NUTRITION in Pregnancy Conference

May 22-23, 2024

Facilitated by:
Shelby Pierce | Pierce Porter Facilitation
Maya Chilese, Ph.D. | Blue Agate Collaborative

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INTRODUCTION

The Nutrition in Pregnancy Conference was held in Washington D.C. on May 22-23, 2024, hosted by the Moore Institute for Nutrition & Wellness at OHSU (Oregon Health & Science University) in collaboration with several brilliant partners.

This documentation provides a summary of the conference and details the depth of wisdom shared by participants about nutrition in pregnancy in America today.

This event was designed as a "think-tank" and aimed to answer the question: "Where are our **best opportunities for collaborative action** to improve nutrition in pregnancy and early childhood?

After robust discussion, those in attendance elevated the following **Top 3 Priorities** to address with collaborative action:

1. Presence of food and nutrition security and access to healthy foods.
2. People with lived experience co-create nutrition in pregnancy systems of care in partnership with organizations at all levels.
3. Emphasis and resources devoted to nutrition education for all medical and health professionals.

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*Questions regarding the process or documentation may be directed to the Co-Facilitators:

Shelby Pierce Pierce Porter Facilitation shelby@pierceporterfacilitation.com	Maya Chilese, Ph.D. Blue Agate Collective drmaya@blueagatecollaborative.com

GAPS & BARRIERS

At the 2022 'Nutrition in Pregnancy: Creating a National Blueprint for Healthy Mothers and Children' conference, attendees identified major gaps and developed action goals to address these gaps. This work was published in the Annals of the New York Academy of Sciences as "Barriers to implementing good nutrition in pregnancy and early childhood: Creating equitable national solutions".

Rainford M, Barbour LA, Birch D, Catalano P, Daniels E, Gremont C, Marshall NE, Wharton K, Thornburg K. Barriers to implementing good nutrition in pregnancy and early childhood: Creating equitable national solutions. Ann N Y Acad Sci. 2024 Apr;1534(1):94-105. doi: 10.1111/nyas.15122. Epub 2024 Mar 23. PMID: 38520393.

The article's Top 10 Gaps & Barriers were the foundation of discussion at this conference on Day 1, and the four categories of Action Goals were reviewed on Day 2.

Top 10 Gaps & Barriers:

1. Presence of food insecurity and inadequate access to healthy foods.
2. Inadequate awareness and coordination of social services (e.g. Medicaid, SNAP, WIC, etc.)
3. Lack of public policies that benefit the health of women before pregnancy, during pregnancy and during lactation.
4. Inadequate funding for nutrition research applied to developmental health.
5. Lack of emphasis and resources devoted to medical nutrition education for all medical professionals.
6. Requirement of community involvement to change the nutritional landscape at the local level; women and communities are currently not engaged in developing solutions.
7. Presence of implicit bias and racial disparities in women's health and birth outcomes. There is also a lack of diversity among nutrition professionals.
8. Nutrition is not embraced as a form of disease prevention on a societal level and among health professionals.
9. Inadequate knowledge of and support for breastfeeding.
10. Lack of comprehensive family leave which is associated with reduced rates of breastfeeding and family nutritional care and increased family stress.

AGENDA

This event was designed to inspire, stimulate and spark collaborative conversations about how to improve the health of women, young children and pregnant people. The facilitation roadmap moved through a series of questions applied to the Top 10 Gaps & Barriers, to deepen our understanding of how these issues are presenting across local community, state and national levels.

Day 1: Wednesday, May 22 | PEOPLE – STORY – PARTNERS |

- Opening Welcome and Call-to-Action from Dr. Kent Thornburg
- Conference Structure and Goals
- Facilitated Discussions - Strategies for addressing gaps/barriers and goals to improve health and nutrition of women, children and pregnant people
- National Panel - Overview of national government programs; how to integrate and collaborate more effectively across programs; how to increase action to improve health of women, children and pregnant people
- Community Panel - Overview of selected community-based programs; how to integrate and collaborate more effectively across programs; how to increase action to improve health of women, children and pregnant people
- Vote for Top 3 Priorities and Wrap-Up

Day 2: Thursday, May 23 | STRATEGY – ACTION |

- Welcome and Day One recap
- Small Group Work - Synthesize day one outcomes and begin small group work developing action plans; Groups agree on how to coordinate action plans, continue collaboration and ensure work moves forward
- Wrap-Up and Next Steps

PARTICIPANTS

Kent Thornburg, Ph.D.
Conference Chair
OHSU Moore Institute for Nutrition & Wellness
thornbur@ohsu.edu

Mandy Burns
Conference Co-Chair
OHSU Moore Institute for Nutrition & Wellness
burnsma@ohsu.edu

Shelby Pierce
Conference Facilitator
Pierce Porter Facilitation
shelby@pierceporterfacilitation.com

Maya Chilese, Ph.D.
Conference Facilitator
Blue Agate Collaborative, LLC
drmaya@blueagatecollaborative.com

Leslie Myatt, Ph.D., FRCOG
Director
OHSU Moore Institute for Nutrition & Wellness
myattl@ohsu.edu

Liana Haywood, M.P.H.
Communications Manager
OHSU Moore Institute for Nutrition & Wellness
haywoodl@ohsu.edu

Bernadette Battilega
Project Coordinator
OHSU Moore Institute for Nutrition & Wellness
battileg@ohsu.edu

Amy Valent, D.O.
Associate Professor of Obstetrics and Gynecology
OHSU
valent@ohsu.edu

Diane Stadler, Ph.D., R.D., LD
Director of Graduate Programs in Human Nutrition
OHSU
stadlerd@ohsu.edu

Solianna Meaza
Interim Director
1,000 Days
smeaza@fhi360.com

Katie Bishop Kendrick, M.S., M.P.H.
National Senior Advocacy Consultant
Voices for Healthy Kids, American Heart Association
katie.bishopkendrick@heart.org

Stephanie Scarmo, Ph.D., M.P.H.
National Senior Director, Policy Research
Voices for Healthy Kids, American Heart Association
stephanie.scarmo@heart.org

Anna Corona, M.P.H., CPH
Sr. Specialist
Child & Adolescent Health Systems Building, Association of Maternal & Child Health Programs
acorona@amchp.org

Ellisa Alvarez
Program Analyst
Association of Maternal & Child Health Programs
ealvarez@amchp.org

Jazmin Long, MSSA, MNO
President & Chief Executive Officer Birthing Beautiful Communities
jlong@birthingbeautiful.org

Krista Lumpkins-Howard
Senior Director of Training & Community Impact Birthing Beautiful Communities
klumpkins@birthingbeautiful.org

Charles Smith, M.S.W.
Director of Health & Wellness
Black Food Sovereignty Coalition
csmith33141@gmail.com

Mike Pomeroy, M.P.H.
VP of Operations
Brighter Bites
mike.pomeroy@brighterbites.org

Rachel Ferencik, M.P.A.
Director, Non-Infectious Disease Programs
CDC Foundation
rferencik@cdcfoundation.org

Sharon Moffatt, M.S.
Senior Advisor
CDC Foundation
smoffatt@cdcfoundation.org

Rachel Landauer, J.D.
Clinical Instructor
Center for Health Law & Policy Innovation, Harvard Law School
rlandauer@law.harvard.edu

Janet de Jesus, M.S., RD
Nutrition Advisor
Office of Disease Prevention and Health Promotion,
Health & Human Services
janet.dejesus@hhs.gov

India Hinton, M.S., M.P.H.
Public Health Analyst / Project Officer
Healthy Start Program, Maternal & Child Health Bureau, Health Resources & Services Administration
ihinton@hrsa.gov

Kristal Dail, M.P.H.
Public Health Analyst
Healthy Start Program, Maternal & Child Health Bureau, Health Resources & Services Administration
kdail@hrsa.gov

Ticess Johnson
Community Participant
Healthy Start Program, Health Resources & Services Administration
ticess.johnson@gmail.com

Tylea Davenport
Community Participant
Healthy Start Program, Health Resources & Services Administration
tyleadeshea96@gmail.com

Michelle Simon, Ph.D.
President & CEO
Institute for Natural Medicine
msimon@naturemed.org

KJ Hertz, M.P.P.
Senior Director, Federal Affairs
March of Dimes
khertz@marchofdimes.org

Belicia Badibanga, M.P.H.
Program Analyst
Maternal, Child & Adolescent Health, National Association of County and City Health Officials
bbadibanga@naccho.org

Freweyni Gemerew, M.P.H.
Senior Program Analyst
Maternal, Child & Adolescent Health, National Association of County and City Health Officials
fgemerew@naccho.org

Harumi Reis-Reilly, M.S., CNS, LDN, IBCLC
Lead Program Analyst
National Association of County and City Health Officials
hreis-reilly@naccho.org

Talei Moore
Program Analyst
Maternal, Child & Adolescent Health, National Association of County and City Health Officials
tmoore@naccho.org

Tucker O'Donnell, M.P.H.
Director
Maternal, Child & Adolescent Health, National Association of County and City Health Officials
todonnell@naccho.org

William Rowe, M.S., Ph.D.
Senior Program Analyst
Maternal, Child & Adolescent Health, National Association of County and City Health Officials
wrowe@naccho.org

Adrianna Nava, Ph.D., M.P.A., MSN, RN
President
National Association of Hispanic Nurses
nava.adrianna@gmail.com

