**Jeanette McCulloch: 00:00**
Good afternoon everybody. I'm just going to give folks a moment to get from the waiting room into our room today, and as soon as we see everybody rolling in, we'll go ahead. We've got a very packed agenda, so so we'll go ahead and get started. So welcome to let's Think Big Launching the Blueprint for Community Birth. I am Jeanette McCulloch. I'm the principal of Birth Swell. And I'm thrilled that you're here for this important conversation. Before we dive in, I want to cover a few housekeeping items just to help us all make the most of our time here together. If you would like to enable live captions, you'll see on the bottom of your screen likely under three dots where you can click on turn on live captions. This will be at the bottom of your Zoom window and this will display real time transcription in English throughout our session. We have disabled the chat feature today so that we can stay focused on our panel discussion, but there's plenty of other ways to stay engaged with a Think Big initiative both in this webinar and beyond, so we'll share those opportunities as we go. We absolutely do want to be hearing from you today, so and we definitely want to be hearing your questions. So please do use the Q and A feature. You'll find that bottom button at the bottom of your screen. What we'll do is as we can Our guests today will be keying in answers and sharing them as we go, but we're also hoping to collect some questions throughout the session and we'll address as many as we can during a dedicated Q and A time near the end of our session today. Do note that today's session is being recorded and that recording will be shared with all registered attendees and it may be posted on our Once that's Live. So keep that in mind as you participate and we will of course let you know when that website launches. If you experience any technical difficulties during today's call, please feel free to just use the Q and A, enter the word TECH in all caps, and our support team will assist you in a little bit. We will be joined by Dr. Melissa Cheney, who's going to be our moderator for today's panel discussion and she'll introduce herself shortly. I'll be behind the scenes helping every keep hitting all the buttons and helping everything run smoothly, but I will be back later to help facilitate the Q and A session. And now I'm honored to introduce someone whose vision and support have made this entire initiative possible, and that is Tanya Khmet Taiwo from the Skyline Foundation. Tanya, thank you so much for being here and for Skyline's incredible partnership in this work and I will hand this over to you. Thank you, Tanya.

**Tanya Khmet Taiwo: 03:28**
Thank you, Jeanette, for your care care of us during this time that we have together. I do want to thank you all for coming. So. Welcome to the launch of Think the blueprint for community birth. If you want to be in the think small initiative, you're in the wrong place in a time when the world feels so scary and hateful. Thank you for resisting the urge to contract. We are here today to publicly and intentionally and joyfully launch a collaborative two year process to envision and design the national infrastructure upgrades needed to expand universal access to community based midwifery care in our country. This work has been funded by Skyline Foundation's birth justice portfolio. The foundation portfolio seeks to improve the birth experience in the United States by working towards the full integration of midwifery into our healthcare system. Our approach aims to address systemic failures to to provide equitable, accessible, respectful, safe and affordable care to all families. We see this initiative, the think big initiative, as integral to our foundation goals of expanding access to the midwifery model of care, promoting the scale and spread of birth centers to increase choice and access and increasing the size and diversity of of

the midwifery workforce to improve outcomes in communities most affected by birth disparities. Thank you. You're in for a treat. But before I go and turn things over to our moderator, Missy Cheney, I leave you with a quote from afro futurist Octavia Butler. We're all capable of climbing so much higher than we usually permit ourselves to to suppose. Thank you and welcome.

**Melissa Cheyney: 05:37**

Thank you so much, Tanya. It is such a pleasure to be here after a year of working together to try to put words to our vision. It's an exciting moment to try and explain that to you and I think for today, for the purpose of today. And let me just say that Jeanette, I can't see the slides, so we'll have to. Let me fix that. Yep, now I can. Thank you. Okay, so for us, for today, this is where the story starts. The U. S. Maternal health care system is failing families. In 2018, the United States Congress commissioned the national academies of science, engineering and medicine so the highest scientific body in the land, funded by the national institutes of Health, to come together to try to answer two urgent questions. The first one was how can evidence informed maternity care system how can an evidence informed maternity care system be designed that allows multiple, safe and supportive options for all childbearing families? And how can birth outcomes be improved across and within all birth settings? 14 experts from different disciplines, neonatologists, midwives, social scientists, were brought together for one year. And against all odds, with lots of debate, discussion, conversation, we developed this consensus statement that names specifically culturally aligned midwifery in all settings as the answer to our national maternity career crisis. This document, this graph that you see here was part of the graphic that really instituted the fear and the concern. What we can see here is that across the rest of the world over the last several decades, maternal mortality has declined by as much as 45%. But in the United States alone, we've seen a rise by 136% in maternal mortality, meaning it's more dangerous to give birth today than it was in our grandparents generation. In recognition that we're going in the wrong direction, Congress instituted this report and we reported back to them. 12 conclusions on February 6, 2020 about what we thought needed to happen in this country. February 6, 2020, was the same day that Trump's first impeachment trial ended in an acquittal and COVID 19 came onto the scene and became our nation's priority. We'll go to the next slide. There's a deep recognition in the work that we were all doing together that this burden of preventable maternal and infant death and suffering is not shared equally across the United States. States, black, rural and indigenous families bear the heaviest burden. And since 2020, the situation has not improved. Recent headlines show us the current reality. Medicaid cuts could shut down rural hospitals and maternity care. Pregnant people, pregnant women have less and less access to maternity care, including midwifery care. And rural health advocates warn that somewhere between 1 and 1.5 and 3 cut of out of three counties will lack obstetric care in the immediate future. We're facing a perfect storm of provider shortages, hospital closures and poly decisions that are worsening access. And all of these are undergirded by a system premised on inequality and systemic racism. Next slide. This means that the findings from the National Academy's report are more important than ever. After extensive research that included community testimony, where we had the opportunity to hear from dozens of groups around the country that are on the ground doing this work. We also were asked to analyze all of the current data in the United States, looking at outcomes and interestingly also to do a comparison to peer nations where we're asked to look at other countries who have similar

