THE ADVISORY COMMITTEE ON INFANT AND MATERNAL MORTALITY (ACIMM)

HYBRID MEETING

AMEREN COMMUNITY ROOM

DELMAR DIVINE

5501 DELMAR BLVD. ST.

LOUIS, MO 63112

12:00 -- 6:00 pm CST

Wednesday, April 3, 2024

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- COMMITTEE MEMBERS -

Sherri L. Alderman, M.D., M.P.H., IMH-E, FAAP
Developmental Behavioral Pediatrician
CDC Act Early Ambassador to Oregon
Help Me Grow Physician Champion

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

M. Kathryn Menard, M.D., M.P.H.
Upjohn Distinguished Professor
Department of Obstetrics and Gynecology
Division of Maternal-Fetal Medicine
University of North Carolina at Chapel Hill

Joy M. Neyhart, D.O., FAAP
Pediatrician

- COMMITTEE MEMBERS, CONTINUED -

Belinda D. Pettiford, M.P.H., B.S., B.A. *(Chairperson)*
Women's Health Branch Head
Women, Infant, and Community Wellness Section
North Carolina Department of Health and Human Services

Marie-Elizabeth Ramas, M.D., FAAFP
Family Practice Physician

Phyllis W. Sharps, Ph.D., R.N., FAAN
Professor Emerita
Johns Hopkins School of Nursing

ShaRhonda Thompson
Consumer/Community Member

Jacob C. Warren, Ph.D., M.B.A., CRA
Dean, College of Health Sciences
University of Wyoming

- EXECUTIVE SECRETARY -

Michael D. Warren, M.D., M.P.H., FAAP

Health Resources and Services Administration

Maternal and Child Health Bureau

Associate Administrator

- DESIGNATED FEDERAL OFFICIAL -

Vanessa Lee, M.P.H.

Health Resources and Services Administration

Maternal and Child Health Bureau

- PROGRAM LEAD -

Sarah Meyerholz, M.P.H.

Health Resources and Services Administration

Maternal and Child Health Bureau

- EX-OFFICIO MEMBERS -

Wendy DeCourcey, Ph.D.
Administration for Children and Families
Social Science Research Analyst
Office of Planning, Research and Evaluation
U.S. Department of Health and Human Services

Charlan Day Kroelinger, Ph.D., M.A.
National Center for Chronic Disease Prevention & Health Promotion, Division of Reproductive Health, Centers for Disease Control and Prevention
Chief, Maternal and Infant Health Branch
U.S. Department of Health and Human Services

Danielle Ely, Ph.D.
National Center for Health Statistics, Centers for Disease Control and Prevention
Health Statistician, Division of Vital Statistics
U.S. Department of Health and Human Services

- EX-OFFICIO MEMBERS, CONTINUED -

Karen Remley, M.D., M.B.A., M.P.H., FAAP
National Center on Birth Defects and Developmental Disabilities, Centers for Disease Control & Prevention
Director, National Center on Birth Defects and Developmental Disabilities
U.S. Department of Health and Human Services

Kristen Zycherman, R.N., B.S.N.
Center for Medicaid and CHIP Services, Centers for Medicare and Medicaid Services
Quality Improvement Technical Director, Division of Quality and Health Outcomes
U.S. Department of Health and Human Services

Tina Pattara-Lau, M.D., FACOG
CDR, U.S. Public Health Service
Indian Health Service
Maternal Child Health Consultant

- EX-OFFICIO MEMBERS, CONTINUED -

Alison Cernich, Ph.D., ABPP-CN

National Institute of Child Health and Human Development, National Institutes of Health

Deputy Director

U.S. Department of Health and Human Services

RDML Felicia Collins, M.D., M.P.H.

Office of Minority Health

Deputy Assistant Secretary for Minority Health

Director, HHS Office of Minority Health

U.S. Department of Health and Human Services

Dorothy Fink, M.D.

Office of Women's Health

Deputy Assistant Secretary, Women's Health Director

U.S. Department of Health and Human Services

- EX-OFFICIO MEMBERS, CONTINUED -

Nima Sheth, M.D., M.P.H.
Substance Abuse and Mental Health Services Administration
Associate Administrator for Women's Services (AAWS)
U.S. Department of Health and Human Services

Caroline Dunn, Ph.D., RDN
Senior Analyst, Food and Nutrition Services
U.S. Department of Agriculture

Alicka Ampry-Samuel
Regional Administrator
Region II—New York and New Jersey
U.S. Department of Housing and Urban Development

Gayle Goldin, M.A.
Division Director, Women's Bureau
U.S. Department of Labor

- EX-OFFICIO MEMBERS, CONTINUED -

Deborah Kilday, M.S.N., R.N.
Senior Public Health Advisor
Office on Women's Health
Office of the Assistant Secretary for Health
U.S. Department of Health and Human Services

P R O C E E D I N G S

Call to Order and Review of Day 1

BELINDA PETTIFORD: Good afternoon, everyone. Hope you had a good evening, and a good morning. Many of us this morning were able to participate in the social determinants of health tour, but I guess I should step back. This is Belinda Pettiford, thank you, Chairlady of the Secretary's Advisory Committee on Infant and Maternal Mortality.

And thank you for those that were able to join us yesterday, and especially thank you for those that have come back, and the other people that are joining us today. We have some people in the room as we're getting situated here, and we have quite a few people that are joining us virtually.

So, if you're having any issues with hearing virtually, please just drop a note in the chat, and our tech team will be on it. So I want us to talk a little bit about yesterday, reviewing yesterday because I think yesterday we had an awesome day because we were able to hear from people here in St. Louis, as well as the State of Missouri.

We were able to really spend some time listening, which is one of the reasons we want to go into communities with these meetings. And so I don't know if anyone has anything they want to share, any thoughts from yesterday, any other Committee members, whether you're ex-officio, or one of the Committee members-?

Anyone have anything to share from yesterday?

Other than we had a wonderful dinner for the many of us that were here last night. We were able to hear from one of the Healthy Start sites here in Missouri. We did get word that, we were expecting to hear from the second Healthy Start site here in Missouri, but we did get word that there was a slight accident. Everyone is fine, so I don't want you all to be worried on that end.

We were able to get a few public comments in yesterday, and we'll have another public comment period today. And then we were able to hear from many of the local partners here.

We had some awesome presentations from Generate Health. They were able to come and share the awesome work that they're doing here in the area, but we were also able to hear from the Director of Health, the City of St. Louis Department of Health, as well as the Director for the County Department of Health, and hearing how they are working together to address Black infant and maternal mortality.

So, any thoughts, or concerns, yes, Kate?

KATHRYN MENARD: Well it’s just, not concern really, but I would just like to thank you all for putting this together the way you have, and the folks that were in the room, contributing in so many important ways It was very, very informative.

And there's a couple of thoughts, one in particular, that keeps resonating in my head that the Director of Health and the Director of Public Health for St. Louis talked about -and it's

almost relevant to almost everything we talk about is how we make information available, and making information available in ways that the public can understand. -

And I reflect on the fact that there's so much---so many opportunities for making information available that we don't always know the best way to do it. It's so, not -easy, but so readily available if we do it the right way.

But I guess I just, you know, one talk after the other--that was a theme, right, in almost everything that we learned about yesterday, so that's my thought.

BELINDA PETTIFORD: Yeah. Thank you, Kate, thank you. I think communication was resonated throughout. Education, communication, sharing of resources, I think that over and over again yesterday.

We were also able to hear from a couple of state leaders with the state approaches they were using to address Black infant and maternal mortalities, so I think that was helpful to the Committee, as we're moving forward with recommendations to the Secretary.

So I do think everything that we heard yesterday, I saw many of us taking notes, and we'll be looking at the minutes as soon as possible, where we actually get the detailed notes, but many of us were making sure we had that information. And I think it will definitely be helpful today as our three workgroups report out, because we were able to have presentations that directly connected to the work of our three workgroups.

So we had a presentation on rural health, and the work there, as well as preconception and interconception care, and then social determinants of health. And speaking of social determinants of health, several of us were able to go on the social determinants of health tour this morning.

And thanks to Generate Health, to Rose, and the rest of the team. We got a little shock while we were out on the tour, an unexpected accident that we were almost in the middle of, but fortunately we had some doctors with us that quickly jumped out of the bus that we were on to check to make sure everyone was okay.

But I think it was, you know, it was a little traumatic for us, and I think all of us starting thinking about the trauma for the individuals that were in the accident. And so I think that again reminds us of what our families that we are working with, the families that we're trying to support to improve outcomes, what their daily lives are like. And I think the social determinants of health tour helped us to see it in real time.

You know, I think all of us talk about social determinants of health, but to be able to go through a community and see the difference between one side of the community versus the other side, where you can clearly see the haves and the have nots. And so I don't know if there are any other members that were able to go on the tour this morning if anything resonated with you.

I know Phyllis talked about, you know, she could have closed her eyes, and it reminded her of Baltimore, and what was

happening in Baltimore, and I think many of us thought about, you know, these are all communities that we live in, where this could have easily been the same story for us. Any thoughts from anyone?

STEVEN CALVIN: I appreciated the tour too, and I would think it was discouraging for me because I was around St. Louis 45 years ago, and it doesn't seem to have changed very much, which is discouraging, but I think there have been changes and we should be encouraged by that too.

BELINDA PETTIFORD: Thank you. That's right, Steve was able to share he was at the hospital—he had worked, or you did your internship, no your fellowship?

STEVEN CALVIN: It was medical school.

BELINDA PETTIFORD: The medical school—part of his medical school was at the----

STEVEN CALVIN: Homer G. Phillips Hospital.

BELDINA PETTIFORD: Homer G. Phillips Hospital, which was the Black hospital at that time that later closed. Anyone else? Don't want to cut any of the members off.

CHARLAN KROELINGER: I have some thoughts from yesterday.

BELINDA PETTIFORD: Sure. Please, Charlan.

CHARLAN KROELINGER: Thank you so much. Charlan Kroelinger. Belinda, I just wanted to thank you and the Planning Committee for putting together the panels yesterday. It was important to hear from the community level, the city, the county and the state, and I think also more importantly to also to see

those recommendations from those groups at those levels. I think that was very powerful and will help the Committee inform the recommendations moving forward, so thank you for that.

BELINDA PETTIFORD: Thank you so much, Charlan, and I must give Vanessa and Sarah much, much credit for all of the work they were doing in front and behind the scenes, and reaching out to people that we thought would really be helpful to hear from while we're here, realizing that we opened this, it's a public meeting, and we open it to everyone, but I totally agree with you.

And I think one of the things that we did ask all of the speakers is tell us what your recommendations are because we are here to listen. And I think that's real important. Yes, Vanessa?

VANESSA LEE: Thank you, Belinda and Charlan, and others who have made those comments, but I also have to credit Kendra—not sure if you're still in the room--and her team at Generate Health really connected us and did a nice warm handoff to the local health department leaders, and many others in town as well as ShaRhonda, so thank you all.

BELINDA PETTIFORD: Thank you, Vanessa. I don't know, can you all hear me if I don't have the microphone in my hand? For those sitting around the table, I'm thinking about those online, so. Wonderful. Okay. All right then, and thank you Maria. I do think we have -I'm- checking to see.

I think we have another one or two members that were not here yesterday that are ex-officios, so we will give----I see

Karen Remley, you've joined us today. If you would like to come off of mute and introduce yourself that would be great.-

KAREN REMLEY: Hi. I'm Karen, excuse me, sorry. I'm Karen Remley, and I'm the Director of the National Center on Birth Defects and Developmental Disabilities, and I look forward to listening and learning, thank you.

BELINDA PETTIFORD: Thank you, Karen. It looks like you're getting your steps in on the meeting.

KAREN REMLEY: I am actually on a walking treadmill, exactly.

BELINDA PETTIFORD: Thank you so much. Did we miss anyone else? That missed the meeting yesterday?

VANESSA LEE: Felicia Collins, who will also be presenting.

BELINDA PETTIFORD: She’s presenting? Sounds good.
VANESSA LEE: She is. She’s also ex-officio. She is.

BELINDA PETTIFORD: RDML Felicia Collins, I see you. Do you want to come in and introduce yourself?

FELICIA COLLINS: Hello everyone, good to be with you. I am Felicia Collins, and I have the pleasure of serving as the Deputy Assistant Secretary for Minority Health and the Director of the Office of Minority Health, and look forward to sharing a little bit more about the work of our office in a few minutes.

BELINDA PETTIFORD: Wonderful. Thank you so much. Appreciate you both joining us today. And if I miss anyone else, raise your hand and let us know now. Come off of mute and

introduce yourself. Okay then, so no other things, any impressions from the social determinants of health tour?

Again, I think we clearly could see in communities where transportation will be a barrier for individuals, where food insecurity could easily be demonstrated. I mean we were in the bus for quite a while before we saw any semblance of a store that you can get food, and at that time it wasn't even a grocery store. It was a gas station.

So, in some of the areas that we drove in it was very clear. And I think there were issues of just looking at how easily people might be depressed. I mean, we were in areas where you walk out your door and you just don't see any hope, I think is one way of putting it, because the homes around you are, some of them are dilapidated, and other areas.

And it may not be that you feel safe in your community. And I think we all saw that as we talk about social determinants of health, but being able to have Generate Health to actually move into an actual tour so you can observe it, and you can feel it while you're there.

And I think even when the person---the individuals had the accident, I think most of us on the bus, if not all of us, for a moment were a little concerned about our safety, and we don't live there, and we're concerned about safety. So if you think about how, you know, how families that we are trying to have an impact on what they're- living with every day, yes?

LEE WILSON: One of the things that struck me was,

while we were driving along we came down to the bottom of the hill, and there was a significant change in the architecture of the houses. They weren't any bigger, but you could tell that they were made in a different era. They were more clapboard material, so they had a brick foundation, and before all the houses were brick they were very small, looked very rundown. But then you moved to the other side, -at the dip in the hill, the houses changed. Some of it looked a little nicer, and some of it looked rundown. And Rose had said that prior to COVID it had all been sort of well maintained, and just the speed at which a community can decline, but then her other comments about the very slow- pace at which a community can recover.

And Steve, as you've just said that you know, 40 years on we have communities that are still where they were, and the comments that were made about Healthy Start and whether if we pull the funds out does it go back? I'm just very struck with the longevity of some of this.

BELINDA PETTIFORD: Thank you for sharing that, Lee. Phyllis?

PHYLLIS SHARPS: I also think it was important. I don't think we talk about this as much, but how even when Black and brown communities are affluent and flourishing, and are attempting to take care of their own, I think about the Homer G. Phillips Hospital, they built this beautiful hospital, and systems and political forces moved to take those things away from them.

They don't put back into the community anything that

would make up for, you know, the resource. And I'm reminded, I know we get impatient in the work that we do, but these systems, you know the poverty and the vulnerability didn't happen overnight. We're looking at hundreds of years of systems and policies that have created the communities that we're working with, so we are wanting to see change because we know people are involved and babies, and mothers.

It's probably going to take a long time, but I think we're at the stage where we really need to transform systems and system thinking and approaches to individuals.

BELINDA PETTIFORD: Thank you, Phyllis. And I think we talked a little bit about that on the tour, around the whole issue that we keep coming up with programs to help individuals. And if we don't address the system, we're going to always have to keep having programs to help individuals one on one. And our issues that we're dealing with around disparities are larger systems issues. And how do you move system change when you may not have political will supporting it? And so I think those are some of the issues that we continue to deal with, that we must be able to move forward, and we need to think about it as recommendations that we move forward to the Secretary.

What are some of the systems areas that we can focus on? Anyone else? Yes, Jacob.

JACOB WARREN: One of the things that struck me is, you know, my role is rural, and I constantly think about how we advocate for rural, how are we not leaving out rural, but it was

helpful for me to see this side as well, to make sure that I'm continuing to respect the unique needs of urban areas as well, as we think through the recommendations, because I always feel like it's you know, rural, rural, rural from my side.

You know, and I always have been saying that things in rural are different. Things in rural are different. Things in urban are different, and so just the helping reinforce the--as we think about urbanicity in geography is to make our recommendations, the importance of both sides of it, including those really unique things that happen in urban that don't happen in rural, so that was helpful to me.

BELINDA PETTIFORD: Excellent points. I was thinking the rural, because I think I mentioned it to someone. I think Vanessa when we were getting off of the bus. I think of the rural nature of my state is predominantly rural, of the isolation.

So you may still be dealing with food deserts because you can't get to them because you're so far away, but you may not have anyone living close to you, so then I pick up on the isolation side of it, which also can lead to depression and a host of other things, so thank you for bringing that up Jacob. Yes, Sherri?

SHERRI ALDERMAN: And to build on that it's---I also was thinking about the similarities to the space-based communities that we visited today and rural communities, access to health care, access to nutritious food, transportation and isolation that can come from being marginalized, and so it's,- -I- think that

there definitely are unique differences, and there are also similarities.

And I wonder if there is an opportunity to build a--some kind of shared voice,that you know, power in numbers, to be able to talk about, you know, some recommendations that would apply to both urban and rural areas too.-

BELINDA PETTIFORD: A very good point. Thank you. And speaking of our tour, we want to thank Rose who just walked in. Our tour leader, so thank you. So now we're going to move on to our agenda and go—we're gonna start with our federal updates. We have two updates that we're happy to have with us today. We have Rear Admiral Felicia Collins, who has already introduced herself.

She's the Deputy Assistant Secretary for Minority Health with the Office of Minority Health. And then right after Felicia, we have Kevin Koenig, who is with the Center for Medicare and Medicaid Innovation. And I guess specifically with CMS, and Kevin is in the room with us. So we're going to turn it over to you now, Rear Admiral Collins.

Federal Updates

FELICIA COLLINS: Well, hello again everyone. It is great to be with you virtually. Sorry that I can't be in the room, but this is the next best thing, and really interesting to hear your conversation about your social determinants of health

tour, and I hope you'll hear in the comments that I am providing how social determinants of health are a big part of what we are focused on within the Office of Minority Health.

Next slide please. As a reminder, as I describe myself in brief, I am a pediatrician by training, but I consider myself a public health practitioner at heart. And it really has been my privilege to have a career in the United States Public Health Service Commission Corps as an officer who has been able to focus on addressing health disparities in a variety of populations. Next slide.

For those of you who may not be familiar with OMH, our mission is to improve the health of racial and ethnic minority in American Indian and Alaskan Native populations through the development of health policies and programs that eliminate health disparities.

Now, we do not provide direct clinical services. We do not provide direct social services. Instead, you can think of us as a research and development shop for policy and program development. And we have a variety of functions, which were noted on the left-hand side of the slide. And all of those functions come together in what we call our unifying goal of SQPQ.

And that stands for the Success, Sustainability and Spread of Health Disparity Reducing Policies, Programs and Practices. And so once we identify a successful policy, program and practice for reducing or eliminating health disparities, we then work to support the sustainability of that policy, program

and practice to include seeking partnerships with other parts of the Department of Health and Human Services, and other partners that can support longer term implementation. Next slide.

Under this unifying goal we have three strategic priorities, and I'll note these priorities are not tied to a particular clinical, or a particular social area because that allows us to very easily integrate the clinical or social determinate of health area or other priority areas of Congress, the Secretary and others into our programmatic framework.

And so in brief, we prioritize supporting states, territories, and tribal organizations overall, in identifying and implementing health disparity reducing policies and programs and practices across varying areas.

While all health care workers play an important role in reducing and eliminating disparities, we are particularly interested in supporting community-based workforce members as a sustainable source of trusted messagers that can improve health outcomes.

And for this community-based workforce, I'm speaking of individuals that go by a variety of names to include community health workers, promotores de salud in the Latino community, and community health representatives in Indian country. And third, we promote culturally and linguistically appropriate services or class as foundational to all of our efforts to reduce and eliminate health disparities, and to promote health equity. -Next slide.

I do want to give a quick shout out to April being National Minority Health Month, and this is our annual observance within the Department of Health and Human Services and beyond to reflect on the health disparities that exist and persist for racial and ethnic minority and American Indian and Alaskan Native populations, and to encourage everyone to take action to end these inequities, including those related to maternal and infant health.

So I encourage you, if you're not already familiar with our efforts, to learn more. Visit us at minorityhealth@hhs.gov to learn more. Next slide. So moving to maternal health. I want to first describe, if you will, I wanted to first lay the foundation in terms of who OMH is, if you will, and how we structure our work. But I also want to provide you with some additional information that provides, if you will, the scaffolding upon which our maternal health activities rest.

And so, indeed, one of our top programmatic areas is maternal health, in alignment with data that depicted disparities for Black and American Indian and Alaska Native communities. Next slide please. As you likely know, Healthy People 2030 provide us with national objectives and data for both infant and maternal deaths within the U.S. including data stratified by race and ethnicity.

And while the rate of infant deaths overall improved over the past decade, the maternal death rate did not improve, and unfortunately disparities across populations exist for both objectives. And so, I just use this as a data-informed way of

just commending the work of this group that is squarely focused on a very, very important area of health outcomes within the United States. Next slide.

I also presume that you are familiar with the White House blueprint for addressing maternal health, and as you likely know the blueprint outlines five focus areas to address maternal health that include increasing access to comprehensive maternal health services, ensuring pregnant and post-partum women are heard and are decision makers in their care, advancing data and research, expanding the perinatal workforce, and strengthening economic and social supports.

And I hope it will be evident through the next several slides that OMH's programmatic work is aimed at addressing material health disparities in alignment with many of these blueprint focus areas. Next slide.

So in the area of grants, in September of 2023 we were really pleased to be able to award over 13 million dollars in grants to 11 organizations that are developing models for integrating community-based maternal support services into perinatal medical systems of care.

And there was some conversation earlier about the importance of addressing systems of care, and so we were very intentional about wanting, bringing the concept of social determinants of health because these community----these community based maternal support services are social and supportive services that address social determinates of health, to help improve health

outcomes.

And we were very intentional about the idea of creating models that integrate these important services into existing medical care systems. Next slide.

In support of culturally and linguistically appropriate care in maternal health, we have a maternal health e--learning program that's part of our broader OMH cultural health suite of e-learning programs. And in the case of the maternal health program, it is a free two hour program that's designed for providers and students seeking knowledge and skills related to cultural competency, cultural humility, person--centered care, and combatting implicit bias across the continuum of maternal health care.

This slide includes some metrics regarding FY 2023 program completion and continuing education credits that have been awarded. But I also want to note that we were able to do analysis of program data that found that the average user scores on a post-test were statistically higher than their pre-test scores, so that was suggestive of positive knowledge gain.

And in addition we had a majority of users that agree that the program was an effective tool to increase knowledge of cultural and linguistic competency, they noted that they would recommend the program to a colleague, and they stated that they would incorporate the information they learned in their daily work. Next slide.