Andrew Bremer, M.D., Ph.D.
Director
Office of Nutrition Research, National Institutes of Health
andrew.bremer@nih.gov

Nicholas Jury, Ph.D.
Director of Legislative Affairs and Policy
Office of Nutrition Research, National Institutes of Health
nicholas.jury@nih.gov

Darlena Birch, M.B.A., RDN
Senior Manager of Public Health Nutrition
National WIC Association
dbirch@nwica.org

Georgia Machell, Ph.D.
President and CEO
National WIC Association
gmachell@nwica.org

Jason Wilson
SVP, Strategic Partnerships
Partnership for a Healthier America
jwilson@ahealthieramerica.org

Lauren Sweeney, Ph.D., RDN
SNAP-Ed Land Grant University Assistant
Land-Grant University, SNAP-Ed
lauren.sweeney@sdstate.edu

Meghan Adler, M.S., RDN, FAND
Nutrition Advisor
Center for Nutrition Policy and Promotion, Food and Nutrition Service, USDA
meghan.adler@usda.gov

Abby Szabo, M.P.A.
Program Manager
Vitamix Foundation
aszabo@vitamixfoundation.org

Natalie Haynes, M.S.
Executive Director
Vitamix Foundation
nhaynes@vitamixfoundation.org

Alejandro Rafael Feo Figarella, M.D.
Academic Director and Medical Advisor
Ceadoula International, LLC
alejandrofeofigarella@gmail.com

I would like to connect about…

- Infant and toddler nutrition security
- All are interesting and good, comprehensive
- Social: structural determinants of health and how it relates to healthy food access
- Creating sustainable and scalable solutions that don't rely 100% on philanthropy to support them
- How doulas and birth workers can bridge the connection between food security and birth XX
- Youth nutritional education program to support health in early reproductive years
- What is needed to support the continuation and expansion of WIC
- Self-efficiency in preparing healthy meals among under-resourced populations
- Funding nutrition initiatives in EOE settings
- How to improve WIC, paid maternity leave, education on healthy food while pregnant, postpartum wellness
- How can we make all states as supportive as Massachusetts on nutritional program

DAY 1

Opening Welcome & Presentation: Kent Thornburg

Improving nutrition before and during pregnancy is necessary for a healthier population, yet it hasn't been a priority. It is not emphasized in most health care education programs, nor is it always included in prenatal care appointments. Recent national collaborations have elevated work around food insecurity and nutrition, but work remains to improve nutrition during these critical windows. We will not improve population health without this emphasis.

The OHSU Moore Institute for Nutrition & Wellness is dedicated to improving the health of this generation and the next through promotion of nutritious diets before and during pregnancy, lactation and the first years of life. In 2019 the OHSU Moore Institute hosted the first Nutrition in Pregnancy Conference, focused on bringing together the latest research. The resulting paper "The importance of nutrition in pregnancy and lactation: lifelong consequences," was published in American Journal of Obstetrics and Gynecology. In 2022 the Moore Institute hosted the second conference, this time with health care providers, educators, and public health program implementers to identify the top gaps and barriers to good nutrition during pregnancy and actionable goals for addressing them. This conference resulted in the paper "Barriers to implementing good nutrition in pregnancy and early childhood: Creating equitable national solutions," published in Annals of the New York Academy of Sciences.

The third Nutrition in Pregnancy Conference started off with an overview of the science behind this work from Moore Institute director emeritus Kent Thornburg, Ph.D.

1. Chronic disease is taking a toll on the health of the American population and the financial stability of the health care system.
    - 6 in 10 U.S. adults have a chronic disease. 4 in 10 have two or more.
    - 86% of U.S. health care dollars go toward treating chronic disease.

2. Poor nutrition before and during pregnancy and in the first years of life affects how robustly the body develops. This leads to structural as well as epigenetic changes that increase the risk for later life chronic disease risk.
    - David Barker, M.D., first identified the connection between birthweight and risk of death from cardiovascular disease as an adult. Both full-term babies with low birthweight (5-6 lbs) and those with high birthweight (above 10 lbs) have increased risk.
    - Research over past three decades found similar associations between birthweight and risk for most chronic diseases. Research has been in done in multiple time periods, geographical areas, cultural and ethnic groups.
    - Beyond birthweight: placental development, maternal phenotype, toxic and environmental stress exposures and paternal impact play a role in chronic disease risk.
    - Four stressors during pregnancy are especially powerful causing detrimental epigenetic changes to offspring: malnutrition, toxic social stress, low oxygen and toxic chemicals.

3. Thus, improving population health will not be possible without improving nutrition before and during pregnancy and in the first years of life.
    - The First 1000 Days, from conception to age two is the most important stage of life where the developing body is most sensitive to inadequate nutrients
    - If a growing embryo, fetus or infant is deficient in nutrients it results in a change in the way important genes are regulated (epigenetics) and imparts elevated risks for a host of chronic diseases in later life.

4. Currently, too little action is being taken on national and community levels to address the epidemic of chronic disease, and work that is happening is disjointed and siloed.
    - It is urgent that steps be taken by government and non-government agencies to ensure that women of reproductive age are well nourished to support the health of the next generation.

NIP CONFERENCE — MAY 2024

DAY 1

How are pregnant people and children doing right now?

What's the story behind nutrition in pregnancy?

Facilitated conversations through the Top 10 Gaps: Stephanie Scarmo

Who are the partners with a role to play?

Facilitated conversations through the Top 10 Gaps: Natalie Haynes

National & Community Panels

National Panel Moderator: Janet de Jesus
Community Panel Moderator: Krista Lumpkins-Howard

Voting on the Top 3 Priorities

Gap 1: FOOD INSECURITY

Presence of food insecurity and inadequate access to healthy foods.

HOW IS THIS GAP SHOWING UP RIGHT NOW?
National & State
✓ WIC enrollment and eligibility **(+1)** ✓ WIC enrollment gap – 50% of those enrolled in other social net programs aren't utilizing WIC ✓ Nutrition security **(+1)** ✓ Identifying state level involvement ✓ Screening in healthcare and responsive action ✓ New Medicaid interventions ($)
Community
✓ Inflation ✓ Geography – rural/urban **(+1)** ✓ Place – population impacts ✓ Best practices for sustainability – lowering food waste and environmental impacts ✓ Funding structures for CBO's **(+1)** ✓ Culturally appropriate foods and care - WIC
Pregnant People & Children
✓ Inflation ✓ Still experiencing poor health outcomes ✓ Availability of time ✓ SMM is still an issue – pregnancy induced HTN

WHAT'S THE STORY BEHIND THIS GAP?

- Lack of access, time, and knowledge for communities/families
- Access: transportation, options, administrative burden (SNAP)
- Not universal in services (some schools, some farm to ECE)
- Lack of culturally appropriate foods and acceptance of cultural inclusive lends in services
- High screenings, but where are the services and warm handoff?
- Research into healthy foods and education
- Need for living wage
- Child tax credit
- Adequate and affordable childcare needed
- Food waste and better, more efficient use/distribution, etc.

- Need larger support for community gardens
- More education of gardening
- SNAP benefits at farmers markets

WHO ARE THE PARTNERS WITH A ROLE TO PLAY?	
National & State	
✓ NIH	✓ WIC
✓ USDA	✓ HRSA
✓ Dept of Transportation	✓ AHA
✓ Big Food/Ag	✓ ACOG/APS
✓ Advocacy organizations (SOS, etc.)	✓ FDA
✓ SNAP	✓ Prison systems (women's)
Community	
✓ Food bank/pantries	✓ Local orgs/non-profit
✓ Schools, Colleges, universities	✓ City government/legislative
✓ Educators	✓ Food is medicine
✓ WIC	✓ Farmers
✓ SNAP **(+1)**	✓ Corner stores/retail marketing
✓ Local farmers & food producers	✓ Unions / Large employers
Direct Supports	
✓ Food bank/pantries	
✓ Schools, Colleges, universities	
✓ WIC	
Who's/What's Missing	
✓ Healthcare orgs/hospitals **(+1)**	✓ Faith community
✓ Community missing from leadership roles	✓ CSA
✓ State/National commitment	✓ Local media outlets
✓ Universities/colleges/high schools	✓ Payers
✓ Transportation	✓ Doulas, CHW's, midwives, OB, Peds
✓ Rideshare companies	✓ School nurses and counselors
✓ Instacart	

Other partners with a role to play:

- Those with lived experience
- Those who believe food insecurity doesn't exist
- Groups that support migrant farmers
- Undocumented workers

Adjacent

- Food producers & restaurants
- Large corporate food industry (Kellogg's)
- Grocery stores
- Hospitals/other large employers of food service

Power

- State & Federal legislators
- Board of Directors
- Stockholders

Questions We Have:

- How do we best distribute nutritious food equitably to alleviate nutrition security?
- How do we best support local farmers to provide healthy foods in a sustainable way?
- How do we minimize food waste and emphasize?

2-3 Key Takeaways/Insights the Group Should Know:

- Food insecurity/nutrition insecurity exists and needs to be addressed
- We have the power as a collective to make this change and achieve this goal!

Gap 2: SOCIAL SERVICES

Inadequate awareness and coordination of social services.