demographics, similar income level. How are they getting outcomes that are so much better than ours. And after extensive research, Nasim came to the conclusion that women and families should have access to the birth setting of their choice and to high quality, respectful maternity care in all settings. Now, this isn't just about where people give birth. This is about prenatal care and postpartum care as well. And we know that about two thirds of preventable deaths to the mother occur in the postpartum period. So this is a little bit about changing the conversation. It's not just about saying, how do we get more home births, how do we get more birth, birth center births? It's about asking how we increase access to high quality, culturally reverent care across the entire childbearing year, regardless of where that person chooses to give birth. The reality is most people may not choose to give birth outside of the hospital, but they can still receive access to community based care. Next slide. So Nasam recommended an expansion of midwifery. The report could not be clearer. Midwifery care should be expanded and better integrated. The recommendations emphasize full integration, not isolated midwifery practice. So as we look across all settings, home, birth center and hospital, we ask the question, how do we make these more accessible to people, importantly for our group? And this is one of the areas of our time together that was perhaps the spiciest, that was deciding who counts as a provider, who counts as an appropriate midwife. And we came to the conclusion that any midwife that meets the ICM definition should be part of the solution, which includes all three credentials in the United States. So we'll move to the next slide. I just wanted to highlight some of the key conclusions that came out of this report. Community based midwives achieve lower intervention rates, fewer cesarean births, episiotomies and inductions, while also being associated with higher levels of satisfaction and experience, experiences of respectful care. Interestingly, as we looked across hundreds and hundreds of studies, no matter what country, every study had the same conclusion. There's a clear benefit to the birthing person for being outside of the hospital, at home, or in a birth center. Midwives provide very high levels of satisfaction and more continuous, individualized and holistic care. And the committee came to the conclusion that community based midwifery is uniquely positioned to address racial, geographic and economic disparities within a well integrated system. Community based midwifery is safe and it's cost effective, especially where systems are integrated and the evidence shows consistent outcomes for mothers and for their children. After the report was published, a group of us came together to envision what our country could look like if there were the resources and the political will to implement the 12 conclusions we put before Congress. I should say that during the time that we're on the National Academies, we're constantly reminded not to editorialize, not to give our opinion, but to stick to the evidence. As soon as the report was out, we decided it was time to editorialize the next slide. You'll see the vision that approximately half of us came up with. So once the committee had completed their work and the consensus report was published, we came together to allow ourselves to imagine what it might look like if we could implement everything in that report. So what you see here is a. It's an amalgam or mixture of modeling from rural states in the United States, and this is the current state. So in many states in the United States, what you have are regions where there are plenty of hospitals and plenty of providers. And those areas are modeled with green here. And you can see the H's stand for hospitals. As you move further out from those green regions, people who are pregnant and looking for care are forced to drive longer and longer distances, sometimes two and even three hours, to receive a 15 minute prenatal visit that they may leave feeling fearful, shamed, blamed,

and uncared for. On the next slide, we asked what would happen if we had the resources to add birth centers, clinics, safe spaces, federally qualified health centers out into the community so that people could at least come to these spaces to establish care to receive prenatal care. And even if they chose to go to the hospital for their birth, they could return to their own community and receive care in the postpartum period by setting some parameters and saying, we want these centers to be 30 to 45 minutes from a hospital. We want to put them in places that have the highest density of population, that are reproductive age. We can model where we might put some of these. And what this does is it improves access to care by about 40%. But you can see there are still many areas that are red and orange. So if we go to the next slide, this is what happens. If we operationalize community based midwives to be out in community providing prenatal and postpartum care. So bringing care to people rather than wrapping care around a facility, especially facilities that are closing right and left, we bring community, birth, community care to people and then they can make the decision where they want to triage to for their birth. What this enables us to do is to provide high quality, culturally reverent care across the entire spectrum. What we envisioned here as well is that when you're placing community midwives out in those areas that need service. We can know a little bit about those communities and we can make sure that the midwifery care, the doula care, the peer supports, the community health workers, the traditional health workers who are on the ground welcoming people into their pregnancy, are culturally aligned. And we even say culturally reverent. And culturally reverent means that we're not only tolerant of difference, but that we recognize that a person's culture, their heritage, their language, their community is an invaluable asset in helping to ensure a healthy pregnancy. So I want to elevate and be reverent around that cultural care, not just aligning it, but revering it. If we go to the next slide, this leads us to our vision. Our vision is universal access in the United States to high quality, culturally reverent, community based perinatal care. This means that when a person finds out they're pregnant, everything they need, not just to survive, but to thrive, is right there in their own community. We're not waiting for government action. We want to build or begin to build the infrastructure. Now, if we go to the next slide, I'll tell you that the way we started was by convening an advisory group of 25 individuals. It was a coalition of the willing. We put out a broad invitation and many people showed up with a commitment to this work. And what we did is we decided, we discussed and tried to identify the the five working areas or the number of areas in the United States that we really would have to focus on reforming and or growing in order to be able to meet that need. And these are the five initial domains. We call them our working areas or our working domains that we know we need to work on to be able to make this vision a reality. So we identified quality improvement, data collection and research, policy reform, workforce development and systems integration. And we model them here as all interlinking because we know that all of these things need to grow simultaneously to be able to meet that need. We also want to recognize that work in all of these domains are already happening. As NACPM and Uplift Lab and other members of this group are traveling around and participating in initiatives all over the country, we see that this work is already happening on the ground in small and in sometimes larger ways. And on the next slide. What this shows is that our initiative is focused on what we say is working harder, not smarter. I mean, working smarter, not harder. What we want to do is create a convening or a container for this work where we bring together delegates and we're Thinking three to four in each. Each group to meet in Portland, Oregon, in October 2026 to create a draft blueprint that

would make this vision explicit in words and an image. I feel like I want to say, too, and I hope this is a message that comes across very clearly today. We're not asking anyone to stop the work that they're already doing. Quite the opposite. We think it will take all of us and then some to implement this work. What we hope will happen, though, is that when we come together, we'll be able to develop a blueprint of what we need in terms of money, people, expertise, and political will to grow each of those five domains sufficiently to support this vision. So we've gotten to the point where we've identified our facilitators. We could not be more excited about the facilitators. What an embarrassment of riches. We had over 50 applicants, and we were able to identify who we think are the perfect people to guide us through this process. And today is really all about inviting everyone, everyone who has a shared or an adjacent vision to collaborate as you feel led. So our next step now is we're going to dig into each one of these domains and hear a little bit about why the domain matters, what are some current opportunities, and what are some challenges. And we're going to conclude today with an open invitation and some pathways for. For you to get involved. Okay, so we are going to move on to discuss quality improvement. So I'd like to introduce to you today Silke Akerson. She's the executive director of the Oregon Perinatal Collaborative and practiced as a home birth midwife for 23 years before moving into public health work. She leads the Community Birth Transfer Partnership, a statewide transfer improvement initiative here in Oregon, and is a consultant in quality improvement for maternal and infant health. So I'll turn it over to you, Silke.

