THE ADVISORY COMMITTEE ON INFANT AND MATERNAL MORTALITY (ACIMM)

HYBRID MEETING

AMEREN COMMUNITY ROOM

DELMAR DIVINE

5501 DELMAR BLVD.

ST. LOUIS, MO 63112

9:00 -- 12:00 pm CST

Thursday, April 4, 2024

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P R O C E E D I N G S

Welcome and Call to Order

BELINDA PETTIFORD: I'd like to welcome everyone back to our Secretary's Advisory Committee on Infant and Maternal Mortality. We hope you had a wonderful evening. I know many of us have been talking about food ever since we got here. We had a great evening, so I hope everyone is enjoying their time.

We can definitely say that St. Louis has rolled out the red carpet for us with their wonderful hospitality and giving us the opportunity to be engaged with all types of people. And I think yesterday we had another wonderful day. And you know I think it was really capped off late yesterday afternoon by our Community Voices panel, and we had the opportunity to listen some more to what individuals with lived experience, people who are here in this community and worked with the topic areas of infant and maternal mortality.

We were able to get their perspective on how do we address Black infant and maternal mortality. And so I know that was a good experience for all of us. And I think yesterday morning many of us were able to again participate in the social determinants of health tour, and even though we talk about social determinants of health, for many of this this is, you know, what we've been talking about for quite some time.

Being able to actually see it in a community and actually fill in and be part of what families are dealing with really helped the Committee to start thinking through this, what our recommendations might be. We have a pretty full agenda this morning, but we're going to try to move it along since we know several of our Committee Members have flights that are going out today, that will need to leave a little bit early.

Discussion of Workgroups

BELINDA PETTIFORD: So I'm going to adjust the agenda just a little bit. We will come back to the American Indian and Alaskan Native recommendations, because at this point I want us to really get into our follow-up discussions from our workgroups yesterday.

So yesterday all three of the workgroups to share and provide a really nice update on the status of the workgroups and what has been occurring, and the various workgroups who have been here from social determinants of health, from our systems health as well as our preconception, interconception.

And each of the workgroups left us, came back to us and said you know we've got a couple questions. Things that we want some feedback from the larger group before we move forward. And so I think that is very important for us to take that time this morning. We're just going to adjust the schedule a little bit,

and move that up so that we can have everyone there.

As a reminder this morning we have two board members that are joining us virtually, Marie Ramas, as well as ShaRhonda Thompson is joining us virtually this morning. And then we have the others that are in the room. Yes, they'll come back today to see us from the HRSA Region 7 office, so wonderful to see you all.

I know we have many Ex-Officio members, and also joining us virtually. If there are any Ex-Officio members that are joining us virtually and did not have an opportunity to introduce yourself, we will just take one moment so we'll know who else is there with us. But if you have not introduced yourself either on Tuesday or Wednesday, I will go through the list if I can figure out if we missed anybody.

Anyone? Let's see. I believe everyone has introduced themselves, or you're being shy today. So Kristen, I don't recall Kristen, did she introduce herself. All right. Moving on then. Back to our workgroup discussions. So we're going to go now to our workgroup leads again because I want us to really go back and think of the questions they asked.

And this one I think we will start with our preconception interconception team, both Phyllis and Joy. And we get back to the question that they asked us to focus on and to think about last night. I guess you want to remind us of your questions.

PHYLLIS SHARPS: I think we asked whether there were

specific examples of rural families, Black mothers and families. That was one. And were we missing anything? And I think the third one was specific issues for Black -- .

BELINDA PETTIFORD: Thank you. I know when the question was asked about what are we missing, I think one of the areas we talked about was misinformation around contraceptive services, such as contraception and general finger pointing. I think that was one of the areas that we brought up yesterday.

But are there any specific areas, and we're opening this up to everyone around rural communities as we think about preconception and interconception care?

KATHRYN MENARD: That's one thing that there will be, you know, overlap, I think certainly since the work that we're completing that will, you know, affect all really is if you think about rural areas. And even not rural areas, is access to information that's delivered through the web, or you know, text, broadband availability, and that sort of thing and how that works and limits.

You know, so much communication moving towards that mechanism, the concern that that can cause a further divide in disparities. It's something I'm not really well-versed in. If we -- this Committee in general needs to learn more about what that is and what recommendations we could put forward. It seems to me to be an important, overarching thing.

BELINDA PETTIFORD: Are you thinking more along in

rural communities having limited access to just technology and internet access, things of that nature.

KATHRYN MENARD: Technology, you know, it could be hard work, you know, but I think more -- at least I'm speaking from my experience. It's more access to internet.

PHYLLIS SHARPS: Actually, that's an issue that crosses urban and rural because we learned in the pandemic cities like Baltimore, major cities, there's certain neighborhoods which didn't have broadband access, so I think it's --

KATHRYN MENARD: I was sharing with ShaRhonda, we were talking about it yesterday. I was sharing with her that when COVID hit the children across the street from me that I live on had trouble with access initial work because we didn't have cable, you know, in our neighborhood so, it's actually something we should -- it has the potential of if it's removed the world is moving to more electronic communication, and seems to be preferred by young people in the listening sessions that we're doing for other work. Yeah. Yet it has that risk of making things worse.

BELINDA PETTIFORD: And then maybe we could get a speaker from, I know many of the states have like rural health programs that are looking at broadband access, but I don't know at the federal level. Is that coming out of the Office of Rural Health? Is there someone there that we maybe can get a speaker that could give us an update, or figure out where that resides?

JACOB WARREN: Either the Office of Rural Health or

SCC, yes, they have a major broadband initiative, and I'm sorry, the FCC.

BELINDA PETTIFORD: Thank you.

PHYLLIS SHARPS: And you know along with that too I think we have to make sure that because vulnerable populations don't have access, but many of them use it for their cell phones, and not you know, laptops or TVs or that kind of thing, so I think as we think about this going ahead, that's something to give consideration to, how to deliver this information and that over and above telemedicine, just the broadening of telehealth is going to be a way they are going to roll out information.

BELINDA PETTIFORD: Marie, I see your hand is up there.

MARIE-ELIZABETH RAMAS: Good morning, folks. Thank you, Belinda. I'm glad that we brought this up, certainly broadband, and I was just about to put this comment in the chat, I know that I have been speaking since the pandemic of broadband access as being a social determinant of health.

I'm not sure of the formality of that reality in the terms of social determinants and health disparities. I'm curious, I know someone said FCC. I'm curious to know if there would be another presenter, or you know representative, that could give us more insights on that, particularly as it relates to not only interconception care, but perinatal care with remote patient monitoring.

That is huge as it relates to our patients that have

gestational diabetes, or who are hypertensive, and you know, pregnant. So I'm curious if the larger group would benefit from hearing from an entity that can speak to specifically broadband access, what's currently being done to expand broadband access, and you know, this concept of broadband access being a social determinant of health.

And I completely double click on whoever said this is not just a rural issue. This is very much an urban issue as well because we saw it during COVID that in urban settings there may be broadband access, but access to devices is limited, and can get in the way of a continuity of care as well, so some households may have one device that they can use, and we definitely saw that on the education side.

So I'd love to hear in addition to FCC, you know, can the Committee get an idea of what current federal programs are available regarding broadband access for states to take advantage of, and whether we can recommend to the Secretary to expand that for, you know, higher access for areas for instance, so that pregnant persons can also have that as a resource.

BELINDA PETTIFORD: Thank you, Marie. I don't see people not supportive of that at this table. I think all of us will definitely be supportive of trying to make sure that we can get someone from either the FCC for rural help, someone to talk about the larger issue. And it was Phyllis that brought up the issue that is beyond rural areas, Marie, just to make sure you

know that.

MARIE-ELIZABETH RAMAS: Thank you.

BELINDA PETTIFORD: It looks like Caroline put in the chat information about what USDA is doing on this work.

MARIE-ELIZABETH RAMAS: Great. That's what Nancy just mentioned as well. USDA and then we wanted everyone to be aware of HRSA's funding of the telehealth resource center programs, so I'll put that in the chat that we can look into all of these in terms of potential speakers, or what can be shared, and I see Caroline is on screen.

BELINDA PETTIFORD: Caroline, did you want to say anything about what you put in the chat?

CAROLINE DUNN: I was just going to say I am by no means USDA's expert on rural access to broadband, but I am happy to connect with our expert if that is something that is desired, so just putting that out there for the USDA side.

BEINDA PETTIFORD: Thank you, so much.

MARIE-ELIZABETH RAMAS: And I think on the action-focus standpoint, it would be really interesting for us to know what already exists, and then we can suggest to the Secretary can this be expanded, particularly for pregnant persons, and peripartum persons, so that we can ensure that they have access for services, no matter where they are, so that's my thought process. I'm thinking more forward.

BELINDA PETTIFORD: I think we should be able to work

to hopefully get someone willing to present in June, for our meeting in June, and that way we'll open it up to everyone and not limit it to a specific workgroup because it goes across. Yes, Jacob?

JACOB WARREN: I wanted to just add on top of that as we think about it is frontier, where when we're talking about that access there's no cell service, so we can't just anchor it on to cellular service, so we might need to think about satellite.

I was thinking to Marie's point if we want to have programs that are providing broadband to pregnant people, we might have to think about satellite, because when I'm there I had a satellite transponder in my car to make sure if something happens I can get help, and people that live there, we need a solution I think.

BELINDA PETTIFORD: That's an excellent point. And I will say even I live in North Carolina. I don't have strong cell phone service to the point that I went to Verizon. And I said I'm paying you a lot of money each month for this, and so they gave me an extender.

It's almost like they just need to build some more towers because they said if you're five miles or beyond where the closest tower is, it's going to impact your cell phone service, and I never realized that because you don't see enough towers to think that most people are in a five-mile radius.

MARIE-ELIZABETH RAMAS: I want to just acknowledge that

ShaRhonda has her hand up, but I'll also just give you a personal anecdote. In New Hampshire, certainly broadband and cell service is an issue, but small towns do not want cellphone towers in the middle of their towns to take away from the charm, or the beauty of the town itself, and so there's this, you know, there's this tension locally that yes, we want access, but we don't want this, you know, this big sore thumb in the middle of our town.

And so, I wonder if that's a similar story in other areas across the country.

BELINDA PETTIFORD: A good point, Marie. Thank you. And yes, ShaRhonda we see your hand, thanks.

SHARHONDA THOMPSON: Hello. What I was going to say is that we also have to think about I know there's a lot of programs for what's considered below poverty level with assistance to broadband, but or internet access, or even hot spots or whatever. But we have to think about those families that fall in between.