In case there's anyone that's not familiar with these

national standards for culturally linguistically appropriate health care, or health appropriate services, and health and health care which we say national class standards for short. I just wanted to share this information and the reference with you.

This is the structure by which we, in the Office of Minority Health operationalize the standards, which are a set of 15 action steps intended to advance health equity, improve quality, and eliminate health care disparities by providing a blueprint for individuals in health and health care organization to implement these culturally linguistically appropriate services.

You'll note that the standards are structured to include a principle standard that serves as the foundation for all other standards, and that principle standard talks about the importance of providing effective, equitable, understandable and respectful quality care and services that are responsive to diverse, cultural health beliefs and practices, preferred languages, health literacy and other communication needs.

The remainder of the standards fall under the three things noted on the slide, which are governance, leadership and workforce, communication and language assistance, and engagement, continuous improvement and accountability. Next slide please.

The last OMH initiative I want to highlight is focused specifically on disparities within American Indian and Alaskan Native populations. We, within the Office of Minority Health, were so excited to be able to partner with the Centers for Disease Control and Prevention, the CDC Foundation, and Merck for Mothers

in creating the Hear Her Campaign for American Indian and Alaskan Native Communities.

And this campaign, the whole goal of the campaign is to amplify the voices of American Indian and Alaskan Native women who have experienced complications during or after pregnancy, and that's one, and to provide information to all on urgent maternal health warning signs.

And then three, if you will, to provide guidance to providers on the importance of culturally and linguistically appropriate care within this population. So through the campaign, American Indian women share their experiences. They speak out about their needs, including, again, a discussion of the importance of culturally competent care for optimal health and wellbeing. -Next slide.

So this is the website and I encourage you if you have not visited this website, you can get there easily if you Google Hear Her AIAN, you will find the website. I encourage you to check it out if you haven't done so already.

The testimonial videos of the women are very, very powerful, and we just were very honored that we were allowed to speak with the women, to have video on their tribal lands and to learn from them, so that we can help to improve health outcomes for American Indians and Alaska Natives. Next slide please.

In closing, you can see that a big part of what we are focused on in the Office of Minority Health in partnership with our other sister agencies, is thinking about social

determinants of health.

And we are convinced that we have to collectively address social determinants of health, including culturally and linguistically appropriate services collectively, in order to address infant and maternal health disparities, and thus the Office of Minority Health works with cross sector partners to share information and to promote actions doing just that, addressing social determinants of health.

And we remain committed to identifying and disseminating national, state and local efforts that effectively respond to social determinants of health in order to improve health outcomes for the populations that we serve. Next slide please.

I do hope that you will stay connected with the work of the Office of Minority Health related to maternal health outcomes and other areas of racial, ethnic and tribal disparities, and you could do so via one or more of the channels or platforms noted on this slide. So with that, next slide please.

Thank you so much for the opportunity to share the work of the Office of Minority Health, and I will turn it back over to the meeting moderator. Thank you.

BELINDA PETTIFORD: Thank you so very much, Felicia. We appreciate that. Are you going to be able to be around a little while, so we can get--in case people have questions, or do you have a hard stop now?

FELICIA COLLINS: I'm gonna----I can stay for another

15 minutes or so, and then I'll be in and out during the course of the day.

BELINDA PETTIFORD: Okay. Well, we'll take five minutes now. Does anyone have any questions for Rear Admiral Collins at this time? Any questions? Any of the Committee members?

STEVEN CALVIN: So, I guess we can hear from here?

BELINDA PETTIFORD: Yes.

STEVEN CALVIN: So yesterday we had a presentation about the increasing rates of syphilis, particularly in Native populations. And Ed Ehlinger, our prior Chair wanted to point out too, just, you know, some of the causes for that related to, what's the--is it Missing and Murdered Women and Girls? Sort of the information of the trauma that a lot of Native women have experienced, so he just wanted to make sure we pointed that out, and I think there was a lot of work on it, with some previously Committee members in that regard.

So do you have any comments about the increasing rates of congenital syphilis, and kind of what your office is focusing on in that regard?

FELICIA COLLINS: So thank you for that question. Yes, many of the efforts are being coordinated—well, I'll say it this way. There are efforts across the whole Department of Health and Human Services in this area, with a lot of them being driven by the Centers for Disease Control and Prevention.

And there's a large coordination effort by the

Assistant Secretary for Health, Rachel Levine, so OMH is absolutely engaged in these efforts. A lot of what we are working to do is to figure out how we can support information and resources actually getting to communities, and that's where I often see the gap.

And so, recently we've had some conversations with colleagues at the CDC and other colleagues that have funding for community health workers, and how can we better engage community health workers in this space? We are working with our colleagues in the Office of Regional Health Operations and the Office of Assistant Secretary for Health.

We have the opportunity to fund one position in that office in each of the ten regions that's focused on minority health. So we have them working with their state and regional colleagues to assess what are the issues that are primarily driving the increased syphilis rates, and how, and to get the feedback, so that we can better think about how we can support those efforts.

And then with our existing grantees, those related to the perinatal health grant that I mentioned, and even others, we are working hard to provide them with resources and information, so that they can support efforts to reduce syphilis, primary, secondary and congenital syphilis, knowing that many of the organizations that receive grants actually have --work in areas that go beyond maybe our grant program, so we may have a grant program if you will, in the area of mental behavioral health.

But that may be one of the areas in which the grantees, which the organization is engaged, and so we're trying very hard to share information broad and wide with all that we work with, and are in contact with.

STEVEN CALVIN: Thank you.

BELINDA PETTIFORD: And thank you so much again, Rear Admiral Collins. I'm sure we're going to want you to come back at some point and give us some more information on the perinatal health initiative, because it directly relates to the work we are doing here. So thank you. I hope you can stay as long as you can. Thank you so much.

FELICIA COLLINS: Thank you.

BELINDA PETTIFORD: We're going to change focus a little bit. Kevin, if you don’t mind. We are fortunate to have with us a HRSA Administrator, Carole Johnson, who is able to join us for a while. I want to be able to hear from her.

Health Resources and Services Administration (HRSA) Remarks

CAROLE JOHNSON: Thank you so much, Belinda. I want to say two things to start. One, Rear Admiral Collins is an example of what great civil servants look like. We are so fortunate that people like Felicia, choose to make federal government service what they do, because she made a huge difference over the years.

Also, I love to pretend I'm Michael Warren. So I want

to start by just telling a story if I can, which is when I first started working in the space of maternal and child morality,- probably—are we good? Probably, I don't even know when this was. It was a long time ago. I read all the AIM reports, and in your old reports there's- a recommendation to the Secretary that Medicaid should be expanded for 12 months post-partum.

Probably the first place anyone anywhere had made that recommendation. And then I became the Human Services Commissioner of New Jersey, and we filed to extend benefits for twelve months postpartum. -We think we were the first, CMS says we were second.

But anyway, the seeds of that were in your recommendations, and so I have benefited from you all thinking big, and welcome the opportunity to encourage you to think big, and tell us what's on the horizon and where we should be going because the fact that now almost every state has done that is because of the seeds of the work that this Committee has been doing for years, so thank you for that.

And like let's keep up the charge, right, in terms of pushing forward. I will say, you know, we're very excited about many things that have happened, you know, the President laying out a blueprint for how we tackle the maternity health crisis. The Vice President convening the first ever cabinet meeting on this topic, where it wasn't just all of us from the Health Department. We are necessary, but not sufficient.

It was also, you know, the Secretary of Housing sat next to Secretary Becerra. The Secretary of Labor sat next to me,

and you know it was all of government because that's what we need. Social determinants manifested at a government level, means labor and housing and transportation and VA, all need to be at the same table with us because there's so much we can do, but there's so much more that we can do when we do it all together.

And that was her charge to us. And so that's why you've seen increasing investments from us on the HRSA side because the President has pushed to say what more can we do? What does it look like? What are the contours of that? How do we get that in the budget?

How do we fight for that in Congress? How do we continue to expand? And that's why we're investing in doulas and more midwives, and really thinking about the workforce, and spending more on loan repayment for OBs to practice in historically underserved areas, in rural communities.

And really thinking about how do we use our health centers that are in high need communities across the country to better expand maternal health care, and so we put dedicated focus grants that- were pretty sizable for the kind of ways we do this work. -Pretty sizable grants on quality improvement and expansion of services.

And we just heard this morning from one of our health centers talking about how that allowed them to launch a midwifery program, or another health center where that allowed them to really build community health workers who were specific to maternal health care, who really are in that first visit are part

of that journey with pregnant women and new moms.

And so, you know, we are thinking about all those places where we can use our current levers, and then the places where there's opportunity for growth and new things. So you know, we launched the Maternal Mental Health Hotline, which I know you all know well, and this is the stories that we hear from callers to the hotline are just amazing.

It's so clear the need is out there. It's so clear that mental health is a huge gap in all the work that happens here, that's why we're expanding our maternal depression program into more states. Missouri just got our most recent grant on that, and to do tele-consultation for OB's and midwives to get direct help from psychiatrists and psychologists.

We have with, you know, the help of the voices of everyone who advocates in this space, we worked with Congress last year to create a path to double the funding in home visiting. That's going to be $400,000.00 more dollars in Missouri this year than last year.

You know, we're doing those things. And we're trying to build what we have, and then think creatively about what's next. And so, what you see in the President's budget for '25, is us saying a couple of things. One, we've heard repeatedly from health care systems that part of the reason why L&D services are closing is because they aren't enough L&D nurses.

Now, is that the only reason? No. But it is part of the reason, and is what people point to, so our budget invests in

training for L&D nurses. Two, you know, we really think we need to have a strategic focus, and this is where I think the Committee can be really helpful to us on what does access look like as hospital consolidation happens?

What, -how do we ensure that there are labor and delivery services in reasonable geographic distance all across the country? You know, I mean March of Dimes calls them maternity care deserts. -You can call them all kinds of things, there are gaps out there, and they are not just in rural communities anymore, right?

They are in exurban areas, suburban areas, there are large urban areas where it's hard to—-like, how do we think about the dynamics around what service delivery needs look like, you know. There are folks who argue that there should be more birthing centers. There are folks who argue that, you know, maybe the- standalone rural ED models should include labor and delivery.

Like there are lots of ways we might solve for this problem, but we have to solve this problem. And your thoughts and ideas about what some of those models might look like I think would be incredibly helpful to us. I suspect my colleague from CMS will talk a little bit about how the Innovation Center at CMS is really leaning into testing new ideas and new models as well.

So I think there's lots of, --there's nothing but interest and opportunity from this administration in what we can do here because we know when we walked in the door and saw the data, you know, in this administration, when we walked in the door

and saw the data about us being, you know, nearly at the bottom of developed nations when it comes to maternal mortality, we said we have to change this.

And that's why you're seeing this across-administration response. I will say, you know, the headwinds are strong. This year the House of Representatives Appropriations Bill proposed zeroing out our Healthy Start Program. Thankfully, the final bill didn't do that, but that's an indicator of sort of the larger environment.

And so, the work that you all are doing to put thoughtful and consensus recommendations together that build on the evidence, or honestly just are built on evidence-informed ideas, like something I think evidence-only can take us down a road of doing what we've always done.

So, you know, where are the seeds of new ideas, and where are they showing promise? And how do we build on those initiatives? Your voice can make a huge difference in this conversation. We're going to spend a lot of time on the Hill convincing people so that we don't lose grounds.

But we also want to use that time to be fighting for what we need going forward. I will tell you the one other thing that we have in the President's budget that is really,- it's frustrating that we had to do this, but we felt like we did, was say okay, we spent a lot of time trying to focus on getting labor and delivery services that are, you know, that adopt aim that are well focused on high- quality-, et cetera.

If those services are going away in some communities, where are those deliveries going to happen? Some of them are going to happen in the ED, so we need to make sure that some of that expertise transfers to the ED, and we do that kind of training and support in EDs across the county.

And so, that's in our budget this year too, is to try to think about how we build some of this capacity in emergency departments because we're going to see more deliveries in emergency departments. And that's not just about labor and delivery, that's probably about the end of Dobbs.

Like there are things that are happening in the larger environment that are going to impact what service delivery looks like going forward, and we need to be thinking about it, and prepared for them. And those are sort of the, today, interim steps.

What's the bigger process look like going forward, and the landscape look like going forward where we can ensure access comprehensively, not just leveraging our health centers, which we need to continue to do, but also what else has to be out there so that we have all the opportunities for everyone to get the services, the highest quality services that they need.

So with that, I'm happy to take questions or comments. But thank you all for your work, and for spending,- I know it takes a lot of time to be part of a Committee like this, but we really value your input and your voice in informing- what we do.

BELINDA PETTIFORD: ShaRhonda?

SHARHONDA THOMPSON: Okay. I'm ShaRhonda Thompson. I know they said say your name, right?

CAROLE JOHNS ON: ShaRhonda, do you think I don’t know who you are?

(Laughter).

SHARHONDA THOMPSON: It's ironic that you brought up health deserts I guess. I was talking to my husband on the way home last night, and I was like it's ironic to me that we're inside of an old hospital, right, but when you look at the area around, there's no other hospital that's anywhere near, and we're talking about, you know, making health accessible.

And I'm like man, we're inside of a building that used to service the people in this community who no longer have that access, so for me it was just an eye-opening realization. I was just like, oh when you think about it it's kind of sad.

But so, that was kind of on my mind as well. But when you say labor and delivery nurses, right. I know we've heard a lot how difficult it is to get Medicaid to pay for doulas and midwives. Is it some way that they can fit under the umbrella of the labor and delivery nurses because they will essentially be able to do that for their patients.

CAROLE JOHNSON: Yeah, yeah. It's a great point. So we think we need all of the above. We need more labor and delivery nurses, but we also need to be training more community-based doulas, right? And then we need,- to me a success for a program like that, for HRSA, is we train and build the model for

how to recruit people into the field of being community-based- doulas.

Build the training so people can get an accreditation and have something to demonstrate for it, and then we work, -and then, you know, what we did in New Jersey was we funded that for a few years, and then we built a Medicaid benefit so we could pay people, but the community based d-oulas were at the table when we tried to figure out how we design the payment and what the service looked like.

Now, I mean, are there people who still wish we paid more? Of course, but unless you're actually thinking about that sustainability part of it, then we're missing part of the equation. My view, and again, this is a place where I think this Committee can really help us is how do we make being a community-based doula a job, right?

Everyone you meet in the community still has three other jobs. We know how valuable it is. When you're a labor and delivery nurse, you're a labor and delivery nurse. Like how do we make it sustainable, so that it's a career path that we can get people on, and help them help us solve for this problem? Thank you.

BELINDA PETTIFORD: Anyone else?

STEVEN CALVIN: Steven Calvin. I'm a maternal fetal medicine doctor that works with midwives, and an advocate for what you're describing. I'm just really encouraged to hear you're already knowledgeable of it. It's like you've been listening in

on many of our Subcommittee meetings.

(Inaudible).

But no, it's very encouraging. I mean you're thinking broadly, you're thinking of all the things that are going to bubble out of here.

CAROLE JOHNSON: I very much appreciate you saying that, but I would----I would welcome your thoughts and ideas because as much as we as a collective are thinking about this next generation of models, we still have places where the, you know, the OB and the midwife, and the doula are not a care team, and how do we build through that I think is part of our challenge.

STEVEN CALVIN: It's doable.

CAROLE JOHNSON: Yeah. I think that's right. There’s some big, successful models out there, but there are also places where, you know, when COVID happened, and we tried to put doulas on the access list, you know, there's a lot that we have to break through still, and your voices matter in that conversation, so thank you.

KATHERYN MENARD: But no pressure, guys.

(Laughter).

BELINDA PETTIFORD: I just want to thank you.

UNIDENTIFIED: Marie has her hand raised.

BELINDA PETTIFORD: Marie!

UNIDENTIFIED: One of our other members has her hand raised.

BELINDA PETTIFORD: Yes, Marie?

MARIE-ELIZABETH RAMAS: Hi everyone, can you hear me okay?

BELINDA PETTIFORD: We can.

MARIE-ELIZABETH RAMAS: Excellent. Really great conversations and reflections. I wanted to add to the discussion about this comprehensiveness and holistic team approach with maternity care, and just want to encourage us not to forget family physicians that also deliver babies and provide comprehensive care for the birthing and infant dyad.

I think one of the difficulties that we've had in family medicine is just getting credentialed within hospital systems and being allowed to provide maternity care in a hospital system, and so I'd love for us to have inclusive language when it comes to that.

Many family doctors, in particular, in rural settings, provide necessary maternity care. I was one of them, and it was really heartwrenching for me moving from the west coast to the east coast because in the west coast I was, you know, doing very high level- surgical procedures for maternity care.

And you know, was able to save many lives as a result of that. But unfortunately, on the east coast, you know, hospital systems were not as welcoming of family physicians who provide higher level of maternity care in an inpatient setting, and so I was unable to continue my surgical obstetrics, despite the fact of having being able to take care of the largest geographic, you know, Cashman area in the State of California as a family

physician.

So, you know, that's another dynamic that I think we don't often consider, or have more opportunity to consider. One of the most enjoyable aspects of my experience delivering babies and taking care of babies and the birthing parent, was being able to do—be a one-stop-shop, and to work intimately with doulas, midwives, and my obstetrician colleagues as well.

But also be a linking point from the inpatient world of delivery to the postnatal aspect of delivery, and have that measure of continuity for patients. I think it's increasingly important when we're talking about health disparities, particularly for our Black- birthing patients and their children as well.

So I'd love for us, and we don't have a lot of information as far as, you know, credentialing is concerned, but certainly from an economic standpoint, we don't also have a lot of data that supports, you know, having family doctors, doulas, midwives and the value from an economic standpoint for hospital systems to encourage those positions as well.

So I think it's something that we need to consider, and I'd be curious to know if there are some case studies that can help us provide a, you know, what is the financial impact of having non-OB clinical supports and extenders for the birthing dyad, both peri-natally and postnatally, and how can we, you know, communicate that in a way that speaks to our policy makers as well.

CAROLE JOHNSON: It's such a fantastic point. I mean let's be clear. This is who is delivering babies in rural communities, right? Like this is what's happening. So offline maybe you could tell me about your east coast experience because I'd love to talk to our colleagues at CMS about how we fix that.

KATHERYN MENARD: CMS, that’s your job.

(Laughter).

CAROLE JOHNSON: Yeah, that’s how we—together. But, I think this is, you know, obviously like in the National Health Service Corp., we count family medicines who deliver in our maternal health loan repayment programs, that's an eligible category. This is what we see in all rural communities. I will tell you we have some trouble on the data. We have some trouble accounting family med doc's who do OB.

Like that--it's hard, and as a consequence it's harder for us to tell the story, so you know, to the extent the Committee can think it can help us think about how to do that because I think you're exactly right. That has to be part of the equation, and we have to make sure.

I mean frankly in the current restrictive environment for training in some states, you know, we're having a hard enough time getting OBs the full complement of training. You know in some states they have to travel out of state for certain training, and we need to make sure family medicine docs are getting that training as well.

BELINDA PETTIFORD: Wonderful. Thank you so very much. I was so happy to hear you're thinking about promising practices, not just the evidence. I knew you would, but I was just making sure. I'm on the same page with that because I think we're missing some opportunities if we only keep following the evidence because we don't take time to develop the evidence.

JOY NEYHART: I have a question to the point you were just making about having to travel for training, and then the restrictions that are happening in some states in terms of there are obstetric providers who are not willing to care for pregnant people until the beginning of the second trimester.

So is there anything that your agency is doing to brace for what will happen when these birthing people, or these pregnant people show up with terrible complications, and there will be a subsequent increase in mortality?

CAROLE Johnson: Yeah. I would say it's all sort of iterative in real time, as this is all happening, right? Like we're trying to work through the like helping the residents that we're funding now, make sure they're getting the full complement of training, even if they're in programs that are in more restrictive states.

We're trying to figure out, like, how to make sure our health centers that are not -- sometimes they get money from the states, sometimes they don't, so they're federally funded, and they get, you know, what are the opportunities to make sure that, you know, we're getting prenatal care there as early as possible,

engagement as early as possible.

We obviously at health centers do,- we provide the protection for all the providers in health centers, so thinking about how we use the footprint in network that we have, but no one would say we have all the answers because we're like all living this in -real time.

JOY NEYHART: Thank you.

BELINDA PETTIFORD: Well thank you so much for joining us. We know you're going to have all day to hang us with us, but we do appreciate you joining us for whatever time you could be here.

CAROLE JOHNSON: Thank you, we really enjoy it. Thank you for the work you're doing, and for spending time on this Committee. I know it takes time away from your fulltime jobs, but it's really, it's- such a public service, so thank you all.

BELINDA PETTIFORD: And now we're going to transition to you Kevin. You have assignments already before you can get into it.

(Laughter).

KEVIN KOENIG: Should I go up to the podium?

BELINDA PETTIFORD: Wherever you're most comfortable.

UNIDENTIFIED: You can stand there, or you can sit here, and I will move over there.

BELINDA PETTIFORD: Or you can sit there.

KEVIN KOENIG: I can sit next to Vanessa because she's a lot more friendly.

BELINDA PETTIFORD: Whatever angle is best, probably where you are, or at the podium. So for people online, I don't know that they'll be able to see if you stand up there.

KEVIN KOENIG: Okay. Well, everyone can hear me I imagine. So great to be here in St. Louis, just six blocks from where I live, so you all traveled a long way to get here, but I- --just a few minutes for me. I'm Kevin Koenig. I work at the CMI on the Center of Maternal Health for TMaH Model, and I'll- walk through our slides here, next slide please.

So let me start by providing a birds-eye view of TMaH. So this is a ten year- model for states where we'll help them develop a whole person approach to pregnancy, childbirth and postpartum care.

We'll provide TA, technical assistance, and resources to up to 15 states, 17 million dollars over ten years to 15 states to help them improve the experience of patient care for their population, reduce avoidable adverse outcomes, and increase access to midwifery and doula services, among other goals. Next slide.

So, Medicaid agencies are obviously the recipients, but they're going to be working very closely with managed care organizations, as well as providers, health systems, birth centers, FQHCs, tribal sites, you know if a state applies and partners with tribal sites.

The ten year model is broken up into two pieces, so there's a three year pre-implementation period where we'll provide

one on one rigorous policy and analytic TA, and then a seven year implementation period. So, in subsequent slides I'll break out what that TA looks like. Next slide.

The 17 million can be used by states to support Medicaid staff, IT infrastructure, training, partnership development and other precursor steps. Next slide.

