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THE SECRETARY'S ADVISORY COMMITTEE ON
INFANT AND MATERNAL MORTALITY
UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES

December 7, 2022
11:00 a.m. - 6:00 p.m. EST

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1 Ed Ehlinger: Thank you Vanessa, and good morning, everyone. I
2 bring you greetings from Minnesota. As you know,
3 the last time we were together was in September,
4 Minnesota, the land of cloudy waters or clouds on
5 the water. And right now, it is Minnesota since
6 we are having a nice little beautiful snowfall
7 that I can see outside my window. So it is nice
8 to be here in the land of the Ojibwe in Dakota
9 people, the ancestral lands. It is really good to
10 see you on this December 7th, 2022. December 7th,
11 a day that will live in infamy. And depending on
12 one's perspective, there are multiple days that
13 could live in infamy. Given the topic today,
14 October 12th, 1492 could be one of those days
15 that would live in infamy.

16 But particularly relevant to our topic today and
17 with the United States, there's three days right
18 around this time, on December 8th, 1829,
19 President Jackson in his first State of the Union
20 address stated his goal of moving all Indians out
21 of the Southeast, the United States, to the West
22 of the Mississippi. And then six months later, he

1 actually signed the Indian Removal Act, May 30th,
2 1830. Then on December 6th, 1830, President
3 Jackson gave his approval for the removal of the
4 Cherokees. He signed off on that on an executive
5 order. And then on December 7th, today, in
6 history in 1831, the removal process began with
7 the Southeast United States moving folks West of
8 the Mississippi. So, lots of days that could live
9 in infamy.

10 So December 7th, 1941, when Pearl Harbor was
11 bombed, a day that live in infamy, but it was
12 also the start of something. It was the start of
13 the pushback against fascism and totalitarianism
14 and efforts to help people eventually. It took a
15 little while to keep people from being killed, to
16 address the genocide that was going on. So
17 bombing of Pearl Harbor, a day that was living
18 infamy, but it was a stimulus for action. And so,
19 I'm hoping that our report that's coming out
20 today, that's going to be approved today, will be
21 that next step. It'll be that first step to
22 address the infamy that has happened prior to

1 now, that it is one of the steps to move us
2 forward to address the issues that are really
3 moving forward. So that's what I'm hoping today.
4 And so, I come to this meeting with bittersweet
5 mixed feelings.

6 It's the last meeting that I'm having of several
7 members and last time I'm chair. But instead of
8 focusing on the sad part, I think there's some
9 sweetness in this, is that we're going to be
10 culminating four years of effort with I think a
11 really, really good report that I'm really,
12 really excited to discuss and move forward
13 because I think it actually move us forward. But
14 before we get to that, let's do some
15 introductions. I introduce myself as Ed Ehlinger.
16 I'm the acting chair from Minnesota. And so let
17 us go around and introduce yourself, so we know
18 who's here. And I'll just call Sherri Alderman.
19 Introduce yourself please.

20 Sherri Alderman: Good morning everyone. My name is Sherri
21 Alderman. I am by training a developmental
22 behavioral pediatrician and am located in Oregon.

1 Ed Ehlinger: Good. Steve Calvin.

2 Steve Calvin: Hi. Steve Calvin. I'm a maternal fetal medicine
3 specialist and I work with midwives at the
4 Minnesota Birth Center in Minnesota.

5 Ed Ehlinger: Good. Charlene Collier.

6 Charlene Collier: Good morning, everyone. I'm Charlene
7 Collier. I'm a general OB-GYN, in Jackson,
8 Mississippi. Good to see everyone.

9 Ed Ehlinger: Tara Sander Lee.

10 Tara Sander Lee: Good morning, everybody. I'm a scientist by
11 training with expertise in pediatric development
12 and disease. And I am currently the Senior Fellow
13 and Director of Life Sciences at the Charlotte
14 Lozier Institute. And I reside in my home state
15 of Wisconsin.

16 Ed Ehlinger: Good. And is Colleen Malloy on? I don't see her
17 name.

18 Vanessa Lee: Ed, sorry, she was unable to make it. So
19 September was going to be her last meeting.

1 Ed Ehlinger: Okay. Kate Menard. Kathryn Menard.

2 Kathryn Menard: Hi. I'm first Kate Menard. I am a maternal-
3 fetal medicine specialist. I'm based in North
4 Carolina at the University of North Carolina
5 Chapel Hill.

6 Ed Ehlinger: Go Tar Heels. Joy Neyhart.

7 Joy Neyhart: I am trying to get my technology going. Good
8 morning. I'm Joy Neyhart, a pediatrician working
9 in Juneau, Alaska. I've been here for 20
10 something years. And most recently have been
11 working with the Southeast Alaska Regional Health
12 Consortium, which is our local tribal health
13 healthcare entity. Happy to be here.

14 Ed Ehlinger: And I hope you didn't sign on at six o'clock your
15 time.

16 Joy Neyhart: Seven.

17 Ed Ehlinger: Good. Good. Janelle Palacios.

18 Janelle Palacios: Good morning, everyone. I'm coming to you
19 from the ancestral Pomo and Miwok lands in

1 Northern California. And I'm Janelle Palacios.
2 I'm Salish and Kootenai. I'm a nurse midwife. And
3 I work in the Bay Area. I'm also a researcher and
4 a consultant. Great to see everyone.

5 Ed Ehlinger: And Magda Peck.

6 Magda Peck: Good morning colleagues. My name is Magda Peck. I
7 woke this morning in Richmond, California, the
8 ancestral lands of the Ohlone peoples. I work as
9 a public health scientist, strategist, and
10 storyteller for social change and health equity.
11 And I am delighted to have served on SACIMM and
12 also become bittersweet that this is the ending
13 and beginnings.

14 Ed Ehlinger: Belinda Pettiford.

15 Belinda Pettiford: Good morning, everyone. I am Belinda
16 Pettiford. I'm also in North Carolina with our
17 state Title Five program. I'm head of Women
18 Infant and Community Wellness. So, it's good to
19 see everyone.

20 Ed Ehlinger: Good. Marie Elizabeth Ramas.

1 Marie-Elizabeth Ramas: Good day everybody. This is Marie
2 Ramas, family physician, calling in from New
3 Hampshire. Practicing family physician, have
4 practiced full spectrum family medicine for over
5 a decade. I'm Commissioner in the Academy of
6 Family Physicians Health of the Public and
7 Sciences Commission. And currently I'm part of
8 the New Hampshire Governor's State Health
9 Assessment, State Health Improvement Plan,
10 particularly with the focus on equity. So thank
11 you so much for the time here. I'm looking
12 forward to an active session today.

13 Ed Ehlinger: Good. Phyllis Sharps.

14 Phyllis Sharps: Good morning. I'm Phyllis Sharps, professor
15 emerita of John Hopkins University School of
16 Nursing. And I'm coming to you from just outside
17 of Baltimore, Maryland.

18 Ed Ehlinger: Good. Sharonda Thompson. Sharonda Thompson.

19 ShaRhonda Thompson: Hello, I'm Sharonda Thompson. I am a
20 community leader and I am calling from St. Louis,
21 Missouri.

1 Ed Ehlinger: Good. Jacob Warren.

2 Jacob Warren: Hi everyone. My name is Jacob Warren. I'm an
3 epidemiologist by training. I'm Dean of the
4 College of Health Sciences at the University of
5 Wyoming. Coming to you from Laramie, which is on
6 the ancestral and traditional lands at the
7 Cheyenne, Arapaho, Crow, and Shoshone.

8 Ed Ehlinger: Good. Well, welcome to all of the appointed
9 members. And now we have the Ex-Officio Members.
10 And I'm just going to ask the Ex-Officios to jump
11 in popcorn style because I'm not sure all of
12 who's here and I don't want to miss anybody. So,
13 all of the Ex-Officios jump in and introduce
14 yourself.

15 Lee Wilson: Good morning. This is Lee Wilson. First, my
16 position is Director of Division of Healthy Start
17 and Perinatal Services in the Maternal and Child
18 Health Bureau at HRSA. All of you know me from
19 our past work and my filling in as the acting
20 designated federal official. Today my role is
21 serving in proxy for Dr. Michael Warren, who is

1 the Director of the associated administrator for
2 the Maternal and Child Health Bureau. Happy to be
3 here with you today and to put some finishing
4 touches on this set of recommendations. Why don't
5 we move to Alison if you're on?

6 Alison Cernich: Sure. Thanks, Lee. Alison Cernich. I'm the
7 Deputy Director of the Eunice Kennedy Shriver
8 National Institute of Child Health and Human
9 Development, hereby representing the NIH. Thanks
10 so much for having me. I think I see Charlan.

11 Charlan Kroelinger: Hey, good morning, everyone. I'm Charlan
12 Kroelinger. I'm the Chief of the Maternal and
13 Infant Health Branch in the Division of
14 Reproductive Health at CDC. And I think I will
15 pass it over to Laura.

16 Laura Kavanagh: Good morning. I'm Laura Kavanagh. I'm the
17 Deputy Associate Administrator for the Maternal
18 and Child Health Bureau. And I will turn it to...
19 Who else is on federal officials? Lee, I'm going
20 to turn back to you to

21 Ed Ehlinger: How about Danielle?

1 Lee Wilson: Tina Pattara Lau.

2 Laura Kavanagh: Thank you.

3 Tina Pattara-Lau: Hello everyone. I'm Tina Pattara Lau. I'm
4 the Maternal Child Health Consultant for Indian
5 Health Service. I'm also an OB-GYN. I still
6 continue to practice here in Phoenix, Arizona on
7 the ancestral lands of the O'Odham tribe. And I
8 work at PIMC, Phoenix Indian Medical Center and
9 Valleywise Medical Center. Thank you for having
10 me today.

11 Ed Ehlinger: Danielle.

12 Danielle Ely: Hi, I'm Danielle Ely. Oh, can you hear me? Okay.
13 I'm Danielle Ely. I work for the National Center
14 for Health Statistics and the Division of Vital
15 Statistics and the Reproductive Statistics
16 Branch. And I manage the Linked Birth and Infant
17 Death file. Thank you.

18 Ed Ehlinger: Anybody else who hasn't been introduced?

19 Magda Peck: Darlene.

1 Ed Ehlinger: All right. Well, welcome everyone. We've got an
2 exciting meeting. I forgot to mention that my
3 virtual backdrop is Big Medicine. It's part of
4 the blanket that was given to me when we were at
5 together at the Shakopee Mdewakanton Sioux
6 community. You can see the buffalo back there.
7 And I'm getting patted on the shoulder by the
8 hands. So, I feel like I'm in good hands at this
9 meeting. And just to remind you, normally, we
10 would have a two-day meeting for those of you who
11 are relatively new. Most of our meetings are two
12 days long. This meeting is just one day. And
13 we're having just one day because not sure yet
14 about the leadership moving forward, and I didn't
15 want to start something brand new that I could
16 not carry forward. Today, it's just going to wrap
17 up and set the stage for the next iteration of
18 SACIMM that's going to be starting right after
19 this meeting. That's why we're just having one
20 day. And so before we get started, let's have
21 approval of the minutes. Does anybody want to
22 motion to approve the minutes?

1 Marie-Elizabeth Ramas: This is Marie. So moved.

2 Ed Ehlinger: All right. Is there a second? Magda seconds.

3 Joy Neyhart: This is Joy. I would second.

4 Ed Ehlinger: All right. And just to let you know that I
5 actually did read the minutes and most of you
6 probably did not, because they were quite long,
7 but they're very helpful. And especially as I've
8 been going back over the last four years in
9 preparation for this meeting and thinking
10 through, having those minutes is really
11 important. So I would just encourage that at
12 least somebody on the committee in addition to
13 the MCHB staff review the minutes just to make
14 sure that they collect things because they're
15 important. They're the historical archive for our
16 meeting, so they're important. So, all in favor
17 of or any discussion about the minutes? We got
18 the motion to approve and second. Any discussion?
19 All right. All in favor, wave at me or say yes.

20 Steve Calvin: Yes.

2 **Finalize Report to the Secretary - *Making Amends:***
3 ***Recommended Strategies and Actions to Improve the Health***
4 ***and Safety of American Indian and Alaska Native Mothers***
5 ***and Infants***

6 Ed Ehlinger: All right. Good. All right. All right. So, we're
7 going to start like we did with many of our
8 meetings, with community voices. This for me is
9 really nice for me because I know CDC has done
10 the HEAR HER campaign, and they've really done
11 the most recent one related to American Indians
12 and Alaska Natives. It's synchronous with what
13 we're doing. So it really feels good that we can
14 start with one of the video clips from the HEAR
15 HER campaign related to American Indian and
16 Alaska Natives. So, let's start with HEAR HER.

17 HEAR HER Video: The circle of life begins with the birth of
18 a child, and that journey begins with pregnancy.
19 People who are pregnant or have had a baby know
20 their bodies, and know when something does not
21 feel right. When they speak, we must listen. Hear
22 her. Learn more at [CDC.gov/HEARHER/AIAN](https://www.cdc.gov/HEARHER/AIAN).

1 My name is-

2 Ed Ehlinger: All right. Thank you. It's a beautiful way to
3 start. That's one of the nice things over the
4 years that we've been doing this is to start with
5 voices. Sometimes in person, sometimes by video,
6 it's sometimes virtual. A nice way. And certainly
7 the meeting that we had on the Shakopee, we've
8 been walking in Sioux land where we heard the
9 stories and heard the voices and just added so
10 much meaning to that. So the first part of our
11 meeting is going to be reviewing the report that
12 we've worked on. And I'm not going to go through
13 the report in great detail because it has been
14 shared with the committee multiple times. And
15 you've got it in your briefing book. And also, I
16 sent a copy to everyone last week in preparation
17 for this meeting. So, I don't think we need to go
18 through it objective by objective because we've
19 had multiple conversations about it, and we've
20 had an opportunity. But I'm just going to go over
21 some summary remarks related to that, and then we

1 can have a little discussion about that
2 afterwards. So, I'm going to share my screen.

3 All right. Here we go. So our report, Making
4 Amends: Recommended Strategies and Actions to
5 Improve the Health and Safety of American Indian
6 and Alaska Native Mothers and Infants. And this
7 record reflects the fact that have really been
8 trying to focus for all of the last four years on
9 actions, trying to do something that we can
10 actually move on. And that was why we really
11 didn't want to say these are recommendations, but
12 these are recommended actions that we want to
13 move forward. And this all started back, not all
14 started, but our first real focus on American
15 Indian and Alaska Natives occurred in June 2021,
16 at our meeting there, when we were finalizing our
17 second report. We had a report to the Secretary
18 related to COVID. And then a year later, we had
19 another report that focused on a whole variety of
20 things, including COVID. But in that conversation
21 for the June 21st, 2021, we made this
22 recommendation that we should get adequately fund

1 the Indian Health Service efforts to reduce
2 infant and maternal mortality.

3 And we recognized that was a fairly, yes, an
4 important recommendation, but a fairly generic
5 one that we hadn't spent a lot of time on it. We
6 realized that if we're going to make some
7 recommendations related to American Indians and
8 Alaska Natives, we really needed to focus
9 attention on it, not just have it be an
10 afterthought. Something that, yeah, we should
11 make that recommendation, but we should actually
12 put some time in on it. So this is where we put
13 this in our recommendations. We did not mention
14 it in our letter to the Secretary, the cover
15 letter. It was in the report, but it was really
16 the beginning of our conversation that... So,
17 during the summer of 2021, we started to really
18 work on the project that we're coming to
19 conclusion on now, or it should say the report
20 that we're coming to conclusion on. The project
21 will continue.

1 Then we had our meeting in September, and this
2 was important for several reasons. This was our
3 first time when we really had a focused session
4 on American Indians/Alaska Natives. And Suzanne
5 England, who was our health consultant, actually
6 wasn't able to show up at this meeting. So, Linda
7 Frizzell testified instead of Suzanne England.
8 But it was important because Janelle set the tone
9 for this. She told a story, she gave the context.
10 And so it was important for a couple of reasons.
11 One, it set the tone for how we are really
12 looking at our report, from what Janelle did to
13 set the context and the tone at that point in
14 time, but also demonstrated her leadership. And
15 this is something, as I talk most through today,
16 I'm thinking about what we did, but I'm also
17 thinking about the group that is continuing on.
18 What can you do? And individuals who step up and
19 have an issue that they want to lead on can do
20 that and you can actually have an impact.

21 And Janelle both set the tone but also said, "I
22 need to lead this." And so we had formed a

1 collaboration to move this forward. And then in
2 December of that year, we had another session.
3 And Captain England was able to join us at that
4 point in time. But we found out that we needed a
5 lot more information than that she provided
6 during that session. So we said we really need to
7 have additional information. So following up that
8 meeting in December, we sent her a letter with a
9 list of data requirement, technical data that we
10 really like, information that we would like. And
11 I have to admit, even to today, we have not
12 received that despite several attempts. And so
13 you'll hear the frustration in my voice about
14 what we haven't been able to get from the in
15 Indian Health Service, which is such an important
16 part of this. But we sent a letter in January,
17 we've had several follow up letters since that
18 time, asking for a variety of pieces of
19 information. Still has not received any of that
20 yet.

21 And then in March, we had another invitation, the
22 Indian Health Service to join us at the meeting,

1 but no one was able to attend. But we did have a
2 session on violence on infant and maternal
3 mortality. Even though it wasn't focused on
4 American Indians/Alaska Natives, the issue became
5 very obvious in this conversation that this was
6 an issue of great importance to American
7 Indians/Alaska Natives. And actually Jacqueline
8 Campbell has actually followed up and been part
9 of our work since this time. A lot of the
10 information from this session has been built into
11 our report in terms of interpersonal violence and
12 also incarceration activities. So that is part of
13 our focus on American Indians. And then following
14 that meeting, we started to draft the
15 recommendations because we anticipated that we
16 were going to have an in-person meeting in June
17 of 2022, and that we would finalize the report.
18 As it turned out, fortunately, I think from my
19 standpoint, that was not our last meeting.

20 And we got extended two more meetings as members
21 of this committee, that allowed us more time to
22 really go into greater depth on the whole issue

1 of birth outcomes for American Indians and Alaska
2 Natives. But that's when we started. And when we
3 came together in June, this was your second
4 meeting, you came on board during this time and
5 actually participated in several of these
6 conversations. And this is the agenda that we had
7 in June where we really started to focus on some
8 of the very specific issues. SID/SUID, Indian
9 Health Service, incarceration, Missing and
10 Murdered Indigenous Women and Girls, and really
11 started to flesh out really some of the specific
12 objectives that we had. And then during the
13 summer of this last year, multiple drafts that we
14 had, at least fifteen drafts, sixteen drafts of
15 our recommendations that have been supported. But
16 even that is less because there were tweaks all
17 along the way. Each draft had multiple tweaks
18 during it, which brought us together in September
19 at the tribal land of the Shakopee Mdewakanton
20 Sioux.

21 And these were the people who presented during
22 that time. And really an impressive list. And

1 those of you who were there, recognized how
2 powerful it was to be on tribal land, hearing
3 those stories, and being able to interact with
4 each other. And so I'm hoping that as SACIMM
5 moves forward, the new group will be able to meet
6 in person a lot more than we were of the cohort
7 that's leaving. We have only had actually three
8 meetings in the four years that we had, we were
9 in person. And those in-person meetings are
10 really important. So, from that, we also got a
11 lot more information. And my hope was that we'd
12 be able to finalize the report at that meeting.
13 But obviously, so much information came in, so
14 much context came in, that it was a blessing. It
15 was a blessing that our terms got extended to
16 December, so we could incorporate all of that.
17 Because I think the richness of the report that
18 we are going to be voting on was really enhanced
19 by the stories that were there.

20 And you'll see in the document where we've
21 included many of the words of the people who
22 testified, the specific words in the quotes, the

1 pullout quotes that were there. And so, the
2 process that we developed, I think the process
3 itself was important. Yes, the final report is
4 important, but the process I think is important
5 is that we had multiple meetings looking at the
6 issue. We had an in-person meeting on tribal
7 land. That's one of the recommendations we're
8 going to have is that if you're going to have
9 some issues related to a particular population,
10 you actually should go there and be with those
11 individuals and talk with them and get their
12 input in their community. We've worked with
13 multiple, not only did we have the sake of
14 meetings, but we also had DRAW and the workgroups
15 DRAW and the Health Equity Workgroup had multiple
16 meetings that had lots of input. And so, a lot of
17 other people were engaged. We reviewed numerous
18 reports and you'll see the documentation in the
19 report, all of the publications that we've
20 referenced.

21 We had the verbal committee testimony, the people
22 that actually came to the committee. But we also

1 had lots of written testimony and a lot of verbal
2 input from people outside of the meetings over
3 the course of the time that we've been working
4 on. And so that all led to what we are going to
5 be talking about today, which is the report that
6 we're going to send, I hope, to the Secretary in
7 the next day or two after we approve it. And
8 it'll have a transmittal letter, which you've
9 seen. We've had the preface. And language
10 matters. And it's interesting, so I've gotten
11 some feedback from tribal members that, yes,
12 thank you for clarifying what terminology you're
13 using. And you may have not paid attention to the
14 last paragraph on the preface, but two-spirit
15 people actually have contacted me saying thank
16 you for acknowledging our existence.

17 I think we worded it that AICMM acknowledges that
18 transgender and gendered non-binary individuals
19 also birth and support infants. And just having
20 that acknowledgement, they recognize that we
21 maybe may not through this whole report used
22 language that is totally inclusive, but the fact

1 that we acknowledge it was really important and
2 we got feedback that way. We have the executive
3 summary. We have the full report, which contains
4 a lot of history and context, which I think is as
5 important as the recommendations. It is the
6 context that makes this really powerful. Then we
7 have the recommended strategies and actions, a
8 lot of references that are there that people can
9 use. And then we have a list of the contributors,
10 quotations from the presenters and the table of
11 some of the recommendations. And you have that if
12 you want a summary, not a brief summary, but a
13 summary on a few pages, I think four pages, where
14 you can actually see all of the recommendations.
15 We had talked about it at our meeting in
16 September.

17 Well, could we prioritize some and make it less?
18 And the feedback that we got particularly from
19 American Indians/Alaska Natives, is you're not
20 comprehensive enough. There's more issues and we
21 recognize that. This is one chance that we have
22 to actually present something from a federal

1 committee, include what you can with that. But
2 also that puts us on record that we need to act
3 on it in a different way. The pressures on us to
4 pull out parts of this to move forward in a
5 particular way, that we can prioritize pieces of
6 this, that we can move forward. And we'll talk
7 about that in our next session when we say, how
8 do we use this report? And so the report is based
9 on all of the data that we looked at,
10 particularly the Broken Promises Report, we had
11 three premises upon which we built our report.

12 One is that the health of American Indian/Alaska
13 Natives has never been a priority in our country.
14 And that has led to a whole bunch of outcomes
15 that are less than optimal. That like every other
16 population, the American Indians/Alaska Natives,
17 their health is determined by the physical,
18 social environment and medical care, so the
19 determinants of health just like everybody else.
20 But because of racism and discrimination, those
21 determinants are not as healthy as many other
22 places. And then some issues because of some of

1 the environmental factors, there are some
2 specific issues that disproportionately affect
3 American Indians/Alaska Native mothers and
4 infants and children. Incarceration, missing and
5 murdered Indigenous women and girls, substance
6 use, mental health. Concerns that are there for a
7 lot of other folks, but particularly American
8 Indians and Alaska Natives. And then also, as we
9 were talking about this, it really came forward
10 that the communities that we've been focusing on,
11 have some inherently protective practices
12 embedded in their culture and we need to call
13 those out.

14 So those are the premises upon which we built the
15 report. And from those premises, we basically had
16 three areas for recommended action. One related
17 to making the health and safety of American
18 Indians/Alaska Natives a priority, improving the
19 living conditions and improving access to high
20 quality healthcare, and then addressing those
21 urgent issues that disproportionately affect
22 American Indian/Alaskan Native women and infants.

1 Instead of having one that was another section
2 just specifically for cultural strength and
3 resilience, we built that into all of the
4 sections so that it is a cross-cutting theme. And
5 in those three areas, so the three areas related
6 to priorities, determinants of health and
7 disproportional issues, we had basically three
8 areas under each one of those. So in the area
9 we're making the health of American
10 Indians/Alaska Native mothers and infants a
11 priority for action, we really had a whole
12 section related to leadership and inclusion and
13 the data sovereignty issue and how who makes
14 determination about what moves forward.

15 We also have a section on the data because one of
16 the ways that we've not made the American Indians
17 and Alaska Natives a priority is because we have
18 not used the data. We've fallen back, we've
19 collectively said the numbers are small.

20 Therefore, some people think, well, they must be
21 insignificant. So, we've focused on data. And
22 then because we are making recommendations to the

1 Secretary of Health and Human Services, we're
2 really focused on particularly the two agencies
3 within the federal government, HRSA and the
4 Maternal and Child Health Bureau. Because they
5 are responsible for multiple programs that
6 directly affect American Indians and Alaska
7 Natives. So we've had some recommendations
8 specific to them. When we talk about this, the
9 DRAW group did a lot of work on this. And Magda
10 leading the DRAW group will be able to respond to
11 any questions that might come up about anything
12 in this area.

13 The second area really focuses on the
14 determinants of health, the social conditions and
15 access to quality healthcare. And Janelle led the
16 work in this area. And we focused on basically,
17 again, on three areas, the Indian Health Service,
18 expanding the workforce and the social
19 determinants of health. And I'm going to spend a
20 little bit more time on this one. The Indian
21 Health Service, we've again, have not been able
22 to get the information that we have. And it is

1 such an important piece of health or important
2 factor in improving the health of American
3 Indians/Alaska Natives, that it needs a lot of
4 attention. And we heard over and over and over
5 again that there's dissatisfaction with the
6 Indian Health Service. Several people suggested
7 we should just do away with it and start all
8 over.

9 We also know that they've been chronically
10 underfunded. So what's the chicken and what's the
11 egg? We're making some recommendations on how we
12 think action should move forward, but this needs
13 to be a priority. We did not do justice, I don't
14 believe, to all of the factors that go into the
15 Indian Health Service. And I'm hoping that SACIMM
16 and the Indian Health Service will be able to
17 form a partnership moving forward, that we can go
18 in greater depth to actually come up with some
19 recommendations that go beyond what we make in
20 this report. These are some bold recommendations
21 that we're making, but I-

1 ... these are some bold recommendations that
2 we're making, but I think that it needs a lot
3 more work. Similarly, Medicaid. Medicaid is again
4 another big issue that has a major impact on the
5 health of American Indians/Alaska Natives. And to
6 get into depth in all of the details of it would
7 require a lot more resources and time than we
8 were able to have. So again, this is another
9 issue that I think needs to be addressed
10 somewhere in the future and that is our
11 recommendation to really focus additional
12 attention on the Indian Health Service,
13 additional attention on Medicaid. And then
14 certainly workforce is one that we really need to
15 focus on along with improving the social
16 determinants of health. And then the third area,
17 we both had specific recommendations for Missing
18 and Murdered Indigenous Women and Girls,
19 incarcerated women.

20 I think this is one of the issues that I think as
21 I talked to SACIMM members, a lot of people
22 didn't recognize how big of an issue this is

1 among American Indians and Alaska Natives in
2 particular. And I think the couple of
3 presentations that we had just really raised this
4 up and I think that is one of the contributions.
5 But you'll also notice in the report that we
6 don't just say you need to have these things for
7 American Indian/Alaskan Native women in prisons,
8 all women need these services if they're
9 pregnant. All women in prisons need these. And
10 because Indigenous women are disproportionately
11 affected, yes, by making all women, it is going
12 to have an impact on American Indian/Alaskan
13 Native women. So this is something that we really
14 want to highlight. Similarly, the violence,
15 again, the lack of data related to the violence
16 and committees put together to address that are
17 things that we address in our report.

18 At our meeting in September, we talked about
19 substance use and mental health. And that this is
20 again another big issue that again, I think,
21 needs more attention. We put together some
22 recommendations related to that, but it is far

1 from comprehensive and I think needs, again, a
2 lot more additional work. But it is there for us
3 to concentrate on. And then those were 58
4 recommendations and we had one that didn't fit
5 necessarily into any of those categories. It was
6 these final recommendations. Our last
7 recommendation based on the fact of what we
8 learned by being on tribal land here in Minnesota
9 in September, that any federal advisory committee
10 that is focusing on issues specific to particular
11 communities, regardless of the topic, not just
12 maternal and infant health, but also other
13 topics, they actually need to hold those meetings
14 in those communities because it assures
15 engagement and better understanding and
16 representation and ownership and accountability.

17 And already, the stories that I'm hearing from
18 other organizations that were at the meeting,
19 they're thinking, "Okay, we need to change how we
20 do our work." And I loved the fact that the
21 President Biden just said, "Hey, we're going to
22 hold a meeting on tribal land here in the near

1 future." I'm going to take ownership that our
2 meeting in September, in Shakopee Mdewakanton
3 Sioux was the stimulus that said maybe we should
4 do that at other levels other than just this
5 advisory committee.

6 So that's just a general overview. So, I just
7 have some questions. I'm going to open it up and
8 these are some of the things that I want you to
9 think about. First of all, do you have any
10 comments or questions about the report? Anything
11 not clear in the report, just things that you
12 need some clarification about or just some
13 general comments about the report. What stands
14 out for you in the report? What really is like,
15 "Oh my God, this is really important?" And then
16 what have you learned? Have you learned about the
17 issues of American Indians/Alaskan Native? What
18 have you learned about the process of putting
19 this report together? What have you learned about
20 the advisory committee? How functional is it in
21 some of these areas? What can it do? How do we
22 interact? What did you learn about that? And then

1 I want you to think about, all right, what are
2 you going to talk about, what part of this report
3 are you going to talk about?

4 I was talking to Magda. She said that she always
5 asked people, "What are you proud of in the work
6 that you're doing?" This is sort of that. What
7 are you proud of? What are you going to raise up
8 from this report? And then lastly, is there
9 anything within this report that you can't live
10 with? Because we're going to be voting on this
11 and if there's something that you can't live
12 with, I need to know that, we need to know that.
13 All right. So I'm going to stop screen sharing
14 and open it up for some conversation related to
15 these questions. And I'm not going to call on
16 anybody. Raise your hand if you have questions
17 related to any of these things. Any comments or
18 questions? What stands out? What have you learned
19 about issues or process or the committee? What do
20 you talk about if you mentioned the report?
21 Sherri.

1 Sherri Alderman: Yes. Well thank you very much. I think that
2 this report is spot on and comprehensive enough
3 to move the dial with action stemming from the
4 report. And I think that this is a phenomenal
5 opportunity. One thing that I'd like to spotlight
6 that really resonates with me that is in the
7 report are the stories. We often create a very
8 objective dispassionate, if you will, report of
9 including data, which is very important. In fact,
10 that's one of our recommendations is that there
11 be more data. I would like to keep in mind that
12 data also includes the qualitative information
13 and including those stories in the report all
14 along the way, I think really captures so much
15 more than that quantitative data can possibly
16 capture. So, thank you very much.

17 Ed Ehlinger: Good. One of the things related to the stories,
18 so those weren't edited, those were the words.
19 And that doesn't mean that we necessarily agree
20 with everything in those stories, but that is the
21 perception of the person talking. So I love that
22 we have our data, which we have researched and

1 have references for, but here's the words of the
2 community that we're focusing on and that gives a
3 little different flavor. Belinda.

4 Belinda Pettiford: Thank you. And I actually am in agreement
5 with Sherri, I think the highlight of the report
6 to me were the stories of individuals. And I am
7 really excited about recommendation number 59
8 where we are just reminded of the whole concept
9 of nothing about us without us. And really
10 thinking through how important it is when we're
11 trying to pull these recommendations together or
12 any effort we're working on that we really need
13 the people that are impacted to be leading and
14 being definitely engaged in the work.

15 I'm also very appreciative of all the time that
16 you and Janelle put into leading this work. We
17 know it was not easy and the fact that we were
18 able to get to this point with very little
19 communication or even engagement with the Indian
20 Health Service, who we would've expected would be
21 at this table, that they would want to be co-

1 leading with us and still being able to get this
2 much done is amazing.

3 And I also appreciate the fact that as much as
4 we're wanting to lift up American Indian and the
5 Indigenous populations and how critical this is
6 and how much this is so delayed that we've needed
7 this for a long, long time that we didn't forget
8 about the rest of the populations that are also
9 impacted. So I think you've done a really good
10 job of incorporating that into the report as
11 well. So, thank you both very much.

12 Ed Ehlinger: And you'll also note, we did use the quote from
13 Julia Lathrop at the beginning of the report that
14 actually by focusing on this population is
15 actually going to benefit every other population,
16 that it is absolutely essential to focus on this
17 population if we're going to make success in the
18 other population. So it's not an either or, it's
19 not a zero sum game. As my favorite Senator Paul
20 Wilson, we all do better when we all do better.
21 Marie.

1 Marie-Elizabeth Ramas: Yes. Just again, echoing the immense
2 amount of appreciation since I'm one of the newer
3 members on the committee here, just the amount of
4 work, the thoughtfulness and co-creation that was
5 involved with for all intents and purposes, for
6 the amount of resources that were provided, is
7 just absolutely tremendous. I appreciate so much
8 the historical factors that were added into the
9 report to not only justify but to remind the
10 reader of the integral aspect of what our history
11 is. So that really just spoke to me and it made
12 alive the in-person experience even more. It was
13 palpable because of our in-person experience that
14 we were gifted by the thought leadership here. So
15 just bravo. And you are correct, this is really
16 just the tip of the iceberg. But I hope that this
17 can help create some guidelines and some way
18 points that our officials can then leverage to
19 dig deeper in and we can continue in the work.

20 Ed Ehlinger: Certainly, thank you. The context really is
21 important and the fact that Janelle is the only
22 Indigenous person on our committee and that she

1 was important in helping to bring that context
2 and that tone highlights the fact that advisory
3 committees need to be more broadly
4 representative. Also, the fact that we were able
5 to get stories when we were on tribal land that
6 we could not have gotten any other way,
7 highlights the fact that we as a society need to
8 be more embracing and go away from the way we've
9 always done business. Because I think as was
10 mentioned earlier, the stories are data, they are
11 qualitative data, but they're powerful data,
12 they're accurate data and it needs to be part of
13 our conversation. Phyllis.

