Health Equity Workgroup

Introductions

Belinda Pettiford:

Hello, everyone. You all got here before Janelle, and I did. Hello everybody.

Pat Loftman:

Hey, Belinda.

Belinda Pettiford:

Hope you all are doing well. Janelle may be late for this one or she may be on her way in. I'll give her a minute. I hope you all have enjoyed the meeting thus far, if you've been able to participate. I joined a little bit late, but I was able to catch up on the discussion. I'm going to give Janelle a minute. Meanwhile, does everyone have the actual recommendations or do we need to be sharing our screen for those?

Charlene Collier:

I like screen sharing generally.

Belinda Pettiford:

Okay. Give me a minute.

Charlene Collier:

[inaudible 00:01:02] the same page, but.

Belinda Pettiford:

Not a problem. I'm going to be the one trying to take notes onto the document with the questions, but let me... Because I have two monitors set up here. Let me just make sure I've got both things pulled up before I start trying to share my screen. And then we'll start off with some brief introductions. So, we'll know everyone that is here. Actually, on this document, we actually... Wait a minute, here it is. Recommendations. And let me see if I can actually share my screen or has it been shut off. Looks like I can-

Christopher Duyos:

You should have screen sharing privileges.

Belinda Pettiford:

Thank you. The voice from somewhere, thank you. I'm going to try... Let me know if you all could still see my screen. Well, because I've

got two monitors, I'm trying to make sure I'm sharing. I'm typing in one and sharing in the other. So, are you all seeing my screen where it says, "Draft Recommendations," or am I sharing on the wrong screen?

Christopher Duyos:

Right now, it's your email.

Speaker 5:

It's your email.

Belinda Pettiford:

I'm sharing my email, I'm sure you all don't want all of those. Okay, let me swap out. Okay. Give me a minute. That lets you know I have too many documents open. Okay. Share on this side. So now you all can see the draft recommendations, correct?

Speaker 5:

Yes, we can.

Belinda Pettiford:

Thank you. And now let me pull up on my other screen the actual document where I'm supposed to be taking notes. You all probably can see that now, but I'm going to move it. Still seeing the draft recommendations.

Pat Loftman:

Yes.

Speaker 5:

Yes.

Belinda Pettiford:

Perfect, it's working. Every once in a while, technology is my friend and then other times, we struggle. But thanks everyone for joining us today. I think we know many of you all, but why don't we take a quick moment, we're not going to use our hour to introduce ourselves, but it will take a quick moment, and everybody just say where they are. And let me see if I can pull up a list somewhere, maybe easier than me telling you to pass it over to the next person. Okay. Give me one moment. And I may not be able to pull up a list because I am... Here it is, the participant list. I can do it and share the screen. Okay. It will start with Jasmine. Will you introduce yourself there? Jasmine? Is that you Charlene? That says Jasmine.

Charlene Collier:

Oh...

Belinda Pettiford:

I'm sorry.

Charlene Collier:

I don't know why my computer reverts to one of our staff sometimes. Charlene Collier, OB-GYN in Mississippi, Chair of the Maternal Mortality Review and Perinatal Quality Collaborative there. And thanks for joining. I will change my name immediately. I'm like, "Who is Jasmine?"

Belinda Pettiford:

Thank you. And I had to look carefully to make sure it was you. Okay. So, otherwise, Jasmine, otherwise known as Charlene. Thank you, Charlene. Pat, if you'll introduce yourself.

Pat Loftman:

I'm Pat Loftman. I'm located in New York city. I'm on the New York City Maternal Mortality Review Committee and the New York Chapter of the New York Midwives.

Belinda Pettiford:

Thank you, Pat. Abigail?

Abigail Duchatelier-Jeudy:

Sorry. I had to find the unmute button. Abigail Duchatelier-Jeudy, Public Health Analyst serving in the Division of Healthy Start and Perinatal Services.

Belinda Pettiford:

Thank you, Abigail, and thank you for pronouncing your name instead of asking me to do it because I will apologize on the front end, but I can get Abigail. So, thank you for joining us.

Cheryl Clark:

Hi, I'm Cheryl Clark. I'm the Associate Director of Equity, Epidemiology and Evaluation at AMCHP.

Belinda Pettiford:

Thank you, Cheryl. Kamisha?

Kamisha Busby:

Good afternoon to you all. My name is Kamisha Busby. I am the MCH Health Equity Program Coordinator for the State of Oklahoma located at the Oklahoma State Department of Health.

Belinda Pettiford:

Thank you, Kamisha. And then your name just disappeared. Kandyce? Unless I'm pronouncing it wrong there. Kandyce Kylick. Am I going to come back to you? Let me see. Kandyce, you look like you are muted. So, if you're trying to speak Kandyce, you are muted. We'll come back to Kandyce. Karen.

Karen Jefferson:

Hi, I'm Karen Jefferson. I'm a Certified Midwife and the Director of Midwifery Practice for the American College of Nurse Midwife.

Belinda Pettiford:

Thank you so very much. Rebekah.

