ADVISORY COMMITTEE ON INFANT AND MATERNAL MORTALITY

US DEPARTMENT OF HEALTH AND HUMAN SERVICES

Virtual Meeting

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Reported by Garrett Lorman

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P R O C E E D I N G S

WELCOME AND CALL TO ORDER

EDWARD EHLINGER: So, good morning or good afternoon to everyone. I hope you had a good restful evening and got rejuvenated after a really great day yesterday. I learned a lot. We really had a lot of good commentary, a lot of good questions, a lot of issues raised. So, thanks for Tara and Steve organizing those sessions and moderating those. I appreciate that.

And so, I'm looking forward to another interesting day. And I know, one of the topics we're going to be talking about today is housing, and I do think we should just take a moment. As I watched the news last night and just saw the devastation in Kentucky and Arkansas and Illinois and Tennessee and just the hundreds and thousands of people who are now homeless as winter is approaching and the devastation and recognizing that, I mean, there are many people throughout the world with, you know, unstable living conditions and they just have to recognize that there's a lot

of lot of housing issues and so, let's just take a second to, you know, send our good wishes their way and think about them at this point in time. So, let's take a couple of seconds to quietly think about all the people with housing instability in this day.

I thank you for that, and I do recognize that we have some new people, or not new people, people who weren't here with us yesterday, so I would like anybody who wasn't introduced, either a SACIMM member or an ex-officio member who didn't get introduced yesterday to introduce themselves today, and I will start with, I see Paul Wise, who wasn't here yesterday. Paul, could you unmute yourself and introduce yourself?

PAUL WISE: Thanks so much, Ed. I'm Paul Wise, Professor of Pediatrics Health Policy and International Studies at Stanford University.

EDWARD EHLINGER: And you missed the fact that I quoted you extensively yesterday.

PAUL WISE: Uh-oh, that's scary.

EDWARD EHLINGER: So, any of the ex-

officio members that didn't introduce themselves yesterday?

WANDA BARFIELD: Yes, hi. I'm Wanda Barfield. I direct the Division of Reproductive Health at CDC, and I was at the meeting for part of it, and it was really great what I saw. It was a really excellent session yesterday.

EDWARD EHLINGER: Great. I'm glad you're here today. I'm glad you were with us a little bit yesterday. Anybody else? Suzanne, I don't think you introduced yourself yesterday. Suzanne England.

SUZANNE ENGLAND: Hi. I'm Suzanne England. I'm the Great Plains Maternal Child Health Consultant in the area and I'm the ex-official number representing the Indian Health Service.

EDWARD EHLINGER: Great. Glad you're with us, and I look forward to your presentation later on today.

All right.

ALISON CERNICH: Ed, I don't think I

introduced myself yesterday. I was on the call.

EDWARD EHLINGER: Okay.

ALISON CERNICH: I'm Alison Cernich. I'm the Deputy Director of the Eunice Kennedy Shriver National Institute for Child Health and Human Development at NIH.

EDWARD EHLINGER: Yeah, good. Well, thank you. And I knew you were with us. I thought you had introduced yourself yesterday. I'm sorry about that. Glad you're here again today.

So, let's get started on another really interesting and important day. As we put this meeting together, there was the Health Equity Committee that put together some recommendations related to race concordant care, and as we discussed those, and I recognized that we needed a little bit more time than the thirty minutes we had. So, those recommendations are in our board book -- in our briefing book -- but we will be talking about race concordant care at our meeting in April. So, be ready for that. And as I

thought about that, you know, getting things on the agenda, I recognized that in every committee on which I serve, the fingerprints of the chair are usually pretty obvious. For some, who are more hands-off, their fingerprints are sometimes difficult to discern. For others, the fingerprints are visible, even without the CSI kind of dusting techniques. And I suspect that even though I try to share the leadership of our SACIMM efforts, I probably tend to be more of the latter, where my fingerprints are a little bit more obvious. I know for sure that that's the case when it comes to the topic, we're going to talk about in this first thirty minutes. That's the issue of narrative and its impact on the health of mothers and infants.

In my almost fifty years of public health work, I have become convinced of the truth of Abe Lincoln's statement that, "Public sentiment is everything. With public sentiment, nothing can fail. Without it, nothing can succeed. Consequently, he who molds public sentiment goes

deeper than he who enact statutes or pronounces decision. He makes statutes and decisions possible or impossible to be executed." And it's the narrative -- end quote -- so then, it's the narrative that shapes the public sentiment. And I think that is obvious in our day and age from the power of social media and the various news media outlets in creating the narrative that is shaping the public opinion in today's world.

So, that's why I have advocated from our very first meeting that we need to focus on creating and advancing a narrative about the importance of mothers and infants. Advancing them as important as they are to the success of our society and that we need to address their needs and doing that is in everybody's best interest.

So, Vice President Kamala Harris gave an example of something that supports that narrative which she stated one week ago yesterday in her opening remarks for the White House Maternal Health Day of Action. She said, "A healthy economy requires healthy mothers and healthy

babies." That highlighted the fact of the importance of moms and babies. That's part of building that narrative, recognizing and saying that over and over again.

But what is narrative? I know there's always a question. Narrative is not just one story. It is a set of stories that we tell that are based on our values, our lived experiences, and our affiliations. It is the context and frame for our stories, and it determines the content of our stories and the lessons we want to emphasize and the words that we use to tell our stories. Narrative is part of our identity, and it shapes how we function in society.

A really gross or blatant example or weird example but despite the fact that I've lived in Minnesota for forty-one years, was employed by the University of Minnesota for sixteen years, and served as Minnesota Health Commissioner for seven years, my growing up in Green Bay, Wisconsin, and getting my undergrad and medical education at the University of Wisconsin, keeps me from abandoning

the narrative that the Packers and the Badgers are better than the Vikings and the Gophers. You know, narratives are powerful, and they stick with you.

So, as I said in our last meeting, my ultimate dream would be to have a "SACIMM report" just like the Flexner, that changes the narrative about the importance of mothers and babies and families for the short-term and the long-term success of our country with the hope that this new narrative would help change local, state, and federal program investment and policy strategies.

The problem is, I don't really know how to make that narrative change happen. I know the first two steps in the process, first identifying the dominant narrative and then creating an alternative or a transformative narrative. So, if you could go to the next slide.

These are just things that I put together. These are not been well vetted, they have not been talked about, have not been discussed, but just generally from conversations

with folks over the last several months, identifying what's the dominant health narrative, and what's an alternative health narrative that we need to look at -- the dominant health narrative and there -- there can be a lot of controversy about this, so I'm not, you know, not sticking with this is the final. But, you know, dominant -- the dominant narrative health is an individual responsibility and competition and consumer choice in healthcare is really important. That anybody can choose to be healthy. It's -- it's a personal choice that they're the major health determinants, that the healthcare sector is responsible for health, that medical care will cure me your fix me if I get sick, and that health is a private matter.

Alternative to that is that health is a collective and a community responsibility. It's a right -- health care is a right and a community good. That health equity and historical trauma are a present challenge. We need balanced investment in medical care and public health.

There's health in all policies. That health is not just the responsibility of the healthcare sector but multiple sectors. And government's role is to protect and advance the public good, that there is a role for government.

So, that's sort of the those contrasting or alternative narratives. Neither one is right or wrong; it's just a different way of looking at the world. And I've been trying to think about how that relates to moms and babies.

So, the next slide sort of talks about and this one actually needs a lot more work -- the dominant narratives regarding mothers and infants. Part of the dominant narrative is that parents are solely responsible for their children, that the private sector and markets will meet the needs of children, that education starts at kindergarten. Disparities are due to parental inadequacies and medical care will cure us if we get sick. Parents know what's best for the family and they alone get to decide what happens to their children and health is a private matter. You can see that it

revolves from the dominant health narrative.

And then, there's an alternative narrative regarding moms and babies is that child during is a family and community in a supportive role responsibility, that parenting and grandparenting is vital work and goes along with the notion of the virtue of work in our dominant narrative, but parenting and grand parenting is, which is unpaid work, is often dismissed as being vital. The long-term viability of our society requires community investment and prioritization of children. That education is an ongoing process, it's transgenerational and there's really no beginning of education, it's always -- it's always happening. And then some families have been structurally disadvantaged and need additional supports, and belonging is more powerful for us than technology. And that children are a community good and require public support.

So, those are, you know, some of the narratives that I've tried to figure out of

identifying what is the current narrative and what might be an alternative narrative. But I don't know how to take the next step, how to change the narrative or at least get an alternative narrative become more visible, if not to become the dominant narrative. And the importance of finding a way of taking that next step was evident to me as I listened to the White House Maternal Health Day of Action and saw the actions that were proposed.

So, on the next slide, these were the actions that were proposed during that Day of Action activity. Now, I have to admit, I take this a little bit out of context because the Build Back Better Bill, which really wasn't highlighted a lot, includes a lot of the stuff that I think really go into a different one -- a different narrative and earned income tax credit and a host of public policies to strengthen nutrition, improve access to childcare, and pre-K, and invest in mental health, and in the workforce, and paid leave, and all of those. But those weren't discussed in the Day of Action. And so, these

were the actions that that were identified, you know, establishment of a birthing friendly hospital, expanding postpartum coverage, get more coverage, expand home visiting, improve the data collection, develop some additional technology, focus on specific disease, hypertension.

So, as I looked at this it had the same feel as that Congressional hearing that Paul Wise and I were on on October 31, 1985, that with the exception of housing, the discussion was mostly around increasing and expanding access to healthcare and improving medical care and the development of ancillary services. Those are still important, but in thirty-six years, they haven't achieved the goals we had hoped for. And so, by coincidence, on the same day that we have the White House Day of Action, I was made aware of an article by Laurie Zephyrin in the September issue of the *American Journal of Public Health* and put the next slide on. And I don't know if you can read this, but her article was, *Changing the Narrative and Accelerating Action to Reduce*

Inequities in Maternal Mortality, and I'll just go through those. Starting at the top, because you probably can't read them, it is really about why are Black people experiencing higher rates of maternal mortality, and then in small print under that is, eclampsia, preeclampsia, postpartum cardiomyopathy, obstetric embolism.

Step 2 then is, why do Black pregnant and birthing people have higher death rates from these conditions? And it goes on and it say under that, increased comorbidities and stress, delays in reaching and accessing care and diagnosis, more severe symptoms, and more advanced disease.

The third step then is, why do Black parents and birthing people not receive the appropriate care based on standards? It goes on to say, less access to care, concentrated use of hospitals with poor quality indicators, not listened to by providers.

The fourth step, why do these factors, decreased access, et cetera, disproportionately affect Black birthing people? Under that, it

says, structural and internalized racism, intersectionality, residential segregation, access to poor quality hospitals, implicit and explicit biases, and disproportionate impact of social determinants.

And finally, the fifth why is the big, big why, which then is legacy of systemic racism, hierarchy of human value entrenched in policies and practices affecting health and health care.

As I looked at the slide, two things jumped out at me. First, we seldom them get past that third step, you know, why do, in this case related to Black maternal mortality, why do Black pregnant and birthing people not receive the risk-appropriate care based on standards. It's about access to care and concentration of hospitals or concentrated use of hospitals with poor quality indicators and not listened to by providers. We often stop there because the narrative -- we're constrained by our dominant narrative about it's all about services and it's about personal choices and it's about medical care. So, we seldom get

beyond step 3.

The second thing that jumped out at me is that the answer to my question of how to change the narrative actually became quite clear, as I looked at this chart. It's as simple as using the techniques that 2- and 3-year-olds do all the time. They keep asking why over and over and over again, why, why, why? That asking that question takes us from the conditions to services to programs to systems to policies and to world views, the narrative that is behind all of these. It changes our focus from individuals to communities. That will then change the narrative about what creates health for mothers and infants.

Asking why helps us expand our understanding of what determines health. Asking why helps us recognize that health is the responsibility of every sector, not just medical care and public health. And asking why reinforces the need to build the capacity of communities to improve their living conditions.

Now, on a broader scale, but certainly

relevant to the social conditions of mothers and infants, is a framework developed by Bobby Millstein when he was at CDC, which is in the next slide.

And here, he lists management of disease -- risks and diseases, which is really a charity narrative, which we do a lot of. It's our world of providing health education, screening tests, disease management, pharmaceuticals, clinical services, and physical and financial aspects -- access. Next slide.

And he really talks to them about democratic self-governance, a social justice narrative where we work about transforming -- transforming deprivation, dependency, violence disconnection, environmental decay, and stress.

And in the next slide, then then focuses on how we do living in those conditions by strengthening all of these factors; democracy, mutual accountability, leaders, plurality, freedom, foresight, the meaning of work, all of the things that really impact overall health. And

he doesn't list the why, but he takes on us those two different narratives, the charity narrative, which embraces the world of providing and the social justice narrative, which embraces the actions of transforming living conditions. And in my view, we need both. We need both charity and justice.

And so, I think, as I think about what we've been doing over the last three and a half years as this committee, I think we have been asking the why since we began our terms in SACIMM. And because of that, I think we have been changing the narrative slowly and probably imperceptibly, but I think we have been changing the narrative.

As I said in my opening comments, we have expanded the focus and shifted the priorities from programs to policies, from medical care to social determinants of health, from race to racism, all with equity, as our North star. You can hear it in our language, in our questions, in our curiosity, and in our stories framed in our values of equity and social justice. I think we have

already started to change the narrative about mothers and babies and what is needed for them to thrive.

So, I ask you to keep asking why and seeking ways to transform the work that will keep mothers and babies healthy. So, I thank you for doing that and I thank you for allowing me as chair to kind of get on my soapbox about narrative and struggle with you and share with you the struggles I have about how we're going to move the narrative forward.

I would like, at some point, and I will do this, I will share those -- those slides that sort of list those alternative narrative and dominant narratives, and I'd love to get some feedback from you, because I think it really would be helpful for us to basically put forward some thoughts about narrative and what are the dominant narratives and what are some alternative narratives.

So, before we move to our next session, I wonder if there's any comments that folks have

about the idea of narrative in our world and what we've done to help shape the narrative about moms and babies. Or maybe I'm just confusing everybody, which may be true. Magda.

MAGDA PECK: I don't think you're confusing the issue, rather helping to frame it. And for that, I want to express my gratitude and I think that there is tension around what is "the narrative" often put as an either/or, and I think that we have within our esteemed gathering of members, those who lead with the upper level why around access and health care and quality and there are others of us who bring the additional layers of why that go to systems and structures and fairness and justice, and I think that the cautionary moment would be to not put this as an either/or but rather to embrace all levels of the why as being essential for change and that the inclusive nature of the deeper whys are what we can elevate without sacrificing the essential focus on access and quality and innovation that we heard yesterday. Our message and narrative is not

-- it's both and, and I think it's helpful for us to frame it and you have helped us frame it with Laurie's help and others, Dr. Zephyrin's help, around -- and Dr. Milstein, about how we cannot stop at access and quality without getting to the deeper, more structural, longitudinal issues of justice.

EDWARD EHLINGER: Thank you.

MAGDA PECK: Thank you.

EDWARD EHLINGER: And you'll notice I don't -- and I never talk about competing narratives, but I agree with you that I think that that there is no right or wrong narrative. They're all needed. That's why I say we need the charity narrative and the justice narrative. We need that the service narrative and the social determinants of health narrative. All of those are necessary.

Often times, it's also where do you -- where do you focus your energy, and so for wherever there's, as I said yesterday, a lot of money kind of goes into funding research around

the -- the service pieces and not as much research goes into the money around all of the other downstream-wise, the social justice wise. So, I think, where we put our energy may be part of that. Dr. Warren.

MICHAEL WARREN: Thank you. And thank you, Dr. Ehlinger for that introduction to really get us thinking. I appreciate your comments. A couple things come to mind for me. One is with Magda's comments about both and. I think reflected in the committee's latest update of the charter and name to include both infant and maternal, we all recognize that these are inextricably linked, that you can't separate the two, and we talked about in this work life course and health the cross the life course, and I think sometimes it gets pitted as an either/or or there's a focus on one versus the other. But really, we -- we can't have healthy infants without thinking about upstream health across the life course and those very infants are going to be then those who bring the next generation of

offspring down the road. And so, thinking about that perspective is really key.

I also appreciate your comment on the inclusivity of narratives. I think one of the things that we are mindful of as we try to advance work is that states and communities are in very different places and thinking about how we meet folks where they are and -- and not have a preconceived notion of you need to do X, Y, and Z, but what -- what is it you're trying to do to advance, and how can we support that is really helpful. It can be a challenging needle to thread sometimes, but I think it's really important. Thank you.

EDWARD EHLINGER: Good. Thanks, Dr. Warren. Dr. Jarris. You got off the phone.

PAUL JARRIS: Yeah. Hi, Ed. Or course, one of the things that impresses me about this is how the thinking has been going on for quite some time in different languages and forms, but this whole systemic approach to this, and it was helpful to have you over yesterday today reflect

some of that. I think the challenge we face though right now is how to broaden our language here so it's accessible to more people. And I think, in particular, if you look at some of the reaction among different political systems now to words of race and structure in the same paragraph getting at structural racism, I mean, we're seeing at universities, the University of Florida where courses have not been approved because they've had those two words in the same course description. So, we've got to think about how to broaden the appeal here to people across the country because at some fundamental level, everybody cares about moms and babies. But our language is going to be so important if we want broader acceptance and broader mobilization. And I'm, you know, I completely resonate with the language you put up there, so I'm not your target audience, but we need to find people who can talk about this in a way that people with different views can hear.

EDWARD EHLINGER: Yeah, I agree, and I think you've been a good model of that. I know

that, you know, we were talking about equity and disparities, and you were always talking about goodness and fairness, you know, as in alternative terms to use, and I think that, you know, always trying to think what the audience is seeing, how we can get across, and trying to use the right words. But I think, speaking of words, you've probably noticed over the last several times that how we talk about the individuals giving birth has changed and, you know, it was really striking yesterday about, you know, birthing individuals and birthing people, I mean, that seemed to be embraced by everyone, whereas a year ago that really sounded strange and it just sort of ever now rolling off of people's tongues and so when you use language, it sometimes becomes normalized and so, we have to think about both what you said, you know, what -- how it responds in the here and now, but how can we actually make some of the same -- the language a little bit more normative as we move forward and language that's inclusive. That's one of the things that's really going on.

Janelle.

JANELLE PALACIOS: Thank you, Ed. I understand the importance of being diplomatic in our word choice and trying to reach a wider audience. But it also can be a double-edged sword where we go back to talking in code, which we've discussed before as well, and already, we see the impacts of some states, in particular, I think it might be Minnesota, where with regards to Title V monies that the states have access to, that when they're trying to improve maternal child health, you know, words like racism and discrimination and these hot topic words that clearly pinpoint what we're trying to measure, what we're trying to affect, are not being used and, instead, you know, other kind of more flowery language or, you know, more general language about like health promotion or health improvement are being used and that's not necessarily getting at the heart of what we're trying to really affect. So, we have to use language that is specific, that is really trying to affect what we want to change, and we have to

have that common language. But to, you know, paint over or give a different glaze to the word racism and what that means, I would argue is not effective.