**Silke Akerson: 20:39**
Thanks, Missy. Jeanette, can I do a sound check? Can you hear me?

**Jeanette McCulloch: 20:45**
You sound great. Go ahead.

**Silke Akerson: 20:48**
Okay, thank you. It's wonderful to be here. And I was really appreciating that last slide, which was showing all of these different domains overlapping and working together, because I'm here to talk about quality improvement, but there is no quality improvement without data, without workforce development, without policy change, and without systems integration. And also, all of those domains need quality improvement to feedback into them, to make them as effective as possible. Next slide. So I think quality improvement is centrally important to really making midwifery accessible to everyone in our country, because it's needed to deliver on the promise of community midwifery. We know that community midwifery can have these incredible outcomes for moms, birthing people and babies, and, and we know that it can be respectful care that really helps people have the optimal experience they can have in this big life transition. But that's not consistent in our communities. We see really high quality care. We see care where we have significant safety concerns and everything in between. And if we're going to scale up and have this kind of care accessible to more and more people, we need to be sure that the care being offered is high quality, safe, respectful care. And that's where quality improvement comes in. Quality improvement is this movement that's been happening not just in healthcare, but I'm going to talk about it in healthcare for a significant amount of time now, some decades, that really looks at problems from a systems level, looks at where are we having poor outcomes,

where are we having clients experience, have poor experiences with care, where are we having concerns? And then looking at the whole system and thinking, how can this system work better? How can these providers, how can these parents, how can these other people working in the system be supported to provide optimal care? And there have started to be some inroads in working in quality improvement in community midwifery, but they're few and far between so far. And mostly people practicing in home birth or birth center practice are kind of on their own in assessing their practices, improving their practices, seeking out continuing education, and all of these other pathways that can help improve quality of care. So community midwives have a lot to learn about quality improvement. And then also our model has so much to offer in terms of helping improve the larger healthcare systems that we're a part of. I have worked on quality improvement mostly at the state level in Oregon, first in the community midwife realm, and then now in the larger realm in our state perinatal quality collaborative. And there are so many places that we can engage that really can offer support to practicing midwives and the families that they serve. And some of the areas that I think are the most important for us to work on are transfer improvement. This is an area where there can be some really significant clinical misses as someone's transitioning from one care team to another. And also it's a time that's pretty fraught, emotionally, socially, interpersonally. There are also some really big opportunities for quality improvement around data collection so that we can actually see the outcomes of the care that we're giving. It's really hard to know about our care if we can't see the whole picture and know what our actual Outcomes are. There are some incredible models around quality improvement related to targeted continuing education for areas that we have recurrent concerns. Also, really important work that can be done around improving peer review and, and sentinel event review so that the learning doesn't just benefit the people who experience that case, but also feeds back to the larger midwifery community and helps us identify where we have problems in our systems and where we can make sure that learning from individual cases, especially rare occurrences, reaches everyone in the community to prevent future concerns. Next slide. So I think that this coordinated quality improvement in community midwifery could really transform our care. And that is something that would take some kinds of systems or structures that in most states we don't currently have. It would take, you know, statewide or national quality improvement organizations or patient safety organizations, or some kind of body that's holding a set of practices and then supporting midwives in learning how to do quality improvement at their practice level, at their community level. I've really seen that quality improvement can increase sustainability and lower risks for midwives. As workers and as human beings, we know that sustainability is a real issue in our profession. There are many, many people who train to become midwives who don't continue practicing for a very long period of time because of how high stress and high commitment this work is. And quality improvement can be one of these approaches to make sure that we don't have additional risk beyond what is really true to the reality of birth and that we create systems that actually support the people working in them. There are some really great models that are ready to go in Oregon and Washington and in the Step Up Together program and probably some other places as well that I'm not thinking of at the moment that are really ready to implement. So there are kind of a package of tools that are ready to go and ready to use. And then one of the other kind of huge opportunities around quality improvement that I've seen firsthand in Oregon is that when we engage in quality improvement in a system wide way, either through perinatal quality collaboratives or PQCs

which exist in every state through our professional organizations or with state departments of health, we start to be seen more and more by other partners in the system as part of the whole. And that helps us move towards systems integration and can also help us move towards real, tangible policy change, we start to show up to our partners across the whole maternal health system and they start to understand where we are part of solutions, what expertise we have to offer and how we could contribute to larger problems, to solutions for larger problems. That affect everyone. Next slide. We do have some challenges in the quality improvement arena. One is that there's fairly minimal skill or experience with quality improvement in the midwifery workforce, and we would need some funding and support to rapidly scale up skill in quality improvement across our workforce. There's some partners, I think, who are really ready to do that work, and I think if we can structure it in some innovative ways, it could be pretty engaging, energizing, and gratifying for people as they get involved. Another challenge that we have is that historically it's been easy for us to identify problems in obstetrics and hospital care, but it's sometimes hard for us to look at our own problems. And that sometimes means we have resistance for working on real problems that we do have around informed choice. In some communities, cumulative risk and neonatal mortality and the hospital, you know, home birth and birth center to hospital transfers are just such an essential part of quality improvement, but they require willing partners in hospitals. And we definitely still have some parts of our country and some communities where there's resistance to collaborative work with community midwives. So that's all I wanted to share. I think, hopefully I stayed in my time and I'm really excited to see how all of these pieces weave together.

**Melissa Cheyney: 30:36**
Thank you so much, Silke. We really appreciate it. And we're ready to move on to the next. We're going to now hear from Tanya, who you've already been introduced to, to say a little bit about the second domain, which is research.