So, I'll get into the model elements. I know I only have around ten minutes total, so I'll go through a lot of slides. I want to save some time for questions for us today too. Next slide.

So, you'll see there's a lot going on in this slide, but the bullets that are bold, or filled in. Those are required elements, so those are part elements across three pillars, whole person care delivery, access to infrastructure and workforce and quality improvement.

States have their own context and population health needs, so we also are providing optional elements. And you can see, you know, what was discussed earlier, like CHW, so some states are considering perinatal CHWs, we want to provide TA for that, or rural partnerships to improve maternal health outcomes, you know, in areas that are lacking access to care.

So, we'll work—and -it's so great to have our HRSA colleagues here where we're communicating about their funding opportunities and synergies with TMaH, and lots of lessons learned from their own great work in the space. So- you'll see, and I'll go into these elements in a little more detail and the technical

assistance available, or examples of that in subsequent slides.

But you'll see that these required elements and optional elements cut across both workforce, you know, increasing access to midwives, doulas, improving the data exchange and data infrastructure for states, and also with community partnerships, and community-based organizations that support social determinants of health.

And we're also trying to help advance inpatient safety protocols in hospitals that there's evidence base that these do lead to better outcomes for birthing people and infants. Next slide please.

So, I won't read through every bullet on here. These slides are also available on the TMaH website. And they might be also available via this Conference here, but I wanted to provide a little bit of examples of the types of technical assistance available. So again, I mentioned a rigorous one on one TA will have. subject matter experts to support the states, and we'll help states look at their midwifery workforce capacity and reimbursement rates. You know, it was discussed earlier as we want to make sure that we're reimbursing providers for, you know, the work performed and it's sustainable that it's something we can pull in and increase and broaden the maternal health workforce, so we're going to be doing that for midwives, looking at reimbursement rates for birth centers.

Helping states cover doulas, you know, lots of states, around 11 states now, cover doulas in Medicaid. But states that

have not yet, what does the set of benefits look like? What do reimbursement rates look like? There's a great brief that was about, you know, doula coverage, and Oregon for example, has increased their rate, Rhode Island has increased their rate to make it a little more sustainable, and pull in doulas into the Medicaid workforce.

Also, standing up doula advisory councils. Two states thus far have doula advisory councils to provide education and training for doulas to be Medicaid providers. That's not an easy thing to do if you're new to Medicaid. How to enroll, what does building look like? When do I get payments, you know, based on my services?

So, we'll provide support there. I mentioned data infrastructure, so linking Medicaid and bio records data, that helps us look at, you know, parent infant dyad outcomes, as well as linking administrative data with WIC and SNAP data, so we can more auto-enroll for eligibility purposes-.

And then developing a payment model, which you know, is no easy fee. I'll have a few slides coming up on that. Next slide please. Quality improvement, I mentioned the inpatient safety bundles, so we're having meetings with HRSA, and in connection with the CDC, and ACOG on supporting relationships with perinatal quality collaboratives in states.

And states have their own set of data and what types of inpatient safety protocols are important for their states, so we'll support them in those initiatives, and then attaining the

birthing-friendly hospital designation as that continues to evolve. Next slide please.

This last one, remote patient monitoring or home monitoring for diabetes and hypertension. Not all states cover this, so we'll help states cover this in the Medicaid program. Also work out the designed implementation of this, what does it look like? What's working? Some states are already, you know, on the path to doing this pretty well, so we'll take lessons learned from them.

And then this large section, risk assessment screening referring for depression, tobacco, substance use disorder, health related social needs. We want to make sure that we're screening and having follow-up for all of- these conditions, or scenarios.

Some states have a good screening regimen that they do. We'll help states thing about how to do that, best practices for it, what does follow-up look like. And finally, developing a health equity plan and that is a big piece. That really cuts across all of these pillars.-

States, many states are already advancing health equity, and it really starts with data collection. How can we collect and stratify demographic data to look at subpopulation outcomes, and how are performance and quality measures varying across a population? -

So we want to reduce those gaps, and so we'll work with states on development and design of a plan, and implementing that plan. Next slide please. I'm going longer I think than ten

minutes, so let me know if I need to move more swiftly. The optional TMaH elements, again these are ones that states can elect to receive technical assistance on.

You'll see there's a mix of workforce. Not all states cover CMs or CPMs, that's a midwife, a free credential, perinatal CHWs, and we'll also create regional partnerships for improvement on the health bill. We would love for states, especially, you know, a lot of states have rural areas that there's maternity care deserts, so we'd love to partner with HRSA, you know, for states that elect to do that.

And there's others here that, you know, for states that aren't covering, for example group perinatal care, there's evidence that that can be very effective, especially if it's a hybrid format, some in-person, some virtual, and maybe formed around certain common themes. Next slide please. Next slide please.

So I mentioned the technical assistance, and I'm selling that because that's such a valuable thing. It's one thing to provide funding. It's another to provide that one on one, week in and week out over three years, you know, tailored assistance, both policy and analytic, to move the needle.

So we'll help doing a payment analyses for reimbursement rates, so we'll help collect data, look at benchmarking, look at----we'll be doing a little bit of a needs assessment for that state, where they're at, and where we want to get them based on milestones that will be in our note flow for

each of these elements.

And guidance to engaging CBOs to address HRSNs or SDOH needs. And then there's a wraparound case studies, learning, peer to peer support that will also be available. States love to talk to other states about what's working or not working, so we'll foster that. Next slide please.

Okay. I mentioned the payment model earlier, next slide please. So, we've looked at the literature on this and what states are doing. You know, there are some states, New Jersey for example have the perinatal episodic care model. We've looked at other states payment approaches.

But what we want to do is have a road map or a glide path to a sustainable VBP and we have a model that we think is going to work for the states and our cohorts. So we'll start with a portion of the cooperative agreement funding, a portion of that 17 million. We'll go to providers that are participating to pay for a set of activities.

Now I'll go--on a subsequent slide I'll list what those activities are. Year four we'll have upside only short savings based on a set of quality measures and a cost benchmark. And then we'll be working with states on, then, the design of a longer term maternal health value based payment strategy. So I'll get into each of these phases in subsequent slides. Next slide please.

So in model year three a portion of the cooperative agreement, or COAg funding, will go into a set of these requirements or activities for participating providers. So we'll

have certain patient safety initiatives that will be required, team-based care. Obviously, quality measure report, and we want to be able to track data on a set of consistent and common measures across states.

Data integration I mentioned earlier that we'll be supporting states and linking Medicaid and Vital Records, but also providers sharing data with one another and with CBOs. You know, we want to have bidirectional information exchange, enhancing access to care, so ensuring that you know, there's a greater ability to receive care for prenatal delivery and postpartum period, and in connections with CBOs.

We put a lot on the CBOs shoulders, you know, when it comes to addressing health-related social needs. We want to make sure there are connections, and in work with the states and the managed care entities on how do we support that, and how are they being compensated for addressing those, you know, food insecurity, housing, transportation, and other needs. Next slide please.

I'll go through the next slide because I think I'm running a little bit long, but I mentioned model year four will have, states will provide performance payment on a set of these quality measures here. These are subject to change, but these are the ones we're digging into, and then a cost benchmark. Next slide please.

And I mentioned the roadmap to value, so we have an internal process where we'll be, --CMS will be leading, but we'll be working with states, keeping an eye on the literature, looking

at the data coming in, and constructing a VPM model, you know, including, exclusion criteria, types of providers, types of prospective or retrospective payments.

What do we think is the best package long-term for a VPB approach, so we'll be coordinating and partnering with states on that. Next slide please. Next slide please. Next slide please. Okay. So that was a lot of info, but we have fact sheets and overview slides on our website, but what we're running now, we're- working on the notice of funding opportunity, which will be released in the spring.

Applications we'll be doing this summer, there will be a review then, and we hope to have that ten year model start, January 2025 is our goal. Next slide please. Visit our website. We have an email inbox that I and others monitor, TMaHmodel@TMS.HHS.gov, please send us any questions. We'll get back to you.

We're hearing a lot of interest from states and others, so we're hoping, you know, we're able to work with as many states as we can, you know, for this TMaH approach. I'll take any questions. Yes?

BELINDA PETTIFORD: I see hands going up fast.

JACOB WARREN: So I did have a quick question. Thank you for this program, and I think it's going to be revolutionary. I think it's wonderful to be involved in. I might be wrong. I might be the only one here from a non-e-xpansion state.

So as we're looking at implementing these really robust

programs and these opportunities, you know, from some of the data we're working on in our rural workgroup, 60% of births to rural Black mothers have been in non-expansion- states.

So how will this opportunity sort of help to support that given that I don't know empirically, but I anticipate those states are going to be less likely to pursue this funding because of the difficulty of wrapping around the services and supporting them long-term.

Has there been any thought given to how this rolls out different in expansion and non-expansion- states?

KEVIN KOENIG: Great question, and you don't have to be an expansion state to apply, but I hear your question is if a state, a non-expansion state may not be interested in this. This is a Medicaid model, and so a state does have to submit an application to receive funding.-

And I should have noted, or made it clear this model can be implemented statewide. A state can elect to implement it statewide, or in a region of their state. Some states may feel less comfortable rolling this model out statewide, you know, which I get. And also it's only 17 million. I say only, that's a considerable amount, but for a Medicaid budget that's not a ton.

We're hoping to you know even if it's a non-expansion state, this crisis really cuts across, you know, whether you are or not. And we'll work with states regardless of where they are to try to implement these sets of elements, and all of- these elements we think can help address the crisis.

So a non-expansion state may say let's try this out in this area of our state and see how it's working. I don't know if I got to your question, but okay.

JACOB WARREN: Thank you.-

KATHRYN MENARD: Two questions. One is--

BELINDA PETTIFORD: They want you to say your name, for transcription.

KATHRYN MENARD: Oh, Kate Menard, I'm a Committee member. Two questions, I wonder how many programs states you plan to fund, or if that's even determined? That's one question, but the more important question is I'm- from a state that recently transitioned to managed care.

KEVIN KOENIG: North Carolina or?

KATHRYN MENARD: Yes. And, so some of you know that we had pretty sophisticated statewide program for a lot of the things that you have on that screen.

KEVIN KOENIG: Yes. We started it. We liked it, yeah.

KATHRYN MENARD: And as I look at this I'm finding it hard to imagine doing those things with five managed care organizations. Can you help me understand, when you get the link, get these programs going, you've got metrics that are, you know, statewide, and you're hearing my grief probably too in the transition, because we're struggling now to really get the same kind of data, and population-based information that we used to have.

KEVIN KOENIG: Okay. Well, and it's different across states, you know, the relationship with the MCOs, their maturity or history of like a data pool, and how the data exchange is happening, and the counter data they're receiving from MCOs. We can, you know, our TA will help states. You know data is the bedrock of really these models because we have to both collect it for payment, monitoring and evaluation.

You'll see on my models there a really rigorous quantitative and qualitative evaluation. The MCOs in each test area have to participate. And the state medical agencies have the keys to that. You know, they with their MCO contracts, can direct them to participate and how they're going to participate within certain, obviously, zones.

But if a state is kind of newer to managed care we understand that, and I know our TA will help states. Our coach and our subject matter experts, we're also very closely linked with CMCS, same for .

I'm not sure if I got to your question completely, but I'm hopeful that our TA can help, you know, with that data exchange, and the types of initiatives that are required for TMaH.

KATHRYN MENARD: And the small piece was--how many?

KEVIN KOENIG: Oh, we will fund up to 15 states, yeah.

KATHRYN MENARD: Thank you.

BELINDA PETTIFORD: This is Belinda.

KEVIN KOENIG: Yes?

BELINDA PETTIFORD: I wanted to say, just--

UNIDENTIFIED: From North Carolina.

(Laughter).

KEVIN KOENIG: Okay, okay great!

BELINDA PETTIFORD: Yes, we're both from North Carolina. But my question is there around in order to be a successful applicant, what is the requirement around community engagement, or in the working with individuals with lived experience or Medicaid beneficiaries? Is there a piece for them in the application that says they must be brought to the table.

KEVIN KOENIG: So we had, you know, thought about that. There's a managed care rule that will require states. It's a proposed rule, and I haven't tracked exactly where it's at in review that will require states to set up their own beneficiary advisory group, and it's called a medical---don't quote me--but a medical assistance group to help to advise- the state on policies.

We didn't want to be redundant, so we spoke with CMCS about that requirement in our initiative versus what this managed care rule will require, but that rule would require states to do that. And we would support states, and incorporating beneficiary, you know, feedback in some of these initiatives.

We also have, you know, a doula advisory council requirement, or if a state doesn't have one already, which will include community representation, both doulas and others as part of that group. Certainly getting a beneficiary voice and lived experience in these initiatives, and how it's implemented is key, and states also will have processes to do that as part of this

managed care.

BELINDA PETTIFORD: Thank you. Anyone else have a question, anyone online? I don't see anyone, thank you so much Kevin. We appreciate it.

KEVIN KOENIG: Thank you for having me!

(Applause).

BELINDA PETTIFORD: Thanks a lot, and we do apologize for our next group of speakers because we are running late again.

But we are now going to move into our Black Women's Health Panel, and we're going to start with Kanika Harris. Kanika is coming to us with the Black Woman's Health Imperative where she's the Senior Director of Maternal and Child Health, Kanika.

Black Women's Health Panel

KANIKA HARRIS: Good afternoon. I don't know if everyone needs a minute to stretch or move around. It's been a minute. I'm flexible, so if you all need a minute. I see people kind of moving a little bit. I'm okay. I'm going to wait to see. L-et me know you guys, everyone is good? -Okay.

Good afternoon. I am here from Washington, D.C. Very happy to be here, right around the corner, happy to be a part of this conversation and hear this conversation as a public health practitioner on the ground, working to increase the perinatal workforce, focusing on prenatal health, and focusing specifically

on different pathways to really increase that perinatal workforce, with many, many legs and arms of impact as well.

So I am with the Black Women's Health Imperative as I mentioned. This is our 40th year anniversary. We started on an HBCU Campus, Spelman University, and our work is very rare and focusing on all things Black women's health. It was the first of its kind. I'm very honored to start and expand their maternal health portfolio.

And so in doing that, I wanted to think about what we saw, the White House blueprint, what was on the table, all the things we're talking about today. I can't see your name in the blue, but you talked a lot about there's so much access to information, and how do we get that information out right?

We also talked about this morning about Medicare expansion and what that really looks like on the ground. So a part of my role is also the health equity advisor for the Maternal Health Task Force of Maryland. And so with all of that information I looked at what does it look like to implement a full spectrum doula program, meaning from prenatal through postpartum, but also looking at the preconception side.

And with that preconception side, what's lacking in preconception health? How are young women thinking about preconception health? And mainly they're thinking about preconception health as a function of reproduction, as a commodity of their bodies. So how can we expand that in a way? Especially for young, Black women where it's not necessarily about my ability

to have babies later, but it really deals with my health along my life course.

Thinking about how social determinants of health affect your body along your life course, and how are you bringing all this information into a doula program, right, beyond this kind of didactic idea of you getting this information and being a practitioner for young Black women. It's so much more than that, and it has to be thought about as more expansive.

So with a grant from Kellogg, they really gave me the permission to think more expansively about what doula training looks like, and I will present that, and I'm very happy to say we also were able to get this program certified for Medicaid reimbursement by the State of Maryland. So next slide please. I know that was a lot.

So I'm just going to share with you a quick video to give you a feel and a tone of kind of like what we were able to produce over the last two years.

(Video played.)

I try to play this video any time I can because I spent a long time making it, so, but that just gives you a feel. That was played at the graduation of the first cohort that was piloted at Morgan State University. We can go to the next slide, sorry.

And when you think about maternal health you have to think about it really along the life course. You have to think about it, implement in conjunction with social determinants of health right where a mother is born, works, plays, worships and

ages. So we know it does not begin when she becomes pregnant, it's shaped by a lifetime of experiences and social conditions, which you all talked about on your tour as well. Next slide.

So thinking about where we are. Some of this was already discussed this morning. We were looking at preconception health as one of HHS's priorities. We already know the statistics as well, and you know, recognizing the midwifery and doula model as a lifesaving strategy, and how can we incorporate that into a HBCU model, and so I'll- go on to the next slide to explain that.

So this is what N.O.U.R.I.S.H. stands for, it's an acronym that stands for new opportunities to uncover our resources, intuition, spirit and healing, next slide. So why HBCUs? When we were thinking about when you expand the perinatal birth workforce who is kind of accessible and available to do that?

I know I look young, but I've been a doula for 20 years, and I graduated my training,- well not 20, almost 20. I graduated my training in 2005, and I'm retired now because I have three kids. And so, how I used to practice and do doula work, I can no longer do that anymore. But where- is a generation of folks that are inspired, that want to go into medicine, that are going to go into research?

Where is the largest number of STEM students in the country, when you're talking about dealing with Black maternal health, and those are HBCU campuses, but additionally HBCU campuses are predominantly underfunded. We don't have any

successful midwifery programs at HBCU campuses. The capacity a lot of times is not there.

We don't have schools of public health. That also leads to not having maternal health programs. Additionally, depending on the funding of the HBCU programs, reproductive health for those students is also really hard to come by. So that's why when thinking about something innovative, we were like let's focus on what's missing, and how we can transfer information at these universities, so next slide.

So our approach was really thinking about how you decolonize knowledge and information in a way that we know works for certain populations. How can you make culture change and paradigm shifts in ways that we know matter, that are usually not accepted in the norms and ways? You know, I would just say in American society.

Example, yoga, everybody knows what yoga is. Everybody practices yoga. It is a very spiritual ritual type of activity that has been normalized now in western society, right? How can we make more room for ways of healing, which I call the healing determinants of health as well, and ways of looking at how social determinants of health have already impacted these incoming college students?

They're already prehypertensive. -A lot of them are already prediabetic because of their exposures already, right? So how are we addressing those issues, making sure they're going into pregnancy healthy and not being blindsided, and also- decolonizing

information in a way that really works for them, and heals where they are right now, from a mental health perspective, from a physical perspective as well?

And again, expanding the legacy of Black midwives and doulas which we know was successful in some of the worst conditions, way worse than what we're experiencing now, right? Next slide please. So what is the N.O.U.R.I.S.H. experience? We also have to think about equitable doula training.

How do we remove barriers from doula training in terms of mentorship, support and finishing their certificate, support in terms of financial support, in terms of what do you need in your doula bag?

How are you going to have the money to get back and forth to see your clients, to finish your certification? We wanted to take all of those barriers out of the equation to make sure. It's one thing to train doulas, but there's a big gap between training them and getting them certified.

So we really have focused on the full spectrum model preconception, fertility, birth and postpartum, but that preconception model of this training would mean that they had to go through their own preconception knowledge and fertility experience themselves.

So they had to learn about their numbers. They had to see a physician. They had to have coaching with a physician. They had to know what their issues where, where their sugar was, hypertension, all those things, and come up with a coaching plan

for themselves, because our model is knowing by doing. If you don't know your own body and where you are, how to take care of yourself, how are you going to take care of someone else?

That was very important. So we spent the first few months just doing that. Our bottom of the bag strategies is what I call the legacy of Black midwives where they had things that they did that was taken away from them when they had to kind of conform to a nursing model of care later. And when they had to conform to kind of like a nursing model of care, and they couldn't use their practices that they knew worked.

So even though they had their bags, and they had to do a different training, their skills were taken away at the bottom of the bag. They still had herbs, supplies and things that they knew worked. They would cut a little slit in their bag and put those things in a bag. So our bottom of the bag strategies are those rituals that we talk about, those things.

A ritual could literally be drinking tea. A ritual could be like how do we get you to focus on different ways to support your mental health? Rituals could be we are giving you storytelling around our own experiences and knowledges, but what are those bottom of the bag strategies that aren't recognized or known in mainstream society, but that we know that you need?

Again, personal health coaching, and I already talked about the memberships, so this was like the model that we used to train doulas where we hoped that it's keeping them healthier with them walking into pregnancy healthier. They have the supplies

they need to finish their training. They have access to information to focus on their mental and physical health, and they're also fully trained, comprehensively trained as doulas. Next slide please.

And so yeah, we can't do that all by ourselves. We are a team of three. We have many partners, and these partners were excited to work with us for free. So Morgan State University was our site, and InoVcares, if you don't know about InoVcares, Mohammad Kamar is an amazing person in reproductive technology who developed online platform working with insurance companies to provide doulas. So our doulas are allowed to do online services as well.

FRAME Fertility is who we worked with that provided the OB/GYN coaching for the trained doulas, and helped them with their own personal health goals. AMAKA Consulting is how we evaluated our program. Health Connect One, we worked with them initially on some strategy around how we developed our program. Knix is one of our funders. Next slide please.

These are our training team. We were in Baltimore at Morgan State. Baltimore is number 45 in terms of maternal mortality in the country, as well as Maryland is. And so we wanted diverse doulas to work with and partner with from the community.

We also wanted doulas that had diverse experiences in terms of, between all of us we have very different birth experiences and stories to share as well. That was really

important. But also when you look at the crazy statistic that, you know, Africans that come to America have the same birth outcomes as their white counterparts here, but one generation, right?

Their birth outcomes start to mirror African Americans. So with that knowledge, Mavhu Hargrove, she has experience of birthing in both Zimbabwe and doing births here, and so we thought it was very important to have her perspective of African traditions and merging that information as well in terms of what happens in Africa, what kind of cultural safety nets they have in place, and how can we use some of that knowledge as well here.

So, and she's also been a doula for many, many years. Next slide. This is just--we're going to go through these quickly. This just gives you some pictures of our training, our in-person- - our goal was to have 20 students, 44 applied. We took all 44 thinking half of them would drop off. That didn't happen. They all stayed the course, 38 ended up graduating. We won't- do that again, next slide.

So these are just to give you some pictures of kind of like what it meant to introduce the ritual. When we started the program we just asked them to, you know, bring something that was important to them to put on an altar of what they want to get out of the program, so kind of seeded in something deeper than themselves, what are they bringing to the table, what ancestors, what family members do they want to come on this process with them to help them really get seeded in the gravity of what was

happening.

And maybe that's another reason why they stayed the course, next slide. And then we also just wanted to just honor them and nurture them in a way that was deeper knowing that you are coming with a lot of heaviness. You're coming with a lot of probably gaps when you talk about those social determinants of health.

And how are we filling those gaps and helping you in a way that you can also have the energy that you need to do this work, next slide. So we, you know like I said, it was a preconception health model. We did exercises. We had people come in and do exercises with them to help them really learn about the importance, and to give them ideas about how you can get those numbers there, next slide.

This is just a little bit of our curriculum. All the things we focused on. We expanded it kind of beyond your traditional doula training because we added miscarriage and infant loss, mental health, first aid, supporting LGBTQ+ families. We also added the business of birth work as well. They really enjoyed these babies for some reason.