EDWARD EHLINGER: Well, yeah. I mean, I'll have to share that -- that when I was State Health Commissioner in 2014, when we put off the report that from the state health department and articulated by an elderly white physician, heterosexual male, that said structural racism is at the core of the disparities in Minnesota had a huge impact. I mean, it changed the conversation. So, sometimes it takes people in leadership positions to make statements that really call out the issue, you know, and I had, fortunately, I had the support of the Governor to be able to make statements like that, but it did change the conversation. And now it is talked about more and certainly the American Indian, the African American, and the immigrant community came forward saying thank you for saying what has been our reality for many, many years and it's nice to have

a state agency make that kind of statement.

So, more to deal with narrative. It is behind everything that we do and think about the narrative that comes out in these next couple of presentations related to indigenous health and housing because we'll see what the narrative evolves from that.

So, with that, let us now move on to the session related to the Health of Indigenous Mothers and Babies and those of you who know me, I try to wear bow ties to reflect the issues of the day and I'm wearing a bow tie that was given to me by a beloved colleague from the American Indian community to highlight this. So, let us now move on to our Indigenous -- Health of Indigenous Mothers and Babies with Janelle.

HEALTH OF INDIGENOUS MOTHERS AND BABIES

JANELLE PALACIOS: Thank you. Greetings everyone. It is my pleasure to share with you today, part two of the Indigenous Maternal Infant Health Panel, and please go ahead and advance the slide.

Before I introduce our panel speakers today, I wanted to quickly refresh your memories of our first panel session held last September. It started with my brief presentation on the history from contact onwards, where I highlighted the systemic policies aimed at annihilating, removing, and imprisoning indigenous people to then assimilating, sterilizing, and quantifying identity of the survivors to present day concerns of high incarceration rates, lack of oversight on the missing and murdered indigenous women and girls epidemic, and ongoing battles of land and health tied to our natural resources. Without understanding how the dual roles of intergenerational transmission of trauma and daily weathering impacts Native people, it was easy to blame the population for high rates of obesity, diabetes, poverty, substance use, preterm birth, low birth weight, poor education attainment, homelessness, violence, and incarceration. Next slide, please.

Dr. Frizzell then shared the political

history background in the Indian health system, and she named three of the parts of the Indian health System. First, Indian Health Service, Tribes and Tribal Organizations, and Urban Indian Health programs. We learned that Indian Health Service is divided into 12 service areas, that it's funded by appropriation, and while Dr. Frizzell shared dated information on IHS per capita expenditures, in 2017 the IHS per capita expenditure for patient health service were just over $3,300 compared to $9,200 per person for health care spending nationally. Dr. Frizzell recommended that better surveillance be conducted to take into account indigenous people's unique identity and support measures that coordinate tribal, local, state, and federal actions to improve health outcomes and address these. Next slide, please.

Dr. Stemmler, a nurse midwife, who was the American College of Nurse Midwife liaison for seven years to ACOG's HIS review committee, shared that all 574 recognized tribes are unique with

extremely limited resources and varying priorities. In general, IHS facilitates -- facilities face chronic provider shortages, limited funding, hybrid record keeping, paper charts and electronic health records, outdated practice policies and standards, limited linkages to outside health centers, and insufficient community outreach. Dr. Stemmler recommended improving telemedicine capacity, supporting perinatal care use and education, target interventions on community concerns, involving tribal communities in these decisions, wider integration of midwifery service, ongoing provider in-services to improve practice and contingency planning for patient care as the patient needs escalate. Next slide, please.

I am going to ask that each of the presenters share their presentations as we hold questions until the end. Today, you will hear from three expert speakers. You will first hear from ex-officio representing HIS, Dr. Suzanne England. Dr. England has spent twenty-six and a

half years nurse officer with Indian Health Service. She has triple boarded as a certified nurse midwife, certified family nurse practitioner, and a certified child family psychiatric nurse practitioner. She has been the Great Plains area maternal child health consultant since 2015. Dr. England maintains clinical competency providing care on the Pine Ridge and Rosebud reservations within the Great Plains area. Next slide, please.

A few months ago, I asked Dr England to share insight into this list of topics and I'm eager to learn more about IHS workforce, Native maternal and infant outcomes, and the result of IHS's fifty-year contract partnership with ACOG as it relates to improving maternal infant health. Next slide. Thank you.

Following Dr. England, we will hear from a Alida Montiel. Alida Montiel is Director of Health and Human services at the Inter Tribal Council of Arizona. Since 1990, her principal responsibility has been to analyze and address

health policy formation for tribal leaders in Arizona, Nevada, and Utah, served by the Phoenix Area Indian Health Service ranging from federal, state, or specific tribal policies and budgetary issues that affect the Native Healthcare System. In January of 2019, Alida stepped into the management of all Health and Human Services Project at the Inter Tribal Council of Arizona.

She serves as the chairperson of the Arizona Advisory Council on Indian Health Care and as a member of the Arizona Behavioral Health Clinic Council. The council monitors and advocates for services provided to clients through Medicaid, CHIP, and block grants awarded to the state. Next slide, please.

And finally, we will hear from Stephanie Bustillo. Ms. Bustillo has been an epidemiologist for the past four years at the Inter Tribal Council of Arizona, Tribal Epidemiology Center where she focuses on the Tribal Epidemiology Centers Public Health Infrastructure CDC grant. Stephanie also works on maternal and child health

topics with Inter Tribal Council of Arizona Special Supplemental Nutrition Program for Women, Infants, and Children.

Welcome. Dr. England, the floor is yours.

SUZANNE ENGLAND: Can someone upload my slide deck please, so they can forward for me. Thank you.

This is the area where I live in western South Dakota, and it borders the Rosebud Reservation. So, that's where I'm speaking to you at today. Next slide, please.

And I'm just going to give a brief overview. You had that that in your fall meeting, but our tribal obligations from the United States Federal Government began with the very beginnings of our country, starting with United States Constitution. So, this has been going on for hundreds of years. The next couple of pieces of legislation moved into 1868 with the Laramie Treaty, especially up in the Great Plains, where I work, and then the Snyder Act in 1921 had that all

Native Americans could become United States citizens. Next slide, please.

And then, then we jumped from the twenties to 1955. That's when the Indian Health Service was formed and that's where Native American Healthcare was transition from the Bureau of Indian Affairs and formally into the Indian Health Service and there were a few changes again until 1975, and that's when Public Law 638, which is now tribes are taking over greater strides control of their own healthcare facilities and their health care. And then we jump into 1976 is with Indian Healthcare Improvement Act that we could have Medicaid and Medicare reimbursement to the Indian Health Service to provide more revenue, to provide increase services to Native Americans. And then jumping into 2010, President -- then President Obama made the Indian Healthcare Improvement Act permanent as part of the Affordable Care Act. Next slide, please.

Just a brief history of improvements in maternal child health in the Indian Health Service

is Eleanor Gregg. She was a Red Cross nurse in the 1920s who came out after World War I, again to my area in the Great Plains are to the Rosebud and the Pine Ridge Reservation, and she went on to start the nursing division in the Indian Health Service and specifically, public health nursing to help improve the health care needs of families, especially in the realm of maternal child health. Next slide, please.

Then, moving on into the early 1970s, Lucille Woodville became the first Chief of Nurse-Midwifery in the Indian Health Service, and that was to combat the high rates of maternal mortality, especially with childbirth and childbirth complications in the Indian Health Service. Next slide, please.

And I just wanted to talk about in the Great Plains area, the area that I serve and also where I've practiced since 1998 as a nurse midwife, is the Midwifery Service was formed in the early -- the thought was in 1967 and it was formed in the early 1970s for that to have great

strides in decreasing [indiscernible] and at Pine Ridge, when we are fully staffed, you will have a compliment of seven nurse-midwives for that. ON to the next slide, please.

And with the Indian Health Service, just a general overview. What our mission is to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level. Our vision is healthy communities and quality healthcare systems through strong partnerships and culturally responsive practices. So, that's what we base all the care that we perform for the people that we serve. Next slide, please.

And with the Indian Healthcare, and this has mentioned just earlier, is the different divisions of Indian Health Service that's through the area offices. We also have through Public Law 69368, Tribally Operated Health Care Services, and we also have Urban Indian Health Care Services in our largest cities throughout the United States. On to the slide, please.

And this is just some general overall health care statistics that you saw in a few earlier slides. Directly with Indian Health Service, we're serving over 2.56 million people and our appropriations increase as our population increases. And looking at the per capita is the Indian Health Service expenditure per person is around $4,000 a year, and then the comparison with United States average of health care expenditures is $9,700. On to the next slide, please.

And for further information, just in general, if people have not explored it is to learn more about Indian Health Service and how we are run, and our different services is the link is www.IHS.gov. On to the next slide, please.

With different career paths for employment for healthcare providers in the Indian Health Service, we have the Civil Service System, we have Direct Tribal Hires, with the compact of the 638 Tribes Controlling Their Health Care Programs, United States Public Health Service Commission Corps, of which I am a member, and many

people come from the various branches of the military. Often times it's Marines, Army, Navy with that and they come on and transition as providers to our system. Next slide, please.

And then, just finding out about employment opportunities looking at the general IHS site, his.gov and USAjobs.gov is for looking for employment opportunities. On to the next slide, please.

And this is some of our recruiting tools to meet the needs for that, as we have IHS loan repayment. Each individual service, you know, also has supplemental loan repayment programs for recruitment, and then we also obtain health care providers to the National Health Service Corps, their loan repayment program. On to the next slide, please.

And I always like to start off with the positives with the Indian Health Service is what we've seen statistically over time, is that we have increase in the age of women giving birth to their first child. With that, also with the

positives, the Indian Health Services providing care that's close to home that families can come visit others. I know there's been some differences in the past two years with COVID, but families can come and visit if there's a loved one in the hospital and for maternal child health is when a child is born that family can surround that woman giving birth. We have public health nurse visits, especially during the prenatal time, and also postpartum and following that child with immunizations, well-child checks, and I'm also happy with the long-term partnership that we have had with ACOG. They come each -- every five years, and they do on-site visits at the different health care facilities, whether they provide childbirth, or if they are clinics or health centers that provide prenatal care, and then there's contracted services for birth. They look at our positives. They also look for areas for improvement. They partner with the Indian Health Service to have national conferences for education for employees that work in tribal facilities and

Indian Health Service facilities so we can provide the latest and greatest in evidence-based care. And one of our strong hubs with ACOG is our organizer, Yvonne Malloy. She's worked with ACOG for many years and works closely with all the different leaders in the different areas in the Indian Health Service. On to the next slide, please.

Where we're at challenges where we're working hard for improvement is with the Indian Health Service. There's many families, especially in the reservation areas, which are mainly located in western United States, they live in remote rural, oftentimes frontier -- frontier areas of the United States and the families are driving over an hour away, sometimes 60 to 100 miles. to get to Indian Health Service Tribal facilities also. Many of the families that we serve live in food deserts. They have difficulty getting access, especially to fresh fruits and vegetables. We have high rates of poverty. And then also, we're working through historical and generational

trauma for different decades with that in different areas of the United States. And right now, specifically in all of our facilities in the Indian Health Service, outside the Indian Health Service, outside travel facilities, is just a dire nursing and health care provider shortage, difficulty recruiting staff, and even having contracts out with varied contract agencies, still they're having difficulties finding staff to recruit to fill the contract positions. Also, with contract positions, more and more facilities have a high rate of contracting staff that may be doing assignments from as short as two weeks to thirteen weeks and then they may change out to different -- different role, different agency, or organization and that doesn't provide continuity for the people that we serve because they're always seeing new faces.

With the areas of substance abuse, especially what's been on the rise within the last five years, is meth. It's an epidemic of methamphetamine use in rural areas, also in urban

areas. Other challenges that we have too, and that was mentioned in some earlier slides, is with the Native American populations, with our statistics in Indian Health Service where statistics come from, is mainly people that are living on reservations and their accesses to the IHS hospitals or in tribal communities, but many of our Native American families live off the reservation. They're living in larger urban centers due to job, education opportunities, and sometimes they're not being statistically looked at for that. There may not be a choice for saying -- where there's a checkbox to say whether a person identifies as being Native American or not, or they may identify with two or more ethnic groups for that, is to gather that data to help meet the needs of the Native American population. So, there's many needs for the rural area and there's also many needs for the urban areas. On to the next slide, please.

Now, I wanted to open it up to any specific questions that people have and if I hear

none, then I'm going to proceed on especially with maternal child health and prenatal care and delivery care. So, I'm going to open it up for say a minute or two if anyone has any questions of anything that I've talked about the current moment.

Okay, and hearing nothing, I'm going to continue on. Another concern, especially in our rural areas for maternal child health, is many times women, they will be receiving their prenatal health care in a rural health center and sometimes a hospital, but there's no delivery capacity and the woman then needs to travel a distance between, say 45 to 100 miles to give birth to a child. One is potential for transportation difficulties. We're getting into winter conditions, so trying to get to the health care facilities to have their child, and also if they're considered a higher risk in their prenatal care, is then they have to go to Level 2, Level 3 tertiary facilities and many times they're giving birth alone, by themselves, because the rest of the family can't

join them if someone comes in and say they're preeclamptic or eclamptic having seizures and they're boarding a fixed wing plane, their family can't go with them. The family will need to follow behind in a car, and if there's transportation difficulties, the only time the family may see that mother and child is when they go to pick them up from the hospital at a further distance at the facility and that can -- that can make it harder.

The beauty of telemedicine is sometimes with the specialist, we can link in with telemedicine. An example in South Dakota, one of our maternal fetal medicine doctors that we contract with, they fly to various areas throughout the state of South Dakota at more local facilities, so that the women that we are serving, they're closer to home, to be able to receive the higher level of care that they need. But often times again, they may be going hours away from their family and their home environment to give birth to their children in a facility that can

meet all of their care needs for that and with that, too, and with the healthcare shortage, sometimes it makes it hard to keep the smaller facilities of functioning, OB Units, Labor and Delivery units due to lack of nursing, lack of provider staff, and that leads into the needs for our emergency departments in rural areas is that they are prepared with emergency childbirth training and also to be able to look for the danger signs, specially i.e. preeclampsia, uncontrolled diabetes. So, that's some of the main concerns and issues that we're looking at and that we partner with the Indian Health Service to have well-trained staff.

And thank you very much for your time. I enjoyed talking to you today.

JANELLE PALACIOS: Thank you, Dr England.

Our next speaker is going to be Alida Montiel and following her, Stephanie Bustillo will go and then we'll have time for questions as well, and please put them in the chat. Thank you.

ALIDA MONTIEL: Good morning. Alida

Montiel, [indiscernible] I'm a member of the Pascua Yaqui Tribe and I gave my greetings to you this morning in my language and said blessings to all from creator.

I wanted to ask our IT to run my slides, please. Thank you so much. Go ahead.

This is my presentation today on improving maternal and infant health outcomes in American Indian communities in Arizona. I'm going to focus on Arizona today. Next.

The Inter Tribal Council is an organization, my board of directors are tribal leaders. It was established in 1952. This was during the termination era and we provided that voice for tribal governments to address common issues and concerns which came together during the termination era. That's when there were Congressional measures being introduced to end the Treaty status of tribal governments.

Inter Tribal Council has been around, but we finally adopted a nonprofit status under the state of Arizona in 1975. Next.

So, the members of ITCA are the highest elected tribal officials, our tribal chairpersons are presidents and our governors. The leaders provide a comprehensive view of the conditions and needs of the communities they represent. So, at the Inter Tribal of Arizona, these are some of our projects. We have Policy and Program Development and Health and Human Services. We work with federal agencies, because they have adopted Tribal Consultation Policies, and this is with regard to the Indian Health Service and the Bureau of Indian Affairs and Bureau of Indian Education Annual Budget Formulation with the Social Services Working Group, Epidemiology Working Group, with Maternal Health Innovation Projects, Teen Pregnancy Prevention, we have an Environmental Program, Educational programs, including an American Indian Research Center for Health and we work with the universities in the region. We have a cultural -- cultural resources, which is all the Tribal Historic Preservation officers and address cultural issues, language preservation, and so

forth. I staff that working group as well. Water policy and water sanitation systems is a huge topic in our region. Tribal Incident Command support really came to life during the COVID-19 and also, we have a Native Voter Initiative. Next.

So, my concern here has been with regard to maternal and infant health is that American Indian cultural practices would improve maternal and infant health outcomes of American Indians, and we also have Alaska Natives who reside in Arizona. So, acknowledgement and acceptance of these practices valued by Tribal Nations should be integrated at medical and community health programs settings. Guidance by traditional practitioners, elders, and indigenous birth workers, and community health organizations and providers that serve our people would achieve is achievable if these practices are honored.

For many of our people, wellness is compared to long-standing traditional practices wherein one balances your mind, body, and spirit

with the environment. That is our formula for wellness, balancing your mind, body, and spirit with the environment. And so, I'm going to talk about how this is incorporated in maternal and infant health. Next.

So, these practices have been incorporated by several IHS Tribal and Urban Indian Health programs and by some managed care providers in Arizona. Our Medicaid system is based on managed care. So, there's a lot of advocacy there in terms of cultural considerations in the managed care system as well. At the present time, traditional healing is not yet covered by Medicaid in Arizona, but services arranged, and expenses of the practitioner are known to be provided via other resources. Access, that's our Medicaid agency, resubmitted, they had to do it another time, resubmitted the Traditional Healing Waiver for Indian Health Tribal and Urban Facilities to CMS, the Centers for Medicare and Medicaid Services, on December 22, 2020 in the Section 1115 Demonstration renewal. The current

waiver has been extended for one year while these negotiations continue.

So, our advocacy for cultural considerations and for incorporating traditional healing has gone to this level of incorporating it in the Section 1115 Waiver. Our Medicaid State Agency concurred with the recommendations of the tribes in this realm after years of hosting a Traditional Healing Work Group. The Traditional Healing Work Group worker was comprised of individuals from the Tribal facilities and from the Indian Health and Urban facilities, and we also invited traditional healers and practitioners, as well as elders and advisors, those that hold long-standing knowledge about our traditional health practices and these -- this is a positive. This -- this wellness approach has been a positive in terms of health, education, and activities in our tribal communities, because we can say, you know, this is prevention, and so you can lessen your chance of having a risk -- a higher risk and a chance and a possibility of, you

know, having to go to the hospital for services. Next.

So, I just wanted to show you this map of where our facilities are, and you can see, they're spread out across the state. I'm not going to tell you all the names and you can see them on the side there. And our region is unique because we have three IHS areas. There's twelve across the nation, three of them include Arizona. So, there's the Navajo Area Indian Health Service, you see them up with the right of the of the map, and that's the Navajo Area Indian Health Service. And you can see, I've inpatient and outpatient facilities, so generally Fort Defiance and Four Corners, Gallup, and Tuba City are the inpatient. I'm telling you about those because that's where you'd have your OB, Labor and Delivery Departments.

The Phoenix Area IHS, the inpatient is the Phoenix Indian Medical Center down in Phoenix at 16th Street in Indian School, the White River Hospital up in the -- northeast of the metro

Phoenix area, and then the Huhakam Memorial Hospital at the Gila River Indian Tribe -- Gila River Indian community. So, there's three inpatient. Labor and Delivery is at Phoenix Indian Medical Center and White River Hospital. But, oh, I think I'm going to get into the but, just hold on. And then the Tucson area IHS, there is one hospital, and that's the Sells Indian Hospital, and the rest is all outpatient. Okay, next.