HOW IS THIS GAP SHOWING UP RIGHT NOW?
National & State
✓ Mistrust in government ✓ Stigma around receiving benefits ✓ Coordination of HRSA – funded early childhood initiatives IMIECHV/Title V ✓ Title V measuring food security
Community
✓ Operational barriers **(+1)** ✓ Administration of state programs to the local level varies greatly ✓ Solution – Care coordinator of all services ✓ Solution - Utilize pediatric visit coordination of services and OBGYN visits ✓ Silos of services (WIC, lactation, clinicians) **(+1)** ✓ Addressing families not just individuals ✓ Provider screening and referrals
Person
✓ Stigma **(+1)** ✓ Misunderstanding resource availability ✓ Confusion in enrolling in programs **(+1)**

WHAT'S THE STORY BEHIND THIS GAP?

- Social service infrastructure is lacking, lack of transportation, very far from home – i.e. rural
- Redlining – shifting of neighborhoods and what was available **(+1)**
- Historical trauma/lack of trust **(+1)**
- Pay gap
- Enabling of services and service coordination
- Social services also see disinvestment/underinvestment; "road to nowhere"
- Do we know enough about the "root cause" of low social service uptake/engagement?
- Lack of BIPOC providers, dietitians, etc.

WHO ARE THE PARTNERS WITH A ROLE TO PLAY?	
National & State	
✓ National WIC Association ✓ Legislators ✓ Government agencies (National, State & Local ✓ Philanthropy	✓ Payers ✓ National non-profits ✓ Data sharing (state)
Community	
✓ Schools/universities ✓ Foodbanks ✓ CBOs ✓ LHDs ✓ CHWs **(+1)** ✓ Urban development and built env ✓ Transportation ✓ Local elected officials ✓ Major retailers ✓ Peds clinicians, health prof	✓ Philanthropy ✓ Faith communities ✓ Retailers **(+1)** ✓ Farmers markets ✓ Health systems **(+1)** ✓ Employers ✓ Healthcare providers ✓ Offices of SS (WIC, etc.) ✓ Lactation consultants and birth workers ✓ Foodbanks, WIC, SNAP
Person & Child	
✓ Family/parents ✓ Childcare providers **(+1)** ✓ Where people of color congregate (barber shops, etc.) ✓ Barriers to childcare	✓ Media outlets ✓ Peers ✓ Local parent groups/listservs ✓ Healthcare providers ✓ Offices of SS (WIC, etc.)
Who's/What's Missing	
✓ Lived exp – children, mothers ✓ Teens **(+1)**	✓ Behavior health ✓ Substance abuse treatment

Questions We Have:

- How can we address stigma at a national, state and local level?

2-3 Key Takeaways/Insights the Group Should Know:

- We need to address historical trauma to reduce stigma
- Awareness of services in continuity of care
- Partnerships → traditional and non-traditional

Gap 3: PUBLIC POLICIES

Lack of public policies that benefit the health of women before pregnancy, during pregnancy and during lactation.

HOW IS THIS GAP SHOWING UP RIGHT NOW?
National & State
✓ Lack of paid family leave **(+2)** ✓ MLA not even close to being sufficient **(+1)** ✓ Fractured and fragmented policies across the 50 states and territories **(+1)** ✓ Access and knowledge issues for programs **(+1)** ✓ Stigmatization of policies around maternal health ✓ Institutionalized culture of not supporting this part of the lifespan (stigmatized) ✓ Research challenges - "wo do not have enough information" - what we need to inform policies
Community
✓ Childcare access and quality ✓ Misconceptions about this topic from various sources ✓ Lack doula's being covered by payors ✓ Lack of appropriate education in schools and in general public about nutrition in pregnancy **(+2)** ✓ Lack of community-based approaches in certain communities ✓ Workplace support and reinforcement of policies ✓ Policies that don't fit around this topic **(+1)** ✓ Solution – Competency in K-12 to introduce concept – Dept of Education
Person
✓ Stigma around this topic ✓ Workplace - No consequence if policies not followed up to individual to make it happen

WHAT'S THE STORY BEHIND THIS GAP?

- Place
- Funding structures and resource allocation
- Nutritious food value
- Power "Big Food" "Big Pharma"
- Intersectionality – disability; gender identity; pregnant people aren't a monolith and policies can't be either
- We have de-valued cooking/food education in the school system; children do not get enough time to eat and for those that eat free lunch – does not meet good nutritional quality measures
- Disaggregates data telling a deeper story – volume (drowning in data)
- Political climates

- Minimum wage
- Cultural food preferences

WHO ARE THE PARTNERS WITH A ROLE TO PLAY?	
National & State	
✓ HHS **(+1)**	✓ La Leche League
✓ USDA	✓ SAMHSA
✓ WIC	✓ Medicaid
✓ IBLLC	✓ CDC
✓ ACOG	✓ NIH
✓ AMCHP	✓ FDA's
✓ March of Dimes	✓ AHA
✓ Lamaze Int'l	✓ Funders
Community	
✓ Media Partners	✓ CBO, providers
✓ Social workers	✓ LHDS
✓ Doulas/CHWs/Midwives	✓ Community-based orgs **(+1)**
✓ Postpartum Services	✓ AFL-CIO, March of Dimes
✓ Peds offices	✓ Funders
✓ Local government agencies	✓ Payers
Direct Supports	
✓ Schools	✓ ECE
✓ Employers **(+1)**	✓ Birthing Persons
✓ Healthcare Providers	✓ Partners/support persons
✓ House & Transport	
Who's/What's Missing	
✓ Voices from community members	✓ Faith based orgs
✓ Politicians/state funding	✓ Farmers, local food co-ops
✓ Payers	✓ Academia

Questions We Have:

- How do we effectively organize fed programs and initiatives to truly reflect community?
- What will it take for women's experiences, value, perspective, dignity to be the lead factor in how to design (redesign) our systems and policies?

2-3 Key Takeaways/Insights the Group Should Know:

- Policies must prioritize dignity
- There is a strong desire for FMLA and Paid Family Leave (and momentum)

Gap 4: NUTRITION RESEARCH

Inadequate funding for nutrition research applied to developmental health.

HOW IS THIS GAP SHOWING UP RIGHT NOW?
National & State
✓ Standardization of nutrition research (NR) methods ✓ Rigor and reproducibility issue in NR ✓ More cohort studies ✓ Lack of policies for distributing funds equally across institutions – or to those with the most impact (implementation research) ✓ National database for datasets to be accessed including HER making FAIR ✓ Review criteria and other factors not always appropriate for NR ✓ Current lack of national standard – state-level difference ✓ Academic partnership
Community
✓ Challenges in recruitment of diverse groups of people – specific to research among pregnant persons **(+1)** ✓ Lack of resources to disseminate findings and imp or NR **(+1)** ✓ More cohort studies
Person
✓ Stigma attached to being involved in NR during this period **(+1)** ✓ NR burdensome to folks in this space ✓ Nutrition research can be very burdensome for participants **(+1)** ✓ How to translate the research to the practical/person-level – stress to consume **(+1)** ✓ Lack of knowledge around nutrition research – takes so much time to get to people

WHAT'S THE STORY BEHIND THIS GAP?

- Corporate interests impending
- Education and awareness
- Defining adequate nutrition
- Diet-related inadequate nutrition disproportionate for lower income
- Housing, food storage, food price, cooking
- Not one approach fits all
- Need to focus on food patterns

WHO ARE THE PARTNERS WITH A ROLE TO PLAY?	
National & State	
✓ Non-profits ✓ CBOs ✓ Equity-focused orgs (NAACP) ✓ Industry (but are they putting up?) ✓ Congress **(+1)** ✓ Academia	✓ State agencies ✓ TA providers ✓ Philanthropies and foundations **(+1)** ✓ NIH **(+1)** ✓ All government funding agencies **(+1)** ✓ Public health assoc.
Community	
✓ CBOs ✓ Academia ✓ Health systems ✓ WIC clinics	✓ IRBs **(+1)** ✓ Loal/state government **(+1)** ✓ Public health depts.
Person & Child	
✓ Paid community-based participatory research **(+1)**	
Who's/What's Missing	
▪ Individuals – especially considering intersectionality, diversity, uninsured/hard to reach **(+1)**	▪ Retailers/farmers ▪ Broadening our definition or "research" (i.e. lived experience); more research **(+1)**

Questions We Have:

- None noted

2-3 Key Takeaways/Insights the Group Should Know:

- NTR research is not standardized
- Refine recruitment strategies to increase diversity in research
- Research is still missing individuals with lived experiences

Gap 5: HEALTHCARE NUTRITION EDUCATION

Lack of emphasis and resources devoted to medical nutrition education for all medical professionals.

HOW IS THIS GAP SHOWING UP RIGHT NOW?
National & State
✓ No national standards **(+1)** ✓ Nutrition not prioritized ✓ Not economically incentivized – money in medicine pharm ✓ Nutrition not reimbursed ✓ Not held accountable for nutrition education (not tested) ✓ Beyond science of nutrition, often disconnected from resources that surround nutrition for referral and connection
Community
✓ Healthcare professionals not trained ✓ Not engaged at community level – don't appreciate unique needs ✓ Medical/health needs are compartmentalized ✓ Reactive vs. preventative medical system **(+1)** ✓ Patient-centered care **(+1)** ✓ Community health workers need to be connected to health system ✓ With less "one size fits all" approach we can better bridge gaps for individual
Pregnant People & Children
✓ Information not given at the right time ✓ Variability of information provided **(+1)** ✓ Facts not translated (what we do) into application ✓ Advocate for wholistic approach instead of dominant medical management approach

WHAT'S THE STORY BEHIND THIS GAP?