They wanted to take the babies home, but the babies were really important for our hands-on postpartum work and support, and baby wearing, and learning baby wearing. Okay, next slide. And this is just like we were just very, very hands on in terms of how we worked with them, in working with the population that most of them haven't had babies, right?

So you know how do you simulate and do as much hands on training as you can? Next slide. More postpartum and traditional baby wearing, which they really loved, next slide. So some of our program outcomes, as you can see, Morgan was really excited about the outcomes of the program. They wanted a big, almost traditional graduation, so we did that.

And I was just like why is this,- why do you want this? Why is this so important? And the students were like this could be the most important graduation of our lives. If we know that health----if we know that education, insurance, where we live is not going to save us, right? If we know those things are not determining- factors of what we leave with, then this is, and so this is why we want to be celebrated.

We weren't expecting such a huge turnout. We weren't expecting for their families to come, and to thank us, but it was a big deal. And we realized that it wasn't just like a doula for Baltimore, it was a doula for their families. Their family was like now we have this knowledge for us. And it should be decolonized in the way that your families have this knowledge.

So this is some of the statistics. 86% retention rate, we did feed them well, so I will say that. We had 38 graduate, 58 percent were sophomores. Most were biology and nursing majors, which was a little intimidating, so we were very robust and rigorous on our training as well.

And what's nice about this I think is that so many of them are going into the nursing and the health care profession.

If they're not working as doulas, they already have this information about how to practice that care, right? Next slide.

They just, they went to the Provost to tell them how they really want this program to continue and more funding. We're always getting told when's the next cohort, so I think that's what that slide is about, next slide.

Some of the testimony is I will be able to take this information that I learned and save it for myself when I have children, as well as pass it along to others. I felt like it was a true sisterhood. It reminded me of how nurturing Black women we are. I felt protected and at peace in this space, next slide.

So, the goal is that they're all working with families right now, and we even had one student that did get pregnant, and she had a baby, and she was able to have the students in the program give her support prenatally, go to her visits with her. She was preeclamptic, but she still was able to have a vaginal birth. She had a huge team around her that pushed for that vaginal birth so-- she was still able to do that.

She had amazing postpartum support. She had support with breast feeding, but this is just to show you right, we're walking out as young women in college preeclamptic. And this is why this kind of information is so important. Right now they're all working with families, they all have mentorship.

We are expecting that over 100 families will be served by this cohort. For them to get their certifications, I think it was Kevin who talked about the barriers of the Medicaid

reimbursement process, but working with the organization MeetMae that is providing them with the insurance for free that they need for the first year to become doulas.

They're doing all the Medicaid paperwork for them for free and getting them into the system, and doing the reimbursement paperwork with them for free, right? Because yes, that's a big barrier if they were to have to figure that out themselves---I can't figure it out, so I can't help in that-.

So we're really happy that there are organizations out there willing to partner with us to take that away as well. And we're just looking to expand to other campuses, to expand this model and get more funding to do this.

And so recommendations, right? So, my recommendations obviously would be to think more expansively about what it takes for doula trainings to be successful, what it takes to not only train doulas, but what it really takes to get them certified, right?

The training is the easy part. The certification is a whole other barrier, and then training programs that really are embedded in community. It's a double-edged sword between what those, -what am I- trying to say, certified what does it look like to have certification and improvement through Medicaid, right?

But I think these programs really have to be looked at on an individual level in terms of what they're doing for that community. Another word that was missing, standardizing. When we're talking about standardizing, let's make sure we're not

missing the meet of what's needed for these programs, and again I forgot, the woman in blue, I didn't catch your name because I was sitting back there.

We talked so much about information and how you transferred this information. It's also how, in language. We talked about language and transferring language. It's not just speaking Spanish or whatever your language, but it's the language of your community as well. And it's how that information is transferred in your community that is so important.

So while standardization does matter, let's not take away from the unique experiences and the cultural dynamics through language and information that's going to be transferred, that's going to make these programs matter. We often need more time to make sure these programs work. They don't happen quickly.

If we really want sustained care in the model approach that works, and more funding for HBCUs. We had so much money come out of HHS for HBCUs, so many of them didn't even have the capacity to apply for the money to get the grant, right?

So there was only a few that could get the grant, and then a lot of the focus is on the few to spread that money to the other HBCUs, so we need to really focus on developing the capacity of those HBCUs to push out the maternal health workforce from a research perspective, from a practitioner perspective as well to do this work. So thank you so much. I don't know if I went over or not.

BELINDA PETTIFORD: We'll take just a few minutes to

see if anyone has any questions, any questions? Can you share about how much it costs to run the program?

KANIKA HARRIS: Yeah. That's a good question. So we have 40 students. I don't think that would be the model moving forward. What makes it a little more difficult is like the salaries of BWHI kind of mixed in with all of that, but what I would say is you know, in terms of we took everything away from them. I mean we took everything out of the equation from a traditional doula program.

So we gave them their own textbooks. We provided their doula bags for them. We provided food. So with all those things I would say it was probably around 1,500 to 2,000 per person because of all these extra things that we added in the mix.

BELINDA PETTIFORD: 1,500 to 2,000 per person.

KANIKA HARRIS: Yeah.

BELINDA PETTIFORD: It's nothing.

(Laughter).

BELINDA PETTIFORD: Nothing at all.

KANIKIA HARRIS: Yeah, in the big scheme of things, but like I’m telling y’all the salaries and all that stuff.

UNIDENTIFIED: That’s everything to get it going.

BELINDA PETTIFORD: Do you have a question?

KATHRYN MENARD: The woman in blue, my name is Kate Menard.

KANIKA HARRIS: Oh, hi!

KATHRYN MENARD: Hello, I'm not a crier, but your

presentation brought tears to me.

KANIKA HARRIS: Thank you.

KATHRYN MENARD: It's just wonderful, and potentially so impactful. But it sounds like the HBCU funded this?

KANIKA HARRIS: No, Kellogg.

KATHRYN MENARD: Okay, Kellogg, so, okay I missed that, okay Kellogg.

KANIKA HARRIS: They just let us flop and try it out on their campus.

KATHRYN MENARD: That's wonderful. Whoever applied to Kellogg, but my question is you said that you know one of the recommendations is find the gap between, I understand we need certification for Medicare payment to make this a career we need payment, you know.

You know, a living wage for these doulas at the minimum, but you know, elevate it to the professional role that they'll play. But what is the gap? We understand what is the gap between the wonderful training you all provided and then certification?

KANIKA HARRIS: Yeah, the gap with certifications is they have to find families to work with, so we do help them find families to work with. The gap is they need mentorship, they're nervous, like even older women would be nervous about just getting a training and working with families, so they need the mentorship. They need doulas in the community that are willing to work with them, and kind of help them.

And I think everyone needs mentorship. I mean they're young, so they're kind of like they have that kind of that but I'm young, I don't know if someone will trust me, you know. So there's that piece and so we want to make sure they're partnered with mentorships to do that.

The other gap is you know if you're talking about community-based doulas, people coming out of the community, being able to make a living wage, what are the finances that they need to get out and work with those moms?

So we provided each of the doulas with a $600.00 stipend to help with transportation, Uber expenses, any additional supplies they may have needed just to take off the financial burden of working with families. So those are some of the gaps in terms of getting them to the place where I can give them a certificate for them to get Medicaid reimbursement.

So a lot of folks will do the training. There's a big gap between that training and people getting certified. And for traditional doula trainings that are trying to make money, that certification part, you're kind of left on your own to figure that out, right? And there is additional trainings that come with the certification that we also took out, like lactation and birthing classes, so we provided that for them too.

So any barriers to getting certified we wanted to take that out, and we did get additional grant money to pay doulas to mentor them and follow them along in that process, and to get those additional classes to them as well.

KATHRYN MENARD: And is there a certain number of like contact hours that they need, or?

KANIKA HARRIS: Yes. Usually traditionally, and we kind of follow that too is you need to work with three families to get certified. Yeah. And so for us one of those families can be virtual, but two families do have to be in-person, and so that can vary from attending a birth, someone has to sign off on that birth, whether it be a midwife, a nurse or an OB, those postpartum hours, you need another doula to sign off, certified doula to sign off on those postpartum hours.

But those are some of the things that we look for, they have to create their own resource list, they have to take additional trainings, they have to write about their experiences, so all of these are traditional parts of that certification that we wanted to make sure that they had wraparound support to finishing.

KATHRYN MENARD: Helpful, thank you.

KANIKA HARRIS: Yeah.

BELINDA PETTIFORD: Thank you so much. Sarah has a quick announcement.

SARAH MEYERHOLZ: A quick announcement for those in the room, if you're planning to order lunch from the deli they close at 3:00. I just sent the link, if you do need to order food I can go pick it up, great.

BELINDA PETTIFORD: And now we're happy to have with us, I'll try to get your name right, Ronke Faleti.

RONKE FALETI: Faleti.

BELINDA PETTIFORD: Faleti. I was so close. Ronke. She's the Founder and Chief Experience Officer with Korede House. Thank you, Ronke.

RONKE FALETI: Thank you so much. Good afternoon. So it was summer of 2017 and I was on maternity leave as Senior Vice President of a innovation group, of a financial service company. I had been there at the time probably over a decade.

I was on leave with my third child, this is (inaudible)-. Her name means to use love as your crown. And about a month into my maternal leave the tears started, and they didn't quite stop. So I started crying, and I couldn't stop crying. And this is my third child, so I thought I was pretty experienced. After the tears came, the thoughts, and those intrusive unwanted thoughts came, so much so that I told my husband I think you better take the baby because I don't trust myself. -I can hurt myself.

And heaven forbid I can hurt her, so he took the baby. And then I found the pamphlet they give you in the hospital. If you are experiencing these types of distress call this number, so I called the number. And I got on the phone with a really kind woman, and we probably talked for 25, 30, maybe 40- minutes.

It helped some, but the tears didn't stop. The difference of the change came when I got familial support. My mother showed up, and she gave me the gift of sleep. I slept for six hours uninterrupted. She took the baby and took care of

whatever else needed to be taken care of.

And when I woke up, I experienced joy again. And it was then that I realized without the intervention of familial support. My blues or distress has turned into something greater. The research shows us- in 2016 research that was done, shows us that followed women for 24 months- postpartum, and what they found was that these women experienced this kind of distress, depression, perinatal anxiety disorder.

They can experience this regardless of race, regardless of income, regardless of their education attainment, and regardless of their level of competence. I mentioned I was a Senior Vice President in a financial services company, to indicate that I experienced it, and I had access. I was privately insured, and other women who have less access also experience this.

A lot of the conversation we've had over the last day and two, as I venture into this space in maternal care, in maternal matters, really sort of is around poverty. You know we see that a lot of unwanted outcomes in maternal mortality and Black maternal health morbidity, part of it has to do with poverty.

And today I'm going to talk a little bit about our state of mothering. I'm going to talk about social mothering, I'm going to talk about the space that we found and was part of care, and how they innovate around it. So a little about me, my name is Ronke Faleti, I'm honored to be here. I thank you for the opportunity, and you all are the brains behind a lot of the work

that we are doing, especially in the clinical sense.

I will be talking to you about nonclinical solutions specifically, like I said, my name is Ronke Faleti, I'm a mother of four. I'm a wife. I have 20 years of experience, 18 of which is in financial services, and over the last year plus it's been in this social venture called Korede House where I'm the founder and the CEO. -And we are focused on creating social connections and familial support for mothers, next slide please.

So on this slide what I really want to point our attention to is the impact of loneliness as an often underappreciated, under reported social determinate of health, especially in the landscape of growing families. There's insufficient support period, as we think about growing families, and for better or worse, we are all here because of a mother.

So 85% of moms feel unsupported by society, so 85, that's almost nine out of ten mothers feel that society does not understand them or support them. According to the Pew Research, 70% of Americans thinks it's harder today to be a mother than it was 20 to 30 years ago.

We know that one in two new moms, especially, feel serious loneliness, and we'll talk about that in a little bit. We know that one in seven mothers I diagnosed, they receive a diagnosis of postpartum depression or one of the PMADs. However, a study does find that up to 50%---I was not diagnosed, up to 50% of women who actually experience- postpartum depression are never diagnosed, and so we have a persistent issue.

We talked a lot about the state of Black maternal health, and Black women are three times more likely to die from a pregnancy related cause, and there's data here that talks about the effect of social support, and so here we know that social connection can increase the odds of survival in, when you look at different types of diseases.

For those who have this report you can see the citation pages here. So the data is clear here, and it's clear as what we've heard before. Women are not supported, and loneliness is a big impact when it comes to support, the next slide please.

All right, so after many years of decline---so this is also a peer research. After many years of decline what we actually see is that women are actually having babies, and they're delaying when they have a baby, but as of now what we'll find is if you click forward for the little animation, what we see is 86%- of U.S. women will become mothers by the time they are 44 years old.

So while they're delaying, they're actually creeping back up and having babies. Like I said, for better or for worse, we are all here because of a mother, and there was a recent research that I found that shows that the quality of the mother's happiness is directly tied to the child's outcomes in life, and so this is something that will impact almost nine out of ten women, and this is something that we need to figure out with this state of mothering, where we are today, just look up and down where we can.

So on the next slide I'm going to introduce you to a concept of this three C's of disconnection. So a lot of work at coordinating health, which is the third space, and a motherhood, and a blur I would say, is around social connections, and so we've identified three C's of disconnection, and that creates or leads us down a solo journey of mothering, especially in America, that results in lives ending prematurely.

So one is convenience, the next one is control, and the next one is capitalistic distraction. So I'll talk about convenience a little bit. So convenience is ease of access, and convenience is really approximated by our technology and our cellphones. Technology gives us access to access, that's actually what it does. It gives us access to connection, but actually doesn't create connection unnecessarily, that's why so many Americans report loneliness.

We have access to each other, but we are actually not talking. We've got control, so what we see here was a beautiful study, as I said, the single family household was a big mistake. And in our culture of what that individualism--by myself--we really do like to have things controlled and neatly, and we live in single family households.

And the other part of control is that sometimes we seed connections and vulnerability to pick fresher ones because we're able to control the boundaries. I give you permission to tell me about myself as opposed to having those relationships and nurturing them.

And then you go into capitalistic distracts, we prioritize productivity, we prioritize, you know, social media, we prioritize the exchange of money instead of exchange of services or ideas, and all of these kind of work together to reinforce themselves as a way that keeps us further disconnected, and again, like I said, impacts lives, and impacts the lives of mothers, especially.

One of the examples that I would say for convenience is that perhaps 20, 30 years ago when somebody had a baby, some of you would have had a baby 20- to 30 years ago. I bed somebody came in and made you a meal or- sat with you.

Now, when me and my friends have a baby, we UberEats. We're losing that social connection, and that's a function of convenience, and that is one of the things that I think we need to look at as an underappreciated measure as a social determinate of health in postpartum women, next slide please.

So, why does this matter and why does it matter specifically to St. Louis? I-f you look at this graphic here you will see that this St. Louis is the number two most loneliest cities in America as measured by number of individuals living alone. And it appears that we're getting lonelier because it says here that loneliness is----hold on, on average the number of people living alone in St. Louis increased by 1.98%- year over year since 2016.

And so this is an important, -loneliness is an important thing that we have to weave into every solution that we

create. Let's talk a little bit about the costs, so again social connections is our jam, and so when you look at the costs of loneliness for an employer base, what you see is that it costs 154 billion dollars-, when you look at people and social support.

So if I were to be replaced at work it will cost about up to two times my salary if it was through my place of work. But what we find is mothers with insufficient postpartum support are four times more likely to quit their jobs. In the rich world we find that 80% of the labor participation gap is due to the motherhood penalty.

So there was a big report that came out in the Economist earlier this year. We don't see the same in a lot of developing world. Motherhood is not a penalty for labor participation partly because of that social mothering, and social support, which I'll talk about in a little bit. Next slide.

As it's been well reported, lacking social connection is as dangerous as smoking 15 cigarettes a day. If it's as dangerous on our health, for our physical health, it's as dangerous for our emotional health and especially the health of new mothers. This is an important social determinant of health.

So I'm going to take you a little back into Africa in the next slide. So in 2021, my family and I got an opportunity to take all four kids to the Serengeti. I am a Nigerian woman, which is in the West Africa, so this was our first time going to East Africa. And there were seeds planted for what is Korede house today. And the seeds that were planted was witness and social

mothering and action in nature.

Yes, when we got on the continent we were mothered by the people of the space. My son was like do you know them? No. No I don't, but they just you know, they recognized that the investment in the children and in the families is an investment in the future, and I think that's just what the culture does.

When we were in the Serengeti, and when we saw the giraffes, we saw the zebras, we saw the elephants, we saw the lions. Unless you see a cub or a baby suckling, you don't know who the mother is. When you see lionesses, it's not by myself, it's not a solo journey. If there's a cub there at least two aunties around.

When you see, like in this image here that I took, when you see the elephants, if that baby moves three inches, they all kind of move with the baby, right? And what you have is, you know, there is evolutionary evidence that suggests that the way that we're able to continue to procreate is because we have a shared load.

And in our culture, that's reinforced by the three C's of this disconnection, we don't have a shared load. It's convenient, you want to control it, and there's all these capitalistic distractions in the way. So in the culture, in an African culture, especially nature, those three C's are absent. People forego, you know, individuals obviously they do forego the convenience and control of maybe having a single family household, you know, it's multigenerational nature, and that helps with

health outcomes.

And people embrace the exchange of services without the exchange of money, and people do lean into inconvenience because I will come and stay with you, I will watch this for you, I will help you. So let's go to the value of social mothering, thank you for the next slide.

So the value of social mothering as we've seen, and research attests is that, it decreases the change of developing postpartum depression, so 36% of women with strong social support have a lower risk, or sorry, women with strong social support have a 36% lower risk of developing postpartum depression.

Women with postpartum depression have a 90% higher health care cost, and we know to treat it's this amount. However, if you have mortality or morbidity the costs to society and the costs per patient is really high, almost at max. So let's enter Korede House. So Korede House is the first of its kind. It's unique in that it is a physical space, it's a third space, it's a village square.

Yesterday we talked a lot about the metaphorical village, how to access the village, and this is the first of its kind. I would hope to be like following the Ronald McDonald House to be everywhere you want to be. So we, like I said, we are a social venture that purposes on social connection and familiar support from others.

We are here in the City of St. Louis. We have 4,500 square feet, and the house was built in 1895, so it is a physical

house that functions of it is broken up, but the first floor is all about social connection. The second one is about ambition. The third one,- the third floor- is about well-being and wellness.

And for those who may not be familiar with the concept of what third space is, it's a home away from home. So your first space is your home. Your second space is your work, and your third place is a place that's neither home or work, but it's a place you can find belonging and support. Me, in the middle the pandemic, I felt myself once again feeling broken. I didn't have a place to go.

I picked up my car keys at 10:00 p.m. at night and I told my husband I'm going on a drive. He was like where are you going? I don't know. I just needed to drive. I called a single mom girlfriend of mine who I thought okay, it will be so weird for me to just pop up, and she lived 30 minutes away, so it was a long enough drive.

So when I got to her house we didn't talk about my problems, I felt better. I was only there like 20 minutes. I came home, and I have three older sisters in different cities. I called them to say where can you go? I couldn't go where you have nowhere to go.

I asked my girlfriends here, and the answers were consistent. I hide in the bathroom. I hide in my car, or I go to Target--not to shop, but to push a cart around, and there are many says that says Target, - or- lots of articles written that says Target is my selfcare, but a lot of women don't- have a place to

treat and a place for respite.

I'm proud to say that the less than a year since we've been opened we have provided over 1,300 hours of child watch to community members, and we've seen over 300 women receive services of our space from empathetic listening to just a respite place, or a place to work and bring their child with you if you want to.

I'm going to talk now about a program that we specifically developed to integrate in the space that we identified of those vital care, so I'm going to pass this here. So our Stage Postpartum Program really talks about the stage of motherhood, direct and postpartum. It's a non-clinical, comprehensive social support for mothers during the postpartum period, promoting maternal wellbeing, family civility, and is a successful transition to work.

It is a 12 week program that is in real life and intensive that follows by nine months of individualized care, one to one coaching, and care support. The gap that I experienced in postpartum was within those 42 to 365 days that we talked about yesterday. It is in that period that we have over 50% of maternal mortality happens, and it is in those periods that you----the child continues to be seen, but the mother does not get any services.

So what our team did was we did a lot of research, and it's wonderful. The NIH compiled so many studies that so many Ph.D.'s and wonderful people have done. And there’s a particular study out of Australia, and what is great about it is it compiles

55 recent papers on postpartum, depression postpartum, anxiety postpartum, and needs for women.

And what we found was that when you have - - (Audio dropped) -- we actually used that study as the basis of creating this stage program. And what we found is that women have four needs. They have one, a need for information. It's my first time doing this, two is psychological support, three, a need for sharing experiences, and they have four, a need for practical support.

And what I have seen, again I'm not a clinician, I have experience mostly in financial services, but I do have experience as a- lived experience as a mother of four, and I have lived experience as a woman who comes from a village, a little village, in Africa. So there are things that I think we can do. I am going to spend a little bit of time here.-

Often times what I have seen in this space is,- I'm going to use a word, which is my language, Kili Kili. Kili Kili means a little bit here, a little bit here, it’s a little bit of sprinkling of services. And what we are doing here is a comprehensive model that is for social mothering. So one, it starts with our parent coaches, so we call those people stage coaches, and we actually begin training our stage coaches- on April 11th.

And so I know the research shows us that women are looking to other women with experience to coach them, and oftentimes family and friends aren't sufficient, most in part

because of the judgement that comes with family and friends. Oh, it's not that bad, and I went through this, blah, blah, blah, right?

So Parents as Teachers is a great novel that shows us about you know, coaching parents, you know. I know also around home visitation, and I'll get to that in a little bit. So our parent coaches, which are called stage coaches are an underpinning of our program because they have that lived experience, and they will receive training, additional training in maternal health.

And what we are proposing is eight weeks of in real life peer group because, you know, like you train a trainer, eventually you want the parent to support each other. And when we think about some of the challenges that women face, especially as mothers in the workforce, and labor participation that I mentioned, and the lack of social support, and it's just I'm doing it by myself.

And you know it takes seven hours to build trust, and in order to build trust, and to create that community you need opportunities to engage with one another. And maybe if a group, no more than about 12, but if a group within the group of 12, maybe three women click, that can now be shared, about child care responsibilities.

And maybe because of that they're able to go on date nights that they weren't able to before because of that, it's special for me as a Black woman who raised children in white spaces, it's important for me to have a peer group where my kids

are able to see kids who look just like them.