So, aligning our OB-GYN and traditional practices, and I wanted them to put -- put them side by side so we can examine what our prenatal obstetrics and labor and delivery best practices are that we have seen in Indian Health Service System. So, best practices would be labor and support services that's family centered at low risk and at full-service birthing centers. That there's birthing options available, birthing ball, walking, fetal monitoring, hydrotherapy for comfort, and medicinal pain control, 24-hour anesthesia consults, lactation support extensive

and that each IHS and Tribal facility that provides low -- full- or low-risk obstetric services are well equipped and staff with trained and experienced providers. So, that would be a set of best practices that we'd like to see reflected throughout our system, our Indian Health Care System.

How do you align that with traditional and culturally supportive services? So, the pregnant family seeks traditional services on their own or at their Indian Health, Tribal, or Urban provider or the Access plan, the Medicaid plan, throughout prenatal and perinatal care. I should have listed postpartum. We have a huge -- legislative efforts have been going on for years to expand our postpartum care beyond the two months we have now, it should really be twelve months.

So, and coordination of care supported and so, that would be a cultural practice that we would like to see honored. And that the pregnant family incorporates traditional practices in their

labor and delivery plan that are honored and that the protocols permit feathers, tobacco ties, and medicine bundles in the birthing suite or the labor and delivery room and that a family member conducts the first washing as a water blessing, protection prayers and songs, and herbal teas to promote optimal labor and delivery. Next.

So, you may know that the Indian Health Service has established a policy to address the rate of maternal mortality that no longer appears to be decreasing and that the general American Indian maternal mortality rate is above the US all races mortality rate. So, the Indian Health Service has addressed this. They've established a committee to address this issue. Next.

So, they're going to establish a Multi-disciplinary Maternal Mortality Review Committee, and so that's really great that they're stepping forward with that and that they're going to have written comments and recorded discussions, they're going to be retained in a locked confidential quality assurance file. Next.

So, the Arizona Department of Health Services funded our organization to address maternal mortality and morbidity in American Indian communities and we established a steering committee that includes community health representatives, maternal health educators, nurse-midwives, OB-GYNs, and traditional healers to help guide and support our actions. Next.

The members -- member tribes of ITCA, Inter Tribal, became aware of labor and delivery closure at the Phoenix Indian Medical Center back in September of 2020. Mothers started being transferred to other hospitals and patients were concerned if Medicaid or a referral system called Purchased Referred Care was going to cover their services. Dr. Reidhead is Director of our region area office, Phoenix Area Indian Health Service, he's met with Tribal leaders. He indicated that it would be a temporary closure and maintenance need had to be -- maintenance needs had to be assessed and then IHS staff indicated there were no patient deaths, injuries, or lawsuits. Next.

Was that my last slide? So, the top issue of the Tribal concern has to do with replacing the Phoenix Indian Medical Center and the White River Hospital. There, we have met -- are long past due for replacement. That's part of the reason they have a high maintenance cost and that so Tribal leaders are advocating for replacement of the Phoenix Indian Medical Center. Meanwhile, we still had to have these maintenance efforts to try to get our OB, labor and delivery -- delivery and our surgical department reopened, and that -- all that happened during the pandemic, oh my gosh. Okay. Next.

So again, our voice, our stories, and our support for the Indian Health Care System must not be quieted. So, we're continuing to monitor that and our moms when the closure happened. It became a news story because moms and their traditional regalia were -- not too often does IHS get a demonstration, you know, right in their front yard, but the moms went out there in their traditional regalia and really were very unhappy

about the closure of OB, labor and delivery. So, I know it's a big concern among our tribes. Thank you very much.

JANELLE PALACIOS: Thank you, Alida. Alida shared some really common concerns that the need and the request for traditional healing and health to be reimbursable as well as the service issue that Dr. England also kind of discussed about that we have facilities, but sometimes they're being -- they're closed and the community is not aware of why, and then we have these patients that don't have services and then have to find service.

So, our next presenter is Stephanie Bustillo. Thank you so much for joining us today, and after Stephanie's presentation, we will have a question and answer. Thank you.

STEPHANIE BUSTILLO: Hi. So, good morning. For this presentation, I'm just going to go over the Severe Maternal Morbidity report that will be on our website this year. Please advance the slide.

So, a bit of an outline for the presentation, some background on SMM, the methodology of the analysis, some background about the Indian Health Services Electronic Data Mart, and limitations and action items. We can through questions at the end. Next slide.

So, Janelle, you mentioned that you guys are pretty well informed. Whenever I do this presentation, I always like to have the distinction between morbidity and mortality identified or clarified. So, morbidity is the decrease in health or quality, whereas mortality is in regard to the actual death. Advance the slide, please.

So, at ITCA, since I've been there, we've been there we've been doing surveillance reports annually, and one of the topics that came up with me attending ADHS meetings was just seeing how highly affected American Indian and Alaska Native women are with mortality and morbidity issues. So, from the CDC's Pregnancy Mortality Surveillance System, what they found is that

American Indians and Alaska Native women have the second highest pregnancy-related mortality ratio to African Americans. Advance the slide.

Okay, and so, that was something that was very interesting for us because we're -- at the TEC, we have access to Indian Health Services Electronic Data Mart. We wanted to see what differences may be presented in that data set. So, if you advance the slide.

Pregnancy-related deaths occurred during pregnancy, time of delivery, and are also considered up to one year postpartum, and from the Pregnancy Mortality Surveillance System Report, they found that approximately 60 percent of all pregnancy-related deaths were preventable. So, next slide.

And so, per the definition of severe maternal morbidity, it's the unexpected outcomes during labor and delivery that result in significant consequences to the women's health. Next slide.

So, from the report, you can see that the

overall rate of severe maternal morbidity with blood transfusions is increasing rapidly, and that's at the very top, and then advance the slide one more time, you'll see that with blood transfusions, that's the main indicator that's pushing that increase. Now, when we remove blood transfusions, you'll see that it's -- it's increasing but it's not as severe as when you include blood transfusions. Next slide.

And at the TEC, we serve Arizona, Nevada, and Utah and Alaska Native population. From the reports that are available from each state, it is really alarming to see that Arizona had a super high rate of morbidity for American Indian/Alaska Native women, especially so since we have a very high population of AI/AN women here. Advance the slide.

You see that for American Indian and Alaska Native women, the severe maternal morbidity rate was 292.6 per 10,000 pregnancy-related hospitalizations compared to 82.1 for white non-Hispanic. For the other states, it's also high,

but it's not nearly that alarming. Advance the slide.

The methodology, the data source is Indian Health Service Electronic Data Mart. Advance the slide. And do it again.

So, the inclusion factors were you had to have a live singleton live birth at the IHS hospital delivery, contain at least one SMM ICD-9 Code presented at the -- during the labor, and women that were non-AI/AN were excluded from the analysis. Next slide.

So, the numerator would be any singleton live births that occur between 2011 and 2015 that included at least one SMM ICD-9 Code. Denominator was all hospital live births of a singleton. Next slide.

So, I'm looking at the results that we have. You can see that the annual rate for an SMM event was increasing between 2011 to 2015. Advance the slide.

Whereas the actual count of hospital deliveries remained the same, around 800 to 700.

Advance the slide.

So, calculating the rate for an SMM event during the IHS EM during 2011 and 2015, the rate was 246.1 per 10,000 live deliveries, which we think back, the Arizona SMM for American Indian/Alaska Native women was around -- was 292. So, it wasn't too far off. Next slide.

And breaking it down, we looked at the maternal age of the groups that were included in the analysis. Between the IHS SMM event group and the hospital delivery group, they're relatively the same between the 19-year-olds and younger, 20- to 29-year-olds, and 30-year-olds and older. Next slide.

And so, you'll see that the rate for 20- to 29-year-olds was the highest and then again it also was the largest age group. Next slide.

So, breaking down by how they were identified, looking at the SMM diagnosis codes and procedure codes, you'll see that the procedure codes identified most of the women. Next slide.

With 86 percent having at least one

procedure code that identified them. And then compared to 18 percent of women being identified via an SMM diagnosis code. You can advance it. One more time.

So, breaking down the top SMM diagnosis codes that were found, the top one was complications during procedure or surgery, then disseminated intravascular coagulation, and condemnation and, thirdly was adult respiratory distress syndrome. Next slide.

Now, looking at the procedure codes at the top, procedure code that identified these women was blood transfusions, which wasn't that surprising, seeing that the national average -- the national average was pushed up beyond blood transfusions. The next top was operations of the heart and pericardium, and then cardio monitoring and hysterectomies being performed were tied for third. So, out of the SMS procedure codes, most women were only identified by one. Next slide. Next slide. Next one.

All right. So, some limitations about

the analysis is that it didn't merge the mother's data with the baby's delivery data. A lot of states did that in their research. They had access to the de-identified data sets. in this analysis, we're just limited to the SMM events that occurred during labor and it didn't identify any postpartum hospital visits. And next slide.

So, this whole analysis focused on SMM event through diagnosis and procedure codes and also didn't include any length of hospital stay, which may also be an indicator for how severe their labor experience was. Next slide.

So, thinking about the limitations of how the analysis was performed, this is a typical pyramid of the continuum of maternal morbidity with the increasing severity going from uncomplicated deliveries at the base up to maternal death at the top. Click the slide.

And what I think after reviewing this presentation, after reviewing the analysis more and more, I think, it was really good at identifying maternal morbidity, not so much severe

maternal morbidity, since I wasn't able to match the women with the birth data and look at the length of stay a little bit more. Next slide.

So, some action items for individuals. We really want that one once an individual finds out that they're pregnant to initiate and continue prenatal care and seek postpartum care. So, for Tribal communities, we want the communities to advertise resources for prenatal and postnatal services, and for Tribal health care providers, we want the patients to be educated about common types of SMM.

When we sent this report to a colleague, she mentioned promoting the Hear Her Campaign, which focuses on having the individual that's pregnant and their family a little bit more aware about what signs to look out for during pregnancy and postpartum. Next slide.

For Tribal leaders and non-Tribal Public Health, we want to work to improve the American Indian and Alaska Natives surveillance data with Tribes, IHS, state registries, and Tribal

Epidemiology Centers and there's one more. So, for the Inter Tribal Council of Arizona, this data was very old. We only focused on 2011 and 2015, just to kind of bring a foundation to the research that's available. For our future work, we would like to work on something that includes 2016 to 2020 data. That would also mean using different ICD codes with ICD-10 and then also looking at IHS EDM to identify potential events that occurred postpartum, since the IHS EDM, it's a unique data set. I feel like future analysis should utilize that where we can track an individual and their hospital visits after their labor and delivery.

And I think if you have questions, that's it. I have some resources in the back of the PowerPoint to include the ICD-9 codes that we use for the analysis for the procedure and diagnosis codes. At that link, we have the report available and there's contact information for the Tribal Epidemiology Center and my E-email information as well.

JANELLE PALACIOS: Thank you, Stephanie.

Thank you everyone for joining us, and I would like to open up this panel now for Q&A. We have about ten minutes for that.

Let's see. I'm trying to see if I see any hands. So, I don't see any hands and so someone can speak up if they do have a question, but one of the pieces that I got from Stephanie -- yes? Go ahead, Belinda.

BELINDA PETTIFORD: Janelle, there are four hands up, actually.

JANELLE PALACIOS: I don't see any.

BELINDA PETTIFORD: But they're up. Steve and Paul and Wanda and Ed and then Paul Wise.

EDWARD EHLINGER: Let's start with Paul.

PAUL JARRIS: Yeah. So, well, thank you, Stephanie, for the presentation. I was curious, there was a big difference between number of diagnostic codes and the number of procedure codes, but far more procedure codes than diagnostic codes. Do you have a sense of why that is? It seems to me in the ideal world, that you

wouldn't do a procedure unless you had a diagnosis, and if you had a diagnosis, you would do, if necessary, do a procedure. But is there some issue with the coding that's going on among the providers or under recognition of conditions?

STEPHANIE BUSTILLO: I'm not quite sure because if their actual classifications used to identify SMM, they are identified by the CDC. So, you only have those, I think it's like fifteen diagnosis codes and seven procedure codes. I think a big reason why you see so many identified via blood transfusions is that might be an indicator that something else was happening that went wrong.

I think it would be interesting to look at is maybe what other diagnosis codes were identified -- were included -- when a woman had to have a blood transfusion.

PAUL JARRIS: Thank you.

EDWARD EHLINGER: Steve Calvin.

STEVEN CALVIN: Sure. Thank you for the presentations, Suzanne, Alida, and Stephanie.

Early in my career, I would have the privilege actually have taken care of Tohono O'odham mothers down in Tucson as a National Health Service Corps doctor and the stuff that you're doing in Arizona is really -- it's wonderful and obviously there are challenges. I have a question. You know, Suzanne, I know you're -- we've -- we've talked in the past about the challenge of the distances and that holds, I think, in Arizona as well. But any three of you or any of the three of you, do you have comments on, you know, we obviously are trying to avoid severe maternal morbidity and wanting to make sure that mothers are as close as they can be to the high level of services, but that's not always possible. How do you -- how do you see the balance of local community care frequently by certified nurse-midwives, and then the desire to have -- have mothers close to high-intensity service or, you know, high-risk services? It's always a challenge, but what are your thoughts on what the future should hold?

ALIDA MONTIEL: I look to the Alaska

model in a way. They have facilities where they have places for patients to stay close to the facility. We took a group of Tribal leaders up to Alaska Native Medical Center because we were trying to get ready for the possible replacement of the Phoenix Indian Medical Center and we wanted to look at what we could utilize, what, you know, it's amazing that they have built a facility that they have in Anchorage. But it's a huge state and, of course, there's a lot of transfer of care via -- I know that happens here with helicopter -- but I know they do air transport. So, that's something that I looked at as well. How do they accommodate the patients when they're transferred into Anchorage? Where do they stay and what resources are provided for them closer to where they're delivering? That's one of the things that the Tribal leaders looked at when we made our recommendation to the Indian Health Service in terms of the Phoenix Indian Medical Center OB, Labor and Delivery. I'm not sure the plans for the white -- White Mountain Apache Tribe and White

River Hospital, what they're planning and design, but that's something that we have considered.

EDWARD EHLINGER: Janelle, can you now see the hands?

JANELLE PALACIOS: Yes, I can. Thank you. Wanda.

WANDA BARFIELD: Yes. First of all, I'd like to congratulate all the presenters for a for an excellent set of presentations. Thank you so much. Lots of questions. But one just in terms of thinking about the issue of risk-appropriate care and how I think you've demonstrated how challenging it is, and you also talked about, you know, nontraditional opportunities. So, I'm just wondering if the speakers could talk about their suggestions of different models. So, we heard a little bit about Alaska, which, yeah, is a great system. There are also other places and other parts of the country in terms of a combination of Telehealth. What -- what are some of the other ways that you're thinking about in terms of meeting the needs of women who have these huge

geographic challenges and, you know, it's sort of similar to some of the work that's also going on in other parts of the world in terms of trying to think about emergency obstetric care.

ALIDA MONTIEL: I'd love to also hear from Ms. England on this. But one of the things that came up in our consultation with tribes is, for example, the Hualapai Tribe at Peach Springs, they do their prenatal care and then they have to transfer the moms and the families from Peach Springs over to Kingman for delivery and that is a long distance. And so, basically the Tribal health leader was saying that, you know, we kind of lose track of them after that point. We need to do a better job, ourselves, through the Indian Health Service possibly of empowering and bolding our system to have the staffing support at the local level to give that support to the family pre-perinatal and postpartum.

WANDA BARFIELD: Thank you.

SUZANNE ENGLAND: And this is Suzanne England and some of the comments that I would like

to make to that is, I think, bringing in like the specialty providers, having them come on site to our facilities, if that's not viable, is increasing work with Telehealth and also, postpartum, we lose many women postpartum. They don't come back in, especially if travel and finances are a big issue. If they're feeling fine, they have other children at home. We need to develop postpartum programs for women that encompass seeing them when they come in for well-child checks and give them something to work on like say more parenting education or programs that meet their needs, not just the standard let's take your blood pressure check and see if you need contraception, things like that, is just more family-focused education, training for them. So, it's a viable like, hey I want to come in and see this, and also like Alida was talking about, traditional care. What I've seen in many of our IHS facilities, we follow some the traditions like, case in point, up here in the Great Plains area, many of the tribes, they may want to take

their placenta home and bury that part of the umbilical cord. Also, when the child is born, if there's an elder there, usually a grandmother or great-grandmother, that they wipe the child's mouth out because they impart part of their spirit, their being upon that child. When I've done it, some mothers have said, yes, you've been imparted your personality upon my child. They like to talk and they're always on the go for that. But when we transfer the women out to many of our referral facilities, I don't think the referral facilities are aware of the cultural implications, and I think education needs to be made. Case in point, I was on an ambulance run to a facility transferring a woman and I was talking to the woman the ambulance saying the usual things like do you want to keep your placenta, do you want to smudge, different things, and she looked at me and she's like no one has asked about this in such a long time because she had experienced other women giving birth in this referral facility. And that showed to me is that some

cultural education needs to take place with our referral hospitals for our patients to improve the care and make it more culturally appropriate.

STEPHANIE BUSTILLO: One of the future projects from the ITCA TEC is thinking about working on data linkages. Through the IHS EDM, we have the registrations. It's going to be hard to say this person is an American Indian during that data set. So, once the Arizona report came out, a big question was what -- what population are they missing that aren't delivering at a regular state hospital versus an IHS facility. That additional push for us to work on that data linkage project and see where these women are going postpartum if they were seeking health care outside the IHS.

JANELLE PALACIOS: Thank you. It is time for us to transfer and hand the baton to the next group. I know --

EDWARD EHLINGER: Let's have Paul Wise have his questions. He's -- he's been online for a while, so do that.

JANELLE PALACIOS: Okay. That's fine. I

just want to be mindful. I know that the next speaker has a timeline too.

EDWARD EHLINGER: Yeah, thank you.

JANELLE PALACIOS: All right, Paul, please.

PAUL WISE: Thank you. These were great presentations, raised a number of important points, and this may be a question for you, Janelle, but I'll also offer it to all of the presenters. What's the main narrative? What's the main message that integrates the three presentations that you would want us to come away with? What is the coherent narrative that would facilitate direct to action as opposed to a number of very specific issues that could be addressed that we've tended to speak about?

EDWARD EHLINGER: Let me -- Janelle, let me respond to that.

JANELLE PALACIOS: Sure.

EDWARD EHLINGER: Because what our plans are is that we're working with -- I'm working with MCHB to actually have our next meeting in April

via an in-person meeting. We're still working on it, depending on what COVID will do, and the hope is that we would have our next in-person meeting on Tribal land, and we would -- we would advance this discussion more and really come up with some recommendations related to American Indian/Alaska Native health. And so, Paul, I think your question about the narrative that we want out of that would be something that I would like the Health Equity Work Group to be thinking about and kind of putting forward so that we have a consistent discussion when we get together in April, I hope, on Tribal land. And what we would also do at that time, I would hope, it would be a three-day meeting. The first day would be actually a community meeting, listening to the voices of urban and Tribal reservation Indians and service providers, where we would just be in a listening session, and then two days of our regular meeting. So, that's what sort of the plans are.

