Advisory Committee

on Infant and Maternal Mortality

Virtual Meeting

11:30 a.m. until 3:00 p.m.

Tuesday, March 21, 2023

Attended via Zoom Webinar

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Reported by P. FLUTIE

- I N D E X -

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CALL TO ORDER AND REVIEW OF DAY 1

BELINDA PETTIFORD: So, good morning, everyone. I hope you all had a wonderful evening and had a good night and are ready for some more exciting work today. It is good to be with you all. Can we go to the full screen, thank you, so we could see each other. Thanks a lot.

So yesterday was a good day and I appreciate those of you who have sent emails since yesterday and dropped tons of notes in the chat. And thank you, Emma, for sending the chat over.

So, today I just want to touch base briefly in case we missed a couple of you all yesterday. We want to give you all a chance to introduce yourselves. Yesterday, when we did our introductions, we used it as an opportunity to share our appreciation for key women in our lives. And so, if you missed it yesterday, we're going to give you a chance to do that. March is Women's Health History Month, so we wanted to make sure

that you had an opportunity to do that. So I'm going to start with the members that we did not have yesterday or we didn't get to hear from them yesterday. So, Steve, would you like to start off, please?

STEVE CALVIN: Sure. Thank you, Belinda, and also I, you know, congratulate you as well in this new role. The very first meeting that I attended, the first day the four of us went out to dinner, and that's when I was introduced to you in, I think, 2019, and I really appreciate you.

So, I'm Steve Calvin. I'm a maternal fetal medicine physician in Minnesota, and I work with midwives at an accredited birth center providing primary midwifery care with the option of out-of-hospital birth centers but connected with hospital systems, and I'm convinced that maternity care reform really does need to start with the Medicaid world, and so, I'm pretty passionate about that.

With regard to women important in my life, when you have an accredited birth center, each birthing room has to have a name. So we have, between the two birthing centers that we have, we have five birthing suites, and they are named for various people, my mother, my wife's mother, a friend who is a midwife, but one of the rooms is named for Elsa Carlson, who is my wife's grandmother. She was a Swedish immigrant and came across on a boat to Ellis Island in 1910. She turned eleven on the boat and she had -- she was stuck on Ellis Island for about a week and a half because she turned 12 on the boat, and they needed to pay a fare that was an adult fare, so they had to wire money. She was coming to basically replace the daughter of an uncle and aunt who had died of cholera in Minnesota.

So, Elsa Carlson was this Swedish immigrant who actually became a maternity nurse. And so, the Else room at our Minnesota Birth Center on Chicago Avenue in Minneapolis has --

bears her name and I got to know her well. She lived a good long life and she also got to know our children. So, our children got to know their great-grandmother, and she was a dear lady. So, I would say that Elsa Carlson would be hero in this Women's History Month.

BELINDA PETTIFORD: Thank you so much, Steve, and for sharing the story behind it. We appreciate it.

And Lee, we want to give you a chance to do it as well.

LEE WILSON: Thank you, Belinda, and good morning to all of you. Thank you for the opportunity to be here and to share. I'm Lee Wilson, the Director of the Division of Healthy Start and Perinatal Services at MCHB HRSA. I think I've met most, if not all of you.

The woman that I choose as my hero is keeping in line with Steve's selection. My grandmother immigrated from Poland in 1930, and she's at the front door -- no -- she brought the

family over from Poland, sent for other family members after she got here and worked for a while, and lived through some pretty dire circumstances as an immigrant in tenement housing without running water and just built a very loving and fortunately prosperous family. So, she just is one of my heroes, and I'm very fortunate to have known her very well. So, that's all. Thank you.

BELINDA PETTIFORD: Thank you, Lee. We appreciate that.

And I think we covered everyone else yesterday. So, just as a quick reminder again, I think we had a really good day yesterday. We were able to get some great federal updates from Michael Warren letting us know about some funding opportunities that are coming out around maternal and infant health in the near future. We were able to hear from Allison, who talked about the expanded work that they are doing, including some community engagement work that I thought was really exciting, and I think others of you felt

that same way.

We were able to then hear from Sarah and Vanessa, who kind of reminded us this is the time of year we've got to give updates to the charter. So, thanks to all of you who have already sent me some suggested changes to the charter or updates for consideration. Remember the rest, please send them my way, I think, by April the 20th is the deadline. So, you still have some time, but please make sure as you're reviewing the charter you pass them on this way.

We also spent a good amount of time revisiting the last set of recommendations that went to Secretary Becerra around American Indian and Native Alaskan, especially around addressing maternal and infant health and wanted to hear what people had been doing, how they were elevating the work, as well as how they continue to elevate the work, and we were able to also bring in some of that same information from our former chair from Ed, as well as from Magda and Janelle and the work

that they have been doing also.

And then we spent a little time talking about framing and how do we message this work in a way that, you know, as they say to the masses that are interested in it, that they know the importance of it, and we spent a little bit of time talking about trying to bring someone in like Frameworks that can kind of help us think through how we're messaging maternal and infant health in our different parts of the country, because the message that may resonate well in North Carolina or even in a part of North Carolina may not resonate as well with someone in Oregon or another part of the country. So, how do we make sure we're considering all of those different parts?

And then, we wrapped up the day with some awesome data information. We had a great data team that shared with us the latest infant mortality data, the maternal mortality data, the pregnancy-related mortality data, as well as the severe maternal morbidity data, and how important

all of that is in making sure that we are aware that, you know, we still have disparities that exist in all of these areas. But not all of the disparities are the direction we think they are. So, making sure we had a really good picture and a way to be able to ask some good questions. So, I appreciate that.

And then we talked a little bit about our next focus area and really trying to figure out where does this committee want to go to next. The last iteration of this committee submitted three sets of recommendations to the Secretary. How do we want to do that, and what do we want to focus on?

And part of that conversation was around how do we elevate the issues and move them into implementation, so not just making recommendations, but make recommendations that are actionable, that we can work with partners from around the country to move the work forward. And I think that is one of the things that we

definitely want to keep at the front and foremost of all of our efforts.

But the number one priority, I think, for all of us has always been centered in remembering why we do this work, and that is one of the reasons I reached out to ShaRhonda, one of our committee members, ShaRhonda Thompson and asked her would she be willing to share a little bit about her story, her maternal and infant story, and how it has impacted her life. And ShaRhonda has agreed to do it today for our meetings. For future meetings, ShaRhonda and I and other committee members can make recommendations, but we always want to make sure that we are reminded why we're doing the work and making sure that we are keeping front and foremost how individuals are impacted.

So, ShaRhonda, I'm going to turn it over to you, dear, if you are there. And ShaRhonda, if you are speaking, you are muted.

SHARHONDA THOMPSON: Hello. I am here. Let me turn my video on.

BELINDA PETTIFORD: Thank you so much, ShaRhonda. We can see you as well.

SHARHONDA THOMPSON: Great. Okay, so my name is ShaRhonda Thompson and I am going to tell my story. Just so you know, as I mentioned yesterday, my mother was instrumental in my life and my motivation. She did make sure that my education was always at the forefront. So, some of the things I've done through my journey as a mother is not average. So, you have to keep that in mind. Even though it's not average for me, it was still difficult, right? There were still issues. So, even with the education that I had, there were still areas that weren't addressed properly. So, imagine if there was someone who did not know their rights -- their patient rights or how to access information. It's even harder for them.

So, I'm not sure who all knows, but I have children that are in two different generations. I have one that's 24 and one that's 10, and my pregnancies were completely different for both of them, and my results were different for both of them, and the way that I dealt with doctors was different with both of them. So, I'm going to kind of give a brief synopsis of both of those.

My first pregnancy, I was young, 19, and that was difficult within itself. I was out of high school, in college, two years out of high school, getting ready to graduate from college because I did some college while I was in high school. So, I had a lot going on. The way that I found out I was pregnant was also, in itself, amazing.

So, I went to the doctor because I was having back pain and the doctor came in the room and was like oh, you have a UTI, that's common in pregnant people. What, was my response.

You know, what, I'm pregnant? Huh? Okay, thanks for letting me know. The doctor was like oh, you didn't know? No, no, didn't know. Thanks for telling me. So, that's how I found out that I was pregnant.

I did not have insurance, so when I went to my first doctor's appointment, I filled out for Medicaid, got approved for Medicaid, received this huge book in the mail, right? I'm an avid reader, so for me, no problem. I also had had a lot of experience in the medical field because, as I mentioned yesterday, my mom had mental health issues and so I was born -- I learned a lot and I helped her a lot to navigate through the medical system as well. So, I learned a lot about the medical system at a very young age. So, I had that knowledge behind me, which was again, not the average knowledge that the average young adult has.

So, I read this huge book and found out about different things that Medicaid would pay

for. There was no one there to help me navigate through this. So, I found out the different things that Medicaid would pay for. I did everything that I could. Lamaze classes, I went to doctor's appointments to visit the doctor to figure out is this the doctor I want for my child -- the pediatrician that I want for my child. So, I did everything. I used the transportation, everything that I read in that book that I could do, I did it. So, I didn't need help in navigating through that.

I had my son, didn't know until after he was born that breaking the water was a requirement. So, I didn't know that I could have had him -- I could have had the option of having him born still in his sac. I didn't realize that was an option. The doctor didn't even mention that it was an option, he just broke the water without asking. So, I didn't find out until afterwards that that was something that could happen. So, I took that into my second pregnancy.

His birth was fast. He was healthy. I breastfed for fifteen months. We went through the WIC system. He was okay.

Fast forward to the little one. So, now I'm 32. When I got pregnant with her, high-risk, of course, because of my maternal age. They found out I had fibroids, so that also put me at high risk because there's fibroids in there with her. Went to the doctor. This time, there's a social worker in the doctor's office to help me navigate through things. That was the best experience ever, right? She pointed me in so many directions. She showed me so many things. She provided me with all of the things in my area that would help me with food, help me with mental health, help me with necessities for the baby, Pampers, cribs, everything. So, she helped me navigate the system that time, so that was a lot easier than the first time.

This time, though, I didn't get a book, I got like a pamphlet with the Medicaid that

was directing me somewhere else to find out additional information, which I did, but I don't see most people doing that either. So, good thing the social worker was there for any questions that I couldn't answer or if I didn't feel like looking up something. So, I definitely am an advocate for having social workers in the doctor's office because I have experienced how much that helped me. So, definitely, I advocate for that.

She, like I said, helped me navigate through everything. She introduced me to Healthy Start, right? I didn't know anything about Healthy Start, didn't know anything about infant mortality. I didn't know anything about what I'm doing today, but this is what started me down that path.

She introduced me to Healthy Start, and I found out a lot. I found out a lot about what was going on in the St. Louis area for other women, women who didn't understand their rights, who didn't read through the books like I did, how

we have some of the best medical systems here in St. Louis, Missouri, but we have infant mortality rates of a third world country. It blew my mind because I didn't understand why. Why, when we have such top-notch health care. So, I got involved. I started listening to those stories that brought me here to where I am today.

But I had my own issues with the little one. I did end up having issues with my pregnancy due to the fibroids and I ended up having a premature birth. She ended up in neonatal for two weeks. She was big, even though she was a preemie. During my time at neonatal, I had a nurse tell my husband, "Oh, tell her to stop coming in here." He was like, "No, I can't tell her that because that's her child. She's not going to stop coming up here every day," because I was bringing my breastmilk, I was pumping, and what she wanted me to do was to stop. There's a way to say things and that wasn't the correct way, but that's another thing in the medical field how

you address people and the way you say things can turn a situation sour real fast. So he's like, Yeah, no, she's not going to stop." I get where she was coming from, she wanted me to rest, but the way she said it just turned the whole situation bad. I obviously didn't want to speak to her after that.

I still kept going to the hospital for two weeks until the little one got out of the neonate unit. Right before we left, I was pulled into the back and the doctor said, "Oh, I just wanted to alert you that your daughter has a peculiar eye shape and because of that, we think she might have Down Syndrome." Scared the crap out of me. Now, mind you, now of the tests that I took or the tests that they gave indicated Down Syndrome. So that just freaked me out.

I hurried up and made her an appointment to a pediatrician, and her pediatrician looked at me and looked at her and he said, "She has your eye shape. There's nothing

wrong with her eyes. I hate that they scare people like that. She's fine." I was like oh, okay. So, that was scary. I get, you know, why she had to tell me, but I'm glad I chose the pediatrician that I did and I had that peace because it was the same pediatrician that I took my son to where we could talk candidly and I was comfortable. So that makes a difference as well having that history with the pediatrician.

But the difference, like I said, between the two -- the huge difference maker was the social worker for me, the difference between those two pregnancies. I think that if I had not had the social worker who introduced me to all of the assistance that I had, the programs that were there, I don't think my outcome would have been as good, I don't think, with the little one. I don't think -- I think I would have had her a lot earlier because I wouldn't have had the nurse coming checking through Healthy Start, and I don't think it would have ended properly. I think it

would have ended badly had I not had that social worker.

So if you're take note from anything from this, just know those social workers that are there to help, they really do help and make a big difference.

BELINDA PETTIFORD: Thank you so very much, ShaRhonda. We appreciate your willingness to share your story and to take the time to do it.

I don't know if anyone has any questions. ShaRhonda, are you good with a couple of questions or comments?

SHARHONDA THOMPSON: I sure am.

BELINDA PETTIFORD: Okay, dear. We'll start with Steve then.

STEVE CALVIN: Yeah. ShaRhonda, thanks for sharing your story. I know in St. Louis, having gone to medical school there a long time ago, but also knowing some of the physicians at some of the institutions that, you know, that are world class there, but obviously not serving

the need in ways that they maybe could be, have you had any interactions with midwives or have any friends or family members that have interacted with midwives in the St. Louis area, or do you have any thoughts on that kind of care model?

SHARHONDA THOMPSON: So, I have been not through my pregnancy, but I have been introduced to midwives in working along with the JAMA Birth Village getting to know them a lot, and that's doulas, but not midwives. I've met a couple midwives at programs as well, and the midwife I love, and it's becoming more popular in our area, midwives and doulas, and I love that interaction as far as the health care. I'm not sure, though, how much they have -- how much information they have on like programs that are offered in the area that would assist their patient. I think the care of the mother during their pregnancy with a midwife is better because it's more personal, and they -- it's not always so clinical the way that they speak to their

patients. It's more of a one-on-one human-to-human versus a doctor-to-patient.

STEVE CALVIN: Great. Thanks, ShaRhonda.

BELINDA PETTIFORD: Thank you.

Joy, I see your hand up as well.

JOY NEYHART: Okay. There, I think the video started. Thank you, ShaRhonda, for sharing your story. And it reminds me that it's so important to involve people with lived experience and peers into programs to help navigate sort of the younger generation and women that are getting pregnant now. So, anyway, I just wanted to thank you for that, and it reminds me of how I can help my institution improve care by integrating peers into pregnancy from the very beginning.

BELINDA PETTIFORD: Thank you, Joy.

