use for pregnancy there is still this stigma that because unfortunately in the past, Black women had our babies taken away from us because of the stigma.

So think about you're going in, you're already walking into a health care system you don't trust. You're coming in with the effects of racism and stress on your body. You're probably coming from a different, a particular neighborhood in which you didn't have access to food, or you didn't have access to equitable services.

And then to put a substance use on top of that. A lot of times what I found in practice is that individuals, they of course were afraid to talk about this at appointments. I will say one thing in the St. Louis region, a lot of times a lot of this type of care was done in the same office that high risk - obstetrical offices, sorry. Slurring- my words here.

One thing I did at one of the health systems that I worked at because I have a passion with addiction care. Since I deliver OB care, I also sort of integrate addiction care as a

family medicine doctor. So one thing I would do as women would come and see me, not only did I take care of them and their babies with this, I was able to also start treatment with epinephrine, I was able to have conversations with women with substance use, talking about the support that they will receive, let them know that your baby is not going to get taking away.

We're here to support you. We're here to make sure that you and your baby have the best outcomes. So I think that's one thing that we definitely need to recognize and highlight. In the same sentence that we talk about mental health, we also need to talk about substance use as well.

Next slide. Access to care matters. Of course, as the issue of access. One thing I would say too is we think about access to care we always talk about getting people to care. But once they get inside of our health care system how are they treated? I think that's a whole different issue that we need to discuss. We all will say access, access, access, which is really great. But we also need to change those systems inside once somebody do access the health care system.

So we'll talk a little about doula and midwiferies and other recommendations that I have with that, but it's beyond access. It's really talking about changing up the care that somebody receives once they even get inside of a health care system. Next slide.

So again, this is our community health improvement plan. What this is, is a collaboration with the City Health Department and the St. Louis County Health Department, in which we

develop a strategic vision to improve the overall health and wellbeing of the community.

And with this collaboration to maybe help improve the plan, we identify priority areas for both city and county. And one of these was maternal child health. Go to the next slide please. So these are some of the cross cutting things. So these are all of the priority areas that we identified, and again, I'm only going to speak to the maternal child health today.

But what we looked at though, the intersection of racism and equity as it relates to all of these, access to systems, and physical accessibility, interventions across the lifespan, so not just only when somebody enters into pregnancy care, but even before upstream. What does reproductive health look like before somebody even gets pregnant?

Participatory driven approaches, Dr. Mati had mentioned that in her talk, and of course trauma informed health care systems, communities. So this is the cross cutting things that we developed, and maternal child health is one of the priorities for the region that both health departments will continue to advocate for, next slide.

So a little bit just deeper details in priority areas. So one of the goals, of course, address racial disparities who reduce morbidity and mortality to improve maternal and infant outcomes. So one of our goals about the city and county, by 2027 an increased percentage of Black and brown pregnant women who receive early and adequate perinatal preventative care by 15%.

So again, we're into where Medicaid coverage - a- lot

of people are not even aware that Medicaid coverage is extended to one year, and we also listed some of our community partners there. Ensure Medicaid retention through increased re-enrollment.

So the whole process that happened here in Missouri was trying to re-enroll the Medicare, you know, it was confusing. Even for me. I had to follow my friends, like hey, what's up, what going on with this? I cannot imagine a community member being able to follow and understand how to enroll in Medicaid.

Increased clinic visits for pregnant people utilizes CHW's support doulas, patient advocates. Again, partnering with the community, and what that looked like now moving forward. And not only relying on individuals that come to us, but for us to go out into the community, and advocate for Medicaid reimbursement.

We could talk a lot about that for doulas. Next slide. I kind of want to get to these recommendations. Again, different goals here. Advocate for doulas to be recognized as part of the care team. Increase implementation and disbursement of evidence-based training modules to providers.

I think when it comes to training providers, I think training is great, but how do you dig deeper and make sure that that training is actually implemented with the labor and delivery experience?

Even in their clinical care. You can do all the training that you want to, but if we don't dig deeper and really undo those biases, and really change to workflows and change to environment, the only thing we're doing is just the same thing, just going through trainings and doing checked boxes. So how do

we make training effective, and how do we truly make the change with training to providers, and everyone that's a part of their care team?

Diversified workforce, reducing the congenital syphilis by 90%. I share the same concerns with Dr. Mati, that we do not talk enough about congenital syphilis, about treatment with syphilis, and connecting women to care. Our health departments actually went through in the case studies to review these gaps in care.

And one thing that we did see that unfortunately in the St. Louis region there are Black women, no matter which hospital system they came in contact with, they were not even offered syphilis screening in addition to treatment. So, my health department, along with Dr. Mati's health department, we are the ones who have to track down individuals to make sure they get treatment.

And especially if they utilize our emergency departments, they're checking tests, but then there's no follow-up-. So making sure we can partner with emergency departments so individuals will know where they can receive free treatment is huge for the St. Louis region. Next slide.

By 2027, reduced pregnancy related health disparities among Black and brown pregnant people by 5% through health promotion and education programs. Again, this is partnering with the community. Education goes a long way. If we don't break down this language and terminology to those that in need that it really matters, what are we doing?

We need to definitely hear from the community, listen to the community, and interpret the information that we have so the community can digest it, and then tell us what to do, or help us make the decision together, not just us always telling community what to do.

Increasing the role of organizations to a statewide. Next slide. And then by 2027 create four opportunities for residents to engage in, and again, this is the community engagement training, and advocating for maternal and child health. So really elevating the voices of the community and empowerment of our community leaders as well. Go to the next slide.

Okay. So what these recommendations, so these signify the reproductive health and access to equitable health care services. So I put this in just because when we think about reproductive health, and everything that's taking place. If we talk about, you know, birth control. We talk about what it means to procreate.

When we talk about you are a single parent compared to being someone that's married. So even sometimes if you're a 15- or 16-year-old, and you are pregnant and you enter this health care system, you're coming in already being judged. You're coming in feeling ashamed. You're coming in feeling all different types of feelings because society has made you feel like that you are worthless because you are a teen that's pregnant.

So, you're already bringing all these feelings into the encounter. So these statements highlight the reproductive health, and normalizing talking about sex, talking about these things,

talking about being pregnant. Let's help empower our women about taking care of their bodies before they even get that positive pregnancy test.

So what does that look like as well? And not only is the access to equitable health care services again, what does it look like once they enter inside the health care system? So not only training, not only diversify workforce, but what's the true work that needs to be done to make sure that anyone woman, Black or brown, that enter a hospital system receives the fair treatment that they need, just like I did when I delivered.

Care coordination with community and reimagine the care team. So that's where doulas come in to play. Community health workers, I'll even add peer recovery specialists because again, if we see that the history of substance use is so predominant in our women, Black women in the State of Missouri, we have to encourage peer recovery specialists.

They have lived experience, and they have a different perspective than some of us, so we may not be able to relate to that woman that's experiencing it. Who should be a part of the care team, and what kind of support does that woman need outside of the physician, outside of the doula, outside of the nurse, and what does the care team truly look like?

Policy development advocacy, we can talk about policy all day, but if we don't listen to the community and what those policies truly mean, again, we're causing more harm than good. And there are so many different examples of policy development on the state level that did not translate down to the community

level.

Stable and sustainable funding. We need funding. Is there a commitment to have ongoing funding streams available for community partners, available for health departments? And as Dr. Mati mentioned, how difficult, what's going to be the hurdles of the barriers in place for us to be able to access those funding?

If you need a 20-page grant document with all these audits and reports, how likely then is somebody going to be able to continue to receive those funds if we don't have that in place?

So what does that look like moving forward to funding for community partners as well as for health departments? We'll talk about a workforce, diverse and equitable workforce department with an educating community with system level changes. Again, they're centering the voice of the community, but more importantly, centering the Black voice in that experience.

And in celebrating Black birthing joy, changing of our language and our narrative. I think we hear so much about the data, the death points, infant mortality. We hear a lot about that, and you have touched on that at your last event,- but- it is so true though that we need to change up that narrative.

What does that mean to have a baby? It should be an exciting experience. It shouldn't be anything that you walk into this experience and you're nervous, you're thinking about an adverse outcome. I mean I want to sue. I was thinking about that, like what if this -- what if that happened? It almost got to the point where I couldn't even enjoy the experience because I was so concerned about oh my goodness, this could happen, this

could happen.

So, what does it mean, even in our hospital systems to celebrating birthing joy? What does that mean? I will say I did -- I think this hospital, particular hospital, do this for every woman, but when I went home I received a congratulations card. All my nurses and care team signed the card, and it was very personal.

They used my name. It wasn't a generic card. I'm going to be honest, to get that while I'm at home three weeks post-partum it was like oh, for me. But doing a little -- little things like that. And I also want to talk a little bit, just speak to the other recommendations on the slide, that when we think about just for practical that if most of the maternal deaths take place between 43 days and one year.

And if we think about after the woman delivers, she has her six- or eight-week visit, and then after that, that's it. So as a health care system, what do we need to do to support the woman that first year out? Should the fourth trimester go beyond the eight-week visit? Should they have her visit in three months? Should they have her visit in six months?

And at those visits should we also screen for depression, for substance use? What other support do you need? So I think reenvisioning how we deliver care and changing up the eight week visit, the 12 year visit, oh now you're discharged from the OB care. No. Because we know that half of the deaths in Missouri occur between 43 days- and one year, that we need to be doing a better job at engaging our moms and getting them in for

proper follow-up-.

And also our babies. Think about when our babies follow-up. I will say I love community health centers. I advocate for them. Community- health centers are true model of collaborative practice.

And I say that because doing that time, not only will I deliver mom and deliver the baby, but we also have pediatricians and internal medicine doctors there.

And we all talk. So let's say for example one of my internal medicine docs, the child had an issue was being seen, you know, the child was, you know, just in the exam room while mom was being seen. We were able to go grab the pediatrician to see the child if something came up. They didn't have to schedule another appointment and wait four to five or six weeks to get back in.

But also looking at that. Who is co-located together for moms and babies? I mean my pediatrician office is about 15 miles from my OB office, but we need to think about co-locating services, so when mom is seen, baby can be seen instead of keeping those visits separate, and waiting for mom to be seen down the road by her PCP, or discharged from OB care, but we need to rethink about co-location of services, as well as continuous support for mom beyond the six or eight week visit.

And I think we can go to the next slide. I think that's it there. Yes. Dr. Mati?

MATIFADZA HLATSHWAYOD-AVIS: Thank- you. I told you.

BELINDA PETTIFORD: We are going to take a moment just to see if there are any questions in the room, and I want to start

with the Committee now, since we have limited time, and I just want to make sure you all have any questions. That would include you, Marie.

MICHAEL WARREN: I have a question. First of all, wow. Can we clone you all, and like deploy you across the U.S.?

MATIFADZA HLATSHWAYO-DAVIS: Tell them it's- all here in St. Louis.

MICHAEL WARREN: I had a bit of a question for you. So this is something that comes up a lot when, and I apologize, I misinterpreted the graph that you had before where when we start to work on disparities issues we see either an equal improvement in white and Black populations, or an increase improvement in white, that's actually magnifying the disparity.

So, from your perspective and the work that you all are doing at the city and county, what are things that we can do to sort of disrupt that, where we're actually focusing on collapsing the disparity? So you have to hit population.

MATIFADZA HLATSHWAYO-DAVIS: If you -ask - when- I joined the city we only had two epidemiologists for the city, so one of my first charges was to increase my epi bureau because you heard how strongly I feel about data as justice. So we have 11 epi's now. But the limitation is that we have not invested in the same quality of metrics in disparities work as we have for the rest of health.

We are still using archaic, and quite frankly, limiting metrics to define what's happening with disparity. So it starts there. My team is limited by zip code level data, and things that

we all know in this room, do not nearly tell the story. So that's number one.

It's important because our ability to have higher quality metrics will allow us to parse out the data better because we were able to, during COVID, have a much more refined system. So I was able to within months call out that for pediatric vaccine, my pediatric vaccine rollout, that there was a much larger divide in the zero to five year age group in the city.

We were able to quickly call that out to the CDC, and we are identified as one of ten cities within weeks. You can't do that across the way with disparities research, so that's the first thing. The second thing is you start in community. You start in community. You don't start at Board tables. You don't start at the national level.

In this country we love to rollout things from the national level, right? We feel good about it. We put billions with a B of money out there. We announce it, and then we sit back. By the time it gets to the states we have 50 incongruent states with a politicized health care system. So we cannot in the standardized way implement those things.

And then I don't even see it. Chile, let me tell you something. Sometimes I read stuff in the New York Times with everybody and I'm like really, they rolled this out? And we've never seen it. We never do. And then it's those barriers that we talked about to really address disparities.

So, if you believe, and I love that the first question was about disparities. That means you care. What is your Board

talking about, about the politicization of it right now? Not being afraid to name it. What strategic ways are you going to go for these dollars, right?

And then within your policies and plans, what have you done to ensure that it is easily accessible at a state and a local level? But we need to talk to community first. And again, people get so excited when, you know, I'm so tired of being the first Black woman as is Kanika. The fact that we had to be the first Black in 2024 is just a shame, for shame, shame on, right?

But we are. Right? And what happens when you're the first Black woman is that everybody gets excited when I speak. Oh, she's speaking on behalf of Black community. Real talk, real, real, real talk. Some of the Black women in this room don't even really relate to me because we're not the same! -I'm from freaking Zimbabwe. I didn't- grow up in St. Louis.

People from St. Louis - you know, some of them are going to look at each other like no, you know what I mean-? So you have to start in community and understand the breadth and depth and width of what it means to be a Black woman and a Black birthing person, not making assumptions from 1985.

From the time I went to medical school some of the things I worked hard, I shouldn't even be doing in practice. The sexual history as I was taught it, is horrible as it pertains to STIs. Right, Joy? I mean Joy's over here like um-hmm, you know what I'm saying like?

So again, are we keeping up with what is needed within Black communities? Are we talking to the community first? But I

do think taking a look at our structures for data are indices matching the issue? Do we have software and hardware? I am in 1985 in my health department. I would love for you all next time why don't you just come to the Delmar Divide. I want you to come to our health department and just peek over the shoulder of my epidemiologist.

It is 1985 in a local health department near you, but that's where I'll stop on disparities.

KANIKA CUNNINGHAM: I agree with everything that she said. While you were talking the only thing -- I don't really hear this talked about too much, and I just want to take a step back and just call this out, like you were hinting to. But when we think about disparities and how our systems became this way, the structure racism that exist, we don't often talk about how the practice of obstetrics even began.

That it began from the perfecting of obstetrical practices by experimentation on Black women and Black bodies. So, I cannot say that oh, that's all gone those years ago, because that trauma still trickles down. So I think that's another thing.

We don't talk about the historical nature, and talk about that it's systems that put Black women in these positions, and we can talk about all these other structures all day, but we have to recognize that even at the very beginning it was our bodies that perfected OB practices to this day, and some of those practices still exist that take place.

Some of those instruments that they used back then we still use on patients today. And so there's trauma that's

triggering, that's weathering on our bodies as well, so I think we have to also recognize that when we have these discussions, when we talk about it, that from the very -- early on, that we were at a disadvantage at the very beginning.

And then I will agree with everything that Dr. Mati said when you talk about the data, talk about partnering with the community, listening. I agree with everything else. I just wanted to call that out and speak to that reality because that's actually playing a part in what we see today with these disparities.

MATIFADZA HLATSHWAYO-DAVIS: And the last thing I'll say is innovation. Innovation is really key.- You've got to throw the textbook out, and I think you're going to hear from a lot of leaders that I have taught me in the room, but the research that's happening in Dr. Copanas, OB/GYN division is revolutionary, and it's really leading nationally.

It's her life's work. I really would listen to her and make sure that you follow-up with her after this. That is a center of research excellence, and it's being led by a visionary Black woman who centers her leadership in the celebration of birthing joy. -I believe in innovation in our programming.

Everything that we do needs to be innovative, and I'm really excited the most by that model of redefining the village and the family unit, and the role, thank you, the role of our midwives and our doulas cannot be under-scourged here. They are quite literally saving health care systems, and we've got to play together well.

Physicians, nurses, social workers, case, CHWs, doulas and midwives, I think that's important to the innovation piece I think is key.

BELINDA PETTIFORD: Steven and ShaRhonda, and then we're going to have to wrap it up. I do apologize.

STEVEN CALVIN: You're good. Thank you both for a fantastic presentation. You mentioned too the financial issue of getting grants and the hassle. I mean it's -what are your thoughts about Medicaid? I mean in general. -You know, all 50 states they all do it differently, and everybody points the finger.

They say the feds won't let us do this, and they'll say well, the state is doing their thing. But there's a lot of money in the system, not as much in unfortunately, some red states, but there's a fair amount of money in the system for care.

What would be your advice about how to address that with the Medicaid managed care organizations, which some of them, they're not just managing care, they're just managing the money.

And there's a lot of money flowing through the system. Do you have thoughts about how to work? I mean the money is there. The money is there by care and then innovation can happen with, you know, health workers, doulas, midwives. How can you change things for the staff?

MATIFADZA HLATSHWAYO-D-AVIS: So I saw the grantee landscape change in academics when the NIH decided to with intention, make it mandatory for certain things to occur in research as it was funded, in order for you to get funded. And it

meant whether or not you liked or cared about Black communities, you had to check a box.

And I didn't like it at first because it seemed very performative, but it's changed the landscape of who gets funded, what projects get done, and the innovation there within as it pertains to disparities. So we saw for example, just a line in NIH funding that said you need to make sure you're collaborating with a community, you know, like a CBO or a health department, or a historically Black college and university.

Meant Harris B, HarrisStowe, a university here in St. Louis, the only historically Black college and university we have, led by a powerful visionary, a Black woman, is important-. So I do think that one of the small things that can happen. I'm not an MBA, I'm not a fiscal guru, so I think there's other more nuanced conversations that can be had.

But just making sure that the way these Medicaid dollars as they're being used, and sometimes reappropriated, have finite expectations for having to work within community, having to engage in community, having to provide resources for community to get those dollars as a rule, not as a choice. Not as something we just talk about it in meetings like this, feel good, go home and put our feet up, right?

But as the only way that you can get these dollars. I think that what I saw happen in the landscape of overall NIH funding is how we should be thinking about this as it pertains to public health funding and Medicaid dollars.

KANIKA CUNNINGHAM: I think with your question, I still

think about system levels, and even though the funding exists, who truly has access to that funding and can make decisions for the funding?

So I think going back for the State of Missouri.

I mean there were, you know, different community partners that came together with Medicaid expansion. There was a lot that took place, and if you think about the reimbursement, and certain providers don't want to see Medicaid patients.