14 Phyllis Sharps: Yes, thank you. Good morning, everyone. I
15 think the report and how we've done it really
16 does very well how I have always framed my
17 research, which is community based and community
18 engaged and that is stories and numbers. And when
19 you can weave those two together, I think you
20 make a much a very compelling document and
21 statement as we've done. I appreciate that if you
22 work in community and you do community research,

1 you know you have to be in the community and you
2 have to hear the voices. And so having a big tent
3 for this committee and inclusiveness and
4 diversity will help us, I think, identify even
5 more issues and more relevant. And I'm a newbie,
6 I think this is my third meeting, but I like that
7 the committee will be flexible enough to get out
8 of our ivy towers and actually go to the
9 communities and hear what folks have to say.

10 Ed Ehlinger: Thank you. Charlene.

11 Charlene Collier: Thank you. Again, I echo the previous
12 sentiments and truly appreciate all of the work
13 that went into the report. And I think the result
14 demonstrates that effort and passion. I echo also
15 the sentiments around recognizing the both hard
16 work of Janelle doing this, but then the fact
17 that being a one and only is a very heavy burden
18 in a committee and a report to this and moving
19 forward that it is not the model. We know how
20 much effort and energy it took to bring in more
21 voices. So I really appreciate that the committee
22 took that effort to not just have one way of

1 getting those voices represented but truly moving
2 forward when we're thinking about who acts on the
3 report, who is empowered to act on the report and
4 who receives the funding to do the actions should
5 again be mostly representative of the Indigenous
6 community.

7 And I think that's most important for as a
8 template that anyone who's going to take it and
9 act upon it acknowledges that they cannot do it
10 unless that who is acting reflects the community
11 who is benefiting and who it's addressing. So
12 hopefully we see that throughout. We do see that
13 throughout the report suggesting who owns the
14 suggestions, who has the power in implementing
15 who is brought in and how to do that. But again,
16 I think if I were on a panel right now addressing
17 Black maternal mortality and I was the only Black
18 woman represented, it would feel like a personal
19 burden, not just on the committee. It would seem
20 like, wow, I am both representing this report for
21 our country and I was a one and only and that
22 shouldn't be going forward.

1 But certainly this represents the need to
2 continue to invest in leaders from the Indigenous
3 community and bringing them in and in the
4 actions, because I know even Janelle is rolling
5 off, the work begins now. It really truly begins
6 now. And this is where the investments have to
7 start happening around who is empowered to carry
8 this message forward. So again, thank you,
9 Janelle and to everyone who put that, and Dr.
10 Ehlinger for making that commitment and not going
11 the easy route. But I hope we won't go the easy
12 route for action as well. So, thank you all.

13 Ed Ehlinger: Thank you, Charlene. Yes, and I certainly concur
14 with you that Janelle, this was a burden on her.
15 And I want to acknowledge the fact that a lot of
16 people did step up to help, in the Workgroup
17 folks, which was people are willing to come
18 forward and also in the American Indian/Alaskan
19 Native community. Certainly here in Minnesota, my
20 colleagues said, "All right, we're going to step
21 up and help you do this," so that it needs a
22 little... having Janelle be part of that helped

1 others come forward. It was sort of the stimulus,
2 it was sort of the boiling rock, if you put it
3 in, it makes things happen. So a lot of other
4 people stepped up, but it was a lot of great
5 leadership from Janelle. Janelle, you're on.

6 Janelle Palacios: Thank you. It was with a lot of mentorship
7 from Dr. Ehlinger and Dr. Magda Peck, both of
8 those, these are amazingly supreme mentors and
9 leaders in their own right with combined, I don't
10 know, should I say a number of years of
11 experience. It feels like 50, 70 years plus of
12 experience combined and an enormous amount of
13 mentorship went through this. And it was through
14 their mentorship that I was able to really have a
15 voice and have a hand in being able to shape this
16 report and being able to share a light on this
17 very dark deep corner of our history and what's
18 going on currently. So I want you all to know
19 that they have heavy hands and influences in the
20 framing of all of this because they've had so
21 much experience. And someone like myself who has
22 not had mentorship in this capacity and being on

1 this committee, it would not have happened
2 without people putting investment into me.

3 So thank you Dr. Magda Peck and Dr. Ehlinger, a
4 lot goes to you as well, the trio of us, but a
5 lot of the mentorship for this, what we're about
6 to set forward and hopefully approve very
7 quickly. And I agree that what Dr. Collier was
8 sharing, that now let's see what the action will
9 be. And yes, there should always be more than one
10 person, that is, one person cannot represent
11 alone. So it is with mixed emotions and also very
12 much happiness for being able to step off lightly
13 off of this committee after all of these four and
14 a half years of work that is culminating in
15 today. So thank you all for being here, and thank
16 you all for your consideration for future
17 mentorship of each other and for the next
18 generation of people to come.

19 Ed Ehlinger: You will note on the transmittal letter to
20 Secretary Becerra, in the past I would sign the
21 letter on behalf of the committee. This letter,
22 it's going to be over my signature and Janelle's

1 signature as co-chair of the Health Equity
2 Workgroup. But also, I think highlighting the
3 fact that this is not just the report from the
4 committee with my signature, but her involvement
5 in it. You got to raise it up. We have to raise
6 up the next generation of leaders and this is one
7 way to do it. Kate.

8 Kathryn Menard: So I'll just build I guess on what others
9 have said. I will echo the appreciation for what
10 Janelle has done and the supports she's gotten
11 from others to do that. But I can't say it any
12 better than Charlene, what lift? And thank you
13 so, so much. But just one comment in the report.
14 I love that it's so beautifully referenced to
15 this document isn't going to be a list of
16 recommendations. This document is going to be a
17 resource for people that are going to be doing
18 the work to follow. And I think that that is
19 going to be very, very, very helpful in such a
20 broad way. So thanks for all the work that went
21 into that. But Janelle, maybe you're rotating off
22 the committee, I would've voted for you to keep

1 on another term, but you're not rotating off this
2 project in any way.

3 You're going to be tapped and tapped and I hope
4 you're willing to keep your hand up and lean in.
5 Tomorrow, for those that don't know, I think it's
6 tomorrow, Janelle, you're doing your webinar on
7 HEAR HER and just I expect that, I hope that
8 we'll be seeing you over and over again and all
9 the other colleagues that you can bring to this
10 work. So, thank you. What I've learned, I have to
11 just say that I've spent a number of years now in
12 the space of healthcare and kind of walking in
13 the public health arena and I learned so much
14 about what my head in the sand was with respect
15 to the issues that were raised by the development
16 of this report. And I'm embarrassed by that but
17 also energized by that. So you've got me as your
18 fan and someone that will carry the flag with
19 you.

20 Ed Ehlinger: Thank you. I'd just be curious of the people who
21 came to the Shakopee Mdewakanton Sioux community,
22 what was your take? I know Kate had mentioned

1 that like, "Oh my God, I never realized what was
2 going on. I know these issues but sort of
3 academically, but this really brought it to the
4 forefront." I'm just curious on what people
5 learned from that experience. Because I think it
6 reflects on what MCHB is going to do, what this
7 committee needs to do, other committees need to
8 do to hear what really comes from that kind of
9 experience. Marie.

10 Marie-Elizabeth Ramas: The stories and just being on native
11 land and understanding the history of the land
12 that we were standing on, that was extremely
13 moving to me. And as a Black woman and as a first
14 generation American here, just the deep
15 connection between Indigenous experiences and the
16 experiences of other communities affected by
17 white supremacy across the world. I think that
18 was just very moving to me that our experiences
19 are really not a mono, they're not unique, that
20 we have similarities that are threaded in so many
21 ways and particularly in the unspoken American
22 history. That there are so many stories that are

1 silenced and canceled out of the collective
2 thoughts of Americans that I think that if we
3 knew, our policies would be done in such a
4 different way, work would be done with such a
5 higher level of urgency than it would have.

6 And so I would not have been able to really
7 appreciate that had we not been in-person. So
8 your recommendation as spot on that when we are
9 talking about maternal infant mortality, and
10 we're talking about a crisis, it is so hard for
11 people who are not affected by it to really
12 understand the impact if they're not experiencing
13 it in some way, shape or form. And that's what an
14 in-person experience has done for me, even as a
15 person who represents multiple historically
16 excluded groups in the United States.

17 Ed Ehlinger: Thank you. Also, one of my beliefs is that if
18 we're not building community capacity, we're not
19 doing our work well. And I was really pleased to
20 see with that meeting in September that people
21 from across the country actually chose to be
22 there in person. Yes, there are some that had to

1 do it virtually, but more came and they formed
2 partnerships and relationships that were new to
3 them and they've continued those conversations so
4 that there is now a network of American
5 Indian/Alaska Native individuals that have not
6 been created before that is now functional. It is
7 sort of building community capacity and that's
8 why having that meeting there had multiple side
9 effects that were really positive. Lee.

10 Lee Wilson: Yeah. Hi folks. Ed, thanks for asking the
11 question. And for me, I maybe have a slightly
12 different view of the takeaway from the meeting.
13 I had two in particular. One, I was so very, very
14 pleased and impressed with the convergence of
15 people situations readiness for the committee to
16 see and hear the messages that were being
17 provided and the degree to which it was sort of
18 absorbed and adopted by the people who were
19 there. So again, thank you, Ed, thank you,
20 Janelle, thank you, Magda and all the other folks
21 who worked to make that happen because it is
22 remarkable how easy in our society it is to

1 overlook what's under the surface and what isn't
2 put right in front of us. And there's a lot of
3 work to be done. The second piece is just how
4 much work there is that needs to be done.

5 I worked with tribal communities for the first 15
6 years of my career in the government and the
7 thing that was startling to me was the impact
8 that this event had on the committee when the
9 conditions of the tribe that we were visiting are
10 so far better than the conditions of the vast
11 majority of tribal groups in the United States,
12 whether they be living on a reservation or in
13 sort of non-reservation urban settings or rural
14 settings. What we saw was a palatial casino with
15 a giant golf course and a lot of people beaming
16 in or coming in and telling very difficult
17 stories, very real stories about their
18 experiences. The shock though comes when you are
19 out on the Navajo reservation and see people in
20 America in the 21st century living without
21 running water or heat or all those other things
22 that we thought we solved many, many decades ago.

1 And so the degree to which we as Americans, as
2 really educated Americans need to go to uncover
3 what's really out there and what dire
4 circumstances certain people live in. So that's
5 all.

6 Ed Ehlinger: Thank you, Lee. That was a really important
7 point. The Shakopee Mdewakanton's from what I
8 understand are one of the richest tribes in the
9 country, if not the richest tribe in the country.
10 So acknowledging that this is not representative
11 of everything else, it gave us a view that was
12 important to get. And because it was close to an
13 airport and I could get urban and tribal Indians
14 together in a spot, it helped meet my needs and
15 our-

16 Lee Wilson: Certainly not intended as a critique.

17 Ed Ehlinger: No, I know. But acknowledging the fact that we
18 need to always expand our view, and nothing
19 represents everything. No one thing represents
20 everything. So keep that in mind and I really

1 appreciate you bringing that up, it's an
2 important point. Magda.

3 Magda Peck: Being there and hearing from our American
4 Indian/Alaska Native folks who came from far and
5 wide allowed me to change the narrative in my
6 head about what this is all about. And we'll be
7 talking a little later about narrative, but as
8 somebody who's focused on urban health issues for
9 most of my career through CityMatCH and
10 otherwise, I had conflated the number that 70% of
11 American Indians/Alaska Natives live off
12 reservation and therefore they must be urban.
13 That is false. And I just want to be very
14 specific as someone who leads our data and
15 research to action, the unlearning that needed to
16 happen was possible because of being on-land and
17 hearing a story told by multiple people from
18 multiple perspectives, that allowed me to
19 literally change the wiring in my brain about who
20 lives where and differentiate between people and
21 population and place, and place matters.

1 So that was an amazing piece and many people
2 helped tell that story. Whether it came from the
3 urban Indian perspective or whether it came from
4 Don Warne's perspective when he showed maps and a
5 diagram that says this is Indigenous, this is
6 this. It literally is like the hotel map on the
7 back of the door that helps you know how to get
8 where you need to go. So narrative change
9 happened viscerally because of the multiple
10 layers of the stories and the information and
11 voices we heard, the place we were at and a
12 chance to process it in real time allowed me to
13 never think that fact or un-fact again. And it's
14 changed how CityMatCH is going to approach this
15 from an urban perspective. And already
16 relationships that have never existed between
17 CityMatCH, which is urban MCH and Urban Indian
18 Health Centers across the country.

19 Those relationships don't exist in Omaha where
20 ironically Omaha, where CityMatCH is, or if it
21 is, it's been on a relational level of somebody
22 knows somebody. But structurally, the urban

1 agenda will be changed in maternal and child
2 health because of the meeting. And a final note,
3 only two, not three. Being on site allowed the
4 divine coincidence of a parallel meeting around
5 tribal health happening in another side of a
6 windowless ballroom in this casino. And to have
7 corralled the women's singers into the room, that
8 spontaneity, that serendipity allowed us to hear
9 their voices. And that would've never happened on
10 Zoom. So a blessing in abundance and may it
11 happen again.

12 Ed Ehlinger: I smile again just thinking about it. That was
13 very cool. Charlene.

14 Charlene Collier: Thank you. Those are definitely excellent
15 reflections. And I wanted to talk about the
16 singers and that they had daughters with them,
17 they had little girls, even a baby. And I
18 remember at the very end of the meeting they were
19 running around with happiness and joy and all
20 over and it was a happy moment. But then just the
21 weight hit of the urgency that what we're working
22 on is to protect those small people and that this

1 shouldn't be a problem for those small people
2 that we saw that day. Those babies, those young
3 people, those little girls. And just
4 acknowledging that it's already taken too long.
5 But being there definitely had that power of
6 connecting with community. And I'm so glad it's
7 in the report as hopefully a requirement that if
8 we're going to travel, that it's not just
9 repeatedly to DC because that comes with money,
10 that comes with booking hotels and fueling
11 conferences and fueling financial places and that
12 could go directly to communities.

13 We have a financial engine that goes behind
14 committees and meetings and conferences and
15 behind that is the cab rides, it's the food, it's
16 all of that. And when it repeatedly goes to DC,
17 yes it benefits that community in some regard,
18 but then there's this opportunity to be closer to
19 the neighborhoods that are being impacted. And
20 truly not just uncovering, I don't think it's
21 hidden, as Lee was mentioning, it's we don't
22 expose ourselves. And it's not a requirement to

1 expose yourself, I think we think looking at data
2 or talking to a person is enough, but truly I
3 don't feel yet completely exposed having just
4 been in the area to the casino, watching some of
5 the videos. But knowing that the more we expose
6 ourselves as a requirement to be able to weigh
7 in, I think is important. And I hope it is
8 carried forward throughout MCHB and certainly
9 this committee. So thank you again Dr. Ehlinger,
10 for the persistence. Because again, the easy way
11 out would've been just Zoom, but this was
12 something very impactful and so thank you.

13 Ed Ehlinger: One of the things that I've certainly learned
14 with working with American Indian/Alaska Natives
15 and what was highlighted at in our time in
16 Shakopee was that the work that we're doing is
17 sacred work. We're dealing with lives of
18 individuals and families and it's a spiritual in
19 a non-religious, well or religious... it's a
20 spiritual kind of activity. And the fact that the
21 tribes will start a meeting with an incantation,
22 with a song, with a prayer. And those meetings

1 that I go to that start like that always are
2 better. And I think we have to acknowledge the
3 work that we are doing, however you define sacred
4 is sort of the work that we do. And we have to, I
5 think, acknowledge that it's important work. And
6 it's a little different than just crunching
7 numbers sometimes, it is actually dealing with
8 the lives of people. And it was just highlighted
9 when we were in Shakopee that when we started the
10 meeting that way it gave it a different feel. All
11 right. Anything else that folks have? First of
12 all, is there anything that people can't live
13 with? Or Magda, you got your hand up.

14 Magda Peck: Yeah, I just want to acknowledge how fabulous it
15 was to be with SACCIMM colleagues. Kate, thanks
16 for your little note about it, the warmth of it
17 there. And I missed some of you. I missed your
18 Jacob. I have not had a chance to have a direct
19 one-on-one with you since you joined this
20 committee, and I'm so glad you're on it. And I
21 was just mindful, not only did it help us,
22 including our federal colleagues. Michael Warren

1 was there for the entire time. He would be here
2 today if he were not on leave. Lee Wilson. And
3 just being able to build the relationships of the
4 people who stand shoulder to shoulder for equity
5 and justice and where we want to wield the
6 influence that we have. And so I was curious at,
7 it's an old Jewish practice that you always tell
8 the story to the person who knows the least and
9 the person who cannot speak or did not experience
10 it. So, Jake, I'm going to pick on you, and
11 others, to say, what is it like for you, and is
12 there anything we can do to try to bring this
13 clearer to life for you so that you are caught
14 up?

15 And I just am mindful for wanting us to all be
16 engaged, and a lot of us were there but not
17 everyone. So it's just great to see you, and I
18 hope you don't mind my being direct in inviting
19 your reflection, by not being there, which is as
20 powerful but different.

21 Jacob Warren: Yeah, no. I definitely appreciate that. And I
22 think one of the things that's actually helped is

1 this, where I got to sort of experience a bit of
2 it vicariously and hearing all of the wonderful
3 things that y'all experienced when you were
4 together was, it was very painful not to be
5 there. I do have to say the timing of my new
6 position was unexpected and just made it where I
7 could not be there. And there was a lot of angst
8 for me in being there because, as someone who
9 focuses on rural issues, and they're not the same
10 domain but there's certainly a lot of overlap in
11 AIAN needs and in the overall needs in rural
12 populations. And us having such a strong tribal
13 presence here in Wyoming, it was very, very
14 painful not to be there and get to experience
15 that in person.

16 But I thank everyone for their conversation today
17 and their reflections and how it helped shape
18 their thoughts, and allowing me the chance to go
19 back and rethink those elements myself as well.
20 So I just want to thank you all for sharing your
21 experience because it's helped me feel like at
22 least I got to be there in spirit.

1 Magda Peck: Thank you for that. And anybody else, Ed?

2 Ed Ehlinger: Well, I would just want to reflect, Magda, and
3 you talked about the relationships. I quote
4 Wendell Berry a lot, the farmer Wendell Barry,
5 who said that, "Speaking about the health of an
6 isolated individual is a contradiction in terms.
7 The smallest unit of health is the community."
8 And health is all about relationships. It's not
9 about individuals. It's about relationships. And
10 so the health of a committee is about
11 relationships, and that's why coming together
12 helped to build those relationships, as you
13 pointed out, Magda. It just adds a different
14 level to our whole conversation. So thank you for
15 bringing that up.

16 Anybody else who'd like to say something. Magda
17 picked on Jacob. I know others were not there. If
18 they would like to step up and say something. I
19 know, Tara, you came in for some of the meeting.
20 You were there virtually for part of it, but not
21 for the whole thing. Any thoughts that you have?

1 Unmute. Unmute.

2 Tara Sander Lee: Sorry. Yeah. I appreciate this opportunity,
3 and I apologize that I couldn't be there. I had
4 requirements. I had to be in DC during that time.
5 I was hopeful that I could have attended had it
6 been in in DC, but I totally understand the need
7 and desire to have it held in Minnesota. It's
8 just I physically couldn't be in two places at
9 one time, but I appreciate the opportunity that
10 you allowed people to attend virtually as they
11 could. And this has just been really helpful. The
12 report is amazing. It's so in depth and thorough,
13 so I just thank everybody for their work that
14 they've done and then just having this recap.
15 It's definitely not the same as being there in
16 person, I know that, but just having this
17 opportunity to hear what your experiences have
18 been has definitely made a difference, so thank
19 you. Always learning. Always learning in this
20 position, that's all I have to say.

21 Ed Ehlinger: Aren't we all? Thank you all. And we're going to
22 have another session. We're going to be talking

1 about how do we use this report. This session,
2 the last hour, 45 minutes or so, was to say just
3 our reflections. What did we learn? I get a sense
4 that people are on board. So I'm going to ask
5 Janelle to make a motion to approve this report.

6

7

Vote to Approve Report

8 Janelle Palacios: Advisory Committee on Infant and Maternal
9 Mortality, colleagues, with a full heart and
10 optimism for the health and well-being of our
11 united nation, move that we approve this report
12 and send it forward to the Secretary of the
13 Health and Human Services.

14 Ed Ehlinger: Thank you. And I would like to have someone from
15 the new cohort of SACIMM members to second that
16 motion. Phyllis, I want you to verbally second
17 that motion.

18 Phyllis Sharps: I, with great appreciation, second the
19 motion.

20 Ed Ehlinger: Any comment? Any additional comments? Hearing
21 none, I ask Vanessa to call the roll.

1 Vanessa Lee: Happy to do so. Sherri Alderman, how do you vote?

2 Sherri Alderman: I gratefully and enthusiastically vote yay.

3 Vanessa Lee: Thank you. Dr. Ehlinger?

4 Ed Ehlinger: Yes, for sure.

5 Vanessa Lee: Steve Calvin?

6 Steve Calvin: Yes as well.

7 Vanessa Lee: Thank you. Charlene Collier?

8 Charlene Collier: Yes, thank you.

9 Vanessa Lee: Thank you. Tara?

10 Tara Sander Lee: Yes, thank you.

11 Vanessa Lee: Thank you. Kate?

12 Kathryn Menard: Yes. With enthusiasm.

13 Vanessa Lee: Joy?

14 Joy Neyhart: Yes, also with enthusiasm.

15 Vanessa Lee: Magda?

1 Magda Peck: Yes, without hesitation, consideration, or doubt.

2 Vanessa Lee: Thank you. Belinda?

3 Belinda Pettiford: 100% yes, if not 110%.

4 Vanessa Lee: Marie?

5 Marie-Elizabeth Ramas: Absolutely, yes.

6 Vanessa Lee: Thank you. ShaRhonda?

7 ShaRhonda Thompson: Yes.

8 Vanessa Lee: Thank you. And Jacob?

9 Jacob Warren: Enthusiastic and humble yes.

10 Vanessa Lee: Excellent. Ed, that is all of the members.

11 Ed Ehlinger: All right. Unanimously approved. I have to tell
12 you, I got a little few tears in my eyes.

13 Vanessa Lee: Oh. The whole time I was listening to you guys, I
14 had tissues on hand. I was about to chat, is
15 anyone else needing the tissues?

16 Ed Ehlinger: I did this more formally than what we would
17 normally would do about everybody saying just say

1 yes, because I think this is a powerful report.
2 This is an important report. This is something
3 that I hope can actually change the direction.
4 Like I said at the beginning, there's been lots
5 of days of infamy and we need to move forward and
6 rectify some of those. And I'm hoping this report
7 is just... I mean, obviously, it's just one small
8 step. There's much more that needs to be done.
9 But it gives some examples. And just from hearing
10 the conversation that you've had over the last
11 hour, it can have an impact. So I have lots of
12 hope that this can move forward. And I hope
13 the...

14 I really wanted to acknowledge the fact that
15 Janelle did so much work on this and wanted her
16 to actually move this forward, but also to have
17 the new group, the continuing cohort, to actually
18 just have ownership of this to move it on, to
19 keep this candle burning and move the light
20 forward. It causes me to be a little emotional
21 about this. This is really a great day for
22 SACIMM, I think.

1 All right. Any other comments before we move on
2 to how to use this report?

3 Let me look at the chat here that I haven't been.
4 All right.

5 **Discussion: Use and Dissemination of the Report**

6 Ed Ehlinger: So we are going to take the next section of, how
7 do we use and disseminate this report? As you've
8 heard all along, certainly at the meeting in
9 September and in putting this together, and as
10 you read the report in our conversation, we
11 created a story. We collected stories. We put the
12 stories together into a broader story of how to
13 move forward in actions. And so it's the stories
14 that really carried the message forward, carried
15 the data forward, carried the need to act
16 forward. And so how do we tell the story of this
17 report? The data story, the personal stories, the
18 lived experience stories, the policy stories, the
19 programs, how do we move them forward? And so I
20 wanted to spend a little time, the next hour or
21 so, talking about how we move this forward. And
22 so I've asked Magda and Janelle, I know that

1 they've been working on storytelling, and so I
2 want them to sort of maybe set the frame for us,
3 how do we use storytelling to advance this
4 report, the recommendations in this report?

5 So I'm going to turn it over to Magda and
6 Janelle, and then we're going to hear from the
7 CDC folks and how they're using their stories to
8 actually move some of the same issues along with
9 the HEAR HER. And then we'll open it up for some
10 broader conversation. So, Magda and Janelle.

11

12

Strategic Storytelling

13 Magda Peck: Sit back. Thank you, all. Janelle and I are
14 delighted to kick off this strategy session that
15 will build upon what Belinda said about the
16 essential need for community voice, what Sherry
17 said about the power of story, what Phyllis said
18 about getting out of our ivory towers, what
19 Charlene said about making the story bring things
20 alive beyond the voice of one.

1 And so today, for the next 15 or 20 minutes,
2 we're going to try to wrap up this notion about
3 strategic storytelling, so that the power of word
4 and voice can do what has been our commitment,
5 and perhaps, in many ways, an imprimatur of this
6 version of a 30 year old advisory committee to
7 the Secretary of Health and Human Services, that
8 being the Advisory Committee on Infant and
9 Maternal Mortality.

10 For the last four years, we have been inviting
11 and elevating and honoring the sacred stories
12 that we own ourselves, hear from others as
13 integral to our work for equity and justice and
14 healthier women, children, families, fathers, and
15 communities. Towards that end, we would like to
16 overview for you the power of story and encourage
17 SACIMM as we use this and bring this set of
18 stories to life, for life, that we do it in an
19 evidence-based way, and we build on the practices
20 that exist already, over generations and in
21 current public health practice.

22 Janelle, help us get started.

1 Janelle Palacios: Of course.

2 So, a story communicates fear, hope, and anxiety.
3 And because we can feel it, we get the moral, not
4 just as a concept, but as a teaching of our
5 hearts. That's the power of story.

6 So, I would like to next share with you Rhonda's
7 story. So, as I cue it up, we will share Rhonda's
8 story. We heard from Rhonda at our in-person
9 September meeting. She's former chairwoman of the
10 Confederated Salish and Kootenai tribes, and most
11 recently, past retired chief lawyer for the same
12 tribe. Rhonda shared her birth experience that
13 happened over 45 years ago. I worked with Rhonda
14 in putting her story into a visual and narrative
15 storytelling. This project was yet to, again,
16 demonstrate the power of story. And in this
17 version, you will hear my voice, but these are
18 her words.

19 Okay, here we go.

20 Oops.

1 Rhonda Swaney: I was newly married at age 24 and pregnant for
2 the first time, working for social services
3 within my rural community. My husband, also
4 young, worked long hours. We had a rocky start to
5 our relationship, filled with violence and
6 alcoholism. But when I became pregnant, we grew
7 as a couple and the violence ended, though his
8 drinking continued. I was dutiful in my
9 pregnancy, scheduling all the prenatal
10 appointments I was told I needed, and rarely
11 canceling them, only when the roads were too icy
12 and dangerous.

13 When I was about six months pregnant, the clinic
14 nurse told me I had protein in my urine. She
15 notified the doctor who said I was fine, not to
16 worry and to go home. That weekend, I became
17 terribly sick. I had the worst migraine in my
18 life. I was nauseous and bleeding. Something was
19 wrong and I felt awful. It was winter and the
20 roads were icy. But I went to the local hospital.
21 I was transferred by ambulance to a larger
22 hospital sixty-five miles away, bleeding and

1 feeling worse, with no details from the medical
2 personnel of what was happening to me and why I
3 felt horrible.

4 When we arrived at the hospital, I found out my
5 daughter had died and I was told they needed to
6 induce me. Shortly after starting the induction,
7 I delivered my stillborn baby girl. I stayed a
8 few days in the hospital, no family or friends at
9 my side. During my recovery, no one educated me
10 on the illness I had just experienced. No one at
11 the hospital asked me how I was doing mentally
12 nor emotionally after having just lost my baby. I
13 was told to take medication to prevent seizures,
14 but no one educated me on how to care for myself
15 postpartum, or after the loss of a baby, nor how
16 long I should wait before trying again.

17 Wanting to move on, we became pregnant quickly.
18 And because I was considered high risk, my clinic
19 appointments were in the larger town. To attend
20 one 15-minute appointment, I had to drive 120
21 miles round trip. At the time, we had just one
22 car we shared. Again, I was pregnant during the

1 winter. The roads were bad, and I had to cancel
2 appointments simply because it was too dangerous
3 to drive.

4 One day at work, while six months pregnant,
5 something felt off. I did not realize my water
6 had broken. I thought I was having light
7 discharge, but then started spotting. I called
8 the doctor's office and was told to come in. When
9 I arrived to the hospital, I was in pre-term
10 labor and bore my son at midnight at our local
11 small hospital. The doctor told me my son would
12 not live throughout the night. I was not allowed
13 to hold my son. They whisked him away to lay in
14 an isolette, alone within the nursery.

15 But you see, my son Kelly is a survivor. He lived
16 despite the doctor's prognosis and was
17 immediately transported 500 miles away to a
18 neonatal center. I could only touch my son, not
19 hold him, just touch him. A week later while
20 visiting him, Kelly was born weighing one pound,
21 12 ounces, and he lost weight his first week of
22 life, weighing one pound, six ounces. Because he

1 was extremely preterm, a lot of the care he
2 received was experimental, and I signed a great
3 deal of paperwork that I did not completely
4 understand, relinquishing the hospital from
5 reliability.

6 The hospital social worker told me that my son
7 would likely die, and she encouraged me not to
8 change my routine at home, to continue working
9 and live my life. My son had many near misses
10 that I witnessed when I was present on the short
11 spans of time I could visit, but I was not able
12 to be with my son the entire time he stayed in
13 the hospital far from home.

14 When he was about three months of age, he was
15 transferred closer to home, to a new neonatal
16 center that had just opened, with staff who were
17 new to their positions, and a number of mistakes
18 were made in my son's care. I was taught CPR in
19 case I needed to resuscitate my baby. And when he
20 was discharged around five months of age, I had
21 to use CPR a few times when he stopped breathing.

1 When I returned to my clinic doctor without any
2 understanding as to why I had a stillborn baby
3 during pre-eclampsia with my first baby, I went
4 into preterm labor with my second, I remember the
5 doctor encouraging me to continue trying for
6 children. He said...

7 Janelle Palacios: When Rhonda shared with us her experience in
8 person at the September meeting, she shared how
9 she felt she was perceived, that she was just
10 another young Native woman who was expected to
11 just have children and have no problems. But when
12 she had problems, that she was not capable of
13 understanding what happened, what was going on.
14 And in addition to that, that she'll be fine and
15 have more children, that there's no need to worry
16 about the previous two that she had just had,
17 just to go on living her life.

18 So she talked about how in that time period being
19 innocent to understanding the dynamics of the
20 larger health system and education, and not
21 realizing that when she brought her child to...
22 When her child was in the hospital and

1 experimental care was given, she didn't
2 understand the power that she was relinquishing,
3 that very much the work that was being done was
4 in service to his life, her son's life, but that
5 it was not really well explained. It was only
6 when years later, in her fifties, when she went
7 back to school and became a lawyer, she realized,
8 thinking back, just what was going on when she
9 was in her young twenties, and reflectively
10 thinking about the power differences, and then
11 also thinking back on her experience as a mother.

12 In this meeting, she shared with us that she
13 still, today, carries the burden of feeling
14 responsible for every step of her pregnancies, in
15 both of them, that she is responsible personally
16 for the outcomes that have happened, not that
17 there was an intention to help ease her pain or
18 help educate her or to do that further. And it's
19 only really recently that she's been able to
20 understand what really happened.

21 So when we talk about stories, we want to think
22 about the dominant stories, the prevailing

1 stories. On one hand, today, that still goes on.
2 A lot of Black Indigenous people of color, women
3 and pregnant people experience a marginalization
4 that, stereotypically, they're drug seeking.
5 Stereotypically, they have higher tolerance for
6 pain. Stereotypically, they have this or that.
7 So, who drives these narratives? That is part of
8 understanding our history, understanding where a
9 dominant perspective comes from.

10 This slide is great because it's demonstrating
11 that story is also scientific. When we hear
12 story, there are chemical changes happening in
13 our brains, because we are making connections to
14 the person who is telling the story to the story
15 itself. And then there are also these chemical
16 connections that are also involved in whether or
17 not we are receiving the message, and if we are
18 about to change how we believe something, our
19 attitudes, our practices, our actions.

20 Storytelling is scientific, and we are just
21 beginning to learn the power of story.

1 Magda and I have worked for some time about how
2 stories can inform, shape, and shift new
3 narratives. And this is where understanding
4 context, understanding someone's story, is
5 helping to reframe the messages that are told or
6 shared about a particular phenomenon. And so
7 Magda will take over next, and she will give a
8 brief overview of... This is very brief. This
9 could be a day-long presentation, but a brief
10 overview of the importance of storytelling,
11 before she gives you examples of storytelling.

12 Magda Peck: One of the things that makes this report so
13 powerful is that we've contextualized the data
14 with stories and with history. That is one of the
15 leading reasons that we need to bring back a
16 centuries and generational long set of practices
17 that allow us to transmit why, how, what, for
18 whom, so what and what next. So we need to not
19 just come out of the ivory tower, we need to use
20 this report, as we can build upon the prior
21 recommendations of the last several years from
22 data to bring data to life, to honor and utilize

1 data through story, so that we can humanize our
2 numbers, so that we can know behind every
3 numerator and every denominator is a mother, a
4 father, a child, a family, a community. And we
5 can elevate and honor lived experiences, not as
6 an extracurricular, but as an integral part. That
7 is one of the implicit ways this report that has
8 just been approved begins to demonstrate a valid
9 and reliable new way of doing business to
10 influence policy.

11 And we do so in an evidence based way, because
12 stories are brain science. Our brains, as the
13 neuroscientists like Antonio Damasio tell us, our
14 brains are wired to make sense. Stories is the
15 way we make sense of what we see, taste, hear,
16 smell, experience over time. So another way to
17 think about is, why not story? Why have we
18 divorced story from data? Our work in bringing
19 this particular report forward, and we hope
20 setting the standard for advisory committees and
21 maternal and child health and public health
22 practice, is to welcome back stories, not in an

1 exercise of community engagement, but in truth
2 telling and shaping solutions that are much more
3 likely to work and last. Next.

4 We have a long tradition in many of our cultures
5 of storytelling. And we also have some current
6 storytelling practices that are happening. I have
7 three slides that just begin to scrape the
8 surface of a diverse perspectives in which
9 storytelling that is evidence-based and
10 experientially-driven by generations of practice
11 are helping us be able to hear, tell, receive,
12 and transmit stories with intention and strategy.