And Lee.

LEE WILSON: Hi. Yes, ShaRhonda, thank you for opening up and sharing with us your

experiences. I appreciate that, and it is one of the things that we really appreciate about these opportunities at the Advisory Committee meeting and what a great -- what good fortune it is that you're one of the members of the committee to be able to share such personal information with us and be involved in decision-making here.

One question that I had about on the talk that you gave us, you mentioned that early on, you had some exposure to Healthy Start, and I wasn't sure if you would be comfortable sharing what those experiences were, how you found the experience of working with that program since it is a significant program here in the Maternal and Child Health Bureau, and just sort of any takeaways or input that you can provide to us on that program, if you recall.

SHARHONDA THOMPSON: Yes. I can tell you now, that was a wonderful experience. Having someone to be able to come to my home and speak to me in a setting that I was comfortable in, not

feeling judged if you asked a question that maybe if you asked your doctor, you may feel like, okay, I can't ask my doctor this question because they may look at me differently.

So, to have someone that you could ask those questions to and even if they didn't know, they would find out an answer for you, at least the nurse that I had coming to visit me, any question that I asked her, if she did not have the answer, she would make sure that she got the answer. She would give me materials to read. Anything that I wanted, anything that I needed, she made sure that I had. And to have that setting inside of my own home, that was wonderful. She came to me when it was convenient for me, and that makes a difference, honestly. Like I said, I don't think my outcome with the little one would have been as good as it was had I not had her because she would check me, she would look at my paperwork from the doctor. She would say, hey, this is what the doctor is saying to you, this is

what's going on, this is what you need to be concerned about or no, you don't need to really be concerned about this. This is just -- so she would break things down for me and that was wonderful.

I enjoyed it so much that as my younger cousins were getting pregnant, I was like oh, you need to get in this program. Have somebody come to you, that way you're not -- you don't -- it's not as difficult. So, have somebody come to you, and I would always meet the, I don't want anyone in my business and it was no, it's not that they're in your business, that's not what they're there for. I was like, she is really there to help. She will help you with any resources that you need. If you need a crib, if you need a pack-and-play, you need diapers, she will make sure that you get them. Just call the number. So, I became an advocate for Healthy Start after that. So, yes, I do love the program and I still advocate for it to this day.

BELINDA PETTIFORD: Thank you, ShaRhonda. Thanks, Lee.

Joy, your hand is -- I can't remember if your hand is back up or --

JOY NEYHART: No, sorry. Let me lower it right now.

BELINDA PETTIFORD: All right, thank you. I don't want to cut anyone off.

And ShaRhonda, you did an awesome job, as I knew you would, but I wanted to see if there's anything, you know, from your experience that you feel like we need to make sure is part of our work moving forward. Any lesson learned, anything that you wish could have been different from your experiences, and we know you shared too, you know, from your child that you had when you were younger, and then the child that you had more recently. So you did share some of those things, but I don't want to leave without seeing if there's something you want to make sure the rest of us are aware of. And if you want to think

about it and drop it in the chat later, you can do that as well. It's whatever you're most comfortable with.

SHARHONDA THOMPSON: One of the things that I'm working on here in the St. Louis area, and I think honestly needs to be worked on everywhere, like I said, that social worker. Having that social worker there in the doctor's office, like it made a huge difference. That social worker knew me, that social worker knew my doctor. If there was any concern, she would talk directly to my doctor and then talk to me and break things down if I needed it. Having that social worker, again, resources, this is what you know -- her knowing me personally, okay, no, you need to call this number for this resource, not this one, and walking me through that so I wasn't spending a lot of time and I wasn't getting frustrated, it made it a lot easier for me to want to make all of my appointments and to make sure that I had everything that I needed at home for me

and the baby. And so for me, that made a huge difference in my second pregnancy.

And another thing that I'm working on here is talking to the doctors that are students -- the medical students and making sure that they understand how you talk to your patient and how you listen to your patient makes a huge difference.

I also have a genetic disorder. So, you can't always go by clinically. You can't go by what the books say. This isn't how this was supposed to go because I have a rare genetic disorder. So it doesn't matter what the book says. My experience is my experience. So, making sure that your doctor actually listens -- that the doctor actually listens to what the patient is saying, not always say well, this is what I've learned about how it should go. And not just missing what the patient is saying, actually listening and learning from that, because I wouldn't have found out about my genetic disorder

had my doctor not listened because I found out about it when I turned 40. So, I've had it all of those years, you know. So having a doctor that actually listens and works on based on what you say versus always just what the book says makes a big difference as well. It makes a big difference in the relationship between the doctor and patient. It means your patient will be more honest with you and actually tell you the things that you need to know as the doctor.

BELINDA PETTIFORD: Thank you, ShaRhonda. It sounds like you're a strong advocate for the CDC's Hear Her Campaign, making sure we are listening.

Michael, I see your hand, and then I think I saw Charlene's, and then we'll finish the questions.

MICHAEL WARREN: Sure. ShaRhonda, thank you so much for sharing your time and your experience and your wisdom with us today, and I love that you are engaged in training the future

workforce. I think that is brilliant on the part of whatever medical school was able to recruit you to do that, and thank you so much for your gift of time and experience with them because it -- it's such a crucial time to help people understand and it's before a lot of us get in and get jaded, and we're still, you know, thinking we can change the world. And so, you're getting to folks at just the right time, so thank you for that.

I did want to share, and I'm going to ask the host to put in the chat for everybody, your comment about the importance of having the social worker in clinic lines up with a funding opportunity, one of the ones I mentioned yesterday, so our Integrated Maternal Health Services Grants that are available that really look at innovative models of care. We think we're going to award maybe five or so of those and these are big grants, about almost $2 million. I think it's $1.8 million each. So, I'll put that link in for folks who are on the call. Please share those

with your networks, because this is a great way to replicate exactly those kinds of models that ShaRhonda was talking about.

BELINDA PETTIFORD: Thank you so much. And Charlene.

CHARLENE COLLIER: Thank you so much. I think, Michael, you hit on it. ShaRhonda, thank you so much, you highlighted some really big things for me where like where care is received and the home visits that were so crucial to you, and the social worker really being in the clinic, and I think perinatal social services is often seen as like, it's not seen as mandatory for setting up a hospital obstetric practice, and it really should just be considered standard of care that if a clinical practice intends to provide care, particularly in areas that are identified as having high social needs, having integrated perinatal social worker should not be something that's optional or grant-dependent, but that's an investment that the hospital should make.

So I'm very excited about the grant funding available, particularly to study the impact and to be able to demonstrate best practices, but truly I think it could happen now for hospitals and health systems to make the investments that co-locate social services within obstetric practices and not have it be something that is necessarily depending on an outside grant. It truly should be like a hospital. It's part of critical care. We wouldn't accept not having labs or mammograms or, you know, CT scan for an ER. These would be like, no, we can't open an ER without a CT scan. We should not be opening -- we should not be running or functioning OB practices, particularly in areas where we have identified high need without integrated perinatal social workers who are well paid and well-integrated, and I think, you know, I think ShaRhonda's example really showed the value of it. Knowing the provider, she doesn't have to leave the clinic to go -- many health departments require like go to

the department to see the social worker or go to a different office, and I think her example was a really great one of why these standards should really be set to that, you know, integrated social services is part of obstetric care. Thank you.

BELINDA PETTIFORD: Thank you, everyone, for your questions and comments, and again, thank you, ShaRhonda, for your willingness to share, and I know you will continue to be an important part of this committee. So, thank you.

PARTNERSHIP PANEL OF NATIONAL ORGANIZATIONS

BELINDA PETTIFORD: Now, we're going to transition into the next phase of our meeting, and we're very pleased to have with us a very esteemed panel with us today.

We're fortunate to have some of our federal partners, but these are individuals that represent national organizations that are focused on maternal and infant health and then beyond.

So, we asked them to come and share with us today about their maternal and infant health portfolio, specifically what they are doing in this arena, but at the same time, we also asked them to kind of share what they're hearing in the field. You know, they have boots on the ground. These are individuals that are working in this arena from a national level and have a reach into communities. And so we wanted to hear a little bit about that.

I've already heard from a few of them that they think that we didn't give them enough time, so we'll see what we can do on the time front. But we did try to limit their time. And so I'm going to go on and introduce all of them, but we'll hold our questions until the end, as we're very accustomed to. If a question comes to you and you're thinking you're not going to remember, drop it in the chat. Otherwise, we will just take questions at the end, and we already have acknowledged that we didn't give you as much time as you wanted, but we think this still will

be a great way to start the conversation.

So, today we have with us Scott Berns. Scott is the President and CEO of the National Institute for Children's Health Quality, otherwise known as NICHQ. We also have Deborah Frazier with us. Deborah is the Chief Executive Office for the National Healthy Start Association. We also have Terrance Moore with us. He's also the CEO for the Association of Maternal and Child Health Programs, otherwise known as AMCHP. And then we have Denise Pecha with us, who is the Deputy Executive Director for CityMatCH. So, I think everyone is very familiar with all of these organizations, but today you get a little deeper dive into specifically the work that they are doing around maternal and infant health. And we'll just go in the order of the names that are on the program, if you all are good with that. So, I'll turn it over to Scott.

SCOTT BERNS: Thank you, Belinda. Hi, everybody. How are you all doing today? I

want to thank Emma, who is going to be doing the slides there in the background, and I'm just checking you can hear me okay.

BELINDA PETTIFORD: We can hear you well.

SCOTT BERNS: Thank you very much. Okay. So, in addition to my background and my title currently at NICHQ that Belinda shared, I should also share that I'm a pediatric emergency physician by training, but I have spent a majority of my career working at the population health level, first at the March of Dimes, and for the past eight years here at NICHQ. Next slide.

A little bit about NICHQ. For over twenty years, NICHQ has solely focused on driving dramatic changes in the complex issues facing children's health. As a bold organization of innovative thinkers and doers, we are particularly proud to have earned a reputation as a national leader for improving the health and well-being of children and their families. Next slide.

Our mission is to drive change to improve children's health and our vision is that every child achieves her, his, their optimal health. Next slide.

Equity is the foundation to everything we do as you see here in this graphic representation of our 2026 Strategic Plan. Next slide.

And I'm proud that in November of 2022, we created the Department of Health Equity Innovation under Vice President Dr. Stacy Scott with the goal of advancing strategies that address systemic health inequities. Next slide.

So, I'd like to highlight two projects that are essential to NICHQ's maternal and infant health efforts. Next slide.

First, since 2017, NICHQ has been a CDC-funded coordinating center for the National Network of Perinatal Quality Collaborative, the NNPQC, to provide resources and expertise to state-based perinatal quality collaboratives or

PQCs. They exist across the nation to enhance the ability -- and so, our role is to enhance the ability of those state PQCs to make measurable improvements in statewide maternal and infant health outcomes. Next slide.

The recently funded 27 PQCs representing twenty-eight states, more than double the number of states funded over the previous five-year cycle of funding from the CDC. Next slide.

Through the NNPQC cooperative agreement, we have four main goals. To support PQC's quality improvement efforts, assist in operationalizing health equity, support peer learning and collaboration, and encourage family engagement. Next slide.

NICHQ also has the privilege of working with a hundred and one Healthy Start communities in thirty-four states, Washington, DC, and Puerto Rico since 2019. Thank you, ShaRhonda, for the introduction to Healthy Start. And these

initiatives operate in communities with infant mortality rates that are at least one and a half times the U.S. national average. Next slide.

As a HRSA-funded technical assistance and support center for these one hundred and one communities, NICHQ supports Healthy Start grantees to enhance and strengthen their capacity to improve health outcomes before, during, and after pregnancy and reduce racial and ethnic disparities in race of infant deaths and negative maternal health outcomes. Next slide.

All of our activities focus on the four Healthy Start approaches; improve women's health, improve family health and wellness, promote systems change, and assure impact and effectiveness through Healthy Start workforce development, data collection, quality improvement, performance monitoring, and program evaluation. Next slide.

So, I'm happy to share with you now some of our observations and what we've heard from

our partners in these two projects and from the field. Next slide.

Perinatal quality collaboratives, which are largely hospital or clinically focused, we hear that the following are needed for healthy pregnancy and birth outcomes. Providers who deliver safe, equitable, and respectful care. Birthing hospitals and facilities should be partnering with these PQCs to ensure data-driven, quality improvement methods are being implemented to reduce severe maternal morbidity and mortality. Engagement of patients in hospital QI initiatives is critical. Conducting patient reported experience measure surveys within hospitals and facilities to obtain the patient lived experience perspective around delivery of care. Access to doulas and midwives, and access to quality services and resources including patient navigators, social workers to support and advocate for patients. Next slide.

In the summer and fall of 2022,

throughout HRSA-funded Healthy Start Initiative, NICHQ had the opportunity to host convenings with Healthy Start community members and partners at the request of the Maternal and Child Health Bureau. These partners were more focused on population-based recommendations including social determinants of health, to improve outcomes and achieve equity in MCH.

We heard the following: be more holistic in our thinking about equity and focus on upstream approaches. Address racism, specifically systems of oppression and institutional racism that are impacting people's ability to access services. Use the reproductive justice framework to guide our work as is being used by National Birth Equity Collaborative, who you will be hearing from later, I think, Black Mothers Matter Alliance, and from others.

Link social determinants of health to clinical data, which could help us have a broader understanding of what is happening to our patients

from their perspective. Talk about family health from the beginning and be more inclusive of fathers, and support racially and culturally concordant care to help break down the social, racial, and clinical patriarchy and hierarchy. Next slide.

What these projects clearly illustrate for me is the need for better synergy and alignment among hospital-focused and community-based initiatives. If we are to be successful, I think, we need to better bring these together to integrate population health and social determinants of health with clinical care.

So, I'm going to conclude with a few things that I'll share with you as potential pieces of this solution -- that overall solution.

First, comprehensive, gender-specific primary care including perinatal mental health, optimal screening, and management of conditions, building and diversifying the maternity care workforce, promoting midwifery and other models of

care including group care, improving quality of health care, and this includes improvement in data and measurement, access to risk-appropriate care and promotion of respectful maternity care, support policies to improve access to care and postpartum support including extension of Medicaid to twelve months postpartum, and the research for better understanding, interventions, and treatment for leading maternal health conditions.

So, key opportunities here include improve data, quality, and measurement. Understanding the populations affected. Clinical research to confirm preventative and interventional strategies. New technologies for risk assessment, diagnosis, and engagement of communities in the research.

So, I'm going to conclude and thank you for the opportunity to be back here with you all to share these brief thoughts with the committee. I look forward to potential opportunities in the future to advance our

collective efforts to improve the health of women, birthing people, infants, and families. Thank you, Belinda.

BELINDA PETTIFORD: Thanks so much, Scott.

And again, we're going to hold the questions. But just as a reminder for the committee, one of the things that we're listening for are areas of alignment as well that may be things that we want to elevate as the committee that we're hearing from these national partners. So just keep that in mind when you're taking your own notes and thinking about your questions.