Rebekah Kirkish:

Can you hear me?

Belinda Pettiford:

I can Rebekah, thank you.

Rebekah Kirkish:

Okay. I'm Rebekah Kirkish. I'm a Health Education Specialist at the Fresno California Department of Public Health on the Babies First Project.

Belinda Pettiford:

Thank you and welcome. Susan.

Susan Bell:

Oops. Hi, I'm Susan Bell. I'm a professional Practice Leader for the Neonatal Intensive Care Unit in Pediatrics at Peacehealth Southwest in Vancouver, Washington.

Belinda Pettiford:

Thank you. Shira.

Shira Rutman:

Hi everyone, my name is Shira Rutman and I'm a consultant with the Miami Environmental and Energy Solutions and a Policy Analyst at the University of California, San Francisco.

Belinda Pettiford:

Thank you, Shira. Zya? And Zya, you are muted as well. Will come back to Zya then. Venus.

Venus Uttchin:

Hi everyone, my name is Venus Uttchin. I'm a Women's Health Analyst based here in San Francisco. Nice to be here.

Belinda Pettiford:

Well, thank you all. Did I miss anyone? I know I called a couple of names and didn't get a response. So, you may be having internet or camera issues. Understand that. Did we miss anyone?

Kristina Wint:

Missed me. Kristina?

Belinda Pettiford:

Thank you, Kristina. Please introduce yourself, dear.

Kristina Wint:

Absolutely. My name is Kristina Wint. I'm the Senior Program Manager for Reproductive and Maternal Health and Wellness also at AMCHP. So happy to be here with you all.

Belinda Pettiford:

Thank you. And for note taking purposes. If you all are able, if you'll drop your name in the chat, that will be helpful as well while we're taking notes. And I know... So, Janelle and I co-chair this group together, Janelle will be joining us. I think she had something else that she had to take care of quickly. So, we're going to move on. So, these are the recommendations, you should be able to see my screen where we have draft recommendations to the HHA Secretary, specifically, around health of First Nation and indigenous mothers and infants. As you can see here, just want to make sure you all see what the recommendations are. And as you look through the recommendations, we do have a couple of questions that we want to get answered and need your feedback on. Ed just talked about the questions, but I'll read them again briefly.

Recommendations

Belinda Pettiford:

Do these recommendations address the most pertinent issues? Are they lacking any important issues? Are there any recommendations that are too general or really not relevant? Are there any recommendations that we should discard because we don't need them? Are there any that could be consolidated or combined? What is the highest part of recommendation of all of these? We were to prioritize this list, what we put at the top. Should some of the recommendations be reframed as expectations, something's assumed to be essential in improving birth outcomes among American Indian, Native American populations and what background information or references should we include and what more do we need to know to make sure we have these recommendations finalized? So, I'm going to let us look at the recommendation and someone's going to help me keep time, unless you all want me to put a timer on.

Belinda Pettiford:

So, you could see here the first round of recommendations here, support the concept and I'm not going to read these to you all. Everybody can see the screen, correct? Anyone that cannot see the screen, I have no problems trying to read them to you.

Cheryl Clark:

Well, this is Cheryl, and I don't know what's going on. I raised my hand and then my application lowers it. Maybe it's trying to tell me something.

Belinda Pettiford:

I'm sorry and because I've got one screen, one monitor.

Cheryl Clark:

No. No. No. It's not you. It's like I said, it doesn't stay out. This is the second meeting it's happened on; I just have a question of clarification-

Belinda Pettiford:

Sure.

Recommendation 3

Cheryl Clark:

Because for number three, about the small numbers and then particularly with three B, there's an issue with suppression because folks don't usually have rules about if the counts below a certain number, they just put an asterisk or suppress that number.

Belinda Pettiford:

Right.

Cheryl Clark:

So, I guess I'm just trying to figure out what folks meant by developing national standards that state should adhere to or reporting small numbers because a lot of them won't even report it because of the suppression issues. So, I'm wondering what they meant by that. If you could just take that back to whoever group created that.

Belinda Pettiford:

Right. We can definitely take it back to draw. I think in first review of it, I think what they're basically saying is we need some consistency around whether it's going to be reported or not. And if it is going to be reported, because we don't want in one area, it's reported and, in another area, it's not and they're all small numbers. So, if it's going to be reported, being consistent of how we're

reporting it, even with small numbers. So, are we reporting it because it's small numbers? We're not reporting it annualized, but we're going to take a five-year average. So, I think that is what they mean, but I am writing myself a note to find that out.

Cheryl Clark:

Yeah. And I think from what I'm understanding that you said it that way, that folks may want under certain conditions or permissions that those numbers are reported, but there's that overarching identity protection.

Belinda Pettiford:

Right.

Cheryl Clark:

So, now that you said that they want basically a standardization of suppression. But also, what they want to have for certain conditions, folks will have those numbers, particularly the communities, to be able to assess, even though in counts, you can still do some kind of trending if you have counts over time or your community even. But how do you protect identity at the same time? I guess that's what I'm wondering should be added to that.