**Tanya Khmet Taiwo: 30:48**
All right, thank you. Next slide, please. So this is, I. This is such a critical domain and, and it's, and it's so important that, that it, that it be led by this, this, this initiative. You know, midwifery and birth justice focused research asks very different questions than the physician led system. It's not solely about what interventions or technology will keep babies and their parents alive, but what do we actually need for optimum outcomes, optimal wellness throughout the life course. We have a very fractured data system in this country that actually reflects our fractured health care system. We know too that there are so many midwives who have held this so dear and work so hard. Both the midwifery researchers as well as the individual midwives who know how critical it is to have the evidence basis for practice, but also to, to leverage, to leverage our profession within the field and leverage our integration into the field. Next slide, please. And there are opportunities, right? There are data collection tools that are specifically designed to collect data about midwifery care in community settings and that in and of itself is something that we should be celebrating. EHRs and electronic health records and birth certificates do provide some opportunity. It's not perfect and they do give us some information about the provider type within hospitals, but less so for community birth. We have, in the era of big data, we have growing data sets that are becoming a bit more usable, although there's still an

incredible amount of work, very rigorous work to begin to sort out the problems that are inherent in using these massive data sets. However, progress is happening and it's happening because the community birth community recognizes that this is critical to our success. And the other side, Next slide please. The other side of opportunities are the challenges. We are in an era where science is not respected. Right. And particularly any science that is going to unearth or shine a light on disparities for any community. Very large data sets that we have relied upon have been shuttered. We also know that research requires coordinated systems. It's not the, we're not in the era of the scientists by themselves working at a bench, but rather teams of folks who are working together sharing data across systems. And, and this can make it hard to build the data sets that have the kinds of variables that we need in order to, in order to build a basis for quality improvement that Silke mentioned, as well as build the basis for the upscaling of our model. We also have the issue of we have a market based system with capitalism at its roots and the data systems that capitalism creates, a lot of times are focused, are using billing data, right? Not necessarily going into the patient record to know exactly what happened for that particular birthing person. And so we have these disparate for profit systems that were created in silos. We also know that midwives are busy and they are not well supported. It's really rare in health care in this country that any care provider is actually entering their own data, right? And we have midwives that are catching the babies and then coming home and spending the time to upload their data. And without any support for both the work of the data entry as well as being able to access the research for professional development and. Yeah, and lastly, I just want to say that it's, it's really hard to ask the doers to also do the research. And certainly many folks we know are in that, in that position, right? Trying to meet grant deadlines, trying to meet submission deadlines and also responding to, responding to their pager, not pager anymore, but responding to the clients that depend on them to be available. And so I think I'm done. And so I'll turn things back over to our moderator.

**Melissa Cheyney: 36:54**
Thank you so much, Tanya. And yes, yes, yes. I was praying that my mom, who is due on the 29th, would wait until after this presentation. I also would just like to name, and I think most of you know this, that Skyline has been, especially in the last four or five years, the primary funder enabling us to develop these really sophisticated data registries that enable us not just to track clinical outcomes, but also to study aspects like cultural alignment and social determinants of health. So, big second, shout out to Skyline for all the support that you've provided for the, for the research, the researchers here in this country. And now we're going to welcome Zul Ruiz Jines, who is a licensed midwife and director of Common Sense Childbirth School of Midwifery and an advocate who is pursuing her master's degree degree in medical anthropology at Oregon State University, where she's researching the impact of community based direct entry midwifery programs. So I'll turn it over to you, Zul.

**Zul Ruiz Ginés: 38:05**
Thank you, missy. I don't see myself yet in the, in the camera.

**Jeanette McCulloch: 38:16**
You're good. And your slides are ready for you whenever you are.

**Zul Ruiz Ginés: 38:19**

Okay, beautiful. Okay, so, hi everyone, and thank you for being here. I'm so excited about this project. So let's begin with, why is this domain important? In 2025, the International Confederation of Midwives launched a global petition calling on governments and health leaders to grow, support and sustain the midwifery workforce by increasing it to reach globally 1 million midwives. The aim was to issue an urgent global call to action on the critical shortage of midwives, pretty much making it impossible to ignore and to place midwives at the center of the conversations in the government, in the media, and in society. We know that access to maternity wards, hospitals, birth centers, doctors, and the rise of cesarean sections worldwide continue to harm women and pregnant people's health and rights. To meet the growing demand for maternity care in the US alone, we need over 8,000 more midwives by 2030 and up to 22,000 midwives by 2050. Now, some of the barriers we're facing in the midwifery workforce in the US is the lack of cultural congruence. This means that midwives that are currently practicing often do not reflect ethnically and culturally, the communities that they're serving or the students that they're training. Next slide, Jeanette. Thank you. Now let's look at some of the opportunities that we're seeing. Well, the greater recognition that physician driven systems are not sustainable. Peer nations have figured out that if origins of poor health are social solutions need to be as well greater awareness that maternity care deserts won't be solved by building more rural hospitals, but by turning to community based providers. So in order to have more midwives, we need to support the growth and sustainability of our current midwifery programs and develop new ones in areas and communities that have been historically underserved, including the rural communities in the U.S. so some of the good news. In the U.S. we currently have 11 make accredited programs, two right now that are pre accredited and four that are in the phase of pre preparation to get pre accreditation. Additionally, it is important to note that not all the states require the Midwifery Education Accreditation Council accreditation and there are other educational programs available in local communities that work in tandem with the portfolio evaluation process. Now, next slide. Some of the challenges. Some of the challenges are the cost of education and it contribute to low retention and low completion rates in the midwifery programs that we currently have. As some of the programs are self pay and we do not have access to financial aid. Unlike peer nations, the US doesn't subsidize education for health care professionals. So some of our students currently are graduating with a debt from anything from $50,000 to as much as $150,000 or more. And you may ask, well, what about grants? Scholarship support? Sure. But even with the scholarship barriers remain during the education period, they can be seen in in the missed income during training, lack of local preceptors or clinical sites, and household support during the clinical portion of the program. We have not yet found an effective way to provide education while ensuring that our students can survive while attending school. These are some of the barriers that need to be addressed to expand and diversify the midwifery workforce. Thank you so much for being here today. And Missy, back over to you.

**Melissa Cheyney: 43:08**

Thank you so much. Zul, I'm noticing that you're literally glowing. So I'm not sure how that's happening because we don't have any sun here in Oregon, but your face is radiating. Okay,

we're going to move on to policy and advocacy and today we have Zev Coulson with us. Zev is a certified professional midwife and legislative policy analyst at nacpm. They've worked in home and birth center settings and they have a background in community organizing. So over to you, Zev.