So first, just de-stigmatize the idea that somebody is on Medicaid, that they're not a second class citizen. That Medicaid is -- it is insurance.

It is, it should be treated and talked about as private insurance. I get the payment and reimbursement models may be differently, but I think when we hear Medicaid there's this automatic inherent stigma that comes along with the Medicaid talk, the conversation.

As far as looking at responsible and the movement of money that is there. It exists. Again, you have certain people who are not even privy to those conversations and being involved, and it goes back to partnering with community and listen to what the community needs and what they want.

So, Medicaid recipients in St. Louis is going to look completely different from Medicaid recipients in Colorado or other areas. So how can we make this Medicaid package unique for the community that they're actually serving? That's something that we don't do with Medicaid. It's just a general, you know, we have guidelines, you know, people who can access Medicaid.

But we don't even think about the uniqueness and the innovation, as to who this money will actually serve, and then who will have access to getting that money with Medicaid. So that would be my, I think the way I will answer that question.

MATIFADZA HLATSHWAYO-DAVIS: And I'm biased in this belief that if you're serious about the answer to this question, Dr. Cunningham and I can make available to you two CEOs in the region who are changing the landscape of what this looks like. And if you haven't already, you do need to meet with the leadership of the Integrated Health Network and the Regional Health Commission, who with intention, and with actual skillsets, background, and you actually made- this happen on behalf of the region and the state.

They can talk to you about what they're doing around those different models, and I think it would be important for your leadership to meet with them, so I'll email you the two CEOs of their organizations.

BELINDA PETTIFORD: Thank you, and ShaRhonda, the last question.

SHARONDA THOMPSON: I want to go back to your metaphorical village. I know in my world I'm like the health advocate for the family. I'm the one who not wanting to, but had to learn the lingo, had to learn what to say to get certain reactions from doctors, and how to make your health care your focus. I had to learn that through necessity of the system that we had.

So, in your village do you have like designated health

advocates, or is that something that's fitting under that umbrella?

MATIFADZA HLATSHWAYO-DAVIS: I love that question, and I love that you quite literally have taken up a seat at the table. I just want to tell you that I honor that, and thank you for your leadership, and being at the advocate's table. I don't know why you made me teary eyed. -

It's emotional. Yeah. It's personal, and you got me amped up. It has to. The village has to have advocates, right because as a physician I will say that if you get me as a doctor, God has blessed you in abundance on that day, right? But even I don't see myself, and unfortunately there aren't a lot of physicians like me and Dr. Cunningham, right?

I had a similar story, but I think centering her birth story was so powerful for today, I'm going to thank you for that, because you didn't have to, and you shouldn't have to share your personal experiences and trauma to teach others, and let that day end. But what I will say is that we have to have in our birthing villages advocates outside of the medical space.

As a physician I say that it's important. Hospitals are unsafe. We just, my family and I just spent a week with our father in the hospital, and there are four physicians in our family. And everybody flew from different states to be with our daddy. And we didn't leave the hospital one hour of a week.

Not one hour. We had like a system. Do you understand me? We had a table such that at any minute of the day one of us was at the bedside. And it wasn't to doctor the medical field, it

was literally to advocate for water. Can you turn our father? Can you feed my father? Where is his food today?

Is someone going to give him a pain pill? This elderly Black man. And it took us being there for every minute of a week of his care, and I'll tell you that if we hadn't there would have been some negative outcomes because we caught them.

Even blankets, I remember there was a day when we said he's freezing in this room. The temperature dropped to 60 in this room post-surgery, and we couldn't get them to bring us blankets, those cheap, thin, ugly blankets in the hospital. These spaces aren't safe, so physicians get so up in arms, oh my gosh, you're insulting us, and it's- our life's work and we care about patients.

It's got nothing to do with us. It's about safe spaces. When his surgeon finally came around, he said we've never seen this before. Why are we so lucky to have y'all? So villages are important. We have to have this. Until the system, until we repair the system we have to create that type of village such that there is an advocate to make sure that the basics, the ombudsman letters I've written for my staff.

I have a manager who was in the ER for 12 hours, and she came to me sobbing and said they had me with dignity, they got me like they didn't even get her one of the cover ups that cover her body. And she had to lift herself from a bed after an accident, and squat in the corner of her room to pee in the United States of America, a Black woman.

Hear me when I say this. The system is not equipped

yet. So we need to create those villages for folks. And what I know is we are. What I know is that hospital leaders, FQHCs, community-based organizations, public health departments are coming together.

What I know is I got my entire team trained by my birthing village on the work of doulas. What I know is we're sponsoring our first doula within our health department, right? Because we know that that advocacy is key. So your leadership is key, and may you use your leadership to innovate around how those villages should look, and what an advocate should look like, so that we're not just making this up as we go. But I do think it has to be central to the village.

KANIKA CUNNINGHAM: You said it all.

BELINDA PETTIFORD: I really appreciate you both willing to share your story. We share them differently, but we really appreciate you sharing it, thank you.

KANIKA CUNNINGHAM: Thank you.

MATIFADZA HLATSHWAYO-DAVIS: Thank- you.

BELINDA PETTIFORD: Please come back, don't leave us.

MATIFADZA HLATSHWAYO-DAVIS: The- food is good, the spring sprang for you all, come back and see us, thank you so much for having us.

MS. PETTIFORD: Yes, we are running behind on schedule, and so I want to thank Kendra and Lora for their patience. We are happy to have both of them here with Generate Health. I think the previous presentation has set the stage for yours. We are actually still meeting.

Advancing Racially Just and Equitable Outcomes in Black Maternal and Infant Health in St. Louis

KENDRA COPANAS: I think we're the last thing keeping everyone from lunch, so we recognize that responsibility to move along and to get wrapped up for lunch, but just such an honor. My name is Kendra Copanas. Welcome to St. Louis, so grateful that you're here to listen and learn from our community, and to follow our amazing local public health leaders.

We are just in a place and time in St. Louis that we have the opportunity to make such an impact that we haven't seen until the last couple of years with the confluence of leadership that we have. So it is an honor to be here, and to share Generate Health's work with you.

I'm here with my colleague, Lora Gully, who will introduce herself when I pass it to her in a moment. And since you've seen the data directly from our local health directors, we know you know the situation in the community. We are not going to focus on the statistics for St. Louis. We really want to talk about our approach to how we are working in community to address racial inequalities for maternal and infant health.

So who is Generate Health? Generate Health, we are a small community based not for profit organization. We are a multi-racial network that has been around for 25 years. We bring together all the stakeholders in the maternal and infant health

space, in particular community, alongside nonprofit, for-profit, government, all of the actors in this work, to address the region's most pressing conditions that are contributing to racial inequities.

We have been a convener and a catalyst for collaborative action across our jurisdictions. We are a complex community having two different counties, and two health departments, and complex jurisdiction. But we bring everybody together in a way that we can collaborate across systems.

In 2018, we made a big change in our organization. We made a decision to put a stake in the ground for zero racial disparities in maternal and infant mortality. And to the question, I think that was asked, you know, part of our belief is that we first have to name it, and be very specific and explicit about what we're focused on.

That has to be central. So we've changed our mission and vision to be explicit and clear about our focus and our priority, and we've continued to learn and evolve since then to the newest vision and mission from about a year and a half ago, that community continues to advise and move us and guide us to be more effective.

And so, we're even more explicit and clear about our focus for Black families in St. Louis to thrive. We believe that when Black birthing people and their babies are thriving, our whole community will be thriving. Next slide. Go back one slide.

I just want to make a note about our language, which I think is so in-line with what we're hearing from our local health

directors. I think part of what makes me so excited about our potential in St. Louis is the alignment around values and direction.

And our vision and our mission is intentionally centering joy and vitality and families thriving. It's not to disacknowledge, or to not acknowledge the very conditions that are unacceptable in our community, it's to do both things. We have knowledge that we are not where we should be, we have a lot of work to do, but we can't stay in that space.

Community has told us this, Black women have told us this, that we can't stay rooted in death and despair and deficits. When we do, we limit our imagination about what can be done to change our community. So even when, you know, the vision of achieving zero racial disparities is critical and important, it won't be achieved by only focusing on disparities, the elimination.

Our community instead is creating what is possible, what is deserved. We need a vision to work towards, not just what do we dismantle, but what are we replacing what we dismantle in our community. And when we stay focused on disparities and we talk all about the data and the statistics, we can inadvertently contribute to a narrative that this is the responsibility of Black women themselves, rather than the systems and structures that have created and are holding these disparities in place.

So it's really important for us to just talk about our language. You heard this from our local health directors. This is, you know, a critical piece for us. So next slide. So at

Generate Health we really see ourself as a systems change agent. We're not a direct service organization, we aren't delivering programs in the typical local sense.

We achieve our mission by the strategies listed on the slide. You know, together with our partners, we are looking at how do we dismantle the harmful practices, policies and systems in place, and then reconstruct and rebuild in ways that are equitable and just.

And we do that by uplifting the experience and leadership of Black women and birthing people. So we make change by organizing networks, and bringing together in close proximity community leaders alongside organizations and providers. Utilizing data from the lens and view of community advocating for policies and systems change. Next slide.

So, just the way our work is set up, our core work is to develop and support community leadership. It's a key role that we play in our community. Racial equity capacity building that to really get to addressing disparities, our region, the systems, the actors in our space, need to have capacity to look at data through a racial equity lens.

They need to have data to look at their own organizations internally through a racial equity lens, so which we bring opportunities to advance capacity building racial equity, and advocacy. And that spreads across our whole organization. And then we have two main initiatives. One is Flourish, which is a community data and story-telling initiative.

And this is where the priorities for our region are set

by community members directly, who've laid out for us the series of priorities and issue areas that are most important and pressing to them. And we take that and use that into our advocacy and to our work with community service providers.

In Bloom Network, that is where we convene and collaborate with service delivery systems to improve the services, so that they center Black women and families. And I'm going to turn it over to my colleague, Lora, to talk more about various parts of our work.

LORA GULLEY: Thank you so much, Kendra. And I get to introduce myself. Lora Gulley. I have the pleasure of holding space with community, those that have lived experiences. And I'm going to tell you I bring forth many of the stories and time and space. Some of it is painful. Some of it is joyful, but all the same, it influences the work that we do.

And so, if you go to the next slide I will start by saying our community leaders work has been a journey. Some ups and downs and all arounds, but for the most part our community leaders has really been a tremendous force. We've had the pleasure of working -- starting with our Health Start investment, having community leadership that was an outgrowth of what we call the Making Change Happen Leadership Academy that helped us better understand what were the needs of moms and babies in our region.

And that really learned that there was so much more to tap into. It was like a well of resource when you have lived experiences, helping to help you better understand how they experience systems. What were some of the barriers and challenges

in community that we may not even have on our radar?

And so, with you all having someone at the table that we have identified as one of our biggest community champions. We had an initiative, Kendra referenced our Flourish initiative, that was primarily led by providers.

And we had some sprinklings of community voices, but not necessarily leading the work until ShaRhonda Thompson, one of our very own, we are claiming her, okay, was passionate about coleading our community leaders cabinet that allowed us to pivot, and really center the voices of community leadership. And so, I'm- grateful and thankful to see her in this platform.

But she was out on the frontlines leading the charge from day one as we evolved through our leadership, and learning about how to do this work. Not from just this transactional, what we can push out to community, but what would it look like to have shared partnership and shared learning?

And that allowed us to really take off, and so now we are really seeing as a spot leader, sought after for community voices. And I wish I could say it was Lora Gulley that was doing it. It was our community leaders that were using their voice. And this is who I get a chance to introduce you to, some of our community leaders that were actually on the frontlines in one of our first cohorts of our community leaders cabinet.

You have here Fern Scott, who is a force to be reckoned with. When she walks in the room everybody knows her. She actually also sits on the, -I know, Generate Health's Board of Directors, but she also saw a need in community. Never ran for

office, never knew about the political scene. -She ran for an automatic seat, like she saw a need in her community, and is continually leading the charge.

We also have Ms. Mia Daughtery, who started her own coaching business called Peaceful Soul, and she's been featured in a lot of our Flourish and YouTube videos that help us get the word out of what the experience is like, to help us improve some of the conditions that Black women and families in our community face.

She also was hired to help co-lead our consumer advisory board, which was helping our regional home visitation collaborative to improve home visitation services. So not just, oh we need to really focus on improving our services, but how and in what way, and how are women and families experiencing those services? And that is where that leadership of that community voice came into play.

And last but not least, you have Miss Rosetta Jackson, who continues to be a leader in helping to meet some of the growing needs. When COVID happened her and her church were out feeding hundreds of people throughout the community, and what became a COVID testing site. But again, you can't tell me community doesn't have some of the what are, you know, what we need to solve some of our issues.

And then what I would like to kind of add before I can ask you to move on to the next slide is we see the value in investing in and building the capacity of community leaders. Those that bring that lived experience and that voice, which we call context leaders. They bring context to help us better

understand.

We are also excited to be launching, and I see my colleague in the back here, Ms. Ronda Smith Branch, who is also helping us to lead the charge with our new fellows group of community leaders, who will receive some leadership training, and be mentored by some of the community leader cabinet members that have come before them.

But this is part of our commitment to allowing for us to grow a cohort of folks that can sit at decision making tables, and help improve the conditions for moms and babies in our region. So, next slide. I want to,- I- say put the kickstand down as kind of a notion to say I want to just take a moment to say you kind of got the lay of the land of what the date and our statistics for our region and state.

But we live in a state that was the first to ban abortions, following the overturning of Roe v. Wade. We are one of four states recognized by the CDC to have an increase, 16% by the way in infant mortality, and are actively, currently actively advancing anti-DEI training and education in our state-.

That's the state in which we live. So, advocacy plays a central role to ensuring that we can address some of what our community needs, and by centering those voices of community, who can better help us better understand than those that have that lived experience, and we can bring forth and lift up those expertise.

So, what Generate Health does is we help drive some of those advocacy efforts that have been prioritized by community, by

censoring that community voice, and participating and helping to create opportunities that our community members can sit at decision making tables like our very own ShaRhonda, doing the dog-gone thing.

So we're so excited. But also bring stakeholders, key stakeholders together, some of which sit at our tables that are using their expertise to testify, to help inform decision makes on what is needed. So we also support other groups, other advocacy efforts that are advocating and participating in local and state coalitions.

We also monitor, we try to keep track of what's happening in terms of the data so that we can help inform both our community and our partners. I absolutely love the conversation earlier talking about how does this trickle down to actually reach those that need the information the most?

We've got to figure that out because that is where we're going to see an opportunity for shifts and changes. And so I think when I think about what Generate Health is doing, you see up here we have some four bucket areas in which we focus our work. That came from community and our community partners, that helped us better understand where should we be focusing our time, energy and resources?

And then, we also modeled after the federal omnibus effort, which is a package of bills that if adopted, could significantly improve Black maternal health. Missouri developed and really massaged what would work here for Missouri? So we have this kind of play on words, it's a Mo Omnibus, of which we are

kind of coleading- to help really bring those voices of what community has said.

Those are Black advocates that are on the front lines that can help us identify what is going to make that difference in improving Black maternal health in our states. And we're doing that as well, next slide.

Now we'll try to beef it up because you know, again, lunch is calling because I'm hungry too.

So, Flourish, as Kendra mentioned, really this is bringing the community together, particularly members of our community and our provider community to really address those systems that are impacting Black families.

And so we have -- Flourish is what really led us to understand what those priorities would be, and we've taken it and run. Again, in partnership and helping to co-lead some of the work that they have prioritized. So in order to do that, you have to listen, you have to support, and really build up where there are gaps in areas that need support.

And so, if we kind of have this notion is that when Black women and birthing people are in positions of influence guess what? Systems change. And that's next slide. So Generate Health synthesizes and disseminates data about the factors contributing to birthing. You all, we have this on our website, and as part of this effort to understand data, we point out to communities to help us understand this.

Help us understand what does it mean to not have, let's just say, to have this disparity gap. There was a disconnect.

But when we start talking about the rates of being able to access care in services, what does that look like in your community? Help us better understand where there are gaps and challenges? That helped us create this hub, and it's rich filled with data.

So I hope you get an opportunity to take a picture of that QR code, and go there and see, and experience, interact with it. We have folks, just a little plug. One of our elected officials at the national level told us hey, I've used -- I went to your website, and I've used that to advocate for increasing resources in our community, so we want to bring those resources back to our state.

So again, there's a resource available for our communities, next slide. I know you all will, this is a special treat. I know you all are going on the social determinates of health tour, so I am going to leave my colleague, Rose Anderson Rice, who will be leading that charge, but this is an opportunity for us to really compliment the traditional training programs that help promote cultural competence and kind of the patient centered care.

It provides that hands-on experience where you get to take in what does it look like to live in a community where you don't see a grocery store for miles and miles on end? You get to see firsthand what this is like. So, I'm not going to steal her thunder, but you will have more of that. Next slide.

The Bloom Network, we heard time and time again from our communities the importance of coordination and the experience of what it's like to have family to care. The Bloom Network is a

collaboration to provide that quality care through home visitation, perinatal, behavioral health, and safe sleep.

And so we have partner organizations in 19 different counties offering a variety of services as a one stop shop for families to find that support. I know Dr. Kanika talked about having the opportunity to have that quality or that coordination happen and how important it is for families to have access to quality care.

And so we have provider organizations that share a referral network to seamlessly surround families with support, particularly during those vulnerable times in their lives. And so we are, through the Bloom Network, closing the gaps between those services, so that no family falls or slips through the crack. So, please take a picture of that QR code and enter the Bloom Network. Next slide.

I will turn it over to Kendra Copanas to talk about the lessons and recommendations.

KENDRA COPANAS: Thank you, Lora. And we just wanted to summarize some key points of our, -of what we've- been learning, and what we might, you know, how that might be useful to ACIMM, and these are focused on the approaches we have found effective, like really building movement towards equity, not the specific clinical issues.

And in all transparency, I'm a social worker, I'm not a clinician, and we center as you hear community, right? This is what our role really is, but and the first and foremost thing is how do we center community leadership and create proximity to

system leadership in real ways that are, -it- is really an effective lever for equitable systems change.

And I think it's become pretty well accepted and understood that, you know, community and context leaders are important stakeholders and understanding the problems facing pregnant and parenting families. You know, lived experience is becoming a very common term.

And I think we really want to encourage thinking beyond and going deeper, and that's been our journey for really extending deeper and continue to learn how to do that more. But when we go beyond surface engagement, and center leadership envisioning and solution finding, and in decision making, we discover better and more successful approaches to issues that matter most, and build trust.