Not income, not low enough to be considered poverty, but not high enough to get everything that they need. Some way we have to help those families as well. I know it's a struggle to be above that poverty line, but if you're just right above it, and you're only right above it because of what you make before taxes.

What they take away from you, so you don't actually see that money that they're counting that's saying that you're above the poverty line, so if there's a way that we can kind of incorporate something for them as well, just as a thought.

BELINDA PETTIFORD: Thank you, ShaRhonda. I think that kind of crosses all of the work we're doing that we need to always remember who are audience is, who we are essentially working and focusing on, and let us not forget that population. Thank you. Okay. Others?

VANESSA LEE: One last resource that I just remembered. So last November FCC did have a joint roundtable with HHS on the intersection between maternal health and broadband data, and I found the recording online, so I'll post that, but we can also see if there's been any follow-up since the roundtable.

But it was to gather thought leaders on the frontlines of the maternal health crisis, including telecommunications and public health to explore the intersection of broadband connectivity and maternal health.

BELINDA PETTIFORD: Can you send that to the group? I connected it to the chat, thanks. Yes, Sherri?

SHERRI ALDERMAN: And what I'm hearing is that that's an unspoken assumption that a pregnant person is not homeless, and so when I think about those who are homeless, I certainly want housing first, and how can we -- how do we engage with them electronically?

I wonder about the library system, when a lot of people you go to the library for internet access, and if there would be a recommendation for the medical system to engage with libraries for more reasons than that, but that would be a real, I think, a very

compelling reason to support libraries to be able to have a private room to have a telemedicine visit, and then more access to Wi-Fi in the library for all sorts of reasons that I won't mention now.

BELINDA PETTIFORD: Thank you, Sherri.

JACOB WARREN: We had that initially. I can't remember who funded it, but we placed telehealth booths in libraries. It might have been USDA that funded it. I'll take a moment to see if I can find what that was.

BELINDA PETTIFORD: And Caroline, I don't know if you heard that or know, if you know whether the USDA may have been piloting something with libraries? If you've heard of something let us know.

CAROLINE DUNN: Sorry. I had not heard of that. I'm happy to reach out and see if that is something I can get more information on before our next meeting for sure.

BELINDA PETTIFORD: Thank you.

NANCY RIOS: May I add something?

BELINDA PETTIFORD: Sure.

NANCY RIOS: So you might want to look at the USDA distance telemedicine program, and actually that program has currently opened up funding opportunities that are pretty open. They have a website where they have the list of all the grantees, and we can look for those kind of projects. And this will be the kind of projects that they will fund.

BELINDA PETTIFORD: Thank you.

NANCY RIOS: I'd be more than happy to send you that link.

CAROLINE DUNN: I have that link. I'll drop that link in the chat too, thank you for recommending that one as well.

BELINDA PETTIFORD: We'll grab everything that's in the chat and get it back out because I know not everybody is on it. Marie put a note in there, it will be interesting to know if HIPAA compliant mechanisms for telehealth services. Right? Good point. Thank you, Marie. Lots of information in the chat. Okay.

So going back to preconception and interconception now. It does seem like there's many areas this is going to cross over into other areas, and what you all are asking about preconception and interconception. I do want to go back to your question is there something missing that you all should be considering around preconception and interconception?

KATHRYN MENARD: I found on this, and I'm just channeling the respected Jacob Warren. You know, I've given some thought to measurements related to preconception health and interconception health, and there's not -- it seems like with all of what we put forward it would be helpful if we, you know, had some data, and maybe if you presented that, and forgive me for that, but if we there were some sort of how we're measuring the effectiveness of what we're doing and not doing in that arena.

PHYLLIS SHARPS: I think one thing we did talk about is

are there existing, so there's assistance so we know what system captures that data? So I think that absolutely would be good. Are there, aren't there and yeah.

KATHRYN MENARD: Sarah knows a bit about this. She actually did several pieces on improvement in that area. She wrote a paper on this a while ago, but it hasn't gotten -- that idea hasn't gotten traction.

LEE WILSON: I'm wondering if Title X would have anybody who could speak with us. Our Title X office is the one who does family planning and --

BELINDA PETTIFORD: Office of Population Affairs?

LEE WILSON: So if we can reach out to them to see.

BELINDA PETTIFORD: We had invited -- at one of the meetings. I don't know if we had OPA though. Okay. We'll put them on the list.

MICHAEL WARREN: Charlan, is there anything from DRH or PRAMS or other systems that might be helpful?

CHARLAN KROELINGER: Well, I do think PRAMS is intending to highlight collecting data in the postpartum period, later in the postpartum period than what they're doing now. So that is up and coming. But those data won't be available for a bit of time. But I can certainly get more specifics on that because we're interested in understanding experiences beyond that 4-6 months that they're seeing fully right now.

BELINDA PETTIFORD: Yeah. It connects so closely to

the 12-month extension you are all talking about. What are we capturing on that time period? What are the data elements? Do we know if individuals are using the service, given access, and what does that look like? And do people realize they have access? Anyone else have anything else that we feel like is missing? Yes, Jacob?

JACOB WARREN: This is sort of anecdotal from my time with our Healthy Start grant. The problem we ran into with interconception care was birth spacing. And the issue we had with birth spacing initially was the gap in time with postpartum extension to be able to have long-acting birth control contraceptives.

But what we found was, we're very grateful for the clinical support we received through our Healthy Start grant, but we initially had a non-racially concorded provider. And once that person left and we had a racially concorded provider, our acceptance of LARC skyrocketed.

And I don't know what we should be doing, exactly. What can we be doing just for rural Black women at least at the counties that we work in that was just an absolute barrier. If it was not coming from someone they trusted they were not able, for obvious historical reasons. I don't know what we can be thinking about to help support, LARC uptake, or just similar items, I don't know what we could do but it's --

BELINDA PETTIFORD: Yes, Joy?

JOY NEYHART: It circles back to workforce development, and recruiting from within the community, providing education and opportunities to become health care workers.

BELINDA PETTIFORD: I think it also goes to the whole issue of coercion, yeah, and that is what communities fear is the coercive nature. Will you try to elevate it to providers, making sure providers are not coercing, that they're still employing all methods and making sure that they're making a choice that's best for them.

PHYLLIS SHARPS: Yeah. I think that's what we talked about in a broader stance is how do we do the messaging around this, because people hear it as coercion, and something negative. And not only historically for African Americans, but just across all of the diverse populations, and so that has really been a challenge.

I mean we've talked a little bit about that in terms of how do you message the message, in a way that someone -- and I think, also there's misinformation about methods that can be used when women are breastfeeding. And sometimes women are discouraged from breastfeeding because providers may have misinformation.

And if you breastfeed you can't use any contraception, and you know, so I think messaging, and education will continue to discuss, but that is an important issue in this area. I wanted to say too that on a different topic, but the kind of families that ShaRhonda was talking about, United Way has the ALICE family and

it's an acronym for Asset Limited, Income Constrained, Employed individuals, so these are people who are employed, but don't make enough money as ShaRhonda said, to meet all of their needs, and so sometimes I think they fall out of services, the same as in poverty.

BELINDA PETTIFORD: Thank you, Phyllis. And I've got Marie up, Marie and then I'll go to Charlan. So please remember to identify yourself before you speak. Remember, we've got others taking minutes, and they won't always recognize our voices.

MARIE-ELIZABETH RAMAS: Thank you. This is Marie Ramas, Committee Member. I'm very happy that we were starting to talk about access to LARCs, long-acting reverse contraception. There are a couple of things that I think may be helpful, and I'd be curious to know about the community psychology around, or cultural psychology around LARCs particularly.

So there is an access issue because for many clinical providers we have to buy the LARCs, and we're not reimbursed for application of the LARCs, and so there's a disincentive from a clinician standpoint for things like the Mirena, the Skyla, and newer generation LARCs.

And then on the patient-side some communities it is very normal for very young people to become pregnant, and it's part of their community and cultural norms. When I was providing maternity care in rural California, it was not uncommon for young ladies within high school age to become pregnant, and to not go to

higher level education, et cetera.

And in some cultures that is part of their norm. And so, how do we provide culturally appropriate education in a way that's trustworthy? And some communities, and particularly in the Black community, there is a concern of putting foreign objects inside of one's body, and you know, seeing this invasive, this procedure, although outpatient, as an invasive procedure.

And then the last thing as far as disincentives to getting these placements of LARCs, particularly is the pain associated with it, and it is not uncommon that you know, women are not, or persons with cervixes are not provided with appropriate anesthesia and pain control when this is being placed.

And it is painful. And so there's this concept of again, the dismissing of women's pain. It was discussed yesterday, and not really understanding or premedicating patients appropriately for these GYN procedures, albeit quick, albeit simple from a procedural standpoint.

So it might be of interest to the group to have a better understanding from a sociologic standpoint, from a public health awareness standpoint. What are some of the disincentives, both on the patient side, and within the clinical side for providing these services?

Another caveat, just as a physician who provides these services, sometimes the actual procedure itself will be paid and reimbursed, but to acquire the long-acting reversible

contraception is still a cost for the practice, and that's included for a federally qualified health center.

So that's something to be considered as well, and you know, might be a low hanging fruit for recommendations. I'm speaking a lot today, but I wanted to make sure that I'm getting this in because it's very important. The other consideration we talked about political determinants of health. In some states that are becoming very restrictive when it comes to interconception, women's bodily autonomy they consider use of LARCs.

There has been legislation where the use of LARCs is considered an abortion, thinking about termination, and when does life begin. Does it start at conception, or does it start afterwards? And so the criminalization of even the process depending on what state one lives in, may also be an inhibitor of access that we need to consider as well.

So, I think that's all I had as far as LARCs are concerned, but it's quite -- it's a volatile space that we're living in right now from a health policy standpoint when it comes to bodily rights of the uterus, so.

BELINDA PETTIFORD: Thank you, Marie, and we appreciate you talking a lot today, that's fine. But you did bring up some excellent points, so we probably need to think through if there's OPA, if there's someone we can get to speak up. Also, you know, there's a national group that focus on pregnancy intendedness,

Upstream U.S.A., so we may even, you know, get someone from there.

I'm familiar with them because we're one of the states that's partnering with them in North Carolina. But it may be another group that we can get to bring some of these issues to the table. But I'm going to turn it over to Charlan.

CHARLAN KROELINGER: Thank you, Charlan Kroelinger, CDC. I think I wanted to build on what Marie mentioned actually, with in terms of patient-centered counseling that's provided, if they're not a suite, I think there also needs to be some examination or inclusion of LARC removal. That can sometimes be a barrier.

And both for the patient and the provider. And some state policies actually have removal included, but some don't have that language, and so there may be questions, or there may be concerns about placement if a patient will come back and ask for it to be removed.