13 After this presentation, we'll be hearing from
14 the HEAR HER Campaign. But it is an example on
15 Wanda Barfield being one of the faculty that we
16 have recruited in our storytelling work. And
17 training will be the first to say that if we
18 cannot hear her or get others to take her story
19 seriously, there are consequences that are life
20 and death threatening.

1 We want to recognize that the Healthy Start
2 Association through the community care initiative
3 of the AIM work has developed a Maternal
4 Monologues Tool Kit about how to convene story
5 circles in communities for people to tell their
6 birth stories in a way that both validates and
7 collects the data that will be able to inform
8 strategy and policy.

9 There's great examples beyond maternal and child
10 health, but a good Young Latina parenting
11 initiative out of Hear Our Stories that UMass
12 Amherst has. It is widespread and growing as a
13 movement for storytelling. And it's enabled with
14 technical assistance and methodologies.
15 StoryCenter in Oakland, California is one of the
16 premier digital storytelling practices that we
17 are brokering, and now that's manifesting in
18 Michigan and Illinois and other places. And you
19 heard a good example of that in the digital story
20 that Janelle told. Both of us are trained by
21 storytelling workshops and capacity building, so
22 that we can spread it on and borrow the

1 storytelling faculty that will help us lift up
2 those stories in digital ways.

3 That digital storytelling has also been brought
4 in from an urban Indian and a tribal, especially
5 an American Indian/Alaska Native perspective,
6 into the National Indian Council on Aging, as
7 well as technical assistance that SAMHSA is
8 bringing around mental health. So, we should know
9 that we join and lead current practices, and
10 there are many more. My ask of you, our ask of
11 you, is to help us build this inventory, not only
12 through SACIMM's work, but from what you know is
13 happening. So, on your to-do list or in the chat
14 box, if you know of strategic storytelling that's
15 happening, please help us build this inventory.
16 It does not exist anywhere as a one-stop shop. We
17 want to make that possible so folks can skip
18 ahead and know exactly how to bring this practice
19 and build on our experience at SACIMM. Next.

20 We also join a larger narrative change that is
21 happening, and the Lost Mother series that
22 ProPublica and NPR put together with reporters

1 Nina Marin and Renee Montagne starting in 2017,
2 has highlighted over six months, and they
3 collected over 5,000 stories, including Shalon
4 Irving's story, a blessed memory, Dr. Shalon
5 Irving of the CDC. This story became, if it can
6 happen to the person who was working directly
7 every day as a physician on preventing Black
8 babies from dying, how is it that her story was
9 not heard or taken seriously?

10 Many of us have heard Calvin Johnson talk about
11 his wife, Kira Johnson, and that has led to HR
12 1212, establishing grants for better outcomes to
13 address racial equity in terms of maternal
14 health. Stories can make that kind of difference.
15 And when it goes mainstream in health affairs,
16 they now have established narrative matters, and
17 other journals have done so as well, bringing
18 into the ivory tower, what has been in town,
19 going to gown, including the stillbirth story
20 from January 2022, which is referenced here. We
21 will make all these slides available to you as

1 part of the record so that you can have them as
2 access.

3 And then last, next slide, if we could just
4 recognize that without us, there has been
5 extraordinary grassroots level through these
6 three great examples, of Birthright that Kimberly
7 Seals Allers talks about, not just the loss, but
8 the unapologetic celebration of Black joy in her
9 podcast. Birth Stories in Color include
10 Indigenous women's stories, which will equip
11 parents on how to navigate that journey, given
12 racism and resistance. And even performances like
13 Wisconsin's Poet Laureate Dasha Kelly Hamilton,
14 who is able to create community conversations on
15 culture and class just by Making Cake. She is
16 also faculty in some of our storytelling training
17 about how do you turn moments into the magic of
18 stories.

19 All of these combined, next slide, into a
20 practice that we encourage for this future work
21 of SACIMM, to be strategic about storytelling,
22 not my Uncle Mickey who goes on for 20 minutes

1 and loses us, to be knowing about the following
2 factors. Next.

3 Storytelling has a science, a knowledge, and an
4 experience. And when it is intentional and
5 purposeful with ethical boundaries, in the right
6 context, can be a power tool for change. So we
7 encourage that as SACIMM uses this story and
8 brings it even further to life, it abides by the
9 best practices of strategic storytelling. We,
10 yes, are not done with this work. Janelle and I
11 and Ken Harris and Calvin Williams and Dominique
12 and Walker and Rosemary Fournier in FMIR.

13 I wanted to mention finally that I've had the
14 pleasure and by full disclosure of being
15 consultant to every opportunity for FMIR Maternal
16 and Infant Mortality Review and Child Death
17 Review to storify the work. So thank you for
18 Marie for posting it. Because storification is
19 what is needed to make amends. It's a word that I
20 don't know if it truly exists, but as it were an
21 official federal body lay, it exists from now on.

1 To storify this work is to give it the power to
2 go from word to deed.

3 So, Janelle, help us look at what strategies you
4 and I and Ed have worked on, as we have brought
5 these approved recommendations into fruition.

6 Janelle Palacios: Right. So definitely, we were all in
7 agreement from one of the very earlier ACIMM
8 meetings four years ago, that the power of story
9 qualitative data was needed. And we were provided
10 an opportunity with the in-person meeting.

11 Now, I will have to say, and give kudos to Dr.
12 Peck that... Dr. Peck is so brilliant that she
13 had a number of amazing ways that story could
14 have been embedded in this report. It is only
15 that gravity holds her down, that we are not
16 doing something super fantastic, fabulous out of
17 this like sphere. But what we have is amazing.

18 So, we recognize that data alone is not
19 sufficient, that numbers do not tell the whole
20 story. And that lived experience is really what
21 needs to help put meaning behind the numbers. And

1 as we have heard by multiple ACIMM members,
2 committee members, that the power of story is
3 real. It is important. They help us frame the
4 narrative, and this is framing the narrative
5 where our recommendations are coming from. So, a
6 lot of you talked about how important it was to
7 get the contextual piece, the history background,
8 that we're backgrounding the recommendations set
9 forth. So, that history piece is important for
10 understanding the recommendations. And then we
11 had lived experience. That is tying in the
12 recommendations, tying in the historical
13 consequences. So, this, making amends, is
14 storifying personified. It's personal. It's
15 interesting, compelling, and universal. We, by
16 engaging people, asking for their stories and
17 then putting it into the report where people can
18 go back and read again and again, it expands the
19 meaningful participation and shared ownership of
20 this. Dr. Ed Ehlinger went back and asked every
21 single person who is quoted in this report if
22 they agreed and making sure that it was

1 representative of what they were actually talking
2 about.

3 So, there has been an agreement that this report
4 is accurate with their lived experience, what
5 they shared. By storifying and by gaining, not
6 just having token visualization or a token
7 presence, by actually engaging people, we are
8 getting people's buy-in. So, the people who had
9 joined us in September and others, other
10 Indigenous people from other communities and
11 organizations, have buy-in into this report as
12 well as us on the committee. We have buy-in
13 because we want to see these stories change. So,
14 with this buy-in, it catalyzes a new partnership
15 through the realization of these shared
16 experiences. And we all come to this
17 understanding, and anyone who reads it, that
18 these are real people, be real experiences.

19 So, we have this commitment that this report will
20 be used as a powerful tool for improving the
21 health and safety of Native American women,
22 American Indian/Alaska Native women and infants

1 and families. It is with, again, a full heart
2 that I am just thanking everyone who has
3 participated in this and would like to again
4 recognize Dr. Magda Peck and Dr. Ed Ehlinger for
5 everything that they have done in helping moving
6 this forward and help framing this context, as
7 well as all the people involved on all the
8 committees that have reviewed the report, our
9 fellow ACIMM members, colleagues, but also the
10 people who have reviewed this report to make it
11 what it is that participated in September, that
12 people with lived experience, experts giving
13 their opinion, giving their testimony, as well as
14 those who were not able to present or join us,
15 but had a vested interest in this and also put
16 their two cents in, making sure that we were
17 accurately representing and sharing what needs to
18 be done.

19 And as you heard from Dr. Ehlinger, there was a
20 request for more. There was a request for more to
21 be put in this report. So, we give it to the next

1 generation to carry forward with the actions. Are
2 there any questions before we move on?

3 Magda Peck: I want to thank you, Janelle, for partnering on
4 this, and I just want to end with a note that
5 I've been doing this work for a number of years,
6 as you all know. I've been part of national
7 advisory committees, and there's a certain sense
8 that a report can sit on a shelf. Our duty is to
9 not let this sit. And there are ways and tools to
10 bring it forward. As Janelle said, I've got ideas
11 on that as somebody who does strategic
12 storytelling for public health, but I want to
13 make sure that our continuing members know that
14 there is a ways and means to bring this to life
15 and that we're on call to you for this work. So,
16 Janelle, thanks for being a good buddy, and I
17 just wanted to echo questions, observations, ante
18 up with your inventory and let us know how we can
19 continue to be of service.

20

21

22

1 **HEAR HER Campaign**

2 Ed Ehlinger: Thank you, Magda and Janelle. That was great.
3 We'll come back to this as we go on with this
4 session to get some feedback, but let's now move
5 on to another kind of storytelling that you
6 mentioned in your little presentation. That's the
7 HEAR HER campaign, and I think we've got Charlan
8 Kroelinger here and Sarah Carrigan, so I'm going
9 to turn it over to you guys.

10 Sarah Carrigan: Yes. Thank you very much. It is a little
11 daunting to follow Magda and Janelle, but I'm
12 very grateful to be here and for the opportunity
13 to present today. And just a moment, actually.
14 Sorry. I just shared, but I always forget that I
15 do need to share sound as well. So, pardon me as
16 I re-share here. Okay. Here we go. Now I'm ready.
17 All right. Well, thank you everybody. My name is
18 Sarah Carrigan, and I am a health communication
19 specialist with CDC's Division of Reproductive
20 Health. I'm joined here today by Dr. Charlan
21 Kroelinger, who you all know, chief of CDC's
22 Division of Reproductive Health's Maternal and

1 Infant Health Branch. Before I begin, I would
2 like to acknowledge and honor the Creek and
3 Cherokee nations and their people on whose
4 ancestral homelands I'm speaking from today. In
5 addition, I do want to note my gratitude to all
6 of the colleagues who have made this work
7 possible. To Delight Satter, Janelle Palacios,
8 all of you in this virtual room, and to others
9 who have helped to raise awareness of the needs
10 of American Indian and Alaska Native mothers and
11 the progress that they've made to improve care.

12 I'd also like to acknowledge the late Leslie
13 Randall for all of her work to advance this
14 awareness. There is still so much to be done, but
15 I am proud and humble to be here with you today
16 to share some of the work that we are doing to
17 hear and talk to American Indian and Alaska
18 Native mothers, their loved ones, and
19 communities. In this presentation, I will share
20 more information about the HEAR HER campaign and
21 the resources that we have produced to serve
22 American Indian and Alaska Native communities.

1 Although deaths related to pregnancy are rare,
2 most are preventable. We lose too many American
3 Indian and Alaska Native mothers each year from
4 complications related to pregnancy. American
5 Indian and Alaska Native woman are two times more
6 likely to die of pregnancy-related causes than
7 white women. This is unacceptable. I want to
8 acknowledge the trauma and the systemic barriers
9 that are linked to the disproportionately high
10 maternal and infant deaths that many tribal
11 communities experience. American Indian's and
12 Alaska Native's maternal health is impacted by
13 the ongoing and historical trauma of systemic
14 racism, colonization, genocide, forced migration,
15 reproductive coercion, and cultural erasure.
16 These factors have led to systemic barriers to
17 care, including higher rates of poverty and long
18 distance to quality healthcare services. Given
19 the disparities that American Indian and Alaska
20 Native people and communities experience, it is a
21 priority for us to reach tribal communities with
22 these resources.

1 Despite these challenges, American Indian and
2 Alaska Native people continue to be resilient and
3 thrive. Many American Indian and Alaskan Native
4 people draw strength from culture and tradition.
5 Their resilience is built through culture,
6 spirituality, shared values, and a strong sense
7 of identity. Culture serves as a protective
8 factor in the health and wellbeing of American
9 Indian and Alaska Native people. We honor the
10 lives of those who have passed on and work to
11 prevent future losses. CDC works to better
12 understand the causes of pregnancy-related deaths
13 and to apply that data to action. Data from CDC
14 surveillance systems and field work has helped to
15 inform the development of the HEAR HER campaign.
16 As many of you are aware, in August of 2020, we
17 launched the HEAR HER campaign to raise awareness
18 of the potentially life-threatening warning signs
19 during and after pregnancy, and to improve
20 communication between healthcare providers and
21 their patients.

1 It's a priority for us to reach tribal
2 communities with these resources. In 2021, HHS
3 Office of Minority Health provided funding to
4 develop a segment of the HEAR HER campaign
5 specifically to reach American Indian and Alaska
6 Native women and communities. With that funding,
7 we have been working with CDC Foundation, Market
8 Vision, which is a creative agency, Gray & Gray,
9 a native-owned and serving marketing agency, and
10 the National Indian Health Board to develop this
11 segment. CDC has worked to include the voices and
12 perspectives of American Indian and Alaska Native
13 people throughout the development of this
14 campaign, and will continue to do so as we
15 continue to develop materials and implement this
16 campaign. We are so grateful to all of the
17 American Indian and Alaska Native people who have
18 contributed their time, experiences, and
19 expertise to this project.

20 Storytelling is the center of this campaign. So,
21 now I would like to share Trivia's story, one of
22 the women who shares as part of this campaign.

1 Before I start, I would like to note that Trivia
2 shares experiences with discrimination when her
3 provider did not respect her cultural practices
4 or listen to her concerns. Her story can be very
5 hard to hear. I encourage you to go off camera or
6 to take the space that you need if this story is
7 triggering for you. We are very grateful to her
8 for sharing her experience, knowing that it could
9 help other mothers to receive better care.

10 Trivia Afraid of Lightning-Craddock: My name is Trivia Afraid
11 of Lightning-Craddock. My Lakota name is Mahka
12 T'a Tuwanpi Win. I'm an enrolled member of the
13 Miniconjou Lakota Tribe of Cheyenne Rivers, South
14 Dakota. In our culture, being a mother is a
15 great, great honor. When I first became a mother,
16 I was actually a teen mother. I had excellent
17 support because of my culture. My aunts, my mom,
18 they were all supportive, excited. Culturally,
19 there are practices that our grandmothers,
20 mothers, and aunts teach young women when they're
21 getting ready to have a baby. I started having
22 issues in my pregnancy in the beginning of my

1 second trimester. I had morning sickness every
2 single day. They shouldn't even call it morning
3 sickness. I could not keep food down. And I kept
4 telling the doctor that something was wrong. This
5 is how I know that he dismissed me from the
6 beginning of prenatal care all the way up to
7 birth.

8 I kept telling him, "Something's not right. I
9 don't feel okay." My OB knew that I wanted my
10 placenta so that I was able to bury it.
11 Culturally, for us as women, it is a part of our
12 body that was connected... It is the life source
13 that was connected to our baby. And they let me
14 know that there was nothing. I was angry and I
15 cried. That night I cried alone holding my
16 daughter. Holding her. I was just crying and I
17 felt like nobody understood or cared. Throwing it
18 away is very disrespectful. It's sacred. So, I go
19 home with baby. I had an infection and I had to
20 go back. They put me on an antibiotic and told me
21 I couldn't nurse my baby. I felt like I had no
22 connection to her. My mom's youngest sister comes

1 back into the room and she's asking me if I'm
2 okay. "It would be really good for you to talk to
3 a counselor because you're displaying signs of
4 postpartum depression." It lasted until my
5 daughter was about nine or 10 months old. Some of
6 the postpartum depression that I can remember
7 were blaming myself.

8 I couldn't even be a mother. I couldn't be a
9 Lakota mother. I started to have suicidal
10 ideation of, "Why even be here if you can't do it
11 right?" It was just dark days. My second child I
12 had about a year later. Oh, I went into the
13 second pregnancy with a mission. I was like a
14 mama bear. I was in protective mode. The new
15 doctor that I was working with not only heard me,
16 he validated me. He let me know that he
17 understood Lakota women's cultural practices when
18 it came to packaging up the placenta. I felt
19 relaxed and safe. I was really mindful and needed
20 to advocate myself. Choosing a safe primary care
21 provider has been at the top of my list. If
22 you're uncomfortable that first visit, change.

1 You do not have to keep that person as your
2 primary. If you feel that there is something
3 wrong, talk to your aunt, your mom, your best
4 friend, your nurse.

5 Your nurse would tell you that it's okay to call
6 whenever they feel that they need to call. Go in.
7 Have it checked. Never discount your gut feeling.
8 Always talk to somebody about how you're feeling.
9 If you're feeling depressed, if you're feeling
10 that you're not good enough, if you're feeling
11 that you can't go through with the birth, if
12 you're having anxiety, if you're having fear,
13 reach out to someone. Don't do it alone. Voice
14 how you feel.

15 Sarah Carrigan: Trivia's story is one of the stories that we
16 share through the HEARHER campaign. We were also
17 able to produce the stories of four more American
18 Indian women who experienced pregnancy-related
19 complications, Sarah, Vanessa, Mona, and Takayla.
20 They share their experiences with pre-eclampsia,
21 HELLP syndrome and postpartum depression, and the
22 importance of sharing your concerns if something

1 feels wrong and getting care immediately. For the
2 sake of time I will not play their stories now,
3 but I encourage you to visit our site to view
4 them. I want to note, CDC also engaged an
5 American Indian photographer to capture
6 culturally relevant photography of American
7 Indian and Alaska Native people, helping to meet
8 another need for diversity and inclusion of this
9 population in public health materials.

10 In addition to the video sharing these women's
11 stories, we've produced educational materials to
12 help raise awareness of the urgent maternal
13 warning signs and improve communication between
14 patients and providers. These materials are all
15 housed on the HEAR HER website, along with
16 additional context and links to the related
17 resources. The first one listed here is the PSA,
18 which I'm grateful. I appreciate the committee
19 playing that at the start of the meeting. What
20 you see on this slide is the Urgent Maternal
21 Warning Signs poster, which helps to raise
22 awareness of the symptoms that could indicate a

1 life-threatening situation. This is one of the
2 highest demand resources that we have in the
3 campaign, and there has already been a lot of
4 interest in getting this resource out into
5 clinics and facilities and to translating the
6 resources to make them more relevant locally.

7 In addition, we've produced conversation guides
8 and palm cards for people who are pregnant and
9 postpartum to help them share symptoms they
10 experience and raise their concerns with their
11 healthcare provider. We also have a handout and
12 palm card aimed at family, friends and other
13 support people. We know that it can be
14 challenging to talk about complications related
15 to pregnancy. This tool can help facilitate
16 conversation and make sure that people who are
17 pregnant or postpartum get the care that they
18 need. Finally, and most importantly, we have
19 materials designed for healthcare professionals.
20 Healthcare professionals play a critical role in
21 eliminating preventable maternal mortality. A
22 critical part of the solution is to really hear

1 women's concerns during and after pregnancy. The
2 materials we've developed emphasize the
3 importance of building a relationship with
4 patients, supporting their cultural strengths,
5 and ensuring they feel safe sharing their needs
6 and concerns. We also share information and
7 resources on providing culturally appropriate
8 care. Understanding and respecting the unique
9 needs and cultural practices of each patient is
10 an important part of building trust and providing
11 medical care.

12 In addition to the downloadable and print
13 resources, we've produced a suite of shareable
14 graphics and social media posts for partners to
15 amplify the message and help get these resources
16 to American Indian and Alaska Native communities.
17 These resources were launched three weeks ago, on
18 November 16th. We are very grateful to be working
19 with the National Indian Health Board on the
20 development and implementation of this campaign.
21 Next year, NIHB will help host a tribal learning
22 collaborative and help build capacity for tribes,

1 tribal organizations, tribal public health, and
2 urban Indian organizations to implement this
3 campaign. We will also use traditional
4 communication strategies, including paid media.
5 Now I'd like to turn it over to my colleague, Dr.
6 Kroelinger.

7 Charlan Kroelinger: Thanks so much, Sarah. Another place where
8 CDC is working to support American Indian and
9 Alaska Native communities and tell a story is to
10 ensure representation in the data. The work that
11 I'm about to present I want to attribute to the
12 maternal mortality prevention team within our
13 division and within the branch that I oversee,
14 and their team lead Dr. David Goodman. In
15 addition to a data brief on all pregnancy-related
16 deaths from state Maternal Mortality Review
17 Committees from 2017 to 2019, we also looked at
18 American Indian and Alaska Native deaths using
19 best practices for data analysis from
20 organizations such as the Urban Indian Health
21 Institute. Today I want to share that approach
22 and findings from that analysis.

1 Understanding differences in the underlying
2 causes of pregnancy-related deaths by race and
3 ethnicity is important for identifying prevention
4 opportunities to reduce pregnancy-related deaths.
5 Accurate classification of race and ethnicity can
6 be challenging. Methodological decisions about
7 racial classification can affect the size and
8 characteristics of the population's use in an
9 analysis. Assessments from other groups have
10 demonstrated the importance of examining
11 pregnancy-related deaths among all American
12 Indian or Alaska Native persons, regardless of
13 notation of Hispanic origins or other or multiple
14 races.

15 This slide describes the alternative approach to
16 classifying pregnancy-related deaths among all
17 American Indian and Alaska Natives that was used
18 for this analysis. As shown in the figure, using
19 this alternate approach to classifying available
20 vital records information on race and ethnicity,
21 17 pregnancy-related deaths were classified as
22 American Indian/Alaska Native. One death with

1 notation of Native American and to specify, other
2 free text field was included. Five American
3 Indian and Alaska Native deaths with notation of
4 Hispanic ethnicity or missing ethnicity were
5 included. And two American Indian/Alaska Native
6 deaths with notation of more than one race were
7 included. While this alternate approach resulted
8 in the increased identification of pregnancy-
9 related death among American Indian and Alaska
10 Native persons, because of known limitations of
11 vital records data for identifying American
12 Indian and Alaska Native persons, 17 is still
13 likely an under-count of death among these
14 persons. The next two slides will describe these
15 17 pregnancy-related deaths.

16 16 of the 17 pregnancy-related deaths among
17 American Indians or Alaska Native persons had a
18 known underlying cause of death. Among those with
19 a known underlying cause of death, mental health
20 conditions were the most frequent, followed by
21 hemorrhage. A Maternal Mortality Review Committee
22 preventability determination was available for 15

1 of the 17 pregnancy-related deaths among American
2 Indian or Alaska Native persons. Among these
3 deaths with a preventability determination, 93%
4 were determined to be preventable. The key
5 findings of this report, which is also available
6 on the CDC website, are that methodological
7 decisions about race classification can impact
8 the size and characteristics of the population
9 used in an analysis. The underlying cause of
10 pregnancy-related death among American Indian and
11 Alaska Native persons was mental health
12 conditions, followed by hemorrhage. And 93% of
13 pregnancy-related deaths among this population
14 were determined to be preventable. Thank you, and
15 please use these email addresses to reach out
16 with any follow-up questions or concerns related
17 to the information that Sarah and I have
18 presented.

19 Ed Ehlinger: Thank you, Sarah and Charlan. I'm going to open
20 it up for a few minutes of any questions or
21 comments that people have, both for Janelle and
22 Magda and also for Sarah and Charlan. Janelle?

1 Janelle Palacios: I have a question for the CDC colleagues.
2 So, thank you for that presentation. That was
3 wonderful. I just want to say thank you for
4 sharing the lived experience of women of color
5 and especially Native American women. I mean,
6 just allowing a format, a platform for people to
7 come and share that. And I want to also thank you
8 for calling out, Sarah, that Indigenous community
9 representatives and Indigenous community
10 businesses were involved in the shaping and
11 crafting of the visual representation. It was
12 amazing to have that because it demonstrates that
13 there is insight knowing that, from the
14 community, they're going to probably know a
15 little bit more of how to work with other native
16 communities, even though we might be different
17 tribes. It reminded me of the urban legend, which
18 I don't think is urban. When the Chevrolet Nova
19 was pushed out in Mexico, no one bought it.
20 It dived. It nose-dived because Nova means no go
21 in Spanish. So, they did not have a cultural
22 responsiveness in that business campaign. So,

1 thank you for not being the Chevrolet Nova of the
2 federal government pushing out something that's
3 very important. Charlan, one of the questions I
4 had. In that free text and when I read the
5 report, I was just wondering, okay, one person
6 wrote in that free text, "Native American." And I
7 was thinking as well, undercounting. Because I
8 know for myself, I personally have written in the
9 free text, "Salish and Kootenai" or "Black."
10 Other people might write in their tribal
11 affiliation and leave it at that and choose not
12 to click a box, but just do the free text box.
13 So, maybe going forward for our partners, think
14 about if you have a free text self-identity box,
15 going through and looking for tribal
16 affiliations, which some people will do, could be
17 another way of capturing a little bit more of the
18 population.

19 And then the last comment is more that this is so
20 powerful and I was tearful the first time that I
21 saw the HEAR HER campaign Native American rollout
22 of the stories, because it to me was the first

1 time that on a national level I could see that
2 Native people's voices were brought to light on
3 this issue. And it was federally-funded. But I
4 also want to recognize that I don't know the
5 dynamics of the federal funding, but this is so
6 important that it continues to need to be funded.
7 I once wrote a paper doing community-based
8 participatory research on a shoestring budget.
9 And I don't know if that was the case for work
10 that happens to be culturally informed, but my
11 experience of working with communities tends to
12 be a lot on a shoestring budget. So, I'm just
13 hoping that the Health and Human Services
14 continues to prioritize these culturally
15 informative and actionable interventions. Thank
16 you.

17

18 **National MCH Organizations from September Meeting**

19 Ed Ehlinger: Thank you, Janelle. I don't see any other hands,
20 so I'm going to move ahead here because we got a
21 couple of other little discussions before we open
22 it up for general comments about how to use this

1 report. I have invited the MCH organizations that
2 were at our September meeting to come and just
3 share a couple of minutes of what their takeaways
4 from the September meeting was and how they might
5 be using this, our report, as they do their work
6 ahead of time and moving forward.

7 And I know that CityMatCH is tied up with a bunch
8 of other things so they can't come. I have not
9 heard back from Healthy Start, but NICHQ and
10 AMCHP said that they were going to be here. And I
11 see Scott and LaToshia are here and I'm not sure
12 about Terrence, if he's here. But let me turn it
13 over to Scott. Give us a couple of minutes of
14 what were your takeaways from the September
15 meeting when you were there, which I thank you
16 for attending, for being there for the whole
17 time, and then how might you use what you've
18 learned during that and this report moving
19 forward with NICHQ.

20 Scott Berns: Thanks, Ed. Hi, everybody. I'm just going to,
21 first, I'm going to ask LaToshia actually to
22 chime in first, but while she's thinking, I'm

1 going to first say that I'd like to honor and
2 acknowledge that I'm dialing in on Zoom today
3 from the ancestral lands of the Wampanoag and the
4 Patuxet peoples. And LaToshia, did you want to
5 start on behalf of NICHQ and then I'm happy to
6 jump in?

7 LaToshia Rouse: I will just say that I'm so glad to be here,
8 but this feels so different than it did when we
9 were in a room together. And being able to feel
10 what it is like when someone is telling a story
11 in person is very different than when you're on
12 Zoom. So, that is one thing that I'm taking away
13 right now is how different this feels versus how
14 it was when we were in a room together. And as
15 far as NICHQ goes, we have started the process of
16 bringing in different organizations that can help
17 us to be able to bring awareness around this. So,
18 we're working through the process of what that
19 looks like and trying to get schedules
20 coordinated, and Scott has a little bit more to
21 say about that.

1 Scott Berns: Thanks, LaToshia. And just as a reminder,
2 LaToshia is a board member at NICHQ and I'm CEO
3 at the National Institute for Children's Health
4 Quality. So, I'd like to share a few other
5 things. First, just a kudos to a tremendous
6 experience at Prior Lake and really we just
7 alluded to, I was dialed in for the last few
8 presentations, the stories that we heard were
9 just so transformative for me personally and
10 professionally, certainly for us as an
11 organization, and so thank you for that. And I
12 was glad to see the stories actually in the
13 report as well, both through written throughout
14 the report and also at the end, the detail there.
15 In terms of takeaways from the meeting, I have to
16 say that I was surprised around the
17 disappointment with the IHS, Indian Health
18 Service, and I do plan on following up with folks
19 there to learn more about that.

20 I think it was painful to hear that. I think
21 despite all good intentions from folks, there's
22 definitely... And I note that you made quite a

1 mention of that in the report. I also appreciated
2 bringing the Broken Promises Report to light. I
3 have brought that up a few times in some of my
4 meetings since then, and there are very few
5 people who are even aware of that report. And so
6 that was an eye-opener for me. I mean, all the
7 presentations were very powerful. Certainly, the
8 pressing issues for Indigenous women around
9 incarceration and violence and violence
10 prevention. Don Warne's presentation, I think he
11 actually presented after I was on a panel and I
12 appreciated him. Although he didn't call me out
13 I'm going to call myself out here, call myself
14 in, to the fact that I talked about power during
15 our panel presentation and he pointed out it was
16 more than being about sharing power.

17 It was about giving up power. And so, I think
18 that, in the terms of NICHQ's anti-racism work
19 and the work we're doing with the equity systems
20 continuum that I mentioned in September, thanks
21 to Dr. Stacey Scott, I need to keep that in mind.
22 And then the last thing I had here was just

1 another mention around the recommendations and
2 just how impressed I am with the vetting that has
3 happened in the work over the last two years. I
4 didn't realize that you've been working on this
5 for such a long period of time. And so Ed, in
6 terms of the question and what LaToshia started
7 talking about and what's changing at NICHQ, I
8 mentioned that this is definitely transformative.
9 I think many of you saw my LinkedIn post. I don't
10 post on social media very often, much to the
11 disappointment, I think, of my communications
12 folks.

13 But when I do, I try to make it meaningful. And I
14 did post on LinkedIn, as did LaToshia after this
15 meeting, in that I made a public commitment that
16 NICHQ would do more. And it's been about three
17 months, a little under three months since that
18 meeting, and I do remain committed to that. And I
19 think Terrence may be on the line shortly to talk
20 about the anti-racism commitment and
21 accountability statement that a number of
22 organizations made to each other, including the

1 folks that were at that meeting in September. And
2 I think that the learnings from Prior Lake will
3 help us be more purposeful, both as organizations
4 but also individually, but also as a group of
5 organizations as we talk about equity and we talk
6 about communities or people of color, that we
7 specifically think about American Indian and
8 Alaska Native communities. I think oftentimes
9 we're talking about the Black community when
10 we're talking about anti-racism efforts and we
11 need to be more...

12 This is what I learned during those two days, to
13 be more purposeful about our language and our
14 efforts. And certainly at NICHQ, I think I
15 mentioned that equity is infused in who we are,
16 what we say, and what we do. And also in that
17 anti-racism commitment and accountability
18 document, we've already been more purposeful. I'm
19 Scott Berns. I'm sorry. I'm Scott Berns from the
20 National Institute for Children's Health Quality,
21 for someone who just chatted in. I can tell you a
22 couple stories, since we're talking about

1 stories, in terms of how I am bringing this
2 report and the experience to our work already.
3 We're working on a number of very large proposals
4 right now at NICHQ. I think I mentioned that
5 we're completely grant funded. Most of it is
6 public funding, meaning government funding.

7 And I found myself and my team now to be much
8 more purposeful in asking questions when we
9 engage families, because we engage families in
10 everything that we do, "What are we doing in the
11 context of the American Indian and Alaska Native
12 community?" So, already in the proposals that
13 we're writing, we're becoming much more
14 purposeful there. I think LaToshia mentioned some
15 meetings that we've been setting up. We do have a
16 meeting next week with the National Indian Health
17 Board, thanks to some connections that we made in
18 Prior Lake. So, that'll be a first for me. And I
19 also can plan...

20 Prior lake. So that'll be your first for me. And
21 I also again plan on reaching out to IHS. So Ed,
22 those are some initial comments to share with

1 folks at ACIMM and others that are dialed in. And
2 LaToshia, you asked a question about Terrance
3 Moore. Help me out.

4 Ed Ehlinger: Terrance is now on. Terrance is now on.

5 Scott Berns: Oh, Terrance is on. He's the CEO at AMCHP.

6 Ed Ehlinger: Yeah. Thank you, Scott. I really appreciate it.
7 And it heartens my soul to hear you say the
8 things that you're doing and the things that came
9 from that meeting. That is really good. And
10 Terrance, why don't you give us a couple minutes
11 of your takeaways from the meeting in September,
12 and how this report might change how AMCHP does
13 its work.

14 Terrance Moore: Thank you all for having us back. And I want
15 to share, I've actually been on for about 45
16 minutes or so, so I've had the opportunity to
17 listen in on the amazing work from the last
18 panel. And want to also thank the members of the
19 committee for being so thoughtful in terms of
20 preparing an encounter with community. Some
21 really robust recommendations for us to think

1 about how we actualize. And so I wanted to spend
2 a little bit of time today; I've had the
3 opportunity to review the 50 pages of
4 recommendations and really mull them over, and
5 think through at least preliminary steps that
6 AMCHP can take moving forward. And I want to
7 pause parenthetically, to say what is special
8 about this particular report, and the leadership
9 of the committee, and Ed, you reaching back out
10 in my long career in public health, rarely have I
11 ever been asked back after a panel discussion to
12 provide thoughtful activities that we can do to
13 actualize this.

14 So I just want to make that note for the record
15 that this is the way we should be doing business
16 in terms of us working in partnership. So I
17 wanted to share a little bit about AMCHP'S
18 strategic plan. This is very much relevant in
19 terms of how we actualize these recommendations.
20 Belinda Pettiford is actually the president of
21 AMCHP. Last month the board of directors approved
22 the organization's strategic plan through 2027.

1 Front and center is an area that is very timely
2 and noteworthy around advancing health equity and
3 reducing racism, or really adhering to our anti-
4 racism principles. I heard Scott mention a moment
5 ago about the collaboration that NICHQ, AMCHP,
6 and other partners in our field are engaged in.
7 CityMatCH being another partner as well. National
8 Healthy Start as well, Al, joined together around
9 our joint commitment across organizations around
10 anti-racism.

11 We meet regularly, bimonthly, to really talk
12 through how we advance our internal efforts, but
13 also how we are working as a collective through
14 this. Why is AMCHP strategic plan in this group
15 important in this discussion? I think all aspects
16 of health equity across all communities,
17 particularly as it relates to Native Americans,
18 Alaskan individuals as well, is area that we see
19 great potential. So, when I was going through the
20 report, there are a few areas that I wanted to
21 flag that I think our organization can commit to
22 right away. It was not lost on me the

1 recommendations and the discussions related to
2 ensuring the end to data erasure.