Belinda Pettiford:

Got it. Thank you for that comment. I am writing it down. And when we report back out, that may be one that I'll just ask you to clarify a little bit further, if need be, but I am putting it on our list.

Charlene Collier:

I think in our past conversations, that has been the historical standard of not reporting because of suppression. And I think the spirit behind this was that it raises the pretty much on Native American, American [inaudible 00:13:44]. It is to say what are examples that everyone can use? And maybe that's just what we need to do is maybe put in here. For example, aggregate data or in terms of a different... Maybe not numbers, whole numbers, maybe changing them over the ratios, it's one in 10 or one in a hundred, and so it's not reporting on that there were five deaths. You could say there's one in 10 births, resulted in a SIDS death or something like that. But I think it's giving states clear examples of how not to just say too small, can't report, so maybe in this foundation saying, "For example," and then tie that to training and...

Cheryl Clark:

Yeah, usually in aggregate, that's not a problem. It's the geographic stratification of things that could be an issue. And if health is tied to where people are, where they live, and the social circumstances they're under. I'm just wondering, I know in some initiatives that AMCHP is involved with folks can't even get access to data that they

are community members. And so, I'm just wondering if that could be addressed to, but I understand what you're saying. But usually in my experience, it's been the more you slice up the geography or something like that, the small older numbers become then it becomes a suppression issue. They'll say at the asterisk means the counts are under 10. And so, that's always implied what that range is, but how does that help people kind of find out and pinpoint who's being impacted and where? But I understand your comment though, thanks.

Belinda Pettiford:

No, thank you both. That was good feedback. And so, I'm definitely putting it in as further clarification, but to pull out that recommendation to look at more at aggregate or at least being consistent on how we're defining too small and cannot report, but really trying to figure out how can we report it in another way, whether it's the aggregate data, whether we're doing it by ratios, et cetera. Good point. Do you all need me to drop the screen? Move down some?

Recommendation 4

Pat Loftman:

Belinda, this is Pat. I just had another comment. I'm just wondering when we're talking about statistical analysis of smaller populations, whether three B and four or have some relationship because is it possible that the smaller population is because of racial misclassification?

Belinda Pettiford:

That is a very good point and definitely can easily be one of those issues. Does anyone else... I saw someone's hand, I thought I saw someone's hand, but I may be...

Pat Loftman:

No, that may be me. Yeah, that may be.

Belinda Pettiford:

Okay. All right. Thank you, Pat.

Charlene Collier:

I think today they brought up including multiple racial identities. You look up if someone reports AIN plus white plus anything else, Hispanic, including the multiracial categories. So, I don't know how to word that exactly, but I know Janelle acknowledged it and thanked the last presenters for aggregating across multiracial that includes any American Indian, Native American. So, I don't know if that's misclassification problem or just how that's the standardized reporting.

Pat Loftman:

Well, I think that's an issue that exists across the board because keep in mind, a lot of this data is based on old data where there were only two or three classifications, white, Negro, other. And over time as people have acknowledged their own racial or ethnic identity, the classifications or how they describe themselves has changed. So, for example, if you're talking about African American, do you identify as Black or do you identify as African American? So, I think it depends on who developed this racial classification system. I don't know if it's the person who is abstracting the data or this is coming from the individuals themselves, how they self-identify.

Belinda Pettiford:

So, I think the key is we want to keep number four because we think that is definitely relevant. That we want to include First Nation representatives and addressing the racial misclassification in the data collection. So, we definitely want to keep it. I think if we can go to our... That first question around, do these recommendations address the most pertinent issues or is there anything we're missing? And so, as we look at the recommendations... And let me go down, because that's the data. Well, we can look at all of them. We don't have to just look at the ones around Data and Surveillance. So, all of these around Data Surveillance, standardization, self-report, which goes back with the misclassification. If we just ask people, it goes a long way, and we struggle many times asking people. But when you ask people, sometimes they look at you strangely as well. So, it's the education across the board.

Pat Loftman:

I think for me, what I thought was really very interesting, is that across the board, there were issues around workforce. When Dr. Christensen was speaking, and she spoke about the paucity of individuals in the workforce who are of American Indian background. And I noted that she talked about getting residents. I remember when I was one of the last national health service core recipients, and I remember my classmates who were assigned to go to places that they really didn't want to go. And so, for them, it was two agonizing years. So, I think the point I'm trying to make without being loquacious, is that to the extent that we can get individuals from the community, into the workforce, into educational systems, people who want to return to their communities. And I think the literature says, that individuals who come from communities return to the communities, I think that should be a goal. So, it was a recurring theme, not only here, but in the workforce section of the health equity workforce group. So, I thought that was interesting.