**Zev Colsen: 43:41**
Thank you, Missy. I also don't yet see my image in the camera. Do others?

**Jeanette McCulloch: 43:48**
We do. We see you're good to go.

**Zev Colsen: 43:50**
Fantastic. Okay, I'll take the next slide please. This domain is important because policy changes lives. You know, the problem is urgent and we live in this drastically hostile policy environment for so many communities. The gap between our current reality and this vision for integrated, universally accessible community midwifery is really wide. And it's also full of barriers. You know, in enabling environments we know that community midwifery care is safe, it's effective, it's affordable, it's person centered. There's all of these incredible benefits, but policy is the thing that allows us to have that enabling environment or not so bad. Policy, conversely, puts midwives and clients at risk. And I just invite us all to frame this domain in that policy is intentional. So like the presence or absence of an enabling environment is a choice made by those who hold power. The system is working for someone and we need to apply pressure to the levers of power because they're not going to give it up without a fight. So I will take the next slide. The priorities that I see in this domain are licensure for all credentialed midwives in all states and decriminalization of non credentialed midwives so that we stop replicating patterns of harm that have occurred for a long time. We need policies that enable midwives to work to their full scope and training, policies that promote integration, that demand reimbursement and that fund workforce development initiatives. Next slide. The opportunities exist, you know, at the state level and at the federal level. And you can see right on the slide that, right, they're concentrated in the state level. But at the federal, we would like to get all credentialed midwives recognized federally within the Social Security Act. And then there's a number of federal bills that are active. The Black Maternal Health Caucus has a far reaching Momnibus Act, Midwives for Moms fund scholarships, the Babies act is funding for establishing new birth centers. And Midwives for Service members would add CPMs and CMS to become eligible for Tricare reimbursement. At the state level, I see it as kind of two buckets. There are states that have licensure and there are states that do not have licensure but still, still have issues. There's not a single state that is doing it all right. So in terms of licensure, CPMs still need 13 states and CMS still need 39 states. In terms of optimization, we're talking about again driving policy making, amendments to current barriers to full scope care, adding gynecological care, making sure medication access is appropriate, that midwives are not subject to physician supervision, and then practice setting certainly in Homes and in birth centers for all credentials of midwives, but also in FQHCs, in which federally qualified health centers, in community clinics, in Planned Parenthood and in the hospital. Integration, I think is an interesting one because we tend to think of it as kind of a sub regulatory activity, I think. Missy, earlier you said we're not

waiting for the government, which is absolutely true. And we need a diversity of tactics to achieve these goals. Right. But there is a role for government in integration in that lawmakers can fund and they can mandate some of these initiatives. So for example, in Massachusetts they have mandated that the Department of Health take a role in integrating and implementing things like transfer systems integration across settings. Access to clinical training sites is another thing the state can facilitate. And then certainly data collection that is comprehensive, that is funded. I saw someone in the Q and A mention that midwives shouldn't have to pay so much money just to submit their data. And then driving QI initiatives based on that data that state agency might play a role in collecting. In terms of policy around reimbursement, it always is shocking to me that insurers are not begging us to contract with them because we would save them money by improving outcomes. But here we are. And so the lawmakers really actually have to be the adult in the room and specify very clearly not only that they have to pay us, but who has to pay us. Public payers, private payers, MCOs, parities for all credentials in all settings. The parent fee, the baby fee, the newborn fee, the facility fee. You have to write law that's very specific in this way because otherwise the insurance companies are not willing to engage for the most part. And then funding workforce development initiatives. So that's scholarship funding, funding for MEEC programs and CM programs. And to Zul's point, we could also see funding for, for PEP applicants and then loan repayment and continuing education that would span across credentials. I'll take the next slide. Yeah. Challenges. We've got some challenges. Opposition. And I think of this also in two categories. We've got kind of industry opposition and then political opposition. Our opposition is generally strong, well funded, well established, and like highly trusted by lawmakers. Recently we saw a joint explanatory statement attached to the ndaa, which is like the budget for the Defense Department, citing concerns about safety and quality for both CPMs and CMS, which is a really disappointing development. Generally, government dysfunction is slowing all policy efforts down. Right now there's very little getting done in Republican states. We're seeing resistance to the creation of licensing boards in a small government way. In democratic states, we're seeing that the agencies, state agencies are just taxed beyond their capacity. For example, where I live in Massachusetts, they're like, we would love to review your CPM regulations, but we're suing the federal government every other day. So we really can't spare the lawyers right now. Racism, misogyny, heterosexism, ableism, capitalism. I could certainly go on. Yes, these are policy challenges. Why? Because who is the most impacted by the problem and who is the most impactful? Are those folks prioritized by those who hold power? Are folks prioritized within our coalitions? Public perception? I think going back to our opposition, they've been engaged in really malicious strategic narrative for a century. So we have a lot of ground to make up there. And those things also tie back to racism and misogyny in many ways and funding. Obviously we have some ride or die funders in this movement. Thank you, Tanya. Thank you, Skyline. But in contrast to our opposition, we're still quite underfunded. That's all I've got. Thank you so much. And I'll pass it back to Missy.

**Melissa Cheyney: 51:53**
Thank you so much. Sev. One of the things that's so exciting about putting this webinar together is it really feels like the group that's gathered here today is just sort of a little microcosm of what could be actually happening at the Think Big convening. There's so much expertise in

our community and I'm really excited to see what can happen with the dedicated time and to map out a blueprint or plan. So with that, we'll move to our last speaker on systems integration. We have Jenny Joseph, who is a British trained midwife and founder of Common Sense Childbirth, Inc. She created the JJ Way, an evidence based maternal healthcare system that has markedly reduced racial disparities and birth outcomes in Central Florida. She also established the nation's first nationally accredited midwifery school owned by black women. Welcome, Jenny.

**Jenny Joseph: 52:42**
Thank you very much and welcome everybody. Thank you for this piece. I'd like to talk a little bit about systems integration. And I'm not talking about nice to have. I'm talking about critical patient safety, life and death level safety. So next slide. When I say systems integration, there's nothing about our system that is currently integrated so people get triaged across siloed settings. And without integration, people are falling through the cracks. And so the system actually causes harm instead of healing. So looking through a midwifery lens is simple. One client, many doors, and whichever door they walk through at Any given time has to be the right door. That's what the no wrong door means in real life, the information follows them, the plan follows them, and the respect follows them. So integration is not only an EHR problem, for example, it's a handoff problem. It's whether we treat community care as legitimate care. It's whether a midwife can reach the right clinician or right service quickly and whether the receiving team already knows and understands their role in the continuum of safe care so that we're not starting in a crisis or from drama. And it's accountability across the whole ecosystem, community settings, EMS systems, hospitals, postpartum supports, so that nobody disappears or is shut out between prenatal care and birth, or between birth and postpartum. Next slide, please. Here's where I want to give you a reality check. So we already have two levels of care. We have the medical levels of care and then we have the community. It's one continuum. And I believe with midwifery at the intersections, we will all win. But do you see what I'm talking about here? So on the right you have the American Congress of Obstetricians and Gynecologists along with the Society of Maternal and Fetal Medicine and they created the levels of maternal care. That document came out in 2019. And so these levels four levels move from the level one, which is the accredited birth center, through to level four, which is of course the top of the facility that you could possibly have to deal with maternity in any given region. So that framework is about where's the right place for this person at this moment, based on acuity and what services are available. On the left of the slide you have the four community levels of care. And this is the part that's usually missing from any systems conversations, the community based access and trust infrastructure. We're naming the real entry points when it comes to maternal health, the community ambassadors that are on the ground, perinatal safe spots, such as the collectives and the birth work entrepreneurs and the community based organizations. Then we have public health. Okay, yeah, we have the standalone clinics, we have the federally qualified health clinics, we have OB providers, private providers, community providers who are privileged to have hospital access as well. And then we have our community led birth centers and our home birth providers. These are all actually in the community space. So these are not extra, these are the front door. These are how we get earlier engagement, earlier listening, earlier triage and fewer crises. These levels are the opportunity. So now here's the bridge for midwifery looking at