And I think some of these lessons that I'm talking about are why we're focused on approaches is because we think that this is how we get to more sustainable, long-lasting- change, that if we really need to change how we do business in a way fundamentally that is going to make equity the default, rather than the exception, and I think this is key.

As just an example, when we talk to an expert in St. Louis, Hira Hudson Banks, who's an expert in antiracism, you know, what would you recommend for us to get more equitable outcomes. She said get every Black and brown woman a doula. -And because that immediate point of service opportunity to be an advocate is important, and makes a huge difference in that individual's experience.

And I think we heard this from our health directors about this immediate need to build a village because our systems need to catch up. We think that if more systems and institutions were centering community and decision making, then we would see more transformative institutions.

And so, you know, implementing transformative and ongoing relationship with community leaders requires skills. It requires capacity and resources. Lora said she doesn't think it's her, but there is some secret sauce that Lora has, that has been doing this for 13 years at Generate Health, and it's a key. It's relationship building, and it's really key to be there and committed, and know authentically that this person cares about you.

But this requires skills, capacity and resources for organizations and institutions. We have seen in St. Louis all of our partners are really open to and wanting to be connected to community members when we convene and bring those parties together.

And often asking for someone to come speak, or join a Committee, but we think there will be-- one of the things that we're doing with our Bloom Network is beginning to partner with community service organizations to develop their own community leadership and decision making in their organization because we think this is -- it can't be just come and listen, and connect a community here at Generate Health, and not really have this impact your decision making in your institution.

So, you know, HRSA, MCHB with Healthy Start has

required, you know, community engagement and leadership. Head Start with boards, FQHC with boards, there is, you know, there is a track record for HRSA holding institutions and grantees accountable.

And I think that there's opportunities to think about that beyond and to CMS, and to NIH. Think about you know, there's IRS requirements for hospitals to have community benefit. What if that required something different in terms of who was making decisions about that community benefit, not just the hospital, but and not just surface, checking a box on a needs assessment that they did to then decide what they're going to already do.

That kind of makes the case for what they're already planning to do. So we encourage more dissemination of effective community leadership practices to the applicants, to the grantees, and to reviewers about how to review and see in the grant applications what is authentic, what is not, you know, what is really meaningful community leadership within an application.

Build capacity and health systems and payers. We had the question about payers and Medicaid, and we've had times when payers come to the table and really listen and learn from community, but we've tried to build this as an ongoing kind of you know reinforcement of feedback loops, and it just stops.

And so we need more ongoing kind of engagements and leaderships within all of these institutions. And then, you know, and invest directly in Black led and block focused community organizations who are already connected and centering community.

The next recommendation is to shift the narrative to

vitality, and we've heard our local health directors also say this, and us talk about it in our vision and mission. It is really important for the reasons I talked about before. And I think it is possible to create and work towards a positive vision of equity, while acknowledging the current state, and not stay rooted in that current state that is unacceptable.

But we found that, you know, the process of visioning that the communities set the vision, and we get behind it, is really empowering, and increasing opportunity for more stakeholders to be part of moving the needle.

And as ACIMM is looking at its recommendations, putting forward the materials, you have the ability to set a national, influence a national feeling around this work, and can choose to adopt or procreate a positive vision of vitality that the federal government is building, or working with community for. Next slide.

So quality programs are really important, but they are not sufficient alone to achieve equity at the local level. And this is, you know, one, sustainability programs is questionable, and a lot of the community based programs are very, you know, they're funded with soft dollars of grants that can come and go.

And so, there is a lot of investment federally in state and national systems change work, which is amazing. And the work that's being done with AIM and all of the federal funding and initiatives. It's really important to look at the systems. We need that at the local level as well.

We can't just have that happening at the state because

programs at the local level are not enough to get us to equity. We need to be able to invest in ecosystem wide coordination, collaboration at the local level. Often what we see happen is this is, you know, maternal and child health is very fragmented experience for women accessing whether it's the prenatal care, the maternal side versus the child side.

The systems are very fragmented. And at the local level if we aren't looking at that as a whole ecosystem. Another reason I, you know, I think this is important because we're talking about the postpartum maternal death rate, and how it happens outside of when women are accessing health care-.

Well, they're accessing home visiting. They're accessing other services, but those are disconnected, and we need a more coordinated approach locally. It doesn't just happen at the state and come down and build these local ecosystems. We need that investment.

And then finally, communities have told us they want and deserve access to diversity and choice in the models of care and the providers that they have access to. And you know, they want to see prenatal care models, home visiting, behavioral health programs that were designed by and for Black women.

And they need access to those supports, and we've got a rich array of enhanced prenatal care that was developed by Black women in St. Louis. It's a group prenatal care model. We have birth village that's been mentioned that's doing remarkable work with expanding doulas, and you know, but this is what we see coming through federal investment, it's focused on evidence based

programs and services.

And evidence based in the home visiting world has had a very high bar of what is deemed evidence based. And communities are wanting community informed practices, not evidence based. And so, we see that there is an opportunity to build a really robust ecosystem of both community informed and evidence based that can be coordinated and work together.

But not if there's barriers to those programs and services being resourced and valued. And so, we really encourage the broadening of the definition of evidence based to recognize the importance of community informed practices and models of care, and to support community models of care.

So I'm going to pause there and have Lora close us out.

LORA GULLEY: Don't go too far. I would just say you have heard us talk a little bit about Generate Health, our approach, and some of the intentional ways that we engage community with the lived experience, and bringing partners together. And I hope that that has really stimulated and/or stirred the pot a bit in terms of your questions or further your desire to advance maternal and infant health.

And so, I will just pause and just ask, and welcome any questions or any comments at this time.

BELINDA PETTIFORD: Thank you. Questions, thoughts, comments?

MICHAEL WARREN: I have a question for you all. Obviously that's why I'm talking, sorry. You all figured out how to overcome a lot of the barriers that were brought up where it's

difficulty in CBOs receiving grant dollars, and translating that into community action, so you all figured out some of those things.

But as we think about the recommendations we could make to remove those barriers for other organizations that could be doing what you're doing in other cities, other counties, other states, what are some of the things that we could recommend that would make it easier for groups like yours to get started and be sustained?

KENDRA COPANAS: I would say we figured it out. We have been really grateful for a long-term relationship with Missouri Foundation for Health and some other local philanthropic entities in our region that have valued system change policy and advocacy work.-

And that is something that there could be more encouragement nationally for more philanthropic community to invest in those because often, you know, there are not that many private foundations and corporations that are investing in the kinds of work we do.

They want the program. They want the program that they can count how many people were impacted. And so, the kinds of work we're doing to be able to be really nimble in community has really been by the grace of relationship with Missouri Foundation for Health and some other local philanthropic entities, and it doesn't go on forever.

And so, we don't necessarily have a way to replace those kinds of dollars. So that is we struggle with it a bit

because when we look at some of the federal grant opportunities they're fairly prescriptive for programs and we don't see ourself fitting, or they're state focused, and we're not a statewide organization. We are part of a lot of statewide efforts, but we're not the ones, you know, really teed up and positioned to go for those funds.

I think that we have a lot of thoughts. We were a Healthy Start grantee for 14 years until 2014. And, you know, so we've been through. We know what it's like to try to manage and administer federal funds, and that's another thing when we look at federal grants. Like do we really want to step into that because it takes quite a bit of resources.

So, you have to be really thoughtful is it going to take you away from your core? Sometimes the timeframe for responding to federal opportunities and to other grant opportunities is too narrow to do the kind of collaborative responses that we would like to be able to do, especially to make sure community is at the table guiding what we do.

And so we need longer lead times and you know, I think that I also really feel strongly about the reviewer side of federal grants and philanthropic private grants that there is an opportunity for there to be more community members directly who experienced the kinds of programs and services that are being supported in those grant dollars to be the reviewers.

We, with our relationship with Missouri Foundation for Health, we had they set aside like 3 million dollars for community leaders from Flourish to decide where to invest the 3 million

dollars in infant mortality reduction. And over the course of about three years they made the decisions of where those grants went.

They reviewed the grants. They said this grant is getting funded because we know this organization and what they do, and MFH executed those grants directly to those organizations. We also set aside a portion of that went to more larger organization with more programmatic, and then we set aside about half of it for community mobilization and innovation grants.

So with smaller grants for organizations that would normally not have qualified for funding from Missouri Foundation for Health. We built in capacity building workshops and supports around them with one of our partners that's in the back there.

We ended up with learning, and we are a maternal and child health coalition, we learned dozens of community based grass roots organizations we didn't know about that were really in neighborhoods helping families that were trusted, and that's helped us broaden our network and our community.

And we wouldn't have known about this without the opportunity to have community lead the process. And so, I think those are -- yes, please.

LORA GULLEY: Because I think one of the things to build on. I'm so glad you broad that up, Kendra, because someone had mentioned, I think it was our Director here talked about the challenges when you have the grant opportunities, but not necessarily the grant writer and the capacity.

And that was critical. Some of those smaller

organizations, that process was informed by our community to say let's not do it. Let's not make this a burdensome process. Let's do it where there's an opportunity where if you can articulate, verbally articulate how you are going, what you're going to do, how it's going to have an impact, and what you're going to do to demonstrate that impact, that would be your grant proposal.

And that was well received, particularly for those that didn't have that infrastructure that we're referring to, and part of the reporting mechanism. We hear that all the time. I think that was part of our work around the capacity building was that was part of the feedback. It's a huge barrier for folks.

And I know the time and energy and attention that it takes to actually do the repair, go through the whole process. So I think providing that as an alternative way, we got to see some really cool proposals that we wouldn't ordinarily have seen.

BELINDA PETTIFORD: Thanks. I thought I saw one more hand?

UNIDENTIFIED PARTICIPANT: So I just had several things that I wanted to share that I want to make sure that Priscilla knows (audio garbled.) - to agencies such as HRSA, and just hearing the things that Lora and Kendra talked about, Dr. Kanika, Dr. Mati, I want to just lift up the political determinants in child birthing, but I definitely would- like to see spoken about more if required. When we are looking at proposal opportunities because that is impacting us significantly.

And as they talked about, you know, things like an abortion ban. Like that impacts us right now here in Missouri.

But it may not impact someone elsewhere. However, if you're not asking those questions and not providing that story. And so then also, and I guess from our history, a meeting that this isn't public health, which is happening right now, and so just really looking at that additional context because as we work for our data, it's extremely important, but it's limiting.

And I know from my team, we are literally telling the history of St. Louis when we are one of the top ten most segregated cities in the country, and we talk about the Delmar Divide, and explain that so our viewers are looking at this really get a picture of what our Committee looks like. But often times they just reference that they've never seen something written like this before.

So, I think if more people knew how helpful and important that story is, and not just the data, that would be important. And then they also, grant management, I know I look up to you guys networks, because there are so many people you all have that are reviewers, but our case law that you know, can support grant management.

You know I've seen that you know we had to do that for covering agencies for school districts that there's no capacity to focus on doing the work, but so many other people cannot do, and so that's important. And then also I really want to encourage you all to flip the way that you think about funding because you do need to be funding these small community organizations.

It's far too often and infuriating honestly, these medical institutions, the universities, even the large nonprofits

are the ones that are getting funding, and they're not the ones who really understand being on the ground, the whole thing where you know that institutional racism is making an impact because they're already so established they're seen as the leader. They know this, and they know that.

And that's incorrect. And they didn't bring in community members or organizations, but they're not really,- they still are just like the data variable are being selected by people, they're selecting the ways that that framework looks. -And I had an opportunity I was writing for the other day, and it was a small mini organization.

They don't have the capacity at all of those other institutes, but they are doing the work, and have the ability to be able to build in capacity. We unfortunately aren’t gonna be able to go after it because hospitals are still installing already.

And so, now we no longer could get that support and literally they were going to bring all of these systems that are doing work across the state together while they're also doing some service delivery with doulas, and training and all of that, to actually see system change happening over the life of that grant.

That's not something that's going to happen, so I just think that's something you all really need to be intentional about, and then putting this work in place instead of it being like well, they don't have it, and so we're just going to see where we always had.

So I think the last thing is just maybe asking people

innovating approaches to things because what we do also is that, and I had a psychologist that told me this, and it made so much sense. Is that the way that you guys asked questions, and they're fine, but they could be better because we should be able to teach you all what you don't know, because you all are coming from the space of this is the model that,- this- is the approach that works.

And a lot of times we are now using this opportunity like taking this to -- not just a seating chart, so the federal agencies because with mental health this is the approach, and we actually had to look at serious mental illness, so we respond to your questions, but then we add some other things you all may not have thought of, so that's the end of that.

I just think that the more people need to know to put that in proposals, but also you all need to start asking people where we're missing, so that when you put those RFPs out, so thank you.

BELINDA PETTIFORD: Thank you, and thank you so much for your presentation. Unfortunately, we are out of time. So hopefully you all can stay around the rest of today. We are late for lunch right now, but we're going to go on with lunch now. I will ask the Committee members if you can pick up your lunch and bring it back so we can start back as close to one o'clock as possible, because I know we have - I mean 1:30. It's possible because I know I seen- Martha, and we have a full agenda this afternoon. So I don't know Sarah or Vanessa, can you give some lunch instructions?

State Approaches to Improving Outcomes for Black and African American Birthing People and Their Families

BELINDA PETTIFORD: So, at this time we are fortunate to have with us representatives to share the State Approaches to Improving Outcomes for Maternal and African American Birthing People and their Families. I'm going to go and introduce the entire panel. Two of them are virtual, but then will turn it over.

We have Martha Smith with us, who is the MCH Director of the Department of Health and Senior Services here in Missouri. I have Heidi Miller with us, who is the Chief Medical Officer at the same location. We have Priscilla Mpasi with us, who is Chair of the Delaware Health Mother and Infant Consortium, so happy to have you here.

And virtually we have Shelby Weeks, who works with me in North Carolina. She's our Infant and Community Health Branch Head working in the Department of Health and Human Services.

And we have Breanna Grant, who is appearing as an Educator with one of our local health departments in North Carolina's Guilford County's Health Department. To promote information, it's the first public health department in the State of North Carolina. Okay. I am going to turn it to over at this time.

MARTHA SMITH: So thank you, Belinda. I can project.

My kids would say I have a big mouth.

BELINDA PETTIFORD: And if you prefer to stand, it's totally up to you.

MARTHA SMITH: So, thank you all for the opportunity to be here and talk about things that we're doing in Missouri to address maternal and infant health. As Belinda said, I'm Martha Smith, and as the MCH Director, my role is really to serve as that Chief Maternal Health Strategist for the State of Missouri.

One of the speakers earlier said that she's an action tank, and I thought you know, that describes a lot of what I do is bringing people together. And so that will be reflected as we talk about efforts going on around the state, and then I have my own here with me.

HEIDI MILLER: I'm Heidi Miller, I'm the Chief Medical Officer at the Missouri Department of Health and Senior Services. Starting this position in May of 2023, and I'm going to say there's been a 50% by efforts, has been specifically for child health. I'm going to be brief like Martha Smith, and I'm eager for us to consider the state ways that we're using our money and resources effectively.

MARTHA SMITH: Heidi always gives me way too much credit. So next slide please. I want to start at a high level because we have really worked hard over the last few years, and at the Department level as well as in MCH to have intentional plans and frameworks to guide our work, and to align, so that we don't have a separate MCH plan that has nothing to do with our Department plan, and with our overall state plan, and really

working to align all of those.

And also working, along with that alignment to align our metrics so that we can measure things effectively, and then we work with our contractors who receive maternal child health funding to do the same. So that I say as things so many times tend to flow downward, we want everything to also flow upward and even more so, because it's the boots on the ground that are really making a difference for us.

So I want to be able to solve that collective state-wide story. So if you look here at our strategic map you see maternal health reflected, really across every single component on the strategic map. And so, links were shared ahead of the meeting and hopefully you all received those, and that was a lot, I know, but maybe you've had a chance to glance and this, and just really see how maternal child health is reflected in our organization, our initial public health services model, performance and reach, workforce strengthening and development, our partnership and collaboration efforts.

And what's in that partnership collaboration, really elevating community voice, and the voice of lived experience. Our work, to make sure that we are advancing diversity and inclusion and ensuring that access for the underserved especially, which really aligns also with the Title V block grant, and its mission. Next slide please.

And so I referenced our foundational public health services model, and I had the opportunity to work on the development of this model back in 2018. And during that

discussion, there was actually consideration to remove maternal child and family health from that model.

And any of you who know me, know that I was a very loud voice in the room to say we absolutely cannot remove maternal child and family health from foundational public health services. It is the beginning and the end of the health of the community. And so, thankfully there were some other champions in the room who joined with me, and you'll see that maternal child and human health remained in the foundational public trust services model.

So when we look at this minimal set of foundational capabilities in areas of expertise that we want to see reflected in every single political health department, 115 of them across the State of Missouri, and we want to see reflected in all of our maternal child health work from a statewide system perspective, we see that we want to address conditions that affect health behaviors and health outcomes in women and their children, and the families and communities within which they live. Next slide please.

I know I am preaching to the choir as they say here, but we all know that as goes the maternal health community and a population, so goes the health of that community and that population. And so, we are using that frame for our messaging and for our planning and our implementation of our work. I truly believe that healthy moms are much more likely to have healthy babies who grow up to be healthy children, healthy adolescents, healthy adults, and the cycle continues and repeats itself.

And the same can be said leads us to unhealthy instead

of healthy. And so our goal is to really drill that down and have healthy women before conception, so that they go into pregnancy healthy, and then they have those better and improved outcomes. Next slide please.

So, we have a pregnancy associated mortality review process in Missouri, and I am proud to say that long before my tenure in this role, maternal mortality prevention, and the programing around that actually started out of the Title V block grant in Missouri.

It now has evolved. It still has Title V block grant support, but it also has significant support through the recent grant from the CDC, as well as some other funding to support our efforts.

But through that process we really have been able to drill down on the social drivers and those root causes contributing to the maternal mortality, as well as the side benefit of now having better understanding and just all the time increasing our understanding as severe material morbidity, and those factors that are contributing to unhealthy women before, during and after pregnancy.

So we know in Missouri annually that through 2020 that about 70 women in Missouri were dying while pregnant, or within one year of pregnancy. Unfortunately, we haven't released our next year for that, but we already know that that number has been increasing since 2020. And if you look on this slide it just highlights some findings.

You've already heard some of these in the previous

presentations. 84% of maternal deaths were deemed preventable. As a nurse, and as someone who is a public health person, before I even knew I was a public health nurse, anything preventable shouldn't be happening. And so we have to figure out how we make that connection to prevent that.