And then I think also reinsertion is another issue for consideration. I'll mention that CDC is updating its medical eligibility criteria, and its selected practice recommendations, and that will be coming up soon, but just wanted to bring that to everyone's attention.

And as Marie mentioned we have examined the reimbursement for the device versus the provider practice expense, and there are some real discrepancies in what's available in certain states, so that might be something to examine as well,

thank you.

BELINDA PETTIFORD: Thank you. Michael?

MICHAEL WARREN: Two quick things. One, I'm quickly building on what Charlan just said, so I just pulled up the women's preventive services guidelines, so you know, these were passed in the ACA, and things that are listed there have to be covered without cost sharing by most insurers, and specifically around contraception.

When these were last updated the initiative added contraceptive care also includes follow-up care, management, evaluation and changes, including removal, continuation, and discontinuation of contraceptives. So there may be an educational opportunity to that point, both to consumers and payers because we know these are not all often well understood.

The second thing is just to plant a seed. We often jump to Medicaid as a source of funding and understandably so. There's also a tool that states have as part of their CHIP funding, so their Children's Health Insurance Program, there's something called Health Services Initiatives, where states can spend up to 10% of their CHIP funds on the administration, and if there's a gap between what they actually spend on admin, and that 10% cap, they can actually pay for a number of other population health service efforts.

So some states use this for example for poison control, for school-based health services, for lead testing and abatement,

for family and planning services, yeah. There's a gap, and I think there's some states that have figured that out and knew how to do it, and some that don't. And it can be a decent sum of money for projects like this, so something for us to think about.

BELINDA PETTIFORD: Thank you.

MICHAEL WARREN: We'll send the link.

BELINDA PETTIFORD: Great. Yes, Steve, and then I'm going to move us to the next.

STEVEN CALVIN: Yeah, I'll do it quickly. Steve Calvin, Committee Member, physician. And piggybacking on what Marie said too, having the experience of 4,000 births over a decade at a birth center, including many from the Somali community, because of the concerns about you know, sort of foreign objects, and things put into the system, there is actually a lot of interest in the fertility awareness kinds of things.

And I know I'm kind of reading, and so as I've read about it, sometimes HHS, and sometimes federal guidance says they don't work very well. And I can tell for sure in training of residents, many OB/GYN residents are told that doesn't work, so but what I would say is there's kind of a movement that's very much crosses ideological lines will have a desire for that kind of information for you know what some people call natural family planning.

But the fertility awareness, and it's very impressive. Obviously, it takes collaboration of partners, and so that makes

you know, sometimes that is a barrier. Anyway, I just wanted to throw that out there that we shouldn't forget about that.

BELINDA PETTIFORD: Thank you, Steve. We're going to go on because we can continue this conversation on moving back to the workgroup for a little bit. But in our rural health workgroup you all had a couple of questions too. One was around the telemedicine model. Remind me your question again.

JACOB WARREN: That we were looking for subject matter experts, and we've got some good referrals.

BELINDA PETTIFORD: And you also wanted representation from individuals who have lived experience, and actually include them into your workgroup right?

KATHRYN MENARD: Right. We got good feedback that we'll be able to -- there will be a mechanism for this.

VANESSA LEE: Yes. We're going to explore using logistics contract which currently has speaker, as you all know speaker and presenter honorariums, and includes their travel. My question was, and this was for all the workgroups, in terms of timing. I mean I don't envision that we could pay for monthly call participation, but potentially you know the next time we gather in person, in June or the fall meeting, if you feel like there's a stage in your recommendations development that would make the most sense to bring in, you know, people with lived experience to review, or you know.

BELINDA PETTIFORD: Can we explore the monthly

participation because the purpose of bringing in individuals with lived experience is to have them equal at the table. And if we only bring them in once a quarter, that is not us doing that. And I know it's not -- it's a system. I deal with the system in my own space. And we've been able to get through, but it takes time. But I don't want us to go down the road of saying you can't do it monthly. I think we need to figure out how we can do it monthly, that is if that that's the purpose of having individuals with lived experience in a workgroup.

And it may be even finding out if they -- you know, if you identify a couple people for your workgroup, they may not want to do it monthly. You know, they may say, you know, I don't have that capacity. I don't have the time. But if they say yes, I would really hate to say to them, but we can't cover your time, but once a quarter.

LEE WILSON: Can I pose a couple questions to you since I'm the person who's going to have argue this for the budget.

BELINDA PETTIFORD: And I can give you some thoughts of how we run in my state.

LEE WILSON: I think we're supportive of the idea and the approach. One of the sensitivities that I have is that because it's a FACA, we have worked very hard to have these workers not have to go through some sort of a clearance process for everyone who might want to participate on these because the FACA rules are very stringent when it comes to how we select who

gets on the -- who gets to weigh in on this.

And so the idea would be how do we put something like this in place, and if we're looking at paying them, it looks like we've got some sort of a process to make sure that we are representative, or not to raise any red flags. I don't want to create a process where we're getting outside input, but the person who is going to give us outside input has to go through some sort of a review.

And so that's what we're trying to balance here as well. We're all supportive of compensating people, and I can work to make those resources available, and this is a good time because we're in the process of putting together what our plan is for the future contract, for the logistics at least, but those are some of the concerns that we have.

BELINDA PETTIFORD: No. Thank you.

LEE WILSON: Charlan is nodding.

BELINDA PETTIFORD: And I apologize if you felt I was saying you weren't supportive.

LEE WILSON: No, no, no.

BELINDA PETTIFORD: I believe you all are supportive. I'm just trying to think. I want to push us to figure out how to do it, so it can be done, versus to say these are the barriers, and how do we go beyond the barriers, so that we can get it done, I think.

LEE WILSON: And we'll think creatively.

MARIE-ELIZABETH RAMAS: Could I offer a suggestion?

LEE WILSON: Of course.

BELINDA PETTIFORD: Yes, Marie?

MARIE-ELIZABETH RAMAS: Thanks. And could a possibility be that we need more than one community member on the Committee period? If we're asking folks to join our subcommittee, then what I'm hearing is that there might be a broader need for particular subject matter experts of particular experiences within the community that are part of this overall Committee itself that could lend to their mentioning of the work.

BELINDA PETTIFORD: You know I think you're on point, Marie, and I think you know, we all rely on ShaRhonda for many aspects of our work, and I think all of us around this table, and our federal partners would say we need more ShaRhondas.

VANESSA LEE: -- gave us that recommendation in 2020, and we have acted.

LEE WILSON: And we submitted that nomination shortly thereafter, and we're still waiting.

BELINDA PETTIFORD: That's what I'm saying, that can't be our only way, no.

KATHRYN MENARD: And we're on a timeline now, right?

LEE WILSON: Yeah.

KATHRYN MENARD: You know, if we're -- we're on a timeline now where Belinda has asked us to prepare recommendations for January. So we were thinking that by, you know, three or four

months from now we're going to get into the writing, you know, and the recommendations. So the input needs to be now if we're going to be genuine in this.

So, if we need a fallback, you know, Jacob and I talked last night about, you know, panel groups, that sort of thing that we could turn around fast without full Committee membership. That might be -- we just need to know what we need to do, you know, in terms of.

VANESSA LEE: And I think if you could identify someone, one or two for June that we could travel in, they could stay, listen, they could speak perhaps, but then also sit in on your workgroup time, and be actively working with you during the meeting where were have the scatter around right now.

KATHRYN MENARD: If the plan is meetings of workgroup meetings during our June meeting, I'm sorry I'll say it again. Then I think that might be a feasible way to do it because you'll be compensating them at that time. Jacob, I don't want to speak for you.

BELINDA PETTIFORD: I don't think June will be an issue if people have -- if the workgroup members, if you've got individuals that you want to identify, that come to you and say they want to be on your workgroup. Because I know one of the young ladies yesterday was interested in joining the Preconception and Interconception Workgroup.

I don't think June is an issue. I think it's the other

meetings outside of June is trying to figure out how to cover and compensate individuals for their time there, just like we are all compensated. So I think that's one of the issues. Sherri?

SHERRI ALDERMAN: This is Sherri Alderman, a Committee Member. As we go down this path, which I think is a really important path and can carry a lot of meaning. And considering budget, we also would want to consider budgeting for simultaneous interpretation, or a person with lived experience that does not -- that has a preferred language other than English.

BELINDA PETTIFORD: Thank you.

VANESSA LEE: And I don't mean to put you on the spot, but do you recall how the last set of recommendations with AIAN, some of the, you know, techniques you guys used then? I mean I didn't participate as much in the workgroups at that time. I know that tribal meeting gave the ability for many to put eyes on the draft, but at that point they were already drafting, it was time to get reactions.

BELINDA PETTIFORD: No. I think that's a great point. And I don't think we did our best job with engaging individuals with lived experience. In all of the workgroups, Janelle and I were doing the health equity one, and you know, we would get feedback, you know, by people that came to the meeting, but I'm not sure we could clearly say we identified individuals with lived experience or community members to join the workgroups.

I think what we relied on is individuals, that

workgroup individuals, and they represented them versus the actual individuals with lived experience. And I don't think, I don't know if Ed or Magda or Janelle, any of them are in the meeting, they can drop it in the chat. But I also don't recall for the data group. I don't recall it for any of the groups that we actually made a concerted effort.

I think when we were getting feedback at the meeting in Minnesota, and that we're able to listen, and that's where we pull in the recommendations. I think this iteration of ACIMM we're basically saying we want to go a step beyond that, and actually bring people in with lived experience to join the workgroups. And we just need to figure out how we can get it done, realizing we don't have much time with these recommendations.

VANESSA LEE: Ed is in the panel of attendees. Do you have anything to add? I know you can't chat it, but if you want to raise your hand we can, if there's anything you want to add. Okay.

BELINDA PETTIFORD: Okay. I think as workgroup leads if you all have identified, you know, one or two individuals with lived experience that you want them to join your workgroup, then you know, reach out and make sure we know, we're trying to figure out what the process will be. And again, June is definite, so that should not be a problem because we can borrow -- as a speaker.

Going back to the rural workgroup, any other questions

that you all want the larger group to discuss?

MICHAEL WARREN: The only one we had is the same with interconception groups, is there anything missing in your perspectives?

STEVEN CALVIN: Steve Calvin again, and what Kate mentioned too about this. It's kind of unique idea about emergency departments alongside birth centers. I mean we've been engaged with Jennifer Vanderlaan from ACNM, a midwifery organization and Julie Wood from Family Medicine. The rural health maternity care situation is a real crisis, and we have to maybe test a few things. I know there will be people saying oh no, you can't do that. You can't have births unless you can do an immediate cesarian with an OB doctor.