PAUL WISE: Thank you both.

EDWARD EHLINGER: All right. Thank you, Janelle, for pulling this together. Thanks for these three presentations. I just had one question and I will leave it unanswered, is that we had this fifty-year contract with ACOG. I would love to see the report ACOG has given related to what they have learned over those fifty years, and I would like to see the IHS evaluation of that of that contract to see what they have identified as the evaluative outcomes from that fifty-year relationship between ACOG and the IHS. So, we will follow up with that later on.

Now, I turn it over to Dr. Magda Peck for our session on housing, a major social determinant of health related to moms and babies. Magda.

HOUSING INSECURITY, EVICTION, AND BIRTH OUTCOMES

MAGDA PECK: Well, thank you. I'm going to encourage everyone to take literally a sixty-second breath and moment because we're going to be shifting, and I will see, the one minute, so that we can clear our minds a bit or at least make room

for the next level of conversation. In the meanwhile, Vanessa, can you verify, I see the Dr. Hamilton is in the house. I was hoping that Dr. Cho is in the house as well. Can you verify that our speakers are present, along with Dr. Cernich?

VANESSA LEE: Yes, they are all here.

MAGDA PECK: Excellent. So, with that breath and in the next hour, what I am delighted to bring before the Secretary's Advisory Committee on Infant and Maternal Mortality is opportunity to augment our shared knowledge base on one key social determinant of health, housing. Consider it based on what Dr. Ehlinger said today, a fourth level why. And in the months ahead, we will identify issues, opportunities, and innovations that may drive forthcoming SACIMM recommendations and influence the narrative about the relationship between housing and health specific to infant and maternal outcomes in health and be part of a larger conversation that is growing.

And amidst persevering pandemic, we do so with urgency and with particular focus today on a

sentinel event of housing insecurity, which is eviction. In his landmark 2016 book, *Evicted*, social scientist and ethnographer, Matthew Desmond, documented the complex systems and powerfully personal perils of unstable, insecure housing in one American city, where I happened to be residing, Milwaukee, Wisconsin. And in the closing chapters of *Evicted*, Dr. Desmond said, "Decent affordable housing should be a basic right for everyone in this country, and the reason is simple. Without stable shelter, everything else falls apart." And once thing to fall apart is human health with long-term lasting consequences, especially, for infants and their families.

A recent published review by Reese documents well the impact of housing on infant health. It is complex, multifaceted, and intergenerational. The key national indicators of child well-being in 2021 validate that the housing that is inadequate, crowded, or too costly can pose serious problems to children's physical, psychological, and material well-being.

Now, this Secretary's Advisory Committee on now Infant and Maternal Mortality has stayed aggressive in advances in clinical medicine and innovations and access and quality of health care for women, birthing individuals, and their infants. The powerful presentations yesterday and before this are highly indicative of our focus around access and quality. But we have centered our work on health equity fueled by growing evidence around root causes, environmental exposures, and upstream factors, including racism.

Now, in our focused attention to the intersection of health and housing, we are in good company today. Just yesterday, the White House hosted a Housing and Help Forum, which brought together stakeholders across the health sector, health providers, leaders of healthcare facilities, experts in health equity to spotlight this intersectional issue impacting health equity, and last week at the mentioned Vice President Harris' remarks and Secretary Becerra's remarks at the White House Forum with the Call to Action.

The only other Cabinet Secretary that appeared was Housing and Urban Development Secretary Marcia Fudge. This is our moment, and we intend to be able to frame this in a broader context with an overview from Dr. Richard Cho, senior advisor for Housing Services at HUD. He was a lead presenter at yesterday's White House Forum in Housing and Health, and he was featured just last month at the National Healthy Start annual meeting.

Following Dr. Cho, we will learn with Dr. Gracie Himmelstein, a colleague and co-author with Dr. Desmond at Princeton, whose April 2021 research paper, which appears in your briefing book, in JAMA Pediatrics documented the toxic intersection of eviction and birth outcomes. And we'll close with a brief commentary from Dr. Alison Cernich, who is our ex-officio member of SACIMM and active participant on the Data and Research to Action Work Group, the DRAW Group, who serves as Deputy Director at NICHD. Dr. Cho's bio is in the briefing book for your review, and we appreciate his joining us for the next twenty

minutes until about 2 p.m., amidst a very compressed schedule. We look forward to following up with any questions he might not be able to answer as he needs to depart early, and we look forward to hearing your comments.

Now, Dr. Cho, we welcome you to the Secretary's Advisory Committee on Infant and Maternal Mortality. Dr. Cho.

RICHARD CHO: Thank you much, Magda, for that kind introduction and also for sharing some of the highlights of the last couple of weeks. As you noted, Secretary Fudge had a chance to speak about the critical role that housing plays in advancing maternal health and reducing maternal mortality, and our deputy secretary yesterday at the White House Forum on the Intersection of Housing and Health talked about the variety of things that HUD is doing to try to address that intersection and as Secretary Fudge elected to say, you know, it's a new day at HUD, and part of that new day involves understanding and really helping others to recognize the

critical role that housing plays in health, including maternal health. So, thank you for that and also thank you to this advisory committee for inviting me to speak today. I'm going to share some slides if I can. Let's see here, and just please give me a thumbs up if you can see my screen. Great, okay.

MAGDA PECK: All good.

RICHARD CHO: Okay. Perfect. So, as you know, HUD is essentially an agency that's responsible for overseeing our nation's housing policies and our community development policies, and our mission is to create strong, sustainable, inclusive, communities and quality, affordable homes for all. As our deputy secretary at that form yesterday noted, you know, we're, better known as being an agency that focuses on housing and community development, but we know and we know that we can't achieve our full mission unless we can also address the health needs of people who are actually in our housing programs, as well as to advance and scale housing assistance so that we

can better improve the health of the many Americans who are in need of housing assistance.

We are a small-to-medium-sized agency. I will note that the Build Back Better Plan that the President has proposed that we hope Congress will take full action on would significantly increase our budget, I think something like doubling our budget, so there's a potential for significant change. I have the honor and privilege of serving as one of Secretary Fudge's senior advisors and I focus on the intersection between housing and health, and so we actually have a dedicated person, which is me, who is focused on thinking about how the way that we can adjust this intersection.

Let me start by just discussing what is housing insecurity and I'll just note we don't have actually a very good singular definition of this because we think about housing needs in a multiplicity of ways. Let me start by saying what we do mean by housing security, and that is that we're talking about housing that is safe, safe

both in terms of public safety, but also where the physical and environmental conditions are conducive to safety. A big part of what HUD does is also to address environmental hazards, as well as lead exposure among people who live in housing, that housing is also physically adequate, has adequate space to meet the needs of families. It's more than a roof over people's heads. It needs to be of high quality, housing that's also affordable. Our typical rule is that housing must, you know, people should pay no more than 30% of their gross monthly income on their housing costs. That it's based on choice and then it's also stable and long-term and predictable, and for most renters, which is the majority of who HUD assists, you know, we look for housing that where people are protected by leases and protected by state, local, and federal housing laws.

There's a range of thinking about the ways that people experience housing insecurity. The most obvious and maybe most acute form being people who are literally homeless, having no home

or where they're residing primarily in an emergency shelter, in unsheltered settings, such as on the streets or in vehicles, or where they're at risk of homelessness, at imminent risk of housing loss, but also people who are rent-burdened, people who are paying more than 30% of their income towards rent, people who are at risk of housing. Magda mentioned -- you mentioned the significant challenges of evictions and foreclosures that has been exacerbated as a result of the COVID pandemic, which I'll talk a little bit more about. But also, people who are overcrowded or in doubled up situations, people who are living in severely inadequate conditions, and one of the terms we often use is worst case housing needs. In fact, a report that we issue every other year looks at the number of people -- of Americans that are experiencing worst case housing needs in our country, and I'll talk a little bit more about that.

We define worst case housing needs as households that are renters but who -- and who do

not receive any form of housing assistance and where they are both low income and paying more than 50% of their income towards rent or where they're living in severely inadequate conditions and or frankly both.

So, what does this look like across the country? Let me start with evictions. We've been looking at Pulse Survey data that's been collected by the US census over roughly the last year or so on the number of households that are facing essentially back rent owed -- that his owed; so, they're falling behind in being able to pay rent and where they're facing eviction. And what that survey data shows is that over that roughly year or more period, about nearly 7 million renters are reporting behind on rent due to or coinciding with the economic fallout of the pandemic. In addition, 3 million or so households are reporting that they're fearful of imminent eviction, so imminent eviction, a notice is about to be issued, or where they've already received a notice.

In addition, our most recent data, which

unfortunately is pre-pandemic, shows that there were at least half a million people on any given night that were experiencing homelessness, many more people over the course of the year, as homelessness is often, for many people, a short-term experience. But where actually homelessness has been increasing since 2016, even after seeing a downward trend from 2010 to 2016. But over the last four years, homelessness has risen by 6 percent.

Our worst-case housing needs, that I mentioned, which our most recent report reports that in 2019, there were 7.7 million households that were either severely rent-burdened and low income or living in inadequate conditions. And where those worst-case housing needs are increasing among non-Hispanic Black households, and so we're seeing non-white households that are experiencing a greater proportion of housing insecurity.

This is data that actually shows over the course of the pandemic that there's been a

fluctuation in the number of households that have experienced some form of housing security -- insecurity as a result of their inability to pay rent on time over the course of the pandemic. But, roughly speaking, that number has gone up and down and there are now a significant rental assistance resources through the American Rescue Plan, as well as the CARES Act that communities have to be able to reduce the threat of evictions. But essentially that number remains high, about 5 million households at any point that are reporting that they are falling behind in rent and facing risk of eviction. So, this is a significant problem in our country.

So, you know, there are also mentioned disparities by race and ethnicity, but also income, sexual orientation, gender identity, and also mentioned disability. So, we're seeing significant housing insecurity that is not equal to all, but it's more -- it's disproportionately experienced by non-white household as well as other marginalized groups and essentially, these

are all issues that have -- were pre-existing prior to the COVID-19 pandemic, but where the COVID-19 pandemic has essentially thrown fuel upon a fire that was already existing in terms of housing insecurity.

So, let me talk about how this relates to maternal health, and essentially, we've been looking at data of the women and children who live in public and other HUD-assisted housing. I should have noted, we have a number of different housing programs, including public housing, that is run by public housing authorities, people who are in private market rental housing, but where their rent is subsidized through rental vouchers that HUD administers through public housing agencies. We also have rental assistance contracts with a number of private owners of housing through what we call our multi-family housing stock and so that is sort of a lay of the land of the different types of rental housing that we administer or regulate in some form, and across that entire portfolio of rental housing that we

administer or provide assistance to, essentially 70 percent of the adults that live in that housing are women, 4.2 million women in total. Seventy-seven percent of the women who live in HUD-assisted housing, identify with being in a racial or ethnic minority group. So, essentially, significant over-represented by women of color. About 50,000 new babies are born every year to HUD-assisted women and children comprise about 35 percent of our renter households. So, 3.3 million children, including nearly 900,000 children that are aged 0-5. So, we're dealing with, you can imagine, primarily single parents, single mother-led households, and many young children living in HUD-assisted housing, and the data that we have on health status indicates that both the women and children tend to report several health challenges, both reporting fair or poor health, having frequent emergency room visits, as well as mental health and behavioral health needs, not to mention chronic conditions, asthma, diabetes. In fact, when the COVID pandemic began, we looked at the

degree to which HUD-assisted households faced a number of risk factors, and we found essentially, they -- they sort of check all the boxes for all the risk factors for COVID-19. They are of advanced age, high prevalence with disabilities, high rates of the chronic health conditions that make people more susceptible to severe illness.

So, I'll also note that the research shows that infancy is the time of life when a person is most likely to live in a homeless shelter, if you can imagine that. I think most of us, when we think about homelessness, tend to imagine a single adult, typically a male, who is living in a tent or in a shelter in our cities. But in fact, the modal sort of age of people who are experiencing homelessness is someone who was an infant and about 10 percent of homeless families have an infant that is under 12 months of age. There are pretty substantial links that show the relationship between housing stability and maternal and child health, where mothers who are experiencing homelessness have higher odds of

experiencing complications during pregnancy, as well as low birth weight, and preterm delivery. Homelessness at infancy is associated with higher odds of poor infant health, as well as long-term adverse experiences.

And then, when you compare women experiencing or mothers experiencing homelessness to those that are housed, those that have a history of homelessness tend to have worse physical and mental health outcomes.

So, let me talk now about some of what we've seen on the positive end of things, where there's been a number of emerging attempts to look at the degree to which the provision of housing assistance coordinated with maternal health services can be a really powerful intervention. There is currently a demonstration taking place in Ohio, known as the Ohio Healthy Beginning to Home Study, that is using a random assignment design, providing a combination of rental assistance in the form of vouchers to unstably housed or homeless pregnant women, and coordinating that

with the delivery of maternal health services, and what they're finding is that the newborns that are in the intervention group are generally born at full term and have healthier weight, less likely to be admitted to the neonatal intensive care unit, and even with NICU is required, their average days spent there is much lower than for the intervention group. So, we are closely tracking that study as it's taking place.

In addition, a long-term study that we're now in twelve -- the twelfth year of, where homeless families with children were randomly assigned to one of four interventions where at the point of assignment, they were either assigned to receive a rental voucher, received temporary housing transitional housing, or short-term rental assistance, or frankly usual care letting them sort of navigate the homeless service system on their own, found that when families received vouchers, so, they actually have permanent housing with deep rental subsidies, they reported fewer child separations through the foster care system,

decreased maternal psychological distress, and frankly, just a number of other improvements.

In Boston, the Boston Public Health Commission and the Boston Housing Authority have also collaborated to provide public housing to homeless and housing insecure pregnant mothers and who have medical risk and are tracking the degree to which the provision of that housing, public housing alongside maternal health services is actually improving maternal health status as well as behavioral health conditions.

So, looking ahead, we are doing a number of things, both in the near term as well as in the long term. In the near term, we have made a strong commitment in partnership with HHS to look at how we can improve outcomes for the women and children who live in HUD-assisted housing today, and that means we are increasing communication, education, and outreach to the women that live in HUD-assisted housing about the degree of the importance of maternal health services and programs like Healthy Start, but also encouraging

them to be able to connect with Healthy Start another maternal health services that HRSA's Maternal and Child Health Bureau provides.

In addition, we're continuing to monitor the emerging evidence on the way that housing assistance coordinated with maternal health and child health services can improve maternal and early health infant health outcomes and looking at ways that in the future, we could potentially provide dedicated housing resources to be able to address and provide housing assistance to unstably housed, housing insecure, or homeless pregnant mothers.

In addition, we are matching our data with HHS in a number of ways to look at the way, the degree to which the women who live in HUD-assisted housing are actually participating in maternal health services, what their maternal health outcomes are, as well as their housing status, and then again engaging with stakeholders to really bring this together. In many instances, and we learned this a lot through our COVID-19

response, the proximity between HUD-assisted housing and the providers of healthcare services, so initially with regard to our COVID-19 response, we found and mapped together where are the public housing, multifamily housing programs, and the homeless shelters in relationship to federally-qualified health centers, and we found in many cases, they're there right next door to each other or within a few miles. But, in many cases, the partnerships where were not there. So, we did a lot of work to broker that. We're building upon that same idea and applying that to maternal health as well, looking at the places where we know there's a higher concentration of mothers who are potential pregnant, women who are potential pregnant mothers and connecting them to the maternal health services that exist.

On the HHS side, we're trying to work with our colleagues at HHS to inform the degree to which maternal health services is attendant to housing needs, and that includes encouraging maternal health services providers to incorporate

housing screening into their existing programs. We anticipate and suspect that most providers of maternal health services don't necessarily ask, are you worried about paying rent, are you worried about losing your housing, do you worry -- are you living in a doubled-up situation, you know, or frankly, are you living in a place that -- where -- or you actually lacking housing assistance? The degree to which you ask the question about what your housing status is like enables you to intervene and potentially connect you to the housing agencies that can help potentially shore up people's housing security, as well as increasing -- we're working together to help prevent evictions, including among women who have children or who are pregnant or parenting.

So, I wanted to share some resources. I'll make sure you all have these slides so that you can actually click the link to these resources, and I may have taken a little bit too much time, so here's my contact information. I am more than happy to answer any questions.

MAGDA PECK: A terrific and speedy overview and, hopefully, a first date, if you will, Dr. Cho, because I think the essential nature here is for us to make sure that we're in a shared space together.

I would like to invite -- and I know, Dr. Cho, you need to leave at the top of the hour -- can you entertain a couple of quick questions now? And I would also encourage all of our participants to please put comments and resources in the in the chat. I want to thank Dr. Jarris for acknowledging the cost of parking and relating our cars to our houses, brilliant, and especially, highlighting -- Thank you, Janelle, and Dr. Palacios, about the relationship to Native American and American Indian communities in terms of housing. So, it's not an urban issue alone.

So, with those two comments, can I see hands raised for comments or questions? What are you most curious about that Dr. Cho can answer right now? I saw a hand go up. Lee, I'm going to start with you.

LEE WILSON: And more of a comment than a question. Richard, thank you very much for doing this. You've become a frequent speaker on our circuit. For the committee members, I wanted to let you know that we have been engaging with HUD in trying to bridge our services and the connection with the HUD services, especially given some of the resources that they make available directly to the same clients that we are trying to serve. So, there's common purpose there. Dr. Cho has spoken at the Healthy Start virtual meeting, we are also exploring options, and it's a bit of a teaser for what we may be able to do in a coming supplement to our grantees around health -- in Healthy Start for further reaching out and use of resources for some sort of a voucher program in circumstances where there's -- where there may be great need. It's a little difficult navigating from the position of Healthy Start and what is allowable and not allowable under our grant provisions. But we're very serious about this. This is one of the real social determinants of

health when it comes to long-term maternal and infant health outcomes. So, Richard, thank you very much, and there will be more to follow from us on this subject.

MAGDA PECK: Thank you very much, Lee. Dr. Ehlinger, final question, and then we'll let Dr. Cho head out. But I want to keep us monitoring the chat before we turn to our next speaker, which will focus specifically on eviction. Ed.

ED EHLINGER: Yeah. When I got into the public health field in the 1970s, the homelessness was not a huge issue. Yes, there were some homeless, but it was -- they were very low prevalence. In the early 1980s, homelessness expanded dramatically, and it has stayed high. What were the policy changes that occurred in the early 80s that led to this explosion of homelessness and housing insecurity and are there things that we can learn from those policy changes that we could correct at this point in time to have a policy approach to changing and addressing

homelessness and housing insecurity?