The majority of those preventable deaths occurred after day 43 postpartum. So, we did not have postpartum extension in Medicaid in Missouri. We do now, and it has been approved through CMS now, and is having been implemented in Missouri, and I really am excited to start seeing accounts from that because I really do feel that's going to play a key part.

And that was one of those efforts from Medicaid expansion, and then most of that extension. Those really were multisectoral and collaborative efforts that everybody played a part in. It wasn't just one person, or one entity that made that happen. -

That really was a system-wide, state-wide effort that all of us sprang that message, championing that cause, and from our own perspectives and our own work really advocating for those changes, and putting it into real life stories that made a difference, that resonated with the decision makers.

We know that in Missouri significant racial disparity persists, and have actually gotten worse over the last several years, so that Black women are about three times as likely as white women to die before that first year postpartum is over. We also know that for pregnancy associated deaths, women who are receiving Medicaid as their insurance coverage are ten times as

likely to die before that first year postpartum comes to an end.

That is staggering to me that it's something that I can't in any way, shape or form, find a reasonable explanation for, which means that we must do something different. Next slide please.

This next slide is busy on purpose, and I left it this way on purpose because I just wanted to highlight a lot of disparities that we see around Missouri, and as you can see, and this is indeed in all of them. As you can see we have a lot of disparities around Missouri. You've already seen a lot of these highlighted from the other presentations, but some things, some statistics that we haven't highlighted.

Trauma and mental health, Black children in Missouri are more likely than white children to experience multiple cases. Remember I talked about if you have healthy children they grow up and they become healthy adults. That cycle continues. So when we're talking about maternal health, we have to talk about children too.

So if you look at all of these, and it's quite obvious that transformative change is paramount for maternal child health and overall population of health in Missouri. Next slide please. So there are multiple efforts in Missouri that are going on to address maternal and infant health and all of these disparities, but as that person who has that responsibility to have a state view, and to look across the state, and understand that there are regional differences.

There are local differences, there are differences in

demographics. I also have that responsibility to see the state as a whole, and what I have seen over time is we have great work going on, but a lot of that work is going on in buckets. It's going on in isolation. And so we aren't realizing the collective impact that we need to realize from a state level.

And so my focus has been on how can we connect all of the great work going on around Missouri, so that we have that collective impact that really starts to show itself in our statewide indicators, so that we go from last to first, so that parts of Missouri is not down on the bottom, those significant indicators around maternal and child health.

So, two years ago we proposed a new decision item, and the Governor Office took that up as one of their priority initiatives in the state's school year of '24 budget. And that was passed at full funding, not I should say, not what I originally requested, but when it finally ended up in the Governor's initiative, we got through the budget process without any other changes, which was a huge success in my book, that the decision makers did not cut anything.

So 4.35 million dollars was allocated for current state fiscal year for maternal mortality.

And it was in five domains of action. And we have contracted with Missouri Hospital Association for three of those domains. Those three domains include quality protocols for prenatal care, so we have about 13 topics that toolkits are being developed around for those protocols to standardize some minimum standards of practice and care.

And then they also are working on a standardized postpartum plan of care, and so when we heard earlier, I think it was Dr. Mati that was talking about after, you know, that six week checkup, six to eight week checkup, what happens then?

And so, again establishing a minimum standard of expectation for that full year of postpartum care. And that may not be from the same provider that delivered their baby, and provided the prenatal care. We want to make sure that they are doing intentional, warm handoffs back to primary care in their local community with someone they already know and trust, and have a relationship with, or if they don't, build that relationship and that trust for them, so that we then not only have a year of postpartum care, but we then can promote interim session care for them, so that their next pregnancy is healthy, and their life trajectory is healthy.

And then we also are working with Missouri Hospital Association to provide several different types of training for all types of providers, not just your licensed medical providers, but your community providers, that full spectrum. And so these include trainings on things such as trauma responsive care, culturally congruent care, health equity.

Focusing on the things that we have heard through our pregnancy associated mortality review, case reviews, as well as things we've heard from various needs assessment and listening sessions of other groups around the state. Respectful care, is another topic in there that has come up so many times in conversations with our community members.

And then they also are doing trainings around screening and referral for mental health, substance use disorder, the cardiovascular disorders of pregnancy, gestational diabetes and other endocrine disorders associated with pregnancy, so some of those high risk scenarios that we know are contributing to maternal health,- poor- maternal health outcomes in Missouri.

And then we're contracting with the University of Missouri, and we have our partners on this project here in the room. For the maternal health access project, and so we're part of that with the HRSA funding they receive for perinatal mental health access, and launched yesterday. That project was- our maternal health access project, Momnibus I think you're calling that, or I may be saying that- wrong.

But we're really excited about the potential of that project as we know maternal mental health and substance use disorder is such a significant contributor to poor maternal health outcomes and maternal mortality in Missouri. And then finally, we are developing an MCH dashboard through the Department. It is getting ready to go live within the next month, and is in the final stages of publishing that.

But it will be an ongoing iterative process where they will continue to add datapoints to that dashboard, and improve it over time. And I'm going to hand it over to Heidi.

HEIDI MILLER: As you know, it's difficult to move the needle on public health records without full engagement with Medicaid. Medicaid is our most disenfranchised obligation. So different state governments run differently, often sometimes the

health department and the Medicaid are the same, and sometimes they're separate.

In the State of Missouri they are separate, so next slide. So in Missouri we tend to be really intentional about reaching out to our other stakeholders and other agencies and partners including Medicaid. And so, less than a year ago we lost another two birthing hospitals in the State of Missouri. We quickly assembled a work group to try to troubleshoot what we would do at a state level.

This interagency work group implemented us, the Department of Health for the State of Missouri, as well as Medicaid, which is called Mo Healthnet in Missouri. We also asked the Hospital Association and the Pregnant Care Association to join us. Next slide.

Since June 2023, we've reviewed over 50 programs and policies to improve maternal health access and outcomes from across the country, internationally, looking for best practices, evidence-based practices, and to try to figure out what will fit within our structures, within the State of Missouri.

And during that period of time we had the painful task of taking these ideas and trying to distill it down to about a dozen. Next slide.

Here's our short list. So as Martha described, this 4.3 million dollars dedicated to all of these different initiatives are ongoing.

We want to further leverage that on specific initiatives. So these are in no particular order, except that

they're rainbow organized, but each of these rose to the surface. It had a very big impact for our state. So that 24/7 call center for patients and providers, that taps right into the access project that Martha had mentioned, so that anybody delivering a baby anywhere, or helping someone during the prenatal and postnatal care can pick up a phone, or have some way of contacting an expert.

It could be a midwife in someone's home delivering a baby, and for them to call online and be able to get an obstetrician on the phone to help with that in the last stages of labor. Or maybe it's a mental health crisis. And this is already starting to be set up, but we need something much more robust to manifest it.

Moving across, telehealth, the return on that is there are a few models that Our Moms Grant has been so helpful in certain locations. And what I realized is that even though Medicaid pays for telehealth, we need sustainable funding that covers not just the position fee, but also the facility fee, but also the equipment fee, and also the on-call fee, so that in the middle of the night you can ask the question of maternal medicine, and we need to be able to do that.

Postpartum home visits are, in many capacities, partnerships between prenatal and birthing facilities. Dr. Bowman and I were speaking of this. Fortunately, the State of Missouri Medicaid unbundled our obstetrical services. What that means is that instead of needing to get all your prenatal, postnatal and delivery from a home facility, otherwise you don't get paid,

everything is fee for service.

So we try to serve women where they are at, and then maybe they need to deliver at the hospital 30 miles away. But that unbundling, I'm actually not----we need to work on this, and foster its partnerships between prenatal care facilities and delivering hospitals to make sure the folks are aware that they're able to do that and get reimbursed.

Rural hospital and obstetric payment reform, doulas and perinatal community health workers, malpractice liability coverage. I was so saddened to speak to the annual conference of the family physicians for the State of Missouri, and I asked them how many of you are delivering babies? And in this room of almost 150 physicians, 19 of them raised their hands.

One person shouted out ask us how many of us used to delivery babies. And I asked that question, and two-thirds- of the room raised their hands. And then when I said why? I received a chorus of malpractice insurance. Recent regulation modernization, we need to integrate midwife obstetrical care.

So we don't need midwives competing with OBs, but we were talking about this earlier, we don't like,- OBs without the work and wisdom of a midwife is underperforming. And midwives benefit from integrated expertise- for the OBs, and we should really foster integrative models.

EMS obstetric readiness training, rural health incentives, and graduate medical education for providers that do both. So next slide. This effort is really fresh, it's in progress involving the needs of the state. We are united in

aligning efforts specifically to avoid duplication, and we're focusing on thriving health before, during and after pregnancy.

And I really like the saying about the sharing data, postpartum is forever. As a pregnant care internist, it doesn't end six weeks postpartum. It doesn't end a year postpartum. Those same ladies who have gestational diabetes, or diabetes or mental disorders or obesity, we really need to take care of it in the full continuum of care.

MARTHA SMITH: Thank you, Heidi. Next slide please. So we were accepted to participate in the National Governor's Association effort to improve maternal health in rural America. So we aren't just focused on rural Missouri, we actually created our plan for participation in that learning collaborative for more of just a statewide effort, understanding that as we work to improve health in rural areas, we will also improve health in urban and vice v-ersa.

They are different. They have unique needs, and sometimes your approaches need to be different, but we can still impact both areas through the same plans. So I don't want to read these, but you can see I love our impact statement, which will be on the left-hand side of the site for you because, excuse me, the impact statement really was a collaborative effort of the four teams coming together and putting that together.

And so, it really does reflect different perspectives and that statewide view. And then our priorities. So, I loved when I heard the St. Louis City and County are developing a strategic plan around maternal health because we are going to be

developing this statewide plan around maternal health, inclusive of all of our partners.

And currently to provide that framework, and then you know, and I think I heard it referenced earlier today. If you have it written down, and you've all agreed upon it, then you can point right back to it. And if you start to stray from it, you say remember, this-- is our guiding light right here.

So really working to take all those pockets of excellent working going on around the state and connect them together is really what we're hoping to achieve. And then also through that wanting to really elevate doulas, community health workers, the full spectrum and different types of midwives, and the community-based providers, and community-based care.

And so, we've been working with our health net partners to develop a state plan amendment for Medicaid to reimburse doulas, and that is in the process of approval because that requires of course, the DMS approval for that. And then we also are now looking at what would it look like for Medicaid to reimburse someone visiting, especially for high-risk moms.

And then also looking at underutilization of Medicaid reimbursement for prenatal case management, and what do we need to do to really fully have that utilized around the state, and maximize that impact. Next slide please.

So our Title V MCH block grant of course is core maternal child health funding, and that funding in and of itself is not a small amount, but neither is it anywhere near what we would need to fund everything that needs to happen in the State of

Missouri. And so, what I always look at that funding, or see it as is that is the funding that pays for me and pays for some other entities, pays for work at the Public Health Departments, other contractors, and we leverage that.

So the work that I did preparing the budget requests for maternal mortality prevention, that was paid for by Title V. We have a budget proposal in this year's budget for Fiscal Year 25 for a fetal and infant mortality review network, a statewide process because as was referenced earlier, our infant mortality increased in 2022.

We do not have a statewide effort to really have a statewide picture of what's going on, so that as we do for pregnancy associated mortality, we can drill down on what the real social drivers, the real root causes are.

And it may even be different in different regions, so we're going to have a regional team approach. Regional will be based on the national model of a two tier, where you have a review team, and I think action team, so that we can really start to have intentional action around infant and fetal mortality.

We see a combined, almost 800 fetal and infant deaths every year in the State of Missouri, and we need to significantly change that trajectory.

So our Title V state action plan, you have eight total national and state performance measures. I just highlighted here three of the performance measures, that most directly impact perinatal health.

So we are working to frame preconception, prenatal and

postpartum health care services. We provide contracts for maternal and child health services to our local public health departments. We currently have 112 of the 115 health departments to accept that funding, and we're going to invest to improve maternal and child health.

And we worked through that contract to promote healthy eating, active living to promote tobacco cessation. We also have some who are specifically working to target substance abuse prevention in both adolescents and in women of childbearing age and American women.

We also provide funding to support teen pregnancy prevention, and then reproductive life planning across the life course. We also, in our perinatal and infant health, of course, are working to improve infant safe sleep. We have a statewide safe sleep strategic plan that was facilitated by NICHQ. And one of the priorities within that plan is to address disparities and provide health equity.

So our plan has a very intentional strategy around promoting health equity because we know that Black babies in Missouri are over two times as likely as white babies to die before their first birthday. And then we have a cost-cutting and systems billing priority, and we really want to address the social determinants of health, then we have to look at for the State Department of Health.

Of course this was drafted back in 2020, lots has changed since then, but what could our role, what should our role and what could our role be as a state department of health within

the political climate that the state department needed to operate within, and so we really decided that we've had a start, and I heard a reference earlier to this too about awareness, and we decided we have to start with making sure we all have a level set.

That we're all starting from bare minimum common understanding of what is health equity, what are the social determinants of health, and what part do all of these play in our health outcomes. And so we started internally. So every FTE that received Title V funding has had to participate in some core training for the past two years.

And then we now, this year, have expanded that to where our contractors are also going to have to participate in some more training. And again, that's just to have a level set around health equity, social determinants of health, and then also health literacy because as we know, if you don't have health literacy, none of your messaging and the work that you do is going to have that cultural congruence, and is it going to be effective?

We have programs who have really lifted up the health literacy part and are really working to reassure that they are providing messaging in languages that will meet the needs of the communities they're targeting.

We are in our needs assessment process for the block grant, and we for the first time, are translating our needs assessment surveys into multiple languages, and we also have planned two focus groups specifically for the Spanish speaking populations in certain parts of the state.

And then also for the first time looking to target some

specific needs assessment components around the adolescent voice, as well as the LGBTQ community. So again, like I said, a lot of what I do, and a lot of how I see my role and the role of the block grant, and the role of the department is to leverage partnerships.

And I spend a lot of my time, and some people will say to me why do you spend so much time traveling? Because if I sit in my office I don't build relationships, and building relationships is what then makes work happen in a collective manner, so next slide please.

We have two overarching principles, that underline all of our work, and those are we want to ensure access to care, including adequate insurance coverage for the MCH health relation, and we saw postpartum expansion and Medicaid expansion as I referenced, both come to Missouri. They're both a reality for us now.

And then we want to promote partnerships and that partnership is at all levels with all people, not just professionals, but the people we serve and really elevating their voices in the decision making process. And relationships I always say, it needs to be authentic. Because if we're not being real with each other, we don't have a relationship. Next slide.

Terms change. The new term is synergy. You know, we call it effective impact, whatever you want to call it. It's when we all can work together. We can all be going in the same direction, but if we're on different tracks and different trains, then we may not end up all at the same place because we may stop

at different places along the way, or we may switch, you know, a train track you can flip a switch, and you go in a different direction.

And so, we need to be on the same train, on the same track, going in the same direction and end up at the same destination. And I really think that's where we'll see the impact and the accelerated outcomes that we want to see.

So finally, just to wrap up really quick, and I told Heidi earlier, I get talking on this, I could talk forever, because it's definitely something I love. It's who I am. It's why I do what I do. And so we were asked, you know, what successes, what lessons learned, what opportunities, what recommendations. And boy was it hard to fit it, I couldn't put a whole lot more.

I think I talked about our successes. A couple of lessons learned. One is access to care does not mean equal access to quality care. And so our goal needs to be access to quality care, and care that is provided by someone that the individual receiving that care trusts.

And then in trauma informed and culturally competent and respectful care is hard work. And I think this is where we really came from, and why we decided on that Title V performance measure to start with providing education and promoting literacy is we don't want it to just be head knowledge, we want for everybody to take that knowledge and make the trip, the 12 to 18 inches down to their heart.

Because it's when we believe it in our heart, and when

our heart changes then our action and our behavior and our priorities change. And the value of lived experience. We have a maternal health action, that work is focused on maternal mental health and substance us out of the University of Missouri, Kansas City, in their Institute for Human Development.

And they are working with women, with lived experience in mental health and substance use, we're all moms. And they actually have a mom's advocacy group. They actually are getting ready to launch a leadership academy for moms with lived experience, so that they can be leaders among their peers, and also leaders at local, regional and state levels with decision makers.

But one of the moms said to me, and it was actually last year when I said nothing for them or to them without someone wanting to take that step further. And I'm going to say nothing for us without us, but also through us. And that was really significant to me, and that stayed with me.

And then the role of social support and primary prevention I think must be prioritized because risk reduction and harm mitigation is essential and important, but if we ever want to truly change our kinds of trajectories, we've got to go upstream and we've really got to start, and I got back to that slide about maternal health, infant health driving population health, we really have to start where begins, and make a difference there, so I can't stress that enough.

And then the postpartum is forever. I didn't come up with that. I borrow, and I don't intend to give it back. So

probably that I heard it just a couple weeks ago at a meeting here in St. Louis. Kendra, you were there. And a lady in the audience made that statement, and it was just like duh. Yeah, so it's mine. I'm claiming it now, along with a lot of other people there I'm sure.

Opportunities. I think we have to, and we are working, but we really have got to continue the work because we're nowhere near done, to really diversify our workforce in maternal and infant health, to make sure that we create safe spaces for all types of providers to work and be accepted and valued as equally important members of the team.

That rural maternal health piece that Dr. Miller referenced. Clinical and community integration. You know, for a long time we always said well hospitals have all the money. We need to learn how to partner with them. Yes we do. We have to learn how to partner with them. They don't necessarily have the money, they do have more of the public health, but we're working on that. We're making progress, but that's still an opportunity.

And then I reference that transition back to primary care, so the postpartum care is not the end care for pregnant women. These others you've seen through the rest of the presentations today. The last one really is something that is interesting here in Missouri.

Improved health care for incarcerated pregnant women and mothers. So going back historically, when the Title V program is a match, you know, we have a match requirement. And part of Missouri's match has historically come from funding that is state

general revenue that provides health care services for women of childbearing age who are incarcerated.

And so that's just kind of in this peripheral you claim that match, that work is going on. And anybody that knows me knows I'm the kind that I don't know, I just ask a lot of questions, and I don't always just accept whatever I'm told, and otherwise. But you know, as I got more involved in my role I was like, okay, but why aren't we playing a part in that if I'm claiming that, I want to know what's going on.

I want to, you know, so I got more involved in that conversation, and more involved in partnering with our Department of Corrections. And then we also in Missouri, have, a couple of years ago legislation that was passed to establish a nursery in one of our two women's facilities here in Missouri.