- Living expenses (i.e., rent, medications)
- Rural, BIPOC, lower income, immigrant/refugee (RIM) communities experiencing lack of access to nutrition and health care
- Cultural differences (certain populations eat different parts of animals, etc.)
- Microbiome differences between countries when RIM enter U.S.
- Income and educational differences among different populations
- 70% of food consumption is UPF
- Cultural norms that drive behaviors including in RIM communities

- Lack of affordable childcare, maternity/paternity leave, lack of paid leave
- Income disparities
- Nutrition only discussed based on disease
- Needs messaging around health optimize

WHO ARE THE PARTNERS WITH A ROLE TO PLAY?	
National & State	
✓ Accrediting bodies **(+1)**	✓ Nonprofits
✓ Public health associations	✓ Medical schools
✓ Congress	✓ Provider associations
✓ Allied health schools	✓ Health insurance providers
✓ Interprofessional collab	
Community	
✓ Healthcare providers	✓ Community experts
✓ Cultural "influencers"	✓ Hospital systems
✓ Teaching kitchens	
Direct Supports	
✓ Teaching kitchens	
✓ Continuing education	
✓ Community based organizations	
Who's/What's Missing	
✓ Community health workers	✓ RDNs **(+1)**
✓ Medical providers	✓ NDTRs
✓ HBCUs and minority serving institutions	✓ Home Ec
✓ Culinary professionals	✓ Instacart
✓ Restaurants	✓ Voice of the individual
✓ Nurses	✓ Medical students
✓ Researchers **(+1)**	✓ Cultural and competent providers

Questions We Have:

- Why is nutrition not prioritized at every level?

2-3 Key Takeaways/Insights the Group Should Know:

- Nutrition is not prioritized
- Medical systems are not in prevention

Gap 6: COMMUNITY INVOLVEMENT

Requirement of community involvement to change the nutritional landscape at the local level; women and communities are currently not engaged in developing solutions.

HOW IS THIS GAP SHOWING UP RIGHT NOW?
National & State
✓ Healthy Start Community Consortium includes Healthy Start and community members to address factors contributing to infant mortality also there are two Healthy Start participants here today **(+1)** ✓ Need to increase funding for community-focused research and interventions **(+1)** ✓ Too much emphasis on short-term results vs. long-term sustainable solutions – years/decades – not months **(+1)** ✓ Perceptions of rigor scalability
Community
✓ Not knowing who is already doing the work **(+1)** ✓ Who should be at the tables ✓ Less person-to-person team building ✓ People need to relearn how to work in a team ✓ Social isolation ✓ Invisible community members ✓ Those outside the immediate circle ✓ The voices you don't hear are the voices who need to be involved the most
Person
✓ Stress!! "Time insecurity"" – no time to participate in community activities **(+1)** ✓ Transient interest in topic – Preg → school → ✓ Paying people for their time and expertise!

WHAT'S THE STORY BEHIND THIS GAP?

- People need to feel more interconnected across community
- Lack of funds, access to resources that are results of decision where certain groups weren't involved
- Behavior change and buy-in are deterred when solutions are not inclusive and representative **(+1)**
- Community members may not have capacity to be involved in efforts or beyond own households
- Lack of understanding about importance of proper nutrition during pregnancy, and also lack of communication from government about it

- Lack of investment into communities on this topic
- Lack of implementing prevention policies in public health including proper nutrition
- Individualism as a culture in the USA leads our design of programs/solutions/interventions, and limits/stigmatizes community involvement

WHO ARE THE PARTNERS WITH A ROLE TO PLAY?	
National & State	
✓ National League of Cities ✓ Nonprofits/NGOs ✓ Food industry	✓ Payers state/national ✓ Farmer
Community	
✓ City/State leaders ✓ Doulas ✓ Food banks, charitable food systems **(+1)** ✓ Faith based orgs ✓ WIC, SNAP **(+1)** ✓ Farmer	✓ Health professionals **(+1)** ✓ Advocacy orgs ✓ Childcare educator, early child, K-12 **(+1)** ✓ Researchers and funders ✓ Health departments **(+1)**
Person	
✓ Clinic – communities ✓ Partners ✓ Kids **(+1)** ✓ Support people	
Who's/What's Missing	
✓ Culture brokers ✓ RD – Public Health Nutritionist ✓ Local grocers ✓ Elected officials ✓ Funders with commitment to sustainable $	✓ Tribal leadership, members ✓ HBCUs and minority serving institutions ✓ The community ✓ Community leaders ✓ Diversity of community ✓ Education on community-based participants research

Questions We Have:

- Is it possible to prioritize prevention when it becomes politicized?

2-3 Key Takeaways/Insights the Group Should Know:

- Sustainability of funding
- Lack of coordinated effort (convener)
- Big interest

Gap 7: RACIAL DISPARITIES

Presence of implicit bias and racial disparities in women's health and birth outcomes. There is also a lack of diversity among nutrition professionals.

HOW IS THIS GAP SHOWING UP RIGHT NOW?
National & State
✓ National data still very bad ✓ Starting to have conversations about the issue ✓ Issues with data not being specific enough **(+1)** ✓ More funding for search in epigenetics ✓ Increase funding for training opportunities
Community
✓ Lack of resources ✓ Most action on bias here **(+1)** ✓ Community orgs work together
Pregnant People & Children
✓ Not seeing change here ✓ Info, education, support, advocacy, empowering

WHAT'S THE STORY BEHIND THIS GAP?

- Simplification of very complex issue (prenatal vitamins are a must; "healthy diet" is secondary)
- Lack of access to variety of "health" foods
- Lack of access to quality health care
- Dismissive of patient's engagement/ knowledge/interest/miscues/lack of cultural sensitivity/lack of respect **(+1)**
- Distrust of health care providers **(+1)**
- Differences in life experiences – inability to translate information/guidance in an applied way
- Lack of diversity in health care providers – social class/experiences/racial-ethnic **(+1)**
- Need to understand and incorporate traditional health care practices
- Misbelief/conceptions of providers for groups that result in downplaying concerns, pain, seriousness of experiences

WHO ARE THE PARTNERS WITH A ROLE TO PLAY?	
National & State	
✓ Congress ✓ Media **(+1)** ✓ Funding organizations ✓ GME/other health professional ed ✓ Data analyst ✓ Training next gen of providers	✓ Policy makers **(+1)** ✓ National associations/NGOs ✓ Policy makers **(+1)** ✓ Researchers ✓ Academic health centers (AHC)
Community	
✓ Educators ✓ Health professionals ✓ Health systems ✓ Health education ✓ Local government – built environment ✓ City/state leaders	✓ Home visiting programs ✓ Women ✓ Birthing centers/hospitals ✓ Doulas **(+1)** ✓ CHNs
Direct Supports	
✓ Family ✓ Employers ✓ Partners/spouse ✓ Women	
Who's/What's Missing	
✓ Representation in the medical profession (women, black women) ✓ Research funders/researchers ✓ Breastfeeding partners ✓ Doulas	✓ Culture brokers ✓ Payors ✓ Women ✓ Disability

Questions We Have:

- How do we improve our data about implicit bias, disparate treatment and what goa to get more movement vs. on implementation, best practices, $?

2-3 Key Takeaways/Insights the Group Should Know:

- Our actions are <u>not</u> translating to change…yet (re: implicit bias)
- Diversity in providers = important
- Dismissive provider = detrimental

Gap 8: DISEASE PREVENTION

Nutrition is not embraced as a form of disease prevention on a societal level and among health professionals.

HOW IS THIS GAP SHOWING UP RIGHT NOW?
National & State
✓ WIC restrictions of F&V ✓ Structure of health care system **(+1)** ✓ Lack of training of medical professionals **(+1)** ✓ No reimbursement for nutrition education **(+1)** ✓ School meals and access to free lunch
Community
✓ SNAP Ed ✓ SNAP incentives ✓ Lack of awareness
Person
✓ Need cooking skills ✓ Not requiring nutrition ed they need ✓ Lack of awareness ✓ Choices of food available and affordable **(+1)**

WHAT'S THE STORY BEHIND THIS GAP?