So, at this time, we're going to turn it over to Deborah Frazier.

DEBORAH FRAZIER: Thank you, Belinda, and thank you to the committee and to our federal partners and our MCH partners for the opportunity to share what we hear from the field.

So, I want to give a brief overview of the -- the National Healthy Start Association.

We represent -- and I think Emma is going to pull up my slides -- we represent the hundred and one Healthy Start programs across the country and about 25% of our portfolio of Healthy Start programs is rural, two of them are tribal, one is Appalachian, and the remainder are scattered across the country. I don't know where the slides are, but I can talk in the meantime until they catch up.

So, one of the things that I want to spend most of my time on is giving directly back on what we hear from our Healthy Start programs. So, we do a number of focus groups and surveys with our Healthy Start members, and for those of you -- and thank you, ShaRhonda, you were a good testimony for the Healthy Start programs. So, Healthy Start is a community-driven, community-based program and it centers the community voice in everything that we do. And so, as an association that represents these programs, one of the things that we want to do is to always listen

to that community voice and our response to these programs.

Emma, do I have the lead in moving these slides?

So, I want to start with --

BELINDA PETTIFORD: Emma, are you able to advance the slides?

EMMA KELLY: Yes, but Deborah, I think you just need to accept. It should be giving you screen control. You will have to accept it.

DEBORAH FRAZIER: Okay, thank you.

I will -- I want to go to -- whenever I can get this control -- okay. I want to go to the -- there we go.

So, I mentioned and ShaRhonda talked ab little bit about what the Healthy Start programs do. So I will just quickly say among the things that we do are -- and Charlene mentioned home visiting. So, we do home visiting care coordination serving pregnant and postpartum women

and their infants and children until the children are 18 months old. We do fatherhood services and engagement, doula services, and then referral and screening and referral for interpersonal violence and depression, as well as health education and linkage to services that moms need.

This is a map of the Healthy Start distribution around the country, and I want to go directly to this survey. So, a couple of years ago, what we were hearing from the Healthy Start communities is a disproportionate impact of COVID, and more importantly to the Healthy Start grantees, the disproportionate impact on their pregnant and postpartum women and breastfeeding women, and they were concerned about how they were going to get the message across to these communities on vaccine hesitancy and the impact of COVID. So, we worked with them to hear from communities about why this hesitancy occurred.

And so these were the responses that we got from across the country. And we use this

response to give feedback in developing solutions to communities by developing a webinar with the pediatric immunologist and OB to address these myths and address these concerns and develop infomatics -- infographics rather for moms and for -- and brochures for public health practitioners.

We also heard from dads, but they were -- they want to be part of the leads in their families with helping to make those decisions. So, we developed particular things for dads.

Ditto for the experts on breastfeeding, subject matter experts for women. So, we heard from them as well.

Again, we have a robust fatherhood program and we hear from fathers on the support that they need in their coparenting journey because fatherhood services is relatively new to many in our communities, and so, they share their stories across many of our briefings and our fatherhood newsletters and in our webinars.

Our Healthy Start project directors

got together with the practitioners and developed this needs assessment asking fathers what they needed in their communities to help support their efforts in being better dads, and this was the response that we received from them. As the note says, there is a bit of difference across regions in the country about what dads need, but this is an overall summary that was reported from fathers across the country.

So, we also have a texting program and enrolled dads in this texting program, and as part of the enrollment process asked fathers what their interaction was. We had a lot of data that came from that texting program. We pulled just this one particular slide about how dads felt they contributed to their families, but also, their participation in the OB visit.

Not surprising to us, most of those dads, independent of being asked by a partner, wanted to attend the OB visit and 97% of them did, in fact, attend the OB visit. But not many of

them felt -- well, at least half of them felt that they were welcome, felt involved in the visit, but did not feel that their concerns were being heard or that they were thoroughly engaged in that visit or felt that they were valued partners in that visit, which says to us that we have work to do with engaging fathers as valued partners in the OB -- in the OB area or in our public health efforts. We know that fathers, when engaged, can improve birth outcomes. So, I think that tells us that we have a bit more work to do in that area.

We are privileged to be partners with HRSA and the Division of Healthy Start in this partnership to address maternal morbidity and mortality in the Alliance for Innovation on Maternal Health Community Care Initiative. And this is an effort where we develop and implement non-hospital focused maternal safety bundles and community-based organizations and outpatient clinical settings. So, if you wonder why we work in outpatient settings, and I think you had a

conversation about maternal deaths and increasing maternal deaths, but what has not changed is where those deaths occur, and most of them occur in non-hospital settings. And so, this is our opportunity to address those deaths in non-hospital settings but also an opportunity to address maternal morbidity with these outpatient bundles.

So, we started with in six pilot sites around the country and part of the work that we're doing in these pilot sites is working with hearing the community voices and how women feel about the care that they're receiving. And so, we've done focus groups in these pilot sites with women who gave birth 18 months to 2 years pre-bundle implementation, and we'll go back and do focus groups later at the end of this project. But I want to -- and these are the discussion topics for the women's focus groups, the mom's focus groups.

So, these are -- this is not the raw

data, but we thought we would take actual quotes from women and share them with you. And although we do have some positive outcomes, most of -- most of the quotes were very similar to what you see here on the screen, which says to us that again, we have a long way to go in earning -- earning the respect and making women feel like they're respected, that they are center stage, the star of the show when they come in to see us during their pregnancy and certainly in the labor and delivery room.

We also, as I said, wanted to hear from fathers and their value and these are the things from those father's focus groups, and we just pulled from two of those things, their engagement in the process and then what resources they needed. And these are again, two responses or several responses from those two things, which also says that we have a way to go to help fathers to feel like they -- they have value in that space and that they're wanted and that their questions

can be answered, and they are true partners in pregnancy and in the postpartum period, and that they get information about breastfeeding and how they can support that process as well, and ditto about parenting.

So, I will leave that, and thank you for the opportunity to share with you.

BELINDA PETTIFORD: Thank you, Deborah, appreciate that.

Now, we're going to turn it over to Terrance, Terrance Moore.

TERRANCE MOORE: Thanks, Belinda, and thanks to the committee for having me and my colleagues back to speak with you about the work that we're doing across our organizations. I'm already seeing lots of alignment as a sort of -- as mentioned on this first slide, An Invitation for Alignment.

I wanted to first wish folks Happy Women's History Month. I'm going to spend some time talking a little bit about these efforts that

are really getting at some of the issues that we've been talking about both in this committee and also in our organizations.

And in keeping with Women's History Month, I want to just give a shoutout to my fabulous colleagues at AMCHP. I get this lofty title as being the CEO, and there are a lot of people supporting me. So, folks who helped with this presentation, my colleague Andria Cornell, Salomé Araya, Shanel Tage, Giannina Ong, formerly with AMCHP Christina Wint, and Lynda Krisowaty on our team at AMCHP.

Before I dive into this presentation, I wanted to also bring up a topic that was mentioned previously. I've been having CEO coffee chats with members over the last year and a half and over and over again, workforce and workforce burnout and crises continue to rise to the surface as issues for concern of our membership and state and local health departments as well as our community-rooted partners that are standing up

programs around the nation. And so, I wanted to with the floor, offer that up. I know that's not a surprise to this committee, but it's definitely a common theme.

I am not going to go deep in terms of all of the work that AMCHP is doing. We did submit to the committee a document that detailed our 2022 accomplishments, what we are proud of, but we did want to go deeper today on a particular project of importance led by our Women and Infants Health Team and also our Evidence and Implementations Team as well. So, we can move to the second slide.

Really wanting to start by sort of situating us and the value structure, what we sort of hold real true here at AMCHP that our reproductive, perinatal, and infant health efforts are guided by these principles you see here and that to improve our help during sensitive timeframes that must center racism as the primary oppressor that exacerbates and impedes our best

progress. And so, being able to name it and constructively face it together and also make mistakes along the way, we believe is important to be able to call in partners as we sort of move along the continuum in this antiracism journey we find ourselves on.

We hope to be assets as an organization in our antiracism work, but really we are here to hold space, hold space for Black and Brown scholars, providers, healers, nurturers, creatives, community-based, and community-rooted organizations that have already held the solutions to the justice work that we know needs to happen, that we, in fact, are not creating anything new, but we are, in fact, just the conduits of this great knowledge that has been out in the ether for generations.

And we want to continue as a national organization of MCH colleagues working in states and communities to be the conduit and helpers of co-creating community and community led by

community-rooted solutions in our health departments, so transforming systems, funding, policy, care, how we collect and utilize data are of the smallest of things we hope to achieve in the coming future. Moving to our next slide.

And so, this particular project that I wanted to spend some time on that Andria and her team lead really stems from a convening that the organization had in 2020. So, we convened a national meeting of public health, health care, and community-based thought leaders, and institutional partners with a role in preterm birth prevention, and the goal of the meeting was to develop joint strategic actions to improve birth outcomes for the mother/baby dyad and particularly related to preventing preterm birth.

And so, the meeting was designed and co-created by thought leaders from the organizations mentioned here, Healthy Connect One, UCSF Preterm Birth Initiative, Commonsense Childbirth, and Mamatoto Village.

The Preterm Birth is a Title V National Outcome Measure that drives the direction of Title V efforts. And so, with a five-year Title V needs assessment in progress, this particular year presented a unique opportunity to provide a critical primer and a refresher on the topic of preterm birth as a public health problem, and a symptoms of greater societal needs, as I previously mentioned. Moving on to the next slide.

So, the teams identified these five strategies, and I'll go into a little bit of detail here, really thinking about our funding structure and really the need to restructure funding requirements to further support community-based organizations and trans-disciplinary perinatal providers and doing this all through an anti-racist health equity-centered, reproductive justice framework.

Also, ensuring that social determinants data and comprehensive perinatal data

systems for state and community-based organizations are invested in and available.

And then there is discussion in strategies around covering costs, and we'll get into that and standardizing the accountability of our existing health systems for patient-centered experiences. Next slide.

So, this waterfall picture really gets at and depicts our current funding structure. You're all very familiar with this. And the Healthy Beginnings with Title V work, our anti-racism and preterm birth prevention learning and practice cohort worked closely with six MCH programs, CDO Pairs, so that state MCH programs could fully dissect the math back to policies and institutional practices that really did take how funding flows from the federal level, as you see here depicted, through the state, and to localities, and really identifying and cracking open what the barriers are to this funding structure and thinking through and collaborating

with partners and hearing from our community-based organizations what we might do differently to support the communities to move the needle forward in terms of better health outcomes. Next slide.

And so here, on this slide, this is a complimentary issue brief that we developed with webinars alongside the meaning. Moving to the next slide.

I think what is important is for folks to really embrace this community engaged and collaborative model, but on the previous slide what is really mentioned that stands out here in terms of investing and comprehensive perinatal data solutions, Dr. Cheryl Clark on our team and Alexis really talks about the need to partner and share power. And so, I'm going to hone over -- hover over the term power -- whatever power means for you. We know that it exists in the sort of the state of the state of how funding flows and really needing to have communities at the decision-making table affirming their rights as

community members and having them provide their knowledge around historically disenfranchised systems to help determine what power and power sharing can look like in the future. Next slide.

I wanted to give a shoutout here to the beautiful artwork that was emphasized and created by Janelle Palacios, who I know is stepping back from the committee, but this really gets at the need for us to cover necessary supports to prevent preterm births. So, this being really the life cycle here. How do we close gaps and intentionally create space for all the individuals and infrastructure that are really holding up the entire system and that have been fractured throughout our work based on funding and based on relationships and how we prioritize various parts of our systems over others. And moving to the next slide.

Really, sort of this gets at how do we cover costs as sort of the brass tacks of covering costs, and this is what some of our

participants said that many community organizations are run by people knee-deep in the work. Many of us have full-time jobs on top of our community work. We don't have time to find the sources of money, let alone meet the requirements to apply for it.

And so, this really captures what I know you all have been hearing. So, what work can we do both at the federal level, but at the state and local level, and that the sort of trans-national organizational level to create space and really engender new ways of doing business that really supports the infrastructures that exist around the country. Next slide.

So, this is really titled You Can't Bundle This. Many of our CDOs really talk about all the sort of tactical ancillary things that they're doing that don't have a CPT code per se, that can't be billed, and so, really thinking about from the Title V perspective, looking at ways to use our Title V Medicaid interagency

agreements as a leverage point for advancing equitable care and really looking at how to coordinate between community partners and the largest birthing hospitals to think through efforts with community-based partners and essentially creating inclusive accountability systems and building those nationwide and holding up examples throughout.

Before I close out here, I want to move us to our next slide. This is AMCHP's Innovation Hub, which is an online searchable repository of what's working in the maternal and child health field, and we also characterize this as practice-based evidence. That includes practices and policy. We really define evidence as anything that demonstrates a given activity as having an intended impact for specific communities, partners, or populations. And so, we know that public health occurs in real world settings, and our evidence should be limited to -- or not be limited to that which comes from a

random control trial of scientific research but we want to be bringing up and holding up evidence and uplifting that as defined by impacting communities.

I wanted to put in a plug that AMCHP is -- has a call for applications for features to Innovation Hub. We encourage CDOs to apply, submissions by April 21st for our spring review, and we also recognize that many organizations are really busy doing their work. And so, we'd be happy to jump on the call to help folks facilitate filling out the application for them, but we invite folks to go to our Innovation Hub, and the link is listed here as well.

And finally, the last slide, the parting words here, we know that advancing racial equity and perinatal health has been through listening to and partnering with Black and Brown scholars, as I mentioned earlier, providers, healers, nurturers, creatives, and community-based, and community-rooted organizations. This

is very difficult work. One of the things I would offer up for this committee and for all of us doing this work is don't be afraid to roll up your sleeves and dive in and that we are really here to help to facilitate space -- brave space to practice, and guess what, we might stumble along the way, but that's part of moving us along the continuum is providing grace and patience with urgency for these problems that we confront.

And I want to thank the committee again and pass the baton back to Belinda.

BELINDA PETTIFORD: Thank you so much, Terrance. We greatly appreciate it.

And now we're going to turn it to Denise.

DENISE PECHA: Thanks, Belinda. I want to thank the committee and ShaRhonda for sharing your experiences.

I also want to acknowledge that I'm in Omaha, Nebraska, which is the Omaha Sioux, Ponca, Pawnee, and Oto as traditional stewards of

this land and their enduring relationship that exists between indigenous peoples in the traditional territories.

Also, a shoutout to social workers. I am a social worker, so I love the fact that the importance and the role they play has been a topic of conversation today.

Okay. I do not have slides, so I'm going to hit on some key points, most of which my colleagues have already talked about. But I will address it from the local level. So, Deborah and I have a lot of commonalities, I think, with what you'll hear.