So where incarcerated pregnant women who give birth while they are in that facility, in that personal facility, then if they qualify, they're still working on all the rules for this, so it hasn't gone into action yet.

If they qualify, then they can stay with their baby in this nursery either until the baby reaches the maximum age, the nursery is going to accommodate, or until this lady is then released back out into the community and can take her baby with her. And I'm excited for the opportunity of that.

I'm from Missouri now. I wasn't always, but I'm from Missouri now, so I'm a little skeptical on show me, so I always told, you know, reserve judgment of how we'll it's going to work until I see it in action, but I'm optimistic. And then

recommendations, so Dr. Warren has heard me talk about my main recommendation many times, and that is I referenced the great work going on in pockets.

And it's really frustrating for me as a state maternal child health director, who's been given this charge by my leadership, you know, to be that chief maternal child health strategist, to learn about something going on around maternal child health in Missouri, and how do be accredited by the federal government, and they knew nothing about it. It's also embarrassing.

You know, I feel kind of at a loss. I mean people start talking to me as if I know this. I'm sorry, but can you please inform me a little more. And so my main ask is please include--every state is required by HRSA to have a state maternal child health director. So if I resigned today, I'm not, -but if I resigned today the Department of Health must immediately- name someone else to be that position.

So utilize that person, and include them and their agency, which is the state lead for maternal child health. Include them in all of those funding relationships, and other convenings or connections that you made, not just for our awareness, but so we can help create that system, and we can fill in gaps, and we can strengthen weak spots, and we can leverage all of those partnerships to maximize that progress and those outcomes.

I think as you help us build a statewide system, we will be better positioned to create system level change, and improve

our outcomes, and I'm sure I probably past time, I have no concept of time.

BELINDA PETTIFORD: We're going to hold questions until the end.

PRISCILLA MPASI: Okay. I am going to stand. Okay. Good afternoon everyone. My name is Dr. Priscilla Mpasi, and I'm here speaking on behalf of the State of Delaware, particularly our Delaware Healthy Mother and Infant Consortium. Just briefly myself, I am a pediatrician by training. In my day job I serve as the Medical Director for the Delaware Medicaid Partners, which is our largest Medicaid ACO in the state, so there is great opportunity for interaction and collaboration.

And as the new Chair, I've been in the Chair position for about a year now for what I will approach as a THMIC. It is a volunteer position, appointed by the Governor, so we will talk about our unique consortium here, how we facilitate our interaction with our Title V Maternal Child Health Bureau to really talk about how we advance health equity and maternal and infant health in the state. Next slide.

But just to start off with our goals, so we talked about we know what the landscape is, right? We've talked about the data, so I'm just going to go into goals. Why we were accepted, we're about 20 years out. It initially started as an Infant Morality Task Force, and then incorporating a maternal component in there.

If you want to eliminate disparities between white, Black and Hispanic infant and maternal mortality rates, reduce the

preterm birth rate from we're currently at 11% to less than 7% to be the lowest in the country, and then develop a model of care that addresses health disparities and helps reduce preterm births. Next slide.

So I do want to talk about initial structure. We have members, as I mentioned, are appointed by the Governor to Executive Committees. We have 21 members, it also includes legislative members as well, so as a group we provide statewide leadership, maternal and child health, and we have eight prongs, so our first prong is partnership collaboration as I mentioned.

We interact with our Division of Public Health. We want to ensure that we also have a footprint with our community grass roots organizations, and we're very focused on program development and initiatives that are going to address the communities and their needs.

Advocacy, so this is advocacy for our communities, but then advocacy towards our general assembly to also drive policy supports, what policies and legislations can we help draft and pass to ensure that we're going to be implementing and sustaining initiatives.

Quality improvement, right? So doing our needs assessment across the state, how can we implement small demonstration projects above the community level to practice level of a hospital level as well. Care access, I think has been mentioned many times, so there can be access in many ways. Do you actually have access to a provider?

Are you able to get to that provider? Are you able to

access a provider of preference, right, someone that may share your lived experiences, or have cultural competence in that regard. Stakeholder training, right, so this is stakeholders for us as members, but also stakeholders for those that deliver infant and maternal care, and addressing social determinants of health, which is as an eighth prong, but really encompasses all of these aspects. Next slide.

So as I mentioned we start with our legislative body, so we have two representatives from the Delaware House of Representatives, and two from the Delaware State Senate, one from the majority and one from the minority caucus of each chamber. We have one representative from a Governor's office, we've enlisted one from the Secretary's Office and Department of Children Youth and Families.

One from the Department of Health and Social Services, and one from the Division of Medicaid and Medical Assistance, so that's to ensure that we have our public health and government agencies around the table. And then we have 15 members who are approved or appointed by the Governor.

We have them in sectors, so we have those that represent the medical aspect, five that represent medical, five that represent social service, and five that represent professional communities as well, the general public.

And then these 15 members are all volunteer times with a minimum term of three years. Some have been extended as much as 15 years. They have been providing their service in that regard, next slide. We have integral committees, with the Executive

Committee, comprised of a Chair and Vice Chair and Chairs of the Committee. I'm actually going to start with the committees underneath.

Initially we had an internal Infant Morbidity Mortality Committee, as you can see that was really focused on data and aspects, and then we expanded to a Well Woman Committee, and then in 2020 added the Well Woman and Black Maternal Health Committee.

We had the Social Determinates of Health Committee, and then our newest committee is the Doula Ad Hoc Committee, so I actually started as a member of the Doula Ad Hoc Committee, coming in as a pediatrician, thinking about the fourth trimester, which really impacts the infant care before becoming Chair of the Committee.

And then you see the dotted line there. We do have a Delaware Perinatal Quality Collaborative. As the chair of the DHMIC I serve as a member. We have a Chair of that, and then all of our major work, all of our hospitals, all of our major organizations, all of our primaries specialty groups, so the American Academy of Pediatrics, ACOG, AAFP have a representative on the Delaware Perinatal collaborative as well. And they have two major workgroups, a maternal health workgroup and a pediatrics workgroup.

So our goal is to try to integrate these words, try not to be in silos, I know when you say the word try, that is the goal of this structure, and I think in the last two years we've really done a lot more to make sure that we're aligned in our work. Next slide.

Okay. So when we received the invitation, and again so appreciative of the Committee to allow us to speak of the work in Delaware. We knew that the data, the landscape was familiar, right? We certainly know that this is impacting across the country, and we certainly know that the most impacted communities are those are Black and brown birthing persons and infants.

So we really wanted to talk about the actual work in the community. That's really been our focus in the last two to three years, is how we're having a community approach to addressing maternal child and health. So I want to start with the work of our Well Women and Black Maternal Health Committee. We can see the goals there is how are we looking at comprehensive and also evidence-based approaches to reproductive and perinatal health?

We certainly are targeting right now the health disparity gap for Black women, which continues to widen, and making sure we're having awareness campaigns as well, and then we're addressing the maternal, mental and behavioral health needs, also a disparity in Black and brown communities.

And so, a major effort that we've had, I really appreciate Dr. Davis talking about this earlier, about what are the communities? I think often times we sit around the table. We think about our expertise. But I often that privileged people come up with privileged thought, and privileged solutions, right?

So it's not what I think, or what I see, right, it's what the community is telling us. So we actually launched the web base, or we targeted the web-based survey as the privilege part.

We actually went into the community. We went to different churches, we went to organizations, we went to practices, right. We actually gathered input on priorities related to the fourth trimester.

So what I had initially written down on my sheet, what my comembers had, didn't exactly match what the community was telling us right, and we had to make some adjustments. And to that in 2023, and so from that we started to now create programs to address what the community and the patients were telling us what their needs are in the fourth trimester. -Next slide.

Okay. So our Social Determinates of Health Committee, and actually if we can go back one slide, or I probably can just say. So the top priorities that came up for fourth trimester health and wellness actually number one was housing. Is that birthing persons, parents, have concern for housing instability. That was number one, tied in with employment, right?

Those were the number one concern is how do we address that, which of the social determinates of health which comes next? Number two was actually food security and breast feeding, so there were the top right. And then number three was mental health services, so that was really important for us to hear that from the Committee, to the first two actually being addressing the social determinants of health. How can I take care of my child if I can't take care of me? Next slide.

So social determinants of health, some major projects since 2022. Again, why I wanted to dovetail into talking about housing. We initially looked at doing a housing pilot for

pregnant low-income women. We wanted to look at housing vouchers, but what we actually found was that the capacity was so high that we actually could not proceed forward with this.-

So we moved forward to small demonstrations projects. I'm sure many of us are familiar with the guaranteed basic income initiative. There have been many around the country. We studied the model done in Richmond, California and in Durham, North Carolina.

And so what we did is we were able to enroll 40 women into the program. We had some funding through MCH but a lot of this funding came from ARPA funds, so the American Rescue Plan Act, we were able to get that approved by the Governor to use that.

And so for the women that were enrolled, we needed initially one who would be eligible for that. The eligibilities come in on the next slide. I want to just do the program design. It's easy person enrolled needed to be in their first or second trimester at a certain poverty level, 185% below the federal poverty level.

They received a monthly stipend, $1,000.00 that they can use on a debit card so that the team could track where the funds were being spent, and we will actually conclude November 2024. We're already starting to see some greats results. Women in the program also received direct access to maternal care, once they delivered from infant care, primary care. We also connect them to a financial coach to learn how to use their funding.

We connect them to services, so again those services

are coming to them. We're not asking them to go to the Department of Health, right, we actually found ways to go to them as well to provide coaching and that. So it's more, we talked about a handout. It was really more like a helping hand up, right, giving them that stipend to get them started.

We've seen some that have again proved to be more financially and personally stable. So we look forward to seeing the final outcomes of our GBI. Next slide please.

So our Doula Ad Hoc Committee, we've heard a lot about the importance and the benefit of doulas. So what we have initially started to do is that we've taken like a three, four prong approach here. So starting with community engagement, we have established partnerships. We have three very qualified health centers in the State of Delaware.

We have three with several locations. So one, we wanted to make sure that we have that partnership making sure that our women and birthing persons of highest risk were actually aware of access to a doula. The second one is education standard of practice, so we are starting to look at we know that there are some certification bodies, but they differ. It's not like medicine or nursing, right, so how are we identifying what is going to be that standard of practice and training.

How are we going to make sure that there is capacity. How do we integrate culturally appropriate doulas through education curricula? And then policy and data, looking to see again how do we impact that at the policy level, talk a little bit about that on the next slide.

How do we also remove structural barriers to facilitate doula integration, and then sustainability, this is really important. We've been fortunate that our division for Medicaid and medical assistance is providing reimbursement for all doula services, but now are doulas, we want to ensure that that's a livable wage for our doulas.

This is an important member of our care team. If they are not able to sustain, and we're not able to provide in this capacity, so we are continuing to look at more reimbursement opportunities. Next slide.

All right. So some of the support of the DHMIC, next slide again. So looking at some strategies that we have. So again policy efforts, these are huge. We certainly know about the Momnibus that was initiated and passed with Congresswoman Robin Kelly, we have the Delaware Momnibus that was passed in 2022, really some of the major highlights of our Momnibus, so it's great to see that this is being done across many states, and we're extending Medicaid coverage the first year postpartum, making sure that we have protections for our pregnant and birthing persons in the correctional facilities.

That was very important as well as making sure that they were not going to be restrained as prisoners, as others, that was a huge bill that passed through. Making sure that again I mentioned the Medicaid. We provide a plan for coverage of doula services. We've talked about requiring bias and competency training for health care workers.

I will say this is something that we're looking more

into, right, as a physician, to practice as a pediatrician, it's been 7 years of training to be able to provide care for children. It is not going to take 7 hours for someone to now remove their bias and have competency, right?

So what are we actually doing when we talked about training for health care workers. What is that? What is the accountability metrics? What is the ongoing training that is required? I think Dr. Miller can agree, many of the physicians around the table, right we're lifelong learners, right? Board certification, license updating rights and what does that really mean when we say training for health care workers is a large discussion in our state?

And then lastly looking at Medicaid coverage to cover doula services for birthing women, pregnancy, labor, delivery and postpartum, so this is an element that we're working on currently, and then we're in the active leaders session. Next slide please.

So then briefly, Healthy Women, Healthy Babies, some states call it Healthy Beginnings, right, so this is a major initiative for us where we have eight community based organizations, all three of our very qualified health centers are engaged, and then we have other community groups as well, so this is allowing us to use a small scale, innovative strategies to ship the impacts, and really focus on social determinants of health in this.

We are now just over three years of implementing Healthy Women, Healthy Babies, and we've served over 550 women. We primarily serve women of color, and we primarily serve women

serviced by Medicaid. Next slide. So some of the aspects that we've been able to complete with Healthy Women Healthy Babies, so again what we focus on is mental health.

We also ensure that we're trying to involve the father. We heard that this morning about the importance of integrating the father in the pregnancy, and delivery as well, physical health social networking, healthy lifestyles, financial stability. We provide education resources, physical and mental health, resources and supports. Once participants are engaged in Healthy Women Health Babies, we follow them through the duration of their pregnancy and postpartum as well. Some of the outcomes that we have seen, so we do have statistically significant data in reductions in stress.

We've talked about the trauma that can get passed off from mother to baby, so reducing that stress in pregnancy has been critical. We've been able to train more doulas, particularly women of color, women from the community, with increased breastfeeding initiation and duration, increasing in feelings of hopefulness has been cited as an outcome and a reduction in final stress.

And so we are launching our Healthy Women Healthy Babies 3.0. We've had more organizations apply for that, and we'll be excited to announce our new grantees in April, later this month. Next slide please.

All right. And then again, just we're talking about just DHMIC-supported sustainability, so again funded through our Division of Public Health, supported through the DHMIC. In the

picture here it's representative, Minnie Minor Brown, who is one of our major maternal health advocates, and one of our sponsors for our Momnibus 2023 as I had mentioned what the program entails.

And you can see some of our recipients in the back, and we've been doing focus studies to not only hear the economic impact, but really their personal and health impact in the program as well. Next slide.

And so as I mentioned, I'll move quickly through this slide again. In order to be eligible, you can see some of the red spots, hot spots, right of those that have some of the highest risk women in pregnancy, so we have a risk factor that looks at the age of the pregnancy, health factors, income levels, that's how we determine our low, medium and high risks, so those that lived in these zones were eligible for the second trimester, and then the income level of that as you can see.

I doubt many of us in this room are having to maintain our livelihood with that gross income, and so that's how we determined who would be eligible, but of course we're having negotiations right, how can we expand eligibility because we know many persons require financial support. Next slide.

Home visiting is great to hear you talk about home visiting as well. This is something that we are continuing. We address infant mortality, premature birth, domestic violence and so forth. Some challenges that we are seeing though is that many family members, pregnant persons are not always comfortable having people come into their home, so that is a huge problem.

And so we've looked at how to train peer supporters of

community health workers that come from the community, so that way there's a greater comfort level and a trust when it comes to the home visiting program. Next slide.

And just to wrap up public education slide. So they mentioned we were determined accepted in 2024----I'm sorry, 2004, and then in 2006 when we became the Delaware Health Mother Infant Consortium, they held their first annual summit, which is a state-wide education day, so we are hosting our 18th annual summit in three weeks from today, and I will have about 350 maternal and child health stakeholders, a full day of education, local and national speakers.

And it's really great because we see the states coming out, not only wanting to learn what the current landscape is, but to understand how their work, their organization, their advocacy can really drive equity forward. Next slide.

So this is to show we have a website that supports the DHMIC, Delaware Thrives, so we want our communities to thrive. We have opportunity to talk about stress. We have opportunities to highlight what may not be as loud and as visible, just to focus on adolescent health, and thinking about adolescents who may have a first pregnancy, so these are some of our health campaigns that we have.

And we actually always get input for certain community groups to make sure that we're capturing from a health literacy standpoint. Again, what I might write, or what the community understand are different, so this is a great way for us to have some community collaboration in our education templates. Next

slide.

Education awareness again, we're very active on Twitter. We're very active on our website. We'll have rotating information about, you know, what are some health information you need, these are some urgent warning signs. In the corner, what is now blasting across all of our social media and the website is for a parent to celebrate Black Maternal Health Week, which starts on April 11th, and we actually have a series of events every day by different organizations as an opportunity to amplify the importance of Black Maternal Health Week, but also to make more visible the organizations that are involved. Next slide.

And then again just a snapshot of some of our social marketing outreach and education that is consumed by our patients, by our community, by our advocates, so that the DHMIC is unique that as a volunteer consortium, we are really -- we say that we embody the footprint and the voice of the community, and these are the different ways that we engage with them, that they can engage with us, making sure that we're amplifying their voice of public health into the state. Next slide.

That wraps us up there. So our wish list and recommendations, we were asked about a wish list. I said is it a wish list or a yes list. So, the things that we wished I think are pretty easy, creative ways to use federal grants. We talked earlier that we when we talked about federal grants the administrative burden that's tied to that may sometimes make us want to stray from that, so there are creative ways to use them, but creative ways are maybe easier ways to access them.

Data, we talk about data, but we're interested in different data here, so we are looking at a statewide integrated organization database. There are so many organizations that say I want to work on this. I want to work on breastfeeding. I want to work on doulas. That is fantastic.

We need to know who is out there, and we want to know what you serve, and how any people you're serving. So we want to track resource utilization. We also want to track who we are not serving so, so many times we'll say 55% of women have access, 500 people have access, but who are we not accessing is what we're trying to identify, so we can know where are the gaps, and how to actually expand our resource to meet capacity.

Primary care promotion, also thinking about life course approaches to reduce high risk pregnancy, and then also expanding and diversifying ways to finance a maternal child's health, a perinatal workforce, thinking about MCTA shortage areas, so maternity care, health professional areas, those areas there, doulas community, right?

So we're thinking about capacity, so again we don't want to create inequity, right, and attempt to have equity for our patients, so this is important. Next slide, and this ends our wish list. Doula integration, so thinking about doulas as part of a medical team.

In the State of Delaware right now doulas can be independent, but we want to look at ways that they are there on day one, so if a patient presents to see their OB/GYN or family women's health provider, and there can already be that discussion

are you interested in a doula? If you are, this is ways to access the doula. Doulas do come to visit.

How we also create hospital standardized policies as well, expanding SIDS education, so again, how do we go into the community, Medicaid expansion use thinking about our SPA amendments, along with the team waivers, and then ultimately collaboration, coordination at the local and state level, so we are not just one group working on this effort, but we are a coordinated effort to address material and child health in the State of Delaware.

I think with that, that closes us out, and we will transition to our friends virtually. I think this is---yes, that's it. Thank you-.