Belinda Pettiford:

Thank you. So, I've gone down to that section around Care Improvement and Workforce Development. So, you can see some of the things that Pat was referring to. These are some of the recommendations. It goes

anywhere from training providers to address racism and discrimination, all the way to diversifying the workforce, require all federal grant applications for healthcare professionals, to include these accountability metrics and applications, to monitor their efforts, to improve the number of Black, brown, and First Nation students that reflects the diversity of the population being served. Some of the work on the lifespan training, all of this, many of these areas, specifically, are referring to how do we diversify the workforce. Any other area that you all want to elevate or pull out or any area that you think we're missing? We've got a whole section here on the Indian Health Service and they shared information with us today. Some of it quite new. So, it was good to have people there that did answer some of the questions that were trying to be asked. Am I moving the screen too fast?

Pat Loftman:

Belinda, my comment would be that this is very comprehensive, and I would applaud whoever developed this. This is really very good.

Belinda Pettiford:

Thank you. We'll share. Very comprehensive. Thank you. Any other comments? We'll move down on the Cultural Strength and Resilience. So, is there anything missing? I know you've just said... Thank you, Pat, for sharing it's very comprehensive, it's very good. Can anyone think of any specific area that's missing or anything that we should have included? Is there anything that we should remove? Or anything that doesn't give us the level of detail we want? I'm going to go back up this time in reverse order. And again, if I'm scrolling too fast, let me know. Again, this is the Cultural Strength and Resilience area.

Charlene Collier:

It's kind of unconventional. I think for me this whole time, there's still so much ignorance and lack of hearing from Native American and indigenous birthing people and communities. Not having that visual, that voice, that connection for some of us that may not work directly with the population, we're still just reading about it. And I think even acknowledging like the CDCs HEAR HER campaign just having people's voices part of the solution and I don't know if there's a way of elevating and understanding of this problem from the voices of the community affected. And even if that can be... It's not conventional, but a visual link or an audio link, or just list that you are recording people with lived experiences telling us what they want and what the problem is and putting that voice as a front, a first thing that anyone who reads recommendation has to first watch, listen, observe. Just take in.

Charlene Collier:

I just think it's part of the problem is invisibility in many of the community. And so, I don't know how we can solve that through this process by starting with, "Before you read this, listen to this." And

I know that's kind of in pulling from the research that was shared earlier by Shira, and just hearing from people, the experts and the quotes, there so much more powerful of putting everything in context. I don't know if that is some way, we can integrate that in this process.

Belinda Pettiford:

No, that's an excellent point. I mean, I wonder is there something, can we add something to this one? Because to me, if I'm remembering correctly, SACIMM has the ability to have 25, 20 some members and to say at least one needs to be from an indigenous community seems low to me. The whole group should just be diverse. But just saying one, I'm always nervous when we ask one person to represent everyone because I think it's putting undue stress and undue pressure on individuals. So, is this something we can add to this one? Or do we just want to start the opening of this section out to talk about the foundation of this is listening to the people with lived experience, the people from the communities. And we started this iteration of SACIMM having individuals with lived experience, come to all of the meetings at least provide a presentation or share their personal experiences at the beginning of the meeting or somewhere intertwined in the meeting.

Belinda Pettiford:

And we probably need to go back to that, because we've stepped away from that. We did it early on. I know in my own state here in North Carolina, we have several kinds of committees, and we make sure at least one person with lived experience is a co-chair when possible. But we also try to set the stage for the meeting, by having a couple of people share their experiences around whatever the topic areas were going to be focused on that day. So, I think what you're saying, Charlene, makes sense. I'm just trying to figure out where do you all think it should go? It's not Indian Health Service per se. It's not well...

Cheryl Clark:

Belinda, I'm just a little bit confused because I'm thinking about how many members are on SACIMM. I don't think there's 20 something and the work groups can be definitely a lot more folks, but there's...

Belinda Pettiford:

No, SACIMM can be 20 something. They just haven't filled all those positions yet.

Cheryl Clark:

Okay.

Belinda Pettiford:

Yes.

Cheryl Clark:
Okay.

Belinda Pettiford:
Yeah. The positions, if I'm remembering correctly, it's 23, 25 or something like that, but not all of the positions have been filled. They haven't been filled my time while I've been on SACIMM.

Cheryl Clark:
Okay. I didn't know that background because I just saw... I think... I don't know how many people it was, but definitely wasn't 25, so...

Belinda Pettiford:
No. Understood.

Cheryl Clark:
Okay. Thank you.

Belinda Pettiford:
No, that's a good point. But how do you all, want to elevate this in these recommendations? Do we want to elevate it at the very beginning and just talk about it in the opening? Do we want it to be a recommendation in all settings when you're talking about these issues? You need to start off by listening to impacted individuals, consumers, and individuals with lived experience that we wanted here in the background.

Charlene Collier:
And I think I was literally thinking of putting in quotes or tagging a video or people talking as something where you actually have to listen before you even read these. So, that's not just say the recommendation is to listen, but to somehow... And I don't know if we can or if there are recommendations that we're just pulling from different resources, but...

Belinda Pettiford:
Well, I think there probably is a way we can drop a link in, but it is the... I want to make sure I'm clear on what the request is. So, are we saying we want them to listen to the voices of individuals of lived experience before they read these recommendations? Or we thinking that should be the way we integrate it in all aspects of our work on infant and maternal mortality? Those are two different things in my mind.