the acog ladder and the community ladder and having those connected and being connected by predictable consult and transfer pathways. Not the personal personality dependent ones, not the who you know, but the reliable and safe transfer pathways that make the difference for life and death. All of these levels and settings, once integrated, would provide the best possible care. That is the intersection of midwifery. Midwives and the midwifery model of care belong at every level and midwifery practice listen in relationship time navigation, respectful escalation becomes the connective tissue between the community access and the higher acuity capability wherever you live. Next slide. So let me land this with what integration looks like in practice because right now the reality is often just this patchwork of willy nilly ness that we end up doing health systems navigation valiantly trying to minimize the harm that these systems create and these really seemingly intractable challenges persist. So this is how we face these challenges head on. First of all, respect and shared governance. Because you cannot integrate a system that doesn't recognize community based care as essential. Community providers need clear thresholds, clear support so that a community team and a hospital team are speaking the same language. We need direct consult lines so we're not improvising in emergencies or we're not letting early warning signs be left unaddressed because of a lack of access to safety or support for either provider or client. We need data and QI across all settings because integration without measurement is just hope. Okay? And we all need to get paid equitably, reliably and consistently. Bottom line, midwives can be and are the integrators clinically, relationally and operationally across this entire perinatal ecosystem. Midwives are holding up the community and we can overcome these challenges once and for all. Thank you very much. Back to you, Missy.

**Melissa Cheyney: 59:06**
Jenny, thank you so much. Wonderful. So now we're going to transition from talking about these five domains to finding out about the process, what we have envisioned and how you can get involved. And for that I'm going to turn it over to Cassandra Jha, who is the Executive Director of NACPM and a certified professional midwife with a PhD in midwifery research. She previously served in executive leadership roles at the National College of Midwifery and the National Education Accreditation Council.

**Cassaundra Jah: 59:40**
Thank you, Missy. So I'm excited to wrap up this presentation with how we believe we're going to accomplish all this wonderful work. I want to acknowledge that it is likely many of you are feeling like you've heard this all before. And I'm going to ask, and I think everyone on this presentation is asking for you to continue to hold hope. We are being very intentional in constructing concrete steps forward while acknowledging and recognizing that this work is both aspirational and pragmatic. Next slide please. So I want to. I want to say, I think it's really important to be really clear that in acpm, Uplift Labs and Burstwell are facilitating a process. One in which experts can convene, think big and have a dialogue on infrastructure creation that makes universal access to community birth possible. Next slide. Our goals right now are to bring together three to four community leaders who are overlapping experts in each of the five domains and then to help these domain work groups develop a roadmap for strengthening their specific area and bringing them all together in person to align those five roadmaps and create

an interdependent work plan. We know that 20 people will not have all the answers. We're building in mechanisms for community members to contribute, voice opinions and provide ideas without making the full time commitment. As a delegate, we believe that this comprehensive approach will lead to an innovative and comprehensive design for building lasting infrastructure. Next slide. All right. Hopefully this diagram isn't too overwhelming. It's meant to help illustrate how that facilitated process and mechanisms for community input is going to work. So, starting on the left, nacpm, Uplift Labs and Birth Swell are mentored by our advisory partners and charged with finding continued funding, coordinating staff activities and keeping the dialogue going. The delegates work together in their domains to create individual work plans. As I said, those work plans are informed not only by their expertise, but also by community thought leaders and organizations with professional on the ground experience about what efficient implementation needs to look like. And our facilitator is helping get these domain groups running smoothly, facilitating the in person convening and delivering a final report that we can share with all of you and potential funders. Next slide. So this is what our timeline currently looks like. As you know, we introduced this idea last year and we're right now currently interviewing facilitators. And today we're going to start the work group development after these work groups engage with community during Q2 of this year, we're all going to get together in the third quarter and integrate the the different domains plans. By the end of this year we will have a written interdependent work plan. Next slide. With this in hand, Missy and I, along with other partners, will approach funders with direct next step asks. We can help match each domain's next step with grant opportunities and speak to individual donors who have a special interest in certain areas. We're going to align funders with next steps. What I really want to convey in this is this is just phase one. We understand that implementation will require additional phases and funding. Next slide. So the part I know you've all been waiting for, how to get involved. So you should see two QR codes. The one on the left is applying to be part of work groups with the potential to take leadership roles in specific areas. You can use the other QR code to participate in an advisory capacity, providing guidance and feedback. And now and throughout the work, both options allow different levels of engagement and increase the diversity of thought skills and perspectives, ensuring that this work is collaborative and community driven. And now I think we're ready for our Q and A.

**Melissa Cheyney: 01:05:14**
Thank you so much, Cassandra. And we'll invite all of the speakers to come back on screen and Jeanette will help us with our Q A.

**Jeanette McCulloch: 01:05:21**
Oh, wonderful. And I just want to say, as everybody gets back on screen, first of all, if you all have questions in the audience, now is your moment to key those into the Q A box because everyone's really excited to answer your questions. And I know we're all excited to be talking about this project with you all today. And I know I am feeling particularly inspired by our conversations. I'm going to go ahead and address some of the questions that have been raised so far. One of the questions was a question about which is so central to research, right? Which is in order to do research, we need data. And so to that end, one of the participants asked about

why is it that midwives and midwifery organizations should have to pay to enter their data into national data banks And Missy, this feels like a good question for you.