So in real life sessions followed by nine virtual group sessions to keep the groups together. And one on one coaching, this is a little bit more clinical in nature. This takes the team model. It gave the village care model, so we have a peer coach, a wellness coach, as well as in home support that's provided.

We talk a lot about doulas. To get certified as a doula, doulas don't get paid very much, although they're trying to get paid. But a lot of the payment really among other states that do pay them now for Medicaid, a lot of the payment is really tied to birth.

And so our doula framework is tied to afterbirth. It's all postpartum in nature, and where we -- the coach that is with them for the 12 weeks, is the one that will likely do the three visits within the 12 weeks postpartum, and then the 18 visits after it could be a doula, it could be that coach, and that person, as I've done it, is they're there to do just whatever the woman needs, and is there for the family.

So it could be I need you to sit with me on the bed for an hour while I cry, or I need you to listen to me, or I need you to you know what, can you wash the dishes? Or you know, can you help me arrange this closet, whatever it is. Most of the home visit programs is a teaching program, it's not the practical support program.

And what the data shows that's effective in combatting a lot of the postpartum stress and anxiety is really that in the

practical support, and that practical support is when we have a village. That's what our aunties did, that's what a doula can do now, and that's a lot of what postpartum doulas do. And so, this model suggests 100 hours of postpartum care from care outside of birth, from care to the 12 to 15 hours of care they might get.

And the next slide are some of the outcomes that we expect, so it's really around resilience, and I would believe that if we have stronger women and stronger mothers, we have stronger families. Yesterday it was wonderful to hear the Missouri Health Department talk about postpartum, and there was concentric circles that showed like, you know, postpartum child outcomes aside, all outcomes.

It all really feeds into each other as I mentioned, the important quality of the mother's happiness is number one, so these are going to the study and indicates not the father in the home, is the quality of a mother's happiness, is the number one indicator of success for that child.

So loneliness is associated with a 40% increased risk of depression, and we know that social support is a key protective factor against postpartum depression. Women who lack social support are two to five times more likely to develop postpartum depression, and then when they do we're not breastfeeding ultimately, costs to society and Medicaid like three million dollars a year.

And you know, the absenteeism it just cascades, and you're not able to be present with your child, there's an amount

of societal costs again as loneliness and isolation will be an underappreciated determinate of health.

The way we intend to---on the next slide, to look at our framework is using the Edinburgh Postnatal Depression Scale, and doing a lot of data collection surveys for participants, to gather quantitative and qualitative experience, and while we are proposing a one year program-, it will be important to track for participation rate and fall off rates, so that's part of what we have on this framework.

On the next slide I'm going to talk about my recommendations to the Advisory Committee on Infant and Maternal Mortality. A lot of the presentation that I showed you here is applicable to all women postpartum. I happen to be a Black woman who has experienced postpartum four times, and one of the things that I experienced with my last child was birth coma for lack of a better word, it is what it is.

When I had my first son, it was my 20th birthday. He and I share a birthday. And I had---I got stuck twice, it's not so big of a deal with the story, but I got an epidural, I got stuck twice, so I had some nerve damage. And for the next five months every time I bent, coughed, carried my baby I had pain, and I would talk to my OB about it and he's- just like you know, it could heal, it can go away, so it is what it is.

So with my next child I thought well you know what? My grandmamma had nine babies, I'm going to try this. And so my next child I was able to successfully deliver without epidural or

without really any medical intervention and you know, it was wonderful because I got up right away, and I was able to walk around.

With my third child, the one that I have the blues with-, we had a textbook delivery. It was so easy, so like you should see my picture immediately after giving birth. My hair was fine. And everybody in the hospital were like you all should teach a class. It was like smooth sailing. I kind of knew my body and I trusted my body. -

And with my next one again, I took myself to the hospital. I thought I was, you know, an OG at this now and my doctor was traveling that day, and although she was in the hospital, she didn't come, and there was a rotating, maybe attendant, another physician who came, and I knew better.

So this is the value of the doula, I think. I knew better than to have my water broken, but I was like--because in the last two births it was what was protective. You know, you don't feel the pain as much, especially when you when don't have an epidural, like you need your water sac. You need it to happen naturally. For me, I needed it to happen naturally.

And I was like maybe nine centimeters, it was like oh you'll have this baby in 15 minutes. I was let's go, I'm ready. Well, all things---I don't even like to think about it. I just remember seeing my husband crying, and I knew things were not great. I ended up having her on the floor, and the room was like filled with so many people. -And my story is not unique

unfortunately.

So when I talk about the recommendations I do think that we need, -Black women especially, need help before pregnancy, during pregnancy and after pregnancy, and one of the held we need is an -opportunity, going back to the needs of women to share experiences and share stories to be able to heal from the trauma.

And part of the way that we do that is with 100 hours of care for Black women postpartum. So I recommend 24 to 55 hours for every postpartum woman, but if we are able to expand it to a year postpartum, and I'm not forgetting again, I really do believe in the comprehensive model, that is our model, that should include peer support because that's the trusted voice.

It should include paraprofessional and professional support to be able to do the assessments, that's the one on coaching, and it should include practical support. So in home visits that are beyond just okay, so do you know how to latch? Do you have the resources? In home visits, that is like an aunt-- somebody that would get into what a lot of postpartum doulas do.

So we talk a lot about how do we professionalize the workforce, and provide emotional care workforce. Our program is designed to train and to employ the maternal care workforce to be able to address a lot of the undesired outcomes that we are coming here to discuss.

So the hours of care is one recommendation.

The three C's. So I think we should talk a lot more about social connection when we think about postpartum care, and

that really dovetails into the last one, which is a post birth plan. Many of us have AIM, it's in the Lexicon, it's kind of in the language, oh do you have a birthing plan? We're going to throw the birthing plan away.

Do you have a birthing plan, do you have a birthing plan? Birthing plans get thrown away because in the, as you are in the moment, it's kind of what you have to figure out what happens, doulas can help you stick to a birthing plan. But we're talking about a birthing plan, and a lot of the studies and research that we've done does address making sure that women have a plan for postpartum support prior to giving birth.

And I think that could include familial support for sure. That can include some peer support. That could include in home visits, and but whatever it is it should be a checkup on the woman, not just in that 42 window, that 42-day window, but 42 to 365 and beyond window.

So thank you so much for the opportunity to talk to you today. This is the true Korede House. Our mission to bring fitness, ease, and inspiration to every mother in the world, and we define a mother as one who matters.

BELINDA PETTIFORD: Thank you so much Ronke. Questions? Questions? Exciting to hear you talk about the 100 hours, because I've heard that in other venues, so it's not the first time I've heard it. This is the first time I've heard it actualized though, that you actually have a plan. Any questions anyone? Nothing virtually?

Thank you so much.

(Applause).

BELINDA PETTIFORD: Okay. So we're going to take a shorter lunch—I'm sure you've about guessed that by now. But we will take 30 minutes. It is now---what time is it, 2:40, so we'll- take to 3:10. That will work.

Workgroup Report Out

BELINDA PETTIFORD: Good afternoon everyone. This is Belinda Pettiford. We are back from our short break. Thank you Marie, for letting us know you are there, thank you all. And thanks to all of you that have been participating virtually. We know that could be more of a challenge, but greatly appreciate the feedback that you are providing, the notes in the chat, as well as chiming in at different times.

At this point on the agenda we are going to have our workgroups do some reporting out, so for those of you who have not been at other second meetings, right now we have three workgroups that are chaired by various members of the----important members of ACIMM, and so we will ask each one of them to take about 15 or so minutes to report out, and let us know kind of the status of the areas that they are working in.

We are hoping to have our recommendations for the Secretary ready by the end of the year at the very latest

beginning of 2025. So we are just doing like a status report at this point, just to see where things are.

I will also say to those you who have not participated before that these workgroups are open, so if you are interested in joining one of them, and being able to provide some of your feedback, feel free to drop us a note in the chat, and we will make the connection to the appropriate Co-Chairs.

We have three workgroups currently. We have our Social Determinant of Health Workgroup which includes Sherri and Marie as Co-Chairs. ShaRhonda also serves on that workgroup. We have our Systems Issues in Rural Health for Kate and Jacob, Co-Chair that workgroup, and Steve also serves on the workgroup.

And then we have our Preconception and Interconception Health Group where Phyllis and Joy CoChair that workgroup. So we are at this point in time we're going to turn it over to Sherri, Marie and ShaRhonda, to give us an update and some reporting out- on the Social Determinant of Health workgroup.

SHERRI ALDERMAN: Thank you, Belinda. This is Sherri. I CoLead as Belinda said, CoLead with Marie Ramas and we are going to be co--presenting along with ShaRhonda, a very good year. I'll start out. We have a really very passionate- group with high expertise in the area of social determinants, or we also refer to it as social drivers of health that lead to health-related social needs.

It's been an exciting process that we've been having from the ACIMM Committee members we currently have ShaRhonda

Thompson, who will speak very briefly, Phyllis Sharps, and then the two CoLeads, myself and Marie Ramas. We do----are very fortunate that we have ShaRhonda to serve with us and can form us as she comes to us with deep lived experience, and her perspective is very valuable.-

So I will hand it up to ShaRhonda to say a few words from what your perspective is.

SHARONDA THOMPSON: Hello, this is ShaRhonda. It's fitting for me today to speak on this. I actually was asked a question yesterday about what I thought was different about being a part of this Committee. And the one thing that I was able to say very loudly is that I feel heard. At these meetings, and definitely at our social determinants of health meetings, I feel heard.

I know I can say I may not understand everything that's going on, but if I have a question, it's answered. It's answered in a way that I completely understand everybody's thought process because that's a big one for me.

I have to know that process in order to move forward. So the fact that I can say that, and I don't feel judged, and I need the answers that I need in order to be the best that I can be with providing my feedback is what I really totally enjoy.

So if anyone is thinking they would like to join one of our workgroups I can tell you now you will be heard. That's I have to say, Marie.

SHERRI ALDERMAN: So Marie, do you want to go next?

MARIE-ELIZABETH RAMAS: Thanks folks. Thank you ShaRhonda, and your voice is so necessary, particularly as we're talking about social drivers. I think a unique opportunity that both Sherri and I are taking hold of is we are tasked with the responsibility of providing something new to the picture here.

Particularly in a public health sphere, we've spoken about social drivers of health for a very long time. There are, you know, fixed spaces where we know there are areas of opportunity for improvement of rural health outcomes, and that do demonstrate reduction of health disparities.

So one of the tests that both Sherri and I have engaged in is trying to identify what are best practices, and what are some different ways of bringing the issue at hand that will speak to our general audiences in a way that is unique and fresh in providing our feedback.

And so it has been delightful getting to work with our stakeholders, co-stakeholders-, and we'll share a little bit of some of the discussions that we've had in our meetings to come. But it has been wonderful getting to work and cofacilitate with Sherri. -

I think that as you hear from our feedback in the next couple of minutes, there will be a couple of new facets that we will encourage our Subcommittee members to look into, some of which were brought up earlier today by some of our presenters, so with that, Sherri, I turn it back to you.

SHERRI ALDERMAN: Thank you, very much Marie. So we

have been meeting on an every other month basis with the Committee, and then Marie and I have been meeting on the alternating months in planning the next meeting that we have scheduled.

And we have been focusing on the typically identified social drivers of health, and have had the honor of having Caroline Dunn speak on nutrition. Having Lara Conklin and Jeanne Lindros from the American Academy of Pediatrics talking about the AAPs initiative, No Child Hungry Partnership, and we have plans to at our next meeting on May 28th, which is an open public meeting, and everyone is welcome to attend virtually, we have someone from Family Connects, which is an evidence-based universally offered home visiting program.

The Executive Director Jenny Jensen will speak, and Marie has made a fabulous connection with the Founder and CEO of Mother of Fact. Marie, would you like to say something about that connection, we're very excited to have that at our next meeting.

MARIE-ELIZABETH RAMAS: Yeah. I had the pleasure of being introduced to the CEO of a new startup company that is trying to reduce the barriers to access of nutrition- health in the perinatal and postnatal periods for both the birthing patient and the infant.

And so, this is a virtual platform that is providing culturally sensitive and appropriate nutrition guidance and support for people who are pregnant, and are in need of nutrition services, whether they have high risk due to morbid obesity, or

other high-risk co-morbidities such as gestational diabetes, or hypertension for instance.

This is really exciting because they work both inpatient and outpatient, and they also are able to bill on behalf of the entity that they are working with, which means that they are coupling diagnosis coding and service coding opportunities, and increasing compensation for the entities that they are working with.

They have contracts all over right now, and they are also undergoing NIH-funded research around appropriate nutrition services, and how it can help reduce adverse outcomes in the perinatal and postnatal period for the birthing patient and infant dyads.

So she has a very compelling value proposition, and their platform that they use is equally exciting to both Sherri and I. So they will be presenting to us on their platform and their services, providing best practices and some case studies, and sharing some of their published art paper and research that they've already engaged in as well, in order to provide insights to our Subcommittee.

We hope that this will help to provide salient examples that can hopefully be scaled when we are writing our final recommendations to the Secretary. We'll be asking additionally if perhaps the greater group would be interested in hearing from them, but certainly as Sherri said, everyone is invited to come to our May meeting as well to listen.

SHERRI ALDERMAN: Thank you Marie. So at a high level we have been exploring more typically identified social determinants of health. We also know that social determinants of health are social drivers of health and not destiny, and so we are also using the term "social drivers of health" to describe what it is that we wish to engage in and make recommendations to address.

So we are really looking also at broadening what are considered to be social drivers of health that we see that are evidence-based, and so we are looking at what those are, and what are we not looking at and should be considering.

And I was very validated by our last speaker because we have been talking about loneliness and isolation as a social driver of health as a basic public health issue, and even our Surgeon General has proclaimed that loneliness and isolation as the epidemic of greatest concern right now.

And so we are looking at the possibility of having the Surgeon General come and speak to us and give us his knowledge about this, and how it can be addressed, and we're very hopeful that that will be able to happen. We also know that as we begin to look at this that we need to look deeper than the social drivers of health specifically, and we need to look at what is it that promotes and preserves those adverse impacts on health.

And so, we are also looking at how we can look at the politics, the political determinants of health. And while we can't change politics overnight, we certainly wish to take them all into consideration as we begin to think about what our

recommendations will be, and to be greater knowledge base and understanding of the political determinates of health.

We are looking at the possibility of having Dr. Daniel Dawes, who is the author of a political determinants of health book to come and also talk with us, and specifically giving us insights into what policies and politics are in place that can actually be more greatly explored to address social drivers of health, so kind of a flow of what we hope that he will be able to get us involved in thinking more about it as we finally make our recommendations.

So a question, or a point of discussion that I would like to put out to the group that we would really benefit from your insights on what are the intersectionality between social drivers of health and the other workgroups, and what you're working on specifically.

And how might we approach handling that to begin to coalesce this into one report with a finite number of recommendations as I think that as we begin to formulate these I'm hopeful that the timing is right to begin to think about and expand and share together what the commonalities are between our group and their workgroup.

BELINDA PETTIFORD: Can I just chime in Sherri on this one? I think that's a great question because I think we all need to think about it. I'm just wondering if we can think about it, and then when we have time tomorrow on the agenda, to just to follow up- on the workgroup that we can have that discussion then,

because I want to make sure that each of the workgroups have time, and we do have to stop by 4:00 for public comments.

MARIE-ELIZABETH RAMAS: Okay, great.

BELINDA PETTIFORD: So everybody remember that question. It's probably your homework assignment for the night.

MARIE-ELIZABETH RAMAS: One more, just a point of consideration then I would want to add ism it has been brought up today and yesterday this concept of social isolation, and how it -how there are disparate effects on different groups. -And would that be something of interest for our social determinants group to look into further?

That would be something that I would love to hear some feedback from the greater Committee about as well.

BELINDA PETTIFORD: Thank you Marie. I'm writing that one down as well. Anything else from your workgroup?

SHERRI ALDERMAN: Oh, no, thank you very much.

MARIE-ELIZABETH RAMAS: Thank you very much.

BELINDA PETTIFORD: Thank you both or all three of you. Okay. So now we're going to switch over to Systems Issues in Rural Health, and turn it over to Jacob and Kate.

KATHRYN MENARD: Jacob’s going to do the report out.

BELINDA PETTIFORD: Oh! Excuse me, Jacob. No, that’s okay.

JACOB WARREN: No yeah, we got it.

KATRHYN MENARD: For efficiency, and I’ll chime in as needed.

JACOB WARREN: We've been having a really great group thanks to Kate and her leadership from the beginning on this. I

joined in after, and I'm just really grateful for all the framework that you and Steve put in place for us to be able to keep working together, so I just wanted to start off for thanking you for everything you've done on this group so far.

So we have three Committee members on the group, so we have Kate, myself, and Steve. We've had great participation from ex-officios as well, reps from IHS, our own -Charlan, a lot of folks who have been involved. We have subject matter experts also from around the table, and Kate tell- me if I miss anybody.

So we've had folks from the California Surgeon General is participating. We had Jennifer Vanderlaan, we'll talk about some of what she's talked about from ACNM for representing their midwives, AHA, just a lot of great groups coming together to look at what we're doing here with support fromVanessa and Sarah as well.

So we've been trying to organize around four themes that we'll talk about, and so it's almost the opposite of what y'all are doing in the SDOH group because in rural we have the same conversation a lot, right? We know what the issues are, and we've identified sort of those same issues, but what are some new recommendations we can make around those issues because we know about rural hospital closures, we know about regionalization of care.

We know these are things that we need to do, but the way we're doing them isn't working, so that's part of what we've been trying to look through is what are new ways to approach these

issues that we have known about for quite some time.

So those four main areas we're looking at are rural hospital closures in maternity care deserts. Looking at recruiting, training and retaining diverse—we'll just add rural in there for this specific one--there was a rural workforce, so that's a huge issue. How we can further leverage telehealth, particularly in accessing prenatal, postpartum and MFM services, and how that factors into the fourth piece rural regionalization of care, so how does telehealth become actually a method by which we can regionalize-?

So we'll talk a little bit more about this in a second. We also have what we're calling a thread across all of that, which is our data. So we're talking about data needs all the time, but when we look at rural, sometimes you literally cannot answer the question because the data are always suppressed.

So if you're wanting to look at health inequities within rural areas, nine times out of ten the data are suppressed because the counts are too low. So we can't look at it. The asks in a grant application to talk about what are the racial ethnic differences in these outcomes, and you cannot produce that information because it's suppressed.

So we're looking at things like that, where the unique data we have for all we just don't have, so it's not necessarily a set of recommendations around it, it's how we think about data across all those areas. For us to be able to evaluate if these things are working, are we implementing them the way they need to

be implemented, all those types of questions.

So we've had three great speakers so far. We meet every month. January had Harold Miller, the President and CEO of the Center for Healthcare Quality and Payment Policy focusing on rural hospital closure and setting the ground for what we need to think about in recommendations, so talked about 100 hospitals have closed in the past 10 years, another 600 are at risk of closure that represents a third of all the hospitals being at risk of closure.

So it's, -the- crisis is continuing in this regard, and underneath all of that, and this is one of the datapoints, it's hard to get to is the L&D unit closure because we all know very frequently which close is the L&D units because they're the most expensive. And so, just because a hospital stays open doesn't mean we have services at that hospital, anyway.

It might be how they save the hospital by axing that service. So some of the main things there is looking at adequate payment, better payment system, again things that we know that happen when you look at new recommendations. At our February meeting we were very fortunate to have Dr. Elizabeth Cherot, the CEO of March of Dimes, and some of her team kind of talk about their new maternity care desert report, which is again, fantastic.

Some presenters yesterday talked about it. It's just a really great drill down to where we have those care deserts, and again helping, but we're not going to go through that. But then, Kate had some fabulous data. Can I share screen? Is that

possible?

UNIDENTIFIED: Oh, yes. Let me make you a panelist.

JACOB WARREN: Great. I will say this was inspired by the others who focus quite a bit on where do we need to prioritize to have the maximum impact. So in the general framework we've been talking about with how are we focusing in on excess Black maternal death, these are the states, and thanks to our colleagues at CDC for getting this data to us so well, so these are the states that are driving rural Black maternal death.

So this is, we can't do again because we want to talk about maternal mortality rates because of the small counts. But this is where rural Black women give birth. So North Carolina, Georgia and Mississippi are the darkest colors there, almost as an X, the X is non-expansion states, you'll sort of see why I was on that theme earlier before.

So you can see there's a pretty direct connection in there, in North Carolina, technically it doesn't have an X, but they just expanded it, so previously the top three states were not expansion states, and those three states alone were almost half of all rural Black births in the United States.

So if we're really wanting to look at recommendations for addressing rural Black maternal mortality, it's pretty clear geographically where that occurs. And I'm going to get beat up when I go home and I don't talk about the fact that the small counts at Wyoming is never going to ping on a map like this, or some frontier areas, but again if we have to prioritize where

we're going to send support and make recommendations that have the biggest impact, we have to sort of think about that reality.

And so the context of what we're thinking with Black maternal death in rural areas, well, the reality of not expansion is really present. So those again, just to---it might be hard to see the legend, but those darkest states have 10 - 20% of all rural Black births in the country, so it's not just what percent are rural, it's 10% of all rural Black- births occur in those states, or higher.

BELINDA PETTIFORD: So do we know what those outcomes are?

JACOB WARREN: The data gets suppressed.

BELINDA PETTIFORD: Too small to even you can figure that out.

JACOB WARREN: I mean, there’s theoretically ways to figure it out, but it's not at the acknowledged, the thing you have to agree to on CDC WONDER in order to get the data. So I just wanted to share that we're trying to help, you know, continue to anchor that because the recommendations we make for rural in the southeast, and I can say this as someone who has been at frontier and in the southeast are different.

The things we need to do in southeast U.S. is way different from what we do in frontier. So not that we don't want to make recommendations across the board, but we really have to make sure they're making an impact.

KATHRYN MENARD: Just a thought too that these are

potentially states that have given this a lot of thought, right? They have rural, and there's a lot of different - the landscape of rural health in Wyoming compared to Georgia, I'll just use your two states is different, but maybe these would be states where we would find those promising programs, you know, that Belinda has encouraged us to find because they've got you know, that population of Black mothers too, and rural Black mothers. So you know, it's- a place for us to look as well.

STEVEN CALVIN: And this slide too is very helpful. Last summer I got asked to give a talk at the ALEC, which is the American Legislative Exchange Council, which was a red state legislative group. They wanted to know about midwifery care, but I didn't have this slide, so I need it next time.