But I think we need to push the envelope a little bit. Not for everybody and every location, but we should figure out a way to try it, and engage the emergency department, the emergency physicians, the surgeon in town to say is this something you would like to add in the community, the midwives and those in the community that are saying hey.

Because they're such, I mean and in Minnesota it's happened four or five times just in the last few years, you know, a community hospital just shuts it down, and then they're mad at the health care organization who then say well, we can't afford it. We can't afford to have the coverage. I don't know how to go forward with that, but maybe by June we could come up with here's

a scenario, here's what we should try, and then make it very specific.

BELINDA PETTIFORD: I don't think -- Kate remind me, in North Carolina one of our hospitals when they were getting ready to close, they switched to only family medicine doctors. Do you remember Chatham?

KATHRYN MENARD: Chatham, very well. It's just an hour south of UNC, and, you know we back them up. They did close their maternity unit, and then years ago, and then opened it again with the family-medicine-led team. And the family medicine providers, you know, had cesarian -- could do a cesarian birth, but the number of births was infrequent, so those family medicine physicians would come up to our unit and operate once in a while, you know, and we would incorporate them, and so that's a -- you know.

BELINDA PETTIFORD: We should find something different.

KATHRYN MENARD: Yeah. And I mean there is a whole evaluation of that program, and there's a lot of bumps, you know. And Jeff Strickler, and he knows a lot about that. He spoke to us at one point.

LEE WILSON: Was he administrative?

KATHRYN MENARD: Yes. He's administrative. But I mean we also, there's a family medicine physician that led it, Martha -- I can't think of her name. But it was done with funding, and really under it by the health system, but it was done

for, you know, it was an educational grant too. Because the idea is we have a family medicine program, a training program, and they wanted their family medicine residents to experience practicing maternity care in a rural area, led by family medicine physicians.

And so there's a lot of evaluation pieces built into that, but it's not a birth center. It's, I mean, they have an operating room, and they have G-1 surgeons down there and all that. So it's very different than what we're talking about, what Steve's talking about, which needs addressing.

You know, I could go on and on, but I think that there's -- we could design something with enough measurement safeguards and that sort of thing that could be a potentially, you know, funded. It's tricky.

BELINDA PETTIFORD: Okay.

SHERRI ALDERMAN: And this is Sherri Alderman, a Committee Member. I'm hearing also another aspect of isolation that impacts health, and that is the providers. And I love hearing the model that's going on in North Carolina where the physicians are practicing in a rural area and have that meaningful connection with more of a hub that can be also shared learning.

JOY NEYHART: This is Joy Neyhart. I wonder about keeping providers, keeping up skills, because you know in a small hospital where there's only a c-section every other month, that's not going to be enough. And I know that in my small hospital in Juneau, Alaska, you have to have x number to maintain your

credentials for that procedure.

So what about having people who are from larger institutions rotate through on like a weekly or two weekly basis, so that if the procedure is needed during that time it gets done by someone who practices in a larger area, and has that skill, and needs to use it all the time, and brings it with them rather than try to keep people in this community up to date because it doesn't seem possible.

The numbers are small, yet you want to maintain the high quality of care. That's a thought.

KATHRYN MENARD: Yeah, and Belinda, this is something that Jim -- Kate Menard again. Belinda knows our region, but our eastern, northern eastern aspect of North Carolina has a lot of variable counties and infrequent births, and that sort of thing.

And we have a very dynamic leader in that. His name is Jim Davinian. He is now thinking about, and their quaternary care center is supportive of getting out, you know he did a lot of outreach, a lot of simulations in these smaller hospitals, but now actually taking providers out there on a rotating basis is something we're thinking about and planning. I don't know if you knew that, but there's ideas, but it hasn't been tested, you know.

MICHAEL WARREN: Michael Warren. This is sort of the conversation that's making me think about the HRSA teaching health center GME model where within the community health centers there's been additional funding for GME, for folks to train, sort of

provide faculty support for training, but also practice.

You're getting the training and the clinical service at the same time. And I wonder if there's -- if it's not, I realize it's not just having a person issue, there are other issues, but I wonder if there's some variations of that model too, that might help with some of the recruitment and retention piece, and to get to what Joy said.

If we could pull in the right persons and talk about what that model is, and how it's been used, but I wonder if there was a variation of that that might work.

BELINDA PETTIFORD: I think that will be helpful to hear someone from that perspective to talk about the program and get someone to the workgroup.

MICHAEL WARREN: Yeah, a Bureau of Health Workforce, between them and our Bureau of Primary Health Care, between the two of them at HRSA.

BELINDA PETTIFORD: We just need to figure out is that something everyone wants to hear or just a specific workgroup is interested in this area. Wonderful, okay. Anything else we think the rural health group was missing, and I think Ed, you've been moved up, and Ed Ehlinger? I don't know if you have anything you want to add in about how we will engage individuals with lived experience?

ED EHLINGER: Yeah. Good morning, everyone. It's really good to see you. I have to compliment you on this meeting,

and the work that went into making this happen. And ShaRhonda and the staff of HRSA and MCHB, it sounds like you really did all of the real good legwork of making this a meaningful meeting, so congratulations.

And I have been, you know, stalking the meeting, and it's been run really well. Belinda, you're doing a great job. So relative to the question of input, this is always one that is difficult. We try to get as many as, you may remember, try to get as many people to come to the meetings and testify as best they could, and that was the reason we brought them to Shakopee.

But in between meetings, both Janelle and I worked a lot with community-based organizations to get their input on the recommendations prior to the recommendations being drafted. So it was again, working with community-based organizations, and the connections that they have with the people that they serve, as opposed to bringing those people to the committees to work, because as we pointed out, there's some difficulty with that, and there's some, you know, it's a logistic kind of challenge. But you know whatever we can do to get those voices is a good thing.

BELINDA PETTIFORD: Thank you so much, Ed, and it is great to see you on the screen. Okay. So we're now going to switch over to the Social Determinants of Health Workgroup. I know one of your areas that you wanted to talk a little bit more was around how the issue of isolation connected with the other

workgroups, not just looking at it as a social determinants of health area, but how it connected to the work of the other workgroups.

BELINDA PETTIFORD: Marie has stepped away, okay thank you.

SHERRI ALDERMAN: This is Sherri Alderman. We are very interested in loneliness and isolation as a social driver of health. We are also very interested in all the other aspects of what we're looking at in terms of social drivers of health, and I hear that the overlap with the other groups. And so I'm curious about how are we -- what could we do to continue to explore those overlapping areas and coalesce our recommendations, given that we are going to be committed to having fewer recommendations than we did previously.

So it's -- and the timing of that. What would be the best timing for the group to begin that process, to begin that process?

BELINDA PETTIFORD: Any thoughts anyone?

PHYLLIS SHARPS: I would think probably by December, September and December meetings. I think workgroups are still gathering information, trying to figure out how to do it. I think that, you know, the cross-cutting edges of that, issues are going to emerge once we present what they're thinking in terms of recommendations.

And I was only on the end of the process for the AIAN

recommendations, but it seemed to me that that was the process, that each subgroup would sign up, and then they would decide several times, several times, you know. And then people won't believe it, but it was condensed some.

And I think also it will have to do with how we frame the preamble of introduction to the recommendations about what's in it. So what I think right now, I think we should just continue to be broad, and gather, think, trust that it's going to come together. I'm sorry, I'm Phyllis.

BELINDA PETTIFORD: Thank you, Phyllis. Yes, Kate?

KATHRYN MENARD: I'll just add to that. Phyllis, I agree with that approach. At the same time, I see that some themes have emerged. I think this broadband discussion was a good one, because that's cross cutting. I think that, and it's not just rural, it's urban. You know it's certainly cross cutting.

The other cross cutting theme is coming through loud and clear to me this week is the need for, you know, the most effective, what is effective, and what are the most effective and cost-effective ways to deliver information in ways that people can receive it. And that's cross cutting. You know, so if we can identify cross-cutting things now that we know that all of us need to learn about, every single person, every workgroup, then we can do that potentially altogether, and not put it on a specific workgroup list.

And the broadband conversation was certainly on our

work list now. It's on the whole groups, right? So I think that's going to come through really importantly in our report, and so my thought.

PHYLLIS SHARPS: I think the other thing.

BELINDA PETTIFORD: Name.

PHYLLIS SHARPS: Phyllis.

BELINDA PETTIFORD: They're texting. Everyone is sending me notes in the chat, they need to know who we are.

PHYLLIS SHARPS: Phyllis, Committee Member. Thank you. I think the other thing that has emerged that's an underlying thing that is the harder issue to address, and I think it came through on the tour. I think it came through a lot of the community voices and some of the programs, is the whole issue around systematic racism.

And you know, it impacts everything that we do, but and this whole notion of political determinants of health, that was a new term for me to think about. But in as much as we can address those, which will come across in how information is delivered, how things are communicated.

But if there are system things that are also getting in the way of rural health, and contraception care, and social determinants, whatever way that we can do it. And I know that HRSA isn't part of the government, the political stuff, all that happened, but we have to address that too.

We're asking multiples, not only just individuals and individual projects. We do that very well. But what we need to also start paying attention to some of the system issues that we can tackle within the purview of the power because there's some members of the community voices said, you know, we're like a rat in a maze, we just keep going around, you know.

Some issues will improve for a cycle, and then they won't, you know.

BELINDA PETTIFORD: Thank you, Phyllis. This is Belinda talking. And I think you worded that very nicely. You did, you did, but I think you know one of the reasons we keep saying we came to Saint Louis was to listen, and pretty much the vast majority of the presentations that we've heard, especially yesterday from the community, they brought up systems issues. Whether it was, you know, racism, whether it was systems issues around other areas, but they keep bringing it up. And I think and then we had our HRSA administrator tell us to be bold, to think outside of the box, and really look at our recommendations from the standpoint it may not be something that can happen immediately, but it is something that we want to say as a Committee that we are elevating, and it is important.

And we have sent that forward so that others know that it is important. So I appreciate you wording it so nicely, and we'll have that for the minutes, so that we can come back to it. But I do think all of us and the work we're doing, and the

workgroup and as we're coming through the recommendations, we need to think boldly. We do need to think outside of the box, you know.

We need to think about what do we really think could move this work forward and we can see improvements? Maybe not immediately, but we should be able to see improvements in the future because it takes quite a bit of time as we all know. Yes, Kate?

KATHRYN MENARD: It's Kate Menard. Sorry. Yesterday when we were listening to the panel, you know, what came loud and clear, what -- I mean that came true for every speaker that racism needs to be addressed. So my question to the group is and so there was well, what do we do about it in terms of?