BELINDA PETTIFORD: I will now transition to North Carolina and I'm going to turn it over to you, Shelby.

SHELBY WEEKS: Thank you, Belinda, and thanks to the Committee for the invitation. We're very excited to be able to share what's going on in the State of North Carolina. Can everyone hear me?

BELINDA PETTIFORD: Yes.

SHELBY WEEKS: Wonderful. Next slide please. Okay. So in North Carolina we had the privilege to work with the Office of Minority Health Resource Center back in 2007. They approached us and asked of our interest in working with a campaign that was getting ready to roll out called A Healthy Baby Begins With You.

At that time there were a number of primarily historically Black colleges and universities that were working

with OMH, and we received the invite, and we're very excited, and became a participant in the effort nationally. So in 2008 we collaborated with OMH in hope that our own initial event under the campaign, Healthy Baby Begins With You, in eastern/northeastern North Carolina.

So we had about 300 people or so, primarily collaborative partners from local health departments, community and faith-based organizations, as well as individuals of reproductive age. We did this with respect to the effort, but it was a really well attended, launch to our work around preconception health in our state.-

In 2010, we launched our first peer educator program, or PPE program, working with colleges and universities around the state. And what our efforts around PPE connect that to our statewide maternal health, or our perinatal health strategic plan under the umbrella of our perinatal health equity collectives.

The link there is on the slide, but this work, our PPE program ties nicely to goal three under the umbrella of our plan, improving health care for all people for productive age, and specifically our work connects to, and helps to increase access to preconception, reproductive and sexual health care, again to this population. Next slide please.

We have one dedicated physician that collaborates with local health departments, colleges, universities, and community based organizations to implement or coordinate and conduct preconception peer educator training. So our goal with this training is to improve the health of the individuals of

reproductive age, and ultimately to reduce infant mortality rates, and improve the number of positive earth outcomes among this population, as well as infant and maternal outcomes.

Our audience with our PPE program are high school and college students, and let me just take a quick step back. Initially when we launched this program our focus was working with college students at four year colleges and universities. And then as we move on through time, we added community colleges to the mix of sites that were trained.

And more recently, because in areas of the state, some states, -some- areas of the state, some of our counties do not have a four year college or university. They don't have a community college. So we have learned to adapt and adjust. So we're working in one particular area of the state that borders Virginia.

They have a few colleges and universities, but sometimes it was a struggle getting connected with those organizations, so our local health department partner in that area reached out to 4H Clubs, reached out to high schools that have a health component that ties to a community college in another county adjacent to that particular area.

So we've learned to adapt and adjust based on the resources that are available in the communities and based on the needs of the interested parties wanting to be trained. So we have expanded our priority audience to work with their peers so that they can be trained, and share those messages on their college campuses, in their community and faith-based organizations, and in

the communities at large.

The program itself has a couple of components. One of the first things that our full-time program manager does in collaboration with the either college or university, and/or local health department is to sit down and figure out what entities, colleges, universities, et cetera, are interested in developing a peer educator program.

The sites have to identify at least one person who will be deemed their advisor to keep the effort going after they participate and complete the initial training. And then one of the most important components of our model is recruitment, not only of the advisor, but more importantly of the peer educators or prospective peer educators themselves.

So that takes time, it takes planning, and we link to the local on campus health centers. We work with health professionals programs, public health entities, where there's graduate or undergraduate programs, but we really reach broadly to identify in collaboration with the site, any potential peer educators who want to be trained, and conduct and carry out these efforts on their campuses and in the communities at large.

The training itself has ebbed and flowed over the years. It initially started out as two and a half, actually, full days of---two and a half days of training in person on the campuses. With COVID, we really had to pivot and adjust because one of the challenges we experienced going through COVID, and working with these entities was we weren't- able to be on campus.

We couldn't access the students on campus, so we ended

up having the students come to a central location on their campuses, and the speakers and the coordinator had to, were- working to implement the training virtually-. So we used a hybrid approach to get the information out to the students.

As time went on, we're now able to, in most instances, provide the training on campus, in the presence of students because it just works more effectively if you have the students present there with you because the training is very interactive.

We offer multiple opportunities for the students and the advisors to come together, break out into small groups because there's specific activities that are built into the training that ultimately when they're done with the training, which is anywhere now between 12 to 16 hours, they come out at the end of the training with a work plan of efforts and activities that they plan to implement on their campuses.

They talk about and start forming those collaborative partnerships with local health departments, and other community and faith-based organizations, and they spell out in that plan what efforts are going to be done on their campuses, and what efforts are going to be done in intermediate at large.

And at a minimum, these sites are supposed to implement two on campus activities, and two activities in the community with collaborative partners. The trainings themselves in terms of topic areas, they range broadly and widely, so we bring in subject matter experts, and especially if we're collaborating with local health departments we ask those partners to look within their health departments and find subject matter experts to speak about

health related and clinically related topics.

But also we ask, and we help facilitate connecting the local health departments that are coleading- the training, to find folks in their community.

So we have relationships with folks across the state that talk about a variety of issues with respect to infant mortality, communication, peer educator 101, you know, what is a peer educator? What is the role in the context of this work? Healthy relationships is probably one of our most popular content areas in the training.

We really work and talk with them about the importance of helping those peers that they're going to be talking too, and having those one on one conversations with. If you're going through a stressful time, you know, helping them to identify red flags and connecting them to on campus and/or community-based resources, so that they don't struggle by themselves, and find themselves in a really challenging situation that may or may not have a good outcome.

Other topics that are infused in the training, most important is equity. You know, talk about health equity, it's defined for them. It's also linked to social determinants of health and what does that mean. We also stress the importance, because this training is not just for future, -individuals- that in the future want to have a baby, the females, but we also are linking to the males, the fathers, future partners.

And we try to bring in males to talk about that conversation because we are seeing a growing number of men that

are wanting to become, and actually complete the peer educator training. In terms of other key messages that are noted on the screen, we have three key areas that we focus in on.

One is making sure that our peer educators that are trained understand what a reproductive life plan and a plan for your life means, and actually helping to provide with them information and prompts to have that conversation with their peers on campus and in the community.

Secondly, we're promoting healthy lifestyles, so that those individual that are talking to their peers understand the importance of knowing your health status, knowing your chronic conditions, knowing your family tree, your family history, knowing where to go for care, and also lastly, making sure that you have a health care provider, and that you're connecting with, and going to that health care provider at least once a year.

So again, that you know your health status. You know what's going on. You're stopping use of illegal substances, or substances just in general that are not good for you, if you're talking about wanting to have a child or children in the future. And again, staying connected with those health and behavioral health resources as well in the community.

And then messages under the umbrella of those three topic areas are listed on the screen. And we also make sure that we bring in partners that can address all of those topics as much as possible. Next slide please.

So we started out with a few four year colleges and universities that were implementation sites. We have grown to

over 20 sites around the State of North Carolina who have been trained and have active peer education programs. We have some rock star programs that are always asked when a new site wants to come onboard, you know, who should we connect to?

Can you connect us to someone that's done this work before, what should we expect? What are the challenges? What are the successes? So we have several schools that have done a phenomenal job of not only implementing this model, but building it into course work, helping students that as they're graduating, their reaching back out and working with other future peer educators that are coming along in the pipeline.

And we've had other students that once they finish the PPE program, they've actually been hired by local health departments who are now working with us to implement this program. I think that is my last slide, so I am going to pivot and turn the mic over to my colleague, Breanna Grant. Thank you.

BELINDA PETTIFORD: Thank you, Shelby. Let's turn it over to Breanna.

BREANNA GRANT: It’s Breanna.

BELINDA PETTIFORD: Thanks Breanna, oh I'm sorry for mispronouncing your name, I should know that.

BREANNA GRANT: Thank you. Please say hello everyone. Perfect, thank you logistics for making things go so smoothly. All right everyone, I am Breanna Grant. My pronouns are she and her, and I serve as the Perinatal Health Coordinator with Every Baby Guildford.

We are an infant mortality reduction strategy serving

in Guildford County Department of Health and Human Services under the Division of Public Health. And so my role, as I lead the perinatal health team, our mission, or our purpose is to strengthen the continued care of reproductive life planning. And we do that through actively moving through our mission to ignite and mobilize Guildford County with partnerships that identify strategies to eliminate racial disparities and prevent infant death.

I'm very happy to be here, that across the nation that we are doing some collective work. And so what we have had the opportunity to do is to be doing all these partnerships that Shelby has elaborated on in Guildford County. And so we've heard some things around on the key messaging already.

Shelby elaborated specifically on reproductive life planning. What I want to call your attention to here is this assessment, this tool that we have created internally with our media relations team. And we stress in our training, in our education model a call to action around are you thinking ahead.

Are you thinking ahead in relation to your preconception and after conception care? And so, of course we are speaking around the preconception care educator model. And so these topics that Shelby mentioned, we do invite our local health educators, as well as our community experts to educate on these topics, so that the students aren't only hearing from us as staff persons, they're also being connected to outdoor and outside community resources, so that while they are on campus, and as they venture and move towards off campus, they're able to connect with

local resources in the community.

And so this call to action, and in this particular physical and digital accessible tool, allows our students to connect with folks both personally and interpersonally on creating dialogue around their reproductive health. It allows them to have an understanding and a framework around whether they want to have children, whether they stand at a yes or a no, to prepare for that, and what that looks like in terms of their primary care.

It also educates and reminds folks of what it looks like having agency and choice over their care. And so, moving specifically on this program model in Guildford County. We have partnered with two sites, the University of North Carolina Greensboro, as well as the North Carolina Agriculture and Technical State University.

And so, we already had, as health educators, we had an existing partnership with both of these sites. As health educators, we were partnering with both sides to implement and kind of roll out the STI/HIV testing events to connect with them and their students, and provide education from our perspective. And so what we did when this award opportunity came up was like hey friends, you know, we have this great opportunity, and we would love to connect with you all to roll out this PPE program model, and they said yes, right?

And so both of these programs are housed under their student health centers, and they have student health employees who are trained in their respective programs around health education program topics, general health and wellness, and focus topics

around adjusted health disparities, within the various communities.

And so what the advisors do on their respective campuses, is they reach out to their student employees and let them know hey, this is a PPE program opportunity, and it looks like this. They educate them on the training components, the time commitment.

As Shelby did mention, it is 12 to 16 hours. And so what we did this particular year pushing out this program, is we looked at the training model, and we saw that a lot of the students really had some feedback around that continuous training instead of that three day collective training.

And so what we were able to do is reach out to our community experts to let them know instead of doing a training day one, day two, day three consecutively, how about we implement a continuous education model? And when we did that, we found that the students were more receptive, and that they could follow through care education even after completing their semester or their year around preconception and interconception health.

And so with both of these sites, what they have done is taken the education that they already had with the programs at USCG and North Carolina ANT, and then we build onto their education with the PPE program model, and they interweave those topics to create those student-led programs and activities for on campus and off campus students, staff, as well as community aligned initiatives.

And the way their students are partnering with

advisors, and I said partnering very intentionally because these are student led programs. It is the students who are getting the training and really putting their creative efforts together, and creating activities to reach their campus body, the student body. And then to also expand on those resources in community to create activities for community, right? Community-led, inviting communities to the conversation before and not after.

And so what they have developed is a constant communication model in where the students are meeting with the advisors weekly or biweekly to provide basic requirements on where they are with program planning and program implementation. And what that allows is a constant continuous and streamline of communication as things are moving forward throughout the semester.

And what I do as the contact in between the partnerships, is I meet with both of the PPE advisors. We have one advisor at University of North Carolina at Greensboro, by the name of Shenaz, and we have two advisors at North Carolina Agriculture and Technical State University by the name of Robbie and Jasmine, and we partner on these monthly meetings, and we call them check-in meetings, where there's standing hours, and where they can join in anytime that they have to provide any questions or comments that we can work through them collectively.

And what that allows is to have that constant communication. We have that change of education, and so when it's time to do those quarterly reports, it isn't anything new. It's familiar and it makes it more streamlined, and so the data

collection and what we push forward makes sense for all parties involved.

And so what this looks like is we all have this collective goal to improve our outcomes is what I'm hearing. And so, we are Every Baby Guilford, understand that we want to push is this collective action framework. Okay, I heard earlier about not working in silos, and we're doing this by increasing the presence of preconception and interconception education, and increasing how often, and how many of these hospitals are using reproductive life and assessment.

And so we at Every Baby Guilford understand that we can't do this work alone. And so, we have to reach out to our folks in the community to really see who has an interest, and who would like to learn more about how to increase this health education across community.

And so we have partnered with both of these college campuses to really educate and empower our student employees to become advocates in peer education, and then understanding that to create sustainability of this message in Guilford County, is going to allow other community members and community partners, so that we are already, you know, resourcing and looking at other opportunities for sustainability.

We're partnering with other community partners. We're partnering with other community members, so we can continue to share this messaging around, improving birth incomes, and how we can collectively do that. And so when you have an interest to join this movement, the way that you can engage with us at Every

Baby Guilford, and Guilford County with this PPE program model, is by connecting with us through this QR code.

We do promote and share education and awareness campaigns as it relates to preconception and interconception health on social media, and we do connect with our PPE partners on our website and social media. And so again, my name is Breanna Grant. I would love for you to join this movement as we work collectively towards eliminating disparities, and in infant deaths and empowering families. Thank you.

BELINDA PETTIFORD: Thank you so very much. This has been a wonderful panel, and I know people have tons of questions, but we're going to need you to hold your questions because we are now scheduled for public comment period, and we have to keep that on schedule, so I'm apologizing to you. I sent you a text.

We do need to go into our public comment period. We have public comments, and then we'll come back.

Public Comment

VANESSA LEE: Thank you, Belinda, and all of the Committee Members know that at every Federal Advisory Committee Meeting we have a portion to have public comments, and so during the registration system if you informed us that you wanted to make one, we are giving each of you three minutes, and I'm just going to go in the order that the requests were received.

So first we have Jackie Leung from the Micronesian Islander Community. Are you on the line? And we have our team at

LRG scanning the Zoom looking for you if you're raising your hand, but we have Jackie Leung requesting to make a comment to the Committee from Micronesian Island Community is the name of the organization. We'll just give that a minute.

Okay. Our next request came from Shirley Crane from Lower Brule Sioux Tribe. I apologize if I'm not pronouncing that correctly. Shirley Crane in South Dakota, from the Lower Brule Sioux Tribe. Also looking out for her online. And we do have a second session for public comments, so they may be joining tomorrow, so we'll be sure to come back.

Next we have Julia Skapik from the National Association of Community Health Centers. And then next Rhonda Smith Branch from Generate Health? Okay. And Joia Crear-Perry. I know you were online, so we'll just take a minute to unmute you, but Joia Crear-Perry from the National Birth Equity Collaborative, hey.

JOIA CREARPERRY: How are you doing? Are you all enjoying St. Louis? It's a beautiful place. So just some comments about what's happened so far today. First, I don't know if you all saw Steve and I did an op--ed around Medicaid and birth centers and midwifery, and it really plays into what we're talking about today with the cost of care and the cost of things. -

We know that we don't have transparency when it comes to how much Medicaid is paying. If you think about how the HMOs were created, they were created to help us solve a problem. If you ever worked for state government, we needed someone to help support us as state governments are using lean, mean machines, and so we though when you bring in these big corporations that they

would help us, but they tend not to tell us what they're doing, and not share information with us.

And so even the syphilis problem, I promise who knows who has syphilis, and who has interconceptual care, the managed Medicaid companies. They have all the data. They have information on the patients before we ever see them. They are tracking them, so I think there's a way for states to hold these corporations who are Fortune 100 corporations accountable, for how, what care they are providing, because this is a relatively new process.

It's only been around for since like the last 15 years or so, so we don't have to act as if we can't hold private companies accountable for using government dollars to care for us. So it's really important to think about that. Also, when we think about I did a report back in 2021, and I shared it with Belinda, and also with Emma, with some of the folks at IHN. It's a group there in St. Louis.

It was on a birth equity index, so we got data from the state and local health department, and we interviewed mamas about their outcomes, and we created an index. Because when you do birth equity, you're not blaming or shaming moms, but you're actually looking at those social determinants and root causes, like racism, classism, and gender oppression.

And so you do things like Dr. Priscilla does, with having a basic income. When we show when people have access to more money, stable housing, they make better decisions. So I know we focus a lot on educating patients, but really what patients

want and ask for are safe homes, safe environments and ways to ensure that they have those things.

And so the last thing, we know that Black Maternal Health Week is coming up. We're excited that HRSA and Dr. Warren and his team are participating, and now that it's become a big thing, and when we made it up, we didn't know that it would become such a big thing at the Black Mama's Medical Alliance, and so how can we really expand on the work of accountability, when I was thinking of all the things that we've been able to do since we created the Black Mama's Medical Alliance. Where we've been stuck is accountability.

So thinking through how the states and local governments or cities, so your city health department had created a community board that's actually holding the hospital accountable for their maternal deaths. I get calls from State Attorneys Generals who want to sue doctors.

As an OB/GYN I promise you lawsuits are not the way to fix maternal mortality, but a state having community accountability and community boards, having doulas and patients who actually work with you through the internal maternal review committees, for actual accountability to review the data and to make sure that the providers who are harmful are no longer providing care.

And the people who don't have respectful maternity care are no longer providing care to the patients, or either are getting training to unlearn the horrible habits that we learned, so that's pretty much it. I thank you all, and it's been a great

day as usual, thank you.

VANESSA LEE: Thank you, Dr. Joia, thank you for your time and those comments. Those will become part of the official record of the meeting, and just moving down, there's just two more on the list. One person is out sick, so hopefully they can maybe join tomorrow, but is Kevin Boyd on the line from Dentistry for Children?

If we don't see Kevin or the others again we'll have a second session tomorrow for public comment, which is when they may be joining. Kevin Boyd from Dentistry for Children? I will turn it back over to you, and again we'll circle back to more public comments tomorrow.

BELINDA PETTIFORD: Thank you, Vanessa. And again we want to definitely thank our panel, but we will take five minutes now, I'm counting it. If you have questions of our panel, then just present it because then we're going to move into the role of Healthy Start. Okay.

UNIDENTIFIED PARTICIPANT: Something about the moms in the correction center, and helping with their baby. Can you elaborate on that a little bit because I kind of heard it. I got the tail end of it on the news the other day, and I didn't get all the information, so since you've brought that up I'd appreciate that information.

MARTHA SMITH: I can tell you what I know, and then if you have questions that I don't know the answers to, I can get those because it's not something that was within our department, but it is a sister agency. So it was passed through the

legislative process, and it was proposed and passed a couple of years ago to establish a nursery in the Vandalia Women's Correctional Facility.