- Not a priority for most professionals
- Food deserts, lack of healthy food access **(+1)**
- Poor choices in stores
- Communities of color do not talk enough about nutrition
- Cultural competency matters **(+1)**
- Prenatal and post partem nutrition are different but not taught
- How long is the postpartum, postpartum is more than 40 days
- Prenatal covers women postpartum mother and child **(+1)**
- Guidance not as strong as it should be
- We are starting too late – must occur years before pregnancy
- Food is the foundation; it's the way in
- Food is health, not just medicine, the goal is to prevent disease so we don't have to treat it
- But food is the best medicine
- Prevention is not a priority; not fiscally lucrative

WHO ARE THE PARTNERS WITH A ROLE TO PLAY?	
National & State	
✓ AMA standards don't prioritize med schools to educate ✓ Equity not a part of our national design ✓ Media ✓ NIH not driving nutrition research as a preventative strategy for chronic disease (+NCCIH) (+USDA) (+CDC + US Preventative Service Task Force)	✓ Accrediting bodies over medical provider groups ✓ Policymakers ✓ Payers – "you can do what we pay for" ✓ Social media
Community	
✓ Community programs for youth and families/caregivers ✓ Schools ✓ Wellness over illness programs – program delivery agents ✓ Agricultural/farming – emphasizing/incentivizing whole food production	✓ Healthcare institute and systems ✓ County/local government and agencies ✓ Cultural taboos/guidance ✓ Religion/faith ✓ Religious spiritual org ✓ City/state leaders
Direct Supports	
✓ Cultural taboos/guidance ✓ Religion/faith ✓ Access to information about nutrition and wellness for the schools and standardly	✓ Family traditions/culture ✓ Grassroots advocacy ✓ Family cultures
Who's/What's Missing	
✓ School boards and educational oversight bodies **(+1)** ✓ Community agencies ✓ Patient-centered care	✓ Providers receiving wrap around education ✓ Mental health care systems ✓ House (HUD)

Questions We Have:

- How to get everyone to the table without incentives?
- Resources for coordination?

2-3 Key Takeaways/Insights the Group Should Know:

- The need to incentivize wellness over illness
- Nutrition related disease prevention goes beyond nutrition professionals (i.e. housing)
- Need for more culturally responsive interventions

Gap 9: SUPPORT FOR BREASTFEEDING

Inadequate knowledge of and support for breastfeeding.

HOW IS THIS GAP SHOWING UP RIGHT NOW?
National & State
✓ Health care system fragmentation ✓ Momentum increasing – CDC support ✓ Lack of cultural competency or standard ✓ Nestle marketing ✓ Baby friendly hospitals ✓ Pump Act; employment support ✓ Milk banks (not enough) ✓ Medicaid expansion ✓ More research on milk production ✓ Silos in systems and composition – peds, ob/gyn ✓ Lack of family leave!! **(+1)** ✓ Lack of childcare – adequate, affordable
Community
✓ Lacation support via doulas ✓ Culturally competent providers ✓ Home visits ✓ Total family education lacks
Pregnant People & Children
✓ Stigma ✓ Initiation is good, maintenance is tough! ✓ Barrier: lack of familiar support ✓ Lack of education during pregnancy re: B.F. ✓ Access to lactation support

WHAT'S THE STORY BEHIND THIS GAP?

- More research on milk production
- Social pressure put on people who are nursing
- Lack of lactation consulting **(+1)**
- Importance of good nutrition during lactation **(+1)**
- Need support system – partner, doulas, social network **(+3)**
- Cultural competency

- Transition going back to work and still breast feeding exclusively
- Having a place when they go back to work that is clean and appropriate to pump
- Breastfeeding support groups
- Creation of consulting for breastfeeding
- Train mother during pregnancy to breastfeed
- Train dads and supporting persons as well
- Baby friendly hospitals

WHO ARE THE PARTNERS WITH A ROLE TO PLAY?	
National & State	
✓ CDC Foundation ✓ Congress ✓ CDC ✓ Medicaid ✓ SNAP	✓ Healthy Start ✓ NIH ✓ TANF ✓ WIC
Community	
✓ Providers ✓ Food programs ✓ Media outlets (PSA) ✓ Business (policy) HR – policies exist but need more support with implementation and use/enrollment ✓ WIC ✓ States (policy)	✓ Community leaders to normalize infant feeding ✓ Cultural norms (groups) **(+1)** ✓ Hospitals (BF friendly) ✓ Universities ✓ WIC ✓ DHS-TANF
Direct Supports	
✓ Lacation consultants ✓ Physicians ✓ Dietitians ✓ Doulas **(+1)** ✓ Midwives ✓ Families ✓ Partners	✓ Nurses ✓ Care teams ✓ Pediatric staff ✓ Hospital staff ✓ Lac staff ✓ Lacation support providers
Who's/What's Missing	
✓ City match ✓ Old Ways Foundation (Boston) ✓ Family childcare – informal	✓ Fathers/Dads bootcamp ✓ Leadership buy-in and commitment from employers

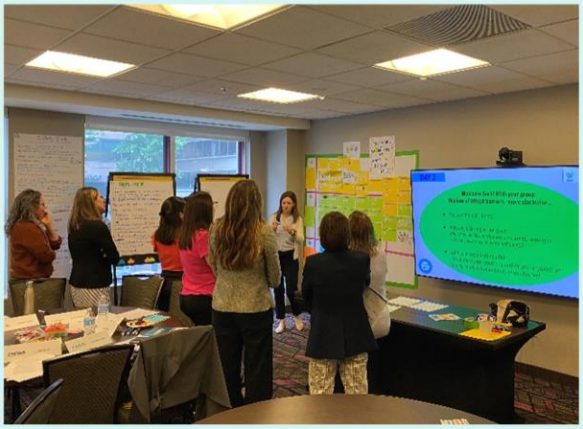
- ✓ ECE
- ✓ Head Start
- ✓ CDC
- ✓ Grandparents
- ✓ Families and work org
- ✓ Billing/insurance for 1:1 care for birthing people (Doulas)
- ✓ Time to BF, pump, stove milk
- ✓ Disability – sensitive care, policies, education
- ✓ Prenatal education →CHWs

Questions We Have:

- How do you get the partners to work together (different levels)?
- How can we respond individually to the individualized challenges that people have?

2-3 Key Takeaways/Insights the Group Should Know:

- No more shaming (when you don't "fit" the model)
- Family leave policies to actually promote/support BF/nutrition
- Affordable childcare



Gap 10: FAMILY LEAVE

Lack of comprehensive family leave which is associated with reduced rates of breastfeeding and family nutritional care and increased family stress.

HOW IS THIS GAP SHOWING UP RIGHT NOW?
National & State
✓ No access at the federal level for federal employees (5 years ago), now we have 12 weeks **(+1)** ✓ Lack of federal comprehensive policies supporting family leave **(+1)** ✓ Lack of childcare providers
Community
✓ Several gaps and disparities that exist for those that have access and those that do not **(+1)** ✓ How does this lack of access exacerbate existing SSDH issues? Lack of childcare **(+1)**
Pregnant People & Children
✓ For most people, lack of comprehensive family leave is incompatible with breastfeeding recommendations **(+2)** ✓ Pressure to return to work early ✓ Undocumented, don't have any protection/support ✓ Parental leave for other parent

WHAT'S THE STORY BEHIND THIS GAP?

- System not designed to support women and young children
- Taking leave needs to be the social norm
- No appreciation for long-term consequences
- Lack of women's autonomy over their bodies
- Availability of healthy food – cheap processed food, power of "big food", structure of food system
- Need more paid leave systems similar to MA – State supported paid family leave – everyone pays a little

WHO ARE THE PARTNERS WITH A ROLE TO PLAY?	
National & State	
✓ Support local orgs ✓ 6 months paid across the board ✓ Nutritional guide culturally competent and linguistic	✓ Large employers **(+2)** ✓ Small and medium employers **(+1)** ✓ Legislature – senators/representatives; POTUS; SCOTUS **(+2)**
Community	

✓ Community partners educated rapport ✓ Local government support and support community orgs	✓ Statewide mandated paid leave option ✓ Support and encouragement from supervisors
Person & Child	
✓ Support people overcoming fear of not having job when they come back ✓ Need to know their rights and what's available ✓ Commit with orgs or government agencies that support family leave	✓ Create pipeline up, community voices heard ✓ HR – educate employees on options and process ✓ Partners/fathers
Who's/What's Missing	
✓ Pregnant employees and their infants/children ✓ Corporate America ✓ Behavioral healthcare/mental health ✓ Disability advocates	✓ Partners of pregnant individuals ✓ Society/pressure to return to work ✓ AFL-CIO and Unions ✓ Universities and research institutions

Questions We Have:

- Where do you go to find out the Family Leave policies on all levels?
- Who will create this information?
- What is the role of the family in finding out this info?
- What is the role of community organizations to assist families with this communication?

2-3 Key Takeaways/Insights the Group Should Know:

- 6 months paid across the board (national standard)
- Nutritional guide cultural competence

National & Community Panels

The afternoon of Day 1 included two moderated panels, expanding dialogue about nutrition and pregnancy and showcasing examples of initiatives from some federal, national and community-based organizations.

NATIONAL:

Overview of national government programs; how to integrate and collaborate more effectively across programs; how to increase action to improve health of women, children and pregnant people.

Moderator: Janet de Jesus - Health and Human Services (HHS)

- Georgia Machell: WIC
- Kristal Dail: Healthy Start
- Meghan Adler: USDA
- Rachel Ferencik: CDC Foundation

COMMUNITY:

Overview of selected community-based programs; how to integrate and collaborate more effectively across programs; how to increase action to improve health of women, children and pregnant people.