My heart just -- I don't know what answer to that, but who does what when, write into our recommendations sort of a thing. And where does that fall in the work? Is that a big agenda on the SDOH Workgroup to kind of tackle that? Does it really quite fit and deep dive into the rural, I think is bigger -- not bigger, different issues there, so I guess I need to know kind of if we're going to do that we need to include that right, as an overarching goal, but where is it sitting?

BELINDA PETTIFORD: Yes, Sherri?

SHERRI ALDERMAN: This is Sherri Alderman. Yes. I think so, and that's something that we are moving in the direction of, I believe, and I definitely invite Marie to chime in when

she's back on this, and that is I'm repeating myself from yesterday. If we don't address the political determinants of health, which is all of that social constructs and legislation, et cetera, that contributes to racism, a racist system, we're just to put it bluntly, we're spitting in the wind with our recommendations.

Because what will prevail, and this is evidenced by history, what will prevail are the political determinants of health after we submit our recommendations at a pinpoint level. So I really welcomed learning more about it myself, and how we can -- and exploring how we can make recommendations that at least put a crack in the political determinants of health, and consider that, so I'll stop there.

BELINDA PETTIFORD: Yes Joy?

JOY NEYHART: This is Joy Neyhart, Committee Member. And to expand on what Kate and Sherri began, you know, what the foundations are going to be -- to breakdown what the structural barriers are, and start in areas that are bringing food -- so grocery stores, bringing transportation -- so public transport, and bringing health care back to where it is taken away where it isn't right now.

This is what we learned on the tour yesterday. This is the foundation, so we can again, recommend programs, but the programs aren't going to go anywhere. There's going to be that spinning wheel until the foundations are brought back.

BELINDA PETTIFORD: Thank you, Joy. Yes, Steve?

STEVEN CALVIN: Steve Calvin, Committee Member. What I was most struck by too, I mean a lot of what we heard, you know, is uncomfortable here. I said a caution that before we get too far into political determinants of health, we have to remember that it's a deeply divided country. We try to find out what is it that actually united us.

And so, I would say the thing that was most powerful to me was hearing Okunsola, the founder of the birth village. She pointed out, I mean she went past things and she said we need risk appropriate care. And I think if there could be, you know, 700 of you know, of Okunsolas in the country that would make a huge difference because she gets it.

She gets stuff that crosses all kinds of political divides, and will say we need the kind of care that is appropriate for low risk mothers. I think she pointed out that she said 90%, and that might be a little high, but the vast majority of pregnant women are low risk, and so it's that kind of thing.

We need to find those kernels and say that's something that I don't think anybody can argue from a political sense or ideologically. They can just say. So I'm not opposed to a description of political determinants of health, but you know, here you are in Missouri where it's the flip opposite of where we are in Minnesota.

Where there's a majority that are doing things that

make a lot of us uncomfortable, sad. So we're going to have to figure out ways to navigate that in a prudent way.

BELINDA PETTIFORD: Thank you. I'm going to get to ShaRhonda, because her hand has been up a minute, and then Sherri.

SHARHONDA THOMPSON: And one thing I do want to recall from yesterday is that it's not just a social determinant of health, or a political determinant of health. One thing that the panel did bring up is that in order for us to be healthy during preconception, that systemic racism has to be addressed even before the pregnancy, so it's an overreaching, it goes into all of our basically to all of our workgroups as something that touches every last one of them.

BELINDA PETTIFORD: Thank you ShaRhonda. Sherri?

PHYLLIS SHARPS: This is Sherri. Again, I agree with everything that's been said, and we do have to be very thoughtful about how we present our recommendations, given the current climate to have any affect at all, so I totally agree with that. I also in thinking about what Joy said, and that is that there were things in place, and then it eroded, or evaporated.

And I wonder, I'm curious why did that happen? And where I go with that is that it was the political determinants of health that prevailed, and so we can have you know, the U.S. culture seems to be -- my perception is that the U.S. culture seems to be very effective at responding to urgent needs, or catastrophe, or you know, some really compelling circumstance that

warrants a social response to address.

And then when that floats by and passes, we go back to business as usual, and those are the insidious presence of political determinants of health. And if we could really make a significant shift in a way that really captures what we all shared, the values that we all share across the board, I think that we can then shift the political determinants of health to be positive ways of addressing health and well-being for families, mothers and babies.

BELINDA PETTIFORD: Thank you, Sherri, and Phyllis is going to be our last one. We'll try to get back onto the schedule a little bit.

PHYLLIS SHARPS: So, you know, certainly we're not going to be able to change the world, but I do think what was really great about the Indian Task Force Native American was a large introduction preamble that kind of gave us the context or the history of the disparities.

And so maybe we can start our documents much like, at least put it out, and you know because of these contexts, this is what we're looking at now, and these are recommendations, you know, that we think that will help move the help in a more positive direction. In the end it's always about power and control, so.

BELINDA PETTIFORD: Thank you. And thank you to everyone for all of your feedback. This has been really a good

conversation around the workgroups. I hope it was helpful, especially to each of the workgroup co-leads, as you're moving to the next level, you know, I've already started thinking about how we do the introduction to our recommendations, because we are focused on improving Black maternal and infant health.

So any thoughts that the rest of you all have, I think we definitely would appreciate receiving them, but thanks everyone. Okay. Anything else around a workgroup at this point in time? No thoughts?

AI/AN Recommendations: Updates

BELINDA PETTIFORD: I'm going to take us back then because we skipped over it, just to make sure we had some of Marie's time, and go back to our area around the recommendations from our -- Making Amends AI/AN recommendations. And really want to see if there's any updates from any work that any of the Committee Members are doing.

I don't if Vanessa, if you have anything you want to share from any of these Ex-Officios on work that's going on the ground working with American Indians, Alaskan Natives to move those recommendations forward.

I know Ed is still in the meeting, so we will take a few moments now to get any update there.

SARAH MEYERHOLZ: Yeah. Happy to give some updates

there. Sarah Meyerholz, the ACIMM program lead. My other half of my job is the program lead for state maternal health innovation, so our updates today will primary focus around what those grantees are doing.

And just to give you like a quick high level overview of what SMHI does, we currently have 35 states with this funding, and it includes entities such as public health departments, universities, hospital systems, and we do have a lot of community-based organization. And their goal is to improve maternal health by establishing a state-wide maternal health task force, improving the collection of use of our state level data on maternal mortality and severe infant morbidity.

And in launching innovative activities, which can fall under health service delivery, enhancing data capacity in other ways, and health disparities. So happy to provide more information about the program overall at any point in time, but I did want to provide just some specific AIAN updates.

On March 13th, the Maternal Health Learning Innovation Center, MHLIC, who is the TA provider for this portfolio, they launched a community practice for any of the state MHLIC awardees, who are interested and authentically engaging in indigenous populations.

So looking forward to seeing where that goes. I have a lot of updates to read, so I'm very sorry, but this is all for the notes. We'll have it on the transcript. So as you all

know there were 59 recommendations. I'm going to speak to three of them today. AIAN 1-D, which talked about consultation and partnership with the AIAN elders and others with relevant lived experience, just paraphrasing that.

We do have two awardees, both in Arizona and Montana for partnering and creating tribal maternal health task forces, and I will include in the chat there's only two tribal specific maternal health strategic plans, yes from Arizona. The Montana team actually sits within Title V. And they cohost four health care immersion days a year with reservation communities. And these immersion days build off of learning and experience of life lessons immersion days that took place in Blackfeet Nation in August 2023.

And these events bring together provider teams from Montana's participating PQC hospitals and other program staff in selected tribal nations. So it's an opportunity to build relationships, gain familiarity and generate multiple compassion and cultural exchange. If you have that you can put it in the chat, thank you.

The next recommendation, number 11, talks about strengthening accountability for how Title V resources are employed within by and for tribal communities. Going back to Montana, which is within Title V, they're currently working with powwow committees to identify opportunities to sponsor dances, and serve as an exhibitor to create a positive presence within tribal

nations, and other indigenous cultural events.

And this allows them to connect with indigenous populations as they start thinking about how to complete their Title V Needs Assessment, so those are every five years. The next one is coming up in 2025. And then the last one is number 26, which is investing in training of AIAN doulas and traditional birth workers, and we're actually moving to Washington state, so the Washington State Maternal Health Innovation Program has a doula Medicaid benefit that's been proposed to the legislature.

And in preparation for this new benefit the Washington State MHI program has partnered with Doulas for All to develop community education and awareness in tribal communities on what a doula is, how BIPOC communities can access doula care, and workforce pathways into doula careers.

In addition to this, the state also launched doula certification in 2023, which would be a requirement for Medicaid billing. The state HOI staff in Washington are also currently collaborating with certification staff to ensure that their funded birth equity partners, which do include two tribal doula organizations have support in applying for certification.

It's a lot of information, but our state MHI portfolio, like I said, is doing a ton of work, not just in AIAN, so if there is every interest in learning about some best practices that we know are coming out of this portfolio, happy to share them at any time and Vanessa, I'll pass it to you.

VANESSA LEE: I have updates from Dr. Tina Pattara-Lau from Indian Health Service. She unfortunately couldn't be here. She's on annual leave today but did send us an update she wanted shared with the Committee. The Indian Health Service Maternal and Child Health Program is still continuing to work on initiatives to expand access to safe, quality maternity care in the community, and reduce maternal and newborn morbidity and mortality.

So they're leading with cultural safety, which means creating programs by and for the people they serve, and they are being intentional about lifting up Indigenous leaders in their work. And some of the examples she shared they fund the maternity care coordinators at federal sites to increase access to screening, education and intervention through telehealth and home visiting during pregnancy and postpartum.

And there will be a partnership with trusted community leaders to extend care beyond the clinic and close the gap between delivery and the critical postpartum period. They will award six million to six sites in April of this year. They're also leading the obstetric readiness in the emergency department, OB Red program to provide sites in maternity care deserts, obstetric services, and with tools and resources to safely triage, stabilize and transfer pregnant persons and newborns.

Over 24 IHS sites have reviewed the manual, five sites and over 225 staff have participated in hands-on simulation training. And they're currently working to provide technical

assistance and training to three additional areas in 2024. And I may mispronounce it, so Imaje from the team? Imaje, thank you, Billings and Navajo.

And last, they provide virtual on demand education and clinical consultation to the field in Indian country, ECHO Care and Access for Pregnant People. We can put this link in the chat too, which is a series that's been attended by over 1,400 participants across all 12 IHS areas. Prior topics have included indigenous birthing practices, indigenous midwifery and doula care in Alaska, and urban Indian substance use treatment centers.