CityMatCH is a membership organization. Our members are local urban MCH. So, it's local public health. What we are seeing is a shift. When I first started at CityMatCH, that MCH work was mostly done at the health department. Over the last six years, we're starting to see a shift to community-based organizations and hospital organizations that are

starting to do some more of that MCH work as public health is being cut as MCH programs are being decimated within health departments and those contracts are going out elsewhere. So that makes our work interesting in that we try to -- back to the alignment piece -- make those connections between the health department and the partners that they may have contracted some of that work out to or if there's bits and pieces that different organizations are doing in that larger MCH umbrella. So, just part of trying to make sure the alignment is happening at that level.

We also work with tribal entities that are local and the Healthy Starts. Some Healthy Starts within health departments and others are not, so making sure that those connections are all happening.

And as it's already been discussed, all of us national organizations on this call are all doing our anti-racism work as organizations

and also collaboratively across our organizations.

We do a lot of capacity building training and technical assistance and that is on both programmatic pieces as well as data. At the local level, there is often a gap in staffing for any epidemiology or data support. So, data may be flowing from the state to the locals, but they may or may not have the staff who can actually do anything with that data.

So, we do a lot of capacity building and trying to help build that, and sometimes they have relationships with universities. But that's an important piece because data has come up repeatedly and that, at the local level, we need to be always paying attention to it and making sure that folks have the ability to actually understand the data. There's other challenges to that, that we'll get to in a minute.

Some of our programing is around conference. We have an annual conference where we deal with a lot of content and where we can also

put that larger MCH umbrella. We have a training course for epidemiologists that we do in partnership with MCHB and CDC. We have some emerging leaders called city leaders to help with the MCH workforce and, as has always been discussed, that workforce is struggling. There is -- there is a shortage and folks are really burnt out. And so, anything that we can do to support them. Then we just have a lot of other projects, as all of our other partner organizations have talked about in the infant mortality and maternal mortality work base, and actually, we have a twenty-year history of working in the perinatal HIV lane, and that also has a lot of work now around syphilis.

And if I can pull us back to the making amends and the focus of the committee last year on American Indian and Alaska Native, we're also hearing that there are -- there is a rise in HIV and syphilis in some of those communities, and that data is struggling to make its way up. We're

just hearing it in pockets. So, that brings me back to that data conversation.

And I know it's been discussed repeatedly, but data invisibility, the challenges of data on where it exists, who has access to it, and then data sovereignty. So, those are all pieces that have already been discussed, but that's still the reality, I think, at all of our levels that we are seeing.

Because I think yesterday you talked about it a little bit, Belinda, you had some people talk about the recommendations from the report last year, but I also wanted to just highlight some of the things.

As many of us know, and as the report indicated, over 50% of the population -- the number varies on who you talk to -- of the American Indian/Alaska Native population lives in urban settings, and as the organization that works with locals who are in the city and county and urban areas, in discussion with our members,

they're often -- they -- they -- they're stuck, even in knowing like what their population is and how -- how many folks identify as American Indian or Alaska Native in their populations. And that gets back to that data invisibility, right, and data sovereignty issues.

So, we are really starting to work with our members and our board and trying to do some work in there and trying to look for some solutions and strategies.

Now, I'm going to pivot into some of the things that we heard when we -- the question that we were asked was what does it take to have a healthy pregnancy and birth outcome, and how can more babies reach their first birthday.

We heard a lot about social determinants from our members, but then people really wanted to highlight the housing and economic stability have to happen first, and that's not a surprise to anybody on this call that we are in a crisis for housing and economic

stability and then, of course, you need to address food security, education, transportation, quality health care, including physical, mental, and oral, and then quality childcare. Families need access to paid family leave during pregnancy and throughout the fourth trimester. That, we heard constantly.

We actually had some of our members extend questions for the committee. So, the questions that they would like to pose to the committee is how can we extend telehealth options for birthing families while we are working to make paid leave a universal federal benefit? So, how do we extend telehealth options while trying to get paid leave as a universal benefit?

How can we bring more postpartum support into the family home rather than require families to go to the doctor's office?

And how can we bring more psychosocial and mental health well-being to families during the fourth trimester in

particular?

And I know, I think I saw it with each of my colleagues, but I think we'd be remiss if we didn't also just acknowledge that the attack on reproductive rights and that that is a struggle being felt at the local level among our members too.

Okay, I wanted to make sure that we have time for questions. So, I will end there, thanks.

BELINDA PETTIFORD: Thank you, Denise. And thank you to all of the panelists. This has been really helpful and thank you so much.

I'm going to open it up now to anyone that has any questions, any thoughts they want to share, anyone on the committee?

And while they are thinking about it, I do have one question that I want you all to just think about, even if you have to drop it in the chat, because you all have done a really good job

of kind of sharing what you're hearing in the field as well as some of the work that you're doing and how the two are connected.

So, I would like to hear, you know, if you had to narrow it down to one thing, what is that critical piece that you're hearing in the field that, you know, right now if we don't elevate it and start addressing it soon, we'll realize truly how fragile our system is. So, I wonder if you all have any of that that you would like to share, or you can just think about it again and drop it in the chat, because I do want to make sure we have time for any of the members to ask questions.

And Marie, I see your hand is up.

MARIE RAMAS: Thank you all for wonderful presentations. They're all so detailed.

One of the things we're trying to focus on over the last day and a half is how do we take all of this information that we know, particularly around the health disparities

surrounding maternal and infant mortality and then how do we make concrete requests for change?

So, something I'm wondering about, the fourth trimester was mentioned by Denise, and this concept of continuity of care after delivery in that first year of life, and there have been some pretty interesting advancements to support this concept.

But another thing I'd like to kind of bring in is this concept of using community health workers, social workers for those community members that are highest risk for adverse outcomes in the perinatal and postnatal period. So, I wonder in the three of your perspectives, have there been -- do you have any research or data that shows the impact or even the ROI of having community health workers or social worker interventions and 1) improved outcomes and 2) maybe even improved cost and spend associated to adverse events postnatally. So, really, the question is, do you have any data that can help

support us in the ask because we know that addressing this issue is important. The question is, how do we materialize some of the work in the shorter term and augment the work that all of your organizations are already doing?

BELINDA PETTIFORD: You can go in any order that you like. So, you all four are on the screen.

MARIE RAMAS: My apologies, the four organizations. Thank you.

DEBORAH FRAZIER. This is Deborah, and I think -- so I will say first of all, I don't have the data off the top of my head. But I think the integration of social work approaches is not necessarily a new approach, and Belinda can -- Belinda knows this. When Healthy Start began, it began with the idea that it was going to be a community-drive, community-based approach, and it was going to address what we now call social determinants of health. And most of those programs, if not all, have social workers embedded

in those programs. It has nurses and social workers.

And I think over time, and it also centered community voices. Community voices actually gave feedback on the approaches of the Healthy Start program, and I think little by little, we may have moved away from that, and it's time to get back to the core of what those programs actually were designed to be. And so, I think we're layering some of that back into the programs, but rather than layering it, integrating that into the approach as an integrated holistic approach. So, it's not necessarily novel, but you can't address social determinants and you can't address racism without having those approaches integrated into the program to be successful.

BELINDA PETTIFORD: Thank you, Deborah.

Anyone else want to chime in, any of the other organizations?

TERRANCE MOORE: I can -- I can chime

in on that with a two-part sort of response to this. One is -- and this is not community health worker or social worker specific, but there is strong data from comments since childbirth and their easy access clinics and perinatal safe spots all are in the Innovation Hub, by the way -- AMCHP's Innovation Hub, that collective community perinatal support or care and support that is delivered by community members in their communities can actually close racial disparities in perinatal health. So, I wanted to point folks there.

There is strong data -- I don't know if we have colleagues from California. I was recently at the National Association of Medicaid Director's Meeting, and there is strong data from using California and other states around sort of paying for particular services because they are -- in fact, have been shown and demonstrated to reduce disparities in communities. So, I think the data is out there.

I would also, you know, as I mentioned early on in my presentation as well, I think sometimes we look for quantitative data. I think it's important for us to really pull in those qualitative stories of how it's working, lives saved, that we know those stories are out there, we've heard them in this committee as well. And so, I would also offer that up as something for us to think about in terms of packing and disseminating, and sharing this information.

BELINDA PETTIFORD: Thanks, Terrance. Oh, Scott, were you going to say something?

SCOTT BERNS: Yeah. You know, there is -- to your question -- I'll lower my hand here -- there is a pretty comprehensive document that I'm happy to share with the committee that was created by Charlie Brewer about a year ago, a little less than a year ago through a group that he pulled together around InCK, Integrated Care for Kids, and it was entitled Why Kids and Why Community Health Workers. And so, while the focus

really was on health care transformation in primary care, there's a whole section in the document to raise questions around the effectiveness and the impact of community health workers. I think he has nearly a hundred references in that document. And so, what I could do is send that to the committee, and then, you know, whatever you all decide to do with it, maybe do your own literature review as well, but he's got some good resources there and references and I'm happy to send -- I can E-mail that you after this session.

BELINDA PETTIFORD: Thank you, Scott.

And ShaRhonda, I see your hand up.

SHARHONDA THOMPSON: Thank you. I know the social determinants of health has been mentioned and the housing crisis has been mentioned. With the focus being on community health workers going to the patient, what's happening in the even with like the housing crisis if the person does not have a stable home or a

stable residence? How are they being met? Are they being met in like a public space? Is there a space that they -- that's set up for them to meet? Are they being met at the doctor's office? Do we have any data, because I do know housing is really bad right now and there's a lot of people that are being displaced. Do we have any data around what's being done in those cases?

DENISE PECHA: Deborah, I'm going to assume that you have stories, and ShaRhonda, thanks. I know what I hear is that the community health workers work with the families either finding those public places, if there's a friend or family that they can meet with there. They are working with them to figure out the best solutions. And in some localities, they're actually working to find temporary housing while they get on a course for more permanent housing. So Deborah, I'll bet you have samples too.

DEBORA FRAZIER: Sorry, I'm sorry. What the Healthy Start workers and community

health workers do and those programs that have social workers, they work with the Healthy Start participants or consumers, as they call them sometimes, those that need housing, to find housing for them and to let them the housing, and we have examples of some programs -- and you may be familiar with the one, Denise, in Boston -- where they have -- they work to get special -- special buildings and housing for pregnant women, and even extended that to fathers with children. So, there are places that in some cities that have extended that for housing, and then there are other examples. I think United Health Group has invested in housing because it's a real crisis, particularly for young families. So, there are examples of that. But I know within the Healthy Start family, housing is a priority for pregnant and postpartum women.

BELINDA PETTIFORD: ShaRhonda, are you good with that? I'm sure there's some other responses that we can get later, but are you good

with that?

SHARHONDA THOMPSON: I am, and I know if you could share those examples, I know you said you had examples. So, if we could share those, that would be wonderful for me to look at.

DEBORAH FRAZIER: Okay, we will.

BELINDA PETTIFORD: Okay. Thank you, Deborah.

Sherri, I see your hand. And Sherri will be the last question.

SHERRI ALDERMAN: Thank you very much. I really appreciate the presentations and I learned a lot.

I was particularly pleased to hear Terrance mention the dyad. We know how important early relationships are and we wish that every caregiver infant has the benefit of secure attachment.

We also know in the infant mental health world that secure attachment does not protect the developing brain of that young child

or infant from environmental impacts. Those environmental experiences that encompass the dyad can be positive or they can be adverse, and when they are adverse, they adversely impact that developing brain significantly. Vicarious racism is an example of that.

I also learned -- I also -- we also know that social determinants of health can be an environmental environment within which the dyad can flourish and thrive and grow.

I learned yesterday that there is robust data on the influence that social determinants of health on the health and well-being of mothers and infants and fetuses.

I would really be very interested in a presentation that presents those data so that we can understand the evidence behind the impact of social determinants on health on the dyad and the developing fetus.

BELINDA PETTIFORD: Thank you, Sherri, for your question.

And again, join me in thanking this panel. I think, you know, they've done an awesome job of sharing what actually occurred.

I think one of the take-home messages that I am hearing from you all is first and foremost, we've got to listen to individuals with lived experience. We've got to elevate community voices, and we've got to meet people where they are. And how do we do all of these things together and really try to, as I say, move forward with, you know, a couple of critical areas, realizing we're not going to cover the whole waterfront, as much as we all would like to.

But thank you all so very much. We appreciate your time. You're welcome to stay on with us.

We are actually going to now take a short break ourselves. So, we are scheduled to be back at 1 -- oh, we're scheduled to be back at 1:00 and it is already 1:00. No, we're scheduled to be back at 1:15. So, we'll come back at 1:20,

and I'll work with the next group. So, we'll see you all shortly, 1:20 Eastern time. Thanks, everyone.

(BREAK.)

BELINDA PETTIFORD: Hello, everyone. I am showing it is 1:20 Eastern Time, and I understand some of you may be off camera or eating your lunch, so that is fine. I know that wasn't much time to grab it and eat it. So, I definitely understand that.

As we come back together, we are excited to bring our next group together, our next panel of national partners who are working in the maternal and infant health arena and hearing more about the work they're doing and specifically narrowing it down again, to the maternal and infant health work as we are thinking about ways that we can prioritize efforts.

So, I will introduce the entire group, at least I think I will. Let me make sure everyone is here. And then we will go in that

order. We will hold questions until the end, because we want to make sure each of the partners get an opportunity to share their information, and if need be, we can follow up with questions.

So, I will start by introducing Elizabeth Cherot, and Elizabeth, please correct if I've mispronounced your name right from the beginning. She's the Chief Medical and Health Officer with the March of Dimes.

We also have with us Lori Freeman, who is the Chief Executive Officer for the National Association of County and City Health Officials, otherwise known as NACCHO.

We have Christi Mackie with us, I see her. Christi is the Vice President for Community Health and Prevention with the Association of State and Territorial Health Officials, also known as ASTHO.

And then, we also have Inas-Khalidah Mahdi, and I do apologize for messing up your name, dear. She's the Vice President of Equity-

Centered Capacity Building for the National Birth Equity Collaborative. And I need to make sure she is actually on. I don't see her yet. So, Emma, let me know if you're seeing her and I am missing her.

EMMA ALLEN: Belinda, we are promoting her to a panelist right now.

BELINDA PETTIFORD: Thank you, dear.

Again, if you need to go off camera to eat lunch, I'm sure our panelists will understand because they may need to be off camera themselves eating lunch until their turn comes.

So, I think we have everyone. So, again, we will go in that order. We will hold questions until the end. So, I will turn it over to you, Elizabeth.

ELIZABETH CHEROT: Thank you. Thank you very much and thank you for having me. And you pronounced my name beautifully, so thank you very much. Always appreciated.

So, I'm Dr. Elizabeth Cherot. I am

the Chief Medical and Health Officer for the March of Dimes, and I'm new. I started just the beginning of January, so I'm humbled to be here and appreciate being able to talk in front of the committee.

I also want to talk about just frankly, there's been a lot of change at the March of Dimes over the last six months. So, we've had a lot of leadership change within the interim CEO and myself starting, and I just wanted to acknowledge that from the beginning. We can go right to the next slide, Emma.