So we had two women's facilities, one in Vandalia and one in Chillicothe. And the one in Vandalia is where this nursery will be established. They're still, and like I said, developing the rules and going through that process at the Department of Corrections.

And so it hasn't been activated yet. They also are still creating the space where this will live. And my understanding is that it is going to have a designated nice space, and I've asked for, when that's ready I'm going to go see it. So, my understanding where they're at so far is they're primarily looking to qualify women to participate in this who will transition out back into the community before their baby would become too old to stay there.

So you know, it's not necessarily going to be for women who still have years on their sentence to stay in the facility there. This will prevent them from having to be separated, and so you know, when we look at the statistics of what we know about when you separate a baby from their mother, even for a short period of time, and the lifelong consequences that we see from that, we haven't looked at this for a bit, those help foster bonding, that mom and baby become attached, and have that initial bonding, et cetera.

As well as, I think there's some great opportunity, and we'll see like I said, I'm reserving my judgment, you know,

whether based on the things that they added, I think it's a great opportunity to also provide parenting training and modeling of, you know, how to take care of a newborn, and all of these things for any moms that don't have that skillset, or haven't had that modeled in their own lives, you know, for them.

So I think that's a great opportunity. But that's what I know about it to this point. It will still be part of the correctional facility. It still will be supervised. There still will be, you know, guards and that kind of thing, so it's you know, not outside of that framework. But what they have told me is that it will not be quite as structured. It won't have the same level of feeling of being incarcerated.

BELINDA PETTIFORD: Any Committee members that have questions?

KATHRYN MENARD: Just one, and if you need to defer it’s okay, I can probably catch Dr. Miller later. So I seriously wrote down your rainbow of real health suggestions, but one thing you mentioned was that you have attempted to unbundle Medicaid reimbursement for care. And my impression is that that's really a barrier to risk appropriate care, and transitions of care that need to happen from rural areas to partner care centers, or patient care centers, even within cities those transitions or barriers.

How is that working out? Well how did you come to that decision, and how is that working out?

HEIDI MILLER: That decision was made by the Medicaid division within the Department of Social Services, so that

preceded my time. But I actually am concerned that it's underrecognized, you know, it takes years for people to figure out that a change has occurred.

I think some folks may not be doing local prenatal care because they figure they can't get reimbursed for it. So the short answer is I don't know what drove it When I have spoken to the Medicaid folks, they did make a comment that they couldn't track the metrics on their pregnant moms because it was all bundled.

But if you have plans for how often you see the doctor and the genetic blood test for syphilis, then they can track all of the metrics, so they really like that. That may have contributed to that decision.

KATHRYN MENARD: Even whether they have a postpartum visit, or whether the onset of prenatal care, with bundled you can't track it. So it's a---

MS. MILLER: It allows a new mom more, so at FQHC we have five FQHC and St. Louis Region, and so if the old model you walk into the wrong FQHC they may turn you away and say no, you're not a patient here. You're a patient of Affinity, so you need to go to Affinity and to turn away a pregnant mother coming in for prenatal visits, it's really painful.

So better for us to design payment systems so that doesn't happen.

MARTHA SMITH: Part of that conversation I was involved, so they invited myself and our maternal mortality coordinator to sit on a Department of Social Services workgroup

with the Health Net focused on maternal and infant health. And that's been going on for probably about three years now that we've been involved in that.

And part of the conversation around de-bundling, both obstetric care as well as care for the entire community, especially in the NICU had to do with what is your motivation and are we incentivizing or de-incentivizing? So just like Heidi talked about, and you talked about risk of perfect care, and making sure that we're transferring appropriately.

In the NICU where we are incentivizing them to put babies in the NICU, they didn't necessarily need to be at a high level NICU, that kind of thing, so a lot of it was around data and metrics, but also around incentivizing the right care.

HEIDI MILLER: And Martha, so I'm getting to up speed as well. Martha, do you know I have the understanding that it's optional, like you can debundle- the care, or you can still bill as bundled. Is that your understanding too?

MARTHA SMITH: Yeah. I think the hope is to get away from the bundle, but yeah, it's not there yet.

BELINDA PETTIFORD: I think we've got one last question, and then I'm going to switch over to Healthy Start.

MICHAEL WARREN: Just a quick kudos. I want to thank our public CBC person for the MMRCs because I think we saw a great example of that today. One, the fact that 50% or more of your deaths are occurring from 43 days, that's not exactly the same as the national level of data, and I think speaks as to why it's so helpful to have that at the state level.

And also, I was particularly struck when you listed your top three causes, mental health, cardiovascular and homicide. And I went back to see have I missed that in the federal data, and injury, which includes homicides further down. So I think it just speaks to the value and appreciates CDC's leadership in supporting the states to build that capacity, and kudos to you all for taking that and running with it because it's so helpful to drive state specific solutions.

BELINDA PETTIFORD: And again, we want to thank the entire panel. We are so sorry we don't have more time because I think we could get more questions, but we may be in touch with you all. So thank you for your time today. As we move into Healthy Start, you can stand up and that's the only break you're getting.

Federal Healthy Start Program: Missouri Grantees

BELINDA PETTIFORD: As a reminder, as an Advisory Committee, we do advise the federal Healthy Start program, so we have on our agenda today representatives from two of the federally funded Healthy Start sites. One will be in-person, one we think might be virtual, we are still working to confirm her location. But at this time I am going to turn it over to Cynthia Dean, who is the Project Director and CEO for Missouri Bootheel Regional Consortium, which is the rural Healthy Start site here in Missouri.

CYNTHIA DEAN: Thank you everyone for your patience and thank you for the opportunity to share information about our program.

And I also want to thank our colleague, Carolyn Davis who is our case manager supervisor who came along as well, and she'll be--you'll be hearing from her tomorrow. Okay. -Next slide.

Okay. Just giving you an overview of the outline of the presentations. I'm going to talk about the introduction, the services, case management, data is always important, marketing platforms, and recommendations to the Committee. So, I don't know, probably many of you have never been to Bootheel, but this we're at the very end of the state, so we don't get out a lot, so it's always good to come to the big city of St. Louis and other places, but we're at the very end of the state.

And as you can see, it's shaped actually like a boot. That's why it's called the Bootheel. It's also very interesting because you see all these states at the bottom of the screen here. We are very accessible to many other urban cities in those states, Kentucky, Chicago, Paducah, Memphis, Blytheville, Arkansas, those are very large cities, and they are right around the Bootheel, and it doesn't take a lot of time to get to those major cities in those areas. Next slide.

So I wanted to give you a history, as Belinda pointed out that we do have two Healthy Start sites in the State of Missouri, one at the very end, and one at the very top. And so, we are the very end, just a little history about where we are. We have been a grant program involved with Healthy Start since 1997, so we are an older project, as I would like to say.

And we also, the very uniqueness about this project is that our original grantee was in St. Louis, which is a very good

area, but Healthy Start, the regional consortium was born out of Healthy Start. So that gives you the strength of a community-based organization that really have empowerment ideas and visions of their own.

And then we transitioned as the grantee to Healthy Start in 2005 and have been the grantee ever since. Next slide. These are some of the services and programs around Healthy Start. One unique thing about Healthy Start is that there are so many other programs that you don't see that's up here that really support Healthy Start as a whole.

Just looking at our case management support groups, our community action network, male engagement, maternal mortality, community doulas, preeclampsia health care programs, Medicaid expansion, leadership training. We were featured in a birthing justice documentary that was done by filmmakers from California who came to the Bootheel a couple years ago, and that was featured last year.

Many of you all have seen that. And we are the only agency in the Bootheel that really have served as a catalyst for the annual Low Birthweight Conference, and that's been going on over 20 years, and we have national speakers from around the country. We've had the Surgeon General there at one time, so we've had great success with this conference every year with many of our local providers.

Ms. Martha Smith was there last year. We had our -- . So we're so glad that she came as well, and she's also very supportive of the Healthy Start Program, and genuinely cares as

well. Next slide.

So just want to give you a little oversight of our data. I know we talked about data a lot, and data plays a big part as we know in funding, but it also constantly gives us an idea of how we're doing, but we also never forget there are people behind the numbers. And so we look at we have virtual---this- is where we are now with our Healthy Start Program.

We're fully customized online database, we have digital curriculums, screenings, provide smartphones to all of our clients in need. We look at the information that's available through a customized database for each one of our clients through education, and we upload all of our forms required by HRSA and other funding sources. Next slide.

So just to give you a little more background what happened when COVID came. And one of the reasons I believe that we made such a smart, smooth transition when COVID hit is that we had so many networks on the ground, so we moved into the digital process with little transition available, and these are some of the things that happened.

We are now better able to track Healthy Start home visits, at least by 60% over the pandemic. We have a full customized database that's been built basically to our program needs. Our system contains a lot of builder tools that we will need for the future. We have complete control of our information giving us data reports when we need them as we need them.

And then looking at the information that we provide for each of our clients through referrals and educations. There are

profiles throughout. The case managers have the access to get to them as they need them. Next slide.

So this just gives you an in-house process that we have. We are constantly looking at data, so not only from HRSA, but other funders and information that we need for our city councilman and others when they want to know what are you doing now, how many people do you serve?

We're easily able to track this information, and we look at this weekly, looking at our caseloads, looking at our visitation schedules, our benchmarks. Look at our recruitment and retention. And when things don't work, we don't sit around and try to do the same thing over that's not working, we're making changes.

We come up with a solution many times, but also we go to our clients. We go to our volunteers. We go, you know, to ask them what can we do to fix this? We need your help. Give us some ideas on moving forward. So we look at all of these things here, and this makes a big difference. We make them part of the solution of the problem. Next slide.

This is a screenshot. Those are not real numbers of what our customized database looks like now. And we're constantly customizing and fine tuning it as we go along. I know the data, the software company that's working with us now on some more changes that we require.

And so this is something that we have where we constantly can ask and put the information in all those case managers, including Ms. Davis and others, and our Ph.D. evaluator

that lives in time. They have access to this information. Next slide.

So, I'm going to move into another program services, we've talked a lot about support groups and behavior health, and that has always been a big part of our program, and we have a very successful program where we have a support group. It started out in person before COVID. We tried it when COVID was over. They want to go back to virtual, so we said okay.

So we have a very successful program ran by state licensed national certified counselors, and the program has been so successful that we had an article that proved the data worked, and the young women that were in the program, the article was accepted and published in the Journal of Medicine.

And also, these clients, they go into the program. They come out different people. And it has a lot to do with the facilitator. She genuinely cares. She has that "it" thing where she knows how to dress, and she's really excited, and I think they catch on to that.

But also, next slide, I want to you show you an individual that is part of that. This is a story I want to share, and this is one of my favorite ones because this is Lakedra Brown. She has several children. She came into the program in the flag group, she had high risk model, with a lot of risk factors. And over the years, over time as you can see she was a legacy recipient for many years.

Lakedra told us that she wanted to be a truck driver, and that was the last thing that we thought that she would want to

be from her vision boards. Well, she said I'm going to show you. So she did. But she also lost 100 pounds, and she came by the office and showed us when she got her truck driver's license and she was on her way out of town, and that's what she was driving. So she made a difference.

It makes a difference when you want to make a difference, and I think she no longer drives truck, but she owns her own home. She has a stable family, and it's a success story here. By working in that---working through the problems, food behavior health over a year, and her daughter, and Lakedra and her daughter were pregnant at the same time, so we had to work with both of them in many capacities, but Ladetra is definitely a success story. -Next slide.

This is Chastity, we're going to move into the Doula. Chastity will be joining us tomorrow. She's driving up. She lives in a lower part of Illinois that's close to our area, so she's coming in, and you'll get a chance to hear from her as well. But this is Chastity, our doula facilitator. Next slide.

These are the trainers that helped Chastity work with our doulas in our community, and these women here are all friends of hers, and they work with her. Isis is wonderful. She came down and did a presentation with us with the Department of Health, a breastfeeding workshop, and these other women are as well. Next slide.

Chastity put together, and even helped design with the clients their own doula bag, so these are the things that she put together that we give our doulas that are in training. And as you

can see, all these things on the side, you know, they get books, they get all these different things here, and they love it. Next slide.

I'm a big fan of male involvement and male engagement in all maternal child and family health programs for many years, and I just feel very strongly that men should always be involved with many of our programs targeting women and children, and infants.

And so this is from one of our classes last year. These are graduates. Next slide. So we talk about community action that works, which is our CAN. And the CAN has so many different layers and levels that they work on throughout the communities over the years as volunteers.

And we treat our CAN members as if they're employees. They get orientation, they get training, and they will be able to provide education where you can't tell them from the staff on Healthy Start because they know it. And these are many of the people that from some of our activities that are involved in CAN.

And we actually, they are able to see the difference that they're making not only as a volunteer, but they share and bring their own stories that make a difference. And we also share data with them. Sometimes when we share data, it's unbelievable. They get upset, and then they say okay, what can we do about this? This is happening in our community.

And I remember there was one session that they talked, we shared the race on teen pregnancy, and it was really hard for them to grasp that the numbers were so high in their particular

county because they didn't want to believe it, but they said okay, we're going to do something about this. We're going to talk to the superintendent at the schools. Next slide.

Okay. I think we -- there you go. So these are just some of the community events that we have, and we have many of those. We have community baby showers, we have different community activities that bring people out, network, provide education in everything that we do, and we get a chance to network with many of our clients that come out with their families and have these types of events. Next slide.

We were fortunate enough during COVID to get two additional grants, one federal and one state, and we vaccinated over 8,000 people, and that is a real number because we had to upload all the data weekly. And so that's a real number. And we were able to vaccinate many of the young women that wanted to get pregnant, and many didn't, but we also were able to get a lot of people involved.

And that's actually we did a report that was featured I understand by another federal agency, and they really liked the information that we provided. And so this is just a snapshot, some of the other things that I talked about that's built around Healthy Start in so many ways, next slide.

Okay. I'm a big fan of marketing, so I get excited when I see our stuff. We've got billboards on Interstate 55, and so that's just one, but we have two others. One of the two others features those two girls at the bottom. It says, "Every Baby Deserves a Healthy Start," and then we have one at the top it

says, "Every Mother Deserves a Healthy Birth." So we have those billboards on Interstate 55.

And these are some of the things that we have. We have as you can see, just recently what we have, we have others. We have a monthly maternal learning collaborative every month on trauma. And this past week we had 154 people on a call for one hour. And then I looked at the registration. There was someone on there from the Philippines. So it's getting bigger and bigger all this while, and we've been doing trauma for about six months.

And it's a lot of people that are engaged, and we have speakers from a large behavioral health center in our area that has a lot of credibility and their staff have the expertise to facilitate those learning collaborative. And then we do workshops all the time on different things, providing education ongoing. Next slide.

Of course education is everywhere. We worked with all of these different things, constantly visual, sending things on our Facebook, on our website, in messaging boards, so that the clients and the community could have this information at their fingertips on their phones, that's mostly where you can reach people now. Next slide.

Okay. We have a podcast, and it is called Healthy Babies Healthy Communities and Healthy Mothers. And this is something that we launched last year. I understand it's doing very well. Next slide.

We also have different activities that bring in different layers of partners from the community, and we

have -- this is part of our CAN activity. We have this was last Halloween when we had ADRASTOS, who is a motorcycle club, and they said okay, we're going to ride for babies.

And so they rode in the parking lot just as a symbol as support as dads for mothers and their infants. And so, they were there, and we had other agencies. We had the miniature horse there that's part of therapy of training for kids and different families. And these are the types of events that we have in our community that really bring a lot of attention to the things that we're doing with infant mortality and maternal mortality. Next slide.

These are many faces of some of the people and children in our community where you see they come together in our area to think about as rural. We cover five counties, and one of our counties from our office is an hour and a half one way, so it's very much rural and people get together, and you can see the faces on many of the children that I always love to see when they're at many of these events. Next slide.

And this is, we showcased this slide. I remember last year when we were at I believe in Colorado, at a conference, and we were able to just kind of put together many of our activities and things to showcase there, but we do provide transportation. We have drivers, and these are some of the things that we have available as I mentioned, for always, definitely looking at things we can do from that end.

Medicaid expansion, we had a specific program funded by the foundation for that, and then these other things here that

we've done. Next slide.

And so these are some of the recommendations. We met with our staff and talked to some of our volunteers, and these are some of the things that we came up with to share with you today. Next slide.

Our successes have really been involved with incentives. Valuing and respect their time because when you go somewhere a lot of people get paid, so volunteers deserve the right to get an incentive. They also trust you. Trust is a big part of any program. As you know in the Bootheel, we do not have a transit system. I don't know if they ever had one, but we don't have one now, and never have since I've been there.

But we do provide transportation for our clients. They're perinatal visits, their week clinics, and it decreases the stress and the tension that many of these mothers have because sometimes if another system takes them, they may have to stay there a couple of hours or longer before they can go back home, before their reroute of the transit system is in place for them to leave.

But having somebody, our drivers take them there, and they stay with them until that appointment is over, and that makes such a big difference. It takes away the stress, and they go to their appointment, they're happy because they know they are going to get back home when they need to be there on time after their appointment.

Now, sometimes they change when they go into the doctor's office, they may start at 10:00 and the doctor has an

emergency, they may have to wait another two hours, you know, this is middle America, where you get an appointment this day, it may be four months before you get another appointment.

So we also look at this, it supports program retention, our successes and things that we've done. Looking at conditional and non-conditional partnerships, the importance of male engagement, our education campaigns, some of those I shared. Next slide.

I can't emphasize the impact that we've talked about social media and the power of it. And we've seen it with our program, through Facebook, through TikTok, YouTube, Instagram, Podcasts, Webinars, Blogs, geo mapping is very important because it gives you the data to show where people are really looking at your information on their cell phones.

We have a song that I'll share at the very end that was created by two rappers out of Kentucky. We have our flyers. We put text messaging boards and things in place. We have virtual workshop trainings, support groups, and we provide a safe space for people listening for transparency.

And I want to say that here's an example, that our doula facilitators shared, she was in the room, the doula was in the room with the doc, and the client didn't want to ask the doc, so they told the doula to ask the doc when they left. So it's that communication, and that safe space where the client has to feel comfortable enough to talk to the doctor about what's really going on, and that's a whole other presentation, but that is something that's always there as a risk factor, as a factor.

Next slide. And it came become very challenging. These are some of the things that we've learned over the years with Healthy Start, and many other capacities. And we talk about this. I have heard this throughout the many presentations today, talking about health equity, and how it must be integrated with policy forces to make change to take place.