The last webinar was recorded on March 26th, and it's available on demand. It's STI screening in pregnancy, how to use field testing and treatment for syphilis, and it was featuring the Navajo area PHN's and the CDC, so we can also put these in the chat. And those are the updates from IHS.

MS. PETTIFORD: Thank you. It sounds like it's simple, we may need a presentation on the MHI.

VANESSA LEE: And we can continue as federal Ex-Officiates in the agencies under HHS to meet quarterly, so in between our whole Committee meetings or aligned with the full Committee meetings. We gather to discuss the AIAN and recommendations, Charlan is often there, as well as all of the folks online, and this continues to be on our radar. We continue to check in with each other about what progress is being made across the Department.

LEE WILSON: A suggestion. This is Lee Wilson. I'm at HRSA. We are maintaining a calendar of various programs that are within the division, and because we've been making so many awards, we've had a lot of kickoff meetings. Some of our programs have like an annual meeting, Kate has been involved of some of the NHI ones, I think that we've been doing.

But I don't know that all of you are aware of those meetings, and they're generally intended as technical assistance, or learning institutes for our grantees on the program specifics, but then also on sort of models or topics that might be useful for their success.

Most of those meetings are public, and I think it might be worthwhile for us to sort of provide to you on a regular basis an update of that calendar if you should choose to sign in, listen in, at your interest.

BELINDA PETTIFORD: Thank you. I think that will be helpful for everyone. And I was able to go to the state one in -- this year. I don't make it there, but I was this year.

LEE WILSON: Did you have fun?

BELINDA PETTIFORD: I did, it was a good meeting.

LEE WILSON: Did you learn a lot?

BELINDA PETTIFORD: I learned some things. I've been doing it a long time. Yes, I learned a whole, whole lot, yes.

KATHRYN MENARD: I sat in, this is Kate. I sat in on

the reviews. I wasn't able to go to this one, but I sat in on the summary, you know, that was provided. There was I think people that aren't as wise as Belinda, learned a ton.

LEE WILSON: Well, Sarah had a big hand in the planning of that whole -- so that you know that, and Vanessa was very involved as well in that, so you know it went off extraordinarily.

BELINDA PETTIFORD: And I actually sat in on the session around the learning collaborative around American Indian and Alaskan Natives, so we're excited to see the next steps on that one. Wonderful. Okay. I don't want to cut anyone off. Do we have any ex-Officio members that want to report anything they're doing around Indigenous populations? And Vanessa did an awesome job pulling everything together. Yes, Joy.

JOY NEYHART: Just a quick comment. This is Joy Neyhart, Committee Member. Thank you for that report because now I feel -- I mean it's very encouraging to see all the hard work that came out of the recommendation compilation that's being put into action, so thank you.

BELINDA PETTIFORD: And it gives you something, this is Belinda, it gives you something also to go back to when you're doing planning in your own states, and your own community, things that you can work on, so it's almost like it's a blueprint in and of itself. It's wonderful. Yes, Charlan?

CHARLAN KROELINGER: Hi. This is Charlan Kroelinger, CDC. I just wanted to emphasize and thank the MCHB leaders for

this Committee, and the quarterly ex-Officio meetings are useful to continue to spread your message around the different agencies in the Department, so you all are being heard.

BELINDA PETTIFORD: So now we can take a ten-minute break just to get us back on schedule. I want us to come back and do next steps and assignments, and when you talk about the June meeting, but I know some of you are going to need to leave in a little bit, so we'll just take maybe more like we could come back at 10:45. That would be great, so maybe like eight minutes.

Next Steps and Assignments

BELINDA PETTIFORD: Hello everyone. We are back, this is Belinda. We're going to move on with our agenda back to at this point we're at Next Steps and Assignments. And part of our conversation around Next Steps and Assignments is really trying to think through kind of what our timeline is to get our recommendations ready.

So as you know, we have a meeting plan for June. We'll be meeting in Rockville, Maryland, June 26 and 27th, and we'll talk a little bit more about that in a few minutes, and then we'll likely meet in September and probably December timeframe, that will -- we can discuss that, but we normally try if we're meeting four times a year that will put us pretty much there.

So it's really thinking through a timeline for the

workgroups to start thinking through your recommendations. So if we look at June, September meetings, we really need to have the recommendations, at least strong drafts of the recommendations by the end of the year, which would kind of put us in mind with maybe having a December meeting.

And this would give us time to have drafts and that will still give us time to gather some feedback from some community partners, from some of the other national organizations that we pulled to the table initially to share with us what they were doing in this area, and what the goal of having our recommendations final, and to the Secretary February-ish, March, so it will be done before my birthday rolls in in March, so that's -- so sometime.

So any thoughts about that timeline? Any concerns about the timeline that we will use a June meeting, we will be in-person, so we will use time for the workgroups to actually meet in-person, or it will still be hybrid for those workgroup members who are not able to attend the meeting in person.

Again, we will meet another time in September timeframe. We'll just have to look at the calendar, because we didn't run that far, but we are going to have that scheduling, as I'm looking at Sarah and Vanessa.

VANESSA LEE: The other contract I think it was October-ish.

BELINDA PETTIFORD: October-ish, okay.

VANESSA LEE: I know November starts to gets hard with the holidays, September is sometimes just a bit too early because we award the new contract in August, so we want our contractor to just have a minute to get up to speed before they're planning because I think the meeting is scheduled for in-person actually. The fall one is another in-person opportunity.

BELINDA PETTIFORD: Right, can we do two more meetings? If one is virtual and one is in person? Well, we're figure it out and get back to it, so don't put it on your calendar yet until you start hearing some dates, but I do think it will give us an opportunity to you know, spend some time -- focus time on it outside of your workgroups.

And I think at this point the biggest focus is on the workgroups, so at the end if we go on a timeframe of having the recommendations in good draft format by the end of the year, with the goal using maybe January to get feedback from partners, and others, at the beginning of 2025, so that we can have a final version of the recommendations February, no later than early March. Does that work for individuals?

STEVEN CALVIN: Would there be new members coming because I think I'm the only one gone after December. Are we still?

BELINDA PETTIFORD: We probably should talk about the timing of the Committee right now because I know we're all waiting for some additional members to come, and we know it's a lot more

members, yes we are. We probably aren't going to get a lot more, but I don't know. Vanessa, could you give an update on where we are with appointments?

VANESSA LEE: Sure. We have six nominees under review that subgroup, or that package. We've been hoping any day now, by you know, each Committee meeting we say by the next one we hope so, that is still our hope. I do want to be clear that package is from the solicitation we did in 2021, so there's folks I think who've been listening over the three days who may have been nominated as part of the solicitation we did last year in 2023.

So that is another package that we -- I'm formulating and will be submitting for review as well, but just to be clear the group that we're waiting on that is currently under review from the solicitation we did a few years ago, so realistically we expect them to be brought on hopefully soon, and then we would have another package that's going to be under review from the 2023 solicitation.

I'm not sure how realistic it is to assume they get appointed in 2024, if it was it would be, you know, later in the calendar year, or 2025, so I think again, people who have been listening in who are part of this most recent solicitation and got nominated we were hopeful, and I'm hoping that it would be a 2024 appointment, but we're just not sure given we're still waiting on this package downtown that's under review first.

BELINDA PETTIFORD: Yes, Joy?

JOY NEYHART: One quick question.

BELINDA PETTIFORD: Joy, name?

JOY NEYHART: Oh Joy Neyhart, sorry, Committee Member. One quick question is the six that are under review, are any of them community members?

LEE WILSON: We cannot discuss the representation of the committee that has been nominated. And just for your information, the length of time that has passed has meant that there has been certain individuals who may have been quite interested, and two years later they may have moved on, so. I can assure you though that all of the recommendations that have been made by the Committee were attempted to be addressed.

We cannot guarantee who makes it through the process.

VANESSA LEE: Okay. Thank you. We heard there about the priorities for community consumers, assuming we're missing out without Janelle Palacios American Indian and Native representation, and all of these in general, so we definitely heard the feedback and tried to incorporate that as we go through all the nominations that we receive.

BELINDA PETTIFORD: And does everyone know when your term expires?

JACOB WARREN: Jacob Warren, Committee Member. That's what I wanted to bring up because there were, as of March, which is our deadline for these recommendations, there are only two of us left. Everyone is going to rotate off in March, by March,

except for two of us, so like for us.

VANESSA LEE: Steve, as you mentioned your term end date is December 31st of this year. All but Belinda, Joy and Marie that term end date is March 13th or 15th of 2025.

KATHRYN MENARD: Okay.

JACOB WARREN: Yeah. So February and March we're going to be -- January, February?

BELINDA PETTIFORD: I'll have to back things up a little bit. So it seems like the last go round there was -- I'm sorry, Michael, there was -- were there extensions?

VANESSA LEE: We did have extensions so that everyone could make it through the tribal meeting and going to meet in person to finalize, and then Ed, his term ended in December, and he submitted right, you know, literally like weeks before his term end date, and we helped facilitate that obviously.

So if you still want to move for early, like March 1st at the latest, you know, we hope you submit that to the Secretary, and everyone is March 15th.

BELINDA PETTIFORD: Okay.

MICHAEL WARREN: This is Michael Warren. So we'll continue to nudge. We nudged, as Vanessa said, on a weekly basis, but if a decision is not in HRSA anymore, it's going through that process. We'll couch this in a very neutral apolitical way. It’s public knowledge that there's an election in November.

If there is an administration change, this is true with

any administration change, so this is not unique to this upcoming election. The process is around things like getting Advisory Committee Members appointed, even routine business, there is often a delay at the beginning, and let me reiterate, any new administration.

And so, I think as we are thinking about things like extensions, just need to keep that in mind, that things in a non-election year might be fast and easy, or easier, are not typically in this, so we just need, and we can think Lee and Vanessa, about just the timing there.

LEE WILSON: And historically, I'm sorry, Lee Wilson. Historically, when there is a party change the rule is that there will be a halt on committees, and committee nomination changes all of that because they tend to be the incoming group wants to ensure that there is fair representation and so when they do that, so.

BELINDA PETTIFORD: Okay. So in reality we need the six people to get on it, so we can focus on -- we don't all focus on it, but we know you all have done everything you can to try to get the six because of the reality we can end up with, like we said, two members. And then we don't really know sitting here today who the Secretary will be.

But I think, unless you all tell me that you have different thoughts, it would make sense for our recommendations to go to whoever the new Secretary is going to be, because we want it to go forward. Or we can back everything else and go with the

current Secretary, but we don't know who the Secretary will be after the elections. It could be the same, or it could be a different one.

So that's the challenge with, you know, coming out with recommendations in an election year. So my thought process was to whoever the Secretary is going to be starting in 2025, that's when the recommendations would go because they would have time to review them, decide how they want to handle them, but they will be coming from this Committee.