RICHARD CHO: Yes. Dr. Ehlinger, thank you so much for that question. I think most people often refer to the deinstitutionalization of mental health institutions in the 60s and 70s as responsible for the growth of homelessness in the 1980s. I think that's an oversimplification. I think that, while that played some role, it was a lot about actually the changes that were happening in at that time cities, although now homelessness is found in almost -- in rural areas and cities and suburbs, but where slum clearance policies, the reduction of cheaper housing in the form of even what was then known as welfare hotels and commercial SROs were being taken down, and in the 1980s, in the Reagan administration, there was a significant policy shift in the disinvestment in HUD assistance. HUD's budget was cut significantly at that time. We essentially have not made up for the cuts made during that time in the subsequent decades. So, we've been dealing with decades of disinvestment and housing

assistance and federal housing assistance in a variety of different programs then. Coupled with that, we're now seeing like housing market conditions that are just pretty -- pretty sort of mind blowing if you go to the west coast, coastal east coast cities. But now, like all across the country, communities that are experiencing significant economic growth as well as population growth are seeing a housing shortage in rental markets, as well as home -- home ownership markets that are just out of reach for so many households. And so, what you then have is a situation where the most vulnerable people end up either being displaced, have to move to further out places, or frankly, displaced to the streets. I'd say it's the disinvestment in housing assistance that is probably the biggest driver of the homelessness rates that we've seen. And that coupled with significant rising in housing costs. I would be remiss if I didn't mention that, you know, through the American Rescue Plan and through the President's Build Back Better Plan, we have an

opportunity to make up for many, many decades of disinvestment where Build Back Better includes $150 billion in investments across a variety of different HUD programs to scale up housing assistance. It's making up for many, many years of lost time with regard to housing and systems keeping up with need. And so, it's a lot in a short period time, but we're very excited about the potential for scaling those housing investments. But thank you for that question.

MAGDA PECK: Thank you for that response. Any final -- if we can be in partnership with you, Dr. Cho, as the Secretary's Advisory Committee, do you have any wish list or ideas you want to leave us with? That goes to Paul Wise's question about what's the narrative, how can we be influencers to change anything? Is there anything you'd like to leave us with as you head out, so we can come back and continue the conversation?

RICHARD CHO: Yes, thank you for that. I would say, you know, just even having this conversation is key. I think we're at the

beginning stages of really looking at how we can more comprehensively attend to the housing needs of women to be able to attend to their maternal health needs and reduce maternal mortality but also increase the awareness about the critical role that housing plays as a social determinant of maternal health. And so, I would encourage the members of this committee to really think about how you can begin to just talk more about housing's role about -- and also to begin adopting practices and encouraging the adoption of practices that help to screen for and understand housing status and frankly, to build collaboration with the housing sector. We are certainly not looking for the maternal health services world to be able to solve housing needs. We're just looking for you all to understand that there are housing needs there and then connect to the programs that HUD administers, the network of housing agencies that provide housing assistance. I think we can do a lot by building those bridges and we are very excited about the partnership with

HRSA and Lee and Michael and others who are here because of the potential for us to be able to build that bridge, strengthen those partnerships at a local level, and then more of the maternal health providers asking about housing status, the more that we at HUD and our housing network are looking at the potential maternal health needs of the people that we assist, I think we can do a lot. So, I would say let's -- let's continue this conversation, let's hope this is not a moment in time, but the beginning of a movement where we can think more wholistically about the needs of pregnant and parenting mothers.

MAGDA PECK: Thank you. To be continued and thank you to Dr. Helms for supporting your being here today. I know she's on our call as well.

With that, keep track of your questions, we're going to move to the second part of our work today. Back in 2016 when Matthew Desmond published his book, *Evictions*, he was at a book signing at a small independent bookstore in

Milwaukee called Boswell Books, and I had a chance to meet him, and he was recent into this publication, and I challenged him then in that kind of direct kind of sometimes charming way that I can be in your face. I said, you know, what about women? What about children? Can you -- can you tell us some of the data, not only about ethnography perspective, but from a health outcomes perspective, and he said we're working on it. And part of we're working on it is the work that he has been doing in the eviction lab at Princeton and in partnership with our next speaker, Dr. Gracie Himmelstein, as we consider this toxic experience a sentinel event in maternal and infant lives. It is all too common in the lived experiences of women and their children, especially women of color.

In her JAMA Pediatrics article, which was included in your briefing book, she concluded that eviction actions during pregnancy are associated with adverse birth outcomes. They have been shown to have lifelong multigenerational consequences.

We have work to do in this area. This is a moment of greatest vulnerability and greatest opportunity, and we look forward to hearing from Dr. Himmelstein, whose bio appears in your briefing book as well. But know that she straddles being a physician internal medicine at UC Medical Center and a candidate in demography at Princeton and an active colleague looking at the intersection of health, inequality, and public policy.

Thank you so much, Dr. Himmelstein, if I can call you Gracie, for being here and being part of this first dance with us. The floor is yours.

GRACIE HIMMELSTEIN: Thanks so much, Magda. I'm so excited to get to share this work and so impressed by all the amazing work that you folks are doing. And I think this is -- Dr. Cho set me up perfectly, because I think that this will be a nice segue into some of the details around eviction and maternal and infant health.

Am I able to control these slides? Okay, perfect. So, I don't think I have to tell this

audience how important health at birth is. We know that health at birth is a major determinant of health across the entire life course. It's a major determinant of economic outcomes, educational outcomes, labor market outcomes. And I think, you know, interestingly, we see that this is transmitted across generations. So, folks that are born low birth, we are more likely to have low birth weight children themselves, and we can see that transmitted across generations.

And I think, you know, a big driver of poor health at birth is maternal disadvantage and there -- and there's a wealth of research that's showing us this, and I think we can think about eviction as sort of a particular form of maternal disadvantage, both as a cause of maternal disadvantage and a consequence.

Okay. So, just to give you an overview of eviction, what this looks like in this country, and I just want to as a side note, you know, I'm happy to talk more about what goes into collecting eviction data, because it's by no means sort of a

straightforward process, and that's why, you know, my data may look a little outdated from 2016, although we do have evidence that these trends have continued. So, overall, about 6 percent of households have an eviction filing. That equates to about 2.4 million filings. So, what I mean when I say a filing is that a landlord has filed an eviction with the Court. This is not the same thing as an eviction judgment, which is when the Court actually would find in favor of the landlord.

Evictions can be for all sorts of different things. Those of you who have read Matthew Desmond's book have heard about a variety of those causes, but most commonly it's for non-payment of rent. You know, we've seen this arising eviction crisis in the past two decades partially just because we just have not kept pace with rent. So, rent has risen 13 percent, income has risen less than half a percent, and I think we can all imagine what that does in terms of the financial precarity of renter households.

And Dr. Cho touched on this a little bit, but when we look at, particularly among poor tenants in the US, over half are considered rent-burdened, by which I mean spend at least about a third of their income on housing. And I think really the point to drive home here is that eviction is a product of this chronic financial precarity of renters. So, I think often times you'll maybe hear stories in the news about people, you know, facing some one-time shock; they lost a job, they had an unexpected medical illness that caused them to be evicted. But really what we're seeing is this sort of epidemic of financial precarity that's due to this mismatch between the increase in wages and the increase in -- in rental prices.

Okay. I just wanted to touch a little bit on eviction in the era of COVID-19, and I think that some of the policy around eviction that came in response to COVID-19 has really brought new awareness to eviction. So, you know, most notably there was the CDC moratorium on eviction,

and it's estimated that that prevented about 1.5 million evictions. It has since expired. We know that eviction rates have risen since the expiration of the moratorium, and I will show you some data on that, and that is especially true in places where there's no state or local moratoriums preventing eviction.

And then, we have some specific data about the relationship between eviction and COVID-19. So, in with higher eviction rates, there was higher rates of COVID-19, including among non-evicted people. Policies that limited evictions resulted in significantly reduced spread and deaths from COVID-19. And then, particularly with relationship to the eviction moratorium, you know, lifting of those moratoria increased the incidence of COVID-19 morbidity and mortality.

Okay. And so, this is just to give us an idea of sort of what the trajectory of evictions have been in the past, you know, year or so of COVID-19. So, this is looking at when the CDC moratorium started in September of 2020 and you

can see that the historic average and the 2020 to 2021 rates diverged significantly, you know, partially before the moratorium in response to some of the things that Dr. Cho was talking about in terms of, you know, actions, unemployment assistance, that sort of thing and that that divergence continued to increase after the moratorium.

So, then the next big question that I think is on a lot of folks' minds is since the end of the moratorium on evictions, what has happened, and I will say that evictions still remain below historic levels, but in places that have lifted those moratoriums and particularly those without the local policies preventing evictions, we have seen an increase in evictions. So, this is data from Houston, and I should add that all of these charts and graphs that you're seeing are available on the Eviction Lab website. We've been tracking over twenty cities since the start of the COVID pandemic and what the eviction rates have been doing there. So, I encourage you all to check

that out if you're interested in seeing sort of what the local eviction landscape looks like in your area.

Okay, and so, you know, Dr. Cho spoke to us about some of the racial disparities and the gender disparities and housing insecurity, and that is, I think, especially true among those who are evicted. So, we know that while about 20 percent of renters are Black, about a third of all eviction filings are against Black renters. So, Black renters are more likely than white renters to face eviction filings.

We know that the risk of eviction is higher for women than men, and that, especially for Black women, we see this sort of compounding disadvantage when it comes to eviction rates.

And I think most notably here, it's the same population at risk of eviction that's at risk of adverse birth outcomes, and that was sort of the driver for the study that I'll describe in a bit more detail shortly.

Okay. So, does eviction compound the

risk of for health at birth? I think that we can think about both those overlapping populations in terms of it being the same population at risk of eviction and at risk of poor birth outcomes, and we can also think about what we know in terms of maternal disadvantage and the risks of maternal disadvantage for birth outcomes.

Okay. So, I spoke about some of the challenges with this data and particularly with the eviction data, we're often sort of gathering that sometimes courthouse by courthouse, sometimes state by state. So, for this project, I looked specifically at Georgia and partially, it was just driven by the way that they collect their data. I'm happy to talk more about that in the Q&A.

But basically, what we did was we linked the birth records and the eviction records of mothers and babies living in Georgia, and we compared women to themselves. And I'll show you what I mean by that. So, when you look at the sample of women who are evicted over here on the right and those who are not evicted over on the

left, you can see that there's some pretty significant differences in educational attainment, in the racial demographics, perhaps most pronounced, and I think unsurprisingly, in all of these birth outcomes that we're interested in. so, this is one of the major challenges, right, whenever we study something like eviction, that there's going to be sort of significant selection or confounders that make it very challenging to actually untangle what is the effect of eviction.

So, to get around this, we actually look just among evicted women, and we looked just at whether they experienced the eviction during the pregnancy or whether they experienced the eviction during a time outside of the pregnancy. So, this is a sample of all evicted women and we're comparing the birth outcomes of babies who were exposed to an eviction during gestation to those who are not, and we see here that those who were exposed to an eviction during gestation had significantly worse birth outcomes.

So, these are just, you know, the sort of

standard measures of infant health that we look at. I'm going to skip over this, but just to give you an idea of sort of what we're talking about here, we see about a 27-gram decline in infant birth weight. So, for, you know, this is for siblings that are born to the same mother. You see this sort of size decline from being exposed to eviction during the pregnancy. We see an increase in the probability of being born low birth weight and we see the increase in the probability of being born prematurely as well.

And just to sort of, I think, you know, these numbers in isolation are perhaps not that meaningful, but just to give you a sense of the sort of size of this finding, this is about a third of the size of the birth weight decrements associated with maternal smoking, and these are similar in size to the improvements in birth weight that we see with the introduction of food stamps and WIC programs.

When we looked by trimester, we see that the second and third trimester of pregnancy are

times of sort of special vulnerability to the effects of eviction in terms of all of the outcomes of interest here.

I think, you know, it is sort of interesting to think about by subgroups. So, are Black mothers, you know, particularly vulnerable to this or, you know, does education -- and really, it was across all subgroups, we see a pretty similar size with, you know, overlapping confidence intervals here. So, you know, I don't think that there's any one subgroup that's -- demographic subgroup that's driving this finding.

Okay. I'm happy to talk sort of about some of them were statistical aspects of this and how we, you know, double checked these results. But I think, you know, sort of to give us -- zoom out and give us a bigger picture of what eviction and infant maternal health has looked like in the literature, I just wanted to just review some of the sort of studies that have influenced my work and that I think are relevant to this topic.

And the first is some of Mat's work about

infants and mothers, and this is looking in the Fragile Families and Child Well-Being Study, which found a significantly higher likelihood of maternal depression and self-reported mother and child health associated with eviction.

Dr. Sandel [phonetic] has found that mothers of young children who experienced an eviction also had higher odds of poor health and it's associated with maternal depressive symptoms and child hospitalizations.

This is a study from Chicago. It's an ecological study that shows that eviction rates are associated with sort of the same outcomes that I was interested in, but this is taking a sort of bird's eye view of that.

And then finally, this is another ecological study showing a similar thing that living in counties with higher eviction rates and again finding that that second and third trimesters were time of particular vulnerability for poor outcome -- poor infant health outcomes associated with eviction.

So, just to turn in the last minute or two about eviction and policy. So, eviction is a policy problem with policy solutions and also eviction policy is health policy. So, if we look at eviction rates across the US, here, you can see the size of these dots are related to or sort of proportional to the amount of evictions in each state. And, you know, South Carolina is really -- it sort of stands out as a leader here, and this is really a product of state and local policy differences across location that influence eviction rates.

So, we know that there's a number of policy interventions that influence this. Some, you know, different cities and localities have tested out providing legal assistance to tenants, and that significantly varies and influences eviction rates. We know, as Dr. Cho was saying, that increasing investment and affordable housing and rental assistance programs is a major influence on eviction rates. And, you know, just that -- to say that any policy that puts money

into the pockets of poor renters is going to be eviction policy. So, changes like increasing the minimum wage, expanding public benefits, Medicaid expansion, that sort of thing, all can greatly reduce the frequency of the evictions.

Okay. So, just to sort of hit on the key takeaways here, we know that eviction during gestation is associated with noteworthy decrements in health at birth. We've seen in my study and across other studies in the literature that the second and third trimesters of gestation are times of particularly heightened vulnerability to eviction and then, just to close, that eviction rates vary very widely across time and space and are highly amenable to policy interventions, and I encourage all of us to think of eviction policy as health policy.

So, I will stop there, and turn it back over to Magda.

MAGDA PECK: Gracie, that was terrific, and I am noting the quote of the day, "Eviction policy is health policy and it's a policy problem

with policy solutions." So, thank you for that. This is opportune moment. I'm going to start with one question from you and then I'm going to ask folks to raise their hand, so that I can call on them next.

So, I have called eviction to be a sentinel event, meaning that it is, or it is a proxy leading edge of what we can -- if we impact eviction, we can address housing stability more broadly. And in doing so, if we if we have ways of not just retrospectively linking the data, but proactively being able to prognosticate who, more than just offering folks resources on how not to be evicted, we might be able to have a greater primary, secondary, and tertiary prevention. So, do you -- do you see eviction and its relationship to the larger housing instability as being the leading edge and maybe could you tell us just a minute about what is the Eviction Lab and why does it exist, because it would seem that you're elevating it. So, help us appreciate why.

GRACIE HIMMELSTEIN: Yeah. Yeah, thanks

so much. That's an excellent question. So, yeah, and I think, you know, part of the contribution of Matt Desmond's work to this has been sort of showing us the cascade of events that can occur after someone is evicted. So, it can, you know, when you're evicted, it can influence your ability to keep a job, right? If you're, you know, trying to sort out your housing, it can influence where kids are able to go to school and influence school moves. So, it really, you know, can be the exactly as you're saying, sort of this sentinel event and sort of initiating this cascade of adverse things that can really influence people's lives. I think that's an important piece of it.

In terms of the prognosticating, there has been definitely some -- some moves around identifying who is at risk of eviction and, particularly, you know, I'm a clinician, I'm a physician, you know, implementing that into our practice in terms of screening for housing insecurity and who might be at risk of eviction and trying to sort of hook people up with some of

these resources that do exist.

And to answer your question about why this Eviction Lab exists, exactly as you said, if we if we think of this as not just the consequence of poverty, but actually as a cause of, you know, the sort of cascading events of insecurity, really getting a handle on the data about who's being evicted, where they're being evicted, what that means for tenants and for sort of our social safety net more generally, is really important.

MAGDA PECK: Thank you for that. I am looking for hands up or questions that you may have because. Tara Sander Lee would please give us a question.

TARA SANDER LEE: Yes. Thank you so much for your presentation. This whole -- whole topic and session, Magda, has been very informative. I guess my question is related to what you presented with eviction and also the HUD talk before that and kind of as a general question of what type of assistance do -- like, what is your ideal policy situation and how -- I'm looking at a timeline.

Like, if you have a woman that is pregnant and definitely needs help and we don't want her to be evicted, what type of policies doing need to put in place that -- and how long will they be in place? I guess I'm looking for a time, like how -- like, are we going to, you know, reduce the chance that she will be evicted through the pregnancy, through postpartum, a year, you know? So, I'm trying to get a feel for the timing of that. If you could maybe just speak a little bit more about that, that would be great.

GRACIE HIMMELSTEIN: Yeah. I think it -- yeah, it's a great question. I think, you know, something that is encouraging in the data is that we do see sort of the significant effects, especially in the second and third trimesters, so, that lets us know that we maybe have a little bit of a window in that first trimester to intervene, which I think -- I think is important.

In terms of what assistance looks like and what the timeline for that could be, so, I think one thing I mentioned was the providing, you

know, even providing legal assistance and, you know, I'm -- we track these formal evictions in the court and one of the reasons I talked about filings as opposed to an eviction judgment where there's a court order is because so many tenants just received the filing, receive the notice of intent to evict, and then take that as I need to get out of here immediately and never even go to court to, you know, sort of fight the eviction. And you see -- so, I think sort of incorporating and there's been some movement towards this like medical, legal partnerships early on in pregnancy, identifying folks at risk of housing insecurity throughout the pregnancy, and getting them sort of hooked up to those services early has the potential to really, you know, have a big influence. Yeah, I think that that would be sort of a priority in my mind.

TARA SANDER LEE: Okay, thank you.

MAGDA PECK: Thank you for the question. Lee Wilson.

LEE WILSON: Dr. Himmelstein, thank you

for your presentation. I guess, building off of something that Magda has said a couple times during the discussion, I agree with her point about the sentinel event nature of eviction, but one of the things that I took from the book when I read it, and it's been a while now, so correct me if I'm wrong, but I think one of the messages that came from the book was that for many, eviction isn't just a sentinel event, it's this -- it's being sucked then in into a cycle that is sort of self-perpetuating. And I guess the question that I would have for you to possibly advise the committee on, from your research, what might be those sorts of buttresses that would be used to help push somebody out of that cycle, you know, for those of us who think about the idea of eviction and then pulling somebody back out. But if you're in it and you've been in it for a while, the tools might be a little bit different.

GRACIE HIMMELSTEIN: Yeah. Yeah. I think that that's absolutely the case and, you know, we definitely do see in the data, we see

that there are folks that are serially evicted and having repeated evictions. I should just say that particularly, you know, when we look at the effects on infant health, it doesn't matter if you're serially evicted or if it's just one eviction. We see the sort of the same decrements there.