It's basically to say okay, there's a lot of controversy about a lot of things, but as red states, you better be aware that looks like that's a heat map that's pretty hot. And you know, so I'm just grateful to be around these people who come up with this kind of information, because it's real information. Here, you've got to focus on this.

JACOB WARREN: So, as I mentioned, we've been going through the four areas. What we've started doing is a mind-mapping process because it's so difficult to consolidate all of these elements now. So at our last meeting we started flushing out one in particular that was looking at the rural workforce element.

And so these are not finalized by any means yet, but

what we've talked through is the availability of training programs, diversity of the workforce, and then the specific disciplines, it's been kind of the thing throughout the past couple days is that it's not just about OBs, it's not just about MFMS, we're not going to solve this anywhere, but particularly in relying on sub-specialty care to exist because we can barely maintain primary care practice.

So training programs again, part of what we're looking at, and it's great to have the presentations we've had, the midwifery, community health workers, looking at FMOB and how we can support the expansion of family med OB practice. One question that came up there is liability.

And so part of what we're hoping to drill down to in the future meetings is working with the folks at FTCA to see what the claims look like for rural FQHCs in maternal outcomes just to have a gauge of risk, and is it higher when we look in rural areas, particularly in those states that have the greatest representation of Black rural folks.

Then, you know, some of the specific disciplines, midwifery, labor and delivery nursing, but gen. surge and family medicine OB, how do we bring these together. There was a great example, I can’t remember who brought it up, Kate, about this care team piece where it was partnership an FM, a midwife and a general surgeon together as kind of an OB team, so there's not an OB in there, but how can sort of the three of them together be an OB?

So those are some of the initial things we're

explaining, we can talk more about any of them later, but we're trying to get it organized down and again, recommendations that have been made before, but are informed by things that happened previously, so we can look out.

KATHRYN MENARD: I did want to mention, Jennifer gave a wonderful presentation on a couple of models of midwifery care in rural areas, and one idea that resonated, I mean a lot of ideas resonated, but that she put forward, but one idea that resonated was if we have hospitals in rural areas that can't afford to keep up----you know, the volume is too small, or the number of births, and you know, the workforce potentially isn't there.

What about, but they have an ED that's totally prepared, and maybe even a surgeon there that's totally prepared to take care of obstetric emergencies and has an alongside birth center with that backup. You know, I work in an area where there's a birth center just a couple miles away, it works great, you know, that ambulance comes in no time, right?

But if it's an hour and a half away I'm a little anxious with that, but could we have a system in place where that emergency preparedness is actually in that well-prepared rural hospital without the full expense of an L&D. I thought that was a really interesting idea. And we need to of course explore that. Anyway, these sorts of things are coming forward from the Committee, lots of good thinking.

Do you want to talk about our questions that we have for the group?

JACOB WARREN: Yeah. So more homework. I'll do it too, Belinda. So I'm not assigning homework, Belinda is assigning you homework. But one element is especially in the MFM role, how we execute rural tele-MFM, because that's just a big issue.

In Wyoming we have one MFM and she does totally tele-practice because you have to, but how do we have a model for folks who are wanting to take that on because before she came last year there was no MFM. One is----

KATHRYN MENARD: Can I add something to that? We don't really have an expert that we have identified in this, you know, that knows a lot about what's available in terms of bandwidth, and where is this practical, and no, you can't do that because we don't have an expert of our subject matter experts where everybody knows, you know, kind of the right person that we could invite, that would be helpful.

BELINDA PETTIFORD: To look for telemedicine.

KATHRYN MENARD: Yeah, and particularly for the OB space, that would be great. And telemedicine potentially. There's tele-education that could be an extension of that as well, you know, the Echobot- models and things like that, but I think that somebody who really knows the issues of you know, there's not cable everywhere, so where is this not going to work, and what would be the way to do it if we wanted to make it complete?

JACOB WARREN: The next piece we've been trying to figure out is a presentation of lived experience on the panel, but how we can compensate them for that time. So there's some things

you have to know, are there ways that we can figure out how to do that because we want to be sure to respect them on their time.

BELINDA PETTIFORD: You're not the first one.

KATHRYN MENARD: But it's--what are we gonna do? I raised a question, and you all answered it, but that's not okay.

JACOB WARREN: I know it's on the grants that we receive that allows us to do that, you know.

VANESSA LEE: If you can be creative about it, I wanted to talk internally, and we didn't get a chance to yet.

JACOB WARREN: You can write it into the contract----

VANESSA LEE: Someday, yeah.

JACOB WARREN: The other piece I want to share with you all is a temperature check on the things that we brought up and go into experiences, do you think we're on the right track, so think about those works.

BELINDA PETTIFORD: And we're going to hold that to the morning, and it looks like Marie has dropped a subject matter expert.

MARIE-ELIZABETH RAMAS: Yeah, Dr. Emily Baker is one of the senior MFM physicians at Lebanon in Dartmouth, Lebanon, New Hampshire, and she has an extensive history working in collaborative models, and interdisciplinary models, and as you all may know northern New Hampshire is not densely populated, and there are lots of considerations as far as rurality is concerned, and maternal deserts, so I think she'd be able to bring a breath of experience that would be refreshing for the Subcommittee.

The other question or consideration that I'm curious about, maybe we can talk a little bit further is the evidence that shows having a particularly a Black clinician helps to reduce morbidity and mortality in the perinatal period, and how do we encourage, particularly Black and BIPOC maternity specialists in a rural setting in order to reduce particularly maternal mortality and fetal mortality.

So I'd be curious to have a little bit more discussion around that.

BELINDA PETTIFORD: Thank you Marie, we're adding it to our list for the morning, okay. Do you have a question?

JOY NEYHART: We also have a--

BELINDA PETTIFORD: Could you speak louder for them? Sorry. And give you name.

JOY NEYHART: Joy Neyhart. To answer pickups or requests, we also have on the ICC PCC Committee have a subject matter expert possibility, and Dr. Ericka Werner from the Society of General Fetal Medicine, she's going to be a speaker.

JACOB WARREN: We need one.

JOY NEYHART: Yeah, 100 percent. And I think the invites for the workgroups go to everybody, don't they?

KATHRYN MENARD: They don't, but I was wondering especially if the topics could be included. I was thinking that could be helpful. Do you know if it's a topic we resonate with and we really want to get on that one. It would be nice.

JOY NEYHART: We'll get you that, okay.

KATHRYN MENARD: If we knew what the agenda was, you know, or topic at least.

JOY NEYHART: Yeah. And Erica we're just coming in as a subject matter expert for Maternal Fetal Medicine.

VANESSA LEE: An SMFM for the preconception.

KATHRYN MENARD: I know, but for—for preconception, okay.

JOY NEYHART: Okay, yes, sorry.

BELINDA PETTIFORD: All right. So thank you, Jacob. We're going to move on quickly to preconception and interconception health, and we're going to turn it over to Joy and Phyllis.

PHYLLIS SHARPS: All right. So Joy and I have been working on the Preconception Interconception Care Group, which I always put backwards, but it is PCC ICC. And we have representatives on our Committee from the March of Dimes, from the Institutes for Medicaid Intervention right out here in the Federation of America, HRSA, and then Child Health Bureau, NIH, and particular NICHD, Department of Labor, CDC, from the National Birth Data Group, and particularly we have---I'm very pleased to have Sarah Verbiest from UNC Chapel Hill, who spoke at the December meeting --.

So we don't have a particular community person. We talked to ShaRhonda, but we would like to have some---I mean I think ShaRhonda- does a wonderful job, but that's a heavy burden to carry, and we are looking for recommendations for other community voices.

However, we do have organizations that work directly with women, families who are impacted by some of the issues we are discussing, and so we have some insight into these experiences, but it would be nice to get another community voice.

So right now, I kind of call us in the phase of casting our net wide. We're trying to look at the whole deal, what is, what's not, is there a limit. I mean it's if you think about preconception and interconception, it seems like it's all of your life, but to just focus on women. So just kind of figuring out what has been done, what are the gaps, and what are the things that are very specific to African American and Black and brown women.

We've had already presentations from Pram, from the Prams for Dad, which is very interesting in terms of male participation and reproductive health and wellbeing. We've heard the history and in that discussion of history of what next steps might be for PCC, and from Sarah Verbiest, and as well as looking for a model she has proposed, which has come under the work of her group of reproductive health wellbeing.

And we looked at a presentation from the Black Health Equity Initiative from Planned Parenthood. Some of the topics that we have discussed are messaging, and lack of information, and access to care, both if care might be available, but there are still barriers receiving care, and a lot of discussion of some of the impact on provider practices related to the recent turning back of Roe vs. Wade, and its impact in practice, and when

providers may see women because they're fearful of some of the repercussions and punitive acts that may be brought against providers.

We've looked at sexual and reproductive health care, and as well as broadening that to more than just women, looking at diverse populations, gender diversity, and males who also -have a part in reproductive health and sexual health. And I think we'll probably have more discussion about syphilis, and we haven't talked a lot about that, but additional -needs for the workgroup.

We've been talking about also federal restrictions and barriers that prevent implementation of technology. And for us it hasn't been so much the telemedicine as telehealth. When you talk about tele, and I know I'm not getting into nuances, but health in terms of giving messages, including some ways of providing education and increasing health literacy for populations we're working with.

Looking at the Medicaid expansion, we heard a lot of expanding care, particularly the interconception care through that first year of life for mothers. And what other venues that could be a part of home visits. Could it be a part of the community health work package for other things that are existing, but could we make sure that there is dedicated attention for them, and for that for women?

What about women with chronic conditions? We have women that in the past would not have lived to childbearing age, but now they are living to childbearing age, and do providers have

the kind of knowledge to help them make decisions, or what kind of provider is needed to help them make decisions and plan for pregnancy or not.

Working with teen and young adult populations, and so the peer, we talked some about the peer educators, so the presentation today with the doulas, and one yesterday on peer educators. Is there a role for that function? And then which gender diverse populations of males?

Our Committee has met as a group every month. We're the third Wednesday of every month--we skipped this month, and there's some scheduling folks, but we'll meet again on May 8th. Joy and I usually meet a couple weeks before the scheduled meeting with Sarah and Vanessa, to kind of plan our agenda, go over what we accomplished in the meeting before, and just plan for the next one.

Other topics that we have coming up is as Joy mentioned, Dr. Erica Werner. She's going to talk to us on improving mother's health during critical time periods. A list of specific funding, federal funding that has been awarded for PCC for conception care. Any innovations that states are using, if we have any data on that we're expecting a presentation from the Medicaid Group in terms of fraud and these ideas, and the national strategic plan for Medicaid with telehealth.

And I don't know if this is the faculty role or not, but I keep thinking we've got to organize this somewhere, someway, conceptually, and so we had a discussion about what would the

reproductive framework work be to organize what we are thinking about in recommendations. And we want the recommendations to build on previous recommendations and/or address for gaps that haven't been addressed as well as looking forward to what needs might be coming.

And then we would like to hear, we've reached out to NIH and NICHD for relevant research and/or the women's health research group at NIH. So our questions are, to the group, what are we missing, and are there specific concerns for Black women that may not be only for Black women, for women, rural communities and Blacks living in rural communities?

Anything else?

JOY NEYHART: I don’t think so. To Sherri's point about finding recommendations, I feel like once folks learn how to do that, once we've each culminated at the end, you know, we if we end up in workgroup sessions, does that make sense?

BELINDA PETTIFORD: Say it one more time?

DR. NEYHARD: Well, in terms of combining, having working combine recommendations, and then cut out the overlap. Should we wait until each work group has finished her work and then hash it out, or?

BELINDA PETTIFORD: I think we'll have some of the conversation tomorrow about trying to figure out where the overlaps are, but we'll need to have some follow-up discussions. And when we meet in June we all would- have had a chance to meet one or two more times.

And as we're seeing where our overlap is we need to figure out, you know, will the recommendation come from both workgroups, or either group, or do we just have one recommendation? Because we haven't really figured out the framing of the report, so the report may not specifically say the recommendations are tied back to a specific workgroup right, and that way we'll take care of—that piece will take care of itself. Do you have a question?

JACOB WARREN: Someone recently shared a concern with me about contraception misinformation and disinformation that seems to be spiking with that sort of perception It has been brought to me, and I don't know if that's on other's radars or not. There was one that was shared with me that was pretty painful to watch.

But I don't know if that's bubbling up, but it seems like of all the groups it might hit closest in this one.

BELINDA PETTIFORD: Great. Can you give us a little more context?

KATHERYN MENARD: TikTok.

JACOB WARREN: TikTok, yeah, was the one that was shared with me. And it's sort of classic approaches where people have---there is a kernel of truth in this, and then it spirals from there. We can share more but yeah, really. And this is--we are talking about contraception. I mean it was -sort of shocking to hear, so just we can share more findings.

BELINDA PETTIFORD: We'll be making sure contraception

is one of the areas you all are discussing. It sounds like you are, so that would include misinformation. Okay. I think we are back on track. Thank you for all this work, you should be proud of yourselves. So we hope to continue our conversation in the morning. We obviously have time to talk about the workgroups, and you know, and where we are, and thinking about next steps. So I'm going to turn it over to Vanessa now for our next public comment.

Public Comment

VANESSA LEE: This is our second and final public comment session for this April ACIMM meeting, and I believe we have our first requester online on the Zoom. Jackie Lou from Micronesian Islander Community, we will work on unmuting you, let you know when you could speak. Has Jackie been unmuted, Emma? Oh okay. Jackie, hold one moment, we're trying to... --

Jackie, if you're in the Zoom you have to accept the invitation to become a panelist. We will circle back, and it sounds like you may want to take a pass, Jackie, but again if you would like to speak we are trying to promote you in Zoom, and you just have to accept. If you continue to decline one more time we'll understand, and just take that as a final answer.

Shirley Crane, Lower Brule Sioux Tribe. I'm going to check one more time if Shirley is on. Okay. And then we were looking for Julia Skapik from National Association of Community

Health Centers? And Julia? How about Kevin Boyd for Dentistry for Children, it appears he is not online either. And then we did have Victoria Leo-Bianchi, Fostering Kids for Life who had put in a request, but she's also not online, so, but I think that's everyone who had requested public comments. If you want to open it up, do you want to take any?

BELINDA PETTIFORD: I'll open it up. Does anyone in the room want to make a public comment?

VANESSA LEE: I think the room has already spoken.

BELINDA PETTIFORD: Okay. Well, we set aside time for public comments. Please know for future meetings you're welcome to sign up for public comments again when we meet in June.

MS. LEE: We did not receive any written public comments, that's also always an option to submit your comments in writing to the Committee. But this go around we didn't receive any.

BELINDA PETTIFORD: Okay. And hopefully everyone heard that, that you always have the option to put it in writing, and we'll make sure it's shared at the meeting. Okay. Well, our next area on the agenda is our Panel of Community Voices, but we are starting that at 12:45, so we'll take a break, a nice little break. You get your break back that you missed earlier. So we'll take a short break now. We can make sure we get the panel ready.

SARAH MEYERHOLZ: Jacob, before we break, can you share with everyone what tool we used?

JACOB WARREN: Yeah, it’s called Miro, for the mind-map piece. It’s--yeah Miro, M-I-R-O. And it’s great, you use it live, so when we have the meeting you can map out what people are saying as they say it. It just helps organize.

BELINDA PETTIFORD: Marie, apparently, she familiar with it, she says Miro is great.

JACOB WARREN: It’s just really—we're having really complex conversations and it helps just put it all together.

BELINDA PETTIFORD: Is it easy to find online? A free software?

JACOB WARREN: It’s the classic—you can do a little bit free, and the rest you pay for.

MARIE-ELIZABETH RAMAS: Yeah it does like live sticky notes, you can have multiple boards going on at once and color-code it, see comments, and you can see people actively moving around the screen so it’s interactive as well.

JACOB WARREN: It’s great, it also gives you the opportunity to--

BELINDA PETTIFORD: That’s what it sounds like.

JACOB WARREN: To be anonymous, so if there’s someone that wants to say something but doesn’t feel comfortable stating it they can put an anonymous post on the board while you’re discussing to raise something.

BELINDA PETTIFORD: Thanks everyone.

Panel of Community Voices

BELINDA PETTIFORD: Good afternoon again everyone. We are back to wrap up our day. One of the most exciting parts of our day that we've been thinking about and planning for a while is our panel of community voices. We also are working with men of the community, individuals here in the room, and others.

We're able to invite other community people that hopefully are listening in to the meeting. So in order to make sure that everybody understands, everyone else, and where we are, at this time before I turn it over to ShaRhonda, who is going to facilitate this session, I just want to give you all a little background, and make sure that everyone has a good understanding of the Secretary's Advisory Committee on Infant and Maternal Mortality.

So, as you already know, I am Belinda Pettiford, and I get to Chair this awesome advisory group. We currently have nine appointed members, and a host of ex-officio members, like Charlan and many others that are participating virtually. This Advisory Committee on Infant and Maternal Mortality advises the Secretary for the U.S. Department of Health and Human Services on activities, partnerships, policies- and programs to reduce or prevent infant and maternal mortality.

So dealing with maternal morbidity, and the ways we can

improve the health of infants and women before, during and after pregnancy. So we kind of wanted to set that stage. I'm sure you've heard of some of the many federal programs that are coming out of the Department of Health and Human Services, some you either work in, or you may have used yourself at different points in time.

So for example, and some of us already having this conversation a few minutes ago. Medicaid or the CHIP, the Child's Health Insurance Program, the WIC Program, the Head Start Program, the Federal Home Visiting Program, and the Healthy Start Program where we had a great presentation on yesterday.

You, or someone you know, may have participated in, or had services at a federally qualified health center, or community health center, or you may have gotten services at one of the Title X planning clinics, all those are areas that we look at under health and human services.

All of these efforts actually play a vital role in supporting our communities and moving our work forward. So if you think about breastfeeding support, you think about nutrition, education and all of those areas. These programs can help improve health outcomes, help children succeed in school, and overall wellbeing for all of us, for you and your families.

But we know that these federal programs and policies, as we've talked about a few minutes ago, I won't call out any names, aren't always working the way they hope they should be working. And there are challenges at time in

assessing -- actually accessing these programs.

And we also know they are not the entire solution to improving infant mortality, or moms---making sure moms don't die because of pregnancy or childbirth. So today we really want to hear from you all. What is missing? What could we be doing differently? -What else should we be doing?

Our Committee is focused on making recommendations again to the Secretary for Health and Human Services for improving these programs and policies in order to address these unacceptable high rates of infant and maternal mortality.

But today we're specifically focused on African American Black families. And so we really do want to hear from you all. We believe that communities and people with lived experiences, those that have been pregnant, given birth, or had a loss, or the people who care for them have ideas and solutions, and we think that is critical.

We know the expertise you bring to the table. We know the wisdom you bring to the table, and that you share within your communities. And so, this afternoon we really want to give space and time in this meeting, as we try to do in others, but we really want to hear from the public. We want to hear from you all.

And we appreciate your willingness to represent your communities today because please know that as far as we have come to St. Louis is to hear from you all. And so, now I'm going to turn it over to ShaRhonda, one of our anchor members who will be leading this session.

SHARONDA THOMPSON: Thank you. Thank you Belinda for that background. My name is ShaRhonda, and a little background on myself. I'm from St. Louis, Missouri. Started with Healthy Start, Healthy Start I was pregnant. My children are 13 and a half years apart, so I was pregnant all over again, new, over the age of 30, it was all, you know, all a little scary.

I did end up having her early.

BELINDA PETTIFORD: Let her borrow the microphone. Oh, you got one?

(Laughter).

SHARHONDA THOMPSON: I did have an early birth. She was six and a half weeks early. I can truly say without Healthy Start and the Nurses for Newborn Program, I probably would have, i-t would have ended differently. -So thankful for the Healthy Start, which got me in touch with Generate Health, which led to the advocacy that I do today.

So that's just a little bit about me. So I will also give each of you a chance to introduce yourselves, just can you give us your name and where you live and work?

RONDA BRANCH: All right. That sounds good I like that. Hello everyone. My name is Ronda Smith Branch, and I am a community organizer with Generate Health as well as Founder and CWO, which I call Chief Wellness Officer, for Worthy and Wellbeing Wellness, which I operate as a life coach that specializes in wellbeing, and a board-certified health and wellness coach.

My goal is to help us understand, and we have the

ability to own our healing, and have that show up in the various ways that people need it for them to move forward and to be healthy, happy and well.

KYRA BETTS: Your voice is so soothing and mine is so not!

(Laughter).

KYRA BETTS: My name is Kyra Betts. I am the Policy and Advocacy Manager for Generate Health. I'm also a doula at DelMarney Marcels. That's enough because again, my voice is not as soothing as hers.

CAROLYN DAVIS: Good afternoon, can you all hear me? My name is Carolyn Davis and I'm the Committee Examiner, and I'm the case manager supervisor at MBRC, also known as Missouri Bootheel Regional Consortium. I've been around for 20 years. Ten years I volunteered, and ten years I've been a fulltime employee. One reason I'm always asked why do you volunteer so much you don't get paid? -

It wasn't the money to me. It was the fact that I believed in they mission and they goals, and I saw the difference that they was making in the community. But I never thought I was gonna be sitting in this seat today because I wanted to keep volunteering and setting my own hours. And now I got that 9 to 5 and they come afterwards. And now I've got that 9:00 to 5:00, everything comes afterwards.

And I never wanted to be a case worker. Never. All I want to do is stay out in the community, recruit and send

them their way, and I stayed behind the doors. But time brings about changes. And you know we have turnovers, in every organization we have turnover. And so, it came to me there was a need for a change in our organization, and I decided to take a step forward.

And as I stated, I moved and moved and moved and moved up until I was in this position. I do have folks that work alongside of me that I supervise. I have seen a lot. I've heard a lot. I've kept a lot and I've cried. When I was a young lady, newly moved here—I moved here about 22, someone recommended that I move to the State of Illinois and move back to the area in 2022, and that's when I got introduced to Healthy Start.

So I really got into the program, and the learning part to me was I did not realize that so many African American babies was dying, and so many Black African American mothers was dying. Because when I grew up that was not a neighborhood conversation. We didn't have mothers dying in my generation, or babies dying. And the reason why I feel that way is because the community was engaged.

If there's a pregnant woman in our neighborhood, and I'm talking about the whole neighborhood, not just the street, if there was a pregnant woman in that neighborhood, and once she had that baby, every women in that neighborhood came and we filled up the tub, the washing machines, and they cooked, and they mopped, and they did everything that that lady need done for six weeks.

For six weeks that mother did not need to clean the

house, and she had enough food, and they tended to the mother's child. And this is one of things that I think is still needed today is that we work in silos and collaboration is not where it should be. So I'll stop right there and let's move on.