But others of you may have different thoughts, so if you do, feel free to share them now with me. I take it that you are all in agreement then.

KATHRYN MENARD: Belinda, if I could just have one question, another naive question.

BELINDA PETTIFORD: Yes, name?

KATHRYN MENARD: Name, Kate Menard. There are exceptions for re-appointment. Is that easier than extensions or no?

BELINDA PETTIFORD: We're good. All right. So then we will look at I'll get with Vanessa and Sarah to figure out when we can meet beyond June. But right now, please make sure you are holding June 26 and 27th on your calendar. That meeting will be in Rockville, Maryland.

We will have an opportunity again to spend quite a bit of time for the workgroups to meet during that time. Yes,

Michael?

MICHAEL WARREN: Sorry. Michael Warren. One thing, and we can talk to Belinda further about this. If the Committee feels really strongly about the timeliness of these appointments and where they are with recommendations, we can talk about a communication from you that might be helpful.

BELINDA PETTIFORD: Yes. I will do that.

MICHAEL WARREN: To us to remind us of the urgency of that that we can use.

Planning for June 2024 Meeting

BELINDA PETTIFORD: Thank you. Thank you. Okay. But as we start thinking about the June meeting, again it will be in Rockville, Maryland. We can use whatever time we want. Right now we're thinking travel in on the 25th, that Tuesday. The meeting will be all day on the 26th. We can also do the meeting all day on the 27th or we can try and wrap up around 2:00 on the 27th and then quite a few people can get a flight back out.

I don't know. I'm coming from North Carolina, I can get a flight out about anytime, so those of you who are not on the east coast, what is kind of your cut-off from being able to get a flight out, or are you good waiting and flying out the next morning?

JOY NEYHART: Yeah. I think the more time we have to

spend together is going to be more helpful, so two full days that's mine.

BELINDA PETTIFORD: Thank you. Others? Do you want a day and a half, or do you want two days? I guess that's the bottom-line question.

SHERRI ALDERMAN: This is Sherri, and I agree with two days long gives us a little time to -- very valuable to be in-person for two days.

BELINDA PETTIFORD: Thank you. Anyone have an issue with two days I guess is going to be the question? That includes anyone that's in -- that would be our Ex-Officios as well, anyone that's participating virtually. So we will go with all day the 26th and 27th.

MARIE-ELIZABETH RAMAS: Hi folks. I'm just hopping back on. The 26th and 27th of what month? I apologize.

BELINDA PETTIFORD: Thank you, Marie. June. We'll be in Rockville, Maryland.

MARIE-ELIZABETH RAMAS: Okay.

BELINDA PETTIFORD: And again, if you are on the east coast you still may be able to get out on the 27th. There's just others may struggle trying to do that. Are there specific presenters or speakers that people want to hear from at that meeting so we could start working on that agenda?

We have already talked about a handful earlier. I know Charlan mentioned someone to me at break. Charlan, if you want to

share that?

CHARLAN KROELINGER: Thank you Belinda. Charlan Kroelinger, CDC. I thought it might be helpful for the Committee to hear from someone who is an expert in systems thinking. It might be helpful, then I can share some names of folks with Belinda and the planning group. Thank you.

BELINDA PETTIFORD: Thank you, Charlan. Yes, Joy?

JOY NEYHART: Joy Neyhart, Committee Member. I reached out to Upstream U.S.A. to see if we could hear from them if that's okay?

BELINDA PETTIFORD: Sure. I'm sure we can get a speaker from them. Yes. So we just have to think through, yes.

JOY NEYHART: Okay.

BELINDA PETTIFORD: Yes?

JACOB WARREN: Jacob Warren, Committee Member. We had also, we're working with a rep from CDC's Office of Rural Health for a while to see if they can be present in June. We have a meeting for this to check in with her, so we might have a rep from there as well to talk about what their new office is.

BELINDA PETTIFORD: This Office of Rural Health?

JACOB WARREN: Yes, CDC.

JOY NEYHART: Joy Neyhart again. Can we recruit someone from the local D.C. area with lived experience to speak to us there?

BELINDA PETTIFORD: Yes. I think we can. I know they

have a Healthy Start site there, and so we try to make sure that is on all of our agenda, so we will work to make sure we have, you know, one or two people from the lived experience, thank you. And we already talked about the FCC or maybe someone with that perspective talking about broadband. Anyone else we're missing?

PHYLLIS SHARPS: Phyllis Sharps, Committee Member. So, you know, in that tri-state D.C., Maryland, Virginia, there are parts of Maryland and Virginia that have rural populations, so those with lived experience. Maybe we could see if we could get some speakers from those areas.

BELINDA PETTIFORD: Okay.

PHYLLIS SHARPS: Particularly from Western Maryland, and some parts of Virginia.

BELINDA PETTIFORD: Can we follow-up with you on that?

PHYLLIS SHARPS: Yeah.

BELINDA PETTIFORD: Okay.

LEE WILSON: And we can talk with our Healthy Start in Greenwich to identify.

SARAH MEYERHOLTZ: Also, the Maryland State Maternal Health Innovation Project, that has a huge focus on telehealth and remote patient monitoring, and they were just refunded last fall. I think they're expanding to more of the rural coastal cities, so they might be a good team to bring in.

KATHRYN MENARD: And I have two thoughts. Kate Menard. I'm just going through my notes from earlier today just making

sure we've grabbed this. We talked about somebody from -- I don't know if this one is specific to the rural committee or broader cross cutting, I defer to you. The Bureau of Health Workforce.

One topic that came up that I think is cross cutting is the idea of racial concordance and building trust. I think particularly since we're focusing on racism and health disparities that that would be, you know, a speaker with expertise on the importance of that, would be helpful. I don't know a particular person unfortunately, so.

VANESSA LEE: Yeah. Under Ed's chair we had a panel on that, so we can bring that back up just to review again. I don't believe -- and they so.

MICHAEL WARREN: ACGME, I think.

PHYLLIS SHARPS: And within that jurisdiction we've got a Historically Black University and medical school at Howard University.

MICHAEL WARREN: Right.

PHYLLIS SHARPS: We have a public health school that is also a Historically Black University, Morgan State University, so they put in speakers from all those entities.

LEE WILSON: This is Lee. We've had our Office of Epidemiology and Research do some collection of articles and published materials on racial concordance as well, and so we can provide what they are able to do for that and summarize that. It's been a big issue with Healthy Start and some of them who do

the work.

BELINDA PETTIFORD: Thank you. Pulling up our agenda for June, I know we're going to spend time with the workgroups. Yes?

SHERRI ALDERMAN: And this is Sherri Alderman. And we've been talking in our workgroup about having the Attorney General come and speak to the document of the epidemic of loneliness and isolation as a public health issue.

BELINDA PETTIFORD: Thank you.

SHERRI ALDERMAN: And Dr. Dawes, Daniel Dawes, from Moorehouse School of Medicine in Atlanta, to speak about the political determinants of health.

BELINDA PETTIFORD: Thank you. I'll get them all for June, again we need to have the workgroups to meet. And maybe if we prioritize them, we might have to get some of them for the next meeting. So I'm assuming you all have a way to contact if we were interested in the Attorney General to make that request?

MICHAEL WARREN: The Surgeon General.

BELINDA PETTIFORD: Surgeon General. I don't think, the Attorney General.

MICHAEL WARREN: I wonder, Michael Warren, related to that. So my read, and it has not been in great detail. My read of that work has been more sort of general population assessment, so loneliness and isolation, and so I don't -- in terms of what the Surgeon General has published, are you aware that he has

published, or are there others who have specifically looked at that?

I mean we heard it in the panel yesterday. Are there other folks who specifically looked at maternal loneliness and isolation that we may also want to think about? I don't know if that's come up in the Committee conversation, or is it just general and we want to extrapolate to this population?

BELINDA PETTIFORD: I don't know if it came up in your workgroups, but I don't recall us talking specifically around maternal and infant death. I know that's what we're thinking, but I'm not aware of anyone that's doing work on this, unless someone else knows, but maybe we can do a list -- a search, to see if there's someone that has written on it, on this topic area, Vanessa --

MARIE-ELIZABETH RAMAS: Hi, this is Marie. It might be helpful to reach out to our friends at ACOG to see if there's any specific materials on maternal isolation.

BELINDA PETTIFORD: Thank you.

SHERRI ALDERMAN: And this is Sherri again. We have in the workgroup talked about home visiting as an approach to addressing loneliness and isolation.

BELINDA PETTIFORD: Well, that gives us a couple of thoughts. We are already filling up our June meeting schedule. We probably want to -- is there a path a day, and that way it will give you time to you know, meet, and you know, have conversations

and do some planning while you're in the meeting, so we'll plan for that.

We just need to figure out where is the best time based on where the other speakers are available. Thank you, ShaRhonda. Yes Jacob?

JACOB WARREN: Jacob Warren, Committee Member. Could you give us the deadlines of what you need from the working groups like by June what you want from us by the September-October-y? You know, just or we can have a discussion about it, but. Where do we need to be to make sure that we're hitting our February-March deadline, you know.

BELINDA PETTIFORD: Right. And I guess I need to really put it in writing to you all, kind of what the schedule is because right now the only event I have in my head is that we need to have strong draft recommendations by the end of the year, but we probably -- I can back it backup, and put it at different points.

So let me put that in writing unless folks have a reason or a need to know right now. Let's think about the steps in the writing process and be very clear on what that means when asking you all to have a draft, you know, what the background is, or any of those areas.

Because remember, when we started down this road, we talked about making sure that we were limiting our recommendations. We were trying to come up with, you know, three

or four recommendations for a workgroup, and we would turn it all in. So, I'm thinking right off the top of my head by September you might need to have your long list, September, October your long list of recommendations, unless you are immediately going directly to your three or four.

Because then we've got to have a period where you narrow it down. And I don't know how your workgroups conversations are occurring because I'm thinking most of you haven't even thought about what your recommendations are. You're still in the gathering, the trying to come up with well, what do we think we should focus on, and for African American Black infant mortality, maternal morbidity and mortality.

So let me put it in writing and get it out to you all in the next two weeks.

KATHRYN MENARD: I'd just -- it's Kate Menard, I'd like to just put a plug in for advanced scheduling. June 26 and 27th. Clinical schedules are made, you know, and this is so it's going to be some jumping through hoops, but if we can get September on the calendar that would be really helpful.

BELINDA PETTIFORD: Right. And I can't remember, we sent the June dates in February? But it may not have been enough notice. I'm trying to remember when we sent it out.

SARAH MEYERHOLZ: That's always the goal.