My agenda is really obviously short. I just wanted to talk about who we are, what we do, how we do it, and how we collaborate. So, we can go right on to the next slide.

Because obviously, I think everybody here today knows that their vision is clear, that no income level, no race, or country should determine, you know, if a mom or baby gets to survive pregnancy or, you know, their first year

of life. So, I'd like to go to the next slide.

This is just the timeline of the March of Dimes, which as a historian in another lifetime, which was my major in college, the 85-year history of the March of Dimes starting with FDR and asking everyone to contribute a dime to pivoting towards after solving, you know, for polio, pivoted towards preterm birth as well as disabilities, and now it's really, as everyone here is trying to lead the way for healthy moms and strong babies. And as it is history month celebrating women, I'm quite humbled to be in a position that Virginia Apgar was the first of. So, we can go to the next slide. So, and actually we can move right onto the next one.

As I think you're all familiar with the rates of adverse birth outcomes that moms and babies and families are facing in the U.S., we think our vision and our mission is very clear. We want to end preventable maternal morbidity and mortality and infant death. We want to do this

through the health equity lens, as that is the only way that we'll be able to achieve this. And ending that health equity gap, as we've heard from so many already today, is a fight and that I think needs to be collaborative and I'm excited to be here today to share what our role has been. You can go to the next slide.

So, really I want to focus on sort of this slide and one other to talk about how and what we've been focusing on, because when we examine the quantitative data and when talking with families to understand their, you know, lived experiences, there's really this strong data that's behind this. We're pointed towards these priorities. So we've been focused on maternal morbidity and mortality around cardiovascular health, mental health, and chronic stress. We've been looking at preterm birth and birth defects. And then, I really want to point out health equity lens and all of this, we've been prioritizing across our portfolio because we've, you know,

these areas were identified with over 600 partners, those subject matter experts as well, and convening members to frame out our national equity framework, which you'll see below here on the slide. You can go to the next slide.

So, I'd like to talk about the channels through which we advance our goals because when I started ten weeks ago, it was really time to solidify what do we do at the March of Dimes, and how do we reach our impact. And what I found, which has been, you know, as I've looked over the hood over the last few weeks, is really that we are really trying to educate both professionals and consumers. We like to educate and we like to advocate as well as research and disseminate those solutions, and we can't do it alone. We're proud to build on our convener role, which I think we've had a strong history to do, but we want to cultivate those impact-driven partnerships and we're working hard with communities across various geographies, which has,

you know, really been the foundation of the March of Dimes. So, we can go to the next slide.

So, I wanted just to highlight some of our portfolio today and sort of the key -- and you can go to the next slide -- thank you, Emma -- just for examples of where we are and what we're doing and highlight specifically around these four key channels of advocacy, research, education, and our partnerships.

So, if I think about advocacy, we've been in the last year really working on the Momnibus Act and really working this year, we're focusing at fourteen state levels. We have boots on the ground there and are working on not just the Preemie Act and protections for pregnant workers, but this medical leave and really expanding as you were all mentioning about the fourth trimester.

I think a lot of you have seen our research and data. I'm very proud of our maternity care desert report. Our next one comes

out this June. So, we're getting that ready for dissemination and trying to build on our legacy of our research.

And then, when I start looking at education and it's about education for support in families and providers, as well as our consumers, and we want to really try and lead towards, you know, directly impacting those healthy pregnancies. And I think we do have a wealth of knowledge within all of us. Our NICU family support is one of our highlights of one of the programs that we do.

And then, I really want to talk about how we advocate for health and equity. We have MABAN, our Mother and Baby Action Network. It’s our national consortium of the four hundred partners, and it’s at the national and state level, and we really bring together to collaborate, to address causes of inequities in maternal health.

And then the last thing I really want

to talk about is just our -- and again, I'm highlight just across these and there's many more -- but really talk about at the local health level, we have a lot of boots on the grounds in our markets, and we've got, you know, seventy in our NICU family supports, but we've got thirty-one markets where we're really trying to expand our local initiatives, doulas being one of them. We just talked about community workers, and I think about -- I think you were, Belinda, talking about the ROI. I think about that on community workers, I think about the ROI on doulas and some of the projects we have, and we'll certainly forward over some of that information.

So, the last slide, as I wrap up, I just want to talk about -- I think there one last one -- more -- just where we are and opportunities to synergize. I think as a new leader within the March of Dimes, I do think one of my biggest priorities in the next year is to think about how we can be collaborative and I want to thank Scott

Berns for reaching out to me within the very first week when I started. I'm excited to join Terrance at AMCHP this year and hope that we can elevate the March of Dimes to be one of those collaborating properties that you all have been working with.

So, as I look at our states and territories and think about our national mission, these are some of the things that we're doing in both of the grassroots, our maternity care desert, and lastly that MABAN or action network.

So, I appreciate the opportunity. Thank you so much. I hope I struck within time. I tried to fly through it. And again, thank you for the time. I think the last slide just has my contact info. So, thanks again.

BELINDA PETTIFORD: Thank you, Elizabeth. We appreciate that and you did well with time.

Now, we're going to turn it over to Lori.

LORI FREEMAN: Good afternoon, the pressure is on I'm going to try to get through mine. It's so great to be here, and thank you for inviting me. I'm Lori Freeman, I'm the CEO of the National Association of County and City Health Officials and I still carry with me a lot of warmth and warm memories of my time as the CEO of AMCHP and it's so great to see some of my old colleagues on the phone here, and thank you for again including NACCHO in this discussion.

So, a little bit about -- next slide, please, thank you Emma -- a little bit about NACCHO. We represent nearly three thousand health departments across the country at the county and city level of governing and our mission is to improve the health of all communities by strengthening and advocating for these health departments, ultimately with a view towards optimal health equity and security for all people in all communities.

These are our -- we are updating our

strategic priorities but these former set of priorities still remain front and center and core to our work in really ensuring that health departments are able to deliver the essential public health services to their communities, that we advocate for them, and that they are recognized as part of the public health system, and that we are always optimizing our strategic alliances and partnerships including those with groups like yourself. Next slide, please.

A little bit about the local health department landscape. This is data from our 2019 profile of local health departments and we repeat this study about every three years. We currently have one in analysis right now. But these types of data don't change that frequently in terms of the programs and clinical programs and services provided directly by our local health departments. And as you can see by this data, adult and childhood immunizations, screening and treatment for chronic and communicable diseases and other

conditions, and certainly maternal and child health services are front and center for many of our health departments.

Adult and child immunizations are the clinical services provided by most local health departments, but there are a healthy portion, about a third, that provide other clinical services including those listed here in the maternal and child health area, and of particular note are the well visits, the home visits, and the well-woman visits to the health departments.

So, I want to say that in our consideration of work together in the future, there are really important touch points that families and mothers and fathers have with local health departments, and I hope we can think together about utilizing those touch points as ways to communicate important information about how moms and families can keep themselves well and prepare themselves for their new families and take care of their existing families. Next slide,

please.

This digs a little bit further, and just wanted to demonstrate it to show you that I didn't mention the WIC services on the other slide, but certainly 70% of our health departments have the WIC programs embedded in their health departments, so another very important touch point for mothers that are seeking information as well as nutrition for their families.

It does vary a little bit by jurisdiction, urbanization versus rural, and the local health departments in rural areas are more likely to provide these services than in urban areas, and the reason for that is because we are seeing kind of a disintegration of rural hospitals occur across the country and often our local health departments are the provider of last resort and the core provider of clinical services in those more rural settings.

Local health departments provide other clinical services to moms and kids and

families such as EPSTD and well child clinics and prenatal care, that's all important as well, and certainly, I mentioned the adult and child immunizations as well. Next slide.

Switching gears just a little bit to talk about the work that we do in maternal child and adolescent health and those types of initiatives. A lot of our work is around providing technical assistance and training in partnership advocacy. Other types of tools and resources model practices to local health departments, and we extend that to community-based organizations as well. Some of the highlights of this portfolio are in the chest and breastfeeding portfolio. We consider ourselves a leader in this area. We have about a decade of experience providing technical assistance and training to local health departments and communities, and two years ago, we launched the Seminole document, The Continuity of Care for Breastfeeding Blueprint that supports communities through system-level

approaches to lactation and ensures that families don't fall through the cracks and discontinue breastfeeding at a critical time in their baby's life.

We've also funded fifteen communities to implement these blueprint activities and to provide monthly and individualized technical assistance to about forty different grant recipients through our Reach grants with racial and ethnic approaches to community health and really focused and highly tuned on individuals who are made vulnerable through the conditions in their community. And we are currently expanding that portfolio work to include work around nutrition and supporting food security in the first thousand days of life as well.

For maternal and child health and a few other areas, namely preparedness, we are working to increase the capacity of local health departments to really center maternal and child care and health care considerations during

emergency preparedness and response efforts to keep them save. They're a special population.

We have annually -- we establish workgroups in skill-based training exercises with over thirty health departments to meet the needs specifically of pregnant people and infants during emergencies, and we also led an action planning process for local health departments where one grantee, Jefferson County in Colorado, was able to identify additional need and increase the inventory of emergency supply kits for this purpose from a quantity of thirty to six hundred and seventy-five to meet the needs of that pregnant people population.

And then throughout COVID and ongoing, we're supporting local health departments and early childhood education programs to really increase the decision-making around COVID mitigation and implement vaccine activities to ensure vaccines for young children and particularly those who are in really low resource

settings. Next slide.

I think the primary concerns at the local level, and this is based on a recent survey to our own Maternal and Child Health Workgroup, themes emerged and pressing concerns included prenatal and postpartum care, critical to, of course, maternal mortality and infant mortality work, substance abuse, mental health concerns, in particular communities that are facing increases in safe sleep related deaths, as well as congenital syphilis.

Across the respondence of that group, there was a lot of emphasis on health equity and population disparities, and we know that our local health departments are really well positioned to address these disparities and resources and outcomes for marginalized communities and identify specific populations that need additional support because they are affected by structural racism, medical racism, low income, undocumented, or young first-time mothers, or those with behavioral

health diagnosis.

What local health departments are doing, they are working in deep partnership within their local communities, especially to combat disparities and they are really truly integral in building coalitions and advisory committees and workgroups across communities to do this work and also, of course, because 70% of WIC is co-located with the local health department and working in close connection with the special health care needs programs.

Robust home visiting programs to increase access to prenatal and postnatal care. Building and implementing individual and community education programs for ongoing maternal and infant mortality concerns, as well as rapid response education opportunities where there are actually increased rates occurring, and local health departments are actively providing screening services for STIs and mental health screening during and after pregnancy as well.

Let me wrap up the next two slides with talking a little bit about our policy and education work. In terms of our policy work, these are all of the -- NACCHO has about a hundred and thirty different policy statements that we developed in close concert. They are developed actually by our local health department officials and their staffs and they help NACCHO to urge action with federal agencies and state public health officials, elected officials, other local health departments and partner organizations, and they drive everything that we do, quite honestly. This is the list and links in your slides to all of our policy statements. I highlighted a few that, I think, are key to the infant and mortality work around women's health, our nurse home visiting programs and healthy father and male involvement. So, I encourage you to check those out as potential resources. Next slide, please.

And then, we're constantly also advocating to Congress and the administration on

these programs to appropriate money to them, to support them, to sustain them long term and not, you know, ensure that they are a part of this, you know, boom and bust funding and that they're regularly sustained, and these are links to all of our letters around maternal and child health that we've written over the past two years in supporting many of these programs including the Maternal and Child Health Services Block Grant.

So, I will end it there and just say thanks again. And again, I would love to explore further conversation with you about how local health departments can really use their connectivity to community to drive messaging and to get people the help that they need to ensure that they have a safe and healthy pre-pregnancy through postpartum care and that their children are safe and health as well. Thanks very much.

BELINDA PETTIFORD: Thank you, Lori. We appreciate that a lot.

All right. Now, we're going to go to

Christi -- Christi with ASTHO. Oh, see you.

CHRISTI MACKIE: Hi. Just before I started, I just wanted to thank you all for your attention today. It's great to be invited to be able to provide an overview of our maternal and child health work at ASTHO. So, next slide, please.

As a quick model set, ASTHO is a nonpartisan member organization and our members and their leadership teams formulate, influence, and implement internal and external policies in that space of the little p.

We're in our second year of implementation of our three-year priorities, and those are racial and health quality workforce development, sustainable infrastructure improvement, data modernization, and evidence-based practice.

You know, our operational model includes leadership development, technical assistance, and capacity building, as well as

government affairs and advocacy, and just in the space of public health. We're structured similarly in our programs to match health departments so that we can marry our expertise and technical assistance to the needs of state health departments. So, obviously, I'm speaking on behalf of maternal and child health, but across the, you know, the government public health. You know, you think about environmental health, health equity, immunizations, chronic disease. You know, we do span different departments and look at where our collective impact can be. Next slide, please.

I'm just going to provide you with a quick overview of her maternal and child health work. I'm going to provide you an update of priorities in maternal and child health based on health officials and what they are seeing rise to the top and then just cover quickly some future opportunities. Next slide, please.

And so, thinking about our impact in this space, you know, recognizing, you know, our

engagement is not the sole source of, you know, impact, but we do try to think about engagement and what that means. And so, we're always looking to advance equitable access to service and care for maternal and child health populations. Next slide, please.

So, we have two sides of our Maternal and Child Health Portfolio. Right now, I'm going to cover our Family and Child Health Portfolio opportunities to work in learning communities. First, we have some work related to PRAMS and it's through the CDC's Division of Reproductive Health. And the purpose of this work is really to support states with data linkages to identify and understand and respond to the complex needs of their maternal populations.

The work also includes conducting and supporting patient-centered research and support of clinical quality improvement. We have work that we affectionately refer to as DREAM, but it's in relation to advancing racial equity, and it's

equity-focused data collection, reporting, and data-driven interventions, so thinking about that qualitative and quantitative data in this space.

And then finally, in this area, we have work in contraceptive access, supporting states with the implementation of certain policies. And so, right now we're focused on prescribing models, increased access to telehealth, delivery of contraceptive care, and improving billing and coding systems for Title X clinics. Next slide, please.

Maternal and Infant Health Portfolio, another one of our lovely acronyms, PRISM, but this is HRSA-funded work in Promoting Innovation in State and Territorial Maternal and Child Health Policymaking. And so, this is a direct collaboration with AMCHP as an affiliate, and our goal here with working with states is to build capacity for policymaking, really looking to improve outcomes for women of reproductive age, and to address substance use in co-occurring

mental health conditions.

We also have a breastfeeding workbook in our portfolio. We've supported this learning community for almost a decade and we've been looking at and implementing supporting states in improving breastfeeding disparities.

We also have work around risk-appropriate care, and this is also funded through CDC or the Division of Reproductive Health. Our focus here are, you know, data-driven best practices via cross-agency collaboration, so thinking about maternal and child health programs and in turn partnering with provider champions and hospital administration, really looking at linking data to conduct a pooled analysis of maternal risk conditions and also, you know, looking by locate assessment tools so that those levels of care for maternal health during delivery. Next slide, please.