3 I think as public health institutions it is
4 paramount that we think through, examine,
5 interrogate our systems and figure out roots and
6 ways that we can collect data better. And that
7 means working in partnership with our colleagues
8 and friends at CDC and HRSA and in other areas of
9 the federal government to ensure that we're
10 collecting accurate data. And data that is not
11 simply just quantitative in nature, but we're
12 looking at qualitative information. Magda Peck
13 talked about, and others, the value and necessity
14 of storytelling.

15 And so in addition to the quantitative
16 information, I think that there's great
17 opportunity to open spaces to allow stories to be
18 part of our overarching narrative and our
19 responses to these grave issues. I think another
20 area that; as part of our anti-racism framework,
21 that was called out in the report is
22 acknowledging the profound harm of the doctrine

1 of discovery that has been part of our discourse
2 as a nation since its inception. And I think as a
3 public health institution it is important and
4 necessary that AMCHP make that a part of every
5 convening and opportunity that we have. That we
6 are part of an infrastructure that essentially is
7 the outskirts of lands being stolen from peoples.
8 And I think we have to just speak truth around
9 where we are and how we got here. So I think that
10 is something we can commit to.

11 I've been talking to our partners internally, our
12 conference leads, our other staff, and there's a
13 discussion that we're having around how we can
14 really open our agendas and meetings. As well,
15 AMCHP's conference is coming up in May, in New
16 Orleans. And I would like to share; you've heard
17 it here first, we would like to open and create
18 space and work in partnership with the committee
19 and others to have a session or sessions to
20 review the recommendations, and to also invite
21 storytelling at our conference. And so I would
22 love to talk specificity with you all and how we

1 might do that. How we might convene the persons
2 that we think could really help us shape sessions
3 during our conference.

4 And then finally, I think the last piece is, just
5 really how do we meaningfully engage the
6 communities? And more than just one set of
7 conferences episodically throughout the year.
8 AMCHP remains really open to meaningful community
9 engagement in all of its forms. And so we hope
10 that this is one of multiple opportunities that
11 will continue to expand those opportunities with
12 community and partnership. So those are my
13 preliminary take takeaways from last month's
14 meeting. And just, again, want to thank the
15 committee and my colleagues for the opportunity
16 to really do deep thinking on this.

17 Ed Ehlinger: Terrance, thank you. I had mentioned earlier that
18 part of our job is to build community capacity,
19 and what I'm hearing from NICHQ and AMCHP is that
20 this conference that we had, the meeting that we
21 had, is building capacity in our community, our
22 MCH community, broadly defined. So, I really

1 appreciate that. And I know, Scott, you said you
2 had a couple of extra other comment to make
3 following up.

4 Scott Berns: Yeah, you sent four questions. I don't know if
5 you're going to get to all of them, but there are
6 a few thing other things I wanted to share. I'm
7 trying to be cognizant of time. In reflecting on
8 some of the other things we're going to be doing,
9 I guess I just want to say that to your last
10 point, Ed, I really feel like we as MCH
11 organizations need to be ambassadors of this
12 report. I think it was Magda who mentioned
13 earlier, we don't want this report to gather dust
14 on a shelf. I've seen many of those over the
15 years, but this is such a powerful document and
16 such important work, and so I've already started
17 doing this. I know Charlan and other folks from
18 the CDC are on the line. And we were in Atlanta
19 last week for the launch of a big project around
20 our perinatal quality collaboratives work, and
21 this has already come up, including some of the
22 data that Charlan showed.

1 And I actually had a meeting with a group of
2 states and they were talking about what they
3 could be doing, and I mentioned this report.
4 Because Ed, I got the report, the draft report
5 two days before that meeting down in Atlanta. And
6 I had asked there as well about the Broken
7 Promises Report; and I was in a room of about 15
8 people in an ad hoc meeting, and not one person
9 raised their hand when I asked if they had
10 actually heard of the Broken Promises Report. And
11 then I mentioned the recommendations coming out.
12 And the folks I was talking to basically work
13 primarily with hospitals who were working to
14 reduce disparities, and tackle equity in the
15 context of maternal morbidity and mortality and
16 infant morbidity and mortality. And it really got
17 the gears going, specifically around data and
18 some of the, they termed it, low-hanging fruit,
19 in terms of some of the data collection that is
20 done.

21 And they don't really have a good grasp on the
22 American Indian/Alaska Native data in terms of

1 outcomes to some of the... I think Janelle
2 mentioned this as well. So anyway, I do think
3 that point is important that we need to take this
4 with us, not literally carry around 50 pages, but
5 take the three large recommendation buckets with
6 us as we're talking. And then in terms of NICHQ's
7 work, I should also say that in our current
8 projects, I mentioned some of the proposals we're
9 working on, but in our current projects we have
10 about a dozen projects including the CDC-funded
11 National Network Perinatal Quality
12 Collaboratives. But much of our work, actually
13 most of our work is funded by HRSA.

14 I should mention that we are the TA and support
15 center, as I think you all know, for Healthy
16 Start and the 101 Healthy Start Communities. And
17 getting back to storytelling, we are launching a
18 story work project. And thanks to Dr. Peck and
19 Dr. Palacios for your help in that regard. And
20 Janelle is taking quite a leadership role there
21 in terms of our specific reach out around the
22 American Indian/Alaska Native community. And so

1 Janelle, I don't know if you want to comment on
2 that, but we are already bringing this to life in
3 terms of the current work that NICHQ is doing. I
4 don't maybe a little handoff to you, or do you
5 want to save that for later?

6 Janelle Palacios: Oh no, I think this is a great time. Just
7 that it was brought up earlier in our
8 conversation that what was recorded in the report
9 is frequently not known, it's not in the public
10 view. It's not in a public consciousness, we're
11 not really taught about the details of our
12 history. And some of the work that I'm working
13 with NICHQ TA Center, is to bring that history to
14 life. So creating more of a contextualized
15 history for understanding the doctrine of
16 discovery, dominant worldviews, and bringing that
17 into how policies and practices were set up in
18 our country, that have created the conditions and
19 outcomes we have today. So that is part of that
20 work, tying in with storytelling, that some
21 Healthy Starts are able to do.

1 Scott Berns: Yeah, thanks Janelle. And there's more to come
2 for sure. And we're gathering ideas, and I'm
3 looking forward to working with all those groups
4 that Terrance and I alluded to, to see what else
5 we could do in the future. And I guess I just
6 should speak for NICHQ, and I'm sure AMCHP feels
7 the same way, I would welcome the opportunity to
8 return whenever you'd like us to return. It's
9 been a great opportunity to continue to check in
10 and check back with y'all, particularly as
11 there's some changeover in some of the leadership
12 there. We're all about continuity, for sure.

13 And I would be remiss to not mention Ken Harris,
14 who is vice president Engagement Community
15 Partnerships from NICHQ, leads the TA support
16 center for Healthy Start, and his commitment not
17 only to that work, but to ACIMM. He's been on the
18 Health Equity Workgroup Committee, and he plans
19 to continue to do that as well. And who knows,
20 maybe there'll be someone from NICHQ in the
21 future who's a formal member of ACIMM, but if
22 that doesn't happen, does not preclude us, will

1 not preclude us from continuing to communicate
2 with y'all, and to disseminate and be ambassadors
3 for particularly, this excellent report that is
4 going to the Secretary soon.

5 Ed Ehlinger: Now, if you guys could hang out for a little
6 while, we have one voice that we haven't heard
7 yet, and that's the Indian Health Service. And I
8 know Tina Pattara-Lau is on, and I'd just like to
9 have her comment a little bit about what she's
10 been hearing. And Indian Health Service, we know,
11 is a crucial part of this whole universe that we
12 have to deal with. So, Tina, welcome. I'm glad
13 you're here with us, and listening, and just any
14 comments that you might have to share with the
15 group.

16 Tina Pattara-Lau: Thank you Dr. Ehlinger. I wanted to
17 acknowledge Dr. Peck had her hand up.

18 Magda Peck: I can go after you. I actually just got some
19 information from CityMatCH folks because they
20 want to be part of this narrative, and I can go

1 after you. I would love to have your voice come
2 first.

3 Ed Ehlinger: Yes, please.

4 Tina Pattara-Lau: Of course. Thank you. Thank you to the
5 committee again for the opportunity to
6 participate. Thank you to Dr. Edward Ehlinger, as
7 well. After I reached out, he invited me to
8 comment. I really do appreciate your team's hard
9 work and dedication to focus and really
10 strengthen the spotlight on American
11 Indian/Alaskan Native maternal and child health
12 over the past two years. As many of you know, I
13 am the Maternal Child Health Consultant for
14 Indian Health Service. This position, before me,
15 was previously vacant for two years. And then
16 before that was about an eight-year term. I'm
17 also an OBGYN, and I'm still actively practicing
18 to serve AI/AN populations, still delivering
19 babies and working in the clinic. So, this is
20 very close to me. Everything I do is to bring our
21 care to the patient. These recommendations will

1 be really helpful in guiding the MCH priorities
2 for IHS.

3 It's a good reminder that we all share the same
4 goal, to continue to improve maternal and child
5 health for all AI/AN communities. For all
6 pregnant people, we can all do better. When I
7 onboarded in June, you heard from myself, as an
8 IHS physician, as well as from Dr. Christensen,
9 our CMO and Elizabeth Carr as our senior staff.
10 In September, it was an honor really and truly to
11 hear aloud the stories and the bravery from the
12 folks who did share. Something that as a
13 healthcare provider, we only have the privilege
14 of hearing behind closed doors, and sometimes
15 under great duress. I am here today to affirm
16 that IHS is present and listening. I'm here to
17 support this committee moving forward. I do
18 comment that, and I agree that words do matter,
19 I'm looking ahead to the sustainability of the
20 healthcare workforce. I remember that it does
21 start with our youth, an influence that the words

1 and stories have on their choices, and then shape
2 the future fabric of our society.

3 I'm one of 76 PHS and IHS physicians who serve as
4 mentors to the next generation of applicants and
5 students in training. And so as we say to them,
6 as they make their decisions about what practices
7 and communities they want to serve, I encourage
8 them to physically visit and rotate at IHS
9 Federal, tribal and urban sites. Talk to the
10 providers, the midwives, nurses, and support
11 staff on the front lines. Listen to the patients
12 in the waiting room. Offer prayer, smudging
13 traditional practices, especially after a loss.
14 Decide what practice is best for you and your
15 family, whether it be the brand-new tertiary care
16 center in the city or a small remote clinic
17 accessible by air. Also consider where your
18 skills are needed. Where will you have an impact?
19 What do you want your legacy to be? It's an honor
20 to serve alongside the people in IHS, who do the
21 work every day, and advocate for our staff and
22 patients.

1 If you'd like to collaborate moving forward, I'll
2 put my email in the chat. You can certainly reach
3 out to me. In line with the CDC report that was
4 released in September of this year, acknowledging
5 the majority of the postpartum deaths occurring
6 postpartum most commonly due to mental health
7 conditions, being suicide and disorders of
8 substance use. We have been working on a couple
9 of initiatives behind the scenes, that I'm happy
10 to share with you at a later time when I get the
11 green light. So again, thank you for the
12 opportunity to participate today.

13 Ed Ehlinger: Thank you. Thank you, Dr. Lau, Tina Pattara-Lau.
14 Appreciate that. And we're going to take a break
15 in about 10 minutes. And I want to have some
16 discussion among ACIMM members about how to use
17 this report. But I built in enough time in this
18 agenda, so we'll be coming back when we talk
19 about the next steps for ACIMM. We'll be able to
20 come bring that up. But Magda, did you have some
21 feedback?

1 Magda Peck: Yeah, I just wanted to be... As Senior Advisor to
2 CityMatCH, in one of my roles. Dr. Denise Pecha
3 was at our meeting and is unable to be with us
4 today, but wanted to affirm, as with the partner
5 MCH organizations, that CityMatCH has already
6 began to run with what was seen, heard,
7 experienced, and learned in our time in Shakopee
8 Mdewakanton Sioux on site. And so specifically
9 three things she asked me to share. One is that
10 given that over 50% of American Indian/Alaskan
11 natives live off of tribal land, and impetus has
12 been initiated for every CityMatCH member health
13 department in local areas to strengthen ties with
14 Urban Indian Health Centers and have other
15 opportunities for unique urban Indian maternal
16 and child health connections. Second, as has been
17 done at the CityMatCH meetings over the last
18 several years, particularly since the time in
19 Rhode Island, the next meeting will be in New
20 Orleans in September 2023.

21 And not only will the local host be the local
22 health department but working directly with

1 tribal communities and populations and
2 organizations within the New Orleans and
3 Louisiana area. And third, the Urban Indian
4 connection was made with relationships, which
5 just reinforces what we heard from the other two
6 organizations, but specifically with the Urban
7 Indian Health Board. And so I think that the
8 catalyst nature is playing out from an urban
9 strategy in addition to what we heard from NICHQ,
10 AMCHP, and indirectly Healthy Start. So Terrance,
11 you're right, oftentimes you give a talk and then
12 you're like, "Huh, what happened to that?" It is
13 our intention to engage the primary MCH
14 organizations, particularly those devoted to
15 health equity and opportunity, not only to carry
16 it forward individually, but ideally for you all
17 to work collectively together in this unique time
18 of opportunity, to address the specific
19 conditions and opportunities of American
20 Indian/Alaska Native mothers and infants. So,
21 thanks on behalf of CityMatCH.

1 Ed Ehlinger: All right, so this is my challenge to the sake of
2 moving forward. I think ACIMM, as an organization
3 or as a committee, I think we've developed some
4 relationships with AMCHP and NICHQ and Healthy
5 Start and CityMatCH, and I hope that
6 organizational relationship continues and grows.
7 But for each individual member, you live in a
8 state, get to know your state MCH director. You
9 live in a state where many of you have Indian
10 health boards, get to know somebody from your
11 Indian Health Board.

12 You live in places where there's cities, and
13 CityMatCH probably has an MCH director, urban MC,
14 get to know that person. We can build these
15 relationships at the local level, at the state
16 level, and at the national level. And that's what
17 I would really encourage you. And certainly, the
18 tribal epidemiology centers, where good source of
19 data, develop some relationships that'll help
20 you. I think no matter what you're doing as
21 individuals, it'll help your professional lives,
22 but it'll also help our work collectively as

1 SACIM, and as a group trying to work for
2 improving ANAI health in our country. Any
3 comments, questions for our panelists? Either
4 CDC, our storytellers are AMCHP and NICHQ? Any
5 questions, comments?

6 Charlene Collier: Hey, this is Charlene. I really enjoy having
7 our colleagues here. I know Scott, LaToshia well.
8 I'm a board member of NICHQ as well, but I think
9 this is the space we should be bringing people
10 in. If the committee begins and ends with us,
11 then we haven't done our job. So I really like
12 the idea of a warm handoff and making it very
13 easy and accessible and talking through it.
14 Because it really is; the document's a document,
15 we read it, but having the ability to talk and
16 see the faces that put it together, to know the
17 effort and work, and know the process. Because
18 the process, even though it was documented, can't
19 be fully lived or experienced. So, I really
20 appreciate the organizations that have joined,
21 and really encourage us to think how, even in
22 small groups within the committee, throughout the

1 year, if it's just that brief meeting to share
2 the report, to really make it a warm handoff.

3 To be something that we, as you mentioned; even
4 if it's in our local state, but even as a
5 committee, even if it isn't a formal full
6 meeting, but inviting partners within communities
7 to be able to... Because I do think it takes that
8 explaining. It's still a government report, it's
9 still from that level, and being able to gain
10 that trust.

11 And I think that is best represented face-to-face
12 or being able to see the faces who are put
13 together, so people aren't like, "It's just
14 another report." And I think it will require
15 verbal communication, face-to-face communication.
16 And it is not enough to post or tweet about, or
17 share, because it is... Alone, it's a document,
18 but when we bring it with ourselves, it becomes
19 something else. And so not to lose that emotion
20 and power that we came to in voting, to affirm
21 it. We don't want to lose that throughout the
22 year, because I think we're at this height of

1 energy now. And to keep that going, it really
2 will be through stories.

3 It'll be through the story of sharing how this
4 report came to be, and not letting that story be
5 lost. And so the more we can continue to plan and
6 be intentional about bringing people in, and
7 repeating the process, and sharing that process.
8 Today should be the first time we do it, but not
9 the last. So yeah, again, I want to thank
10 everyone from AMCHP, the CDC, and the teams who
11 are here. And hopefully it won't be the last time
12 we get to promote the report together.

13 Ed Ehlinger: I talked about health is about partnerships. And
14 being in partnership actually requires some
15 accountability to each other. And that's the
16 reason of inviting these folks back again.
17 Because they need to be accountable to us, and us
18 to them. And so you have that accountability with
19 each other. It keeps the partnership active,
20 keeps it current, keeps it moving forward. And
21 so, I hope that SACIMM continues that
22 partnership, and holds each other accountable. We

1 need to be accountable as a committee to keep
2 moving the needle forward. And you as partners,
3 NICHQ, and AMCHP, and CityMatCH, and Healthy
4 Start, are also part of that partner. So that's
5 the accountability piece.

6 Magda Peck: And to follow up on that quickly, is that four
7 years ago; and we'll talk about this at the end
8 of the day, SACIMM was dismantled, not visible,
9 not terribly viable. It had not met for two years
10 or more. And one of our commitments, as we came
11 on, 10 or 12 of us at most, was to raise the
12 visibility and viability and voice of SACIM. And
13 I just want to acknowledge that this conversation
14 is demonstrative of that restoration and growth,
15 and opened doors for the next iteration of SACIM.
16 So that the silence will not be acceptable. And
17 the strategy makes us be the ambassadors for word
18 to deed. So, Ed, great leadership on that
19 intention. And this is a manifestation that I
20 observe, is different from four years ago.

21
22

1

Break

2 Ed Ehlinger: All right. Well, we've been sitting... At least
3 I've been sitting for a while. I think it's time
4 to take a break. More conversation will continue.
5 This is never a be all, end all. But I think we
6 need to take a little break, so let us take a 17
7 or 18-minute break. We'll be back at two o'clock
8 for some public comment if there is some. So,
9 thank you for joining us. Terrance, Scott,
10 LaToshia, Tina, thank you. And Charlan and Sarah,
11 all great presentations. A lot of good
12 information. And we'll see you back in about 15
13 minutes.

14

Public Comment

15 Ed Ehlinger: All right. Welcome back. It is now afternoon
16 here. I know some are still in morning mode, but
17 it's good to be back. We'll wait till we see a
18 few more images. That's good. So I have to share
19 a little bit of something that just brought a
20 little joy to me just now. So as we were ending
21 up the last session, I'm sitting here in front of
22 my computer listening to all of these wonderful

1 discussions. The snow stopped falling, and the
2 sun came out. And I don't know about where you
3 are, but here in Minnesota at this dark time of
4 the year, people put lights out and they have
5 this new thing where you have little sparkly
6 lights that go all over people's houses, little
7 dots of light, of different colored light. I
8 don't know if that goes on in your territory, but
9 here in Minnesota that happens.

10 And so, I'm sitting here, and the sun comes out,
11 and all of a sudden, I see these little sparkles
12 all over my wall. What's happening is the
13 sunshine is hitting this tie that Janelle gave
14 me. And it is like a prism that's just sparkling
15 throughout my wall. There's got to be some
16 symbolism in that. But it was like, "Oh my
17 goodness, this is just way too cool." So, thank
18 you, sun. Thank you, snow. Thank you, Janelle,
19 for the gift. And it just seemed appropriate at
20 the time where we were sharing the connections
21 that we had with what the work that we're doing,
22 with what's going on in NICHQ, and CityMatCH, and

1 AMCHP. So it was just a nice convergence of
2 stuff. All right. We're at a point where every
3 meeting we... Because we're a public group, it
4 needs to have some public comment. And Vanessa,
5 are there public comments that are going to be
6 available to us?

7 Vanessa Lee: Thank you. And yes, we have one person who has
8 requested to provide public comments orally to
9 the committee, Joy Burkhard. Thank you for being
10 on. You're from 2020 Mom, so I'm going to turn it
11 over to you to introduce yourself and share your
12 comments with the committee.

13 Joy Burkhard: Great. Hello, everyone. Like you heard, my name
14 is Joy Burkhard. I'm the founder and executive
15 director of the nonprofit organization 2020 Mom,
16 soon to be called the Policy Center for Maternal
17 Mental Health. We are a national nonprofit whose
18 mission is to close gaps in maternal mental
19 health care. We've recently been named a field
20 catalyst by Bridgespan for our 10-plus years of
21 work, advancing the field of maternal mental
22 health often in unseen ways. And my job as the

1 executive director is to be sure that we are
2 being seen and our important messages, and work
3 together, continue to move forward. I want to
4 acknowledge, just like so many of you have today,
5 that I reside on the homelands of the beautiful
6 and wise Tataviam people. And Tataviam is a
7 Serrano word meaning people facing the sun. I
8 think that's very apropos for what we just heard
9 about with the sparkles on the wall and so much
10 more earlier.

11 It's also a unique opportunity for me to honor
12 the dear Navajo woman that helped raise me and my
13 twin sister who were born prematurely almost 50
14 years ago. She nurtured us in powerful ways and
15 her name was Gussie. And Dr. Peck, it's nice to
16 see you again, and also colleagues from AMCHP,
17 CityMatCH, and NICHQ. Dr. Peck, we've met at APHA
18 and at UCSF from various projects. And I also had
19 the privilege of being honored by the APHA with
20 the Maternal and Child Health award for
21 leadership and advocacy in 2019. So I just wanted
22 to make remarks to just thank you this committee

1 for lifting up the important work, not just in
2 infant health and prevention of mortality but
3 also maternal health and maternal mortality, and
4 for acknowledging the critical intersection that
5 for so long, I think, has gone unnoticed.

6 And I'm here today to share with this esteemed
7 committee the importance of continuing to
8 prioritize maternal mental health. As you may
9 know, it's one in five women on average who
10 suffer from maternal mental health disorders. And
11 Black women, and Indigenous women suffer at
12 nearly twice the rate as white women. And as you
13 know from the latest report issued by the CDC in
14 September, which we're so grateful, was unveiled
15 at a congressional briefing that we hosted
16 through our project called the Mom Congress. We
17 heard from our colleagues from the CDC today that
18 maternal mental health conditions, defined by the
19 CDC, as suicide and drug overdose are the leading
20 causes of maternal death. Native women and white
21 women are particularly at risk of death to these
22 conditions. At 2020 Mom, our work involves

1 centering mother's stories and lifting critical
2 and creative policy solutions that are aimed at
3 closing gaps in the health care delivery system.

4 And we're interested in reducing birth trauma,
5 which we heard about in stories today, and also
6 ensuring that all women are screened, accurately
7 diagnosed, and offered a range of evidence-based
8 treatment options. Your new report is an
9 important one, and the stories we heard today
10 illustrate the critical need to do more and to do
11 much more quickly. I wanted to share three
12 opportunities that struck me as you were making
13 remarks. One is to highlight the opportunity to
14 further interagency and inter-committee work
15 around the issue of maternal mental health. The
16 TRIUMPH for New Moms Act addresses this. It's a
17 pending piece of legislation, and this need, and
18 it's expected to pass through the omnibus and be
19 signed into law. But regardless of its fate,
20 given things are so touchy on the hill right now,
21 I really want to emphasize there's an important
22 opportunity here.

1 Again, regardless of its fate, given maternal
2 mental health has not fit neatly into any one
3 agency or committee's scope, and deserves to be
4 lifted out of the cracks it's fallen into. I also
5 wish to share there is, for the first time in the
6 US, a set of US data on how often women and other
7 birthing people are being screened for maternal
8 mental health disorders through a new set of
9 HEDIS data. The results show that less than 20%
10 of all women in the US are being screened, which
11 we expected, but it's no less heartbreaking. I'm
12 happy to share more about those rates with any of
13 you in the chat here. And then finally, I want to
14 invite the committee to join our 13th annual
15 Maternal Mental Health FORUM this March to
16 present the new report on Indigenous maternal
17 health and maternal mortality. Thank you for your
18 leadership, and for all that's yet to come for
19 maternal mental health. Thank you.

20 Vanessa Lee: Thank you so much, Joy. Any comments or questions
21 from the committee members for Joy? Oh, Belinda.
22 I see your hand is up.

1 Belinda Pettiford: Thank you, Joy, for coming and sharing your
2 comments today. Two quick questions. I would like
3 to hear more on the HEDIS measure, because that
4 is an area that we've been looking at in many
5 parts of the country, and I know my own status
6 and area that we have been trying to elevate with
7 some work. And then the second thing is probably
8 a quicker thing. You shared a forum that you're
9 hosting in March. Do you actually have the dates
10 that you can drop in the chat or you can share
11 them with the group?

12 Joy Burkhard: Yep. I can drop both links for both of those. The
13 HEDIS data and the forum into the chat. It's
14 March 22nd through the 24th, and I'll drop that
15 into chat here in just a moment. Thank you for
16 the questions.

17 Belinda Pettiford: Thank you so much, and thank you for
18 continuing to remind us to make sure that
19 maternal mental health is on the forefront of our
20 work. Thanks.

21 Joy Burkhard: Thank you.

1 Vanessa Lee: Janelle, I saw your hand.

2 Janelle Palacios: Oh, thank you. No, just thank you as well,
3 Joy, and I would've echoed the same questions
4 that Belinda shared. And just... Again, as a
5 clinician, lend my voice to the experience that
6 nearly every person, that pregnant person I take
7 care of on the floor, the unit, the labor and
8 delivery unit, and postpartum has some degree of
9 mental health concern, and that there needs to be
10 much more awareness about this. I'm really glad
11 to hear about the work that your organization is
12 doing. And then when we talk about Native
13 American women in particular, or women from
14 marginalized communities, historically
15 marginalized communities and backgrounds that
16 contextualizing this whole historical piece and
17 all the systems in place, that there is ample
18 room for more work to be done, understanding the
19 perinatal mental health concerns and its effect
20 intergenerationally. So, wonderful to hear that
21 this is work that you're doing and that you have

1 a forum focused on Native American people. Thank
2 you.

3 Vanessa Lee: Great. Thank you to the members. And thank you
4 again, Joy, so much. And we see your resources
5 put into the chat. Thank you again. Magda.

6 Magda Peck: Yes. Joy, how great to see you again. Thanks for
7 your continued leadership. It's more of a
8 question back to Ed and to the committee. Your
9 third point was an opportunity to have the
10 findings of SACIMM and this report presented at
11 your annual meeting. And I thank you for that
12 opportunity on behalf of this group. And it begs
13 the question about dissemination that we can come
14 back to Ed about how... If we all are ambassadors
15 for this work, in what form can we put together
16 some tools that will allow us to be able to make
17 presentations and some clarity about who speaks
18 for SACIMM going forward, would be helpful, given
19 this entrée that we have already from Joy and her
20 group. And as folks will be in demand, how do we
21 tell one story, and what are the storytelling
22 tools that we shape together as we serve as

1 ambassadors in the field? So Joy, thanks for the
2 question and I'll refer it back to Ed as we do
3 further conversation about dissemination.

4 Ed Ehlinger: That will be part of the conversation a little
5 bit later, without a doubt. And Marie?

6 Marie-Elizabeth Ramas: Yes, thank you for the presentation. I
7 echo the resounding need for better support
8 services for our birthing parents and behavior
9 health. I know that many facilities are requiring
10 depression screening to be done when birthing
11 parents come in to deliver. The problem is, is
12 what happens after they screen positive, and the
13 vast majority of... Well, I can't say that. A
14 disproportionate amount of BIPOC birthing parents
15 don't have the same measure of access to Quality
16 Behavioral Health Services. And so I'm wondering
17 if there's a space here, Ms. Burkhard, of
18 incorporating and aligning with primary care,
19 specifically with our family physician and
20 internal medicine to help create a continuum of
21 care for our birthing parents. So I know there's
22 that six-week postpartum phase, obviously, then

1 afterwards, then what? And oftentimes, coming
2 back to their medical home, there might be
3 nuances in presentation that is not necessarily
4 picked up immediately, postpartum that needs to
5 be followed through with. So, I'm curious if you
6 have any insights on that as we think about how
7 to share this information to our circles of
8 influence.

9 Joy Burkhard: Thank you so much for the question, and I will do
10 my best to keep it brief and welcome some ongoing
11 conversation in whatever way works best for the
12 committee. Certainly, the challenge even outside
13 of hospital settings in some states including
14 California where I reside, there are mandates for
15 providers to screen for maternal mental health
16 disorders. But then what question is quite a
17 significant one, and unless you're in a community
18 that has built up these systems, largely, the
19 health delivery system in part because of the
20 bifurcation of payment, I need to add, is that
21 important challenge is one I think needs to be
22 addressed. But the bifurcation of mental health

1 delivery from medical care is a real challenge
2 for us, and I think is really at the root for
3 this lack of referral pathways. But we also have
4 significant workforce shortages in the behavioral
5 health system with psychiatrists and peer support
6 workers according to HRSA's analysis being the
7 fields that have the greatest opportunity for
8 growth or the greatest workforce shortages.

9 But every single state has significant workforce
10 shortages, particularly post-COVID for behavioral
11 health. So it's an opportunity for us to really
12 lean in. We have identified essentially 50 levers
13 that need to be pulled to address this
14 substantive problem. It's why none of us have
15 solved this problem yet because it's so complex
16 in part, because of these health delivery issues.
17 And the last thing I will say... And about twenty
18 of them have been pulled. One is that there
19 should be a HEDIS measure. We just we're
20 successful in getting that HEDIS measure through
21 a few private funders developed, tested, and now,
22 results shared. There's about 30 levers still to

1 pull in this space, just to give you some
2 context. So a lot more work that we need to do
3 together, which is really why I wanted to come
4 here. The last thing I'll say is that there's
5 really an effort in the field to identify
6 obstetric providers as the medical home for
7 pregnancy in the perinatal period as an important
8 place for screening to happen and to begin early
9 in pregnancy given the links to preterm birth and
10 poor birth outcomes.

11 And also because of the number of women entering
12 pregnancy with undiagnosed, untreated mental
13 health disorders like anxiety and depression. And
14 so my personal perspective is there's no wrong
15 door. It doesn't hurt for a hospital to
16 necessarily screen, but the home base in terms of
17 who should be responsible. Some obstetricians
18 don't necessarily agree, although the field, I
19 think, is acknowledging this, including ACOG and
20 our midwifery societies that the obstetrician
21 should be the home base for screening and initial
22 treatment plan development. We're doing some

1 interesting work to study the use of peer support
2 specialists to augment obstetric capacity to
3 screen. So having a peer assist with screening,
4 brief intervention, and even care coordination.
5 But there's a lot of work to do in all these
6 spaces. So just to acknowledge that it's quite
7 complex, and appreciate the question, and happy
8 to talk more offline.

9 Marie-Elizabeth Ramas: Thank you.

10 Ed Ehlinger: One more comment. Lee.

11 Lee Wilson: Sure. Thank you. Joy, I appreciate your comments,
12 and just want to remind the committee that HRSA
13 MCHB has a number of programs that are focusing
14 on the maternal behavioral health issues,
15 maternal mental health issues. We have our MDRBD
16 program, the Maternal Depression and Related
17 Behavioral Disorders program, which is in seven
18 states. We're looking at recompeting this
19 program, and potentially, depending on what we
20 receive in 2023, to complete that program and
21 award a larger number of grants. That program is

1 a Doc-to-Doc program. So if a healthcare
2 professional identifies an individual who has a
3 condition that they can't quite get a handle on
4 or they feel they need some other professional
5 support, they can use this line for that. We also
6 have presented to you on a couple occasions about
7 the maternal mental health hotline, and we are
8 using that to try to reach more individuals who
9 are experiencing perinatal mental health issues,
10 and to link them to available services in their
11 community. So if in the future you would like
12 more background information or materials, we can
13 arrange for presentations on that. Thank you.

14 Joy Burkhard: Thanks, Lee. I'll just quickly add. We hope that
15 someday there might be a national hotline for Doc
16 to Doc consults. Just given the challenge it is
17 for states to get these lines up and running
18 could take another 20 to 30 years to reach all
19 states. So anyway, more to come on some possible
20 policy solutions there. We're told that it is not
21 probably the congress to introduce such a
22 measure, and to let this work take hold with

1 increasing the number of grants to states through
2 HRSA and the current structure. So, thank you,
3 Lee, and to HRSA for all your work.

4 Lee Wilson: Keep up the good fight, Joy.

5 Joy Burkhard: Indeed. Thanks, everyone.

6 Vanessa Lee: Thank you. Thank you, Joy. And that concludes our
7 public comment segments. I'll turn it back over
8 to you, Ed, for the next piece of our agenda.

9 Ed Ehlinger: Yes, and Ms. Burkhard, thank you for your
10 comments. And you raised a couple of issues. One,
11 there are myriad issues facing moms and infants,
12 and there are multiple partners. So, I think that
13 we need to look at the broad range of issues.
14 What can SACIMM actually do something about, and
15 who are the partners we need to partner with?
16 Yes, CityMatCH, and AMCHP, and NICHQ, and Healthy
17 Start are among those, but there are a whole
18 bunch of others that we need to reach out to. So,
19 we'll keep that in mind as we move forward.

20

21

1 **Federal Update: Healthy Start Program**

2 Ed Ehlinger: All right. Next, we're going to move on to our
3 federal update and some information about Healthy
4 Start. And I know Benita Baker is here. Benita,
5 are you going to be starting it out?

6 Benita Baker: Yeah, I'm going to start it out. Lee's going to
7 help me. But I'd like to welcome everyone. Good
8 afternoon. My name is Benita Baker. I am the
9 branch chief for Healthy Start in the division.
10 While we know ACIMM is charged with providing the
11 Secretary advice and recommendations on how to
12 improve infant mortality and related adverse
13 birth outcomes, including the administration of
14 the Healthy Start program. We wanted to give you
15 a brief overview for the new folks and the
16 current on the Healthy Start's current
17 activities. Receive your feedback on how MCHB and
18 Healthy Start can help communities advance social
19 determinants of health in Healthy Start. So, I
20 will start out with a little bit of background on
21 Healthy Start. As most of you know, Healthy Start
22 was first established as the presidential

1 initiative in 1991. It started as a community-
2 driven demonstration project based on nine
3 interventions.