Charlene Collier:
I think it stands as both, certainly define ways of hearing, but I was just trying to think of ways to [inaudible 00:29:05].

Belinda Pettiford:

Okay.

Charlene Collier:

Quotes in the actual recommendations, but we don't...

Pat Loftman:

This is Pat. As the presentation on Sudden Infant Death was being presented, I asked myself whether there was any generational historic information that could be gleaned from the elders about this issue, because I said to myself, "I can't understand why there are so many Sudden Infant Deaths among indigenous children." Has that historically always been the case, because I don't believe that there were cribs historically. So, there had to have been some sharing of surfaces and were children that... Was there an experience that children died? So, I think what I'm saying is I just don't understand, and I can't accept the explanations for the Sudden Infant Deaths that we're seeing among indigenous children. And so that's a question that I would want to come to ask the elders because that's where the history is. And so somehow the generational history has to be elicited from this particular generation of indigenous individuals because I think it would help us understand what we're seeing today. I don't know if I'm explaining myself well, it just didn't make sense that so many children would die. Did they always die? I don't think so, but I don't know.

Belinda Pettiford:

So, you're basically saying we need to integrate the historical perspective of elders in helping to understand how we got here?

Pat Loftman:

Yeah. But it's not the perspective. It's what happened. Did children die in the past? Because they shared surfaces with their parents. Did they die? And if they didn't, then why didn't they? And then, why are we seeing what we're seeing today? We don't know because we've never asked the elders what was the experience? What's the history?

Belinda Pettiford:

Okay.

Pat Loftman:

This is the data that we're seeing today, but we don't know what happened 50 years ago.

Belinda Pettiford:

Yeah. We don't know if the numbers are getting worse or if they're getting better or if this is a reported issue because [inaudible 00:31:34]

Pat Loftman:
Or whether this was an issue at all.

Belinda Pettiford:
Right. Okay. So, I'll put that in as a potential recommendation on the SIDS/SUID because right now, as you can see the recommendations of support interventions that target social, environmental, and economic conditions, as well as support cultural and linguistically. Now, I have a pet peeve, because I do not like using the term target because I don't think most people want to target on their back. So, I tend to say focus instead of target, I know tons of people do that. It's just one of my it's my personal pet peeve, I'll move on.

Pat Loftman:
Well, I would've [inaudible 00:32:19].

Belinda Pettiford:
So, which of these recommendations do... What are the highest priority recommendations? So, if we had to put these in an order of priority.

Abigail Duchatelier-Jeudy:
Mrs. Pettiford before you move on, you had asked what's missing and I'm sorry, I didn't-

Belinda Pettiford:
Sure.

Abigail Duchatelier-Jeudy:
See the whole document. We realize at HRSA, we see at HHS actually there's a concerted effort to engage governors in health. And it gets to not only the social determines of health, but the political determine of health when we think about equity. And I was wondering if there's something that in this recommendation that seeks to support or encourage the secretary of health and human services to continue engaging and teaching and helping governors understand the impact of health. So, I came from a PhD program where they were very intentional about recruiting policy makers to help them understand early childhood development and influence early childhood development. People at the governor's office and different office and they are seeing a lot of results from that, so I don't know if there was something in this recommendation to just continue to encourage the HHS secretary to engage governors, mayors, those who are holding the purse, the budgets on health and help them understand the impact of health decisions. Budget health decision.

Belinda Pettiford:
I don't recall... That was a great point, Abigail, thank you. I don't recall a specific area on making sure we're educating policy makers,

governors, mayors, congressional people that are holding the funding. So, we can definitely add that in. I'm writing it over here as another area. That should be... Yup, I'm adding it here. Need to ensure that governors, mayors, policy makers, et cetera, funding, and you said are educated on these issues.

Abigail Duchatelier-Jeudy:

Yeah. It's more like you showing the link between budget decision and health outcome. It's really helping people understand the impact. Well, I wouldn't say impact of decision because it may not, it's not a punitive activity, but just help people be mindful or seen the numbers more concrete, these dollars that whether you allocate or don't allocate, they're not just dollars, there's life impact on them.

Belinda Pettiford:

Thank you. Okay, Abigail, thank you. Putting it down as an additional one. Any others that you all can think of?

Recommendation 6

Kandyce Kylick:

Hi, I just had one question. It was a bit further down, I believe. Under the health services section, I believe. And I guess I know one of the things that we kind of... As I'm going through the document, and I'm seeing it's really a focus on making sure that we kind of go back to those traditional practices. And I believe it was Pat who kind of mentioned it of, what if their traditional practices had better health outcomes for instance than our current policies and practices are. And maybe that could have impacted just hypothetically speaking.

Kandyce Kylick:

And so, when we are having these topics like number six, so we're improving the communications between IHS and tribal communities when changes in policies and programs are implemented. I know that the programs and things that are on this document are trying to support those cultural and traditional things they'd actually do as far as their health, but what if they're not completely in line with current practices and they had better health outcomes. And so, I think sometimes, I guess, what does that look like if their traditional practices and cultural practices do not necessarily align directly with the safe sleep protocols that we see right now? What does that look like with implementing interventions in that case? I guess it just more my question since it's sometimes they can be kind of butting heads.