**Melissa Cheyney: 01:06:30**
Yes, I can take that question. I think what I would say is that my initial thought is I agree. I think in an ideal world there would be sufficient funding to community based midwives to have their own quality improvement tool, their own data collection tool that is fully grant funded or fully supported by a government entity. In reality, the cost of developing a high quality data collection tool that allows us all to have access to our outcomes immediately so that we can shape the care that we're giving to our clients costs money and actually costs quite a lot of money. So I can speak most concretely about the community based community birth data registry. The cbdr, which I co direct with Mark Boberg. Skyline, has generously funded the programming of the system, the staff that it takes to run it, the ongoing cost, and that's in the hundreds of thousands of dollars. The cost to run it are related to long term data storage. And so when you are charged with for participation, it is related to these costs that are very difficult to cover, which is the long term, ongoing in perpetuity storage of your data. And so the three data sets that currently exist all charge approximately the same amount of money. In the CBDR, it's $4.50 per course of care in perpetuity, which means the average midwife is paying somewhere between 90 and maybe as high as $500 to enter their data if they work in a very, very busy birth center. I don't foresee that changing anytime soon though. Tanya and I have had a lot of conversations about grant writing to eventually do our best to make participation free. I hope that that comes to pass. And then the final thing I'll say is that some states have recognized the importance of covering those costs. So California, Massachusetts, Virginia, several states have stepped up to cover those costs and we.

**Jeanette McCulloch: 01:08:40**
Oh wonderful. Thank you. Missy and I did get a question about the code links and I wanted to let everybody know a few things. One is we'll pop those back up on the screen so if you didn't get the QR code right away, you could get them there. I also dropped those links in the chat, but we also have a website, it's think big initiative.org and they're not up there yet, but they will be shortly. And we'll also email them to everybody who registered. So you'll be able to get those that way as well. And I see that somebody has their hand raised. And unfortunately we don't have the capacity to allow, we don't have the technical capacity to hear you talk. So if it's possible for you to drop your question into the Q and A, we'd love to catch up with you there. And if for any reason you have questions, let's say you're on your phone, you can't find the Q and A button, but you have a burning question, go to the website. We have a contact form there. Key it in there and we'll be sure to get back to you. We also have a question about is there a role here for State Pew. Oh my goodness, PQCs or do you see that as being something for after, when the plan is developed?

**Silke Akerson: 01:10:01**
I want to answer that question. I am the executive director of the Oregon Perinatal Quality Collaborative, which is the Perinatal Quality Collaborative in Oregon. So there is already a role in this development process where we have kind of someone thinking about PQCs and thinking

about that role for those of you who aren't familiar, every state has a perinatal quality collaborative in the US at this point, and the PQC's job is to look at all the births in that state, hospital births, home births, birth center births, and see where there are too many moms or birthing people or babies dying or being harmed or having poor outcomes, and then to create quality improvement initiatives and other programs to turn that care around and make sure everyone's receiving excellent care. So in the kind of implementation phase, it'll be really important for community midwives and community midwife organizations to be working within and with their PQCs. And in the development phase, I'm bringing the PQC perspective to the table and making sure that we're thinking about ourselves as part of these whole systems of birth. I think for so long, community midwives have kind of been siloed and thinking it's like community midwifery and then the rest of birth. And our job here is to think about how are we part of the whole. And PQCs are one piece of that.

**Jeanette McCulloch: 01:11:38**
Oh, thank you, Silke. And we are getting a number of questions about logistics related to the application. So when we follow up with everybody who participates, we will send out some more detailed information about if you're having trouble because it requires Google or due dates or any of that sort of information, we will absolutely make that all available. There is a question about the cost associated with being a delegate in terms of travel and other expenses and maybe Ms. Cassandra, do you want to take up that question? Cassandra? Ms.

**Melissa Cheyney: 01:12:19**
I was just about to point to Cassandra. We have been able to secure funding to support the convening, so we are not asking delegates to pay out of pocket to travel here. Your costs will be covered for your time spent at the convening.

**Jeanette McCulloch: 01:12:39**
And if you're having any trouble with the text in the chat, I don't know how to change that setting so that the link is copyable while we are live in the webinar. If you know the answer to that, you can key it into the question and I will make that possible. Otherwise, we'll be sure that you get that in your email and it will also be available on the website. There is a question that I bet is for you, Zeb, which is, is there any current legislation for midwives, either cnm, CPM, or lm, to have loans covered? Oh, that might actually also be a workforce question. So let me throw that out broadly, because that's a this is, this is one of the reasons why this is so important is there's such an important intersection between policy, between all of these issues. Right. Between workforce policy, any of these issues. But the question, and I'll leave it open to whomever can jump in, is anyone aware of legislation for midwives to have their loans covered by NHS or ihs?

**Cassaundra Jah: 01:13:44**
So maybe I'll jump in here and say the Midwives for Moms act at the federal level is what is, what is on the table right now. We also, in partnership with AABC and BCE and the Policy Institute, acnm, probably missing other people, send in letters for appropriation annually to have money allocated specifically to midwifery education. And depending on which one we're looking at, whether it's the scholarships for disadvantaged students or the one more focused on

midwifery Specifically, it's between 5 and $8 million annually that we've been able to secure with that ongoing advocacy every year. Midwives for Moms would make that a permanent funding stream. So, so that's the answer to that question. I, I think, and I'm certainly not the expert in this, but I, I do believe that CNMs and CMS have more mechanisms for reimbursement of their student loans at the state level, but also at their institutional level than CPMs do. I don't, I can't think of any state bills right now that are talking specifically about student loan reimbursement.

**Zev Colsen: 01:15:12**
There is a state bill in Massachusetts right now that has a state funded student loan reimbursement element for both CNMs and CPMs. We don't have CM licensure here, but unfortunately it's the establishment of a fund and that fund would not be actually funded with this bill. So you can see when I say, like the gap is so wide and there's all these barriers. Yeah, that's one of them. I would also say I don't think that we got renewed funding this past year from those appropriations for midwifery scholarships, which was a huge blow to midwives who are being funded through their education from that mechanism.

**Jeanette McCulloch: 01:16:09**
And there. Thank you, Zev. And there is a great question here that I'd like to broaden. There's a question about is there a partnership or plans for a partnership with the Maternal Health Research Centers of Excellence located at universities across the country and funded out of the nih. I'm wondering if you can speak to both that and potentially other partnerships, conversations that are underway as well. And Missy, I'm looking at you.

**Melissa Cheyney: 01:16:44**
I know, I was thinking wait and see if Cassandra jumps in. And Cassandra, I think you can speak to some of the other partnerships. But I will say yes, whoever put that in the chat, you are really aligned with our thinking. One of the reasons why UPLIFT and NACPM gathered together for this is we had hoped to bring the Oregon State University foundation into the conversation with the hopes that we eventually might be able to have a center for excellence that was devoted specifically to community birth, and that that is something that. That we dream about, that we imagine having an institute that. That many of you, we hope, would be part of. Yes, those conversations are underway now. What about other partnerships, Cassandra, do you want to address that? There are many.