4 I won't go into those, but outreach and
5 recruitment, adolescent services were a few.
6 Started with 15 sites, and at that time, they
7 received a significant amount of funds, around
8 4.6 million per year for five years. The goal was
9 to identify community-based driven approaches
10 that would help to reduce infant mortality by 50%
11 over a five-year period. That was a very lofty
12 goal. As you know, we did not make that. We
13 continued to strive. A lot of the original 15 are
14 still Healthy Start grantees to this day. Next
15 slide, please. I'm going to skip forward to our
16 most recent competition that occurred in 2019.
17 After multiple rounds of funding since that first
18 funding, we went through a demonstration phase,
19 we went through a mentoring phase, we went
20 through a replication phase, and we're at the
21 phase now where we are on the four approaches,
22 which I'll go over a little later on.

1 Currently, the project period was April 1, 2019
2 to March 31st, 2024. There are 101 Healthy Start
3 sites located in 35 states. The District of
4 Columbia and Puerto Rico funding at that is
5 125,000,000 for the program, but 980,000 per
6 award. Next slide, please. Okay. So, this is just
7 another overview. The purpose of Healthy Start is
8 to improve health outcomes before, during, and
9 after pregnancy, and reduce racial and ethnic
10 differences. The reach, we talked about the
11 reach, and that should indicate as of 2021. So
12 where Healthy Start works in communities with
13 infant mortality rates of at least one and a half
14 times the national average and high rates of low
15 birth weight, preterm birth, and maternal
16 mortality. Slide six, please. Current Healthy
17 Start core elements. Healthy Start services are
18 currently within four core elements which focus
19 on decreasing infant mortality and emphasizing
20 women's health-

21 Mortality and emphasizing women's health, family
22 health and community and population health. Next

1 slide please. These are the populations we serve.
2 Birthing people, fathers and partners, infants,
3 and children up to 18 months. Next slide please.
4 These are the current Healthy Start Program
5 Services. This is not an all-inclusive list. We
6 have grantees who have resources from all
7 different places other than the feds and are able
8 to provide more resources such as job placement,
9 job readiness, things like that, that did not
10 typically fall under the normal base services for
11 Healthy Start. Next slide please. Healthy Start,
12 our current Healthy Start legislation, and it has
13 since its inception, called for establishment of
14 a community consortium. At this time, we call
15 that a Community Action Network. It consists of
16 organizations in the community that serve the
17 same populations as Healthy Start or address the
18 same issues that Healthy Start addresses. It also
19 includes organizations which are not typically at
20 the MCH table, such as HUD, Department of
21 Transportation, which that's now getting a lot
22 better, and also people with lived experience.

1 Next slide please. To support, in addition to our
2 Federal Project Officers, we have a TA and
3 support center we call the EPIC Center. The
4 National Institute for Children's Health Quality
5 is the organization providing those services. The
6 TA and Support Center supports our Healthy Start
7 grantees in improving their service delivery, in
8 meeting their required benchmarks that have been
9 established for Healthy Start. In addition to
10 providing topical webinars, learning cohorts and
11 academies on various topics and emerging issues,
12 training and certification scholarships, such as
13 lactation consultants, and individualized
14 technical assistance for each grantee.

15 I'm sorry.

16 I'm sorry. Okay. Next slide please. So, in
17 addition to the base Healthy Start activities,
18 there are a few activities that have come about
19 since 2019, funding that has come about in order
20 to provide additional activities. One of those
21 activities is what we call Clinician Funding
22 Congress, in 2019, appropriate around \$15 million

1 a year for our grantees, to increase clinical
2 services within their project. So, they were to
3 hire clinicians to provide postpartum care,
4 prenatal care, to expand the capacity for direct
5 assets to care for the Healthy Start
6 participants. Next slide please. Last year and
7 this year, we gave money to our grantees, this
8 was not appropriated money, this was leftover
9 money that was unobligated, but we were able to
10 provide supplements to our grantees, to increase
11 availability of doulas, and these funds were
12 provided for hiring, training and certification
13 of doulas. Next slide please.

14 So, I know Dr. Warren has talked a lot about his
15 Infant Health Equity by 2030, I call it
16 initiative. So, we're doing a lot of work around
17 that throughout Healthy Start. One of the things
18 we did last year was to provide supplements to
19 our grantees to develop action plans for systems
20 level changes, and to address social determinants
21 of health that may impact disparities in infant
22 mortality in their communities. The overall goal

1 of this was to reduce disparities within the
2 counties that had the highest number of excess
3 non-Hispanic Black and non-Hispanic American
4 Indian/Alaskan Native infant deaths. So, our
5 grantees last year developed these action plans.
6 They are working with our TAS, our TA and Support
7 Center for any additional TA that is needed, any
8 community workshops that they may need to help
9 support bringing their community on board with
10 implementing these action plans.

11 Again, next slide please. I'm sorry. The
12 listening Session. So, again, one of the goals in
13 this MCHB strategic plan is around achieving
14 health equity. We know that American
15 Indians/Alaskan Natives and African Americans
16 experienced poor perinatal outcomes. Again, many
17 of these outcomes are due to systemic inequities
18 and limited access to care. So, maternal child
19 health, the division has facilitated and attended
20 a few listening sessions, with the idea in mind
21 to help with developing new or revising current
22 programs, in order to receive information to help

1 us increase equity in our programming. As well as
2 framing no flows, Notice of Funding
3 Opportunities, so that grantees can incorporate
4 equity in all their activities that they provide.
5 Next slide please.

6 One listening session was an HHS Roundtable with
7 community-based doula organizations. There were
8 other organizations, federal organizations
9 invited, CMS, of course HRSA was there, doula
10 organizations and individual doulas. Some of the
11 points that came out, this is not all inclusive,
12 but some of the key themes were that we should
13 include mentorship in doula trainings. Some
14 doulas are very experienced, while newer ones are
15 not, so we should include those in our
16 programming fund, doulas, doula training and
17 mentoring, and strengthen the administrative
18 support for doula programs, offered tiered doula
19 training and certification requirements, and fund
20 models that support both doulas and midwives.
21 Next slide please.

1 The division held four convenings for MCH
2 alignment and impact towards Infant Health
3 Equity. These convenings were specifically to
4 address Dr. Warren's 2030 initiative to bring
5 together MCH stakeholders and partners from a
6 variety of levels, national, state, local,
7 federal, to again work toward reducing those high
8 disparities among Black, American Indian, and
9 other groups. Some of the key themes that came
10 out, again, not all inclusive, were that we had
11 to make community engagement stronger somehow.
12 Workforce development, include people of all
13 populations in our workforce development
14 activities. Strengthen community relationships
15 again, and look beyond the clinical perspective
16 and tie program requirements to funding. Next
17 slide, please.

18 When we in the division held two Listening
19 Sessions with our current grantees, just to
20 attain their perspectives on the strengths,
21 challenges, any emerging issues on the current
22 Healthy Start program, to help and provide

1 recommendations to inform us on the next phase,
2 iteration, of Healthy Start. Healthy Start
3 recompetes in FY24. So, we're gathering all the
4 information from all of these Listening Sessions
5 to help inform our programming. Some of the key
6 themes that came out of those Listening Sessions,
7 one was funding. It's always funding, funding,
8 more funding. I just pulled out these two. There
9 were themes around funding for all types of
10 activities. Behavior health, they want more
11 funding for behavior health. This has been a
12 stickler with our grantees again because they
13 screen but have nowhere to refer. Possibly don't
14 have the resources to hire clinicians to provide
15 these services.

16 In addition, they want to focus... In 2019, we
17 had a larger focus on fathers. We had a larger
18 focus, but we still are not there with fathers as
19 we are with pregnant women. Of course, that's
20 really not our charge, but we do know it helps
21 with women's health and reduction of infant
22 mortality. So, they want to focus a little more,

1 have benchmarks around men's health and that kind
2 of thing. They focused on data. A lot of requests
3 for changes in our data collection tools, and
4 Healthy Start has, I believe, nine benchmarks.
5 So, they gave us suggestions for changes in the
6 benchmarks to make them a little more relevant to
7 the programming. Healthy Start has a required
8 participant count of 300 pregnant, actually it's
9 total 700, which includes 100 men. A lot of the
10 grantees want us to take another look at that
11 count, because they believe it's too high based
12 on the amount of funds that they receive, and the
13 activities that they are required to perform.
14 Eligibility, again father/partner engagement,
15 workforce development, that comes up again, and
16 they want us to strengthen our requirements for
17 local evaluation.

18 Okay. Now we get to questions for consideration.
19 The redesign, as I said, the redesign of Healthy
20 Start will... We hope to have an increased focus
21 on equity and requirements for the grantees to
22 focus more on equity. So, we have a few questions

1 for you, the body. You don't have to answer them
2 now. We do have a Federal Register Notice that is
3 coming out here shortly, probably either later
4 this week or early next week, where we're seeking
5 input from the public on topics related to
6 design, implementation, evaluation. Your input
7 and expertise would be invaluable to our efforts
8 to better support the Healthy Start grantees and
9 their families. We hope that you could circulate
10 that RFI around to your networks and partners.
11 That is all I have. Lee, do you want to add any
12 additional information?

13 Lee Wilson: Thank you, Benita. No, I appreciate you taking
14 the time to run through this. I know for, excuse
15 me, those committee members who've been working
16 with the projects and with the committee and
17 Healthy Start for quite some time, are familiar
18 with a lot of the base information. We have gone
19 through a number of different permutations and
20 are seeking input based on, not only the
21 continuing desire for the program to be
22 addressing the perinatal health outcomes of the

1 underserved, and the individuals who have
2 greatest need in the community, but also some of
3 the priorities that have evolved over recent
4 years. Especially as it relates to racial and
5 ethnic disparities, and access issues that we are
6 all very, very mindful of.

7 So, we are beating the bushes to make sure that
8 we seek whatever input we can, from as many
9 sources as we can. So, this is an offer to you to
10 provide input now, to provide input to us later.
11 We'll provide an opportunity at our next meeting,
12 since our anticipated release of the announcement
13 will be sometime late summer, early fall of 2023.
14 So, this isn't the only opportunity you will have
15 to provide input, but we wanted to give an
16 opportunity for you to think good and long on
17 these issues. You can also respond directly to
18 the Federal Register Notice, which will be
19 tabulating the input that we receive from other
20 sources, outside sources. So, thank you very
21 much, and we are open to questions.

1 Ed Ehlinger: Lee, I have a question. When you talk about 'we'
2 are seeking input, are you talking about HRSA,
3 MCHB, or are you talking about HRSA, MCHB and the
4 projects themselves? Because the community
5 engagement strategy, how you do that will depend
6 on the numerator you're using. There's some
7 techniques of getting community engagement and
8 you need some training. So, I don't know if
9 you're talking only federal officials, or if
10 you're talking also the local folks at the same
11 time.

12 Lee Wilson: We're talking to all of the above. The
13 information will be disseminated broadly to
14 various target groups. If there are
15 recommendations that are specific to how programs
16 might want to operate, our intention is to share
17 the input that is received with existing grantees
18 and future grantees, as well as to use the input
19 by HRSA, MCHB, to make adjustments in the design.
20 Tighten up in areas where there might be
21 recommendations that we think should be supported
22 for tightening, or loosening. A lot of what we've

1 been hearing from various sources, including from
2 this committee on issues like doula support, on
3 issues like community outreach, the individuals
4 that we're hiring, is to allow for maximum
5 flexibility for culture and community to reflect
6 their own desires.

7 So, we will be cataloging it and as we are trying
8 to hit as many bases as we can, we are also
9 trying to be responsive and share that
10 information with as many as we can. Our Federal
11 Register Notice and some of the questions that we
12 have put in there, have gone through review from
13 our data people, our Office of General Counsel,
14 and different sources. So, we are trying to make
15 sure that it is a comprehensive and reliable
16 source of input for us.

17 Ed Ehlinger: Good. Good. Steve?

18 Steve Calvin: Yep. So, thank you. Thank you, Lee, and thank
19 you, Benita. I have a question. Since federally
20 qualified health centers are... They're under
21 HRSA I think. Is there any dovetailing of the

1 work that you're doing? The reason I ask is that
2 here in the Twin Cities, just recently, we've had
3 an outreach from one of the FQHCs to say, how can
4 we begin to provide comprehensive care,
5 particularly midwife directed care, things that
6 fit within the context of the Strong Start Study
7 results, do you have any guidance on that or any
8 thoughts?

9 Benita Baker: So, FQHCs would be an eligible entity to apply
10 for Healthy Start, and we do have several FQHCs
11 that are Healthy Start projects.

12 Steve Calvin: Okay. Well, maybe I should just do a little
13 looking into... I'll look at your grantees and
14 see what kinds of things have already been done.

15 Lee Wilson: So, Steven, let me burrow in a little bit on the
16 question. As Benita said, we do have a number of
17 Healthy Starts that are dual grant recipients, so
18 they're a recipient of a Healthy Start and of a
19 Community Health Center award. Many of our health
20 centers, if they're not attached to a Community
21 Health Center, have referral arrangements to

1 either Community Health Centers or other health
2 providers. Is there something that you're looking
3 for related to Strong Start, or some other
4 program that you want to make a recommendation
5 about?

6 Steve Calvin: Sure. Maybe I should end up doing that separately
7 as well. It's just that, we do hear a lot, and I
8 totally understand because the value of doula
9 services and midwife-led primary maternity care,
10 it's just really well known that that all works.
11 But it seems that in many states, and even on the
12 federal level, we just do it piecemeal. We kind
13 of say, "Well, let's support doula services." It
14 really needs to be comprehensive. I think FQHCs
15 are definitely a good forum. I know there's one
16 in DC, and there's one in Chicago, and early in
17 my career I worked in one in Tucson, that has
18 subsequently become much bigger. So, I don't
19 know. I suppose maybe I'll look at the links that
20 you both provided and see what kind of
21 opportunity there is for input. Because I think I

1 could give at least a sense for how things might
2 be done a little bit differently.

3 Lee Wilson: I think that would be helpful. I also think that
4 it may be helpful for us to tap into you for
5 input in the future. You may be aware, I think
6 Dr. Warren presented at our last meeting, that
7 Congress has proposed providing additional
8 resources to us to develop a doula grant program.
9 One of the priorities that that grant program is
10 bound by, is the desire to make doula services
11 more institutionalized, and more professionally
12 sustainable in the community, so that individuals
13 can be doulas as a profession and live off of
14 whatever that salary might be, and that it be
15 more of a recognized and reimbursable approach,
16 that is not just underwritten by some other
17 nonprofit organization, but how do we
18 institutionalize it so that there's Medicaid
19 reimbursement, if that's a possibility?

20 AIR has just released a report on a number of
21 states that are using the Medicaid 1115 waiver
22 and as an option for testing out the funding of

1 doulas through Medicaid. There are a number of
2 strategies that we're all pursuing on this front,
3 or at least rummaging through. If this is
4 something that you're interested in, we could
5 keep you in the loop on the discussions.

6 Steve Calvin: I'd appreciate it. Thanks very much for your
7 work.

8 Lee Wilson: Sure.

9 Ed Ehlinger: Magda? You're muted. You're still muted, Magda.

10 Magda Peck: All right?

11 Ed Ehlinger: There you go.

12 Lee Wilson: There you go.

13 Magda Peck: All right. Try it again. It automatically muted
14 me. I just want to thank you for the update. For
15 those of us who've known the Healthy Start
16 Project since its preconception years, it is
17 great to have a new snapshot for the refrigerator
18 of the kit. So, thank you for that, number one.
19 Two quick questions. The first is general, the

1 other is quite specific. The general is just, how
2 optimistic are you, or how likely is it, that the
3 Infant Health Equity goals by 2030 can be
4 reached? Given that, as you described them, lofty
5 goals of 1991, were only reached, by Belinda's
6 note, by one Healthy Start site. So, I'm trying
7 to get a sense of the goal setting for 2030, and
8 how optimistic you are that can be reached, or is
9 that aspirational? Just to calibrate. That's one.

10 The second is that our focus of our current
11 Making Amends Report is specifically to the
12 American Indian/Alaskan Native families. Those
13 numbers, as we know, were quite small. Those
14 numbers have been accompanied by marginalization
15 and data erasure. Under many of the previous
16 Healthy Start applications, the numbers of deaths
17 would never have been large enough to qualify for
18 a Healthy Start site. So, I was wondering if you
19 can comment on strategies for reaching the
20 American Indian/Alaskan Native populations, where
21 they are, with targeted impact, and how Healthy

1 Start can be part of this movement to make
2 amends. So, optimism and numbers.

3 Benita Baker: I'll tackle the second question first. So, we are
4 looking at strategies that will ease some of the
5 burden on those populations in applying, and both
6 activities, required activities. Now, Lee, I'm
7 not clear on how much, because this is a
8 competition, how much I can say around that. So,
9 if you want to step in.

10 Lee Wilson: Sure. Magda, and the rest of the group, I will
11 talk about this later on. I know that Etta is
12 going to ask us for input on what we've taken
13 away from the various meetings that we've had in
14 recent years. One of the most important things I
15 think for HRSA, is to provide us, that the
16 committee provides us not only with a set of
17 recommendations, but language from an outside
18 body that is representative of a cross-section of
19 experts and key informants, on directions that we
20 should use. So, that we can then turn around and
21 say, not only is HRSA thinking about this, but
22 here is this advisory committee which has advised

1 us to do X, Y or Z. The whole doula initiative
2 and the way we crafted it as a supplement to the
3 Healthy Start grants, was heavily influenced by
4 the recommendations that this committee made to
5 us about two years ago, or a year and a half ago.

6 Similarly, we are taking these recommendations
7 from the last meeting in September, which had
8 some very strong recommendations for Healthy
9 Start, and the fact that it excluded a number of
10 communities because of size or rurality and
11 numbers. So, we are very mindful of those
12 recommendations, and we are boiling them into the
13 soup that we're making here, which will be the
14 new Healthy Start. I don't know that I really
15 like that analogy, but it seemed to fit when I
16 was speaking.

17 Magda Peck: I thank you for that. I just think that the
18 paradox that we point out is that numbers are too
19 small to be counted, therefore they don't count.
20 Yet the criteria of the guidance is what reflects
21 policy. I'm also mindful of the voices of
22 testimony that say, "Why are we competing for

1 something for which we've already paid?" So, both
2 issues, the, why are we an equal competition when
3 it's an unequal oppression, and how do we then
4 not get penalized for the small numbers for which
5 we are not responsible? So, the paradox feels
6 very strong when it comes to this programmatic
7 level, and I just think this is where the
8 accountability is. Thank you for the invitation
9 for us to help you shape that guidance in a way
10 that can make amends.

11 Lee Wilson: We have many, many, many competing priorities,
12 and sometimes we are maybe not as genius at
13 addressing all of them. I know that part of our
14 charges to do demonstrations, part of Dr.
15 Warren's charge, is to move the needle on the
16 numbers, and to bring equity into play in what
17 those numbers reflect. Part of the commitment
18 that the federal government has made, whether
19 that be assigned to HRSA or to somebody else, is
20 to care for the health needs of American Indians
21 and Native Alaskans. That being said, we also
22 have very large populations of African Americans

1 who have very, very troubling health outcomes
2 too. We're also wrestling with compounding social
3 issues of poverty and access, and other resulting
4 consequences. So, would that we had more
5 resources to be able to address all of these
6 things, but we definitely hear you. We are
7 definitely trying, and the reason we bring you
8 here to put us to the test is because we want to
9 do our best here.

10 Magda Peck: Thank you.

11 Ed Ehlinger: Belinda?

12 Belinda Pettiford: Thank you, Ed. Thank you, Benita, so much
13 for your presentation, and Lee, for your comments
14 and full disclosure. I've been engaged with
15 Healthy Start for the last 25 years, being a site
16 here in North Carolina. I mean, I think one of
17 the areas that I stay focused on and stay
18 concerned about is our conversation on community
19 engagement. I'm wondering, with the new
20 competition, is there any consideration of giving
21 sites a menu to select from, versus requiring

1 everything? Because when you are having a
2 conversation with a community and you're saying,
3 "Well, tell me how this can be designed," and
4 it's really already designed for you, it is
5 really not being true to the community engagement
6 process. I think if there's any opportunity to
7 think through, is there a way to give a menu and
8 say, "These are the 10 things that Healthy Start
9 wants to focus on. Are there six of them that you
10 think will work best in your community, versus
11 seeing all of them?"

12 Because that is some of the pushback we get in
13 our community engagement discussions is, "Well,
14 you already tell me you've got to do this, this,
15 this, and this, and you're telling me this is how
16 much money you've got, so tell me really what
17 engagement are you providing me?" So, it's just
18 something to consider. I realize that you may or
19 may not be able to do it, but if we're going to
20 tap the conversation around community engagement,
21 we really want to make sure that the community is
22 at the table, and we're listening to the feedback

1 that they're giving us. I think that is one of
2 those critical pieces that is easy to get lost in
3 the process, and tell everyone we're doing
4 community engagement. Communities know better, if
5 it's not genuine, if it's not authentic. So,
6 thank you.

7 Benita Baker: Thanks, Belinda.

8 Ed Ehlinger: ShaRhonda? ShaRhonda, unmute yourself and ask
9 your question.

10 ShaRhonda Thompson: Okay. Sorry about that. My question is back
11 to the doula, the doula program. When it comes to
12 that, I know training is involved and that
13 training has a price. Are we looking at ways to
14 ensure that once we get to the point where the
15 doulas are being paid and it's actually a career,
16 are we going to make sure that the people who are
17 using doulas basically are represented? So,
18 people of color, are we going to do something to
19 make sure that they can afford the training to
20 become doulas, so that they can represent the
21 community, so that they match the community? Are

1 we going to do something like that? Because I
2 know in our area, we're trying to use Medicaid
3 for doulas, but the training, the cost of the
4 training for people, women of color to become
5 doulas, usually is too much for them to pay based
6 on the area that we live in, and the poverty that
7 we're facing. So, now you have doulas can get
8 paid with Medicaid, but we don't have enough
9 doulas to match the community.

10 Benita Baker: So, in 2023, this is a proposed budget, the \$20
11 million, these grants are open to-

12 to all entities, whereas the previous was open to
13 Healthy Start. And what we are looking at doing
14 is writing the NOFO in such a way that those
15 higher-risk communities can come in for the
16 grant. I don't know if you've ever heard of
17 Adarand, but we cannot direct funds to a specific
18 population. We have to sort of tweak things. And
19 that particular grant covers the training for the
20 doulas that will be hired and the certification.
21 It will if we get the funds.

1 ShaRhonda Thompson: Okay. Thank you.

2 Ed Ehlinger: All right, Benita, thank you. And Lee, thank you.

3 Benita Baker: Thanks.

4 Ed Ehlinger: Appreciate that. It's a good lead into our next
5 conversation since Healthy Start and SACIMM
6 started at the same time.

7

8 **Review the Work and Accomplishments of ACIMM**

9 Ed Ehlinger: So, we're going to take the next hour or so to
10 look back at what SACIMM has done over the last
11 four years, but do this not because for just
12 recalling history, but actually as an example of
13 setting the stage for what needs to happen moving
14 forward. I mean we learn from what has happened
15 in the past and we use that as a springboard to
16 move forward. So, I'm going to go back through a
17 little bit of history and what has happened over
18 the last four years. Then going to have Dr. Art
19 James who kind of kicked off our session back in
20 2018 to do about 15 minutes to set a little stage
21 about racism that formed the basis of a lot of

1 our work. And then look at what the workgroups
2 have done over the last four years. See what MCHB
3 has thought about the last four years and then
4 get some feedback from the members in terms of
5 what we have learned. So let me again share my
6 screen here.

7 All right. So, we came on board, at least a group
8 of us, in 2018. We were appointed way before
9 that, but it took a long time to get the
10 committee started. It had a hiatus as was
11 mentioned earlier for several years. But we had
12 our first meeting in December 2018. But as Benita
13 said, the advisory committee, infant mortality
14 was started in 1991 and it was linked directly
15 with Healthy Start and we were to serve as its
16 advisory body. And I'm not sure how much that
17 happened in the earlier years, but we've had
18 certainly some conversations about Healthy Start.
19 But I'm not sure it was as robust as what was
20 thought about initially.

21 But also as I thought about the 1991 start, Paul
22 Wise, who was a member of this committee for the

1 last four years and I were actually people who
2 testified back in the eighties, that led to the
3 start of Healthy Start, which was in response to
4 some major changes in public health that really
5 disadvantaged maternal and child health and the
6 establishment of Healthy Start was in response to
7 community pressure, particularly from the
8 American Academy of Pediatrics among others to
9 actually do something.

10 And as Magda pointed out, I was running or she
11 pointed out, you mentioned about the disadvantage
12 of some group. I was working as the Maternal and
13 Child Health Director in the city of Minneapolis.
14 And even though we had the greatest disparities
15 among African-Americans in terms of birth
16 outcomes and we had the third largest population
17 of urban American Indians in the country, we did
18 not qualify because our numbers were too low,
19 even though the statistics were... The data were
20 pretty startling. We just didn't qualify. So, it
21 was basically a... Hate to say it, it
22 particularly disadvantaged American Indian

1 communities. And it could be talked about as
2 being structural racism that got perpetuated. But
3 be that as... So that's why I make the argument
4 from history that I think this committee needs to
5 have some young folks and it needs to have some
6 people with some history that can bring all of
7 those perspectives together so that you learn
8 from what it is.

9 Because the experience that I've had has dictated
10 a lot of what I've done and I've learned from a
11 lot from others as the process goes on, so one
12 point to make. The other is that here we are in
13 2022. Our work has been built on the work of
14 previous committees and as best we can, we
15 learned from that. And certainly, there weren't a
16 lot of reports that came out from ACIMM over the
17 years, but the ones that we sort of reviewed were
18 the ones in 2001 and 2013, the group with Kay
19 Johnson as the chair and we've learned from that.
20 The other thing that came out was that ACIMM was
21 linked to the Premie Reauthorization Act, again,
22 which is something we've talked about in the past

1 but we've not done a lot of work on. And I know
2 that Lee had some plans on how we're going to be
3 doing that.

4 So I'm just thinking that it's part of our
5 history and it needs to be part of our future.
6 And then part of our history is the charter
7 reauthorization, how we had our charter from 1991
8 and how we reauthorized it and expanded in 2019
9 and 2021. We came on board in '18. We had nine
10 members that we started in 2018; Tara Sander Lee,
11 and Steve Calvin came on in 2020. Vijya Hogan was
12 part of our original group, and she left us very
13 shortly after starting, so I think it was in 2019
14 that she left. And Paul Wise, Paul Jarris, and
15 Jeanne Conry were with us pretty much through
16 this last year. We had a good group and now we
17 got the new group that has come on in 2022. One
18 of the accomplishments that we made was the
19 charter. It was scheduled to be disadvantage
20 or... Well, I'm not sure if I have that.

21 At one point the committee was going to be gone
22 away because of the president wanting to increase

1 the efficiency of government. And we argued about
2 it and we were able to maintain the advisory
3 committee. So that was one of the things that we
4 did just to maintain SACIMM. The other is that we
5 expanded the charter to include maternal
6 mortality and severe maternal morbidity, which
7 had previously just spent infant mortality
8 because the diet was so important, we argued that
9 it needed to have including maternal mortality.
10 And then we also expanded it to include
11 disparities in inequities and some of the social
12 issues that caused the disparities in inequities,
13 particularly around health and social and
14 economic and environmental factors. Those were
15 new things that were added as we started to
16 realize as public health said, as institute of
17 medicine said what public health is what we do
18 collectively to assure the conditions in which
19 people can be healthy.

20 And those were some of the conditions that we
21 started to focus on as opposed to simply the
22 medical care or the diseases, really focusing on

1 the conditions that really affected it. And that
2 act impacted a lot of what we did over the last
3 four years. As I went back over the history and I
4 look back on our second meeting. Our first
5 meeting was in December 2018. Our second meeting
6 was in April 2019 and on that meeting, this is
7 what we talked about and what we thought about.
8 We should build a strong research base, build on
9 that, that was established by previous advisory
10 committees because they had a lot of academics,
11 did a lot of research, looked at a lot of data.
12 We wanted to use that and build on that for
13 looking at programs and policies. We wanted to
14 center our issues around poverty, economic
15 policy, and social and economic safety net.

16 Work to advance equity, expand our focus to
17 include maternal mortality and focus on the
18 impact of racism. That is what we decided on in
19 the first couple of meetings. And that's what I
20 think our actions over the last four years have
21 really continued to be fairly consistent with
22 focusing on those issues. And also in that

1 meeting adopted some simple rules. Simple rules
2 are when you're dealing with complex situations,
3 when you're dealing with complexity models, you
4 need to have some simple rules to move. And the
5 simple rules that have sort of guide guided our
6 work. Remember every baby and mother, center on
7 equity, listen to community voices, build
8 capacity, focus on connections, ask powerful
9 questions, and seize opportunities. Just our
10 conversation in the last couple of hours were
11 really said. We're centering on equity. We're
12 listening to community voices. We're building
13 capacity. We're focusing on connections. We're
14 asking the powerful questions. It just is... And
15 now I think looking forward, seizing the
16 opportunity. I think we've been true over the
17 last four years to the simple rules that we set
18 about on back in 2018, 2019.

19 This is what I had... So one of the things that
20 we really accomplished was we preserved ACIMM
21 because the White House had an executive order
22 that wanted to reduce the number of advisory

1 committees and we argued that we needed to
2 continue ACIMM. And so, we did that. We expanded
3 the charter. I think the fact that we got the
4 Secretary of Health and Human Services to
5 actually come to our meeting, even though it
6 wasn't in-person, it was virtual. I don't know if
7 any previous ACIMM had the Secretary actually
8 come to the meeting. That I think is a success.
9 We had the Assistant Secretary for Health come
10 and join us. We had all the HRSA administrators,
11 and I know they've come to previous meetings, but
12 every HRSA administrator came and met with our
13 committee, which says that we're building the
14 gravitas of the committee and we're actually
15 getting some visibility.

16 We're being recognized as some group that needs
17 to be at least listened to. And then we submitted
18 three reports. I think this is fairly remarkable
19 given the fact that there's not a lot of staff
20 dedicated to this. We have great staff and I want
21 to compliment the MHB staff who've worked with us
22 over the years. Really good staff, but they don't

1 have a lot of resources to help. A lot of it is
2 the volunteer work of this committee. Oh yes, we
3 get paid or whatever for the meeting, but a lot
4 of work goes on besides that. And we came up with
5 three reports. The first one was in June 2020,
6 which was really focusing on COVID-19. I think
7 that had a huge impact because nobody was paying
8 attention to the maternal and child health
9 outcomes of COVID and we called attention to
10 that.

11 With our second report in August 2021, we again
12 updated some of those COVID recommendations.
13 Again, bringing forth the issues that moms and
14 babies really needed to be paid attention to
15 during COVID and I think that added a lot to the
16 conversation. Similarly, in August 2021 with the
17 report that we had, we broke some new ground with
18 migrant and border health, with the physical
19 environment, the environmental toxins, and
20 workforce, and systems of care issues that we
21 really brought forward to the Secretary. And then
22 certainly then the third report that we approved

1 just earlier today was the American Indian/Alaska
2 Native birth outcomes report. So I think in
3 having three significant reports over these four
4 years has been quite an accomplishment. So I
5 really appreciate the work that all of the
6 individuals who were involved on the committee,
7 but also the people in the workgroups that have
8 been part of this have been really, really
9 helpful.

10 And just from my personal... I think I love the
11 fact that we've been able to listen to community
12 voices. I think we've elevated those stories.
13 We've elevated the community. We recognize the
14 importance. I think the gravitas of ACIMM has
15 increased, just the connections that we have with
16 the major MCH organizations and others. I know
17 just from ASTHO, the Association of State and
18 Territorial Health officials, which represents
19 Commissioners of Health. They recognize what
20 we're doing and pay attention and they've taken
21 the recommendations that we've had and built them
22 into their policy statements. So people are

1 looking to our committee as a place for
2 information and some leadership. We've certainly
3 enhanced partnerships. Also, think this is a
4 mixed measure. When we first started we had two
5 meetings a year with an issue as important as
6 infant and maternal mortality. Two meetings a
7 year was not enough to actually do the work.

8 Now we've got four meetings a year, but that
9 requires a lot more work and that will require a
10 bigger investment, certainly from MCHB, in terms
11 of supporting this committee because it's
12 difficult as they are well aware. Every three
13 months comes pretty quickly. Having a meeting
14 outside of DC was no small feat. And again, I
15 thank Lee for making that happen, but I think
16 that is a major accomplishment and that set...
17 Just by doing it once it sets the tone that it
18 can be done again. And I have to... I'm probably
19 overstepping here. But I think that the White
20 House Initiative on American Indian/Alaska
21 Natives actually was probably stimulated at least
22 a little bit by what we were doing and the work

1 that we've been doing. They're following our
2 example. And then I think the fact that we
3 expanded our scope to include the border issues
4 and immigration and environmental health issues
5 and racism and equity broke some new ground that
6 really had not been broken in the past.

7 So I think we have done a lot. I've been really
8 proud of the work that this committee has done. I
9 think we have done a lot and we'll be hearing
10 from others, but this is just my kind of rapid
11 overview of what I've seen over the last four
12 years. But I wanted to go next to reflect back to
13 the very first meeting we had in December 2018.
14 At that meeting, we invited Dr. Art James who had
15 been on the previous SACIMM committee to talk
16 about inequities and racism because he had been
17 doing some work on it and we were thinking that
18 we should probably focus on that. So Art came and
19 gave a talk and the slides of his talk are in the
20 briefing book. I've asked him not to go through
21 that whole presentation, but to sort of now come
22 back four years later because his work really

1 stimulated us to really focus on structural
2 racism as one of the major causes of the problems
3 that we have.

4 So I've asked Art to come back and in 15 minutes
5 sort of give us... All right, where have we come?
6 What has happened in the last four years, and
7 what still needs to be done? Thinking in terms of
8 the next iteration of SACM, how can it next move
9 this work where we're really advancing health
10 equity and optimal health for all mothers and
11 babies? So I'm going to turn it over to Art. Art,
12 like I say, a former SACM committee member and
13 Art just recently was awarded the Martha May
14 Elliot Award from the American Public Health
15 Association for his many years of work on
16 advancing health equity and addressing racism,
17 particularly in Ohio and also in Michigan, but
18 also being just a great role model for a lot of
19 folks working on equity in the maternal and child
20 health world. So I'm going to turn it over to
21 Art. Welcome back to the committee.

22 Arthur James: Thank you very much.

1 Ed Ehlinger: Glad you're here. And I hope you're doing okay.

2 Arthur James: Yeah, I'm doing well enough, let's put it that
3 way. Let's see if I can share my screen here.
4 Doesn't look like it.