BELINDA PETTIFORD: Yes. It's a lot of calendars.

KATHRYN MENARD: I understand.

BELINDA PETTIFORD: But if we're going to do September, October, we should be able to get that out, so maybe next week. And we'll start looking at calendars, yeah. We should be able to get the dates out for the rest of the year because we just need to figure out if we can do one more meeting, or two more. One could be virtual, and one could be in person. I'm not a clinician, but my calendar fills up.

And Marie has put in the AAFP annual meeting would be September the 22 through the 26th, but she will not be available. If you know you're not going to be available the rest of the year just drop us a line. You only have excused absences to say you have to be at this other event. Any other thoughts, concerns? Suggestions around the June meeting? Any other thoughts or concern in general? Yes, Sherri?

SHERRI ALDERMAN: This is Sherri Alderman. I think this has been a really fabulous, good use of time today, and the speakers were incredible and to be able to sit together around the table and work together is just you know, phenomenal. And I want to thank everyone who worked so hard to make this so successful.

And to have representation, more than representation, but actually colleagues and champions for this work at the table is really very valuable, and it gives me a lot of inspiration and a lot of hope. We have focused over the last three days, we focused very much on maternal health, which is critically important for the issues that we're faced with in this country.

And certainly, when I think about the babies and the maternal health, and the father's as well, it is really, really critically important, and we also know from an infant mental health perspective that when we address the issues with the maternal health, associated related maternal health, there's still a baby who has been impacted, and the baby does not automatically get fixed when we fix the maternal health.

And so there are so many factors that play into the mental health of a baby, and one child, and one is the health and well-being of those adults who are with that child, and care for that child. They are very much impacted, more so than the adults. It's psychologically, behaviorally, physically in an environment of adversity.

And that there is certainly an opportunity for a repair, but that really needs to be intentional. And one thing that I was sitting here thinking about is about half of the infant deaths due to child abuse or neglect, are -- is an issue of an infant mortality that we haven't like shown as just one example, when we think about it from the baby's perspective.

And so I don't know where I'm going with this. I still have a lot to reflect on to be able to have a direction, but I don't want us to forget about the babies, as we're really working so hard to address these huge issues, and I just appreciate the opportunity to express that.

BELINDA PETTIFORD: No. Thank you, Sherri. And just

know that when Sarah, Vanessa and I were meeting to plan, we were trying to make sure we had presentations that included a focus on -- that's the reason we definitely wanted Healthy Start because their primary focus is on improving birth outcomes. But you know, it includes maternal health as well.

But we wanted to have a Black infant health program in California come and present, and something came up. They just couldn't get permission that quickly, so we will probably have them down for June. And there are other areas, you know, programs that you all are aware that you want to hear. There's some lessons learned or something related to Black infant mortality let us know, and we'll definitely add them on.

But you're right, it seems like since we've changed the charter to talk about maternal health we have inundated it with maternal health, realizing that most of us notice the infant and the maternal it's the dyad of working together, but thank you for your feedback on it. Marie, I see your hand is up.

MARIE-ELIZABETH RAMAS: I'm glad you brought that up, Sherri. I think the March of Dimes would be a great resource to help with connecting with neonatal mortality morbidity. I can share a contact of one of the leading neonatologists that work very closely with March of Dimes and has worked on several campaigns with them.

And that might work well for our Committee purposes to hear about their work.

BELINDA PETTIFORD: Thank you, Marie. If you'll drop it in a chat or send us an email that will be good. And Sherri?

SHERRI ALDERMAN: This is Sherri again. And also, Alisha Lieberman is a huge figure in the world of infant mental health and has developed over the decades of contributions that she has made to that field, an evidence-based approach to addressing and prevention of transgenerational child abuse, so she might be a potential speaker as well.

BELINDA PETTIFORD: And you've got her contact if you could drop it. Thank you.

Meeting Evaluations and Closing Observations

BELINDA PETTIFORD: Now we're getting ready to start losing people. So as we are wrapping up I do want to give everyone a chance, if you'd like, not to be forced. If you've got any closing thoughts, anything that resonated with you deeply during this meeting that we are really were able to have in-person.

We cannot thank the people of St. Louis and Missouri enough for welcoming us here, laying out the red carpet for us. They have really been awesome to work with at every level, and who could have expected that we would be in such a beautiful space that has so much rich history that talks about, you know, some of the challenges and divides, and the history of why we're dealing

with some of these issues still today.

So the fact that they again opened their arms to us. I don't know if any of them are still here, but we'll definitely send them a nice thank you note. Some of them are still around, and so we'll send something in writing back just to thank them. But anyone have anything they want to share as we wrap up?

STEVEN CALVIN: Steve Calvin, Committee Member. So I'd like to just thank ShaRhonda. She's kind of our local host. And for me this was really interesting, because it was a block down memory lane, and it was very enlightening, and I'm really grateful to be part of this group.

BELINDA PETTIFORD: Thank you, Steve. Anyone else like to chime in? Yes Marie?

MARIE-ELIZABETH RAMAS: Hi, Marie Ramas. Wonderful meeting everyone, and albeit I was remote, I was very much enriched by all of the thoughtful presentations, and subject matter experts. Something that was very striking to me is again, how do we create and bring new and refreshing information as it relates to maternal health, Black maternal infant health?

As this has been unfortunately a lasting cry for many, many years. One of the things that I believe we have an opportunity in is helping to bridge a gap of perhaps more traditional ways of looking at maternal infant health, Black maternal infant health, and providing a fresh perspective and different lenses that perhaps, you know, the Secretary and our

federal government has not yet been able to incorporate.

And hearing, particularly the stories of our community members, and the wonderful work that they're doing. I see a lot of potential on providing salient examples of integration of both traditional and culturally sensitive approaches into this medical life space that we've created for our birthing people and the children that they birth.

So I'm really encouraged to take a look at this in the lens of what are some potential programs, offerings, that potentially the Secretary can help promote and enhance as it relates to populations of priority, but specifically for our Black population within the United States?

Again, I see the work that we're doing here as a steppingstone. Very often in our American history the plight and the work that's done for, with, and on behalf of our Black community members, often bleeds over into other minority or historically excluded populations as well.

And so I take this work very seriously in the sense that this could, the work and the recommendations that are provided to our Secretary, could very well be an impetus to creating more intentional policy that can not only affect Black maternal infant health in the crisis that we're facing, but other communities and populations that have been historically excluded.

So I am refreshed. I am reinvigorated, and I thank you all for sharing in this space with me.

BELINDA PETTIFORD: Thank you so much, Marie. ShaRhonda?

SHARHONDA THOMPSON: Hey. I just want to say one thing. One of the common threads for every board that I've sat on, every cabinet that I've sat on, one of the common threads that I hear a lot, even here, is educate, educate, educate. And the only thing I want to kind of bring for us to think about to think outside of the box, are we educating the right people?

Right? Should that burden be on the patient to be educated in order to get the care that they deserve? That's just something that we I think has to be brought to the table, and shed a light on because is it really truly fair that the only way that they can get the care that they deserve is if they're educated in something that's really not something that they should be familiar with unless that's the role that they want to play in life, right?

If they want to be in the medical field then yeah, then they'll be educated in that field. But to say to a patient oh, you didn't get this type of care because you didn't know it existed is just something that we have to all think about.

BELINDA PETTIFORD: Thank you, ShaRhonda. You know we always appreciate your feedback, thank you. Anyone else?

MICHAEL WARREN: It's Michael Warren. I just want to thank, I appreciate some of the community members acknowledging, but I want to reiterate the thanks for the intentionality that went into planning from our team, and in particular Vanessa and

Sarah.

I think it was reflected in the panels that we heard from. And really appreciated the panelists commenting on the approach of asking them how they wanted this to go, rather than sort of coming in with assumptions, and really recognizing the wisdom and the lived experience. I just want to acknowledge them for this work.

BELINDA PETTIFORD: I don't want to cut anyone off. Yes, Vanessa?

VANESSA LEE: Thank you, Dr. Warren for that, and we couldn't have done obviously without ShaRhonda as others have said, being the local. She really did give us suggestions and recommendations for many sites that we were considering, and then she connected us to Generate Health, you know, who is a tenant of this building.

And Kendra and her team at Generate Health just did a really nice job letting us know who the local players were, including the two health departments, and did a really warm handoff to us to Dr. Mati and Dr. Cunningham. And it was through them that we found even more local organizations, as well as two of the speakers with lived experience, and then Generate Health and Healthy Start of course, contributed as well to that panel.

So it was a team effort. Both, you know, our team back home and the team here in St. Louis, and of course with our Chair Belinda, all of the support and input she gave to the agenda. And

then last, we really modeled if off of the work that had been done for the tribal meeting. I mean we saw just how successful that was in September of 2022 in Minneapolis, so we didn't feel like we needed to recreate the wheel.

So I just want to credit Dr. Ehlinger and Janelle, Magda, Belinda, and those that had rolled off for their work on the creation of that agenda, which was a model this went off of. And last, just thank you all for making that recommendation to us to have these meetings in the communities that we're actually discussing, and if you want to re-emphasize that in your next set of recommendations, Belinda.

BELINDA PETTIFORD: Yeah. I want to thank everyone for all the time and energy and the thought that you put into this meeting, and for everyone being willing to, you know, we come to St. Louis to hear from the community, to hear from a part of the community that doesn't always get the opportunity to have folks, you know, come in and listen.

And I think we would do a disservice to them if we're not listening to the recommendations that they shared with us, as well as many others. This has been a joy to work with this group. ShaRhonda was also right from the beginning when I reached out to her. I said ShaRhonda, are you good if we come to St. Louis?

And she said St. Louis? And I was like yes, St. Louis, your home. So she was wonderful right from the beginning. And then after a very short meeting with both Vanessa and Sarah

they ran with it, but it was awesome to have, you know, Generate Health and all of the other players.

We had really no one that told us no. They found out we were coming, and you know they moved heaven and earth to try to make sure we could be where we thought it was best for us to be, and I think it was demonstrated in everything that was done. So thank you all so very much for your ongoing leadership, your time, your commitment to move this work forward.

It is not easy. Please take care of yourself. Don't forget self-care, and in the midst of all of this as we tell others all the time, you know, we have to remember to take care of ourselves, so as we bring this meeting to a close, we say thank you all of those that joined us virtually.

We miss giving you a hug in case you weren't able to be here in person because Belinda is a hugger. But otherwise, we look forward to seeing you hopefully in Rockville, or in virtual land somewhere. Thanks everyone.

(Whereupon the Advisory Committee on Infant and Maternal Mortality (ACIMM) adjourned at 12:32 p.m. EST)