Belinda Pettiford:

So, do we think that goes... Thank you, Kandyce. That's excellent point. Do we think that goes under the Cultural Strength and Resilience, or I'm just trying to think where we can include that? Is

the comment... How do we... It's not actually how do we deal with it is, it's actually kind of like you said, connected back to what Pat was saying around the historical perspective and experiences. So, if we find out that they have a way of doing it that doesn't always support what the general evidence-based guidelines or the evidence-based practice guidelines, but it's working for them. What do you do with that information? I mean...

Kandyce Kylick:

Correct. What if they had better health outcomes based on their... I think Kristina put in their reclamation of traditional practices. Their traditional practices, if that worked, if we are really trying to support them culturally and their spiritual views and all of those things, what if that does not align with general evidence-based practices? And would that be something where they would still be able to get funding? They would still be able to get the support if it's not in line with what evidence is saying. Is there [inaudible 00:38:21]

Pat Loftman:

But Kandyce, keep in mind that the evidence did not include the traditional practices.

Kandyce Kylick:

Exactly.

Pat Loftman:

So, we have no opportunity to evaluate.

Kandyce Kylick:

Right. Same. And so, it's like, are we making sure that our funding is going to still be able to support them, even if the current data does not say that this should be supported? How can we ensure that they're still getting that backing? I think everybody's kind of getting in that, how do we make sure their stories are getting heard? Their practices are being supported and all of those things, even if it's no data currently that [inaudible 00:38:53] it. Are we going to be able to take the qualitative component? Listening to those stories, is that going to be sufficient enough to get sufficient funding and support for these programs? And can we make sure that's something that's integrated in here?

Belinda Pettiford:

So, should the recommendation be to ensure they still receive funding, even if they don't follow the generally accepted evidence-based strategies and their traditional practice to give them better outcomes or something of that nature?

Pat Loftman:

I don't think that would go over well, to be very polite.

Shira Rutman:
I offer a suggestion. This is Shira.

Pat Loftman:
Yeah.

Belinda Pettiford:
Yes, Shira. Thank you.

Shira Rutman:
I really appreciate these comments and considerations. And I think one way to frame, what I think I'm understanding here is really about the need to value traditional knowledge systems and to value community-based knowledge systems and I think those don't necessarily have to be in conflict. The Healthy Native Babies Project that I spoke about is one example, that really worked hard to marry the federal standards from the AAP and traditional practices and recommendations and finding ways to do that, again by valuing traditional Native practices and knowledge systems. And so, I think ultimately, what that, specifically, looks like will have to be determined within those conversations, but the approach for valuing, giving equal value to those knowledge systems, these other types of knowledge systems is really the place to start those conversations and considerations.

Belinda Pettiford:
Thank you, Shira. I just want to make sure I got your recommendation right. So, you said, value traditional Native practices. Obviously, I didn't get it all. Can you say it again, so I can type it up on this document?

Shira Rutman:
Yeah. I would suggest using language around traditional knowledge system.

Pat Loftman:
Right. That's what I would do.

Shira Rutman:
[inaudible 00:41:19]

Belinda Pettiford:
So [inaudible 00:41:21]

Shira Rutman:
Yes.

Belinda Pettiford:
Say that again, value traditional Native practices because I've got to make it a recommendation.

Shira Rutman:
Yes. Value traditional Native...

Belinda Pettiford:
Knowledge systems.

Shira Rutman:
Knowledge Systems in approaching. Well, I'm trying to find which language you're adding it into. Is this a new...

Belinda Pettiford:
Well, I wonder should it fall under the Cultural Strength and Resilience, or is there a certain area? Because I'm not sure if it's Indian Health Service and I'm not sure if it is care, I guess it could fall on a Care Improvement and Workforce Development. It's not specific to SID/SUID, incarceration, substance abuse and I would always, I say substance use instead of abuse.

Pat Loftman:
Right.

Belinda Pettiford:
So, I may change that.

Shira Rutman:
If you think that [inaudible 00:42:20] at the end and I think potentially I've provided some feedback to Janelle in the past on versions of this and can take a look and make some suggestions about sprinkling, it in other places as well. I think it does. I think you're right. I think it does come up in other places, but that it could be a standalone item at the end where you are now in the document too.

Belinda Pettiford:
So, added under Cultural Strength and Resilience. So, value traditional Native knowledge systems and approaching... Well, in working with Native American communities.

Shira Rutman:
Yeah.

Belinda Pettiford:
Yeah.

Shira Rutman:
[inaudible 00:43:02]

Pat Loftman:
And in providing services.

Shira Rutman:
Right. Or developing policy, designing policy [inaudible 00:43:08] everything.

Pat Loftman:
Or [inaudible 00:43:08], policy, imposing programs.

Shira Rutman:
Yeah.