5 Marie-Elizabeth Ramas: We can see your screen.

6 Ed Ehlinger: There you go.

7 Arthur James: Great. So I had the pleasure of serving on SACIMM
8 for several years just prior to the current group
9 that is stepping down. It was a big pleasure. I
10 think all of us recognize that we have few
11 opportunities to influence policies and things
12 nationally, especially where something is as
13 important as maternal child health is concerned.

14 I've used this title slide often in my talks
15 because in my opinion, I think that the biggest
16 challenge that maternal child health faces is the
17 racial disparity in birth outcomes. So I start
18 with this slide that looks at maternal mortality
19 on the left, infant mortality on the right. What
20 I want to point out is that in both examples,

1 Black in maternal mortality is the worst followed
2 by the maternal mortality for Native Americans.
3 The same is the case for infant mortality. And
4 since we know that the International Genome
5 Project says that we're all 99.9% genetically the
6 same. So that tells us that physiologically there
7 are no significant differences in us by race to
8 account for the disparities that we see in death.
9 The question for us is how long are we going to
10 tolerate this? How long are we going to accept
11 these kinds of patterns because they're wrong?

12 Let's see if I can, and in order to eliminate the
13 disparity, I often digress to this slide which
14 says that if we want the guy who was behind to
15 catch up to the guy who was in front and we want
16 to do that without the guy who was in front
17 slowing down, then we have to figure out a way
18 for the guy who is behind to run faster than the
19 guy who is in front in order to eliminate that
20 gap. And so it is with the disparities that we
21 see in maternal and infant morbidity and
22 mortality. We have to double, triple, quadruple

1 down in the communities that are suffering the
2 most in order to eliminate the gap and the
3 opportunity to survive childbirth in the first
4 year of life. But having given versions of this
5 talk in actually 38 of our 48 continental states,
6 I often get a lot of pushback.

7 People tell me that it would be wrong for us ever
8 to think about decreasing the infant mortality
9 rate for one group more than we do for another
10 group. That it would be immoral, unfair, and
11 unjust. But in fact, we've been doing that for
12 decades. But it has been because the White infant
13 mortality rate has been the benefit that we've
14 behaved as if that's normal. I won't go through
15 my full data presentation, but there are a couple
16 of characteristics of the data that I do want to
17 point out. So this is looking at Ohio, although
18 we've done this for the United States and for
19 several other states, it's called a crude
20 survival time lag. What I mean by this is that if
21 we look at the most recent Black infant
22 mortality, in this case in the state of Ohio, and

1 go back in time to find a comparable White infant
2 mortality rate in Ohio, we have to go back 44
3 years.

4 This suggests then that if we allow this pattern
5 to persist, if we don't disrupt this pattern,
6 then what the state of Ohio is telling people who
7 look like me is that we have to wait until the
8 year 2063 for Black babies to have the same
9 opportunity of surviving the first year of life
10 as White babies did in 2019. And we think that's
11 wrong and we know that we can do better. This
12 looks at a similar dataset, but for a century,
13 essentially. Black infant mortality in red, White
14 infant mortality in green. The first thing I want
15 you to notice is the disparity curve and how the
16 disparity curve for the most part increases. It
17 increases because we have improved the White
18 infant mortality rate at a faster pace than we've
19 improved the Black infant mortality rate.

20 We have to continue to work real hard to improve
21 the White infant mortality rate to the best of
22 our capability, but we have to do much better for

1 communities of color. But I want to look at this
2 same data set and apply that crude survival time
3 lag because I think it adds some urgency to the
4 work that you're engaged in. If we look back in
5 1935, we had to go back 15 years to find a
6 comparable White infant mortality rate. 1960, we
7 had to go back 20 years to find a comparable
8 White infant mortality rate. 2017, we had to go
9 back 37 years. The point here is that this is
10 work that we can't keep delaying. We can't keep
11 kicking this equity can down the road. It's not
12 working. We are allowing mothers and babies to
13 die for reasons that we can prevent.

14 Martin Luther King said this, "We are confronted
15 with the fierce urgency of now. In this unfolding
16 conundrum of life and history, there is such a
17 thing as being too late. Procrastination is still
18 the thief of time. Life often leaves us standing
19 bare, naked, and dejected with a lost
20 opportunity. The tide of in the affairs of humans
21 does not remain at flood - it ebbs. We may cry
22 out desperately for time to pause in her passage,

1 but time is adamant to every plea in rushes on.
2 Over the bleached bones and jumbled residues of
3 numerous civilizations are written the pathetic
4 words, 'Too late.' There is an invisible book of
5 life that faithfully records our vigilance or our
6 neglect. Omar Khayyam is right: 'The moving
7 finger writes, and having writ moves on.'"

8 This is part of your biggest challenge in
9 accepting the responsibility of being a part of
10 ACIMM. We have to move this equity issue forward.
11 Another piece of this that I think drives home
12 the point. Again, I'm going to use Ohio data to
13 make this point is that in the state of Ohio
14 where healthy people are concerned. We have
15 achieved healthy people infant mortality goals,
16 three of the previous four decades of healthy
17 people.

18 And we did so in advance of the goal date for
19 White babies. The state of Ohio has never
20 achieved any healthy people goal for Black
21 babies. I highlighted Ohio because that's where I
22 live, but there are several states that fall into

1 this category. We have to change this. It's just
2 totally unacceptable. So I posed this question,
3 why do Black mothers and babies... Do Black
4 mothers and babies matter or to soften the
5 question, do they matter as much as White babies?
6 And while everyone says yes, I don't think our
7 actions support this response. So why does this
8 disparity exist? Where Native Americans are
9 concerned, does it have anything to do with this
10 history of taking their land from them,
11 subjecting them to marginalization and
12 reservations, chasing them away in this Trail of
13 Tears and almost committing complete genocide to
14 a population of people?

15 Where African Americans are concerned, does it
16 have anything to do with since 1619, Africans
17 being brought here and enslaved for 246 years
18 followed by 99 years of Jim Crow? It has only
19 been 58 years since the passage of the Civil
20 Rights Act and I think most of us who are Black
21 would suggest to you that the playing field has
22 never been leveled even since the passage of the

1 Civil Rights Act. The 246 years of slavery and
2 the 99 years of Jim Crow to this day account for
3 86% of the African-American experience. But when
4 we compare Blacks and Whites in any domain, we
5 never mentioned this history. We never admit the
6 significant period of time where we've provided
7 substantial advantage to those of us who are
8 White while simultaneously subjecting those of us
9 who are Black to a significant disadvantage. And
10 these efforts have not diminished. Think about
11 what's going on nationwide with the efforts to
12 suppress the vote, for example, in communities of
13 color.

14 My point is that the racial disparities that
15 exist in this country exist because we made them
16 this way. They are not natural, but we behave as
17 if they are. We act as if there's something
18 physiologically so substantially different
19 between those of us who are Black and those of us
20 who are White, that those differences explain
21 away the disparities that we see. And that's just
22 not the case. The disparities occur because we

1 made them this way. Richard Wilkerson, who's one
2 of the co-authors of the World Health
3 Organization's work on the social determinants of
4 health, talks about the impact of inequality and
5 how being subjected to inequality or racism, the
6 stress that it creates over a long period of
7 time, that it changes our physiology and as a
8 consequence, places us at increased risk for
9 cardiovascular and immune system problems, makes
10 us vulnerable to a wide range of diseases.

11 When we see pregnant women today, if they've
12 experienced a substantial amount of stress, we
13 are not reluctant at all to suggest to them that
14 the experience of that stress can increase the
15 risk of a compromised outcome to the pregnancy.
16 That the stress somehow gets under her skin and
17 gets incorporated into her physiology. Not only
18 that, but the experience of that stress and the
19 incorporation in her physiology also influences
20 her fetus and can place the fetus and increased
21 risk for a compromised outcome. But the other
22 piece of this is that we also believe that the

1 baby who survives a stressful pregnancy can pass
2 on those physiologic changes to subsequent
3 generations.

4 And so this is something again where we can't
5 keep kicking this can down the road. Nancy
6 Krieger tells us that social inequality kills. It
7 deprives individuals and communities of a healthy
8 start in life, increases their burden of
9 disability and disease, and brings early death.
10 Poverty and discrimination and adequate medical
11 care and violation of human rights all act as
12 powerful social determinants of who lives and who
13 dies, at what age, and what degree of suffering.
14 So what do we do with this situation that we've
15 created where we've provided a substantial
16 advantage to one group while simultaneously
17 subjecting another to a substantial disadvantage?
18 Having heard a portion of your conversation
19 earlier about the important work of the doulas
20 provide, I think that that's extremely important.
21 But doulas don't eradicate these obstacles that
22 this person is being subjected to. I'll talk a

1 little bit more about that in a couple of other
2 slides. We've set up the rules in this country so
3 that some of us have more of an opportunity to be
4 successful than others. And it's not because
5 those of us who are successful are better than or
6 more deserving than others, and it certainly
7 isn't because of group-level flaws amongst those
8 of us who suffer disproportionately. Again, this
9 is not natural.

10 In maternal child health, this is our challenge.
11 We have to stand in this gap while simultaneously
12 working to eliminate the gap. And a big
13 contributor to that gap is racism. What we do
14 currently is we invest in a lot of help programs.
15 So we help the lady on the right by carrying the
16 ball around her ankle, by helping her negotiate
17 around the obstacles. All very important stuff
18 that we need to do. But at some point in time, we
19 need to change our focus to permanently remove
20 the obstacles that are put in her place so that
21 she has the same opportunity to be successful as
22 the individual on the left.

1 Therefore, I've tried to make the point that our
2 goal is not health equity. Our goal should be to
3 achieve overall equity. Amara Jones has taught us
4 that in order for that to happen, at least three
5 things need to occur. We need to value all
6 individuals and populations equally, we need to
7 recognize and rectify historical injustice, and
8 we need to provide resources according to need.
9 Nelson Mandela has taught us that it always seems
10 impossible until it's done. Thank you.

11 Ed Ehlinger: Art. Thank you very, very much. And I think the
12 members of the committee who didn't hear Art's
13 presentation back in 2018 can see why we really
14 chose to focus on the issues in the path as
15 opposed to focusing a lot on the medical care
16 pieces. As important as medical care is, they
17 were not what we viewed as the most important
18 thing that SACM could be doing over the last four
19 years. And so that's why we focused on equity and
20 particularly on structural racism. A lot of our
21 recommendations were really about doing that. So
22 I'm going to open up for a few minutes here just

1 to see if anybody has some comments related to
2 what Art has before we move on to other
3 reflections of the last four years. Marie?

4 Marie-Elizabeth Ramas: Thank you so much for our compelling
5 presentation. And it is good to see once again
6 that we are amongst family at this virtual table.
7 So thank you so much for your work that you are
8 doing. And this really highlights for me why it
9 is extremely important for bodies such as this to
10 be representative of the groups that have
11 historically been silenced. And that last
12 picture, Mr. James, of all of the obstacles that
13 one faces in order to get to the goal of wellness
14 is daunting, and those obstacles were placed in
15 her path. They were not natural, which I
16 recognize as well. And so my question is, with
17 all of us having our own circles of influence all
18 across the United States, what have been some key
19 mitigation strategies that you have observed in
20 your journey-
21 Mitigation strategies that you have observed in
22 your journey as a leader that has supported

1 accountability in policy work, in providing
2 necessary funding and support to result in better
3 outcomes. Can you share from your wisdom?

4 Arthur James: Yeah, so I'm going to start moving backwards and
5 I'll start with actually the work provided by Dr.
6 Warren and Dr. Hirai a journal article that they
7 published in February of this year, Journal of
8 Pediatrics, Accelerating Upstream Together, where
9 they actually talk about the importance of
10 achieving equity and they get more granular about
11 it. Not only talk about the importance of
12 achieving equity, but what it's going to take in
13 terms of the number of babies that we need to
14 save every day, every month, every year in order
15 to achieve equity. And I want to make clear that
16 when we're talking about achieving equity, we're
17 not just talking about achieving Healthy People
18 2030 goals for Black babies or for Native
19 American babies. We're talking about equity,
20 which means that our goal is to achieve the same
21 degree of successful birth outcomes for those
22 groups as we do for whites.

1 It's a tall, tall task. I honestly don't know
2 that we can accomplish it by 2030, but it's
3 important that we put it out there as our
4 benchmark, and not just that. We are in 2022 now,
5 essentially 2023. We can calculate what it's
6 going to take in terms of the degree of
7 improvement in the infant mortality rates for all
8 groups between now and 2030. So it gives us a
9 barometer for where we are in terms of achieving
10 that goal of equity. And almost in all cases,
11 we're going to document falling behind. What that
12 ought to tell us though, is the degree to which
13 we need to step up our efforts in order to
14 achieve those equity goals. I also think since
15 we've talked about Healthy Start, that since
16 Healthy Start is one of the projects in this
17 country that receive so much support from the
18 federal government that at the very least we
19 ought to hold Healthy Start sites to achieving
20 equity for a lot of different reasons, not the
21 least of which is that it proves to the rest of
22 the nation that it can be done.

1 I also would encourage you all who are part of
2 this group to use this bully pulpit, to use it
3 aggressively to make the point that needs to be
4 made in order to try to save our babies. Because
5 what we're doing now is just totally, absolutely
6 beyond any shadow of a doubt unacceptable,
7 because we know we can do better. Yes, it means
8 that we have to address things like poverty, but
9 we can do that. I know it means that it's going
10 to take a lot of money, a lot of resources, more
11 than just HRSA is going to be able to put on the
12 table, but if we make it a priority, we can move
13 this needle in the right direction. And I also
14 want to make sure that I don't demean the
15 importance of the research that's gone on in
16 terms of improving clinical care, but I think
17 most of us know that the biggest contributors to
18 the disparities that we experience are the
19 nonclinical issues that adversely influence
20 populations of color.

21 And we have to have the courage to support those
22 communities to get out there and advocate for

1 that. In another city, maybe we'll have an
2 opportunity at some other time, or I can send you
3 some additional information. But in Kalamazoo
4 County back in the year 2000, we were able to
5 help Kalamazoo County get close to achieving
6 Healthy People 2000 goals for Black infant
7 mortality. One of the few counties in the country
8 that got so close to accomplishing that goal.
9 Nothing special about Kalamazoo County, I
10 guarantee you. When we started the project,
11 Kalamazoo County had the highest Black infant
12 mortality rate in the state of Michigan. The
13 state of Michigan at the time had the highest
14 Black infant mortality rate in the nation, and we
15 were able to decrease the infant mortality rate
16 from about 30 to about 10, 9.9. So, it can be
17 done. It takes a lot of work to do it and
18 sometimes it gets discouraging because it takes
19 so much work, it requires so much of us.

20 Ed Ehlinger: All right. Before I turn over to Janelle, I do
21 want to make one point that you made related to

1 the question that was just asked. One of your
2 slides that you used.

3 Arthur James: Yep.

4 Ed Ehlinger: Let me just bring this up. This slide. You'll
5 note that the times that there were three times
6 in this chart when the disparities went down. One
7 was in the early 1900s when a social model was
8 used as opposed to a medical model was used to
9 deal with all of the poverty issues, the
10 children's rights issues, the women's issues,
11 women got the right to vote during that time. The
12 second time it went down was during the Great
13 Depression and the World War because people, one,
14 we had the Social Security Act with the maternal
15 and child health, but also all of the social
16 security issues, it brought down disparities. And
17 we got together in photo war. We all came
18 together as one people.

19 The third time in this 100 years was during the
20 War on Poverty when we had a health and all
21 policies approach to health. The War on Poverty

1 and the Great Society Program was very successful
2 in reducing disparities. Those were all policy
3 issues. It was a health and all policies
4 approach. And I think that is what I was hoping,
5 and that's what I'm hoping that SACIMM can do, is
6 focusing on the same kinds of approaches that
7 were used in the early 1900s, the mid 1930s and
8 forties. And in 1960 or in 1960s. Janelle?

9 Janelle Palacios: Dr. James, it is always, always a pleasure
10 to learn from you and to be here with you. And
11 every time that I hear parts of your
12 presentation, new thoughts come to mind. And from
13 the very beginning of being on ACIMM, I have
14 advocated that we have to see each other as
15 humans and that we have to have nationwide
16 recognition and healing together. That there has
17 to be where we are in relationships and in
18 community with one another because we don't see
19 that. And it has come to the surface more so in
20 the past eight years than any other time.

21 And we have to be very frank about stating which
22 people are valued more in terms of funding, in

1 terms of our outcomes, because we see that. So we
2 have to be very frank of keeping that at the
3 forefront and asking why can't we all have an
4 equal access to health and wellbeing? Why can't
5 we all be at this same level? One of the parts
6 that jumped out to me is that it is newish,
7 scientifically discovered what many Indigenous
8 communities knew around the world, that the
9 health of the pregnant person and the infant
10 relied on what her relationship in the world was.
11 So being in a stressful environment was going to
12 impact both of them. And that there are cultural
13 protections in a number of Native American
14 cultures where a pregnant person should not be
15 around death, should not be around war, and that
16 was just to protect that dyad.

17 And it is only now recently that we were coming
18 that Western science is able to document this in
19 terms of risk for hypertension, risk for
20 preeclampsia, other kind of comorbidities and
21 chronic health diseases. So it's great to get
22 recognition that our cultures and committees that

1 have been marginalized, in fact were very, very
2 wise and have been practicing healthy ways of
3 keeping and protecting their families and people
4 healthy and we have a long ways to go to be
5 there. I look forward for any additional other
6 wise thoughts you have in terms of, what else is
7 needed? What else has to be done? What action has
8 to be taken immediately now to achieve equity on
9 a fast track? Because we know that we can take a
10 few centuries to get us to where we can all be at
11 a more equitable place, but we don't want that,
12 we want it fast tracked. So what does that look
13 like when we fast track it? Aside from doing more
14 funding, what else has to happen?

15 Ed Ehlinger: So be before I have Art answer, I would like to
16 have Charlie make the last comment and then we'll
17 give Art the last word before we move on.

18 Charlene Collier: Okay. I'll be quick. Thank you so much Dr.
19 James. As a OBGYN, and you're one of my true
20 heroes and I thank you for your comments and
21 particularly acknowledging the mindset of
22 resistance as it relates to focusing on the

1 populations who need it most and not making the
2 assumption that everyone believes that those who
3 need the most should get the most. And I think
4 that scarcity mindset has been present
5 throughout, of course, all of our culture. It is
6 a reflection of white supremacy and racism and I
7 think calling it out, naming it, and really
8 pointing to who's responsible for continuously
9 breaking it down because it continues to be this
10 silent thing when it's said, we're going to apply
11 practices that everyone can benefit from, but as
12 you mentioned, it is going to accelerate
13 improvements in some, but it's not enough for
14 those who need more.

15 And so, it's this unspoken thing often and I
16 think it's being able to break it down. How does
17 it get called out more when it's happening? And
18 just, I appreciate you really voicing that that
19 is an underlying theme within both hospital
20 initiatives, public health initiatives, that
21 there is a willful resistance to the attempts to
22 apply the funding, apply the focus where it is

1 needed most. It's not just, oh, there's not
2 enough funding, it's really acknowledging that
3 discomfort that is part of our culture and how we
4 have to break that down. So I just want to thank
5 you for that and just see as you answered Dr.
6 Palacios, if you have other suggestions on how we
7 continue to name that specifically as something
8 that we see in public health and in health
9 policy. Thank you.

10 Ed Ehlinger: All right, we'll give you the last word before we
11 move on so you can...big challenge again.

12 Arthur James: Janelle, I'm sorry, but my computer went offline
13 while you were talking, so I didn't hear your
14 final question. I do want to say the following
15 for those of you who are new to this committee,
16 that one of the wonderful things you have is the
17 group of people that you're working with at HRSA,
18 they get this. They get it, they want to do
19 something about it. So, you have to help them.
20 And that's a big part of the task that is on the
21 plate for you. Janelle, what was your question?
22 I'm sorry.

1 Janelle Palacios: No, my pleasure. No, Art, what
2 recommendations do you have? What guidance do you
3 have in terms of fast tracking that we get to
4 equity? We don't want to wait a few centuries, we
5 wanted immediate. So what other ideas do you have
6 for this committee and for our partners to fast
7 track?

8 Arthur James: Yeah.

9 Janelle Palacios: Thank you.

10 Arthur James: I think that and in general is that we need to
11 begin a much more earnest effort to address the
12 social determinants and the disparities that
13 exist there. Often I'm asked, well, which social
14 determinants should we address? And I don't have
15 a pat answer for that because I think every
16 community is different enough that my suggestion
17 is that you start with the social determinant in
18 your community that you can garner the most
19 support for. Sort of what Belinda was talking
20 about earlier when she asked about a portfolio
21 approach, if you will, for Healthy Start

1 projects. But that once you pick a social
2 determinant to work on, let's say you decide to
3 work on housing, that in addition to working on
4 that, you need to schedule a time to onboard
5 addressing the other social determinants because
6 they're like dominoes. If you don't graduate from
7 high school, that influences the kind of job
8 you're able to get, how much money you're able to
9 make, whether or not you have insurance, the
10 neighborhood that you live in, et cetera, et
11 cetera, et cetera.

12 So that you have to onboard addressing them all.
13 And just like I've tried to show in the disparity
14 data in this quest for equity, how we can measure
15 our progress, you can do that for each of the
16 social determinants. So that's one piece.

17 Obviously, I also think we need to work on the
18 clinical stuff, but my emphasis would be on the
19 social determinant piece. The challenge for the
20 social determinant piece is that of course it's
21 going to take a longer period of time for us to
22 reap the benefits from doing that work. So it's

1 not a fast track, but it's a track that we need
2 to be on.

3 Ed Ehlinger: Thank you very much, Art.

4 Arthur James: Thank you. Appreciate the-

5 Dr. Ed Ehlinger: That was very helpful in both in reflecting
6 back but also giving stimulus to move forward.
7 That is exactly what I was hoping you would do,
8 and you did it with such grace and wisdom. Thank
9 you, thank you, thank you.

10 Arthur James: Thank you. Good luck to you guys.

11 Ed Ehlinger: Thanks. All right. Now over the last three years,
12 three and a half years, a lot of the work that
13 we've done has been done through the workgroups.
14 So I'm going to just ask each of the chairs of
15 the workgroups to give just a brief summary of
16 what happened? What have we learned? What kind of
17 accomplishments do we have? And let's start with
18 Steve. He is the head of the chairing the
19 Workforce and Qualities of Care Workgroup. Had a
20 lot of work early on when we were looking at

1 COVID and the systems reform of our first two
2 recommendations. Your Workgroup did a lot of work
3 on that. Give us a little background, little
4 update on what you see happened over the last
5 four years.

6 Steve Calvin: Sure. Well, it's very abbreviated in the last
7 year and a half or so, and I think I'd have to
8 apologize for that. But it was quite interesting,
9 particularly when we had Suzanne England and
10 others join us because that was the first time...
11 I mean, I've had a peripheral interest in kind of
12 what was happening, especially out in the tribal
13 lands in South Dakota. But anyway, the workforce
14 issue is, it's a huge one. And I think as we go
15 forward, all the folks that have joined us from
16 various places all the way from Alaska to North
17 Carolina, I mean we have a wide range of
18 experience. So we know for sure within the
19 profession of those who care for pregnant moms
20 and babies, that we are going to have a shortage
21 of physicians and midwives. And I think that's
22 going to be a very important issue for access.

1 And then as we develop those workforces, having
2 those workforces look a lot more like the folks
3 that they're caring for will be incredibly
4 important. So that's my summary.

5 Ed Ehlinger: All right, good. I forgot to mention that the
6 workgroups are not statutorily there. They were
7 just ad hoc workgroups that the committee decided
8 that that's what we needed. We wanted to have one
9 on data, wanted to have one on health equity, and
10 we wanted to have one on care and workforce. And
11 so whether those continue will really be up to
12 the group as they move forward. But they've been
13 very helpful to me in terms of helping get the
14 work done and moving forth an agenda. Janelle and
15 Belinda, the two of you co-chaired the Health
16 Equity Workgroup. What have you learned over the
17 last four years?

18 Janelle Palacios: Belinda, would you like to start?

19 Belinda Pettiford: Sure, I'll get started, Janelle. I think the
20 main thing was, I think the insight of just
21 actually standing up a Health Equity Workgroup

1 was important. I think we all knew it was needed
2 and I think Art kicked off our earlier meeting,
3 as you mentioned earlier, and reminded us we have
4 got to make sure we have a Health Equity
5 Workgroup, but we also need to make sure it's
6 infused with all of the other work. I think the
7 opportunity to bring others in, so like the rest
8 of the workgroups, we didn't limit it to just the
9 members of ACIMM. We just wanted to make sure
10 that people that were interested, we reached out
11 and we accepted all. I think we spent quite a bit
12 of time looking at the inequities, especially
13 around COVID early on and I think that was an
14 important piece. And it was, as I think you said
15 earlier, one of those areas that we hadn't talked
16 much about and we were in the midst of it and
17 everybody was struggling and we were really
18 concerned about it.

19 So, I think the Health Equity Workgroup took that
20 on as a challenge and said, these are areas that
21 we needed to focus on. I think the other area
22 that we were excited about was workforce

1 diversification. I mean, we spent time on having
2 conversations around race concordant care, and
3 cultural sensitivity, and making sure that the
4 workforce was representative of the populations
5 being served. And if we couldn't get to
6 concordant care that we at least make sure people
7 felt comfortable and that people were culturally
8 sensitive and understood and took in the cultural
9 perspectives of the people that they were
10 actually serving.

11 We spent time and elevated the work of doulas. We
12 talked about nurse midwives and the importance of
13 them and them being able to practice under their
14 own authority. We talked about community health
15 workers. I think we went the gamut on that. And
16 then I think with Janelle's leadership, this is
17 where the work around the focus on American
18 Indian and Alaska Natives started. I think we
19 started those conversations and that workgroup
20 and with Janelle's leadership, we're able to
21 elevate it and bring it to the recommendations we

1 bring forward today. And I'll turn it over to
2 you, Janelle.

3 Janelle Palacios: No, everything ditto. Carbon copy of what
4 Belinda just shared. It was really wonderful to
5 be able to work with a diverse group of people on
6 the Health Equity Workgroup. That was really,
7 really wonderful. We had community people
8 involved, we had academic people involved, we had
9 federal organized partners involved. We had a lot
10 of representation. And so it was really wonderful
11 to be able to have people's insights from
12 different career pathways and different slices of
13 looking at maternal child health that has really
14 given him a rich experience and enlightenment to
15 that work.

16 So I do want to say I have a very special place
17 and thanks for recognition for Belinda in working
18 on all of this as well, because Belinda really
19 also was a mentor and helped shape the Workgroup
20 that we were working on and had a lot of
21 knowledge and access to the different
22 partnerships that were going on. So that was

1 really wonderful. And then the second person I'd
2 really like to call out and thank and I'm not
3 sure if she's even present is Pat Loftman. Pat
4 was really instrumental in working on both our
5 Health Equity Workgroup and then also she worked
6 a little bit more, some with quality and access,
7 but really brought forward the voice of diverse
8 care experiences and allowing pregnant people to
9 have a choice. And that was really important to
10 have her voice in that work.

11 Ed Ehlinger: Thank you, yes. And we raised the issue of
12 bringing in new folks. So, we got a lot of new
13 people who came in and worked with us. They
14 expanded the workforce working on all of this,
15 and Magda was the head of the Data and Research
16 to Action Workgroup, DRAW.

17 Magda Peck: DRAW. If you don't have a good acronym, you don't
18 usually get funded. So old habits die hard. I was
19 hearkening back to when we first met and tried to
20 figure out how to organize the work and we came
21 up with these three workgroups and some of us had
22 some suggestions about having these three parts

1 work together. And I just want to reflect for a
2 moment that it comes from the ideas and
3 leadership of a former surgeon general named
4 Julius Richmond, who together with Milton
5 Kotelchuck, came up with a tripartite model of
6 how to make policy happen. And it would take a
7 knowledge base, the data, the research, it would
8 take a social strategy that programs and the
9 services we do and it would take political will.
10 And that if you have only two, the stool won't
11 stand. And in many ways, the Data and Research to
12 Action Workgroup is the knowledge-based part of
13 our three-legged sacrum stool to get work done.

14 And the social strategy focusing on healthcare
15 and access and workforce was one of our major
16 areas. And in many ways the Health Equity
17 Workgroup was the anchor for political will. As
18 you had heard from Art James, the willful
19 resistance that we can expect when we want to
20 fast track the oppression undoing and taking and
21 dismantling the obstacles in her way. So in that
22 context, it's both what we did, but it's as much

1 what we did together. And the overlap between the
2 first two groups reports that you heard, Ed's
3 prior report, let me just compliment that. So
4 that's the context and framework for my just
5 summing up four years of working in this
6 workgroup. We were initiated to serve a very
7 specific purpose, to assure that our ongoing
8 deliberations and decision making for producing
9 strategic policy recommendations were based on
10 evidence and science that was credible and
11 reliable and timely and relevant.

12 And we did an initial assessment more broadly
13 when we were still trying to figure out what do
14 we respond to beyond COVID. And we acknowledged
15 low capacity, and under staffing, the inability
16 for the workforce to do its job around data and
17 the incompleteness of data, particularly missing
18 on race and ethnicity, that it was not uniform
19 and there were no unique identifiers and that
20 hard sources were hard to talk to because of
21 HIPAA. And it was timely in a slow way overall.
22 And that especially data on racism was

1 unmeasured, unavailable, uneven. And there were
2 such limited data about special populations,
3 including we said four years ago, the
4 incarcerated, undocumented, people at intimate
5 partner violence risk, housing, and crowding, and
6 insecurity, homelessness, or shelter based. And
7 that there were silo data and there was very
8 little interoperability to link systems together
9 across housing, and criminal justice, and food
10 and nutrition.

11 So that this social determinants health had a
12 knowledge base that was integrated that told a
13 more powerful story. And we were also reminded by
14 Paul Wise, a former member of SACIMM and also an
15 earliest member of DRAW, that we needed to build
16 cross-disciplinary bridges for a common wisdom
17 and that we had to be as much about redesigning
18 the architecture of data as deciding which
19 variables we might want to measure. So when I
20 think in that context about what were our leading
21 accomplishments as the Data and Research to
22 Action Workgroup, cumulatively through two

1 administrations, racial reckoning, pandemic and
2 COVID-19, a major economic downturn among other
3 challenges, we focused on what the knowledge base
4 needed to support in a supporting role around
5 COVID-19 prevention, around undoing racism and
6 racial equity, around strengthening data systems
7 and building data capacity and data workforce.
8 And through expanded mortality review and then
9 specifically focusing on American Indian and
10 Alaskan Native photos so that the report we gave
11 has the research base, has the evidence base, has
12 the stories all wound into one compelling report.

13 We did that with a lot of volunteer effort and
14 amazing people. And before I thank them, I just
15 want to end with recognizing the other
16 consequences and advancements besides the work.
17 SACIMM allowed us through DRAW and to bring back
18 to you all to validate the power of stories as
19 data that lived experience is valued expertise to
20 storify the work that's in SACIMM recommendations
21 from the first to the second to the last. And may
22 it continue not to have stories illustrate, but

1 stories drive. We provided timely consultation so
2 when CDC is going to revise PRAMS, they could
3 come to draw at SACIMM and we could convene
4 partners and experts and be able to give back
5 within three days the results that they needed to
6 be able to inform their own new recommendations
7 and guidance. So this notion of a timely
8 consultation of a broad group of people was there
9 because we had the architecture, the human
10 architecture of working collaboratively and as
11 needed, we brought in the other two workgroups
12 because they were seamlessly interrelated.

13 We were a catalyst for some strategic
14 collaboration across generations, across sectors,
15 across disciplines, in a diverse kind of way. I
16 love that we brought the housing folks in, which
17 was never been at this table, has not been yet
18 mentioned in our accomplishments, but we didn't
19 need recommendations, we just needed people to
20 talk to each other. So when Housing and Urban
21 Development leaders showed up, it was a catalyst
22 for HRSA and MCHB to be able to do their job even

1 better. As Art said, help them do their job as an
2 independent outside group.

3 And last, in the process part of the benefits of
4 DRAW was capacity building. I had the joy and
5 pleasure of mentoring people and learning from a
6 younger generation. And so the leadership is
7 stronger, the innovation is greater, and the
8 science has even more robust integrity. I thank
9 Sherri Alderman and Ndidiamaka Amutah-Onukagha,
10 Wanda Barfield, Cheryl Broussard, Jackie
11 Campbell, Alison Cernich, Cheryl Clark, Jeanne
12 Conry, Ada Determan, Danielle Ely, Rosemary
13 Fournier, Carol Gilbert, Neeru Gupta, Leslie
14 Kowalewski, Charlan Kroelinger, Janelle, Ed, and
15 Paul Wise, and Ellen Tilden among many. I know
16 this sounds like the Academy Awards, but it
17 really is all of the 20 people who showed up
18 again and again and again to do the work of
19 translating data to action. It's been a hoot and
20 I hope that you continue to engage and expand
21 this diverse representative group of people to

1 make a greater difference together. Thanks for
2 the opportunity, Ed, for the reflection.

3 Ed Ehlinger: Yeah, thanks Magda. Thanks, Janelle. Thanks,
4 Belinda. Thanks, Steve. You guys did great work
5 that that's where really the rubber met the road
6 of moving this forward. The other place I would
7 like to have some feedback or some insight is
8 from MCHB, who has worked with us over these four
9 years and helped us move along. I'm just curious
10 on, I don't know, Vanessa or Lee, thoughts about
11 what did we get done? What didn't we get done?
12 How did we do it? What was our report card?

13 Lee Wilson: I'm going to let Vanessa go first.

14 Vanessa Lee: Oh, okay. Thank you. I was going to let you go
15 first. I'll have to pull up my notes. I just
16 jotted a few. I knew many of what I was thinking
17 was already going to said, but yeah, you have an
18 A plus from me. It's truly been a gift and just a
19 tremendous professional opportunity to get to
20 work with all of you. And I love working with the
21 committee. It's going to be in my future for as

1 long as I can tell, and I'm excited about working
2 with the other members continuing on. But I think
3 this group, as you said, Ed and others, I've
4 really appreciated just you drawing more
5 attention to those social and structural
6 determinants, especially after we saw Art
7 present, just how critical that was back in 2018.
8 And I think you really have moved us in MCHB as
9 you can see, hopefully in some of our funding
10 opportunities to not just focus on that clinical
11 care or those medical interventions.