So, state health official priorities. You know, ASTHO conducts research now at two

points every year, and we call it our environmental stand. Really, the purpose here is to identify the [indiscernible] public health trends and issues across the U.S. It really -- it's comprised of a scan of state health improvement plans, which can be semi-static, just depending on where states are in their implementation. But we also conduct surveys that are administered to help officials across ten regions, and we do that two times a year, and we're looking to see what is rising to the top of their priorities, where we can support them, or where we need to advocate for them. Next slide, please.

And so, within the environmental scan, there's a focus obviously on maternal and child health and three areas emerge including youth mental health and social well-being, maternal and infant mortality and morbidity, racial and socioeconomic inequities, and perinatal outcomes.

So, looking at the areas supporting youth mental and social well-being, we've identified several strategies that are being implemented or where states are looking to implement to address this area, you know, including expanding community-based opportunities, youth mentoring, peer support to reduce social isolation, loneliness, interpersonal violence, depression, and adverse childhood experiences.

When we look at maternal and infant mortality, the focus with state health agencies really is increasing prenatal screening for pregnancy risk factors, those areas like hypertension, diabetes, heart disease, substance use disorders, building hospital and birthing center capacities to provide high-quality and life-saving care to all mothers and infants, and, you know, state and territory health agencies are also, you know, taking action to diversify and develop an anti-racist, culturally competent infant and maternal workforce. Next slide,

please.

So, future opportunities, what is rising to the top for state health agencies and health officials? Next slide, please.

Zero-three nutrition security, so really trying to move upstream looking at the issue based on some recent information out of the CDC's Injury Center. You know, they've identified nutrition security as an adverse childhood experience thinking through where we can be supportive of health agencies in this space.

Next, we've got maternal severe morbidity and mortality. We've established a technical package to help health officials understand their authority and influence to address maternal morbidity and mortality. You know, we recognize that, you know, we're a piece of the puzzle and we're not the only players in this space and collectively, you know, we're thinking about really trying to focus in on the role of health officials and their agencies and

what they can do. Next slide, please.

And then just, you know, really digging in, I have been in this space for about two years now helping state health departments understand their role in supporting communities, what place-based community-led approaches look like, where they need to implement workforce development, think about data, data equity, how it's collected and reporting, and then also really sit back and take a look at finance systems, you know, what's in place to be supportive of funding communities directly or intermediaries, and really taking a look at braiding and blending funding streams, how we think about embedding equity into our existing programmatic areas, really thinking about longevity and sustainability of that work.

And then finally, you know, continuing to address poly-substance use among pregnant women. You know, we've been focused here for a number of years and, you know, what we do know is outcomes really haven't improved over the

pandemic, so there's still a need to focus in these areas. Next slide, please.

And I will wrap up and answer questions as part of the panel later. So, thank you.

BELINDA PETTIFORD: Thank you, Christi.

And now we're definitely last but not least, we're going to go to Inas, and please pronounce your name for me.

INAS-KHALIDAH MAHDI: Thank you. It's Inas-Khalidah.

BELINDA PETTIFORD: Inas-Khalidah. Thank you, dear.

INAS-KHALIDAH MAHDI: Thank you. Yes, the pressure is on now. So, I will try to bring it all together and make sure everybody is still here. I see some familiar faces, and it's good to be with you all this afternoon.

So, my name is Inas-Khalidah Mahdi. I'm the Vice President of Equity-Centered Capacity

Building at the National Birth Equity Collaborative.

Our equity-centered capacity building work typically focuses on organizational equity assessment, training, technical assistance, and we do this work with our health systems, with payers, with PQCs, MMRCs, and CBOs.

In the community, our community-oriented work is more so focused on shifting power to communities, research, and policy advocacy. So, I'm going to do something a little bit different today. I'm going to talk a little bit about our frameworks upholding index efforts, right? How do we advance this work, and this is the work essentially that underpins everything we do from measured development, from policy advocacy, from our reproductive and sexual well-being practices, and so on and so forth. So, let's jump right into it. Next slide.

So, what is birth equity? I know we're talking a lot about health equity, and in

this group, I might be preaching to the choir. But birth equity in 2015 was a term that was conceptualized by the founder of NBEC, Dr. Joia Crear-Perry, who I'm sure you all are very familiar with. Dr. Joia crafted a definition that roots a lot of the work that we do today. She was able to draw on health equity terminology and reproductive justice framing and capture what it means to advocate for women and families to have the opportunity to have a healthy birth with zero barriers.

Also within this definition is the keen understanding that there are certain racialized and marginalized groups that suffer from the poorest outcomes.

So, with this in mind, birth equity, the framework for our work is the assurance of the condition of optimal births for all people with the willingness to address racial and social inequities in a sustained effort. Next slide.

So, NBEC, as some of you are familiar

with our history, we started out very much centered in Black infant health, and since our inception, our mission has somewhat shifted. We've begun to grow in terms of our programs and policies and really respond to the voices of community. We originally centered our work on infants with the goal to reduce Black infant mortality across the U.S. by 25% in ten years.

Now, our mission is somewhat updated. We create transnational solutions that optimize not only infant health, but Black maternal, sexual, and reproductive well-being. We shift systems and culture through training, research, technical assistant, policy advocacy, and our community-centered collaboration. And all of this, of course, is reflected from what we hear in community.

We center our values of radial joy, reproductive and sexual freedom, the importance and significance of Black lives, sisterhood, anti-

racism, shifting power, and Black feminism and womanism.

And, like a lot of other organizations, our vision is centered on family. Our vision is that all Black mamas, babies, and their villages are able to thrive. Next slide.

Sop, on this slide, you'll see one of our early publications that came out of our work that was centered in infant health outcomes. This paper, Separate and unequal: Structural racism and infant mortality, is one of the first pieces published from our campaign for Black Babies Project in 2017, funded by the WK Kellogg Foundation.

In this research project, we partnered with researchers at Tulane University and the Institute for Women and Ethnic Studies in New Orleans. And the primary research aim here was to determine the weighted impact of structural racism and social determinants on infant mortality. Are there particular social

determinants of health that matter more than others, or is it a convergence of indicators that are more important, right? And so, from this research, we landed on one of the primary tools that we use to guide our work today. Next slide.

That is the Birth Equity Index. The Birth Equity Index really came from this research in the Campaign for Black Babies because we needed quantifiable context on which cities have the largest burden of Black infant death, and what else was happening in those cities that we could begin to trace some of these trends.

So, the Birth Equity Index essentially combines indicators related to root causes of health inequities with social determinants that has empirical evidence on their relevance to infant mortality. The Birth Equity Index was developed to identify community level characteristics that were associated with an increased risk of Black infant mortality across one hundred United States metropolitan cities, and

this index drew data from multiple public data sources on the following topics: education, unemployment, residential segregation, adult smoking, poor mental health, poor physical health day, adult obesity, limited access to healthy foods, homicide rate, crime, air pollution, [indiscernible], and structural racism.

We tried to do this in a way that challenged, at that time, the way that data around structural racism was being collected and compiling this together in an index to say how can we -- how can we better predict what's happening for infant mortality across these different cities. Next slide.

So, on this index, this really allowed us to place those social determinants and health outcomes in perspectives for a lot of our health system partners and leaders that we were working with. So, I mentioned we worked with health departments, we worked with health system leaders, we worked with hospitals, we worked with

CBOs, PQCs, MMRCs, essentially everyone is a partner at some point.

And in the index, of course, we focused on structural determinants rather than placing blame solely on Black families and Black birthing people, which we know is our history. We tried to do a better job of looking at what are the ways in which environmental racism, redlining, and state-sanctioned violence, and structural factors show that. And we did this not solely because our mission is that Black babies, their mamas, and villages thrive, but also because we've got a lot of partners coming to us saying where do we start? What's the best place to start? Where, like, you know, here's how much money we have, we've got a limited amount of funds, where are we going to see the most impact?

So, what we were able to do was say okay, from this list of cities, here are the factors, right, that are closely -- most closely impacting infant mortality in your city. So, we

got a long list of cities that you see here, and as much as we would have liked to work with each of them, because of funding and capacity, we were limited, and had to select a certain number to work with.

We ended up working with Montgomery, Alabama, New Orleans, Louisiana, Jackson Mississippi, Detroit, Michigan, Chicago, Cleveland, and Baltimore as we began our Campaign for Black Babies, and with this work, we were able to identify those high impacts of social and structural determinants of health alongside health system leaders to develop equity plans, also to build long-term relationships with our community-based partners, conduct birth equity and implicit bias trainings with health care providers, conduct grand rounds with OB/GYNs who were in training, and plan future research in these cities after the project's completion. Next slide.

So, we -- you'll see on here there is a red dot for where our Campaign for Black Babies

cities are located and also Promising Practice cities. We ended up categorizing the DC/DMV area, New York, Boston, and Los Angeles as Promising Practice cities. We had best practice cities as well, but those were specific to those projects that had been very rigorously evaluated and published.

Those who were Promising Practices were initiatives that displayed some positive impacts on health outcomes. Because even in 2017, we were aware of other birth equity programming in those local health departments and health systems because we were in partnership with collaborators and innovators in the community. And we hope that simply by highlighting some of those efforts, we could begin to offer scale to those best parts so that we could transfer that to larger cities with dense Black populations.

But even in those cities that we have Promising Practices or Best Practices, we know that social determinant data is but one piece of

the equation. We knew that in order to further illuminate how we could improve birth outcomes, we had to talk to Black birthing people, right? We needed to listen to them, which it sounds very similar to what's been said today over and over again, making sure that we're incorporating their lived experiences in community as well as in their care settings and the way that we really understand and gather the nuance from those social determinants of health.

Since then, we've continuously expanded our research and programing to more diligently include patient experience, and it is now the most central aspect of all index research projects and programing for Black birthing people. Everything is centered on lived experience and patient perspective.

So, it's not listed here on the slide, but like I mentioned at the beginning, a lot of our work and measured development, we are working right now a patient-reported experience

measure in collaboration with Johns Hopkins to be included in hospital discharge surveys so that we are able to really take those lived experiences of Black birthing people and really, really hone that into say what are the particular things that are emerging from experiences of Black birthing people that have not been captured, and we're doing that in partnership with CBOs as a way to be able to continue to shift power back to communities so that communities have this data and that communities can continue to hold health systems and hospitals, health departments all accountable there. Next slide.

So, what are the things that we've learned? It doesn't sound shocking and revolutionary, but I think about eight years ago, it was, you know, it was a big deal. I think we all know now the analogy of, you know, treating the mom as the wrapper and the baby as the candy and tossing the mom out.

So, a lot of the early lessons that

we learned were that, you know, we could not focus solely on infant health and that the biggest leverage point we have for infant health equity was maternal health. We know that birth outcomes are determined by people's access to information, resources, quality of care, and equitable health care institutions.

And the Birth Equity Index, as our tool, has great implications for Black maternal and infant health outcomes. We know that by quantifying and comparing the structural and social determinants of Black maternal and infant health at the city level can help to better galvanize our leadership to improve structural conditions. We also know that the index can provide those actionable points that I mentioned earlier, and everyone wants to know where to start and where you can intervene based on empirical evidence.

Black people who are capable of pregnancy and birthing people, researchers,

policy-makers, urban planners, and other stakeholders can use the index as a guide for their research and decision-making, and we hope that the index continues to shift power to communities so that they are able to hold that and they can inform decisions about where they'd like to advocate in the community.

We also know that there is an opportunity for city-level collaborations from different organizations that have varying rankings inside of the index, right? There are other opportunities to translate proven strategies through city-to-city learning.

And lastly, identifying the associations and index can really help to direct more specific funding, awareness, and policy changes towards improving those health outcomes. We know that in addition to really looking at people's lived experiences, a lot of our work centers on reproductive justice. Reproductive justice is the right to bodily autonomy, the right

to have a child or not have a child, the right to parent the children that we have in safe and sustainable environments, and if we don't have that framing to apply to our work, we'll be continuously digging for the wrong indicators.

So, this index is also, you know, the undergirding really centers on reproductive justice in the way that we are looking at well-being and not solely on did mom survive, did baby survive. Are we looking more holistically at the whole person, which is what a lot of our researchers told us consistently is that people want to be viewed as whole individuals, not shocking, and the way that we approach this work is through using a lens of research, justice, and cultural humility, continuing to work in partnership and synergy with community, drawing on the lived experiences, feeding that data back to community, ensuring that communities are actually holding that data and that we're able to amplify those efforts.

I did a list here -- we've got a long list of community partners that have been supportive of our work employing the Birth Equity Index. I see some of them listed here today.

In terms of future opportunities or next steps, we are looking to update the index. There are lots of new indicators since 2017. There are lots of new ways to capture some of this data. We're looking at a pretty significant reworking where we have data that is not necessarily individualized, but we can look at things that were proxies for social and structural determinants of health and get more specific indicators for those.

So, that's really what we're working on. Everything that we do with our Birth Equity Index really drives a lot of our programming, like I mentioned, around policy, training, advocacy, and community power building.

So, that's the framework, and I'm happy to answer any questions at the end about

other ways that we're specifically using the tool. I'll go to the next slide, which I think might be the last one.

Thank you, and my E-mail address is listed there. I'll turn it back over to you.

BELINDA PETTIFORD: Thank you so very much. We appreciate all of the wonderful information each one of you have shared with us.

I think we probably have time maybe for just one question, only because we've got public comment, and we have to go to that at 2:10. So, does anyone on the committee or anyone else have a question that they would like to ask this panel? Are you overwhelmed with information? I don't want to cut anyone off.

I think the same question we asked the previous panel, we may follow up and send back to you all as well. There's so many moving parts in the maternal and infant health arena, and we're trying to figure out where there's alignment, where there are areas that you all have identified

from your partners or your members that should really be elevated at this point in time that we can try to move further into action. And so, if there is something around in that area that you all are interested in us working with you all on or are interested in sharing with us, we -- Sarah and I will follow up and Vanessa with an E-mail to give you all a chance to think a little bit about that, because I am sure our team is getting a little -- that is true, would it be possible to put the Birth Equity Index research publication in the chat. Thank you so much. That's a note that I wrote down as well, but I was just going to send you a separate e-mail. So, thanks for sharing with everybody. It is coming.

So, thank you all. So, please join me in thanking this panel. We appreciate everything you all have done today. Thank you all so much. You're welcome to hang out a little bit longer if you want to, but if not, we will be in touch.

And at this time, we're going to turn it over to Sarah, and Sarah is going to lead our public comment period. Thanks.

PUBLIC COMMENTS

SARAH MEYERHOLZ: Thanks, Belinda. I'm happy to be here today. Thanks to all our presenters. Like Belinda said, I will be handling the public comments. So, once you hear your name called, please raise your hand using the raise hand function at the bottom of your screen so that our contractors can unmute you. We will be starting with Jester Jersey. We see you, and you should be unmuted shortly.