SHARONDA THOMPSON: We have you virtual?

OKUNSOLA AMADOU: Yes.

SHARONDA THOMPSON: There you go.

OKUNSOLA AMADOU: Good afternoon everyone. Thank you so much for having me here. I'm really hoping that you can hear me loud enough in this space, but my name is Okunsola Amadou. I'm Founder and CEO of Jamaa Birth Village, and I'm also a midwife. I'm a traditional and a certified professional midwife. I'm a doula as well as a doula trainer, and I'm also a mother. So I'm a mother first.

I'm really happy to be here because I do bring lived experience of being a mom for 23 years, being in Black maternal health for 15 years, but just as our beautiful panelist just stated from the Missouri Regional Bootheel Consortium, I bring the traditional midwife perspective where I've lived in Africa. I've done global maternal health work, and she's absolutely right.

A lot of clinical providers, and even some community programs focus so much on the mom is pregnant now, what can we do? And it's really this rushing and this haste, and there's not enough pre-preparation. There's not enough true village support, and there's not enough extensive postpartum support that includes everybody. -

And so, I'm really excited about joining in the energy that she just provided, so that we can talk about the real embodiment, the true embodiment of providing perinatal care, not just pregnancy care and postpartum care, but full perinatal pre-conception fertility all the way beyond, you know, the first 40 days.

So, at Jamaa we have multiple models that we would consider innovative, pioneer models where we have a wraparound holistic midwifery care model integrating both doula and midwifery care, as well as mental health care support, herbal apothecary, community gardens, as well as mother, baby items.

We also work at the state legislative level and with hospitals across Missouri, and rural communities to help to ensure that their communities also have access to midwives and doulas. And we work at the national level through Black Mamas Matter Alliance, as well as AM CHIP and other recognized organizations to bring traditional and community-based solutions to the forefront.

So, I'm excited to be here, and thank you all again, and I'm looking forward to going deeper with some of the questions we have prepared.

SHARONDA THOMPSON: Thank you all for being here. I appreciate you all showing up to give us this perspective today. As Belinda shared, this Committee is interested in hearing from you. We rely on community input to help us understand the needs and the challenges, and also the success that's been experienced. The stories and the feedback that you provide, that will allow us

to include recommendations to the Secretary related to policy and program decisions, funding allocations, and program improvements.

The input, -without the input from the community and those closest to them, which would be you all, we wouldn't be able to effectively address the unique needs of communities across the country. So with that, I'd like to ask a few questions. The first question is from your own experience, or from what you've heard, or -community- from the community, or a client, what do you think is helpful to have a healthy and joyful pregnancy and birth? -Who would like to go first?

KYRA BETTS: So, those things aren't separate, right? Personally in the community. And I'm saying that they aren't separate. All this is the same thing. And community, relationship, appropriate levels of care, support, people who are bringing joy into your space, and not bringing negative energy into your space.

Culturally appropriate care, people who understand you, people who understand your culture, like all of those things. People are aware, and when I say people I mean like your care provider, your doula, or your midwife, or your dietician, or whoever it is that you are involved with during your pregnancy.

To really create joy you have to have lots of support. Pregnancy, very critically changes who you are as a person. It changes your brain chemistry. It changes the way that you interact and see the world. And in order to see that in a positive way, and not see that as oh my God, what did I do, having

people around you that can feed you emotionally, mentally, spiritually, physically, medically, they can really get into that space with you, and find the joy with you I think is really important.

RONDA BRANCH: I think maybe an understanding, right? The level of humanity needed,- I think I immediately thought about how my baby was my first baby, right? This was not your first birth, this was not the first person that you had taken care of today who had a child, so you treated me as if I was the second or third or fourth, or tenth or twelf-th, whoever, how many people that you had delivered that day, treated me as if I were one of them as well.

And so, I like that you are just excited about me keeping this baby here healthy, happy and whole as I am over check, next, check, next, which inevitably leads you to missing things, not feeling like you're--the patient not feeling supported, or understood in a way that is meaningful, just that.

And I'm the kind of person that you know, I will find a way to connect, right? When I had my daughter in 2019, it was during the Stanley Cup run, and so the intern resident came in. He had on a Boston Bruins lanyard or something, whoever we were playing opposite, and I was like okay, no, you can't deliver my baby because you've got to take that lanyard off.

You know, like I know how to try to connect, but I realize that you do that. I did that previously out of need for like, see me, right? Like I know that if I don't connect with

you, then you'll treat me just like you treat the others. How do I distinguish myself so that I get special treatment?

So to have to do those mental gymnastics is a part of that weathering thing that we experience as women of African descent, and how that plays out in our ability to be healthy while we are having our children.

CAROLYN DAVIS: So I feel a lot of is, we still have a lot of systemic racism in our communities, not just the Bootheels, it's other places. So because I'm a Black Afro- American woman, maybe you don't see the fault the way I see the fault-. And if there is not ( ) that’s not your business, your business is to give -me - , so we still have a lot of systemic racism that our clients go through. -

It's hard enough that you've got to try to get to the doctor, 100 miles or 50 miles because you don't have a OB in the town that you live in. I have been in a doctor office when I was in the community. I've been in the doctor's offices where this young lady walked to the doctor in the rain, and she was 15 minutes late. And we said you have to turn around, we saw her again, where are you, you're 15 minutes late.

I got out of the rain, she stood up, I said excuse me, did you just walk all the way up here in the rain? Evidently you didn't have transportation, and I said you aren't going to wait? And I had a badge, so I don't really think they knew who I really was, and so I had a name tag on, and so I talked to the nurse and I said can you all just make an exception just this once?

And in my whole career and my program, and I guarantee you, her next appointment she'll be on time, because I'll make sure she gets here. She said hold on. I said yes, ma'am. So she went back there and she talked to the doctor, and so I had never met the doctor. I had just started going to the doctor's office doing recruiting.

And so she went back, and she talked to the doctor and the doctor peeped around the corner and said, who is she again. I heard it. And she said oh well, yeah, I'll go ahead and see her, I have 30 minutes. You have 30 minutes on the next visit, you're going to take that 30 minutes and let that young lady walk back home in the rain? So I didn't say nothing but I was thinking to myself, and so he took her in, and when she came out I introduced myself to her because they took her right back.

I introduced myself to her and told her who I was and what I did and how our program worked. And she signed up, and then she brought somebody else to sign up, and she brought somebody else to sign up. So by me speaking for her that day she got me two more recruits into the program.

So sometimes we standby, we see things happen, we just let it go. It's okay to stay in your lane when you need to stay in your lane, but sometimes you need to get out of your lane, and you need to be the advocate for the person that can't advocate for theyself. They can't advocate for theyself, can't speak for theyself. They don't know how--like she didn't speak up for herself, a lot of young ladies wouldn't have spoke up for

theyself. Mine was like get this baby out, let's go.

So we are treated differently whether we have private insurance, or we've got Medicaid, whether we're married, whether we're single, it does not matter. We are always treated different. And until we do some systematic changes, and treat everybody like a human, things are not going to get better.

We've seen a little bit of twists and turns like we're going to get a little bit, twists and turns, and a little bit better, but that's not enough. We need everybody to be treated equal. We had one young lady, she said I been going to the doctor, I been going to the doctor, they take her blood pressure, they take my temperature. I got preeclampsia, but I don't know what blood pressure, what is preeclampsia?

They don't take the time to explain to this young lady that she had preeclampsia. Never took the time to tell this young lady what her blood pressure were. Never gave her a treatment plan. Never gave her a blood pressure cuff. So those are some of the things that we integrate in our case management is we tell them, this is what preeclampsia is.

This is what your blood pressure should be. This is what your blood pressure should be. Red light, green light, yellow light. This is what you do if this happens, if this happens, this is what you need to do. So we do the preeclampsia class also to let them know that you can have a right to know what your blood pressure is, whether you have preeclampsia or not.

Because if it's 110 over 50 today and it's 250 over 120

tomorrow, you better know. So I think the treatment that they give, they don't get a treatment plan. Every pregnant woman should not only receive a birthing plan, but she needs a treatment plan. So what am I going to do when my feet swell, why are my feet swelling, why is my hands swelling?

That's just natural, it'll go away--No. That's not natural, that's not going to go away. So this is the treatment plan to see what's causing it in the first place, and what we could do to not make that happen. So the time that they spend is like number one, like she said, number one, number two, then three then four, okay you go, my (inaudible)-. -

They did not take the time to really give them babies that come into the office that they need to kind of know what zone they be in, whether they're in the danger zone or if they're safe. I know someone who has been sent home from the hospital, she said they told her she was just two centimeters dilated. She got home, before she could get back to the hospital she had the baby.

Okay. Your two fingers don't add up to my ten fingers. I'm dilating, and I'm dilating real quick and I need some medical help. Come back when you're six fingers--I don't know when I'm six fingers. I'm not,- you know, when I'm- dilated that many fingers or centimeters, whatever you want to call it. All I know is that baby is pushing. I'm in pain and I need some help.

And so a lot of times when you think everybody is not drug seeking. Don't always label us as seeking for drugs, because you're in pain that doesn't mean you want drugs. That just means

you want to know why you're in pain. The same experience I had. I went to the doctor complaining about whatever it was. Oh, do you want pain pills? No. I don't not want pain pills.

I got a purse full of pain pills. I don't want no pain pill. I want to know what's causing this pain. I had septic, two inches from that, but they wanted to know if I want pain pills, no I do not. I want to know why the pain is causing me to hurt all over my body. That's not the answer--pain pills were not the answer for me. So I would not let them give me pain pills. I wanted to know how fast that pain come, and I wasn't pregnant.

I wanted to know what is that pain and why it's coming. What's it coming from, is it moving or is it staying? I don't need no pain pill. And I hurt. And I laid there hurting until they starting doing tests and they just sent me home. That's not the answer for me. And so many women go through that, because they don't advocate for themselves, so that’s why we advocate for them or try to wrap our services around those we serve. And now I'm going to stop and let somebody else talk.

OKUNSOLA AMADOU: Thank you for that, and I sat with this question a bit, mostly I think when I sat with this question I didn't feel that it moved through my heart as a midwife. I felt it moved through my heart as when I was a teen mom. And so, my first child I was pregnant with him at 13, and I was pregnant with him at an age where, you know, life was already compounded and hard.

Going to school was hard. Peer pressure was hard. I

had an amazing, my parents were absolutely amazing, but there was time poverty in my home, meaning that parents are working multiple jobs. My mom was in school, you know, it's five children at home.

So we have this system where it's set up that doesn't fully support the family. And so when I thought about what would have helped me to have a healthy and joyful pregnancy experience, I feel like it would have been if I already previously had access to a healthy and joyful life, that my community would have already come together, and would have been supporting me, educating me and looking out for me.

You know, traditionally in communities, once a girl hits menarche, or a little bit before she hits menarche, they start to educate her about this is what you're menstrual cycle is, this is what it means, this is how your body is going to change. Your mental and emotional moods can change whenever this happens, and maybe you should eat different around that time.

And you know, we can make sure you don't have many chores around the house at that time. So if we start to think about what's going to make a pregnant person or a woman happy or healthy in pregnancy, like how are we treating them when they're on their menstrual cycles?

We're still expecting women who are on their menstrual cycles to still raise kids, and cook and go to work like they're not bleeding. And so that same patriarchal and colonized thought process, the same pathological thought process then carries on to pregnancy where we expect women to keep working, and doing all of

this work as if they are not pregnant, and for them to stop working one week or two weeks before their due date.

So, thinking about those experiences, thinking about the many, many moms that I've seen across my career where I'm trying to give them nutritional advice, joyful advice, like what are some of the things that bring you joy? How are you sleeping, eating, thinking, resting, decompressing?

And they're like I have to do this, I have to do that, there's no one to help me. So I try to assist them in delegating, but it's so hard because there's already a mountain on top of them. So my answer to this is a system. We need to as a system, help to restructure communities, help to make sure that we are supporting families, and making sure their resources are available, and making sure that across the sector, not just OB and L&D providers, we need to make sure across the system government officials, everybody has proper comprehensive anti-bias, anti-racism, culturally congruency changes.

Because all of the procedures, laws, and policies are coming from the top down. And if we just cherry pick whoever is going to go through a bar training, or cultural congruency training. There is still a gap, and we're still losing sight of what we need to do. So if we ensure that at every single level in our society that people are addressing their bias, addressing systemic and structural racism, then we can really reshape our country to bring families closer together to shorten the work week, or find some kind of way to better take care of people who

are in the childbearing ages.

Make sure there's access to transportation and housing, really thinking about the reproductive justice framework that was created by those amazing Black women, 12 Black women in 1994, which addresses all of those areas. So healthy, joyful pregnancies start before the pregnancy, and we're missing the mark there. And that's my---let's- change the system and the structure completely, altogether.

RONDA BRANCH: I wanted to add to what you beautifully just spoke about and how it manifested personally, and I'll just wrap it up really quickly, is I do this right, we go, and we have these panels, and we speak about our experience. And recently, it came to me on one panel that I did not feel that I had the right to tell you no about my own body.

So think about the level of systemic racism and racialized trauma you have to endure to, -and this is my baby four, I'm 40 years old. I was 35 when I had her, married, private insurance, checked all the boxes, right? That means in our "system" that I trusted, which you can't- trust systems, so you know, whatever.

But that meant that I was supposed to have a heathy outcome at the end. I was supposed to be happy. This equals joy. I checked all the boxes, that equals joy. But then you realize that you don't even feel like you have your own agency enough to say, and I'm educated enough to advocate for myself as best I could, still did not have a positive experience because I felt

like I could not tell them what to do with my own body. It doesn't belong to me, right?

Like you have to live in this space to understand what it means to feel like you cannot tell someone what to do with your own body. So I wanted to add that we talk about overhead, it starts when I'm a child and understanding what it means to have a healthy relationship with my cycle.

I tell my daughter, and she's like no, you don't have to be afraid of any of those things. That is your good china, you have a uterus, this is just what it does,- right? If we don't get that education, if we're- not treated that way in childhood in our educational settings, it translates to what we experience every single day hearing from community members, our own experiences.

And one young lady that I was working with not so long ago, and she said I don't like the fact that I don't get to see my baby all the time because I go to this publicly funded clinic. I can just hear, you know, they do the doppler. I do know that the heart rate is there or whatever, but I don't get to have a sonogram that helps me connect in a way that someone with private insurance would, the frequency.

So now you're impacting this woman's ability to connect with her child because she goes to a clinic, you know. Like if you think about it on a granular level, those are the things that we're missing, and that big systems decide are not important because they don't equal financial gain, capitalistic structures that, you know, make sense, what's the bottom line, what's the

ROI?

The ROI is this person gets to experience their child and loved one in a way that impacts their child as they grow old so that they can fulfill the capitalistic space. So, having those understandings of let's think beyond what we know, and that we're the experts because you're not.

People are their own experts for their lived experiences and for their own bodies. So, bringing it full circle, when you feel like your body doesn't belong to you because of the color of your skin, that translates in a way that leads to unhealthy outcomes.

SHARONDA THOMPSON: Thank you ladies. Great information. Loving it, loving it, let's keep going. Next question. What helps a mom and her baby stay healthy and thrive? I think that's the key word for me, thrive after the birth.

KYRA BETTS: After the birth? All the same things I said before. After birth is really critical, right? And when you think about our maternal mortality rate, and you think about the timeframe that we are learning that people are the most fragile, then 42 to 100 day period, that's usually when the excitement of their new baby has worn off. That's usually when your family is not really coming to see you much anymore.

You've had your six week visit, and now you just have to sit there and figure out who you are, because as I said before, it changes everything about you. So now, a lot of the times because we don't have a wonderful parental leave in this country,

a lot of people feel like they are by themselves with a brand new baby that does not speak English, and they cannot actively communicate with.

And so you are healing, and you are learning who you are after the rebirth because every single time when you have a baby you're rebirthed, okay. I never believed that until I had second baby. You know it was like oh, all over again. I just figured her out, and now I got a new her.

But I think that's literally exactly what happens. And in that space you need support. You need help. You need access to your provider. You need adequate access to a provider that can listen to you, and can trust you, and can care about you, and can hear you.

You need access to a provider that you can say hey, I'm struggling. And they say okay, let's figure this out together. What do you mean struggling? And not, oh, well, do you think you're going to kill your baby? Because the first thing you're going to say is no. The next day you're going to say there's nothing else, right, and then you're going to go home and now this seed has been planted in your already fragile mind, and so now you are terrified of something that you had never considered before.

So in that postpartum period, in that space you need support in many, many ways. Medical support, partner support. When I was born my dad, -that was the first time he had ever seen a baby born because his other children he was- off in the other room waiting, right?

That's that generation. In this generation, all of our partners for the most part are there. Our support people are there. Where is the support for them? Where is the education for them? Where is the education for our partners about perinatal disorder, or about postpartum rage, or about taking care of a baby?

And these things, it does exist right? On the other side of a pay wall. And so we already exist in a space where we have learned basically nothing relevant about our reproductive care, about babies, or anything like that. When you look at most Home Ec classes, they give you the baby, it terrifies you, so that you never actually learn anything about taking care of a baby.

So your partner doesn't know. You're figuring it out. They're figuring you out. You're excited that this little baby has been born, also people aren't coming to see you as much, and you are alone. And the thing that I created within my doula business it was called The Golden Hour.

And the Golden Hour was a Black mothers support group, right? It started out with breastfeeding, and then it became I don't care how you feed your baby, just come, right? And it was for an hour once a week that we could talk and build community. Most of our conversations stopped being about our babies within like the first two weeks.

We had conversations for about our sadness or our joy, or whatever TV show we were watching, whatever, because we had built a community because you need it. You need that. In other

countries women who have babies, they put them together, right. You go to your postpartum wing and there's two women in the room because they're not going to look over at you like, oh she looks crazy too. I'm all right. Okay. Oh, her baby is crying too. I didn't do this. I didn't break this baby, it's just a baby, it's going to cry. I'm a little delusional, I've been up for three days. I'm going to have a baby, but then I see her baby is crying, so I'm okay.

So that's the one, that's what the short answer is support and care, familiarity, love, community, and again, I cannot emphasis enough adequate, appropriate useful health care.

OKUNSOLA AMADOUU: Yeah. I wanna—oh, okay I saw the microphone going up, okay. I wanted to follow up with that. That was really powerful, Krya, and it was like you know really genuine and authentic and honest. And I want to walk it back a bit because we have organizations like the World Health Organization who has told us that the critical parts of postpartum goes -up to year two.

However, all of our models, especially the American model treats postpartum as if it stops at six weeks. And all of your subsequent gyn visits, or your gyno visits, you know, if you happen to get one, they're treating that visit as an isolated visit, not as if you just had a baby.

So it's your well woman exam, let's do that. Not you're still technically in postpartum. So we're completely missing the mark again, systemic structural issues that are

impacting all women, but that grossly, negatively impacts Black women at a higher rate, of course. That's why we're here.

So with that being said, in order to have a healthy, thriving, postpartum period, we first need to get it across the system loud and proud in a campaign that postpartum is actually two years. That you can be mentally and emotionally fine the first year, and have a major life change. You change your job, you have a breakup, you've got to leave your house because they found mold in your house, and you have got to move in your mom's basement.

Whatever it is, it can trigger mental health issues, so I'll stop there with the two years. Now if we walk it back down to the American variation of six weeks, what's happening at that six week visit? I'm sitting in the waiting room for one hour with probably a crying baby. And then you all have the nerve to let me see my provider for five minutes, while I'm crying on the table, eyes are puffy, you may possibly do an Edinburg postnatal screening.

By the way, make this a note. It needs to be a perinatal screening. Why is it postnatal? It needs to start from the first visit. Do the baseline. How did you start your care, and keep checking. And then, I don't want to get mixed up in it, we have to make sure these spaces are sacred and safe as Kyra said, because if you approach me in the wrong way, I'm not going to tell you the truth if you want to screen me.

So, if I know this is a safe and sacred space to say

I'm falling apart, and it's not my fault, I just need help. Then you can screen people appropriately, and don't screen me and then not do anything. Don't screen me just to put it in my file, and you don't have adequate ways to do a warm referral, meaning I have a relationship and a contact at this place, and I'm going to directly move you in, and I have a team member who is going to follow up- to say was this person taken care of.

It's over for the paper referrals. It's not working. So back to what I was saying about the six weeks, we are missing the mark there, and people are not getting the adequate care at six weeks, so they're going home defeated. And as Kyra also said, that 40 to 100 plus day mark, that's why we're losing women.

So if we move it back down, why in all of the green, luscious, beautiful planet of our world, why do we speed up our prenatal visits at 28 to biweekly, weekly at 36, and even more if you happen to go postdate. But as soon as a major event happens, let alone if it's a C--section, why do we shrink those visits to where you get a six week visit, and the only way you get a two week visit is if you have a surgery-, or something major comes up.

It makes no sense. So with that being said, I cannot thrive after birth if I don't have adequate care, and if when I do come you all aren't taking very well good care of me, so the condensed finalized answer with that is building a strong village as best as possible. A lot of my family say I don't have anyone to help me, no one is there, so I say well, who do you trust?

And then I teach them how to delegate in pregnancy,

because a lot of women that are afraid to speak up and say I need help, or they, you know, it's hard to bring people into their life because of how the system is. So I help them start to delegate early on, identify who can cook, clean, watch the kids.

In other cultures as soon as a woman becomes pregnant she moves out of her own house and into the mother-in--law's house, or somebody else's house until a few months after she has the baby, so that she's not regularly doing chores and things, so it doesn't- just start in postpartum.

We're already removing those responsibilities from you. So let's help people identify who their family is or friends. If they really don't have it, and they can get a doula, the doula can help them to build a community-based village that can support, and again to thrive in postpartum it starts in pregnancy.

There's so much more I can say, but in respect to my co-panelists and the floor of the event, I will stop there.

CAROLYN DAVIS: So I'll go next. So I believe that education, I really like to push education. If you educate the pregnant mom while she's pregnant what's going to happen after she has the baby. So if you got a birthing plan, we should also have a plan for interconception.

If I know what I want at birth, after you have this baby, you should already have something you can think about who is going to help me, am I going to stay for six weeks. And I think if they have a doula this is a big help. When you educate them on if you do this, this is what's going to happen. If you don't do

this, this is what's going to happen.

You come back to your six week checkup you may run into complications. You need to come back to the six week- checkup because there's a possibility that this will happen. So if you ingrain that in they mind, this is what's going to happen, or this could happen. So education they received through the time they're- pregnant will carry them on to the time after they have the baby.

If I know that I can't go lift 20 pounds, once I have my baby, I'm not going to lift the 20 pounds. If I don't know that 20 pounds is going to cause more harm to my body, I'm going go ahead and lift it. But if I know that's going to cause an effect, I'm not going to do that.