12 So I've appreciated that and I think that's a
13 huge accomplishment to see within our portfolio,
14 the work moving again towards social and
15 structural determinants. Ed, you said this
16 earlier and so did Terrence more, but I truly
17 believe you've increased the knowledge and
18 capacity of MCHB staff, our HRSA grantees who
19 call in to listen every quarter, all these public
20 health professionals that I see coming just to
21 listen in on your committee business. So I really
22 think you've changed the field around the

1 country, again, by increasing our knowledge and
2 our capacity. You've brought such amazing
3 speakers, guest presenters, people with lived
4 experience, the community members-

5 guest presenters, people with lived experience,
6 the community members. I hear every time we have
7 a meeting afterwards, "Oh my gosh, I learned so
8 much. I want to get connected with this person
9 and that person." I think that's a huge
10 accomplishment of you all as a committee.

11 And then again, your helpful advice and
12 recommendations to HRSA on what we need in
13 membership. I know you guys give us a lot of
14 thoughts and input on that, and we really are
15 taking that in. You've reminded us who's missing
16 from the committee, what perspectives we're
17 missing, who we need to include. Just make a
18 plug. As you guys know, we have that federal
19 register notice out right now calling for new
20 member nominations. We have kept in mind all
21 those recommendations that Belinda, you and the
22 workgroup that you led gave us.

1 Now, that's about two years old so we want more
2 thoughts from you all on who's missing. Again,
3 what is that expertise or experience that we need
4 to make sure the committee has so that we stay on
5 the pulse of what's needed to, again, eliminate
6 those disparities?

7 And Lee, I'll turn it over to you. Those were my
8 three.

9 Lee Wilson: Vanessa, that sounded like a lot more than three
10 and it covered a lot of what I was going to say.
11 For me, coming into this role three years ago
12 this month and having you, Ed, Jeanie, Magda,
13 Janelle, Belinda, and others here, many of you I
14 had met before, but your reputations preceded
15 you. Having you as a real... The words I jotted
16 down are touchstone, anchor, guide, source of
17 input, knowledge, and balance in a situation
18 where the division was having some difficulties.
19 We were having to be facing COVID. We were
20 looking at reorganizing. We had tons of staff who
21 were being deployed or sick or pulled out.

1 I may have not said it directly to you, but there
2 was this sense that I could lean a little towards
3 the wall that was the advisory committee. Or if I
4 got too far afield, that one of you would've
5 picked up the phone and called me and said,
6 "Something's going on here. What are you doing?"
7 Knowing that it wasn't going to be self-
8 interested because you wanted me to give you a
9 grant for something to do it, although I'm sure
10 that some of you will be coming later on to do
11 that.

12 But the point was that you have been very much an
13 informed and objective source of information,
14 both for me and for the division. I have greatly
15 appreciated that, not only in guiding me as I've
16 tried to work with our staff to clarify what our
17 direction is, especially as we have been
18 strapped, but fortunate enough to get additional
19 resources.

20 I think most concretely, your input, as I've said
21 on so many occasions, is what we have used to
22 ground and justify many of the advancements that

1 we are trying to bring to program. As I've said,
2 Doulas is a good example that some of the idea,
3 design, and factors that we have tried to build
4 into the Doula Program, into the Catalyst Program
5 are those things that Art James has raised
6 because you've brought Art to us are the things
7 that Ed has tried to attend to, that Magda has
8 raised in the data activities, and frankly that
9 Belinda has told me from her couple decades worth
10 of work on the Healthy Start program. We have
11 just benefited so greatly from the work that
12 you've provided, especially in this last couple
13 years.

14 And Ed, I'm going to say my farewells in a little
15 while to those of you who are going off, but the
16 stature of the committee is so different from
17 where it was 3, 4, 5 years ago when the committee
18 was really in question of its continued
19 existence. I think I'll leave it with that.

20 Ed Ehlinger: Thank you, Lee and Vanessa. I appreciate that.
21 The purpose of this reflection was not to try to
22 get kudos about what has happened because I think

1 we've done a whole lot, but actually to set the
2 stage for the next step. What did you hear?
3 Somebody says we have big shoes to fill. That
4 means you have some obligation, you have some
5 responsibilities, you have to carry on whatever.
6 I mean, we all carry the baton for a while and
7 then hand it off.

8 I hope this last hour, just what we've done, how
9 we've done it, what's worked, the accomplishments
10 we have is just to set the stage for the next
11 step.

12 **Break**

13 Ed Ehlinger: And after a break of 15 minutes, we're going to
14 come back and talk about that next step. Refresh
15 your water or your coffee or whatever lovely
16 beverage you're doing and we'll see you back here
17 at 4:30.

18 Magda Peck: I would say we are not adjourned, Dr. Ehlinger.

19 Ed Ehlinger: Say that again.

1 Magda Peck: Right. No, the slide said adjourn, and I was
2 like, "Not so fast."

3 Kathryn Menard: Slide said adjourn.

4 Ed Ehlinger: We are definitely not there yet. We have work to
5 do. We can't shirk our duty. We have to fulfill
6 all the requirements. Everything on the agenda
7 has to be covered.

8 Magda Peck: And you're keeping it very well on time. I so
9 appreciate that, Ed.

10 Ed Ehlinger: Well, being a chair of a committee has some
11 responsibilities and I try to take them
12 seriously. I take them seriously. I don't try to.
13 I take them seriously.

14 Magda Peck: And you do. Well done.

15 Vanessa Lee: Going to say, Ed, if this is just you trying to
16 take them seriously, I can't imagine what taking
17 it seriously would look like.

1 Ed Ehlinger: Yeah. People say, "I would like to thank you." I
2 say, "No, just thank them." Don't say, "I would
3 like to." Just thank them.

4 Vanessa Lee: I have a list of things I've learned from you,
5 Ed, and that's one of them. There was a letter we
6 were trying to write; it was an invite letter for
7 the September meeting. It was something along the
8 lines of just invite me instead of saying, "I
9 would like to invite you."

10 Ed Ehlinger: All right, we got another minute yet before we
11 reach the witching hour of starting.

12

13 **Next Steps for ACIMM**

14 Ed Ehlinger: All right. Welcome back. We have an hour and a
15 half left on our agenda. Whether we take all that
16 time is up to us. But there are three things that
17 I want to accomplish at least. I want to get an
18 update from MCHB of all of the administrative
19 stuff, so I'll start with Vanessa. Then I'm going
20 to want some response from all of you about how
21 are you going to use the report that we approved

1 earlier today? How are you going to disseminate
2 it and use it? Then we can talk about the next
3 steps for ACIMM moving forward. Then we can say
4 goodbyes. We've got time to do that.

5 Initially, I had thought that we would know who
6 the next chair is going to be, but that's not
7 possible. I was going to hand it off to let that
8 person, whoever that might be, to take that part
9 of the agenda. But I will work to fulfill my role
10 right up to the end of this meeting, and hope
11 that those of you who are staying on will keep in
12 the back of your mind, all right, one of the
13 things we're talking about that you might be able
14 to use as you move forward as members of SACIMM.

15 Vanessa, why don't you give us an update of where
16 we are, whatever the administrative issues that
17 we need to know about at this point in time?

18 Vanessa Lee: Okay, thank you, Ed. Yes, we had hoped we would
19 be able to share who the next chair of the
20 committee was by this meeting. It is our
21 intention to have that resolved by the next

1 committee meeting, which is slated for March.
2 I'll just say we have dates still to be
3 determined, but the next meeting would be virtual
4 and in March. Again, our plan is to have the next
5 chair in place by that meeting, or before that
6 meeting, excuse me, so that they can be running
7 the meeting in March. Otherwise, I learned it
8 defaults to the DFO as your chair. I would rather
9 be working with somebody than running the
10 meeting.

11 Marie-Elizabeth Ramas: Do we have dates for that, Vanessa?

12 Vanessa Lee: We do not yet have dates for the March meeting,
13 but Abigail, if you're still on, or Lee, maybe we
14 can look back at what week we were looking at in
15 the contract with the logistics with LRG. If I
16 find that before the end of our call today, I'll
17 put it in the chat.

18 Then thanks, Marie, for meetings for 2023. We
19 have planned through the remainder of this fiscal
20 year. As I mentioned, in March we are planning
21 for a virtual meeting. And then in June of 2023,

1 again, exact dates to be determined, we are
2 planning for an in-person meeting. Then actually
3 next summer, are recompeting the logistics
4 contract. That's just why we don't have dates or
5 months yet for the remainder of 2023. But we
6 typically hold another meeting in the fall, as
7 you guys saw, in September or October sometimes.
8 And then another one towards the end of the
9 calendar year. But we should know more by the
10 summer in terms of the remainder of the meetings
11 in 2023. March and June, we'll be in touch with
12 dates, or we can do a Doodle poll if we have some
13 dates in mind among the members.

14 Again, working on solidifying the next chair. And
15 then in terms of filling the remaining and also
16 new vacant member spots on the committee, as you
17 guys know in the charter we're allowed to have up
18 to 21 members on the committee. It's always been
19 our goal to get as close to that number as
20 possible or a full set of 21. We are at a point
21 where the terms are pretty staggered now, so it's
22 continuously people rolling off and us bringing

1 on new people. But our goal is always to get as
2 close to 21 as we can.

3 We have a package of seven nominees that is in
4 the process of being reviewed for approval. We
5 hope that at some point in early 2023, we can
6 bring on potentially up to seven new members
7 through the committee. Again, that is under
8 review and going through the approval process
9 right now. I think we had mentioned that package
10 to you all before.

11 And then as I said earlier, we have a new call
12 for nominations out. The last time we did a call
13 for nominations was January of 2020. That list
14 now is two years old so it's coming up on
15 expiring. For federal advisory committees, those
16 nomination lists last about two years. We just
17 put out a federal register notice soliciting new
18 nominations. People can self-nominate. Please
19 help us spread the word. The nomination packages
20 are due January 23rd. I can put more information
21 in the chat to the link and also where you can
22 find it on our website.

1 logistics support contract that we have with LRG.
2 It is always, unfortunately, just a one-year
3 contract, so we continuously have to complete it
4 after a year's time. But we are committed to
5 keeping that logistics contract in place to
6 support the committee in terms of meetings, any
7 kind of report writing, we can build that in. Of
8 course, they support travel for speakers,
9 presenters, the honorarium, things like that.

10 But as we re-complete that and put together that
11 scope of work, if there's needs that you guys
12 feel like you have that weren't being met
13 previously in terms of logistics or that type of
14 logistical support, please let me know. We're
15 committed to continuing that contract.

16 Then in terms of staffing and MCHB support, I
17 will remain the DFO. I have half of my time to
18 support the committee. It doesn't always seem
19 like that probably, Ed, or feel that way, but
20 I've gotten assurance from our leadership that
21 more of my time hopefully can be freed up to
22 fulfill that time allotment.

1 And then we did get approval for another halftime
2 person, half of a person's time to, again,
3 support the committee as a programmatic lead.
4 They would have program content background and be
5 able to support the committee with that knowledge
6 base. They're called typically the principal
7 staff person.

8 And then we will continue to have Abigail as the
9 contractor officer's representative who focuses
10 on the meetings. And then Michelle Lowe, of
11 course, who many of you know, and has supported
12 the committee as the management analyst for
13 years. She does all of the administrative travel,
14 other tasks to help me and the principal staff
15 person.

16 And then Lee will remain heavily involved as
17 well, as you've seen in the past few years since
18 he's been the division director. He has no plans
19 to step back. I think he also enjoys working with
20 the committee and sees the importance of the
21 committee, so I know he plans to continue his
22 involvement as well and support.

1 Ed Ehlinger: It just struck me when we were meeting at
2 Shakopee that that was a crash course in maternal
3 and child health. An intern working with that
4 would've been just so much really helpful as an
5 education experience and the connections that are
6 made. Any kind of work that can be done to have
7 internships or students involved or something to
8 help support would be helpful. Because I put in a
9 lot of time and I guess whoever is going to be
10 the next chair might actually have a real job and
11 may not have the same amount of time that I had,
12 so it would be nice to have that support.

13 Vanessa Lee: Yes, and I will take note of that. We have been
14 involving our division of MCH workforce and
15 development more. They are helping us get the
16 word out in terms of nominations to the MCH
17 training programs, a lot of their grantees that
18 are in the training and workforce development
19 space. We've noted, Belinda, as you and others
20 have said, we need more early career
21 professionals hopefully on the committee. They

1 are crafting some language to hone in on in their
2 outreach and promotion.

3 And then they also have connections with the
4 Historically Black Colleges and Universities.
5 They sent out the call for nominations to that
6 group that they now organize again with the
7 HBCUs. We were excited about that. And then our
8 office of tribal affairs at HRSA has blasted out
9 the announcement to all of their connections and
10 networks, listservs, to hopefully get more
11 American Indian/Alaska Native, and Indigenous
12 representation on the committee.

13 Ed Ehlinger: And then before I turn it over to Magda, because
14 I see your hand up, Magda. I'm not ignoring you.

15 Magda Peck: I was just playing with my CI. I was adjusting my
16 sound, Ed.

17 Ed Ehlinger: Well, one of the-
18 Yeah. But one of the things that has happened is
19 that things happen at the federal level that I
20 was not aware of until right at, like the Tribal

1 Summit that's happening, was unaware of it. The
2 Women's Health Initiative wasn't aware. I mean,
3 there needs to be better connection between
4 what's going on federally and getting that
5 information to SACM so that it can actually
6 either participate in or something. So I mean, I
7 hope that there'd be a little bit better
8 connection. That would be one of the things I
9 would suggest working on. Magda.

10 Magda Peck: Well, I'm going to underscore something you
11 already brought up, Ed, with a little more
12 specificity. When I think about the number of
13 volunteer hours just between Janelle and Ed and
14 me and trying to get this report done without any
15 real staffing, it is a labor of love, but it
16 seemed like such a missed opportunity. As
17 somebody who graduated from an MCH training
18 program at one of your schools, if I had had the
19 opportunity to be able to get credit and be able
20 to be aligned with as student staff to SACIMM, it
21 would've been extraordinary. In fact, that's a
22 role that I played as a student with other

1 conferences, and that's how I got to know Julie
2 Richmond. That's how you get to know and network.

3 So it's not so much the, yes, we could use the
4 help, but it's such a missed opportunity. I would
5 say that it's also a missed opportunity to forge
6 the connections between those that are in nurse
7 midwifery programs and those that are in
8 physician training programs and those... So if
9 we're looking for, and those are from other
10 sectors, so I know that's its own infrastructure
11 to develop, but strong ideas and strong
12 commitment to try to make that happen because
13 students will be the pipeline forsake, but a
14 pipeline for policy. I think that it's an
15 extraordinarily missed opportunity to not have
16 them see how the sausage is made.

17 Ed Ehlinger: Thank you, Magda. All right. Anything else,
18 Vanessa?

19 Vanessa Lee: I don't think so. I'm taking notes, so thank you.
20 Those were all really helpful recommendations.
21 Yes, Magda, I remember sitting in a committee

1 meeting in 2013, which I realized, "Oh my gosh,
2 that was almost 10 years ago," and watching Kay
3 Johnson facilitate. They were approving the 2013
4 recommendations actually, and hearing and
5 learning. I was taking all these notes. So yeah,
6 I agree. It's an opportunity that should be
7 shared and I will try to promote that more.

8 Magda Peck: It could be built into the MCH training grants,
9 just saying. It's all in the guidance. Sorry. I'm
10 done.

11 Ed Ehlinger: All right, good. All right. I'm sure we'll
12 come... If there's anything else, we got a little
13 time at the end. Let's now talk about the report,
14 the use and dissemination of the report. I'll
15 tell you what I'm going to do with it. I'm really
16 proud of this. I am going to send it to my two
17 senators with a personal letter saying, "Dear
18 Senator Smith, Dear Senator Klobuchar, this is
19 what happened. This is what... And Senator
20 Klobuchar, as you're thinking about running for
21 president, thank you for coming to our meeting
22 and giving us a video welcoming. Here's what

1 needs to happen." Sending it to my governor. I'm
2 sending it to all of the agency folks, the
3 different agencies. I'll send it to the Astro
4 director and I'll send it to some of the schools
5 of public health folks to just say, "Hey, look at
6 what happened. This is what we did."

7 I will send it to all of my American Indian
8 colleagues that I worked with in public health to
9 say, "Thank you for your input. How can we
10 partner in getting this out and accelerated out
11 there?" I mean, it's a communication tool. I'm
12 going to send it to students who have
13 expressed... I mentor a lot of students. They're
14 going see this and say, "Oh, look at what can
15 happen if you get a group of folks together and
16 work together. You can create something like
17 this." That's where I'm going to start. So I'm
18 curious on how you are going to use this report.
19 It's comprehensive. It's got a lot of
20 information. You've got 59, and Janelle said you
21 want to make it 60. We have 59 recommendations,
22 but it's a tenant upon us to take that apart and

1 use it in different ways. So I'm just curious on
2 how you're going to use it. Kate.

3 Kathryn Menard: Well, I'll tell you what I'd like to do is,
4 of course, I want HRSA to use it in a big way,
5 but I'd like to spread the word in my realm of
6 influence. That includes, I have an academic
7 community, of course, but more importantly, I'm
8 part of the Maternal Health Learning Innovation
9 Center, which is HRSA funded, which has a really
10 broad reach. I'm the executive group, executive
11 leadership for the AIM initiative, which touches
12 a lot of POCs across the country, perinatal
13 quality collaboratives, across the country. I'm
14 on the Society for Maternal Fetal Medicine
15 Quality and Safety Committee that touches a lot
16 of maternal fetal medicine specialists that are
17 interested in improvement. Anyway, there's a
18 list, but I don't need...

19 But what I would want or need to do that would be
20 like I'd maybe get about 10 minutes on their
21 agenda, on one of these meeting agendas where I
22 could run through something. So if I had a cliff

1 note, executive summary, slide deck, here's the
2 language, run it presentation, I could get it out
3 in a lot of places with that warm handoff that
4 Charlene was saying is important, right? Because
5 they know me, and they trust me. That would be a
6 way that I think a lot of us could use those
7 avenues through various paths.

8 Ed Ehlinger: That raises the question that Magda raised
9 earlier about this meeting that's coming up in
10 March. Who's going to present at that and could
11 present at that would require putting together a
12 short presentation that might be helpful. So I
13 think that just needs to be a strategy to think
14 about, because I will be using this and I'll be
15 probably synthesizing some things for, depending
16 on who I'm talking to, making my own slide deck
17 about what's going to happen. But I think I will
18 certainly continue to work with Janelle and Magda
19 on as we go back and forth, because we've
20 developed a nice little relationship here around
21 this report to try to help each other. I know
22 they're going to be doing it with something

1 related to the storytelling. So there might be
2 some slide decks going with that. So it's a good
3 question of how we're going to do that, but I
4 think it's possible.

5 Kathryn Menard: Yeah, I think audience is important, Ed, but
6 I think consistency is really important too. So
7 it would really be great to have something that
8 we could all get behind and modify as necessary
9 per audience.

10 Ed Ehlinger: Good thought. Marie, I know you said there would
11 be a press release. I wondered about that in the
12 past with the other reports, and HRSA does not
13 have a mechanism for press releases that I'm
14 aware of. So I've been trying to work with AMCHP
15 and CityMatCH and March of Dimes to see if they
16 could do a press release about this report that
17 just came out. I'm going to continue to do that,
18 and maybe we'll have to ask Lee and Vanessa if
19 HRSA ever puts out press releases for stuff like
20 this. But now...

1 Marie-Elizabeth Ramas: Yeah, I think this would be a missed
2 opportunity, particularly for the NHSC
3 scholarship program and loan repayment program.
4 These are the people that should know about a
5 report like this. If there's certainly mechanisms
6 for HRSA to contact the health centers and
7 clinics that are involved in that program. So at
8 a minimum, I would hope that this is communicated
9 to that group. If not, then that will be my
10 number one recommendation for the American
11 Academy of Family Physicians to release a press
12 release specifically around this document and
13 this list of recommendations, like I mentioned
14 earlier, on the Commission of Health of the
15 Public and Sciences for the American Academy of
16 Family Physicians. So, I will put this as a new
17 agenda, a new topic to present for our February
18 meeting that we have every year. I, too, will be
19 sharing with my state governor and as a president
20 of the New Hampshire AFP chapter in the Medical
21 Society Governance Council for New Hampshire, I
22 can share this amongst multiple medical
23 associations. I think this would be of importance

1 to share with our National Association of
2 Community Health Centers as well.

3 So I plan to submit a possible speaking
4 presentation for the national, the NAC
5 essentially, annual meeting to talk about social
6 determinants and health equity regarding this
7 report. I think another opportunity, and again, I
8 have to agree with Kate, not only releasing
9 information in a wave, but being consistent, just
10 like contractions, to make sure that we come and
11 we come with a level of intensity and frequency.
12 So really planning out how are we going to create
13 a cadence of remembrance to keep this information
14 in the forefront of policy-makers, decision-
15 makers in our respective fields. I really do, and
16 Kate, if you want to collaborate, I'm happy to
17 try to do some respect with the immense amount of
18 work that Ed, Magda, and Janelle have done in
19 curating a template of a deck at least. But I
20 think having some uniformity in how we message
21 will increase the impact at the end of the day

1 and making sure that we're sharing stories. I
2 think that is so powerful.

3 So I had put in a couple of my colleagues that
4 are storytelling strategists, and I think this
5 would be a unique possible project that we can do
6 in sharing stories that reflect the work here. In
7 addition to sharing stories, how can we think
8 about involving our media, our local media
9 outlets, our local newspapers and journals. So
10 those are just some things that I've been
11 thinking about in preparation for the meeting on
12 how to continue to move the work forward and
13 bring it in front of the eyes that probably need
14 to see it the most.

15 Ed Ehlinger: I like your metaphor. So how I've forgotten, how
16 many stages of labor are there? I know how many
17 trimesters there are. How many?

18 Marie-Elizabeth Ramas: They say there's three.

19 Ed Ehlinger: The first stage of labor and the contractions
20 have to...

1 Marie-Elizabeth Ramas: That's right. So we can build some of
2 that energy up, right?

3 Ed Ehlinger: Yep.

4 Magda Peck: Latent phase, active phase.

5 Lee Wilson: Don't they say when you're a hammer, everything's
6 a nail, when you're an OBGYN, everything's a
7 delivery?

8 Marie-Elizabeth Ramas: Or a family doctor that delivers.

9 Lee Wilson: Or a family doctor.

10 Marie-Elizabeth Ramas: Correct. You're right.

11 Ed Ehlinger: Lee, is there any problem with any member of the
12 committee speaking about this report? I mean, we
13 can't speak for the federal government for sure,
14 but any cautions that we should be aware of?

15 Lee Wilson: I'm going to ask for Vanessa to chime in as well.
16 You are committee members and so you can speak as
17 committee members. You are not taking a position
18 for the federal government in its use of that
19 information or whether it's directing. I mean,

1 that's up to the Secretary on how the Secretary
2 wants or chooses to pursue the recommendations
3 that you have provided. But I do think HRSA's in
4 a really weird position on this because we
5 facilitate your work, we send it up to the
6 Secretary, the Secretary's supposed to make a
7 decision. The Secretary's going to come back and
8 ask us what we think and ask us to draft a
9 response to the letter that we helped you write
10 but based on what the Secretary wants to commit
11 or not commit. So I do think that it is
12 probably... You're going to get a less massaged
13 letter to go to the Secretary and public comment
14 if you do it separate from having HRSA drafted
15 for you because of that very middle role that we
16 play.

17 Ed Ehlinger: Well, we drafted... I mean, we have drafted a
18 letter and it's been approved.

19 Lee Wilson: No, no, no, no, no. I understand. I'm saying if
20 you want to make hay out of this, if you want to
21 go to the press or do those sorts of things,
22 we're not going to do that because it would then,

1 as an arm of the Secretary, imply the Secretary
2 has adopted.

3 Ed Ehlinger: Okay, I see. Okay. Thank you. I misheard that.
4 Janelle?

5 Janelle Palacios: This question is for Lee. So as of tomorrow
6 or maybe 4:00 PM my time or 2:30 PM my time, am I
7 technically off the ACIMM committee?

8 Ed Ehlinger: December 15th, you're off? Yeah.

9 Janelle Palacios: Okay. I have a few more days. Okay. That is
10 just a question because then once I'm off, I can
11 then have an opinion about this recommendation
12 and report. Okay. Because I have just been
13 texting and I am setting up a local NPRKQED
14 podcast interview that will hopefully come to
15 fruition where we can talk about this report. So
16 I will be contacting you and looping you in as
17 well, Alexis Madrigal, on the forum. Yeah.

18 Magda Peck: Big one.

19 Janelle Palacios: Okay.

1 Magda Peck: Excited about this.

2 Janelle Palacios: Encouraging people to look at your local NPR
3 stations, your local radio stations as well,
4 podcast hosts.

5 Lee Wilson: Fantastic.

6 Magda Peck: Excellent.

7 Lee Wilson: Congratulations. Keep up the good work. Keep up
8 the pressure. I may get my hand slapped for
9 saying keep up the pressure, but my job is
10 actually to help advocate for these particular
11 issues. So as I said, your job is to advise the
12 government.

13 Janelle Palacios: Well, I hope Secretary Becerra would extend
14 don't do mild to MCHB staff as well.

15 Lee Wilson: I have no fears. That's why I just said it. If I
16 did, I would've kept my mouth shut.

17 Ed Ehlinger: I know when we were in Shakopee, the newspaper
18 was here and we got the articles. So I, again,
19 will follow up with the news media to say, "All

1 right, you've heard it earlier on and here's what
2 the result was." I'm sure we'll get some meetings
3 with the editorial writers. Particularly those of
4 you who have American Indian communities within
5 wherever you live, meeting with the editorial
6 boards would really be a good thing to do.

7 Belinda?

8 Belinda Pettiford: Yes, I was looking at Vanessa's note in the
9 chat, but at the same time, I was thinking of the
10 places that... Well, of course I've already
11 shared it with the board of AMCHP and I plan to
12 do the same thing with the Board of the National
13 Healthy Start Association. The National Healthy
14 Start Association conference is coming up in
15 March, and I think this is an agenda item that
16 that planning committee was looking at. So, there
17 may be another opportunity there. I know it's
18 coming up in March, I just don't have the dates
19 in my head right now. Then also just thinking
20 about it in my own state, I mean, I've sent it
21 out, those recommendations out to our North
22 Carolina Commission of Indian Affairs early on to

1 get feedback and have since scheduled a meeting
2 to just sit down with the executive director and
3 walk through it. Because they take the leadership
4 in much of the work with our American Indian
5 community and our state. But we have strong
6 partnerships with many of them and actually fund
7 several American Indian organizations. So we're
8 looking at ways to spread it out.

9 We're also planning to share with our Maternal
10 Mortality Review Committee that Kate Menard sits
11 on and our Perinatal Health Equity Collective,
12 and others, and looking at the recommendations
13 and how they connect to the recommendations of
14 our perinatal health strategic plan, which we
15 have buy-in from many around our state, which
16 includes our village-to-village team, which are
17 community leaders and individuals with lived
18 experience. So I think there's tons of
19 opportunities for us to get this information out.
20 I think in partnership with our Commission on
21 Indian Affairs, I think it could also end up
22 being in the media. I will ask our commission to

1 take the lead, but I think in partnership with
2 the commission and me being part of State Title
3 V, there's an opportunity for us to work together
4 on making sure these recommendations are shared
5 broadly around our state and looking for other
6 opportunities. We have 12 tribes in North
7 Carolina and lots of opportunities to connect
8 with them. Some urban, some not as urban, only
9 one is federally recognized.

10 But we have several, quite a few, that are state
11 recognized. So I do think there are
12 opportunities, but we will not limit it to just
13 American Indian/Alaska Native individuals and
14 organizations because we think this is a message
15 that should resonate with everyone. That's why
16 we're really looking at our Perinatal Health
17 Equity Collective and potentially looking at our
18 February meeting to share this more broadly with
19 them.

20 Ed Ehlinger: Thank you. Other thoughts? Certainly, I'm going
21 to be... There are a couple of edits that I went
22 through just commas here and periods there. So

1 I'm going to be finalizing the final copy
2 tomorrow morning. So if you have any little teeny
3 tiny edits or I know there's some Workgroup
4 Members that didn't get listed, I'm going to put
5 those in there. Nothing substantial because that
6 would mean another revote. But just any kind of
7 edits, get them to me by tomorrow morning, before
8 tomorrow morning or before noon tomorrow because
9 then I'll get it to Vanessa and we can get it
10 out. Janelle, I'm sure they will need your
11 electronic signature in order to put... They have
12 mine already, so we'd like to get this out as
13 soon as possible. Magda?

14 Magda Peck: I want to go back to, on a personal note,
15 certainly through my networks will continue to
16 encourage its dissemination. That's obviously
17 through CityMatCH, through the University of
18 Nebraska where I still hold a faculty
19 appointment, and in other venues. So, ditto and
20 the like. It might be one of the things that I
21 wanted to go back to, the comment about strategy
22 is to ask how we do both, sow the seeds of it,

1 just put it out there as much as you can and let
2 it organically take root and, or can we track,
3 it's a natural experiment. How do you use
4 strategic communication to impact policy at
5 different levels, and how do we leverage each
6 other's communications, and how are the tools
7 that we use to communicate about this now that
8 there is an executive summary and a table, at
9 least, how do we create other tools that allow us
10 to be able to send the same subset of information
11 in strategic waves? Last, how do we track this?

12 So, with the three of us stepping off, who've
13 been the ones who've been living with this for
14 three months, who, and we don't have a new chair,
15 I'm curious about who gets copied. Is there any
16 opportunity to report back so that Ed is copied
17 or Vanessa's copied or someone? There's a
18 repository of a three- to six-month strategy of
19 disseminating this so that it is elevated and
20 illuminated. So, I'm curious who's the CC to
21 when, Belinda, you send it out, or who would be
22 the blind copy? But I think it'd be fascinating

1 to know because we're committed to go from word
2 to deed and a lot of people will do a lot of
3 stuff, but I don't have a sense of how we will
4 know what the collective impact is of our various
5 levels of communication and networks.

6 So, I'm curious if there's a central way to track
7 that or a place to put tools of letters we've
8 written so you don't have to write a new letter.
9 There's an efficiency that we can introduce and
10 I'm curious if SACM is willing to continue that
11 in some level, some ad hoc collection of a few of
12 you and to the degree that you want any of our
13 help still, you can ask, but it just feels
14 strategy would be really important because it'll
15 get old real soon and it's so old a grievance
16 anyway, we can't afford to let it be declared
17 stale.

18 Sherri Alderman: I just want to add. Well, I just think one
19 possibility to get this out there in the media, I
20 wonder if Ed and Janelle and Magda should write
21 an opinion piece, an op-ed, contact Washington
22 Post, New York Times, see if they're interested.

1 I think that would be the way to get it out. Then
2 once you have something like that, then you're
3 going to have multiple media sources that are
4 going to be interested. So, I think that the
5 three of you did so much work on this, I think
6 you should maybe write up something.

7 Ed Ehlinger: Yeah, that was my plan after I get off the
8 committee when I can do it as a private citizen
9 and not a member of the committee, will be that.
10 Also, thank you, Tara. I think that's a great
11 idea. Also, second, what Lee said, I think any
12 communication we have, we should BCC Vanessa,
13 blind copy Vanessa on it. She would be the place
14 at least until SACM gets official leadership and
15 then they can figure out how best to do that. I'm
16 also curious, I don't see any other hands of
17 appointed members. I'm curious about the Ex-
18 Officio Members. How are you going to use this
19 report?

20 Magda Peck: Crickets.

21 Ed Ehlinger: That's right. I can wait.

1 Charlan Kroelinger: No, sorry. This is Charlan. I was just
2 having to unmute and turn on the camera.
3 Apologies. I think we at CDC really value the
4 words, the presentations, and the thoughts of
5 this committee. I take everything back to the
6 division and the branch. Wanda also, even though
7 is not so active a member of this committee is
8 engaged in conversation with me constantly about
9 this. So as Kate mentioned early on, we plan to
10 highlight this once it's released among our
11 programs in the division. I'm sure my colleagues
12 and other parts of the agency have similar
13 thoughts.

14 Alison Cernich: I'll just second Charlan's comment and I
15 apologize. I'm covering for our director today,
16 so I've been in and out all day, but I've already
17 distributed the report to our entire Internal
18 Health Task Force internally. We've also taken it
19 into consideration. I shared an early draft with
20 those who did a tribal consultation around our
21 maternal health research centers of excellence.
22 So that has already been incorporated into the

1 design of our funding opportunity. It's a \$24
2 million funding opportunity that went out this
3 year. We are planning to do another tribal
4 consultation after the awards, especially with
5 those organizations that may be partnering with
6 tribal communities. But in addition, we have
7 other opportunities that are being shaped with
8 this consideration already in mind. So, we
9 absolutely value this and have already really
10 disseminated it pretty widely across NIH,
11 especially with leaders in maternal health.

12 Dr. Ed Ehlinger: Great. Yanique?

13 Yanique Edmond: Well, I am having issues trying to get on
14 camera, but want to echo what others said. As far
15 as OMH, this information is really, right now,
16 we're reviewing it to see how it aligns with some
17 of the work that we're doing around perinatal,
18 around our Center for Indigenous Health Equity.
19 So really wanting to be very purposeful and
20 strategic in how we use the information within
21 this report for not only current projects, but
22 how do we operationalize it? How do we use the

1 recommendations to assess kind of actions? So
2 right now, my role in representing the deputy
3 director on this committee is to bring it to them
4 and to have a dialogue around the alignment of
5 the recommendations with the vision of the Office
6 of Minority Health.

7 Ed Ehlinger: Excellent, thank you. Lee.

8 Lee Wilson: Yeah, I've mentioned this before, but just to say
9 that our office will be responsible for working
10 with the Office of the Secretary on generating
11 any specific responses that will come out of the
12 department to the recommendations that you're
13 making. So, we'll have a hand in that piece. The
14 other thing that is particularly useful for us
15 right now is as we're working to design some of
16 our newer programs or redesign existing programs
17 for the competitions in pretty much every program
18 that we have in the division of Healthy Start and
19 Perinatal Services will be recompeted over the
20 next two years to try to incorporate the
21 recommendations that you're making into the
22 design work of those new competitions. So, for

1 doulas, for the Maternal Health Innovations
2 program, for the Healthy Start program, and any
3 other activities, MDRBD and things like that. So,
4 it will be a very useful and practical tool for
5 us.