In terms of your question though about the sort of cycle of events and what we can do to intervene on somebody who is sort of, you know, having multiple evictions, and I do -- I agree with you, I think that some of the sort of housing vouchers, housing assistance that we might typically think of could be challenging in that case.

I do think, you know, pregnancy is an interesting time because folks are coming into contact with social workers and physicians and other clinicians, you know, often during that pregnancy and that offers sort of a particular moment for intervention in terms of getting people hooked up to the services that they need.

So, yeah, I wish I had a better answer about how -- how we could help those folks, but I do think that seeing pregnancy as an opportunity to intervene, both on those serially evicted and those evicted once is a particularly important point.

LEE WILSON: Thank you.

MAGDA PECK: Thank you for the question. I'm going to close this out with a commentary and to introduce it, I want to acknowledge this thoughtful literature review by Jason Reese [phonetic] that appeared couple of months ago identified multiple ways to influence change. So, I want to respond to Lee's question with the framework that Dr. Reese put forth in his review.

One is that we have to start by better understanding housing in its historic and contemporary social context. It is a determinant of health if you read the Color of Law, if you go back in time, much like the antecedents to structural racism. Housing has its own structural impediments baked in and the more we understand

the historical contemporary dynamics, the better we'll be able to align our work and health equity to include that housing focus.

Second is that housing is both a stressor and the stress. It is one of these wonderful moebius [phonetic] where it both stresses women and can be a prediction of increased stress and poor outcomes, and then it accumulates over time and it gets embedded in the ways that lives are structured, and so, particularly impacting Black, indigenous, and other persons of color.

So, let's just look at how that flow around stress plays out specifically with eviction and with housing, more broadly.

And last, housing can be a lever for health improvement. We have -- we have an open door that has not yet come to SACIMM from HUD and from researchers and Eviction Lab and others. This is our moment. So, in that spirit of what we can do to better inform, to leverage, and to put it in its context, I'm going to borrow an extra two minutes, Dr. Ehlinger, and ask Dr. Cernich if

she would give us some commentary because some of the funding from NICHD has gone to the work that we heard talked about today. So, Alison, would you give us a commentary to come home, and then we will be following up as a committee to see what is possible and what influence we can have. Dr. Cernich.

ALISON CERNICH: Sure. Thank you, and thank you, Dr. Himmelstein. You know, we have -- we have read your publication and many of the other publications coming out of some of our longitudinal studies and some of our population health centers with -- with great interest around these -- these issues.

I think I can -- I can be very brief. I think, number one, and I think the point about the second and third trimester is really notable. There is a different inflammatory environment in pregnancy, and so, I think even from the perspective of biology and health, these events are not just events in the social sphere. They are events that impact the health of the person

because of their impact on the health of the body, and we do provoke actual responses behind the biology through our social determinants of health.

I think the other main point is that some of these folks are multiply disadvantaged. They have the disadvantage of lower educational attainment. They have race and ethnic challenges. They have lower SES. And so, their opportunity to move to better environments is limited. We had a recent publication last week that even looked at police presence in neighborhoods and how that impacted maternal health.

And so, I think just the environment in which one lives, regardless of their eviction status, I think we need to understand the multiple disadvantages that individuals are encountering and how that influences their health, specifically the health of mothers and babies and parents and babies.

And I think, you know, finally, when I think it's one of the things that we mentioned, we mentioned that -- there was a mention of the

Fragile Families Study, and I think one of the things that our longitudinal data allows us to do is to look at the intergenerational transmission. I think the thing that we sometimes forget, is this is not just one parent and one child and has been mentioned across. Even genetically, this is past those stress responses, those intergenerational traumas are past. And so, we don't recognize that, and I think this kind of gets to the question about the time period of impact. The time period of impact is not just around the pregnancy or the postpartum period. The time period of impact is the life of that parent and the life of that child and the transmission across the generation.

And so, I think it's really important for us to remember that these are heritable responses, these are heritable influences. And if we do not try to disrupt them, we really are putting ourselves in the position where we will allow these health disparities to continue.

So, that's my brief commentary, Magda,

and I thank the committee for the opportunity to help shape this and to really -- to hear some really great research and policy in this area. So, thanks so much.

MAGDA PECK: Thank you so much, Alison. Thank you, Gracie. And let's all give them an appropriate round of applause. You could even take yourselves off of mute to make that happen. Dr. Ehlinger, thank you for letting us borrow the five minutes back. And with that, I pass it on to you just segue into a break and the rest of the day. This is a conversation for action to be continued with urgency and purpose. All the best, thank you.

EDWARD EHLINGER: All right. Well, thanks to everybody on the panel, and great discussion, lots of questions were raised. It really struck me how physicians and clinicians are getting involved. Vote ER, where the docs actually talking about voting made a difference. Docs need to talk about housing and health professionals need to talk about housing. Lots of

-- lots of food for thought and more conversation is needed. But what is needed right now is a ten-minute break. So, we will be back in ten minutes.

BREAK

PLANNING FOR A FUTURE EVIDENCE REVIEW AND DISCUSSION ON THE IMPACT OF ABORTION ON INFANT AND MATERNAL MORTALITY

EDWARD EHLINGER: Welcome back, everyone. I hope we are all back and ready to enter into this homestretch of our two-day meeting. A lot of stuff going on and as I mentioned in my beginning conversation this morning that -- about fingerprints on SACIMM. My fingerprints are all over this session and I acknowledge that because our charge as SACIMM is to address the impact or address the issues that impact infant and maternal mortality and morbidity, and abortion is one of those issues. But because of its controversial nature, it is a difficult issue to address. Many people believe that because discussions about abortion mostly revolve around issues of values and morality, where there are often irresolvable

conflicts, we can't have a productive conversation about abortion. But it is a public health issue that has implications for the health of mothers and infants. So, I think we need to talk about it.

I also believe that there are objective data about the impact of abortion on maternal and infant mortality that could be the basis for a productive discussion on the issue. That's why I've added this session to our agenda, to help us develop a frame for a future discussion of abortion. We won't discuss abortion at this time, but we're going to be talking about a frame for discussion of abortion that doesn't address the legality or the morality but focuses on scientific evidence and research. So, the next slide, I have -- I looked at the -- our charge, and this is our charge. I just want to make sure that we stay within our charge and the description of duties of SACIMM from our charter.

With the goal of reducing infant and maternal mortality and morbidity and improving

health status before, during, and after pregnancy, SACIMM advises the Secretary of the Department of Health and human services on the following: Department activities, partnerships, policies, and programs. How best to coordinate federal, state, local, and tribal governmental efforts. How to influence similar efforts in the private and voluntary sectors. Also, on factors contributing to disparities and equity seen in birth outcomes for women infants. And the health, social, economic, environmental factors contributing to the inequities and policies, programs, resources, instructional systems, level changes required to address the disparities and inequities in infant mortality related to adverse birth outcomes and maternal health outcomes.

That is our charge. That is the description of our duties. So, with that scope of SACIMM's charge and duties, what questions should SACIMM consider regarding future evidence review and discussion of the impact of abortion on infant and maternal mortality?

I raise that question. I'm going to want all of you -- and I'm going to turn it over to Glenda Eoyang shortly to tell you the process -- but I really would like for SACIMM members, both regular members and ex-officio members and members of the SACIMM Work Groups, to participate in this effort to raise the questions that SACIMM should consider regarding future evidence review and discussion of the impact of abortion on infant and maternal mortality.

So, I now turn it over to Glenda Eoyang, Dr. Glenda Eoyang, who was with us a year ago talking -- using the power of questions as we talked about racism. So, Glenda, I turn it over to you.

GLENDA EOYANG: Thank you, Ed. I really appreciate it and appreciate this opportunity to be with your community today.

So, in Human Systems Dynamics, we work in worlds that are complex and uncertain and difficult, challenging in many, many ways. But one of the things we know for sure is that inquiry

can light the way through very difficult challenging times. So, when we say inquiry, and this is what we're going to invite you into as we work in this very structured facilitation process. What we mean by inquiry is when you're stuck, you can find a way forward, and this is if you're stuck individually or if we're stuck as a community, the path forward opens when we're able to take our judgment that has us stuck and turn it into curiosity.

Now, that's, not to say judgment is a bad thing. There are some times when you need to have judgment. But when it has you stuck, you need to be able to open it into curiosity. When conflict has you stock, inquiry can help you into shared exploration. Inquiry can help turn defensiveness into shared exploration or assumptions into questions. And so, we find that this is a practice that rather than closing down options, possibilities for understanding others, and working together, inquiry helps to open up that space so that we can find some way forward

together. And we do this in a very simple but structured process. It's called the power of inquiry. And it's a practice that will help groups. It's helped many different groups find action in complex situations.

So, the first step in the power of inquiry is that a question is framed, and Dr. Ehlinger has given us the question. We will be going back to it in a moment, so it stays tight in your mind.

Then we ask questions. Now, those questions are not answered at this moment. We collect them. And by collecting them, we have a chance to surface the questions we may hold and listen to others' questions, and in this particular case, we want to make sure that we follow the rules of inquiry.

We'll give you a bit of time to think about questions, evidence-based questions you're aware of and would like to share.

We're focusing specifically on objective evidentiary questions or sources of evidence.

Now, this may be in the past, research that's been done, evidence that currently exists. It may be evidence that might be gathered and presented in future. And we'd like for you to listen to the questions that others ask and let them inspire you to questions of your own.

And then we'll take a moment just to breathe deeply and reflect and then those questions collected will be passed on for later inquiry and use in a future conversation -- to design a future conversation.

So, I invite you to take a deep breath and what I'm going to ask you to do is to open your chat, if you would please. I'm going to open mine in this moment. And I'm going to ask you to type your questions into chat and when you type a question, I'll be tracking and that will be the way to queue you up. I'll see your name, I'll call your name, and I'll ask you to speak your question out loud, not a story about it, not background, not explanation of why. Simply read the question aloud and then we'll go to the next

person.

We're going to do this for about ten minutes. But, before we step into that, I'm going to give you just three minutes of quiet time to write on a piece of paper questions that you might want to ask, questions that you think that SACIMM should deal with in the future around the evidence base. So, three minutes starting now. Breathe deeply and collect your questions.

PAUL JARRIS: Could you put the charge back up, Ed?

EDWARD EHLINGER: Go to the previous slide.

GLENDA EOYANG: There we go. Thank you.

[Three-minute pause.]

BELINDA PETTIFORD: Glenda, do you want us to be sending our questions now or are we in this waiting period?

GLENDA EOYANG: You can -- you can either put them in now, or you can put them in later. That's fine. We'll be speaking them. We have about thirty seconds, and then we'll start

speaking them out. They'll come up in the same sequence regardless of whether you put in now or later.

EDWARD EHLINGER: And I understand there may be -- there may be some folks who don't want to ask any questions and have their name addressed to it. If you wanted to just send me a private chat, I can, you know, you know how to do that by just get me on there and since -- and it wouldn't be -- your name wouldn't be noted on the overall chat.

GLENDA EOYANG: And that will not be included in the final chat. So, if you prefer to send one anonymously, you can send it privately to Ed. Okay, thank you. That's our three minutes.

I'm going to make apologies ahead of time if I mispronounce names, but I will do my best. So, let's start with Jeanne Conry. Would you like to say your question, please?

JEANNE CONRY: Certainly. What is the impact of restricting access to abortion on maternal health and maternal mortality --

morbidity, mortality?

GLENDA EOYANG: Thank you. Janelle Palacios, please.

JANELLE PALACIOS: Sure. What are the socioeconomic effects of having access to abortion or not having access to abortion for women, families, communities, and populations?

GLENDA EOYANG: Thank you, and you have a second?

JANELLE PALACIOS: Yes, I do. I have -- I'm scrolling find it.

GLENDA EOYANG: I believe that the next one is what are the socioeconomic effects of not having access to abortion.

JANELLE PALACIOS: I tied that in. I tied that in. I have a third. What are the links between abortion and contraception access and use?

GLENDA EOYANG: Thank you. Jeanne Conry, I believe you have another.

JEANNE CONRY: I'm just standardizing the definition to the infant mortality. How is infant mortality defined? I understand the definition of

mortality between birth and one year. So we have agreement on a definition?

GLENDA EOYANG: Excellent. Thank you. Colleen Malloy, please. Colleen Malloy.

COLLEEN MALLOY: Yes. I just wrote why do women of color experience higher rates of abortion than other groups, but I just wanted to say like I kind of wanted to talk about preterm birth and how abortion fits into this. I don't know -- this seems like a different way to discuss this topic than we've discussed other things, but.

GLENDA EOYANG: It is -- it is different, and I wonder if you might be able to frame the question around that topic so that it will be available for later conversation.

COLLEEN MALLOY: Sure.

GLENDA EOYANG: That would be great. Thank you. Paul Wise.

PAUL WISE: Well, I'm not sure I'm following the rules here, so I apologize.

GLENDA EOYANG: That's okay.

PAUL WISE: I've built a career on doing

that. My question is, does anyone really feel that this process will immunize SACIMM from intense, likely lethal controversy, particularly if the less progressive Congress is elected in the mid-term?

GLENDA EOYANG: We are collecting questions. Tara Sander, please, Sander Lee.

TARA SANDER LEE: Yeah. So, my question is, what are the dangers to women in having an abortion and what are the risks to future pregnancies and impact on preterm birth?

GLENDA EOYANG: Thank you. Jeanne Conry.

JEANNE CONRY: Uh-oh. Let's see. How does the death of a mother impact the health of her family and community?

GLENDA EOYANG: Thank you. Janelle Palacios.

JANELLE PALACIOS: What are the links between abortion and contraception access and use?

GLENDA EOYANG: Thank you. Belinda Pettiford.

BELINDA PETTIFORD: What is the impact on

individuals and families related to abortion services access?

GLENDA EOYANG: Thank you. Steven Calvin.

STEVEN CALVIN: I'm muted. Do prior preterm or do prior pregnancy outcomes impact preterm birth risk?

GLENDA EOYANG: Thank you. Jeanne Conry.

JEANNE CONRY: Which poses a greater risk to a woman, abortion or carrying a pregnancy, and how do we define the types of risks?

GLENDA EOYANG: Thank you. Magda, and I'm sorry, I cannot see your last name.

MAGDA PECK: What is the impact of being denied or turned away from abortion for a woman and does it have subsequent impact on the health of her or her future children?

GLENDA EOYANG: Thank you. Jeanne Conry.

JEANNE CONRY: What is the evidence source?

GLENDA EOYANG: Thank you. Magda.

MAGDA PECK: Who gets to decide what's

evidence and what if we can't agree on the same set of facts here within SACIMM?

GLENDA EOYANG: Great question. Paul Jarris.

PAUL JARRIS: Yeah, I was in the interest of establishing the state of knowledge, I was wondering if MCH staff are available to really assist in formulating a literature search and then doing a comprehensive scientific research and import into that in response to, I think, the last question, that includes ranking the evidence and the quality of the studies so we can consider that, because I think we'll find a huge range of quality. So, I guess, you know, very time intensive, resource intensive. Can the MCH MC staff do that for us? MCHB staff.

GLENDA EOYANG: Thank you. Jeanne Conry.

JEANNE CONRY: Let's see. Uh-oh. Let me see where we are. What are the risks of abortion?

GLENDA EOYANG: Thank you. Colleen Malloy.

COLLEEN MALLOY: Hold on. I've got to --

I'd like to talk about -- can we talk about risks that lead to preterm birth, which can include various published factors, including history of surgical abortion?

GLENDA EOYANG: Thank you. Tara Sander.

TARA SANDER LEE: How does access to abortion help reduce infant mortality?

GLENDA EOYANG: Thank you. Janelle Palacios.

JANELLE PALACIOS: Over time, how has policy changes regarding abortion affected women, children, families, communities, and populations?

GLENDA EOYANG: Thank you. Magda, I believe your next. No?

MAGDA PECK: I think I already said mine.

GLENDA EOYANG: Yes, good. Thank you.

MAGDA PECK: I've got a new one I'm putting in.

GLENDA EOYANG: Okay.

MAGDA PECK: Should I just say it? Which is, how does our discussion and deliberation of SACIMM change, given our expanded duties to

address maternal mortality and morbidity? How has it changed now that we've shifted from an exclusive focus on infant health to a mandate to look at maternal health and morbidity?

GLENDA EOYANG: Thank you. Let's see. I believe -- oh.

UNIDENTIFIED FEMALE SPEAKER: I think Janelle was next.

GLENDA EOYANG: Yes, thank you. Janelle Palacios, please.

JANELLE PALACIOS: Oh, no. I said mine already.

GLENDA EOYANG: Okay, thanks. Paul Jarris, I believe is next.

PAUL JARRIS: Yeah. I think that my question is how and who makes the risk benefit decisions, yeah, given that any medical intervention has a risk and a benefit?

GLENDA EOYANG: Thank you. Magda.

MAGDA PECK: I already said it.

GLENDA EOYANG: All right. Thank you. And Jeanne.

JEANNE CONRY: How does global research impact United States understanding or interpretation of data?

GLENDA EOYANG: Thank you. Excellent. Thank you. I believe that that is the number. We should pause for just a moment. Is there anyone who has not had a chance to speak their question? Well, thank you. I appreciate that and I am now going to pass it back to Dr. Ed Ehlinger. And thank you for this, and I look forward to hearing how this conversation moves forward in the future.

EDWARD EHLINGER: Thank you, Glenda, and thank all of you who submitted questions. It's certainly a varying group of questions with wide ranging issues that we need to consider, and I particularly am cognizant of the risks of bringing this up and so, Paul Wise's question is a legitimate one, that that I debated back and forth or discussed back and forth with MCHB but that it is going to be part of the discussion that I hope to have.

So, what my plan is is to take all of

these questions -- and if there are other questions that come to mind, if you want to send them to me later that that's fine too -- and then I would like to have a small group of SACIMM members, both regular members, ex-officio members, and even work group members, come together. At least one or ideally two members from each of the work groups so we'd have a broad ranging group, to meet two or three times within the next two months to curate those questions that we've generated in this session and then recommend how we might put together a session on abortion and how that session should be framed and organized for our April meeting.

I would suggest people who might -- and then, I would hope that they might be able to take a life course perspective, not just for one individual event, but as we look at all of our issues related to life course, and if they come up with some recommendation on how we might be able to move forward, maybe they -- and have them suggest who might be able to review the data and

brief the Committee on the questions that are raised.

So, I want you to think about, would you be willing to participate in that kind of a meeting, two to three meetings within the next couple of months to curate the questions, have a discussion about how we might frame these questions, and put parameters on them and organize them for a session that we would have at our April meeting.

I'd like you to think about that and let me know if you're willing to participate sometime within the next week, and then I will get back to you about our next steps at that point in time.

TARA SANDER LEE: Can I ask a question, Ed?

EDWARD EHLINGER: Sure.

TARA SANDER LEE: I guess I'm just wondering why, if our work was brought forward that we wanted to present on this topic. Why is this becoming such a huge event to probe, you know, to come up with a program for the next

meeting? I guess, I don't -- I don't understand why this is becoming such a huge ordeal.