Moderator: Krista Lumpkins-Howard - Birthing Beautiful Communities

- Chuck Smith: Black Food Sovereignty
- Harumi Reis-Reilly: NACCHO
- Mike Pomeroy: Brighter Bites
- Les Myatt: OHSU
- Jazmin Long: Birthing Beautiful Communities

NACCHO resources referenced by Harumi Reis-Reilly:

Continuity of Care in Breastfeeding Blueprint | Culturally Diverse Infant and Toddler Toolkit

Vote for Top 3 Priorities

Prior to the conference, a survey was distributed that included a question about perceived urgency among the Top 10 Gaps & Barriers. About half of all registered attendees were able to respond, resulting in these:

- *Presence of food insecurity and inadequate access to healthy foods.*
- *Lack of public policies that benefit the health of women before and during pregnancy and during lactation.*
- *Implicit bias and racial disparities in women's health and birth outcomes.*

At the end of Day 1, participants were asked to review the expanded wisdom collectively produced and vote to consensus on Top 3 Priorities to focus on during Day 2. While all of the Top 10 Gaps & Barriers are critical, participants were urged to consider which offer the best opportunity for collaborative action. Each participant had three votes, placing one dot on each of their preferred top three potential priorities.

1. **Presence of food insecurity and inadequate access to healthy foods. (18)**
2. Inadequate awareness and coordination of social services (e.g. Medicaid, SNAP, WIC, etc.) **(6)**
3. Lack of public policies that benefit the health of women before pregnancy, during pregnancy and during lactation. **(13)**
4. Inadequate funding for nutrition research applied to developmental health. **(2)**
5. **Lack of emphasis and resources devoted to medical nutrition education for all medical professionals. (14)**
6. **Requirement of community involvement to change the nutritional landscape at the local level; women and communities are currently not engaged in developing solutions. (14)**
7. Presence of implicit bias and racial disparities in women's health and birth outcomes. There is also a lack of diversity among nutrition professionals. **(5)**
8. Nutrition is not embraced as a form of disease prevention on a societal level and among health professionals. **(13)**
9. Inadequate knowledge of and support for breastfeeding. **(1)**
10. Lack of comprehensive family leave which is associated with reduced rates of breastfeeding and family nutritional care and increased family stress. **(3)**

DAY 1 CLOSING:

As the first day closed, participants were invited to offer reflections, including the identification of any gaps and barriers the research article did not include. **Misinformation** was named as a key issue complicating nutrition in pregnancy at all levels. While all participants agreed, this was not included in the voting. It was also noted that advancing equity must be threaded throughout the Top 3 Priorities, particularly addressing the racial disparities produced by systemic injustice.

DAY 2

What's the desired condition of well-being?

Facilitated small group vision casting

What works to improve nutrition in pregnancy?

What do we propose to do?

Facilitated small group conversations about strategies and best opportunities for collaborative action

What do we commit to do?

Facilitated small group action planning

PRIORITY 1:
Presence of food and nutrition security and access to healthy foods

WHAT IS THE DESIRED CONDITION OF WELL-BEING? (IDEAL STATE)

- Economic security for families
- Living wage/jobs for all
- Nutrition secure – available, affordable, stability, utilization of healthy foods
- Healthy choice is easy choice, enjoyable, culturally appropriate, affirming **(+1)**
- Available locally
- Healthy pregnant people and their families
- Reinvent family/community meals
- More farmer's markets equitably available
- Places to do physical activity
- We see less need for focus on substance abuse
- Every home has a garden (vegetable)/greenspace
- Robust community food systems
- Nutrition education **(+1)**
- Food prep/tactical life skills get life skills back in to middle/high schools **(+1)**
- Business & health interests align
- Marketing of nutritious food
- No need for food banks
- Shifting the role of food banks
- Define what healthy nutrition is **(+1)**
- Less chronic disease, improvement in mental health **(+1)**
- Healthy food is a right
- Disparities don't exist
- More garden – sustainable
- More local food production
- Reduce food waste – more policies around waste **(+1)**
- More education on cooking, a community approach to eating
- All schools receive nutrition education **(+1)**
- Increase awareness of nutrition
- Everyone has enough time to cook and eat **(+1)**
- Universal school meal, summer meals
- Farm to institution **(+1)**
- Changes to subsidy system **(+1)**

- More awareness to the importance of nutrition security for policy makers
- No more/not needed – full utilization of WIC, SNAP, etc.
- No need for safety net programs
- No aggressive marketing **(+1)**
- Impossible to find inequities in policies and practices
- Reparations to BIPOC individuals, communities, farmers
- Healthy foods and healthcare are human rights **(+1)**
- Only financial support for regenerative and sustainable food supply
- Open source seeds for everyone
- Decentivizing UPFS "industrialized" and incentivizing whole foods **(+3)**
- Access to affordable/free childcare **(+1)**
- Food sovereignty **(+1)**
- Living wage **(+1)**

WHAT WORKS TO IMPROVE NUTRITION IN PREGNANCY?

NEW & ADDITONAL GOALS aligned with this Priority and Organizations that are already working on them:
1. Medicaid coverage of a range of HRSN services and supports ✓ CHLPI 2. Cross-cutting 2h. Support the workforce of nutrition assistance programs. (i.e. funding, capacity, diversity, tribal-focused, etc.) ✓ AMCHP ✓ CHLPI ✓ HRSA ✓ NACCHO ✓ Vitamix 3. Tech to support nutrition Assistance
CROSS CUTTING GOALS aligned with this Priority and Organizations that are already working on them:
1. Make maternal and infant health a visible priority for government and nonprofit organizations. Educate leaders about how good nutrition during development and across the lifespan can positively impact maternal and infant health outcomes and long-term population health. ✓ AMCHP ✓ CDC Foundation

- ✓ Cea Doula
- ✓ CHLPI
- ✓ Institute for Natural Medicine
- ✓ Land-grant University, SNAP-ED
- ✓ March of Dimes
- ✓ NACCHO
- ✓ OHSU

2. Focus on broad and swift implementation of evidence-based strategies for developing effective programs for improving nutrition and stress environments in women of reproductive age. Examples include providing resources for the expansion of WIC and the Supplemental Nutritional Assistance Program (SNAP). Food & Friends is example of medically tailored food delivery.

- ✓ AMCHP
- ✓ American Heart Association

2a. Expand the impact of WIC and SNAP programs.

- ✓ Land Grant Sovereignty, Snap ED

2e. Provide stable and consistent funding for WIC.

- ✓ AHA/VFHK
- ✓ AMCHP

2g. Streamline qualification and application processes for various benefit programs.

- ✓ AHA/VFHK

3. Reduce racial disparity in pregnancy and childbirth outcomes.

- ✓ AMCHP
- ✓ Cea Doula
- ✓ NACCHO
- ✓ OHSU
- ✓ Vitamix

3a. Identify and expand programs that improve health disparities.

3.b Address structural racism (e.g., breastfeeding, implicit bias in healthcare, health promotion, food deserts).

- AMCHP

4. Prioritize community-driven and community-centered messaging and solutions.

- ✓ AMCHP
- ✓ CHLPI
- ✓ OHSU
- ✓ Land-Grant University, SNAP-Ed
- ✓ Vitamix

4a. Engage with communities to identify needs and develop solutions.

- ✓ American Heart Association/Voices for Healthy Kids
- ✓ AMCHP

- ✓ CDC Foundation
- ✓ CHLPI
- ✓ HRSA
- ✓ NACCHO
- ✓ OHSU
- ✓ Land-Grant University, SNAP-Ed
- ✓ Vitamix

4b. Value expertise from people with lived experience.

- ✓ AHA/VFHK
- ✓ AMCHP
- ✓ HRSA
- ✓ NACCHO
- ✓ OHSU

4c. Use community-based participatory research methods.

- ✓ Cea Doula
- ✓ Land-Grant University, SNAP-Ed
- ✓ OHSU

4d. Personalize messaging to meet the needs of specific communities.

- ✓ Land-Grant University, SNAP-Ed

4e. Develop and use simple, community-centered nutrition messages and education strategies.

- ✓ Institute for Natural Medicine
- ✓ Land-Grant University, SNAP-Ed

4f. Take an affirming, strength-based approach that connects to cultural foods.

- ✓ AMCHP
- ✓ Black Food Sovereignty Coalition

4g. Create simple tools and resources (e.g., endorsement system for nutrition messaging, simplified nutrition labels, education toolkits).

- ✓ Cea Doula
- ✓ OHSU
- ✓ Land-Grant University, SNAP-Ed

4h. Use social media campaigns to reach communities where they are.

- ✓ Cea Doula
- ✓ OHSU
- ✓ Land-Grant University, SNAP-Ed

4i. Leverage the power of personal stories (not facts) to communicate key messages.

- ✓ AHA/VFHK
- ✓ AMCHP
- ✓ CDC Foundation
- ✓ HRSA

- ✓ OHSU

4j. Provide nutrition and cooking education "early and often".

- ✓ Institute for Natural Medicine
- ✓ OHSU
- ✓ Land-Grant University, SNAP-Ed

POLICY AND INTERVENTION GOALS aligned with this Priority and Organizations that are already working on them:

1. Ensure high-quality and culturally competent clinical care.
   - ✓ Cea Doula
   - ✓ OHSU
   - ✓ Vitamix

1a. Provide culturally sensitive interventions.
   - ✓ Cea Doula
   - ✓ HRSA
   - ✓ NACCHO
   - ✓ OHSU

1b. Require ***responsive*** cultural competence, implicit bias, and anti-racism training for providers.
   - ✓ NACCHO
   - ✓ OHSU

1d. Increase presence of registered dieticians/registered dietitian nutritionists in clinics.
   - ✓ NAACHO
   - ✓ OHSU

1e. Promote a team approach for patients (eg, leverage a patient navigator role).
   - ✓ AMCHP
   - ✓ CHLPI
   - ✓ NAACHO

2. Improve the coverage of nutrition, maternal, lactation, and neonatal services under Medicaid and other insurance.
   - ✓ AHA/VFHK
   - ✓ AMCHP
   - ✓ CHLPI

2a. Add additional billable Current Procedural Terminology® codes for specific nutrition
   - ✓ CHLPI

2c. Present to the National Association for Medicaid Providers on the importance of nutrition, the developmental origins of health and disease, and racial health Disparities ***and other policymakers.***
   - ✓ CHLPI

2d. Promote coverage of successful interventions with positive patient outcomes and

economic benefits.