Pat Loftman:
Yeah. I like the language, Sheri because this actually could be universal across the board.

Shira Rutman:
Right.

Belinda Pettiford:
Okay. We want that to be a new recommendation. And then I just put a note to... Does anyone have a problem with me saying substance use instead of substance abuse?

Pat Loftman:
Not at all.

Prioritization

Belinda Pettiford:
So, I know we are struggling, and we have 12 minutes. So, which one would we prioritize at the top? What would be... We had to put this in order.

Pat Loftman:
Are we supposed to... Is the task to prioritize an area or a specific issue? I'm not sure.

Belinda Pettiford:
The question is what are the highest priority recommendations?

Pat Loftman:

Can I make two suggestions? I would say funding would be number one priority and then-

Belinda Pettiford:

So, let's see where that falls. So that falls under... Because I'm trying to see, did we actually pull-out funding? Well, the funding falls in a couple of places. So, we talk about funding on the Care Improvement and Workforce Development around increasing title five funding. What else did we talk about funding? Don't think we... Though many places probably would need funding, even though we didn't call funding out. So, something like providing universal health screening and assessment for all incarcerated women will probably take some resources to do that. So, are we saying any area that requires funding, we want to prioritize it? Do we think the Data and Surveillance area should be prioritized or a certain recommendation under it? Do we think the whole area we just talked about under a Cultural Strength and Resilience?

Pat Loftman:

Or could we use funding as an umbrella for Indian Health Service in terms of provision of services? I'm just throwing that out, I don't know. But for me, funding is critical. Not necessarily specific to a specific area, but overall because funding affects so many different areas.

Belinda Pettiford:

Thank you. Others?

Shira Rutman:

I added just a couple that I see as kind of more umbrella as well. One of those is the pipelines.

Pat Loftman:

That was my number two.

Belinda Pettiford:

Are you adding them somewhere? So, you are in the chat. Oh my gosh, I am not even paying any attention to the chat. I'm sorry you all. I have two screens going and cannot see the chat.

Pat Loftman:

Belinda, do you want me to do the chat for you?

Belinda Pettiford:

Yes. If someone can keep call out the chat, so we're not missing them because Belinda is missing them and it looks like there's 26 comments there, I'm sorry. What was the one you were saying, Shira?

Pat Loftman:

Shira said, "I see the pipeline as a critical and wide-reaching focus area. I also prioritize strength-based approaches." I think that's excellent.

Belinda Pettiford:

Talking about the pipeline under Workforce Development.

Pat Loftman:

Workforce Development.

Belinda Pettiford:

Okay.

Shira Rutman:

And I agree with you Pat, I think the funding... Yeah. I'm not sure where that falls. It sounds like it's sprinkled in, which is maybe a good approach, but I guess it could also be... I don't know if you were suggesting adding it in as an overarching. I think it's very tricky what that specific recommendation would be. Some of my colleagues, I think would recommend that funding for IHS, others recommend funding other organizations, so it's hard. That's a tricky one.

Belinda Pettiford:

So, we're saying funding is critical as it affects so many different areas. So, we're not specifically saying where the funding, we'll just say funding is needed wherever and we won't specifically connect it to the IHS because it's in all throughout this document, there will be some funding needs.

Pat Loftman:

And then there's another comment that there's no recommendation to accountability. That could be a wonderful addition and the broken promises 2018 report recommended a number of issues on funding data, SDOH issues, but also creating a body position to be the point for integrating all MCH Native work within DHHS.

Belinda Pettiford:

So, let's make sure I got there. So, we need a recommendation on accountability.

Pat Loftman:

Account. Yes.

Belinda Pettiford:

So, what would our recommendation be?

Pat Loftman:
I think that was Zya.

Janelle Palacios:
Sorry. You're seeing my daughter's chat name. It's Janelle..

Pat Loftman:
Okay.

Belinda Pettiford:
And I was just calling on you Zya earlier.

Janelle Palacios:
No, I'm sorry. I'm trying to still navigate the other meeting, but...

Belinda Pettiford:
That's fine, we've got several things going here. So, I've been taking notes and can report back out with some help from the larger group as needed. And Pat is going through the chat. So, if what we have so far, overall, we think these are very comprehensive, very good recommendations. We think are critical pieces, it is so important to listen to the voices of the community, as part of the solutions. We actually think that as these recommendations are being submitted, that there should be a video clip at the beginning of the recommendation. But as we integrate it in all efforts related to infant mortality, infant and maternal mortality, there should be a way that you need to watch, listen, observe, integrating people with lived experience. So, hear people's stories before you start working on this and keep that at the forefront of all of our work. There are some areas that we feel like we probably need to get more clarification on or add on recommendation.

Belinda Pettiford:
We need a recommendation on accountability, not quite sure what. I think the only thing near accountability we put in here was the metrics on the Workforce Development one, where if you've given out HRSA funding that they need to show. There was some metrics around... Help me remember. [inaudible 00:50:32] There was the metrics around applications.

Pat Loftman:
Right.