EDWARD EHLINGER: Well, abortion, as I said in my introductory comments, abortion is an issue that impacts maternal and infant health, and our charge is to look at issues affecting infant and maternal mortality. The question was raised by some members of our committee about the impact of certain procedures on preterm birth -- abortion procedures on preterm birth, and it seemed like we needed to have a broader conversation than just something focused on one specific issue related to the topic. So, that's why I decided that we should raise the questions, particularly given our expanded charter about infant maternal mortality, to have -- at least explore the possibilities of having a session to discuss them, and the power of questions, this power of inquiry was a nice way to bring up the questions that we might want to consider.

TARA SANDER LEE: I just, I respect you, Ed, and I respect this committee. I just have to

be honest, that we have not taken this approach with any other topic associated with infant or maternal mortality. We have not taken this approach. So, I -- I just -- I respectfully disagree that this is the best approach on how to handle this, so.

EDWARD EHLINGER: I hear you.

TARA SANDER LEE: But, with that said, I'd be more than happy to participate in however we go forward. So, I -- I would be happy to volunteer.

COLLEEN MALLOY: I mean, I kind of would just like to jump in because I have been talking to Ed for probably at least a year, if not more, about wanting to give a presentation on preterm birth as related to infant mortality and being a direct driver as such, and abortion was part of that, but the bigger topic was preterm birth, which, you know, we've been exposed to a lot of different factors related to infant mortality and then it was, you know, I don't remember ever voting on changing the name of the committee to

include maternal mortality as well. But that was -- a decision was made, so we accepted that. And I think that, you know, I don't think it's unreasonable to have a discussion on preterm birth as relates to infant mortality and maternal mortality and the fact that, because it includes a piece of abortion, this become a completely different approach, and we're going to pull other people and -- and, I mean, we had environmental discussions, we've had eviction discussions, we've had references to lots of different things that, you know, we're adults here, and I think if there's evidence to be presented and you started off today by saying, you know I just can't figure out why we can't make any improvement in this issue, you know, we're just befuddled. We have all these hopes and dreams, we want to help people, we want to make things better for people. And then, on the other hand, you have a group of people that are saying, well look, here's something that, you know, you might want to at least listen to this presentation, see what -- if

this makes a difference in the lives of families in America. No, we're going to instead like, you know, I've been put off for a long time, to be honest, and like I -- now it's going to be -- I mean, I don't understand. Like if those presentations that have been made throughout the entire time I've been on this committee, some of which I agree with and some which I don't, but at least I can be an adult and I can listen to what someone has to say in a respectful manner and let them present data that's been published in legitimate journals and have people, you know, come and speak to the group who had stories to tell. And I just -- it's very frustrating to me that somehow because this topic is abortion that somehow we're having like this totally different approach when all we want -- we didn't want to talk about anything other than, you know, published studies that looked at like the effects of abortion on women's lives and like I just, you know, there hasn't been this counterpoint approach to every other topic that we've done. And like,

to be honest, I wasn't -- no one who wanted to give a presentation on abortion. We were talking about preterm birth, but I think it's been kind of -- I listened to this -- even the discussion this morning that showed the data, which I don't know if it was presented by, I think, Stephanie Bustillo, and I thought, you know, this is interesting, like this is -- these are medical fact. Like, we keep being told oh, medical issues, that's not that important. It's all social determinants of health. But, at the same time, if you're saying why haven't we made progress in this area, and there's people saying, well, maybe there are some medical things that actually are important things to consider when it looks at infant mortality and maternal mortality, because if you haven't solved the puzzle, we're clearly missing some pieces. So, why can't we look at all the pieces?

EDWARD EHLINGER: All right. Well, I mean, this -- obviously, this is a controversial issue, it's a public health issue, trying to find

ways through the power of inquiry to find some way that we might be able to address it and stick to the scientific and objective data related to that. That's what I'm hoping that this little, small work group will decide whether we go ahead or not with our conversations. This seemed like an appropriate way to deal with a controversial issue, one of the more controversial we have in our society. One that we are confronted with as public health providers and clinical care providers all the time. So, that was just the decision that I made that we would use this technique of trying to see if we can't address an issue that is of concern in our society.

So, with that, I am going to leave it at that and hope you can, if you're interested in being on a committee, let me know and then within the next week and I will then get back to those who have volunteered, and we'll move forward with from that point on.

PAUL JARRIS: Ed, could I just say that, you know, when we were listening to Colleen and

Tara, and I can hear frustration, where you want to bring something forward and it sounds like perhaps you think that this is going to perhaps stall that or complicated it. But, let me tell you from my point of view, I'm -- in anticipation of this meeting, I got on and started looking at the literature to see what I could find and realized that I need to know a whole lot more, and I would like to have that knowledge before entering the conversation from an open-minded point of view. What do I need to know about this area? And that's what I was hoping, if we could get -- and I hope the MCHB staff to really do a good scientific literature review. Then we could all start a conversation with similar knowledge backgrounds, because this inherently is an area under which is under -- rides on top of values, which makes it, you know, much more than many other areas. It makes it a much more sensitive area, which to me, makes it that much more important to see what is valid literature out there about different procedures, their impact,

and because there are a number, and many other things, timing, and all that other stuff. So, I'm hoping that this can inform and result in a better conversation. I know at least it will allow me to participate in a more educated fashion if I know what's in the literature, because I don't.

EDWARD EHLINGER: Yeah, well, that's one of my goals. So, thank you for articulating that.

I also want to be sensitive to the fact that we have public comment, and I always want to make sure that we do that on time. So, Vanessa do we have public comment -- comments at this point in time?

PUBLIC COMMENT

VANESSA LEE: Sure, thank you. And we did not receive any written comments this time. We have one request for oral public comment. So, if LRG could help us unmute Dr. Jen Villavicencio. I hope I'm pronouncing your last name correct, and I apologize if I'm not. Dr. Villavicencio is the Lead for Equity Transformation at the American

College of Obstetrics and Gynecologists or ACOG.

JEN VILLAVICENCIO: Hi.

VANESSA LEE: Oh, great. We can hear you.

JEN VILLAVICENCIO: Am I able to get on camera or just do audio?

VANESSA LEE: Emma, do attendees have the ability to turn on camera? I'm not sure that we've done that in the past.

EMMA KELLY: If you allow it, one second, it will reenter you into Zoom.

JEN VILLAVICENCIO: There we go. Hello.

VANESSA LEE: Great, thank you.

JEN VILLAVICENCIO: Thank you all for allowing me to have a public comment. As was mentioned, my name is Dr. Jen Villavicencio. I'm the lead Equity Transformation at the American College of Obstetricians and Gynecologists, and I really thank you for the opportunity to offer these comments.

I'm a board-certified obstetrician gynecologist who provides comprehensive evidence-

based reproductive healthcare to my patients. That includes delivering babies, doing cancer screenings, prescribing contraception, as well as providing abortion care.

I understand that abortion can be a complex subject for many. It is often times a complex issue for many of my patients. What I hope to impart to you today is that abortion is a common, normal, and safe part of the reproductive lives of Americans and restricting abortion has dire consequences.

ACOG's statement of policy on abortion states unequivocally that induced abortion is an essential component of women's health care. It also states that, like all medical matters, decisions regarding abortion should be made by patients in consultation with their health care providers and without undue interference by outside parties.

An incredibly important part of caring for my patients is offering them compassionate and fact-based counseling, which includes ensuring

that each individual I care for is fully informed about the risks, benefits, and alternatives associated with the myriad medical procedures, including pregnancy termination.

I sit with each patient, discuss their individual situation, their individual health status, their particular concerns, and ensure that their consent is truly informed and personalized.

What's reassuring to so many of my patients is that abortion, both procedural and medication, is extremely safe. The science on the safety of abortion, both short and long term, impacts on mental and physical health is settled. I know that this committee is looking at the evidence and what I can tell you is that evidence is there, and it's settled.

This fact was reinforced recently by the National Academies of Sciences, Engineering, and Medicine in their 2018 consensus report titled The Safety and Quality of Abortion Care in the United States. This study was a comprehensive review of the state of the science on safety and quality of

abortion services in the US.

Before the advisory committee embarks on an evidence review and discussion on the impact of abortion on infant and maternal mortality, ACOG strongly recommends that the committee thoroughly review the conclusions of the National Academies study. For instance, the National Academies Consensus Study once again debunked pervasive myths and concluded that abortion does not increase the risk of secondary infertility, pregnancy-related hypertensive disorders, abnormal placentation, preterm birth and delivery, breast cancer, or mental health disorders.

Further and specific to the advisory committee's consideration of the impact of abortion on maternal mortality, the National Academies Consensus Study confirms that death associated with illegal abortion in the United States is an exceedingly rare event, and it is a small fraction of deaths associated with childbirth.

The study's review of the evidence also

found that the mortality is lower than that for other common medical procedures such as colonoscopies, dental procedures, and adult tonsillectomies. In fact, consensus study found that the biggest threats to the quality of abortion care in the United States are the unnecessary and burdensome government regulations that undermined evidence-based care that I try to provide to my patients every day.

These conclusions reinforced the advisory committee's time is best spent focusing on developing recommendations for the Secretary to address the pressing drivers of maternal and infant mortality, including addressing inequities in outcomes resulting from individual and systemic racism and social determinants of health.

Interestingly, we have excellent data from the groundbreaking turn-away study that demonstrates that women who are turned away and denied a needed abortion and went on to give birth, experience an increase in household poverty lasting at least four years, relative to those who

received their needed abortion.

Years after abortion denial, women were more likely to not have enough money to cover basic expenses like food, housing, and transportation. Additionally, being denied an abortion lowered a woman's credit score, increased a woman's amount of debt, and increased the number of negative public financial records, such as bankruptcy and evictions, which was previously talked at this committee meeting -- talked about this committee meeting.

This turn-away study also demonstrated the negative impacts of not being able to access an abortion on somebody's existing children. The majority of women seeking abortions are already mothers. The children women already have at the time they seek their abortions show worse child development when their mother is denied an abortion compared to the children of women who are able to receive their needed abortion. Children --

EDWARD EHLINGER: Can you wrap up your

presentation?

JEN VILLAVICENCIO: -- as a result of abortion denial are likely to live below the federal poverty level than children born from a subsequent pregnancy to women who received the abortion.

The science and evidence supporting the safety of abortion care in the United States is clear. The science about the impact on maternal health and impact of child welfare is settled.

As the committee considers its next steps, we strongly urge you to consider the negative impacts that legislative restrictions have on infant and maternal mortality as well as consider the wealth and multitude of data affirming the safety of abortion.

Thank you again for the opportunity to provide public comments on behalf of the American College of Obstetricians and Gynecologists. We hope you will continue to consider ACOG a trusted partner as you pursue the critical objectives of the advisory committee. Thank you.

VANESSA LEE: Thank you. And that concludes that. That was to the committee members, the only request to be had received for public comments. Thank you again, Dr. Villavicencio.

DISCUSSION AND NEXT STEPS

EDWARD EHLINGER: Thank you, Vanessa. Vanessa, before we just have some general conversation, maybe are there some -- first of all, public comment is public comment. It was not organized. I did not want to have to have any conversation. That was part of my working with MCHB that we would not discuss abortion at this topic, but just raise the question. So, I'm going to stick with that.

Vanessa, do you want to give us any updates from the administrative standpoint before we can do some closing conversations?

PAUL JARRIS: You're muted, Vanessa.

VANESSA LEE: Sorry about that. Thank you. I have a number of updates. I'm just

pulling up my notes to make sure I don't miss anything. But something since our last meeting in September as we've been discussing, the committee charter was renewed for another two years. You can see on the screen -- and Ed actually already went over this as part of the last session -- in italics and bold, you can see where some of the language has changed just so slightly. I think it shouldn't look too different from what you've already been doing and prioritizing if anything. I think the charter and the name change is actually just finally catching up to what the committee has been prioritizing and working on for the last I would say eighteen to twenty-four months.

So, Ed, as you were talking about changing the narrative, I really do think the charter reflects sort of these changes in narrative that we're seeing, again this tie between infant and maternal mortality, we've expanded to not only talk about programs but partnerships and policies, the health of women

before, during, and after pregnancy. It was you and others that it brought to our attention, we were missing tribal and territorial governmental efforts. So, we made sure to add that language in. It had just said federal, state, and local efforts. We've also -- we've always called out the Healthy Start Program and Healthy People 2030. just wanted to let you know we've also called out Title V, the state block grants for maternal and child health, and then also looking for your advice on how to influence similar efforts in the private and voluntary sectors.

And then finally, based on again a lot of the work that the committee has been doing over the last several years, we just wanted to formalize it and put it into the charter that you are to look at factors beyond just medical healthcare, as you guys have already been doing, looking at those policies and programs, resources and systems level changes pertaining to factors that are in the environment, social factors, economic factors. So, again, all the work that

you've been doing over the last few years just finally kind of getting it into the charter as your official sort of charge, scope, and description of duties. And then, as we've talked about, the name change, again just sort of catching up with where you've already been going with the committee's work.

So, that's the charter. Thank you, Emma, for pulling that up.

We also were just informed that the committee by-laws have been approved by HRSA. So, after this meeting, we'll be sure to share copy with all of you and include it in the next briefing book.

Just a quick update. We've been, as you know, working to bring on new members. We have about eleven vacancies on the committee right now. And so, we do anticipate being able to appoint about eight to nine more members by the next meeting. And speaking of the next two meetings, we are in the planning for those. As Ed shared, we are exploring the possibility of an off-site,

in-person meeting in April and the dates we're looking at are April 5th, 6th, and 7th. So, if you guys could jot those down and just take a look on your calendars. We hope that will work for the majority of all of you, again looking at a three-day meeting this time, and it would be Tuesday, April 5th through Thursday, April 7th. So, the 5th, 6th, and 7th of April.

TARA SANDER LEE: Would those be full days? Sorry to interrupt you. I was wondering just for planning purposes. Are those going to be full days, like there's no hope of travel on those days? Like, we'd have to travel the day before and the day after?

VANESSA LEE: No. that's a good question. I think, typically the last day ends early enough that folks can travel home that same day. I know it's tough to spend another night when the meeting is done. So, I think, in the past -- and Ed, you've seen, I think or many of you have been part of a lot of the in-person meetings. It's been a few years since we've held

them. I think people typically travel in the night before the meeting starts and then again get to leave on that last day, we ended earlier. So, it would not be full, full days on day one or day three probably.

MAGDA PECK: Vanessa, is there a hybrid option?

VANESSA LEE: Yes. I think we would have to still --

MAGDA PECK: Because I -- and what are -- and what are your contingencies? It's just -- I just want to recognize something that's been involved in the City Match and the National MCHB and Epidemiology meetings slated to be in New Orleans there in spirit with the pandemic persisting. I just -- can you give us any sense of by when you would make the decision if we blocked these three days, if it went to either not in-person or would it be the same amount of time? How are you thinking about that?

VANESSA LEE: Yeah, and I'll let Lee speak to the, you know, timing of when we might

know sort of HHS policy around in-person meetings or any changes that might come from that. But even if we were to hold this meeting in person, we would still offer the virtual component -- our participation virtually through Zoom because we do have to make -- as Federal Advisory Committee meetings, the -- all of our meetings accessible to the public. So, several of you will remember, even when we held these meetings in our HRSA Park One Building, we always had the Adobe Connect running so that people could participate virtually. So, we will definitely make that an option, even if we do hold the meetings in person.

In terms of when we might be able to make a decision on whether we will go virtual -- fully virtual or try for in-person, and if the dates will be impacted by that, Lee or Dr. ___, do you have any sense of that?

LEE WILSON: Let me -- let me jump in here. Magda, great question, thank you. Three weeks ago when we were really deep in the weeds of talking through some of this, we were absolutely

certain that March would be a reasonable date for us to have an in-person meeting. So, cancellation is always going to be an option in this environment, it seems. We are hoping to get a better sense over the next few weeks to see whether or not the omicron variant is changing what government policy is and if there's a sense that that policy will be sort of long lasting. But that, you know, that is a crystal ball approach here that we don't know. We are intent, just as background, for these discussions about this next in-person meeting. I don't want to go into too many details because we're still in the discussion and approval stages. But the goal here is to make this next meeting a very experiential meeting. So, it would be in person, but it would not be -- the ideal would not be to do it in DC. So, some of that will also -- some of the travel arrangements would also be contingent on the site. That being said, as a backup we have already reserved the space in Washington as option two and then option three would be virtual. We will be

exploring the arrangements for travel and the meeting beginning probably in January, just because everything is still very much up in the air, and we will keep you posted on our steps at this point. But we want -- did want to give you the opportunity to weigh in on whether those days were going to work for you, since we had promised that we were going to be surveying you before final decisions and to see whether there were, at this point, any real obstacles. So, thank you.

EDWARD EHLINGER: Yeah, and if we don't do an on-site meeting outside of Washington, we would probably go from three days to two days, because the third day is really one of community meetings, getting community input on the issues that we're talking about. So, that would be the one difference.

MAGDA PECK: I will note that it is during National Public Health Week for those of us who come from a public health perspective that may or may not be of relevance. And it's also -- April 7th is World Health Day, Jeanne, so as you

try to bring in global perspectives, I just acknowledge it. As Ed always knows, there's always something else to mark that's going on.

BELINDA PETTIFORD: That is also the date that the Maternal Health Learning and Innovation Center, the same week they asked us to hold the date for their meeting. So, but you're right, there's always going to be a conflict. But I would really hate to conflict with maternal health again.

MAGDA PECK: That would again be ironic, but not surprising.

VANESSA LEE: Thank you all for that. We will note all of this. The meeting after the April one that we envisioned was -- would occur in early June, so we are still looking at dates on this end that we could throw out to you as options. But again, hoping that next meeting after the April one would be early June, just to catch all of you, the members that have terms that will end either in June or July of next year. Again, we just want one more meeting with you and

Ed, did you want to talk a little bit about your vision for the June meeting?

EDWARD EHLINGER: Well, the goal is to come up -- what -- if we have some recommendations that we want to move forward, particularly in the area of indigenous health, I want to kind of finalize those in June, so we would send something off as -- with the group that we have. So, that -- between now and June, we would want to work on any recommendations that might come forward, for example, the race concordant care recommendations, which I hope to talk about at our April meeting. We'd try to talk those through and then finalize them in June to forward to the Secretary.

VANESSA LEE: Right. Great, thank you.

EDWARD EHLINGER: Yeah, I also -- I hope, we'll have new members on in April, so that we can then start to sort of having a hand-off, a warm hand-off to the next group of MCH leaders that will be working at SACIMM, and we'll have two meetings to do that.

VANESSA LEE: Great, yep. And we really

do hope by the June meeting, we can convene everyone in person, and in that case, it would be at our HRSA offices, the Park One building in Rockville.

There was a question about ethics review, especially for members that are going to be rolling off next summer. We did find out from our HRSA Ethics Team that this is an annual filing, and it occurs, now, at the same time for everyone, regardless of your start date on the committee. So, the annual deadline is always May of every year. And so, in order to participate in that June meeting, we would --

MAGDA PECK: Vanessa, you're on mute.

VANESSA LEE: I am so sorry. I thought I unmuted myself. I was -- actually, Magda, this was about a question you had at the last meeting for those who may be rolling off next summer, which you have to complete an ethics review again, and unfortunately, we found out it is every May. So, in order to participate in that June meeting we're talking about, we would need everyone to do

their usual ethics filing and review in May of next year again just to be cleared by the June meeting that we hope all of you will be able to participate in before your term ends. So, I did just want to get back to you all on that.