**Cassaundra Jah: 01:17:33**
Sorry, I was over here in the Q and A. So other partnerships in. I'm assuming you mean partnership organizations with this Think Big initiative. So one of the pieces that we have really discovered as we've went into community and floated this idea and stuff, is this ongoing reality that organizations are not being maybe as transparent as we could be with the different projects that we're working on, and that we could do a better job in being more transparent so that we could bring alignment and be more efficient, so that we're not reinventing the wheel in every single state, but can move some of that forward. Some of the discussions that we've had is we're working on a grant with Dr. Felix at John Hopkins, along with Birth Center Equity and some other partners there. That was the first time that I saw everybody willing to put on the

table, like, here's the things we're working on. Like, wait a second. That's very similar to what we're working on. Let's see if we can get together and align. Or maybe there's something that both of us could use that neither one of us have the money to invest in that thing alone, but we could combine efforts. So there's some of that going on with some of those players. We have another grant through the Pritzker Children's Initiative that is working on state advocacy. We just got together with six partners there. Let me see if I can name them all off the top of my head. So NAB the nab, nbma, bce, aabc. B. I already said that. I feel like I'm on the spot here.

**Tanya Khmet Taiwo: 01:19:39**
Elephant Circle.

**Cassaundra Jah: 01:19:47**
Thank you. Yeah, yeah. So, yes, lots of partnerships. And I will tell you, and I think, Missy, this is probably your. Your experience, too. Like, we're getting emails, multiple emails every week. Like, can we. Can we have a conversation? What are you working on? How can we coordinate? Can we just simply start with uplifting each other and highlighting the work that, that these partners are doing. Because as Missy said earlier in the presentation, please, please don't stop your work. We need you to be doing that. And we want to find ways to uplift that and coordinate it with this other work.

**Jeanette McCulloch: 01:20:27**
And I think that is one of the many parts of this project that I find particularly inspirational and important is having been in this work for some time, is the importance of finding the space for everybody to come together and share the work that they are doing on and find those sorts of synergies. And there was a question that I really loved because it is very much in line with the vision of this, which is, hey, let's think big to Jenny and Zulu. What is your ideal midwifery training program and what would need to happen for that to manifest? Big question.

**Jenny Joseph: 01:21:19**
Who answered? Well, let's answer together. I mean, I think we've already clearly defined what community midwifery education needs to look like. And the biggest issue, of course, right now is access. Access. And I think will continue for a good minute to be an access issue. Right. Because all the things we've talked about today point to without the support and integration, we're not going to have the sustainability built into midwifery school and obviously early midwifery practice. At the same time, the value of having access to really craft what midwifery looks like from the community level is really important for our future because finally we can really get to the meat and potatoes of what do students actually need to know? So, yes, we're in a bit of a no man's land as we try to build out as many preceptor sites as we can for these students, clinical sites for these students. But also we can look at it from a point of view of this is now we've integrated finally the cultural and respectful pieces that were, I'm just going to say out loud, we're missing in the midwifery genre. Okay. The other thing that gives me real hope is as I see, every time we come together, however we come together, we see our familiar faces, we see our sisters, we see our siblings who are already and have already been in this fight. And so we know that they are going to keep informing the midwifery education that is needed,

necessary and essential so that at the other side of this, and we will get to the other side, generationally speaking, maybe, but when we get to the other side, it will be because we have been able to build on a collaborative way of looking at getting this education strongly and foundationally put in place to continue bringing the true midwifery practice back to the communities and the trusted providers back to the communities who have been in place for millennia until America. So would you say any more? What do you want to say?

**Zul Ruiz Ginés: 01:23:19**
I think the only thing that I will add, Jenny and Magna, thank you for that question. I would like to see more local programs being built. I would love to see the students being able to learn with their peers, with their peers that they're going to be working because I think that is the key for sustainability of not just our program but our midwives. Not to see as a director, I see so many of our wonderful students that create friendships, but they're in two completely different states. So I dream to see students in the same community that they can learn from the instructors that are there, from their preceptors, that they can do study groups together and that that just not happen over zoom.

**Jeanette McCulloch: 01:24:08**
And that is a perfect transition. Zul to a few different comments that were coming up that were not necessarily questions but follow ups which are just such an example of what folks have to share. Someone said just what you're saying, Zul, that we should be discussing the integration of midwifery into local communities, particularly in this case into state, public and community colleges because of access and affordability, which we all know is a is a viable option. Someone shared that Washington does have language to extend NHSC type funding to include LMS using STAT funds. And another person shares that we're working with CMQCC in California to increase smooth transition. And there's also someone asking about if anybody is participating at AM CHIP or HHS Conference on Women's Health in D.C. because they will be. They will be there as well. So I'll be sure to connect that with anybody who is. And before I turn this over to Missy, just to wrap things up, I just wanted to share. Oops. Which I misplaced. I think it might have moved to. Ah, here we go. Reflection from someone who's been a part of our community for a long time, just sharing her gratitude and excitement to see this initiative launch that it was her dream since her birth in 1976 when she had her first baby at home with what was then an unlicensed midwife and how she committed herself to making midwifery accessible and for growing the profession. Thank you all for growing the baton. It's a relay race after all. And I think that is one of the, it's really thank you for sharing that. I think that's, that's very powerful to watch that, that progression take place with that, Missy, I'm going to turn this over. I'm going to pop back up the how you can get involved slide in case anybody else would like to check on that. And then I'm going to hand this over to you to wrap us up for today.

**Melissa Cheyney: 01:26:28**
Okay, that sounds great. So I'll start with a big thank you to all of our participants today. Thank you so much for coming and sharing your knowledge. It's been wonderful. And as I said, just this just exciting glimpse into what can happen when we get the right people in the room, right room having the right conversation. So as we close today, I was going to leave you with a a

powerful quote that comes from the parable of the Sower, written by Octavia, Octavia Butler. And it focuses on adaptability, resilience, and the power of human agency to shape the future, even in the face of adversity. And she said, all that you touch, you change. All that you change changes you. The only lasting truth is change. God is change. I'll leave us with that and hope, hopes that we see change. Thanks, everyone.

**Jeanette McCulloch: 01:27:26**
Thank you, everybody. Take care.