6 Ed Ehlinger: Good. Thanks. Danielle.

7 Danielle Ely: Hi. So, I know that I'm a little lower on the
8 totem pole than many of the other federal members
9 here, but one of the things that I have been
10 trying to do is sending the different
11 recommendations to my supervisor and different
12 people in our department. One of the things that
13 I have been able to convince them of is possibly
14 doing some reports on American Indian/Alaska
15 Natives, specifically just focusing on those
16 because historically, we have not been able to...
17 I shouldn't say we have not been able to, but the
18 number's been small, so it's harder to manipulate
19 or to show the data. So we've been in discussion
20 of how we can show data, different information we
21 could include just to push forward these
22 different outcomes for infants as well as some of

1 the prior information in the last meeting or the
2 last few meetings actually about how to include
3 not just non-Hispanic, but also Hispanic and
4 multi-race when counting American Indian because
5 of the history involved.

6 Ed Ehlinger: Thank you. You raise a point, Danielle, that as
7 we transition to the next phase of our
8 conversation here about how to use this and how
9 SACM should move forward, it reminds me of the
10 quotation that Mandela used. There was a
11 quotation for Marianne Williamson, I'm sure
12 you've all heard it. It says, "Our deepest fear
13 is not that we are inadequate. Our deepest fear
14 is that we are powerful beyond measure." Wherever
15 you are in your organization, it is our light,
16 not our darkness, that most frightens us. We ask
17 ourselves, "Who am I to be brilliant, gorgeous,
18 talented, fabulous?" Actually, who are you not to
19 be? You are a child of God, your playing small
20 doesn't serve the world. There's nothing
21 enlightened about shrinking so that other people
22 won't feel insecure around you. We are all meant

1 to shine. I think that's how often are you asked
2 to be on a federal advisory committee? How many
3 people in this country get the opportunity to be
4 on a federal advisory committee? That is a big
5 deal. Whether you think so or not, I think it's a
6 big deal. You are here for a purpose.

7 You've got a reason. You are here because you've
8 got some connections, you've got some talents,
9 you've got some experience. So don't be small,
10 don't be small. Be bold and be bright and shine,
11 which takes us to, all right, what are we going
12 to do now? We, meaning I'm going to be a SACM
13 alum, so I'll continue to talk about we. What are
14 the next steps for this committee moving forward?
15 Now, I did one-on-one interviews with all of the
16 members that are going off the committee and I
17 did one-on-one interviews with all of the
18 committee members who are going to be staying on,
19 and these were just some of the things that I
20 heard in those one-on-ones. Then just as a
21 kickoff, we talked about several people said,
22 "Whatever we do, it has to be actionable and

1 sustainable, actionable and sustainable, rural
2 issues, funding particularly around that
3 community health workers, health equity and
4 social justice, value-based care, the role HRSA
5 can play in infant and maternal mortality around
6 community health centers, levels of care, safety
7 bundles, community engagement, pregnancy medical
8 homes, mother and infant separation."

9 We heard about that in terms of the incarceration
10 piece is a huge piece. "Domestic violence, home
11 visiting, early childhood mental health." We
12 heard about that again today. Those were some of
13 the issues of people when you came onto this
14 committee, said those were issues that you wanted
15 to be engaged with. So, what are the issues? What
16 are the things? How is this committee going to
17 move forward? I'm not going to be the chair, but
18 you guys are going to be members. Where do you
19 want to go? Where do you want to take it? What
20 are the issues you want to deal with? Let's do a
21 little brainstorming here so that you can get it
22 into the minutes and whoever ends up being the

1 leader chair can have something to start to react
2 to.

3 Charlene Collier: I mean, I think I would throw out stress or
4 toxic stress as a thing that is, to me,
5 underpinning. It's like when you say, "What is
6 the path?" We saw it with Dr. James' talk and
7 when you say racism or when you say social
8 determinants of health, they have this common
9 pathway of putting people under these toxic
10 levels of stress. I think there's spaces as an
11 OBGYN when I hear presentations on work and what
12 is a normal amount of work. I feel like so much
13 of it is grounded in the history of slavery about
14 what a pregnant woman should or shouldn't do
15 while she's pregnant is upholding a system of
16 don't rest. I see doctors fight giving a note to
17 take a day off almost harder than I see them
18 fight to end the maternal mortality they get
19 their ruffles...

20 I see them fight to end maternal mortality and
21 they get their feathers ruffled. So, I think
22 it's, even in medicine, we just haven't

1 acknowledged stress as a true thing and how we
2 combat it and how it gets acknowledged. I myself
3 was told by a doctor when I was having trouble
4 getting pregnant, when I said, "Oh, I think it's
5 stress," and then he learned I was an OB-GYN, he
6 said, "Now I find it laughable to know you're an
7 OB-GYN and you thought your fertility was related
8 to stress." He took time to go back and say, "Oh
9 yeah, that's funny now. I can laugh, because
10 you're a doctor and you should know better that
11 it isn't related to that."

12 So, it's just something out there that I think
13 the pathways that lead to stillbirth, to
14 preeclampsia, to preterm birth, which is a
15 leading cause of infant death, to the
16 hypertension, where's all this hypertension
17 coming from, we have a toxic environment in so
18 many ways. And I feel like calling that out
19 somehow. But that's where...

20 Ed Ehlinger: All right. Good. Phyllis.

1 Phyllis Sharps: I think we have to continue to emphasize in
2 all that we do the health equity issues and
3 moving that forward. I think as Dr. James pointed
4 out, there is still a lot to do, and I think we
5 have the power to keep pushing it and keep
6 pushing it. The other thing is I think there's
7 going to continue to be a challenge on how we
8 keep women's health and reproductive healthcare
9 safe for women. And current things that have
10 happened in legislatures and how states are going
11 to make decisions have, I think, the potential to
12 really increase the disparities in perinatal and
13 women's health, and particularly for the
14 populations that tend to bear the burdens the
15 most. So, I think we need to keep a watch on that
16 and what we may need to think about on how not
17 only keeping it safe for the women, but the
18 providers also.

19 Ed Ehlinger: Thank you. And certainly, one of the things I'm
20 hoping that we were unable to do very much, I
21 think the focus with Indian Health Service. So
22 much work needs to be done with the Indian Health

1 Service. We need the data that we asked for and
2 we need to start a... somebody needs to start a
3 dialogue with them to actually have an evaluation
4 of their contract with ACOG, what compacts, and
5 the various ways that they provide care. I hope
6 somehow that keeps on the forefront, because that
7 ball has started to roll, and we need to keep it
8 moving. Janelle.

9 Janelle Palacios: Thank you. I would just lend my voice in
10 support of that, that I would hope that the
11 committee would continue to follow this thread
12 with action and to keep pushing and keep asking,
13 because as you have heard from Ed, that Indian
14 Health Service has been invited a number of times
15 and high level officers, and it's been very, very
16 difficult to have them engaged on a meaningful
17 level where we are actually getting answers.

18 So, one of the critiques we've heard about
19 possible inability to access data through Indian
20 Health Services, that local tribes, for their
21 protection, might choose or might desire not to
22 share that information. And I would advocate that

1 then we will never know the true disparity. So,
2 if any organization hides behind or uses that as
3 an example or an excuse for not being able to
4 release data, then we are not able to truly
5 understand what really is happening in the
6 community.

7 And so, the other larger picture is that for as
8 much as Indian Health Service has... the history
9 has been rocky and it has been intentionally made
10 so. It has been hobbled by how much funding they
11 have been given historically. It's been hobbled
12 by lack of accountability on a number of
13 measures. So, it has been intentionally designed
14 not to fulfill its obligation in the most optimal
15 way.

16 And so that is not necessarily a reflection on
17 Indian Health Service and the people who work
18 there, but it is a reflection of the government,
19 that those involved in being able to have the
20 power to fund, make decisions, and provide more
21 access, resources, and services have decided not
22 to. And this is where we are.

1 The last thing I would just say, following about
2 what Charlene was saying, talking about with this
3 thread of looking at clinical practice, I would
4 ask that my clinician fellows out there continue
5 to watch the rates of C-sections and if they rise
6 over time among low risk people as we institute
7 new criteria for what is considered hypertension,
8 chronic hypertension, because... And for the
9 people who are not clinicians, there's been a
10 change, a movement of change of how we rule
11 people in for hypertension.

12 And if we are looking at hypertension as a facet
13 of stress, toxic stress, and if we aren't taking
14 blood pressures correctly in clinic, someone, I,
15 when I was 23, could have had an elevated blood
16 pressure of 132 over 90, and then seven years
17 later present and be pregnant and in pain, going
18 through labor, have an elevated pressure of 145
19 over 97, I could technically, and some hospitals
20 are using this, technically be ruled in for
21 chronic hypertension and be treated as someone
22 who has chronic hypertension and be encouraged to

1 be induced or have my labor affected because of
2 this new diagnosis. So just please pay attention.
3 There sometimes is a very big disconnect between
4 science and clinical practice and common sense.

5 Ed Ehlinger: All right. Interesting.

6 Kathryn Menard: Got you on that one, Janelle.

7 Ed Ehlinger: Marie. Oh, Marie and then Kate.

8 Marie-Elizabeth Ramas: Kate, is this in relation to what
9 Janelle was talking about? No?

10 Kathryn Menard: Please go ahead.

11 Marie-Elizabeth Ramas: Okay.

12 Kathryn Menard: Please go ahead.

13 Marie-Elizabeth Ramas: Sure. A few things come to mind that I
14 think would be good synergy with the work that's
15 been done and bring meaningful information for
16 where our healthcare system is going. So, the
17 first thing is this concept of what a clinician
18 is and defining clinicians around the infant
19 maternal space. We had some compelling stories

1 that, depending on one's cultural background, the
2 traditional idea of a maternal clinician provider
3 may not be as inclusive with certain cultures,
4 particularly with our Indigenous brothers and
5 sisters.

6 And so, are we missing opportunities for
7 paraclinical support to be extensions of clinical
8 team? And then also, how do we incentivize the
9 pathways that lead to more support? So, the
10 defining clinicians and then also workforce comes
11 just naturally to that.

12 The second thing is data, data, data. There is a
13 lack of congruency from the federal side to the
14 state side and even from an institution to an
15 institution basis on what demographic information
16 and how it's defined and how it's documented. We
17 cannot understand disparities without
18 understanding data and having consistent and
19 congruent ways of measuring success and measuring
20 demographics. And I think we heard allusion to
21 that earlier today. So that would be, I think, a
22 real important area of necessity, particularly as

1 CMS and HRSA are starting to talk about wanting
2 to reduce health disparities and using segregate
3 data and codes, diagnosis codes in order to help
4 identify disparities and reduction in disparities
5 with their payment models.

6 And then the third aspect to follow with that is
7 really doing a deep dive in what is the return in
8 investment of investing in social determinants of
9 health and picking maybe one area to do a deeper
10 dive in and creating a model that really can
11 explain what is the return of investment for
12 particular aspects of social determinant support
13 in medicalized settings.

14 So, I think that we're starting to understand,
15 for instance, providing transportation vouchers
16 and we're seeing some health insurance payers
17 paying for certain aspects of social determinants
18 in order to help improve access to care. But
19 there really is not, that I can tell in the work
20 that I do, a lot of concrete information that can
21 further support the work.

1 So, I think particularly around maternal infant
2 health, we could provide a compelling argument if
3 we wanted to use or build upon the information
4 that we've curated in our American Indian/Native
5 Alaska populations and using those as case
6 representations to help create essentially a
7 fiscal model. I think that would be very
8 compelling as well.

9 So those three areas, workforce pathways, and
10 then how do we redefine and reorganize the
11 clinician and paraclinical support in maternal
12 infant care data, and how do we create more
13 consistency and congruency in data reporting from
14 a federal level and state level if we can create
15 recommendations? And then the third thing is,
16 what is the return on investment, the fiscal
17 investment, when we are now talking about social
18 determinants and health outcomes?

19 Ed Ehlinger: Great. Kate.

20 Kathryn Menard: So, I'll first say that I fully... I hope we
21 don't finish our meeting tonight without having a

1 real plan for carrying forward how we're going to
2 really catalog how we're going to disseminate
3 this work and share this work across. If no one
4 else wants to volunteer to serve as the
5 repository, I'll put my hand up to gather that
6 information and bring it back to the committee
7 when we reconvene. But I think that that's going
8 to be really important so that we can, from that,
9 have a work plan for going forward with respect
10 to the work you all have already put into this.

11 The next big thing, and I think in my mind, I
12 think the members are all taking this
13 responsibility very seriously, and I think we
14 need both a short-term and long-term plan. I
15 think we heard very clearly from Dr. James that
16 the marathon is going to be picking up some of
17 the really underlying social determinants of
18 health that need to be tackled. Our resources
19 aren't there for a quick fist on any of that, but
20 we do have influences. The sprint is things that
21 we have immediate influence over, that the
22 committee members and HRSA have immediate

1 influence over. So, I think we should pick a
2 blend of short term and long term.

3 And I guess I would put forward as our sprint our
4 short term is improving access to culturally
5 congruent and respectful, risk appropriate care.
6 That lumps together a lot of things we've talked
7 about. It's bringing more to those who need more.
8 It's identifying the pockets that need support,
9 rural health, and distance travel. We've heard so
10 much about inner cities and the poverty that's
11 there, access to specialty care, access to mental
12 health services, access to substance abuse. Just
13 taking that umbrella look at where access is and
14 isn't and not separating the social determinants
15 of health from the clinical work, because I think
16 getting over some of those barriers that Dr.
17 James showed on the path toward better health is
18 what we have to do now until we can figure out
19 the longer term solution to removing those
20 barriers. So...

21 Ed Ehlinger: Good. Well, you'll notice in our report, we put
22 social determinants and clinical care, the Indian

1 Health Service as direct care, under the same
2 category, because they are.

3 Kathryn Menard: Same. Yeah. Same.

4 Ed Ehlinger: Yeah. Steve.

5 Steve Calvin: Yeah, I just wanted to second. I'm really
6 grateful to have a colleague. Kate's insights are
7 really valuable. And we have pediatricians,
8 obstetricians, and family medicine. I really hope
9 somebody will be able to... They won't replace
10 Janelle, but we have to have a midwife or two.
11 That has to be the case. And having community
12 members. ShaRhonda, her perspective, your
13 perspective, ShaRhonda, from St. Louis as a
14 consumer of healthcare and a leader in your
15 community is really, really valuable. Anyway, we
16 have to get a midwife. So, listen up, Lee and
17 Vanessa.

18 Ed Ehlinger: Thank you. Thank you. Magda.

19 Magda Peck: Actually, Belinda, you had your hand up before me
20 and then you dropped out. Do you want to speak?

1 Belinda Pettiford: No. Mine was around social determinants of
2 health, so I dropped the rest of my comments in
3 the chat. I was following up on what Marie said
4 and then what Ms. Janelle put in a chat. So, I'm
5 good. Thank you.

6 Magda Peck: All right. Just want to make sure we're queuing
7 up right. And so, there's not more to add. The
8 list is quite extensive as I hear our new
9 colleagues and continuing colleagues move
10 forward. I'm wondering about how the three
11 different missives reports that we have sent on
12 also continue to stay on the burner as opposed to
13 falling off.

14 And what I mean by that is, in the first, the
15 response to COVID and then the follow-up response
16 to COVID, there's a series of sequelae of COVID
17 and pandemic. And there's the tri-demic and
18 there's RSV. There may be some urgent issues. And
19 I would encourage our members that are continuing
20 to not put that on the back burner or take it
21 off, but to be able to continue to say, "Well, is

1 there anything more that needs to be done?" even
2 if it's just a proforma review.

3 With focus on environmental health and climate
4 change, we didn't go very far or deep. And it's
5 not like, "Oh we did that. Check the box." So,
6 I'd encourage you to think about how can we drill
7 down deeper, the way we went from Indian Health
8 Service down to a full report. So, I'm curious
9 about how particularly physical, environmental
10 health, and climate change and climate science,
11 we can continue to stay on the forefront of that.

12 Immigration and what's happening at the border
13 and global migration and movement and
14 displacement, particularly in times of war, is
15 something that has an impact on our populations.
16 And so, circle back to that and say "What has
17 been done, hence accountability? And what more
18 might we want specifically to dive into?"

19 I would add to that housing and housing security,
20 because as pandemic protections are easing and
21 abating and disappearing, the crunch on housing

1 and the affordability of housing and people who
2 are unhoused and are housing insecure is going to
3 be paramount. So how do we circle back to what we
4 already reviewed in one meeting and ask, "Is it
5 time for us to go deeper on this, beyond making
6 the connections between HUD and HRSA stronger?"

7 So, I don't want to add anything new. I want as a
8 parting member to be able to say, "Review the
9 recommendations that were sent before and don't
10 let them die." Hold their feet to the fire on
11 accountability because the tepid letters that
12 come back are like, "Well, thanks so much. We'll
13 be in touch." And I think that, if not for
14 SACCIM, it will not be elevated again in the same
15 way.

16 So as Art said, "Use the bully pulpit, but hold
17 the folks we advise accountable." So, I just
18 encourage you to start there and be able to
19 connect what else you want to do with what has
20 already been said and done. I don't think it's
21 necessary to go back to 2013, but there are now
22 three substantive documents that give you a place

1 to jump off from and go deeper while holding them
2 accountable for what they already received.

3 Thanks so much.

4 Ed Ehlinger: Magda, you said, "If not for SACCIM, many of the
5 issues would be forsaken."

6 Magda Peck: I was tempted to say that. That was your pun, not
7 mine. Heard it.

8 Ed Ehlinger: But you prompted it. Sharonda.

9 ShaRhonda Thompson: What I want to say and just remind everyone
10 is what the Secretary asked us, to be bold. I
11 don't want us to lose that fire. I don't want us
12 to lose our way. I want us to remain bold in what
13 we say and what we recommend, because it's going
14 to take that in order to get any type of a
15 change. Sometimes, it's more than just making a
16 suggestion. It's, "Hey, look. This is what needs
17 to be done," and I just want us to remember that
18 and stick to that in the days coming forward.

19 Ed Ehlinger: Yes. I love that he put as a challenge, "Don't do
20 mild when it comes to making a difference." And

1 so, I think that is your charge that we've got.

2 And we will do that.

3 And one of the things I will certainly do, I will

4 connect with Vanessa next week and try to figure

5 out how to communicate back some of the next

6 steps that we're hearing in this little

7 conversation and see where we go from here. But

8 it really will be the next group that will take

9 leadership. I will certainly be around to help.

10 I'm an alum now and so is Janelle and Magda and

11 Belinda. But we won't go away. This is our work.

12 It's part of our life's work. It's not just a job

13 once you get done and you go on to something

14 else.

15 So, all right. There's a lot of challenges, and I

16 will certainly be glad to help whoever gets to

17 chair this just to facilitate she, her, him, they

18 in whatever the work that gets done. Be glad to

19 help.

20

21

22

1 **Wrap-Up and Transition**

2 Ed Ehlinger: But let's wrap up. I would like to give the
3 members who are leaving a chance to say a few
4 words. We've got not everybody. I think we've got
5 Belinda and Janelle and Magda and myself.
6 Belinda, any comments that you would like to
7 leave with this group?

8 Belinda Pettiford: Sure. Yes. I will say this has been such an
9 amazing opportunity to work with an awesome team.
10 I feel like we have tried our best to move this
11 work forward, and I don't think we're leaving
12 anything on the table that we thought we
13 shouldn't try. And I will say that the lifelong
14 friendship that I now have with Janelle will
15 remain. She and I truly bonded over this work
16 with our cohort with the Health Equity Workgroup.
17 But I also think it is just such an awesome team
18 to work with that I feel like the four of us that
19 are leaving are leaving you all in a good place.
20 I think it is totally up to you which direction
21 you choose to take it in. I think the work of

1 health equity has to be part of this. That is my
2 virtual soapbox or in-person soapbox or whichever
3 soapbox you want to put it on, because I think
4 the data is very clear. If we don't address our
5 inequities, we are not going to continue. We're
6 not going to see improvements. And that is with
7 all populations.

8 And so, I think it is so important that you all
9 continue this great work and know that I am here,
10 willing and available to assist any way that I
11 can. And I know that Janelle and Ed and ... so
12 much. I consider it a pleasure to have worked
13 with you all in this great group. Thanks.

14 Ed Ehlinger: Thank you. Thank you for your work. It's been
15 incredible. You're a good colleague. Magda, what
16 would you like to say?

17 Magda Peck: Well, I want to first respond to Vanessa's
18 question, which is really great. What does it
19 look like? How does accountability work? That's
20 my first comment, which is don't let them off
21 easy. I started with the easiest thing is for us

1 to write a bold report and then it like rain on a
2 hot day dissipates on the pavement and there is
3 no trace. We better leave a trace. Part of that
4 is this notion of accountability. It's to ask for
5 a report, to get a reporting back. And this
6 happens with the Ex-Officios. We've heard them
7 say, "This is what we're going to do with this
8 report." At your next meeting, I'm encouraging a
9 pattern, like Terrence Moore noted today, follow
10 it back. Don't just do the one-off and check it
11 and say, "Well yeah, didn't we already do
12 housing?" So, I'm just encouraging an iterative
13 way because it's the tenacity and the iterative
14 circling back that will serve you well.

15 It has served us well. I really loved having a
16 conversation with Kay Johnson who is the prior
17 chair, just about what advice she had. She didn't
18 have an opportunity to have a handoff like this.
19 The notion about continuing to turn the heat up
20 and hold them accountable was something that she
21 taught me. So that's the first, is continue to
22 politely push back and just keep the heat on.

1 This is adaptive leadership. If you don't turn up
2 the heat, it is not going to change, because
3 that's what we're thinking about as systems
4 change.

5 And the second is I'm hugely proud of the story
6 work here. This is not rocket science. It's not
7 the first. But as a scientist who's been a
8 storyteller, I felt like it had a bifurcated life
9 and a bifurcated soul, and to weave the story and
10 the science together. Data never speak for
11 themselves. It's not data to policy. So, fuel it
12 with stories. I love how many of you are
13 captivated and compelled to do the story work. Be
14 strategic and evidence-based about it and bring
15 the data and the recommendations to life.

16 And the last is that we've experienced with the
17 newbies a lot of concordance. It's been a really
18 joyful, easy, and not terribly noisy time. It has
19 not always been that way in SCIMM over time in
20 its 30 years. I think it's essential to create a
21 place for disagreement and doubt, to be able to
22 have the courage to challenge each other. So,

1 Tara, you and I do not agree on some fundamental
2 approaches to women's health, and we both are
3 passionate about needing to get there for the
4 greater good. Building a respect with people with
5 difference and a diversity of perspectives and
6 beliefs has to be brought into SACIMM so it is
7 not group think.

8 And for those of you who I've disagreed with,
9 thank you for that gift and thank you for
10 allowing us to find common ground. We can model
11 that in a polarized nation, especially now. So
12 don't be afraid to take on the hot stuff and
13 welcome doubt, not as disloyalty but as the giver
14 of truth. So, I just hope that you find a way to
15 welcome the tension that can be creative with
16 respect. Then we can model away on taking on the
17 toughest stuff in SACIMM and not avoid conflict,
18 but mine it for the best possible result, because
19 that's what folks are counting on us for. That's
20 what doing bold is for me. So, thanks for the
21 accountability and the heat. Thanks for
22 storifying the space. Thanks for finding a place

1 for doubt not to be disloyal but the handmaiden
2 of truth. And thanks for the opportunity to be a
3 collaborative leader for the greater good. On
4 call to you. You know where to find me. Back to
5 you, Ed.

6 Ed Ehlinger: All right. Thank you, Magda. That highlights that
7 where there's tension, that's where the energy
8 is. So don't avoid tension. Certainly, in my
9 leadership, you go where the tension is because
10 that's where the energy is. Janelle, some
11 comments from you at the end here.

12 Janelle Palacios: Yeah. Thank you for this opportunity to
13 share. I agree that what has been shared already
14 and a big key experience that I have come to
15 realize is very precious is definitely the
16 relationships that I have formed with my
17 colleagues and the mentorship and it's the
18 friendships. Having not participated in this
19 forum, I would not have made those friendships.
20 And the fact that in our in-person meeting I also
21 happened to bring my oldest child, my daughter
22 Zaya, and it was a move to demonstrate what her

1 mom does because she doesn't know what I do when
2 I walk into the office and I'm on the computer.
3 She knows when I go to work in the clinic and the
4 hospital and that I'm going to go help people
5 with their babies, but she doesn't know what this
6 is. This is very abstract. So, she got a little
7 peek at what I do and she took notes because
8 there were some free pamphlets to take notes on,
9 and she shared with me some of her notes and it
10 was very adorable.

11 One of the things she wrote in her notebook was
12 that she was very inspired to see a powerful
13 woman, her mother, doing work. And then she had
14 another note. Her note was in reference to what
15 Lee Wilson had said to her about how she is the
16 next generation, she is the next person to take
17 on this work as well. So, it inspired my daughter
18 that when we returned home, she is a very shy
19 person to begin with, but she started raising her
20 hand, participating and then she was tapped to
21 participate in her school's anti-bullying two-day
22 mentorship program. So it was really great to see

1 that just a few minutes of someone's time and
2 seeing a model of what a different future could
3 look like, inspired my daughter to go down a
4 different path. So, we talked about pipeline, we
5 talked about mentorship and so I really encourage
6 you to continue with that along the way. Build
7 relationships with one another. Yes, tension
8 helps people grow and be challenged. Finding
9 commonalities and finding common ground.

10 I will end with another little anecdote that as a
11 midwife, I meet people on a day-to-day basis, or
12 I should say night-to-night basis because I only
13 work at nighttime. I have no idea who these
14 people are. I've never met them before. People
15 come with all sorts of emotions, whether it's
16 someone who's having a very fast labor and
17 they're scared and terrified of the experience
18 they're having, the fear about their previous
19 childbirth experience or someone who's new to
20 this experience and being induced. I am there to
21 help them and to care for them and to give them
22 my love basically. That's what I'm doing. I'm

1 sharing myself with them and I'm holding their
2 hand and I'm reassuring them that I'm there with
3 them and I'm going to be present. And that is
4 something that we need more of in our nation,
5 more in our community. And the more that we can
6 model that, the more that we can care for one
7 another, I am very hopeful that we can change
8 hearts and minds. Thank you.

9 Ed Ehlinger: Thank you, Janelle. Another anecdote. After our
10 meeting in September, Magda, Janelle and I and
11 Janelle's daughter went to the cultural center
12 and we're going through there, and just seeing
13 Janelle sit down on the floor with her daughter
14 and talk about stuff in this cultural center, it
15 was remarkable. The parent-child connection that
16 was being modeled was just wonderful. It was just
17 great. Lee and Vanessa, any thoughts that you
18 have as we're starting to close?

19 Lee Wilson: So, I'm going to go first since Vanessa stole my
20 suggestions last time, my comments. I'm going to
21 possibly steal hers. First, it has been a great
22 honor and privilege to participate in this

1 activity over the last three plus years. It has
2 really influenced me on how much committees are
3 dynamic and how they have the ability to be great
4 or be small depending on the constellation of
5 individuals who are involved, and in particular
6 the commitment that the individuals choose to
7 invest in the direction of the committee, the
8 recommendations that it makes and the obstacles
9 that are put before it. So, what I would like to
10 say, A) is you have made change in me and I
11 appreciate that and I thank you for that. And
12 then B), what I'd like to do is just say thank
13 you for the extraordinary work that the four of
14 you and the larger committee, but the four of you
15 who are rolling off have brought to this work.

16 At the end of the day, all relationships are in
17 some way mirrored on family. So, there is this
18 side of Ed and Magda that have been the parental
19 units of this endeavor for the last couple years,
20 at least to me. So even though I've been charged
21 with managing this, it's definitely been out of
22 respect and deference to the input and

1 suggestions, even when the agency has said, "Try
2 to tone them down a little bit." It's always go
3 to them and politely say, "Well whatever, and
4 wink wink, but that's just a suggestion. You may
5 want to do what you want to do." But to the two
6 of you, thank you for modeling commitment and
7 dedication when this was done for basically free
8 on your part. That says a tremendous amount not
9 only to your commitment but to the energy that
10 the two of you have brought to the table.

11 We will sorely miss Ed and his energy. It does
12 wear us out periodically, but it has really made
13 for his goal and my goal of turning this advisory
14 committee into something that needs to be
15 reckoned with and something that an organization
16 that has a voice and a reputation that is making
17 change in the community and in the country. So,
18 to that, I thank you.

19 To Belinda, Belinda and I are a little closer to
20 brother and sister and so I would like to say
21 thank you to her for just the little nudges now
22 and again about looking this way or looking that

1 way. A little reinforcement sometimes when I felt
2 like I might be stepping out of turn. And then
3 just her gentle grace, her intellect and her
4 expertise have been truly, truly remarkable,
5 valuable, and influential both on the committee
6 and on me. I look forward to working with her
7 more, given the fact that she is a long-term
8 investor in the Healthy Start program and in
9 these efforts.

10 And then finally to Janelle, who since I don't
11 have any children, I can't say daughter, but who
12 is very much like one of my nieces in many, many
13 ways, especially appearance. And just the
14 surprise and excitement and potential realized
15 and being realized that I see there in you and
16 the modeling that you're doing for the generation
17 below you and that sense that you're not going to
18 rest until things are resolved and put right. I
19 respect that and I value that, and I offer and
20 extend my support in the future as your bright
21 future is realized. So, thank you to the four of

1 you and to the convergence of the rest of the
2 committee that have made this all possible.

3 The rankling and wrangling of some of these
4 ideas, the different people who disagreed not
5 only on wording and the amount of wording
6 discussions that went into those minutes that we
7 just shared with you this last time around, but
8 also really trying to resolve some intractable
9 issues that we are all dealing with here from
10 different angles and perspectives. So, thank you
11 to you all. The committee will continue in part
12 because of the great investment that you all have
13 made. I am saying these words for myself, but I'm
14 also saying them for Dr. Warren and for the
15 agency and for the department. Many, many thanks.
16 You'll be receiving gold embossed little sheets
17 of congratulatory paper with signatures on it to
18 acknowledge your hard work, but that's just a
19 token of what is really behind a great deal of
20 thanks and appreciation.

21 Ed Ehlinger: Vanessa.

1 Vanessa Lee: It's hard to follow that. Lee, you're right, you
2 got to go first, so you took some of mine. I
3 won't say too much. I'm like Belinda and Janelle.
4 I will need the tissues if I start to go off, so
5 you can expect, I think personal emails from me
6 with more of my thanks and gratitude. But I just
7 will sum it up by saying, as Lee said, you guys
8 have just really influenced me. I feel like a
9 better person because of you. Better definitely
10 public health and maternal and child health
11 professional, but even just a better parent. I
12 mean I've learned so much from all of you guys on
13 a professional and personal level. So, thank you.

14 Ed Ehlinger: And certainly, my thanks to Lee and Vanessa and
15 Michael Warren. Really good colleagues to work
16 with. The support that they've given has just
17 been great. The risks that they've taken, I mean,
18 I don't know about risk, but the energy that
19 they've expended to make some things happen that
20 wouldn't have happened otherwise, I really
21 appreciate that. And certainly, I appreciate all
22 of the new friends that I have gotten. I wish I'd

1 be able to spend more time with the new group
2 because I'm just really impressed with what you
3 bring to the table. Certainly I've learned a lot
4 from all of the colleagues, the three others on
5 this call, but also Paul Wise and Paul Jarris and
6 Jeanie Connery and Vijya and Colleen I've all
7 learned something from because they all bring
8 something different. Just having those
9 partnerships and those friendships has just been
10 really, really good.

11 I just really appreciate the opportunity that
12 I've had. Like I told you, how often do you get
13 to be on a federal advisory committee? I mean, of
14 all of the three hundred million people in this
15 country, how many people are on federal advisory
16 committees? I mean, it's infinitesimally small,
17 so this is a big deal. Having the opportunity to
18 work with other people on something like this is
19 really important, so it has been really
20 gratifying for me. It's bittersweet because it's
21 been fun working with you and it's bittersweet
22 ... The bitterness is, not bitterness. The

1 sadness is that there's so much that needs to be
2 done. The work that's coming ahead is going to be
3 really, really important.

4 So, I'm going to end with just a thanks all
5 around, but it wouldn't be me if I didn't end on
6 some historical note. 58 years ago this week, Dr.
7 Martin Luther King Jr. gave his Nobel Peace Prize
8 lecture. In that lecture, he identified three
9 existential challenges facing the world in 1964:
10 nuclear war, poverty, and racial injustice.
11 Poverty, nuclear war, and racial injustice 58
12 years ago. Those are still with us today. Now we
13 have to add pandemics and climate change as other
14 existential threats, but I'm sure he would've
15 done that at the same time. And he identified the
16 fact that all of those existential threats were
17 linked. He said, "Each of these problems, while
18 appearing to be separate and isolated, is
19 inextricably bound to the other." And in my time
20 in public health, I realize that they are all
21 bound and they are all bound by the values that
22 we bring, the narrative that's created in our

1 society, and that if we can deal with inequities,
2 if we can deal with the disparities, we will
3 actually impact climate change, we will actually
4 impact the threat of nuclear war, we will
5 actually impact poverty.

6 Focusing on inequities is crucial to all of the
7 other issues that we faced as a society. He also
8 said, "We live in a day when civilization is
9 shifting its basic outlook, a major turning point
10 in history where the presuppositions on which
11 society is structured are being analyzed, sharply
12 challenged and profoundly changed. What we are
13 seeing now is the realization of an idea whose
14 time has come. Yes, we are shifting our basic
15 outlooks." I think COVID has been a gift and the
16 racial justice protests following the murder of
17 George Floyd has been a gift in that it has
18 identified the fact that all of our systems are
19 failing. All of our systems need to be
20 transformed. So, we are at a time with the
21 realization, as Dr. King said, of an idea whose
22 time has come. And you're at the cusp of that.

1 You have a place to actually impact how we shift,
2 how we structure the world, how we structure our
3 systems moving forward for moms and babies.

4 He ended his comment in his Nobel Peace Prize
5 lecture 58 years ago this week by saying, "There
6 is no deficit in human resources. The deficit is
7 in the human will." I trust that you've got ...
8 You know resources, yes, they're an issue, but
9 there's no deficit in those resources. It's in
10 the human will if there is any deficit at all. I
11 just trust that each of you moving this forward
12 will not shirk from the duty that you've got, the
13 political will, the human will, the social
14 justice will to move forward. So, I trust that
15 you're going to move forward and it's going to be
16 fun watching you move the needle. So, thank you
17 all. It's been a great meeting, a great four
18 years. Done a lot of work and we're moving on
19 with gusto and we're not doing it mildly. So,
20 thank you all. Have a great holiday season,
21 whatever you celebrate.

22

1

Adjourn

2 Magda Peck: Thank you, Ed. Let's give him a round of
3 applause.

4 Ed Ehlinger: Bye-bye.