It is hard for rural areas where you have a lot of economic, as I pointed out, instability things that occur. In February we had a plant that employed 500 people, and this is real, it's on the news. They came to work Wednesday. They didn't have a job after Saturday of that same, with no notice. Now that's the level of economic instability that impacts infrastructures that are already vulnerable in so many ways.

So this is the real world, and we had another plant to close that had almost 800 people. They at least gave them a month, but this plan did not. And so you look at all that transitioning and redirecting, and all that stuff trickles down to many of our programs that are already vulnerable, as a nonprofit and community based programs in our communities that have such an impact.

We have food insecurity where many of our mothers, they want food, but not for themselves, but for their children. So these are things that we're looking at, and we're working with food banks as partners now. We met with them the other day because it's really getting to be a problem. We never had clients asking can we help them get food.

And so you look at postpartum care, and we talked about

this earlier. We believe that it should continue, as someone said, forever. I mean it's not something that should go away because it's ongoing, the whole process of what we're doing is ongoing.

Looking at the social factors, we talked about housing, substance issues, all these things play a key role as we know in social determinants of health. And then we look at location does matter. Many of our communities, many of our clients their communities may be, you may already know. I'm sure you know this in rural areas, but we have five counties, and there may be one large community in that specific county, and that county sometimes has more I'd say potential to move things forward in the community, except, especially when something major has happened, like a factory closed, but another town may not.

So you have towns, you have one or two major towns, and a whole area where there's not a whole lot going on except those one or two communities. So that's something to think about, the culture. It does matter where a person lives, how they live, and what they get and what they can't get because it's just not there for them to get.

Then you look at I believe that you can't underestimate the money that you need to put into staff development and training. That is so important for any program. Next slide. These are some of the things that we have talked about to improve our economy, things you've heard already today.

Communication, empowering people to take ownership of what's going on with them, and they articulate that, and

technology, the importance of it, increased awareness and education. Looking at the many partnerships and collaborations of things that we do not do them by ourselves, we have many partners that really care about what we're doing to help us.

We share resources and expertise, and advocate for policy change, looking at community-based interventions, looking at the life's stretches that's tied to emotional health. And then doulas, we can't say how important they are in making changes in the birth outcomes for many of our clients and our families. Next slide.

These are some of the recommendations. Recognize the impact and delay of not addressing unconscious bias in health quality of care. Sometimes we know things need to change, but people need to accept the fact that if they don't change there's going to be long-term consequences and generational impacts that's happened, as we see, that's- happening now.

We look at people need to know their voice and opinions matter, no matter where they are and who they are. We look at how to increase capacity to advance health equity in many ways, and then look at healthy babies that begin with healthy parents, I mean from the very beginning. Next slide.

So this is our song, that these two rappers made for our Healthy Start, and it's very short, and it will just give you the upbeat that we try to keep the momentum going in many ways with our programs.

(Song playing.)

CYNTHIA DEAN: Other programs over the years that have

supported Healthy Start because Healthy Start is like a nucleus that everything else is going around it, and so those are just some of the things that we do. We've been around a long time. We don't have time to share everything, but those are some of the main things that I hope that give you insight into what we do, and why we do it. Thank you.

BELINDA PETTIFORD: Thanks, Cynthia. Question for Cynthia. Cynthia, can you share how frequently your CAN meets? Your community action network and your size?

CYNTHIA DEAN: Our CAN meets the fourth Thursday of every month, and that has happened for many years, and the only time that they change the date is Christmas of next year. And they have an annual volunteer appreciation program every year, usually before Christmas that when we acknowledge the CAN members for their volunteer service, and also our case managers they graduate, not only the case manager, but the clients of the case manager have a bimonthly volunteer appreciation as well.

UNIDENTIFIED: Do you mind standing at the podium? -For anyone in the back.

BELINDA PETTIFORD: Okay. And piggybacking off of that, for those CAN meetings, what's the length of time, and then I know you mentioned incentives, what type of incentive?

CYNTHIA DEAN: It's varied over the years based on funding. And our CAN members have, they were getting like $25.00 in gift cards, you know, for participating. And we put a lot of effort and time into developing our CAN. They get educated on when we receive a grant, not just Healthy Start, but other grants

that may be relating to Healthy Start as well.

And the time of the meetings are usually an hour and half to two hours depending on if we have a workshop. There's not a CAN meeting where we don't have an education presentation there. We keep the education at the forefront of everything that we do.

BELINDA PETTIFORD: Okay. Thank you. Anyone else? Thank you Cynthia. And I don't think we have Shannon, so we will follow-up and try to make sure she's okay, since we have not heard from her today. Okay, so we've already had public comment, you didn't- really get a break.

So we're going to move on because the goal is to try to get us out as close to 4:00 as possible. We've had some awesome presentations today, and I think as a Committee one of our focus areas was to listen. You know, we asked all of the presenters to give us some recommendations, some thoughts around how we can improve infant and maternal health specifically, and how we can do it working with African American/Black communities.

And so, I really want us to just take a moment and think about does anyone have any questions, any thoughts, anything that resonated with you today. You know, we have our three workgroups that will be reporting out tomorrow, so we have our rural health groups.

So we made sure that all of the presentations today connected one way or another to one of the workgroups, and so our rural workgroup, we've got a social determinants of health, and we've got a preconception and interconception one. And some of our presentations touched all of them, which was nice.

LEE WILSON: Can I just saying something. I think Cynthia did a very nice presentation. For those of you who aren't as familiar with Healthy Start, and what we do, there are 101 Healthy Start grants around the country. We're in the process of doing the re-competition right now.

They are on a five year cycle. We've had a couple increases over the last few years, so we have awarded a few extra grants, a catalyst grant and an enhancement grant with small twists. Usually we pilot it with a group of like ten grants, and then you see it in the next full grant announcement. So we will be awarding approximately 103 grants. The plan is to make those new awards by May 1, and so we're in the process of reviewing right now. I really appreciate what we just saw in many ways because it is emblematic of what Healthy Start is doing from the perspective of tailoring their specific program to where that community is, and the experiences that they live with on a daily basis in the community, and the environment that that community resides in.

So you will see when you see 101 Healthy Starts, you see 101 Healthy Starts, and you see one Healthy Start, because there are things that are central to all of them, the community engagement, the working mothers, now the clinical support that's provided that could be a springboard for things like the syphilis discussions that we've had today.

But also this involvement of the community through their community action network to help drive leadership in potentially making changes in the social determinants of health. So it's one of our signature programs at MCHB, and I think Cynthia

did a tremendous job of representing everyone, and I'm going to steal your rap.

SHARHONDA THOMPSON: Lee, I actually participated in the Healthy Start program in St. Louis. That's how I met Generate Health, that's how I became a community champion, so Healthy Start does, it touches everybody. It's wonderful.

LEE WILSON: Just wanted to share that if anyone has any other questions, you're more than welcome to reach out to me or Bonita Baker, who is the branch chief over the Healthy Start program. Also, for the Advisory Committee we try to have an annual meeting. Last year we did four regional meetings, or five regional meetings around the country.

But you are welcome to join us for the annual Healthy Start meeting if that is something that you would like to do, and we can try and work out the arrangements if travel is a difficulty for you.

BELINDA PETTIFORD: Is it a state yet?

LEE WILSON: I was hoping Michael would be here to hear me announce that we wanted to do it, and maybe just slide that in.

BELINDA PETTIFORD: I'll make sure we send it out to the full Committee once you have it written.

SHERRI ANDERSON: And I wanted to thank you Cynthia for the great presentation, and something that I'm trying to connect that I'm not being very successful at in my mind is the earlier presentation talking about if we really are going to go deep into communities we need to reach out in a way that supports them to be able to get the funding to do the work that they're many times

already doing and wish to build upon. And so, how does Healthy Start address that wanting to really have an equitable approach to the programing, and at the same time requiring grant application, data collection, and reporting, how does that happen?

LEE WILSON: Yes.

(Laughter).

LEE WILSON: Cynthia, do you want to...?

CYNTHIA DEAN: Yes. You have to have people on staff, you know, we look at everything that we're doing, it's a lot of people there that you don't see that's dedicated and committed to the work that they're doing. And we hired people that are from the region where we live, so they understand the dynamics and the challenges within those communities.

And then we also look at, I mentioned staffing, training, you know, staff is your biggest asset when you have a program like this. And making sure that they get the updates and the training and everything they need, you know, to help them do what we need done in that specific program.

It is a lot when you look at all the balls, and that's just half, that's not even a part of it with all the things that we do with Healthy Start, as I mentioned. But it's rewarding to see the impact that we do have on the clients. In many of the programs, you know five years is not a long time. It takes five years to really see it through, the data, and all the other things that you talk about. It takes about a year for implementation, you know, with mini grants, but then the other years you begin to see how it all comes together, but you have to have people in the

right place that want to do the job. I think that's a big challenge as well.

BELINDA PETTIFORD: And I will add to it because for transparency, we are a Healthy Start site, I actually have two out of my office. And what we do to support community organizations and our local health departments, because I work for State Title V, is we apply for the funding. We collaborate with them, we do the grant writing for these, but then we subcontract much of the monies out to support the fact that when we meet with our partner, we can't write this grant. We don't want to be responsible for this, we don't want to be responsible for that.

But we do it as a collaboration, so some of heavy lifting, we do, so like the project director we employ the project director, the work that happens in the community on the ground is because we pass the monies through to them.

LEE WILSON: There are a number of internal steps that we've tried to take incrementally to help. I mean realistically we all do want to reach into the community, but just because you're at the community level doesn't necessarily mean you're equipped or responsible enough to continue something over an extended period of time.

So yes, we support the concept and the idea, but this is an operation. The federal government doesn't give away 5 million dollars to a program without expectation that there's going to be some sort of a reporting and accountability for that, especially when you're working with clients.

On the flip side though, we have tried to convert a lot

of our data requirements to data requirements that we can pull down from one that CDC collects, and make that available to applicants, so that when they put together their application, we have a mapping tool, that you can go to the mapping tool and you can identify your region on the mapping tool, and the data will pre-populate, so you can use that.

We have epidemiologists on our staff who are able to assist, provide technical assistance in working with the writers to help them be able to answer some of the questions, up to the point that it would be unfair and we're giving you an advantage over somebody else, an advantage.

Similarly, with our data tracking tools, some of the organizations that have received funding have their own in-house system, they may be attached to a community health center or something else, but we actually invested a few million dollars into developing a client level intake and tracking monitoring system that interfaces directly with the system to upload the information. It does all of the processing, generation and uploads that in the event that you don't have a system that you want, you can just take it off the shelf.

You can also adapt it if you want, and we will provide technical assistance to do that, so that we are taking care of some of the sort of infrastructure needs that you might have with your current. It doesn't do it all, but we feel like we are making progress on that front.

SHERRI ANDERSON: So after they're granted, there are supports that do make it equitably accessible to many different

organizations. So what words of inspiration, Cynthia, do you have for an organization that aspires to be an organization like yours, so ready for this kind of process, and engagement and funding sources? And how did you get there?

CYNTHIA DEAN: First of all, if an organization wants to do what we do, they really need to know all the challenges that comes with it. It's not easy. But the benefits of it are rewarding, but they have to know this is something they want to do. And you can't do it alone. You have a multidisciplinary level of partnerships that exist, like was said, you know contract things out to different individuals. -

So it takes a lot, we talked about it really, it takes a lot for a Healthy Start program, and I think that's why it's so unique within our communities, because it's community driven, but it also has a layer to where everybody in the community can be a part of it if they choose.

You know, it's anybody in that community can be part of Healthy Start, and so if the people in the community have to want it, and also people that's running it have to make sure they do what they're supposed to do on many different levels, because they're a high level accountability, which there should be, and transparency that's involved in these types of programs.

CYNTHIA DAVIS: I just want to comment because they don't give us enough credit, and never does, but that's okay. When she talked about finding staff and volunteers, leadership, a great leader, leadership is the key. And I say that because during the COVID years we never stopped working. Everybody stayed

home, everybody wasn't working, we were still working.

Because it's equivalent to being trained. Every day my daughter said Mama, now you bring one more in this house I'm screaming. She said Ms. Jeannie, you all don't have enough seats. And Ms. Jeannie got everything we need-- We've got a bathtub, we got iPhone. If this don’t make- our jobs easier it’s gonna make going to make us a better client and we get it. There's- no excuse for us not to do our work.

There's times when people called in sick, you know, emergencies happened. Our volunteers could come there, they could answer that phone, they could put those packets together. We have our volunteers come in and they put those outreach packets together. We could answer those phones, we need drivers to pick up and drop off our clients at they door. So we’re being cross cutting there's a lot that we still need to learn, because we're doing cross training all the time, that if somebody leaves, and there's nobody to do his position, somebody can step in and that ball gonna keep rolling, it's not going to stop.

And that's leadership. And don’t think she don’t come up and answer the phone, and give a kid a pamper or what a parent or client needs. She shows--you know they say put your money where your mouth is, she puts her money where her mouth is, so we feel good when we do something, because we see her doing things. Like, Miss Dean is back, we gotta go.

So they know if she's upfront they really filled in for her because she's got a lot of stuff to do, continuous stuff, it's all important, the stuff that she don't need to be doing, but we

are trained to grow and take over and do it, so I will always say a good leader is the best thing. I don't call her a boss, I call her a---she- is my boss, but I consider her as a big asset to all the case managers.

We really do our job, and it's the leadership. We cannot do our job unless we have great leaders to say okay, we need this here, so this is what we need to do to get you over here. And we don't get a prize for it, we get trained and we get the opportunity to go back anywhere. If you don't understand it, you need to come and find out what you did and how you can better yourself in that area.

So leadership to me is something you could start off with. It's lot based on hiring, but if you have a great leadership that's going to lead you, and not micromanage you and helps you to empower yourself, then you can empower others, you have a team.

LEE WILSON: The one thing that we haven't talked about is that there is a need requirement. There is a need requirement for the program, so the community has to have an infant mortality rate that's one and a half times the national average, or greater. And then a certain number of deaths in the community to qualify, so that it's not a very small population that they're serving to get to that rate.

So we have increasingly been focusing our attention on the communities that have the largest number of infant deaths as possible, so that we can be very - I don't like using the word, but pragmatic in our approach to trying to reduce the infant

mortality rate, and in particular reduce- the disparity and infant mortality over time so.

JOY NEYHART: So we need to make this program--

LEE WILSON: Bigger? Yes.

JOY NEHART: But we need to work toward making it smaller, then, because if you need to have a certain maximum of infant mortality, then that’s what we are trying to get away from.

BELINDA PETTIFORD: At one point there were 300 communities identified that would quality for Health Start, and so now we're back to 100.

LEE WILSON: No, no, no, that was county, so there were 300 counties in the United States that had infant mortality rates and birth outcomes that qualified them. Now, we all know that some countries are large, and they have a city in the country, and so you could actually have more than one grant in that particular area.

But that was the way of getting our arms around it. There are now about 400, slightly around 400 that are in some way would qualify, so the numbers are significant. What we have funding for is 100 to 105, so the need is probably three to four times greater than what we have the resources to be able to support.

JOY NEYHART: The goal can be to decrease the need.

LEE WILSON: Well, and one of the difficulties is that we have -- I don't want to turn this into a Healthy Start meeting, but one of the difficulties that we have is we do have a number of long-standing communities, and they are places where there are

long-standing factors, social factors, societal factors that contribute to the disparity being high, the discrepancy between them and the rest of the country being high.

There are some communities that sort of graduate from the programs statistically that they've brought their infant mortality rate down, which we're very happy about that. We're very proud, we're very sad that we lose them, and we're very concerned that they may be going back up once the funding goes away.

And so we just don't know like what is going to happen there. We always talk to them about sustainability, and what are your approaches, but we also know that there isn't money just floating around out there for you to pick up if the Healthy Start program goes away.

BELINDA PETTIFORD: All right. Any other thoughts, questions, concerns? It's gotten quiet, but it is after our planned 4:00. So in the morning we have the social determinants of health tour, that will pick us up at the hotel at 9:00. Will they bring us here afterwards or will they'll drop us off back at the hotel?

VANESSA LEE: Back at the hotel.

BELINDA PETTIFORD: So we'll be back at the hotel. We will start here at 12:00 tomorrow. Early on in our agenda we have Administrative Carole Johnson, a HRSA Administrator. She will be onsite to give us some greetings, and we'll have some more updates, but in the afternoon we'll focus on the work we put out, so three workgroups that have been leading for some time now, and

will gives them an opportunity to kind of share where they are moving with their workgroup, and you know, and getting any feedback that we may hear from others through that time.

So we do have some time scheduled on the agenda. And I think the area that many of us are excited about is we do have a panel of community voices scheduled for tomorrow, hence the reason that we're going to end later because we wanted to make sure we didn't have that too early in the day. And ShaRhonda will moderate that session for us, and so we're looking forward to that. So just know that tomorrow, read your agenda carefully.

We start at the hotel from 9:00 to 11:00. Grab a snack if you want to, but we delayed lunch until around 2:00 because we're going until 6:00. Or you can grab lunch early and have a snack at lunch, whatever works for you.

VANESSA LEE: So following the format that you gave us for-- --

BELINDA PETTIFORD: Right. We're giving each workgroup 15 to 20 minutes to report out. Give you all something to think about.

KATHRYN MENARD: Okay. So the format that was given to us you don't need back, just remember workgroup 1, the template and that's kind of what you want.

VANESSA LEE: We're going to follow the template to guide your report out in place of them.

BELINDA PETTIFORD: And if you can send me a template over I could --

VANESSA LEE: We have it, yes. It's in the note. It's

in the brief.

BELINDA PETTIFORD: It's in the briefing book, but I thought you were --if you make changes.

VANESSA LEE: I have them printed out. Do you need a copy?

BELINDA PETTIFORD: If we could get them emailed to everyone, but if they make changes tonight, we'll wait.

VANESSA LEE: Okay.

BELINDA PETTIFORD: Well thanks everyone. We talked about doing dinner.

VANESSA LEE: Yes. If you're coming to dinner you should have gotten an email from me. We're going to Salt and Smoke, if you want to meet in the lobby of the hotel at 5:45 we'll go over together. 6:00 ish, we there at 6:00 ish.

BELINDA PETTIFORD: Didn’t we see that last night as we were walking down the street?

VANESSA LEE: Yes, it's about a ten-minute walk.

BELINDA PETTIFORD: Okay.

VANESSA LEE: See you there, or otherwise see you tomorrow morning.

BELINDA PETTIFORD: Thank you all. Some of you can come back tomorrow, not all.