JESTER JERSEY: Okay. I believe I'm unmuted now. Is that correct?

BELINDA PETTIFORD: We can hear you.

JESTER JERSEY: Okay, thank you. Thank you.

I want to start by stating that I

have no pharmaceutical affiliations nor conflicts to disclose.

Good afternoon ACIMM committee members. Thank you for allowing me to present. For the last two years, I volunteered as a trusted messenger advocating for collaborative efforts between government and community-based service organizations. Previously, I worked with Kiwanis and UNICEF on the Eliminate Project, a global campaign to vaccinate women of childbearing age against maternal and neonatal tetanus from 2010 to 2020. Shortly afterwards, the pandemic began. Today, I volunteer with Vaccinate Your Family and continue vaccine advocacy against vaccine-preventable diseases. Because of the work that I and others have done, we have saved many lives, but more needs to be done.

This past winter also saw the arrival of the triple-demic where COVID, the flu, and RSV occurred conjointly. Additionally, we saw the resurgence of polio and measles cases

demonstrating the importance of routine vaccinations and continuing to fund the Public Health Service Act, Section 317 Immunization Program. Not only did the COVID pandemic decrease vaccines rates, according to the CDC, it unfortunately also marked an increase in U.S. maternal casualties in 2021, particularly among minority populations.

As the nation slowly emerges from another difficult winter, there is hope that RSV vaccines may be available shortly. However, there is concern that like with recent vaccine rates for COVID boosters and the flu, vaccination rates were also lagging.

I want to suggest to the committee to work with community-based service organizations to help boost vaccine rates. From my work with Kiwanis, UNICEF, and Vaccinate Your Family, more investment in trusted messaging is needed to address current infant and maternal health needs.

Two years ago, U.S. Surgeon General

Vivek Murphy said trusted messengers are the key to boosting vaccine rates. Recently, the International Federation of Red Cross and Red Crescent Society Secretary General Jagan Chapagain again mentioned the importance of community-based organizations and response and preparedness. Not only are community-based organizations and volunteer members like me located in communities nationwide, but we've been involved in many national and global health efforts. We can instill trust through vaccine messaging, reach underserved communities, and leverage local foundations of trust.

For this reason, I recommend to the Advisory Committee on Infant and Maternal Mortality, the CDC, other health committees, and the Department of Health and Human Services, and even President Joe Biden to please reach out to community-based service organizations to collaborate on future vaccine campaign efforts. Together we can renew interest in immunizations,

help those who have missed routine vaccinations catch up, and help save American lives all of ages, especially mothers and young children.

Thank you for your time and consideration. Stay safe and have a nice day.

SARAH MEYERHOLZ: Thank you so much, Jester.

I will now turn it to the committee and Belinda, our chairperson, if there are any follow-up questions or comments.

BELINDA PETTIFORD: Thank you, Sarah, and thank you, Jester, for your comments.

Is there anyone on the committee that has a follow-up question or follow-up response for Jester? I think your request is pretty much -- or your comment is pretty much in line with some of the things we've been talking about today about the importance of community engagement, working with community organizations, meeting people where they are, elevating the work of individuals with lived experience. So, I think we are in line with

what you are requesting and appreciate your comments. But I do want to open it up in case there are any other committee members that have something they would like to share.

Yes, Marie.

MARIE RAMAS: Thank you. Thank you for the comment today. Absolutely, it's important for us in whatever messaging we work on to discuss the matter of vaccine equity and vaccine access. It is an issue that is unfortunately threatened in this current climate and culture. So, I very much appreciate the comments today, and we'll keep that in sound mind as we move forward.

BELINDA PETTIFORD: Thank you, Marie.

I don't see anyone else's hand up, Sarah.

So, again, Jester, thank you so very much for taking time to come and be with us and to share your comments.

SARAH MEYERHOLZ: Thanks, Belinda. I actually don't have any other comments to raise up

to the committee. But, just to remind folks, if you do want to provide a comment in the future, you will see in the Federal Register Notice when that goes out, the due date for public comment. So, please feel free to reach out to our E-mail address, which is sacim@hrsa.gov if you have any questions about that, and Belinda, I will turn it back to you.

BELINDA PETTIFORD: Thank you, Sarah.

So, now we're going to go into the next part of our agenda. Now we're ahead four minutes. So, you just never know how the day is going to go. I'm sure we'd rather be ahead than behind. So, now we're going to go into next steps and thinking about assignments.

NEXT STEPS AND ASSIGNMENTS

BELINDA PETTIFORD: A few things I wanted to touch base today on is, you know, in the past with our last committee, we actually had

workgroups that were in place, and many of you participated on some of those workgroups. You know, we had one around equity, we had one on data, one more focused on clinical services, and we've not made a decision as to whether we want to continue those groups or operate in a different format or even come up with new workgroups. So, we actually have that opportunity to do that. So, I would like your thoughts on that.

But as you're thinking about that, one of the things before we leave today that I think would be really helpful is if we could take some time, similar to what we did yesterday, and really think about are there a couple of areas that we want to move forward. In looking at my notes last night, a couple of areas that I saw was the area around maternal mental health or mental well-being in general. I think we brought up the issue around -- we did talk a little bit around -- as I'm looking at the wrong notes -- we talked a little bit around, I think, community engagement

as well as elevating the voices of individuals with lived experience.

But I would like today for us as a community to try to narrow it down to maybe two or three areas. You know, listening to our partners today, I think one of the areas that again came up with the community engagement, community involvement, listening to voices, and elevating the voices of individuals with lived experience. I think mental health came up again today as well.

I also think one of the other areas that I heard in several of the presentations was around workforce development and are we managing all of the workforce challenges, because all of us are dealing with more and more vacancies.

So, I didn't know if you all have things that you all want to share because I would like to have the opportunity to hear from everyone. And everyone doesn't have to speak at one time.

Thank you, Phyllis.

PHYLLIS SHARPS: Only because I've got to leave in a few minutes. But one of the things that I did hear, I think, across several presentations were people were beginning to catalog or show case or develop the evidence for best practices, and I know that was something I brought up last year -- yesterday. So, I do think it would be, I mean, there's a lot of really neat stuff going on as I listened to the different agencies. But I think either looking at some of the best practices, particularly around community engagement and how do we translate what we know from, you know, providers and research to community, because a big part of maternal and child health is in the community, over and above what we do in our institutions and clinics and that kind of thing.

BELINDA PETTIFORD: Thank you, Phyllis. Excellent point, and I think some of the data that was even shared yesterday, if not today, kind of reminded us where many of the outcomes

that we're seeing are not just in the clinic, it is what happens in our broader communities. So, thanks, Phyllis.

Kate, I see your hand.

KATE MENARD: Thanks, Belinda. Belinda, I thought, you know, this afternoon we heard, you know, kind of brilliantly brought forward kind of the alignment concept, you know, and brought up a number of very strong organizations to talk about what they're doing and help us think about how all of this can be aligned towards, you know, the common goals.

What I'm -- I'm actually reflecting on the integrated maternal health model, you know, that HRSA has recently released, you know, a funding opportunity for integrated maternal health models, and it references the pregnancy medical home, which Belinda and I are near and dear to the heart, you know, for Belinda and I with some experiences long ago when we designed that.

But the alignment piece -- my strong

bias is the alignment piece is, I mean, it's great if it includes all of these public health entities. But if it doesn't literally integrate with the clinical entities, then we miss a huge opportunity.

I think about the inclusive language that we use in these meetings. We always learn so much when I'm with the public health community, you know, with the perspectives and, you know, mandate really that we -- that we engage -- that we, you know, bring in the community voice and that sort of thing.

In the clinical arena, you know, that's rare to see people really talking about it and then doing that really well. Present company in exception, Steve, but you know -- you know, it's -- so -- but bringing, I mean, I would just love for us to think about ways we can actually make that -- that alignment include behavioral health, include social supports, include the clinical, and really kind of move it all together.

And that's not a real well-thought through suggestion for our focus, but I think it can -- it ties together many of the things that we've talked about today and yesterday.

BELINDA PETTIFORD: Thank you, Kate. I think I was following you well. So, thank you.

And I did find my notes from yesterday. I knew I had them here on this desk, and I know yesterday we talked about communication with patients and how we're doing that.

We also talked about do we need to spend a little time getting lessons learned, and it may tie back to what Phyllis was bringing up, getting lessons learned from communities, states, entities that have done a good job with this. You know, what have they done that really has helped their outcomes move to improvement and, you know, are we taking those lessons learned and how are we elevating them for others and moving them into other communities.

Yes, Charlene.

CHARLENE COLLIER: Thank you for mentioning that. I do think we spend a lot of time looking at the poor outcomes and maybe not enough looking at the positive outcomes, like, I think, Commonsense Childbirth or Mamatoto's Village. They share their numbers and how they have lowered, you know, poor birth outcome rates, and they say what works and then it's like okay, well, that's not scalable or we don't like listen enough to that or elevate that enough, and there's like joyful and positive birth experience, and I think in us bringing that up and like how that really centers joy and the positivity around outcomes because it isn't all from a detriment perspective. It isn't all about like what's lacking. But truly, there are people having, you know, good positive birth outcomes and sharing what those wins are, and I think that's an important opportunity to kind of frame from less of a, you know, fixing problems, from like elevating solutions and they are within Black

communities, they are within birthing communities that we are often looking at those poor outcomes in and we're not like looking at what's working or we don't give enough voice to that. So, I think some opportunity there.

The other part that comes to my mind is really like funding the future of some of these submissions. I think so much of this comes down to like money, and at the end of the day, like how do you get resources to people in a sustainable way. It's not a topic people are often comfortable with, but it's like yes, there are great grants, but they can't go to everybody. They can't go and get the whole country, so like when you're looking, you know, like best case scenario, once all these grants are implemented, where are the gaps located and what are the solutions for those places to scale because there are things like that have been mentioned over the past two days, midwifery care, WIC, things that we've known forever that have improved outcomes,

but are they really, you know, being distributed, and then how do we fund the expansion, and where do we, you know, who covers those costs? If it's not federal, then how does federal support, you know, academic or clinical sectors, private sector, like how do we get these solutions funded in a sustainable way? Thank you.

BELINDA PETTIFORD: Thank you, Charlene. Great points.

Marie, I see your hand.

MARIE RAMAS: Yes, thank you, Belinda. I think to that point, something that keeps coming back over and over again for me is the -- the need to center again Black and Brown experience within maternal and infant health, and what does that look like in the continuum of preventive care. I think we often silo the discussion in just the peripartum/prenatal period and then we forget the patients and the children that are born from those pregnancies after the fact.

And I focus on Black and Brown maternal and infant care because although the rates have decreased, the actual absolute numbers of deaths are still atrocious, and they are more than they were twenty years ago. So, even those percentage wise, we're doing better, our population is higher, and still -- the disparities are still very stark comparing even between racial groups.

So, I think a spin on the discussion of racial equity regarding this, what are practical applications of interventions and practices that can help improve birth outcomes and birth experience. So, I wonder if that could be potentially a thesis statement for us.

BELINDA PETTIFORD: Thank you, Marie. I was getting it down. So, great point.

I see several other hands. Steve, I see yours.

STEVE CALVIN: Sure, thank you. So, I agree with Kate, Charlene, and Marie as well

that the whole idea to the funding, I think it was a year and a half ago where I did a little presentation to the committee on how much money is spent in the maternity and newborn care world per year in the U.S., and it's like $140-plus billion and of that, Medicaid is probably $40 to $50 billion, I would think. So, it's not as if there isn't money in the system.

One of the things I would recommend as a committee is that we take a look at what are the -- what are the barriers to getting paid through the current system. I mean, we see it currently here in the Twin Cities and everywhere else. Midwife-led care sometimes has a hard time getting the support that it really deserves and needs, the same with doula services as well. So, that would be a focus that I would recommend that we just start looking at how the current system is paying, because it's in many cases, not paying adequately for the kinds of midwife, doula, and integrated into the medical system. I mean

obviously, as a maternal and fetal medicine physician, I know that physicians have to be involved. So, that would be my recommendation.

BELINDA PETTIFORD: Thank you, Steve.

Tara.

TARA SANDER LEE: Yesh, I just -- it's kind of a follow-up to what I said yesterday. I just -- I think we just need to -- I think there's definitely a need for improved standardization and when collecting and reporting maternal mortality data in all the states. So, I really think that there needs to be an effort to do that and to through the data, and I know that every state is doing their best, and I know you talked yesterday, Belinda, about like how each state has a different system and that, you know, they're trying to make it through those boxes of information as quickly as possible in those reports. But I just think that there is a clear lack of standardization and I think that there's some significant room for improvement there so

that we have the best picture of what's going on in this country.

BELINDA PETTIFORD: Thanks, Tara.

And Jacob.

JACOB WARREN: Hi everyone. Sorry I wasn't on a little earlier. You know how work goes, right?

I had a few thoughts as we think about the conversation. I wanted to just lift up what you're saying, Belinda, about maternal health and workforce. You know, it's my day-to-day with workforce as well, but I think it's something that we should look at in terms of the way that workforce issues across health care are destabilizing maternal health almost by proxy because, you know, in the work that we see in rural health care, maternal units are some of the first things to close at the hospitals. And so, I think that's part of how we stabilize the maternal health care system is talking about the broader health care workforce needs because it's just the

natural flow, right? We start cutting maternal care and then we start cutting emergency rooms. And so, I think that's something for us to continue the conversation on.

And then, you know, we commented a bit on it yesterday and just reflecting more on this kind of -- there's a bit of two Americas in expansion and non-expansion states, and not that Medicaid is everything, but as we look at and we talk about best practices and things that can be rolled out, how we're doing that within that context that there are things that will work very well in certain states that will not work in others and then we look at our non-expansion states, they're in the south where these disparities are the most pressing. So, how we make sure that we identify best practices that fit within each state's reality of implementation I think is another piece for us to think through.

BELINDA PETTIFORD: We were losing you a little bit right there at the end, Jacob.

For some reason, your voice went down. But I think I got it with, you know, the last part you were talking about the two Americas, the states that have expanded Medicaid and those that have not and how it impacts overall maternal and infant health, if I was hearing you correctly.

JACOB WARREN: Yes, and then if we think about best practices, how we make sure we're looking in both settings so we can put forward best practices that people can implement in their states?

BELINDA PETTIFORD: Thank you. And I don't want to jinx us here in North Carolina, but we're closer to expansion than we've ever been. So, send positive thoughts to North Carolina, everybody.

I don't want to cut anyone off. Anyone else have anything they want to share? Because all of these are really good ideas. We're going to have to try to figure out how to narrow them down or at least, you know, figure out do we

put them under different little buckets or pockets so that we can include as many as possible but also making sure we're including it from a standpoint that there's some action that can occur.