- ✓ AMCHP
- ✓ CHLPI

3. Increase access to affordable and nutritious food.

- ✓ AHA/VFHK
- ✓ Black Food Sovereignty Coalition
- ✓ CDC Foundation
- ✓ CHLPI
- ✓ NACCHO
- ✓ OHSU
- ✓ Land-Grant University, SNAP-Ed
- ✓ Vitamix

3b. Increase community demand for fruits and vegetables.

- ✓ AHA/VFHK
- ✓ OHSU
- ✓ Land-Grant University, SNAP-Ed

3c. Coordinate grocery delivery to underserved communities.

- ✓ CHLPI
- ✓ OHSU

3d. Work with National Grocers Association to eliminate food deserts.

- ✓ CDC Foundation

3e. Support improvements to school lunch programs.

- ✓ AHA/VFHK
- ✓ Land-Grant University, SNAP-Ed
- ✓ OHSU

4. Integrate nutrition interventions with social support services.

- ✓ AMCHP
- ✓ CHLPI
- ✓ NACCHO

4a. Integrate nutrition education and/or food delivery with home-health care visits and/or doula-based care.

- ✓ Cea Doula
- ✓ CHLPI (advocate for)

4b. Include support at preconception, during pregnancy, and postpartum.

- ✓ AMCHP
- ✓ Cea Doula
- ✓ CHLPI
- ✓ March of Dimes
- ✓ NACCHO

- ✓ OHSU
- ✓ Land -Grant University, SNAP-Ed

4c. Provide grants for pilot projects on integrated services.

- ✓ AMCHP
- ✓ CHLPI (Advocate for grants, TA)
- ✓ HRSA
- ✓ NAACHO

5. Implement universal paid family leave to facilitate the institution of early good nutritional practices.

- ✓ AHA/VFHK

6. Enhance support and education for breastfeeding and lactation.

- ✓ Cea Doula
- ✓ NACCHO
- ✓ Vitamix

6a. Grow the lactation consultant workforce by incentivizing training and/or training community health workers.

- ✓ NACCHO

6b. Destigmatize public breastfeeding.

- ✓ Cea Doula
- ✓ NACCHO

6c. Support parents who return to work with easy access to lactation suites, breast pumps, and other support.

- ✓ AMCHP
- ✓ NACCHO
- ✓ OHSU

7. Provide greater financial security as a means to help people make healthy choices.

- ✓ AHA/VFHK
- ✓ CHLPI

7a. Increase support for childcare.

- ✓ AHA/VFHK
- ✓ AMCHP

8. Partner with community-based organizations to deliver care and resources.

- ✓ AHA/VFHK
- ✓ AMCHP
- ✓ CHLPI
- ✓ Institute for Natural Medicine
- ✓ NACCHO
- ✓ OHSU
- ✓ Land-Grant University, SNAP-Ed
- ✓ Vitamix

HEALTHCARE PROFESSIONAL TRAINING GOALS aligned with this Priority and Organizations that are already working on them:
1. Expand nutrition education across healthcare professional training programs and mandate some degree of competency in Continuing Medical Education-related or board renewal activities. ✓ ACOG ✓ Cea Doula ✓ CHLPI ✓ OHSU ✓ VITAMIX FOUNDATION 1a. Set meaningful requirements for nutritional knowledge in professional colleges. ✓ ACOG ✓ CHLPI ✓ OHSU 1b. Inspire health care professionals to elevate the role of nutrition to their patients. ✓ ACOG ✓ CHLPI ✓ Institute for Natural Medicine ✓ NAACHO ✓ OHSU
RESEARCH GOALS aligned with this Priority and Organizations that are already working on them:
3. Prioritize cost analysis research of effective programs to demonstrate economic as well as health benefits. ✓ AHA/VFHK 4. Diversify the scientific pipeline so that racial and ethnic influences and inequalities can be better understood and more effectively addressed. ✓ AHA/VFHK

WHERE ARE OUR BEST OPPORTUNITIES FOR COLLABORATIVE ACTION?

Collective Monitoring & Shared Learning 	Reduce racial disparity in pregnancy and childbirth outcomes. ✓ AMCHP ✓ Black Food Sovereignty Coalition ✓ CEA Doula ✓ HRSA ✓ NACCHO ✓ OHSU ✓ Vitamix Increase access to affordable and nutritious food. ✓ Black Food Sovereignty Coalition ✓ CDC Foundation ✓ CLHPI ✓ Land-Grant University, SNAP-Ed ✓ NACCHO ✓ OHSU ✓ Vitamix ✓ Voices for Healthy Kids
Coordinate & Strengthen Existing 	Inspire health care professionals to elevate the role of nutrition to their patients. ✓ ACOG ✓ CHLPI ✓ HRSA ✓ Institute of Natural Medicine ✓ NACCHO ✓ OHSU Include support at preconception, during pregnancy, and postpartum. ✓ AMCHP ✓ CEA Doula ✓ CHLPI ✓ Land-Grant University, SNAP-Ed ✓ MOD ✓ NACCHO ✓ OHSU Make maternal and infant health a visible priority for government and nonprofit organizations. Educate leaders about how good nutrition, learning development

	and across the lifespan can positively impact maternal and infant health outcomes and long-term population health. ✓ AMCHP ✓ CDC Foundation ✓ CEA Doula ✓ CHLPI ✓ Institute of Natural Medicine ✓ Land-Grant University, SNAP-Ed ✓ MOD ✓ NACCHO ✓ OHSU Focus on broad and swift implementation of evidence-based strategies for developing effective programs for improving nutrition and stress environments in women of reproductive age. Examples include providing resources for the expansion of WIC and Supplemental Nutritional Assistance Program (SNAP), Food and Friends is example of medically tailored food delivery. ✓ AMCHP ✓ CDC Foundation ✓ CHLPI ✓ Land-Grant University, SNAP-Ed ✓ Voices for Health Kids <u>Principle:</u> Center Community in all workgroups Partner with community-based organizations to delivery care and resources. ✓ AMCHP ✓ CHLPI ✓ CDC Foundation ✓ Institute of Natural Medicine ✓ Land-Grant University, SNAP-Ed ✓ NACCHO ✓ OHSU ✓ Vitamix ✓ Voices for Healthy Kids Prioritize community-driven and community-centered messaging and solutions. ✓ AMCHP ✓ Black Food Sovereignty Coalition ✓ CHLPI ✓ Institute of Natural Medicine

	✓ Land-Grant University, SNAP-Ed ✓ OHSU ✓ Vitamix Engage with communities to identify needs and develop solutions. ✓ AMCHP ✓ CDC Foundation ✓ CHLPI ✓ HRSA ✓ Land-Grant University, SNAP-Ed ✓ NACCHO ✓ OHSU ✓ Vitamix ✓ Voices for Healthy Kids Leverage the power of personal stories (not facts) to communicate key messages. ✓ AMCHP ✓ HRSA ✓ OHSU ✓ Voices for Healthy Kids
Explore Innovation & New Opportunities 	Tech to support nutrition assistance ✓ CDC Foundation Support the workforce of nutrition assistance programs, (i.e., funding, capacity, diversity, tribal-focused, etc.) ✓ AMCHP ✓ HRSA ✓ NACCHO ✓ Vitamix Expand nutrition education across healthcare professional training programs and mandate some degree of competency in Continuing Medical Education-related or board renewal activities. ✓ ACOG ✓ CDC Foundation ✓ CEA Doula ✓ CHLPI ✓ OHSU

PRIORITY 2:
People with lived experience co-create nutrition in pregnancy systems of care in partnership with organizations at all levels

WHAT IS THE DESIRED CONDITION OF WELL-BEING? (IDEAL STATE)

- Trust **(+1)** based on granting-simplify **(+1)**/streamline
- Reporting process and application process – make it easy!
- Nation nutrition education strategy in coordination with community leaders and federal partners **(+1)**
- Communities deciding farm space, crops, what is grown, how it is distributed; Local farmers **(+1)** – who grows it!
- Well-funded through government and private sources **(+1)**
- For the community – by the community – report back to community **(+3)**
- Long term relationships/continuity/trust
- Community-based participator research and implementation – program design where certain % involvement is community members **(+2)**
- Empower, reinforce and support community members – compensate for time and knowledge **(+2)**
- Catalyze capacity building
- Nutrition education and applied food preparation in high schools **(+1)**
- Teachers college and community colleges
- Accountability for the system to value and prioritize community involvement, needs, wants
- Community is well-funded to have own infrastructure
- Community involved in what, how, when, where the solutions are done
- Representation – dedicated seats: language, youth, adolescents contribute to the conversation and advocacy efforts and decisions
- Community sets policy agenda
- Share community solutions with other communities
- We hear about community successes often
- Community involvement is a normal and celebrated practice that you are able to prioritize
- Community programs are sustained
- Supporting community economy
- Appropriately resourced
- Birthing people are leading the work – leadership roles, set the table **(+2)**
- Every community decides their own food sovereignty **(+2)**
- CAB to local government to provide input to decision makers and that the decision makers <u>don't hoard power</u> – community decision makers **(+1)**
- Elected officials held accountable – sustainable accountability
- Elected officials made of community members with lived experience
- CBO collaboration and alignment of goals

- Collaboration is financially supported **(+1)**
- Required – build collaboration into grant funding
- More grant pathways for nutrition **(+1)**
- Longer duration/flexibility, long term outcomes **(+1)**

WHAT WORKS TO IMPROVE NUTRITION IN PREGNANCY?