Belinda Pettiford:
So, that's most of these places we didn't build in accountability. We also talked about we need to ensure that policy makers, governors, mayors, people who were holding the purse strings, people who have the funding are educated on these issues and really help them understand

the impact of the budget on these health outcomes. That was a recommendation from Abigail. We need to integrate the historical experience of elders in helping to understand specifically why the SID/SUID numbers are so high. Have they always been high or has something changed that we missed? Is it better reporting or are the numbers just continually getting higher?

Belinda Pettiford:

As we're trying to prioritize some of the recommendations, we said funding is critical, as it affects so many different areas of the recommendations. We also think the pipeline is part of Workforce Development is important. Shira, I think you were saying something else. Can you help me remember what it was? And did we have a couple of-

Shira Rutman:

Sorry. Yeah.

Belinda Pettiford:

No, you go on. You go on.

Shira Rutman:

We did add in to the strengths at the bottom, something around valuing Native knowledge systems and approaching policies and programs.

Belinda Pettiford:

Right. Yeah. We've got four other areas we've got under Cultural Strength and Resilience, value traditional Native knowledge systems in providing services, designing programs, policies, et cetera, and working with American Indian, Native American communities. We talked about including multiple racial categories that include any American Indian, Native American. We talked about three B. Really trying to get a better handle on what we mean by standardization of suppression. Is it more around, do we get counts over time and because we know importance of protecting identity. So, is it really around aggregating data sharing or change to ratios so that we can actually have a way to report even beyond the small numbers. So, really trying to figure out those areas.

Pat Loftman:

Can I just interject? We only have three minutes left. It's 4:27.

Belinda Pettiford:

Yes. Yes, you can Pat.

Pat Loftman:

Okay.

Belinda Pettiford:
Is it something you want to say?

Pat Loftman:
No. No. No. No.

Belinda Pettiford:
I'm sorry. Oh, thank you. You were telling me the time.

Pat Loftman:
[inaudible 00:53:14] timetable.

Belinda Pettiford:
You were doing the time but thank you dear. I'm sorry. Thought you were trying to say something. We did talk about; we were going to change substance abuse to substance use in the document. And we talked about... Something for us to think about is if we find out, and I think it's connected back to the value traditional Native knowledge system. So, I think we could probably pull that one out because I think it's around... If we find out that, the traditional practices may not be in line with what we consider evidence-based strategies, will they still receive the funding? Are we really listening to valuing traditional Native knowledge systems? So, I think that all of that connects. We did not eliminate anything. We are struggling, prioritizing things, but right now we have prioritized funding as well as the pipeline as part of Workforce Development. And there's some more comments in the chat. I agree with adding this as accountability recommendation. Thank you. So, is this the accountability recommendation, someone? Well, thank you. Well, someone actually came up with one, let me try to cut and paste it over.

Belinda Pettiford:
Accountability recommendation. So, now keep in mind, these recommendations are going to the secretary. They're not actually going to Congress, but we will definitely put them in here so we can tell the secretary of what Congress should do. We may have to just wordsmith it a little bit. Which gets us to the accountability piece. Congress should provide funding to establish an inter-agency working group to share expertise and develop and improve systems and methodologies that federal government agencies could replicate for the collection of accurate and disaggregated data on small and hard to count populations such as Native America, Native Hawaiians or other Pacific Islander racial groups. And this is coming directly from the broken promises 2018 report. Everybody good with that one? And thank you whoever said that.

Pat Loftman:
That's Janelle.

Closing

Belinda Pettiford:
Thank you, Janelle. Were you already headed in? Got it. Anything else from the promises report that we need to move over?

Janelle Palacios:
There's a lot. There's stuff I sent to Magda.

Belinda Pettiford:
So, they're going to come out when we report out in a few minutes.

Janelle Palacios:
Yeah. Basically, another big one is just the overall congressional appropriation that it should actually match what is needed and it doesn't do that, Indian Health Service in particular.

Pat Loftman:
So, Belinda, that would be consistent with the funding piece.

Belinda Pettiford:
Right. I think the only thing different Janelle that we said is that we didn't want to assume all of the funding would go to Indian Health Services because they may need to go other places.

Janelle Palacios:
Agree. Yeah.

Pat Loftman:
Okay. Time keeping, it's 4:31.

Christopher Duyos:
Yeah. If you all could start making your way back to the main room once you're ready, just use the links you used earlier this morning to first sign on.

Belinda Pettiford:
So, thank you, Janelle. Okay. Thank you. So, Janelle, I need to pull this one out because you turned it into a recommendation instead of to the secretary, instead of to Congress.

Janelle Palacios:
I can send it to you on a chat.

Belinda Pettiford:

I just pulled it out of the chat. I'm just moving it over here into this other document.

Janelle Palacios:

Okay.

Belinda Pettiford:

Got it. Thank you all.

Shira Rutman:

Thank you so much.

Belinda Pettiford:

No. I appreciate everyone's comments. As I tried to leave stop sharing helps.

Pat Loftman:

Okay.

Belinda Pettiford:

See you all in a minute.