You know, I think that, you know, what Charlene is saying and several of you all have said about the funding, I am always amazed when I get a grant application and there's that section on sustainability and every time I want to just write if you remove $2 million, this is not sustainable. But you always have to come up with a sustainability plan and there's always a few points that you get with sustainability, but in reality, for most of us, it is not realistic, and I think our communities will say that exact same thing.

Yeah, Lee, I didn't mean to overlook you. I see your hand.

LEE WILSON: No, that's okay, thanks. I'm not going to make a suggestion about topics

for you to be considering or discussing because that's not really my place. What I do want, given my role in working within the Bureau and with this committee, is just to encourage you as you're sifting through your priorities and sort of deciding on where you want to focus your attention because we all have limited attention and resources to be able to devote to these efforts, if you could focus on those things that are recommendations that you feel you would like for the secretary and the agencies within the department to be hearing. As the Advisory Committee on Infant and Maternal Mortality to the Secretary, the work that you are charged with is to be an advisor to whomever is the Secretary, and as you're collecting this information and filtering it, part of that filtering process is what is it that he should be hearing from a diverse and representative and informed community such as yourselves.

So, in setting your priorities, I

would encourage you to be thinking that way. That's all.

BELINDA PETTIFORD: Thank you, Lee. We appreciate the reminder, as always. So, thank you.

We're going to get in our lane, but we are definitely going to make sure our priorities are areas that we feel like the Secretary can have an impact because ultimately --

LEE WILSON: You have a choice on what lanes you want. Just make sure you know it's your lane you want.

BELINDA PETTIFORD: Thank you. We appreciate that.

And I don't want to cut anyone off, and we still have a little bit more time.

Yes, Steve.

STEVE CALVIN: So, I did catch part of Alison Cernich's presentation yesterday and another thought that came up, I think, in the last year as well about the whole area of stillbirth

because it is somewhere between 20 and 25,000, and that's if you define it as 28 weeks and beyond, but there's, you know, even earlier. That is an area that we probably with a future meeting could have a presentation. The Welcome Trust is doing a really great international study. They're actually spending $50 million on stillbirth around the world. It's about 2 million stillbirths, most of them in Africa. And anyway, there's just, you know, all of the different causes for stillbirth. Some of them are maternal, some are fetal, I mean, the placenta is kind of the common denominator and I think that would be of interest to us because it has such an impact. The loss of children from stillbirth is actually four times the loss of children from pediatric cancer. So, I mean, it impacts families in, I mean, in ways that, you know, I think all of us have had some connection, whether as clinicians or family members. So, I would just recommend that we at least have a presentation because it -- it ties in with what

our remit is as a committee.

BELINDA PETTIFORD: Thank you, Steve. We'll put it down on the list for future presentations. And if there's another future presentation that you all are interested in, if you want to share that now, that will work also.

Yes, Charlene.

CHARLENE COLLIER: Yeah, I wanted to agree with Steve. I've been wanting to mention stillbirth the last couple of days, also knowing internally and in certain locations in the U.S., just there are bundles around reducing stillbirth, focusing on tobacco cessation, Kick Counts, the Management of Growth Restriction, the Count the Kicks Initiative that's been launched in several locations has seen improvements without other explanations of what was going on besides their campaign, and there are, you know, like I said, efforts that could be packaged and done nationally that have been done in other countries pretty successfully, knowing we're also thinking about

preterm births, but the growth restriction parameters, I know they've changed even since when I was a resident that now only isolated abdominal circumference is enough to call a baby growth restricted. We see a lot more being born a little close to late preterm, but like empowering. So, that may balance both, like you're reducing stillbirths, but you may be increasing some preterm deliveries based on increased monitoring.

So, I think we have to balance when we have initiatives to reduce stillbirth that we don't see, you know, those shifts in the data, not really accounting and understanding how they balance together because we want live babies, and that is more important and, you know, I will take a happy kicking 36-weeker if we are identified by, you know, reduced fetal movement or growth restrictions. So, I think there's some space there where we're not confusing, you know, wins in a certain area for losses in another. But I definitely agree that there is an opportunity

there for structured, you know, effort around stillbirth that we haven't really seen before.

BELINDA PETTIFORD: Thank you.

Anyone else? So then we want for future presentations around stillbirths, we know we want something potentially around lessons learned on what is working in the field, about a couple of other areas that we maybe can get people to come in and share some presentations.

TARA SANDER LEE: Just one thought. I've heard some presentations recently about like traditions that are in the NICU, and I'd love to get physician feedback on this, especially for pregnant women that are dealing with drug abuse and that, you know, once they have the baby that instead of separating mom from baby, that they're finding that some of the best care is, you know, is to actually have that mom hold her baby, you know, in the NICU and this is where, you know, my expertise goes out the window. But, you know, instead of separating mom from baby and then

treating baby, because they -- they actually give them actually like opioids, right, low doses, right, so like if there -- if there has been exposure in utero. So I just -- I don't know if there's some research that we want to look into just best practices because I know that -- I just saw a lot of -- saw talks today referenced opioid addiction and dealing with that. So I just wonder if people have some thoughts.

BELINDA PETTIFORD: Alison dropped in the chat there will be a major publication on this coming soon from NIH, Eat, Sleep, Console Protocol, and Alternatives to Other Opioid Treatments.

TARA SANDER LEE: Great. That's awesome. I'd love to -- that would be -- I think that would be really great to hear more about that data.

BELINDA PETTIFORD: Yeah. Alison, if you could keep us in the information loop on that when it comes out so that we can get a

presentation, that would be great.

ALISON CERNICH: We can invite the investigator out. I'll check in with Lee. But it should -- our hope is it's coming out relatively soon.

TARA SANDER LEE: Awesome. Thank you, Alison.

KATE MENARD: Belinda, to the previous point about implementation, you know this Eat, Sleep, Console is not -- is not new, but I just have no idea how broadly it's been adopted, you know, and what -- what are the levers, you know, once you've identified practices like that that are, you know, what are the levers to really disseminate those things to scale, you know. I really have no idea how broadly those concepts are implemented.

BELINDA PETTIFORD: I think that's in a couple of our areas that we mentioned is there's a couple of things we're thinking of working in certain areas, but how do you scale it and how do

you resource it, and how do you move it around to other communities.

I also see where Sherri wants a presentation on social determinants of health data. So, we'll have to figure out who the best folks are that can do that. I have it on the list, Sherri.

Jacob, I see your hand.

JACOB WARREN: Sorry. I sort of wanted to echo was Sherri was saying because I think it's, you know, and I fall victim to this when anyone probably -- we tell it very clinically, right, and still much of the bigger picture here is social determinants, and I know we're trying to narrow our list, but I think that's something that I don't know if the committee has tackled before. You know, please let me know if so. But a set of recommendations that's specifically focused on how we can address the broader social determinants of health, I think, could be something for us to consider

looking at because it's looking at it from a very different angle from the way that sometimes things happen, and we all know the much broader role that plays in overall health-heavy specific outcomes. So, how are we maybe getting something very specific on social determinants that we can then, you know --

BELINDA PETTIFORD: Thank you, Jacob. You know, I think it also connects back to what Marie was, you know, encouraging us to do around centering the Black/Brown experience and just trying to connect all of the pieces. I think we tend to go to our comfort zone and go to clinical care, making sure people get into early prenatal care.

We have an opportunity as a community to go outside of that. We can do that. You know, we can go and look at, I think, at our last committee, we had someone come and talk to us about housing, and I think even our conversation around housing was so you're telling us what's

happening at HUD, so how does this translate in our communities and who do we talk to in our communities about these issues.

And so, I think it's a couple of those types of areas that we can definitely elevate social determinants of health, realizing that we need a good mixture for our work.

We've got a nice list to work with. There's activity on addressing social determinants of health in some states with a Medicaid waiver. Our state in North Carolina is one of them with our Healthy Opportunities work. So, you're correct, Sherri, North Carolina is on that list, and we're working through that where Medicaid now can pay for transportation, there's some food insecurities, connection to housing and employment, and some of those areas. So, I do think there are some opportunities for us to hear more about those and think through are there specific recommendations that we want to make to the Secretary.

Now that we have this pretty comprehensive list, it will be helpful if there are one or two of you all or all of you all that want to be engaged in a smaller conversation around how do we narrow this down and how do we have it ready for, you know, presentation for our next meeting. You know, Sarah, Vanessa, and I can talk about it, but it's always nice to have some input from the rest of the committee. We can start with a draft and then share it with the rest of the committee for you all to give feedback. But if there's anyone or multiple ones of you that are interested in being part of a smaller conversation around this so that we can move this forward and have something more to share for our June meeting, that would be helpful.

You don't have to volunteer today unless you just want to. You can drop it in the chat, you can send an e-mail, you can send me a text. As I say, you don't have to avoid the eye contact now, you just don't have to do it, it's

volunteer.

Another thing that we wanted to touch base on, and I'm going to turn this over to you, Sarah, to talk a little bit about the June meeting.

SARAH MEYERHOLZ: Yes. Thanks, Belinda.

So, you may have seen, I think Vanessa sent out a note, it was either late last year or early this year, I can't remember. I can't believe it's almost already April. But we are planning our June meeting here at headquarters in Rockville, Maryland. So, you should be hearing from Michelle soon or maybe you already have heard from her about preparing to travel here. So, very exciting to see you all in person. If you do have questions, feel free to reach out to Vanessa or myself directly, and I think the dates for those are the 13th and 14th of June. So, if you haven't -- we'll send a message soon just to make sure we get that on your calendars. But if you have

questions, just let us know.

Anything else about that or any questions initially about the upcoming June meeting?

BELINDA PETTIFORD: I see Joy's hand.

JOY NEYHART: I'm just wondering if those dates are firm for June.

SARAH MEYERHOLZ: I believe they are, Joy, but we will be in touch because I know we internally were talking about your situation of traveling here.

JOY NEYHART: Thank you.

BELINDA PETTIFORD: Joy, what is your time difference from the rest of us?

JOY NEYHART: Alaska is four hours behind, sorry, Eastern Time.

BELINDA PETTIFORD: Okay, thank you. We will try to do better with our virtual meetings so that you don't have to be up at 4 a.m. or something.

JOY NEYHART: Oh, it's okay. I start

my workday around seven anyway. So, this is actually perfect timing. Yeah, thanks.

BELINDA PETTIFORD: Wonderful. I always feel bad when I think is she still in bed, because I would try to still be in the bed at that time. Thank you.

I don't want to cut anyone off. I do think this has been a great conversation and good discussion always. And I appreciate all of the work that each and every one of you do in your communities but also the expertise and the feedback that you bring to this committee.

Yes, Sherri.

SHERRI ALDERMAN: And I just real quick wanted to ask if it's possible to get the agenda out as soon as is practical. I live on the West Coast, and I'm in a position of making a decision whether or not I can travel home at the end of the second day or if I need to wait until the next day to travel. And so, that would be helpful for me to know what the agenda is, not the

items, but the time that we would end on the second day. Thank you.

BELINDA PETTIFORD: No, that's a great point, and Sarah, Vanessa, and I and anyone else, we will work on that to try to get some dates and sometimes out as early in April as possible so that people can start thinking about their travel arrangements and things of that nature. So, we will definitely do that. So, great feedback, Sherri.

I know we still have thirteen minutes. Does anyone have any closing words they want to share?

MEETING EVALUATION AND CLOSING OBSERVATIONS

BELINDA PETTIFORD: I see there are tons of funding opportunities still going in the chat, the Perinatal Quality Collaboratives are implementing clinical community linkages. Thank you, Charlan. And Emma, again, you said you sent

it last night. You don't have to say something unless you just have a burning thought that you need to get off your chest before you leave today.

SARAH MEYERHOLZ: Belinda, I do have two closing reminders for folks, if that's okay.

So, just two quick comments to the committee members. You may have seen an e-mail from someone from the public who wants to provide a comment. So, just to let you know, we have spoken to him, and he will be having the opportunity to speak to you in June. So, feel free to take a look at what he shared, and then we'll provide that to you in the briefing book as we prepare for June.

And then just my last other quick reminder, please continue to share feedback and input on the charter and bylaws by April 20th to Belinda, but Vanessa and I are also available if you want to talk through anything. Thanks, Belinda.

BELINDA PETTIFORD: Thank you. And

again, I appreciate those of you have already sent some feedback, because I got several last night. So, I'll just hold onto all of them and send them over to you all, Sarah, after that time period.

KATE MENARD: Belinda, may I make one comment?

BELINDA PETTIFORD: Sure.

KATE MENARD: Sarah and everyone else who did all the organizing, Belinda and everybody, thank you.

Sarah, in terms of like I'm used to now having, you know, been through a couple of meetings now and getting a very complete minutes of this meeting, but right before the next meeting. But there's so much -- there was so much rich information here, that while it's fresh in my mind, I'd love to be able to go back and review some of those links that are in the chat and some of the articles that people reference and that kind of thing. If there was -- if there's an opportunity to just give a short summary of those

things, I'd be appreciative. I'm not sure if others would find that helpful, but I would.

BELINDA PETTIFORD: We've talked about it a little bit, Kate. Is there a way we can kind of narrow down the briefing book but also get the minutes out as soon as possible while they're still fresh in people's minds. We're hoping to be able to follow the partners that presented today to get their presentations sent back out sooner versus later because we know during that time period, other parties come up. So, we're going to do our best, you know, working with everybody's competing priorities to try to share the information out as soon as possible after this meeting. If there's something very specific that you want, again, I think we can get the presentations the quickest because they're basically just we're asking the presenters -- I think we've got most of their presentations. I think we had one or two that didn't have a slide deck. But since then, they have -- we've been

chatting and they're going to send us slide decks. So, we'll have that information in writing as well.

KATE MENARD: Yeah. Even if it's as simple as the chat notes, you know, the links in the chat, that would be super. But thank you, Belinda. I appreciate that.

BELINDA PETTIFORD: No problem. Very good point, thank you.

And thank you, Sarah. She's willing and happy to hear any quality improvement that we can do in this process. We're all about QI.

Joy, is your hand back up? Did I overlook you?

JOY NEYHART: No.

BELINDA PETTIFORD: Okay, thank you.

Well, as I say, I do appreciate everything that you all have done. I appreciate all of your time and your energy. The staff here are wonderful. It was wonderful working with Sarah and Vanessa. So, I pass it on to you and to

Lee, and I know Michael had to leave early. Thanks to all of the work that LRG has done to make sure we have an amazing meeting. And all of the parts worked smoothly, and no one could tell if something wasn't working totally correct behind the scenes because we had an awesome team working through that.

I leave with you all one of my favorite quotes from Maya Angelo and that is, if you're always trying to be normal, you never know how amazing you really can be. So, I'll leave that with each of you. I look forward to our next time of gathering. And if you need me in the meantime, you know how to find me. I'll be here in North Carolina with positive hopes for Medicaid expansion. So, take care, everyone, and talk to you soon. Bye bye.

(WHEREUPON, THE MEETING WAS CONCLUDED AT 3:00 P.M. E.T.)