And then, the last --

MAGDA PECK: And Ed, could you --

VANESSA LEE: Go ahead.

MAGDA PECK: I'm sorry. And Ed, could you also imagine that there -- there could be something forthcoming cumulative from immigration or from COVID or from housing? Do we still have an opportunity perhaps to bundle recommendations that might be opportune, with the June transition time?

EDWARD EHLINGER: Yes, of course, I mean that's -- that's the last chance of this current group of SACIMM members to come forward with recommendation that I hope we would have the work done prior to June, so that we could finalize them in June and send them on. So, between now and, you know, with one more meeting in between that,

their work needs to be done and anything that people like might like to move forward in terms of recommendations.

MAGDA PECK: And I would just add process-wise that if you know who -- Vanessa, we don't know, and I don't know when we would know who the new eight to 10 people are. One way to get folks involved early is to have them join one of our working groups. And so, I think the idea of the transitions not waiting until we're on site, but potentially engage people when you're able to reveal that mystery to us, because it remains a mystery, that would be very helpful, so that we can both get them involved in the work aligned with where their greatest interests and capacity and impact can be had, particularly in the Data and Research to Action Working Group, we're always looking for folks who want to further that aspect.

EDWARD EHLINGER: So, what my plan is is once I get the names of these folks, I will try to do one-on-one interviews with them, just like I

did with all of you and to orient them to the committee and the work that is being done and see how they want to use their talents and skills and interests, working through and being members of the work group would be part of that.

VANESSA LEE: Okay, thank you, yes. And then, speaking of members and sort of changes, I did want to share some staffing updates for the next six months or so. So, I will actually be going out on maternity leave in early January. So, this will be, unfortunately, my last meeting with all of you, until the June one, and then I'll be back. But, in my absence, Lee Wilson is going to serve as the acting DFO. You'll continue, of course, to get support from our logistics contractor team at LRG, our management analyst Michelle Loh, but I also want to introduce you to two new members of our ACIMM team at MCHB that are going to be stepping in much more, especially, while I'm on maternity leave. So, Ann Leach, I don't know if you're able to go off camera and say hello, but she's our MCHB colleague who's actually

done a lot of work behind the scenes with several of our advisory committees out of MCHB. She's going to be stepping in for a few months as the program lead and working closely with Lee. And then, many of you knew Julian de Stefano who served as the contracting officer's representative or core for the logistics contract and supported ACIMM in a number of ways. She retired in August, but I'm happy to announce that my colleague Abigail Duchatelier- Jeudy is on the line, and she's going to be the core for the ACIMM contract and so you'll probably hear from her time to time, or at least see her on these committee meetings.

Lee or anyone else, is there anything that I missed before I turn it over to Ed?

LEE WILSON: Yes. Since you're making the big reveal today, congratulations to you, Vanessa, on the planning and all that goes into having a safe and healthy delivery. You've been doing a great job and holding it together as you get close to going out on maternity leave. And so many, many thanks for your attention to detail,

your thoroughness, and always pleasant professional approach to managing this committee. So, thank you very much.

VANESSA LEE: Thank you.

EDWARD EHLINGER: I certainly second that heartily.

VANESSA LEE: Thank you. Thanks. I'm getting some kind notes in the chat. So, thank you all so much. Okay. I think that's all the updates and announcements I had, Ed. So, I'll turn it over to you for other next steps or discussion.

EDWARD EHLINGER: All right. Well, you know, we've got about twenty minutes left, and I don't think we have to go to that time. But I'm going to, you know, end up by just having you all kind of go around and any takeaways that you have from this -- the meeting that we've had over the last couple of days. But I do want to highlight the fact that at our next meeting, we certainly are going to continue on with the health of indigenous mothers and infants. So, we're going

to, I hope, come up with some recommendations. We will be doing a review of the race concordant care recommendations that that came forward. Whether or not we go ahead with a session related to the impact of abortion on infant and maternal mortality will depend on what the conversations occur in that small group. There is one other issue that has been raised in the past that we haven't addressed, and that's the impact of violence on infant and maternal mortality, and I'd be interested if anybody else would like to see that as part of a session because it is -- violence is one of the -- a leading cause, not the leading cause, but a leading cause of maternal mortality and I think has some impact on infant mortality and we've not addressed that much in our times.

And then I also asked that through the work groups, if there are other issues that you would like to consider for the next meeting, you know, bring them up through the work group.

So, those are -- that's sort of my

planning for the next session and, as I said, I hope to be contacting the new members and getting their interests and have them get engaged and hit the ground running when we meet in April.

So, with that, I just would to go around and to get some final takeaways from the last two days from you in the last fifteen minutes that we have. And I will again go counterclockwise-- counterclockwise on my screen and I, Magda, you're in my upper left-hand corner. So, any takeaways that you have.

MAGDA PECK: Thank you, Ed, for organizing a very strong meeting. Thank you to HRSA and MCHB for back boning this. Thank you to contractors and thanks to my colleagues for bringing their best forward. So, the process is always one which takes a lot of work and I'm incredibly impressed and grateful for the quality of the presentations. Every one of them was high caliber from the clinical side to the public health side to the larger intersectoral side. My takeaway quote is eviction policy is health policy

and that we have an extraordinary opportunity to hang at the intersection of health and housing in a way that can look directly at reducing risks of adverse outcomes for mothers and infants and birthing people. So, thank you for inviting that session and I hope it is not a one-off, as Dr. Cho hoped it is not either. Thank you all, colleagues.

EDWARD EHLINGER: Colleen Malloy.

COLLEEN MALLOY: Yeah. Thank you for the meeting. I appreciate all the presentations and hopefully look forward to more in the future. Congratulations on Vanessa's baby. I think it's apropos that we celebrate pregnancy and celebrate babies. So, that's the whole reason why I'm part of this committee is to keep the babies at the forefront and happy American families. So, thank you.

EDWARD EHLINGER: Paul Wise.

PAUL WISE: First, I want to convey gratitude to you, Ed, and to MCHB not only for making sure that our meetings are productive, but

also for everything MCHB is doing with the current challenges. My hope is that we can develop strategic coherence that would amplify the work of this committee in public discourse. I think the focus on indigenous health was very important today, and I look forward to continuing to elevate those issues and create a coherent narrative that would, in fact, elevate these issues in a public sphere. So, thank you.

EDWARD EHLINGER: Thank you. Steve Calvin.

STEVEN CALVIN: Hi. I also enjoyed all the presentations. I particularly enjoyed the indigenous care things because of my ties to Arizona, just knowing what's going on there. I'm also grateful to, I think, thanks Paul Jarris for articulating, I think, what I feel about this, you know, very hot button topic, and I should say, Ed, I'm happy about the way that this was launched, the discussion, because I think just laying out questions and then putting a pathway together to just, you know, figure out where the evidence is.

I would greatly appreciate, you know, Wanda Barfield and Alison's Cernich's involvement or anybody else from the from the government angle. I'm just looking forward to a discussion of evidence.

EDWARD EHLINGER: Great. Thanks, Steve. Paul Jarris. Unmute.

PAUL JARRIS: That was all the part about you, Ed. I guess I have to keep going. No, thanks, Ed, for, you know, all your thought and putting us together because I know you put a lot of time and effort into it, and of course Hear Her quotes. Also, Vanessa, congratulations. I think number three now? Two, okay. Two for now. Well, good luck and congratulations. And Lee, thank you, also and Michael. Good conversation, excellent presentations, and I look forward to the remaining few meetings while I'm on the committee, and I think it would be wonderful to meet on Indian country and have an experiential meeting. That would be eye-opening for all of us. Thank you.

EDWARD EHLINGER: That's my hope, too. Janelle.

JANELLE PALACIOS: Thank you. I hear a little one. You don't have to shush the baby. I, of course, am very honored and privileged to be here at this table with you all. You all have a lot of expertise and just being able to peek inside of your brains as you chat and the people that you bring forward for presentations has always like really grown my understanding of a number of issues, but also allowing me a space to be here with you has been very, very -- it's been a place that not very many people are able to be at in this definitely from my background, my position. So, thank you and Ed has been a wonderful steward through all of this. I really enjoy having Ed as the leader of this and I know he likes to call himself the acting chair and he is like definitely the chair, is not the acting chair, but he is the soul of this cart.

I would like to say that the parting kind of like over the past two days what I'm left with

increasingly is similar to what Elliot -- Dr. Elliot Main said yesterday. He shared that throughout all this time that he's done his work in perinatal health and looking at disparities, race, ethnicity is just a marker for what we're really trying to get at. We're trying to get experiences and just if I could reference Dr. Seuss, who had the star bellied snitches, I think, sneetches, we have visual representation that calls out difference and we use that and that is what is represent -- that is what has manifested in our current outcomes. I think that is what I am taking away from this. So, I'm looking farther down the future, an issue that was brought up today a little bit, I don't know if you have noticed that Alida Montiel shared with you that she is indigenous. She is, you know, from Arizona, from her community Pascua Yaqui, but that is a community that has been crossed by the border that we adhere to them -- the US Mexico border. So, she is Pascua Yaqui, but she's also Mexicana. She's Mexican as well. And so, we have these dual

identities and that when we look at Native populations and knowing the historical context for just marginalizing these people and then further abusing them in their identity that largely, we have to look at this as a community-wide issue. What is the health of our nation, if not the health of our community? And maternal infant is a big marker for that, which is why we have lagged so far behind in these industrialized -- when we're compared to our industrialized neighbors.

So, the parting kind of like overtone that I have come from this is that we are a community, and we have to start taking care of each other as one.

EDWARD EHLINGER: Grandma Conry.

JEANNE CONRY: Thank you. I've got her kind of asleep now. Ed, first of all, thank you to how you really manage to begin the meetings with a fabulous perspective summarizing and just kind of helping direct us and then do the same thing with closure. You really do a wonderful job.

I wanted to go back to September, when it was World Patient Safety Day. Respectful care is the center of our sphere of influence and understanding. So, it's respect for our patients, our colleagues, and collaborators and I feel like this meeting, with all the talks, everybody's perspective was really about respectful care, respect at so many different levels, and I really appreciated how important that was.

Vanessa, congratulations to you. I'm excited and we look forward to baby pictures. Ed, I appreciate the life course perspective. Maternal Child Health Bureau has done a fabulous job really advocating for the life course perspective, and I think that has to be how we go forward. It affects everything. And I always say that when we invest in the health of women, we invest in the health of mothers, we're investing in our current generation and future generations. So, although we have started with infant mortality, I know that the reason that I was brought on at the start of this was a perspective

for how investing in moms impacted infant mortality, and I believe we've heard that in many different ways.

And finally, I'm delighted that we were able to get Elliot here because he's been such a guiding light for so many years, starting with California, but across the United States.

And final note, violence would be a really important topic. We've got a lot of research that shows, you know, we screen for diabetes, yet violence is more common in pregnancy. So, why aren't we screening are doing more? Thank you.

EDWARD EHLINGER: Thank you, Jeanne. Tara Sander Lee.

TARA SANDER LEE: Thank you. I just, yes, I share congratulations. Congratulations to you, Vanessa. So excited for you and just Godspeed to you in the -- in the days and months ahead.

I just I -- I want to thank everybody. I know that everybody's work -- is working very

hard. Ed, I know that there's a lot of behind the scenes work that you do in addition to what we do not. You know, what we don't see and what we do see. So, I know you're doing a lot of work, and we thank you for your leadership. I thank everybody that coordinated the excellent sessions and topics that we discussed. I thought that this was a really good representation of the committee this session. I thought we heard from all the different work groups. So, I hope that that is what we see in future meetings, because I really greatly appreciated moderating the session. I hope that I get more opportunities to do so. You know, the session that I moderated, I think there really is a serious need for improving access to fetal interventions that will decrease infant mortality and that we need to put some serious focus into these birth defects but also recognizing that we need to minimize the risk to the mothers.

So, I look forward to future discussions and I look forward to future meetings and bringing

on more team members, too because I think that's just going to make our discussions richer and just make sure that we are all encompassing. So, thank you.

EDWARD EHLINGER: Thank you. Belinda.

BELINDA PETTIFORD: Hello, everyone. I also would like to join in what everyone else said, Ed, and thanking you for your leadership. You know, this is -- these are not easy meetings to put together. You do an excellent job of keeping us focused and working behind the scenes to make sure that it all comes together, and it looks like we are back together and did an excellent job planning when much of it was you behind the scenes. And then the leadership that you provide once the meeting starts. Greatly appreciate that, as well as the work of MCHB, Ms. Vanessa Lee, Michael, anyone that's working on the effort. I do think this was a wonderful meeting. I enjoyed all of the topic areas. I mean, I could connect easily to all of the topic areas, to work we're doing here my own state. As Janelle knows,

I have put up -- I put a copy in the mail to her our North Carolina Medical Journal that was just released week, our sole journal this year -- this month is on the health of American Indian populations in North Carolina. We have thirteen tribes in North Carolina, one federally recognized, one trying to get federally recognized. So, I definitely enjoyed the session on indigenous populations.

But, as Janelle put in the chat earlier and then Magda reiterated, I think the area that I was really focused and excited on was the health -- housing policy is a health policy, and I really think we need to really do what we can to make sure that we're improving our messaging on that and people see the connection to it. We talk about it, but we need to make sure that all of us see that connection, and I thought it was an excellent session, as all of them were.

So, I hope each and every one of you get to continue to enjoy this holiday season. It's good to be with everyone for two days.

EDWARD EHLINGER: Okay. Dr. Warren.

MICHAEL WARREN: Thank you. I want to first start out sharing congratulations also to Vanessa. We're so fortunate to have her on our team and while Vanessa is out, we will be sharing a publication that she co-authored along with other folks on our MCHB team, a perspectives piece in pediatrics on accelerating equity and infant mortality, specifically calling out the need to address racial equity. So, congratulations, Vanessa, on that.

I also want to thank all of you for your contributions. You know, one of the charges of this committee is to advise the department and you do that, in many ways. One of the ways, as you saw with your recommendations, doing that formally but you also do that informally, and as we anticipate the FY-22 budget, as we anticipate the provisions in Build Back Better, there are lots of provisions for MCH work and your conversations over the past few days have been really helpful as we think about how we formulate those programs and

moving that work forward. I think the presentations were incredibly thoughtful and well organized and I appreciate our committee members leading those. It was maybe the -- I won't say the best because I don't want to put down the other meetings -- but, really, really a fantastic set of presentations. So, thank you all, I hope you all have a wonderful and healthy holiday season.

EDWARD EHLINGER: Thank you. Dr. Barfield.

WANDA BARFIELD: Yes. So, I just want to say many thanks to the committee. The amount of effort and hard work that goes into pulling the meetings together is really impressive. But what's also incredibly impressive has been the work of the subcommittee. So, particularly the work led by Magda Peck and all of the issues around data, as well as really the opportunity to hear from all these fabulous speakers and just I also want to acknowledge the incredible work that the team at MCHB does to really prepare, you know.

Helping to support a federal advisory committee takes a lot of effort and input and it's really great to see how well they are supporting this group of incredible members.

And, as Michael was saying, you know, 2022 will be a very interesting year. It's going to be an incredible opportunity. We hope to see some of the work and the effort of supporting maternal health come to fruition, and we will still need the committee's input in terms of getting, you know, really learning about these opportunities.

And lastly, I appreciate Janelle's comments on the sneetches. That's been the best demonstration of racial differences, because if you look at the story, the difference is only a star. We'll always find differences, unfortunately.

EDWARD EHLINGER: Great. Thank you, Wanda. Lee.

LEE WILSON: Thank you, folks. I'll be brief. I appreciate the hard work that went into

this meeting and the real thoughtfulness that has gone into trying to make sure that these meetings over time are relevant and can produce good recommendations for us as a group, and as the circles move out, ultimately to the Secretary and to the department for the way we -- for the way we operate and address maternal and infant health.

I do want to leave the group with one thought, and that is that Glenda, when she was here last time, brought up the idea of wicked problems, and those are the problems that are generally unsolvable because of a lot of complications that we not necessarily or aren't necessarily able to get over. I see my charge here in working with all of you is to try to make sure that it is a safe place to discuss some of those issues, and from my work with each and every one of you, I have observed each of you trying to make it in it as accommodating a place as possible for these wicked issues to be discussed. And so, where it might feel like there are slights or difficulties or lack of attention, I'd like to

believe that none of that is -- that none of that is deliberate, and that we are all trying to get to the issues to have clear, accurate evidence-informed recommendations. And so, Ed, I want to thank you for your deliberate and hard work at getting us to this place, even if not everybody maybe feels like it was handled as directly as it might be, I think, the intention is to try to make sure that it's safe and comfortable and we're addressing things that we actually have the ability to influence. So, I encourage you all to work with the group in that spirit and I thank you for the opportunity to be here with all of you.

EDWARD EHLINGER: Thank you. And Vanessa Lee, do you want any comments -- closing comments from you?

VANESSA LEE: Just, as always, I'm so appreciative of you, Ed, and all of those on the committee and our ex-officio members. I learn so much from all of you at each meeting and, as others have said, it just seems to get better and better. But it's not just professionally but, as

you all know, know personally, you know I learned a lot as going through a second pregnancy, I'm actually about to meet with our doula. So, again, I take in everything I hear and learn from all of you at these meetings and try to again apply professionally but also personally lately. And I just want to thank you for the hard work you do in between the meetings, and of course over these last two days. As Lee and Dr. Warren said, we take it all in and try to weave it into our everyday work. So, again, just really appreciative and grateful for all of you. Thank you.

EDWARD EHLINGER: And thank you for your work. Are there any other ex-officio members who would like to have a closing thought that I haven't -- I don't see any on the video. So, any Ex-Officios that want to say a closing word?

All right. If not, I always learn so much from these meetings. I appreciate working with you. I love the perspectives that you all bring to the table. So, I'm not going to close

with any, you know, particular inspiring words from myself. But next week is solstice. The light is going to return. We are going to get increasing light. So, stay with that. And also, regardless of your religious background or no religious background, whether you believe in Christmas or not, or whatever, no matter what, you're going to be inundated with Christmas music. I mean, you can't get away from it. It is everywhere, and there is one Johnny Mathis song that I, you know, I just want to leave you with just parts of that. It says a silent wish sails the seven seas, the winds of change whisper in the trees, and the walls of doubt crumble tossed and torn. This comes to pass when a child is born. All this happens because the world is waiting -- waiting for a child of whatever color, but a child that will grow up and turn tears to laughter, hate to love, war to peace, and everyone to everyone's neighbor, and misery and suffering will be words to be forgotten forever. It's all a dream, an illusion now. It must come true sometime soon,

somehow. All across this land, dawn's a brand-new morn, this comes to pass, when a child is born.

Every child is that child. Every child will change the world. Every child brings hope. Every child brings our future forward. Every child moves history forward. So, the work that we do is for every child that is born that will make that wish come true.

So, have a happy holiday season, have a happy solstice, and may we get together again with increasing light in the new year. So, have a good rest of the day.

TARA SANDER LEE: Merry Christmas, everyone.

[Whereupon the meeting was adjourned.]