So if you educate them during their pregnancy of the consequences that could go on after they're pregnant, I think that's a big plus because if they don't know, they don't know. Your time is no longer your time while she had that baby, that’s the baby time. You don't get to sleep when you want to sleep,you gotta get up when that baby get up, and that baby is going to cry, you have to change that baby, you have to give that baby a bottle, or their breast, or whatever type of formula you're feeding that baby. You've got to feed the baby. You have to move where the baby moves.

If you want to take a nap, take a nap when the baby is taking a nap. So all this stuff should come before she has the baby to prepare for what's going to happen after she has the baby,

so she can expect this. A lot of people had a baby and think okay, that's fine, and don't safe sleep.

That's a big plus to educating. A lot of young ladies I talk to they're like well I can put the baby on the couch, he's not gonna move. I say ma'am, can that baby move in your stomach? Yes. Then it can move out your stomach. And most of it is small education like that that saves babies' life. Just to let them know practice safe sleep, put the baby on his back, or on her back, alone in a crib, and none of that pretty stuff. You can pin it on the wall, but don't put it in the baby bed. Do whatever you want to do with it, just don't put it in the baby bed.

Educate them on safe sleep, how you act when the baby's crying, shaking the baby won't make the baby be quiet Don't shake your baby. Car seat safety. When you're going on the road and you see little kids there waving hi, that kid is not in a car seat? No. Education is the key, it's during pregnancy, after pregnancy, education, education.

Sooner or later they're going to get it. They're going to get it. I tell my daughter stop putting the baby on the couch. They ain't hurting nothing, she's just two weeks old. Stop putting the baby on the couch. It ain't hurting her, she's just two weeks old. We was in the kitchen cooking, and it goes to the living room guess where the baby was? On the floor.

You could have the baby on the floor in a room with you. No. The baby moves. So she found out, but it took her going into the living room seeing the baby on the floor. I'm sitting

here with my mouth open. She slipped off that couch and went right on the floor. I didn't hear no bump them, she didn't bump, but she scooted herself off the couch.

It's those types of education that we have right in our palms, and we need to teach that stuff here. You have to take care of yourself. You have to be mentally and physically able to take care of yourself now, so you can take care of that newborn child. It's a lot of energy, it's a lot of time, it's stressful. I've been there a couple times. I know.

With my first baby I made a lot of mistakes, but I guarantee you the rest of them I got it down pat. They all kept up there because they are different people, but I knew what to do at the time I had that second baby. And it's education, education, education. And we also like smoking, you have to really educate them on that. You could smoke, and it's fine if you smoke, but don't smoke while you're pregnant, and don't smoke around the baby, go outside.

If you have a piece on your body, take it off, wash your hands, have a baby. It's the education. I don't smoke by the baby. That's second- and third-hand smoke, it will get your baby to have some, you're going to have a medical problem. So is there education that we provide to our clients and to the community when they're pregnant and just get the community as whole because maybe I can't reach the mother, but maybe I could reach the grandmom, and say you know, this is good.

And they listen to grandmom because everybody's mama

does, right? So when you can reach one, you might be able to reach the other, so you can educate not only the parent of the baby, but you're educating community as well.

RONDA BRANCH: I was thinking as you just said that at the end, one of the new girls at school. And I was at a school today and there's a young lady who is pregnant. Her baby is due in July. And I just watched her like oh, you're in high school when you're pregnant, like whatever. I just watched her like do you know you're in danger?

Like Sally, you and that girl, that you don't really have a complete understanding of what that means, right? So you think about returning joy and thriving spaces to people. Having them understand the education of course is what we're talking about. They're doing it in a way where they can relate to this 17 maybe year old girl can say oh, I need to be able to tell someone I don't like that.

Oh, I need to be able to share with someone that I'm struggling here, and making those spaces psychologically safe enough for that to occur. So I just kind of wanted to piggyback. It's an educational piece, but also letting people know that this is one of the most like life and death type, you are at the bring, you know, bring new life into the world, and that it's a really big deal.

Not to scare you, but for you to understand that this process is really, really serious, and what that means for your body. So understanding that on the front end, during and after of

course is what everyone is saying because we know that it's the truth. We know that it works, and we know that it's what community needs because we've experienced it as community, and we help people who experience it daily, as community.

SHARONDA THOMPSON: Education is empowerment, yeah. Another question. Are there specific strengths, supports, or assets we see in your community or area, or within the families you know or work with that you want to mention? So what's working?

KYRA BETTS: Community gardens. Access to the midwifery care model, community organization that can help with convention to resources, so like the diaper bag, portable cribs, because you can tell if it's safe sleep, or if they don't have a - save sleep, sorry to use the word. So that, of course, but then I'm- also seeing right in this generation of a return to like closeknit community, right?

Closeknit grouping where it may not be their grandmother that comes, but your sister, or your sister-in--law, who is like I don't care what you say, I'm here. I'm going to help you. Go lay down, and just tell me what you need. And getting back in that space I think is going to be-,-- it's going to be a really big problem for them to fix, right?

Because if you have access to first of all the community education is surrounded, which we're starting to see some of that through community organizations, and being your sister who just learned about preeclampsia, and learned that

you're still at risk after you have a baby, if she looks at you and your face is swollen, and your feet are swollen, you're like oh, God I'm just tired. If she can say, no, no, no, no, you need to go to the hospital.

And she can also help you advocate for yourself. And I see that, and I've seen that. And I had my first baby during COVID, and so I had my second baby last year, and I had so much of that. And I still have so much of that because I'm still within that one year period of people saying no, I'm going to help you.

I'm going to do that for you. I don't care what you say because we have pride. Women have a lot of pride. We live in a society that glorified the snap back and the get back, and act like birth didn't faze you. But one of the most important things that I'm seeing is people telling I will cherish this time, cherish this change.

Cherish this experience, and while you know, I will figure these dishes out.

RONDA BRANCH: I wanted to really quick say about because we've been thinking about the village a lot, right, talk about the village. And we know that the proverb, well, some of know that the proverb says it takes a whole village to raise a child, and you know, most of the time in our systemic way of thinking we say like hold, like one, two, three, four, five, six, seven, all of you all.

It takes a whole village, body, mind, soul, bio, social, spiritual space, where people are healthy, and that sister

has to be healthy enough to say I have time and space for you, right? So that person also has to be whole in thinking, they are. So now we're looking at what does it look like to have wholes for community, or whole as they are.

They have options to what it looks like for livable wages, and the ability to get to that job, and not have to ride the bus for four hours to make less than $20.00, you see. So I mean the ability for the village to remain whole, to show up for that person is inevitably going to impact how we get to the healthy outcome.

And so, when we're talking about what we see in community, you have grass roots organization, you have communities that are coming together and forming, you know, that village. You know, well I ain't in one right now, but I can call so and so to help you get it right, so having access to whole beings, which means that we have to state the ability for people to get and remain, I say, attain, sustain, maintain your wellbeing space.

And if we're not doing that, as a Department of Health and Human Services, then what are we here for? If people are not well, then we don't have the ability to do this at all. We don't have the ability to teach them and train them on what it looks like to take care of your body before pregnancy, the perinatal period does not matter if I do not have whole beings in my space to rely upon.

OKUNSOLA AMADOU: And I want to add to that. I know we're getting really close, so I'll try to be as brief as I can.

And I just really want to encourage you all out of everything that we've shared, to not attempt to put this in a pathological, clinical, landscape, as much as possible because that further, like we can talk about perinatal screenings.

We can talk about needing more appointments, or longer appointments, and things of that nature, but then it further isolates us. And I'm saying that because 90% of women and people who become pregnant in the U.S. are low risk. They don't have any complications. And so, we're not practicing risk appropriate care. We're not putting people in the right care spaces, and we need---we have enough OBs.-

We need more OBs in rural communities, but we also need more midwives, because if not, then to when people are, you know, are low risk and healthy, then they can maybe go with a midwife and spend 45 minutes or an hour on a visit. Have that holistic care where all of these different spaces are taken care of. And then have enough OBs who aren't burnt out to deal with the higher at-risk people. -

So I wanted to say that if we keep approaching this from a pathological experience, like every client has a disease or a disorder, and we have to over intervene, and we're going to continue to treat this from a fractured nature. In regards to what's working we, in our community, from the things that I can see, is that moms are forming their own support circles without structures.

I remember when we first started, you know, Jamaa, you

know women, they would meet each other in passing at the village, and they would exchange numbers. We weren't creating an email list, and we weren't saying get together on Tuesdays every night.

And then we did start holding the formal circle in a group, but you know, eventually as that passed, as things changed, you know, I would see my different moms from Jamaa out in the community. And they'll say you know, so and so, we meet up every week. We exchanged food from our gardens.

So what I think is working is that people are getting back to just building those relationships. We're moving out of fear of getting close to each other again, and I love to see babies growing up together, and mothers continuing their relationship outside of the care that they've had at Jamaa on their own.

I feel like it's teaching people to not have to rely on systems and organizations, but if we do our work well enough, and we empower them, then that means that they can continue on without us, which is what we need for people to be able to rely on their community and not systems.

BELINDA PETTIFORD: ShaRhonda, I don't want to interrupt. Please forgive me for interrupting you, but I want to make sure.

SHARONDA THOMPSON: The last question, that's next. We're on the same page. You think that was working well?

CAROLYN DAVIS: I think.

SHARONDA THOMPSON: Okay.

CAROLYN DAVIS: I think the collaboration that I mentioned again, has been kind of working a lot because we do have a lot of work, but we still have some organizations that build that, and they just don't have the means to corroborate some of the activities that's going on in their community.

We have some help, insurance companies, Allstate. We have our baby showers, and we have--I mean their organization comes in and gives information, they talk to us. So it is working. If you collaborate that is working to collaborate.

You have to build that trust in the organization that you're dealing with. Everybody don't trust, and that's a problem. And we hear stories, but we don't know what the real reason is. I remember, me and my coworker, we rolled up and went to the houses, and we knocked on the door, and they won't talk to us.

And so, finally I knocked on the door and I said may I have a minute of your time. So the lady got to the door, and I told her who I was, but also the program, and so they invited me in, me and my coworker in to talk to. And we got the young lady that was pregnant in a program, and so we came back out, we were sitting there by the fence and because who ever let us in the door must be somebody they trust, or was connected to.

So I had to go talk outside, but when we first drove up, bam, bam, bam, you could hear them slamming the doors and running. And I think you know, one of the young ladies, I think she kind of knew my face, but she didn't know where I worked. And so, I said because the trust issue because in the time somebody

comes to their door, or come into community with a badge on, the first thing they think is the DCI.

They're coming to inspect me. They're coming to take my kid away. And so, I don't know how to take that away from them, but it's bad when you go to the community, and everybody stands at the door. I hear some bad stories. I hear some good stories. I don't know. But I do know that I have had to help deal with some of the youngest cases that we had in our organizations.

And they were sweet, but there was a battle to get there. And there's so much that have to happen to get that child back into their home, and was all legal. I don't know because I don't know what, you know, what they can or cannot do when they come down to the issues. But we took this young lady to court. We took her to outside behavior health classes. We did everything that it's so hard to do with, and I mean this went on for a whole year before she had that child back into her home.

And that's so bad. I had to go inspect her house to make sure that everything was plugged up, everything was gone, make sure she had -- I mean it was a whole list. And every time you get one, there's another being picked up, it never ending. And so she gave up, she just gave up. And I said you've got to fight, you've got to fight, it's not a game here.

They're serious. You need to do whatever it is from A to Z, back from Z to A. This young lady had the keys to her own house. About nine or ten o'clock that morning. Four o'clock that

evening she got a phone call and the nurse told her, we found you a bed, you need to go stay until 30 days with good in-home behavior. She went to pieces. She did everything I asked her to do. Never found her a bed, for a whole year. But we had to take her to the place, get her dropped off. We still did, take care of her phone. When she got up she called me, she screamed and scared me to death. I didn't know what's wrong.

Back in court the next week she went to court. She called me, she screamed at me, and she said I got my baby back, and when she seen me, my colleague and I didn't know who it was, and someone was just charging at me. She just said I'm so glad they had Healthy Start. I'm going to do that. I'm going to make it.

She said you all had to see it. I'm back, I did this, but it was a battle. And it's not just there in this organization, it's other organizations that and like I say all that they know is, you know, we don't have anyone to take her. We don't have no guidelines that you could be, you have this much money, you can't do that.

You're pregnant. You can have a baby tomorrow, everybody takes you food, everybody see to the baby until 18 months old, and so she graduated out of the program successfully. She still has her child, and she still sees her mental health specialist on an outpatient basis. But she said the reason they took her bed was because she had a doctor's prescription to smoke marijuana.

And so I could relate to a young lady telling her story today. So like I said, some of the organizations the people do work for the client, and then some of them get to slide. It just depends on what it is.

SHARONDA THOMPSON: The last thing, real fast. If there was one thing, one thing that you would want us to pass on to the Secretary of the Department of Health what would that be?

KYRA BETTS: The problem that we are experiencing in this maternal care crisis is unique. It is fixable, right? We have other developed nations that do not have the problems that we have, right? So that means that there is a will that has been invented. We have to stop treating the maternal care crisis like it's some mystery, magical thing that we don't know what's happening.

We have to stop asking that we cannot deal with our roots and pull out racism. We have to address that. We have to address medical racism, medical abuse, obstetrical abuse. We have to do all of that in order to fix any of this. It will not matter how many midwives. It will not matter how many nurse practitioners.

We could build five houses in every rural area, not houses, hospitals, in every rural area to take care of prenatal people. If we do not address the system or rampant racism in the United States in our health care system, every piece of work that we all do is for nothing. We have to address that. We have to fix that. We have to hold providers accountable with community

and say that they are harmful.

And until we do that you all wasted three days. We wasted a little more than an hour of your time because nothing will be fixed, and nothing will change our Black women, Black birthing people, until we address the way that the system has abused, disenfranchised, mistreated, hated, and killed us.

And I wrote that earlier because I worked through many questions, and picked this one. That's the one.

SHARONDA THOMPSON: I bet you're glad you did.

OKUNSOLA AMADOUU: And I'll follow up with that, and I absolutely agree. And that is why we cannot approach this as an isolated thing where we just want -to - I know currently in the State of Missouri, the goal is to do and place a bias training in the maternal child health field, and we have to do it everywhere. So- you know, back to my statement earlier.

Every single sector of America identified every single sector, like everything, everyone has to go through a restructure, and we need to be honest about the value and the power and just the essence of you know, what it means to be Black. And we really have to restructure the mindset around training and education that perpetuates, that Black people are lesser than, don't feel pain the same way, like all of it has to be changed.

And I know it's not going to happen overnight, but we can't just start at maternal child health. We need to start at the top. So what I want to wrap up saying the one thing that I want you all to focus on that I know you can do right now, while

we advocate for system wide change from the absolute top down, is that we need to activate risk appropriate care now.

That's it. It is the difference between Canada and Europe, and some African and South American countries is that they actually put people with the providers that match their risk range, and it's if we continue to put capitalism over the individual wellbeing of the patients and clients who need to be served, then we're going to keep getting the same result.

So why do we want to focus on implicit bias and cultural congruency training. We need to say loud and proud, just as much as we say loud and proud, the postpartum, the critical postpartum is two years. We need to say loud and proud that we need risk appropriate care, and we do need to end this OB midwife word that was started by obstetricians, that was started by the federal government by the Shephard Towner Act, and coming off of the Flexner Report.

We know how harmful it has been. It's not enough to say that. We have to get risk appropriate care and we have to get retrained and restructured. That's my thing that I would like to leave.

RONDA BRANCH: And to even, make that even more exponential in my opinion, taking the risk appropriate care and doing it in a way that is customizable to that space, right? Creating a framework, or having the flexibility within that to pull out exactly what each institution needs because it's not going to be the same across the board.

So we can get a risk appropriate care to the people, and we can say that that is what needs to happen within a framework of how does this particular hospital system need to handle the instances of bias, issues that it has? What does it need to look like? What is this, and I call it a wellbeing action report.

What is well about this organization? What needs to happen for this organization to reach all these holistic goals of being psychological safe in your mind, body, soul and spirit, right? If we do that, then within a way that says as I said we're going to beat this because you all got to be, okay, so your people need to experience this.

And your people need to experiment this kind of. There is no across the board anymore. We are individual human beings. We have to treat these spaces as if they are customized to see me as the human I am, as Rhonda, and Sharise, not number 3643725, which was a mistake to begin with, right.

So the ability to customize what these institutions need exactly for that institution because what BJC needs is not going to be what Mercy needs. They might need the same thing, but they're probably going to need to be delivered differently. Do we have people available to hold space so we can explore this explicit bias in a safe way?

I can guarantee you nobody wants to say sometimes I get scared when a Black guy walks past me to another Black person, and be like you know, I could understand why you feel that way because

of this. We can have a conversation about that, right?

I'm not saying we have to hold space for everyone because it should not be on us. It's not on us for you to get it figured out, however, if we can figure out a way for those exchanges to occur in a customized way that we use each individual hospital system what they will need specifically, we might be able to get something there.

RONDA DAVIS: I know everybody else hates that, but we need to change the tone. They have gone through so much. They lost children, they lost sisters, they lost brothers, they lost mothers. Unpredictable death, uncontrollable death. It could have been any of us. We listen to the stats, we look at the numbers, and they're like night and day.

I'm going to reroute this thing right now. So let's talk about some funding. And the reason I'm going to talk about funding is because sometimes we have a tendency to put all our eggs in one basket, and we wait to see them hatch. And one might hatch today, one might hatch tomorrow, and one might hatch next week.

But being in a community I see were funding has run out in organizations. It's great to have fundings in different organizations, but they run out. But you still got the other organization that everybody depends on, or everybody things we have this, and we have that, and we don't.

And I'm not just talking about MRC and Head Start, I'm talking about other organizations that's at the table, or should

be at the table. So if we put all our eggs in one basket when they all hatch there is nothing there, right? So when we put all our funds in organization, when we've got 20 organizations in the community with this whole organization running out of funds, then five are out.

And the reason I'm saying is because I did what so many pregnant moms, so many, and by the way we have served over 156 baby moms this year, but in general for our pregnant moms and the section models, we have served that many. Some moms don't even have $60.00 to pay for a deposit, with no income, with $20.00 for rent. $60.00. And they can't get that $60.00 in thirty days, guess what? They lose their spot.

So they don't have no money, the charity don't have no money. They don't have, nobody got no money, but these clients are out, there's a session that's just run out. Why is all the funding be putting in one place? Or not being divided equal enough so that other organizations can help the clients, all the people that they serve?

I had a mother that had her lights turned off. That mother was getting her gas turned off. We called everyplace in the Bootheel that's supposed to have funding to help this young lady. The money ran out. That's the year we did close out the books, we had no emergency funds, nothing was left. Our pot is dry.

So, I tell people to find other organizations for emergency purpose, a funding stream- t-hat when you have a lady

that needs $60.00 to remain in her own house, and to not be homeless and pregnant, $20.00 for her lights, $30.00 for her gas, $50.00 for water, this is a true story that I'm telling because I actually had to help this young lady, and not just one, but several.

So what do you do with the ones that got the funds, don't have the funds anymore, and you don't have the funds? Nobody has an answer right? Nobody. I can't give $150.00 I'm short myself. I live paycheck to paycheck just like everybody else. And that's where I started thinking I can't do it.

Is that, are there other organizations that could help pull this piece to at least to get her into a house, or to keep their lights on, or to keep their gas on? Or to not get their keys taken back? Trust me, the minute your light goes out, in public housing, you are out the door. The minute your gas go out in public housing, you are out the door.

The minute you don't have food in your house for three days, DCF is coming to you. This is true. I didn't just make this up. So my thing today is if there could be some type of funding, and the other organizations can get some, because instead of the one that's already getting it, and I'm glad they got it, and they do a lot of help, but it runs out.

So if there were reimbursement funds were there's a young lady who needs to go to the doctor, she might have insurance, but her copay might be $50.00. She don't have $50.00. Just a thought for today, and after that I rest.

SHARDONA THOMPSON: Thank you ladies. You have given us a lot to feed off of. We'll definitely take it to heart, and use it in our recommendations. We appreciate you.

CAROLYN DAVIS: I just want to say I really appreciate you being here today. Thank you for giving me a chance to voice for those who don't have a voice today. I appreciate you listening, and I'm looking for some results.

The Mourning Project

BELINDA PETTIFORD: Thank you all so very much. We could not have asked for any more. Please know that. And thank you. And sorry for keeping you a little bit over. I knew that. Thank you very much. As we get ready to wrap up, just before we wrap up I did get to Carla, Carla Duncan, she put a card on your place before we went on break earlier to talk a little -- she wants to just give us a quick announcement about The Mourning Project, and so we told her we would give her a minute or two, and she waited to the end, so thank you, Carla.

CARLA DUNCAN: Thank you very much. I'll make this quick. Based on a mom's, several pregnancies, and her mom on her death bed still mourning those babies she had lost, decided to start this project called The Mourning Project. So Mary has 20,000 pair of baby booties made from makers all across the United States.

And they are in Arizona, and they're coming next to St. Louis. Mary would love it if they went to Texas, went to Washington, D.C., but we're talking about then going down to the Bootheel, so after that they can go wherever they need to go. How many of you remember when you saw the Aids quilts? I mean it sticks with you to see that, and Mary feels that seeing these 20,000 hand-made baby booties will stick with folks too, and understand the severity of, you know, that this is happening in the United States, and it shouldn't be.

So that's the deal. There's information there if you're interested, contact Mary. They will come to St. Louis in June and July. The transfer gallery, the baby booties will be there. We're working with PBS, Channel 9 and public radio to have the baby booties at the Commons, so folks can see them outside.

And we're working on a panel discussion. So if any of you would be like, - I'd be interested in panel discussions type of thing, let us know because that is something that we want to invite the region to, to hear the thoughts from many of the people. So that's it. Are there any questions? -Thank you.

BELINDA PETTIFORD: Thank you so much, Carla. And thank you for the work you all are doing to bring awareness to the issue of infant mortality in the country, so thank you.

CARLA DUNCAN: Thank you. It's been an interesting conversion.

BELINDA PETTIFORD: So as far as the Committee, you know your assignment for tonight. We have a couple of questions we want to talk about tomorrow, otherwise we will call this meeting adjourned. Thank you all so much that have been able to join us for the last two days. Please there is not enough words for us to tell you how much we appreciate it.

And ShaRhonda, we'll get you in the morning, because you've done an awesome job with the panel. I hope everyone has a wonderful evening, so thank you all.