NEW & ADDITIONAL GOALS aligned with this barrier and organizations that are already working on them:
1. Food is a right. ("Cross-cutting Goal #5.") ✓ CDC Foundation ✓ Black Food Sovereignty Coalition ✓ March of Dimes ✓ WIC 2. Maternal Mental Health & for people of all reproductive age (and Youth, etc) ✓ Reduce barriers/stress to enrollment ✓ Eliminate enrollment ✓ Screening ✓ ACOG ✓ March of Dimes 3. Community members <u>leading</u> solutions ("Cross-cutting Goal 4.K) ✓ CDC Foundation ✓ Black Food Sovereignty Coalition ✓ NACCHO ✓ OHSU 4. Compensate fairly for intellectual expertise and grants allow to pay people directly ✓ AMCHP
CROSS CUTTING GOALS aligned with this Priority and Organizations that are already working on them:
2. Focus on broad and swift implementation of evidence-based strategies for developing effective programs for improving nutrition and stress environments in women of reproductive age. Examples include providing resources for the expansion of WIC and the Supplemental Nutritional Assistance Program (SNAP). Food & Friends is example of medically tailored food delivery. g. Streamline qualification and application processes for various benefit programs. ✓ AHA/VFHK 3.Reduce racial disparity in pregnancy and childbirth outcomes.

- ✓ AMCHP
- ✓ HRSA
- ✓ WIC

3a. Identify and expand programs that improve health disparities.

- ✓ AMCHP
- ✓ HRSA
- ✓ March of Dimes

3b. Address structural racism (eg, breastfeeding, implicit bias in healthcare, health promotion, food deserts).

- ✓ AMCHP

4. Prioritize community-driven and community-centered messaging and solutions.

- ✓ AHA/VFHK
- ✓ Black Food Sovereignty Coalition
- ✓ Institute for Natural Medicine
- ✓ NAACHO
- ✓ OHSU

4b. Value expertise from people with lived experience. ***Center & adequately compensate people with lived experience.***

- ✓ *AMCHP*
- ✓ *CDC Foundation*

4c. Use community-based participatory research methods.

- ✓ AMCHP
- ✓ NACCHO
- ✓ OHSU
- ✓ Land-Grant University, SNAP-Ed

4d. Personalize messaging to meet the needs of specific communities.

- ✓ Cea Doula
- ✓ Land-Grant University, SNAP-Ed
- ✓ Vitamix with 1,000 Days

4e. Develop and use simple, community-centered nutrition messages and education strategies.

- ✓ Institute for Natural Medicine
- ✓ OHSU
- ✓ Land-Grant University, SNAP-Ed

4f. Take an affirming, strength-based approach that connects to cultural foods.

- ✓ AMCHP
- ✓ Cea Doula
- ✓ NACCHO
- ✓ WIC

4g. Create simple tools and resources (eg, endorsement system for nutrition messaging, simplified nutrition labels, education toolkits).

- ✓ CDC foundation
- ✓ Land-Grant University, SNAP-Ed

4h. Use social media campaigns to reach communities where they are.

- ✓ Land-Grant University, SNAP-Ed
- ✓ WIC

4i. Leverage the power of personal stories (not facts) to communicate key messages.

- ✓ AHA/VFHK
- ✓ AMCHP
- ✓ Black Sovereignty Food coalition
- ✓ CDC Foundation
- ✓ NACCHO
- ✓ Vitamix

4j. Provide nutrition and cooking education "early and often".

- ✓ CDC Foundation
- ✓ NACCHO
- ✓ OHSU
- ✓ Land-Grant University, SNAP-Ed
- ✓ Vitamix

POLICY AND INTERVENTION GOALS aligned with this Priority and Organizations that are already working on them:

1. Ensure high-quality and culturally competent clinical care.
   d. Increase presence of registered dieticians/registered dietitian nutritionists in clinics.
   - ✓ OHSU
   - ✓ WIC

2. Improve the coverage of nutrition, maternal, lactation, and neonatal services under Medicaid and other insurance.
   - ✓ CHLPI

3. Increase access to affordable and nutritious food.
   - ✓ AHA/VFHK
   - ✓ WIC
   - ✓ VITAMIX

4. Integrate nutrition interventions with social support services.
   - ✓ CHLPI

4a. Integrate nutrition education and/or food delivery with home-health care visits and/or doula-based care.

- ✓ March of Dimes

- ✓ Vitamix

HEALTHCARE PROFESSIONAL TRAINING GOALS aligned with this Priority and Organizations that are already working on them:

1. Expand nutrition education across healthcare professional training programs and mandate some degree of competency in Continuing Medical Education-related or board renewal activities.
   - ✓ CEO DOULA

1B. Inspire health care professionals to elevate the role of nutrition to their patients.
   - ✓ ACOG
   - ✓ Cea Doula
   - ✓ NACCHO
   - ✓ OHSU

3) Build a medical consensus statement across the largest associations (AHA, American Medical Association [AMA], AAFP, AAP, ACOG) about the powerful role of nutrition in maternal and child health.
   - ✓ Cea Doula

WHERE ARE OUR BEST OPPORTUNITIES FOR COLLABORATIVE ACTION?

Collective Monitoring & Shared Learning	✓ No data provided
Coordinate & Strengthen Existing 	Value expertise from people with lived experience ✓ AMCHP ✓ CDC Foundation Compensate fairly for intellectual expertise and grants allow to pay people directly ✓ AMCHP Develop and use simple, community-centered nutrition messages and education strategies ✓ Institute for Natural Medicine ✓ Land-Grant University, SNAP-Ed ✓ OHSU Community members leading solutions ✓ Birthing Beautiful Communities ✓ Black Food Sovereignty Coalition

	✓ CDC Foundation ✓ HRSA ✓ NACCHO ✓ OHSU Engage with communities to identify needs and develop solutions ✓ AMCHP ✓ Birthing Beautiful Communities ✓ Black Food Sovereignty Coalition ✓ HRSA x2 ✓ Land-Grant University, SNAP-Ed ✓ OHSU ✓ March of Dimes ✓ National WIC Association Increase access to affordable and nutritious food ✓ National WIC Association ✓ Vitamix ✓ Voices for Healthy Kids (cross collaborate with food insecurity work group)
Explore Innovation & New Opportunities 	Use social media campaigns to reach communities where they are ✓ CEA Doula ✓ HRSA ✓ National WIC Association Food is a right ✓ Black Food Sovereignty Coalition ✓ CDC Foundation ✓ March of Dimes ✓ National WIC Association Maternal mental health and for people of all repro age (and youth, etc.); reduce barriers/stress to enrollment; eliminate enrollment screening ✓ ACOG ✓ March of Dimes
NEED	A liaison to communicate and integrate the strategy with other 2 gaps.

PRIORITY 3:
Emphasis and resources devoted to nutrition education for all medical and health professionals

WHAT IS THE DESIRED CONDITION OF WELL-BEING? (IDEAL STATE)

- Natural conversation
- Natural collaborative, consistent professional discussion/support
- Lower stigma
- Integrative approach (nutrition)
- Nutrition is not an elective
- 4 CR nutrition course is prerequisite for all prg
- Time and reimbursed
- Respect for importance of nutrition (and professionals)
- Experiential learning in women's health
- More education around nutrition in pregnancy **(+1)**
- More research – maternal nutrition – well-designed studies
- Inclusive definition → health worker team MD, RD, RN< PA, health workers, public health, etc.
- De-emphasize degrees based knowledge (e.g. Dieticians) – lean into community knowledge – look to the elders; research isn't everything; decolonize research
- Workforce that reflects community/overall demo
- Medical professionals have time to prioritize nutrition as preventative care and chronic care management
- Nutrition checkpoints built into screening and medical care designs and models
- SDoH does not become an added bias and safety/care is the only focus
- Medical professionals receive implicit bias training before, during, after medical training/throughout career
- Insurance payors prioritize nutrition
- DGA are well-known and referenced and implemented
- Continuity of care in nutrition ed. for patients
- Medical professionals and care team are aware of local/national safety nets
- "Well"-ness systems
- Insurance is not a barrier for nutrition ed

WHAT WORKS TO IMPROVE NUTRITION IN PREGNANCY?

NEW & ADDITIONAL GOALS aligned with this barrier and organizations that are already working on them:

1. Add developmental health content to the "Teaching Kitchen Collaborative" Initiative
    - ✓ Cea Doula International
    - ✓ OHSU
    - ✓ Vitamix
2. Develop and implement and use interprofessional nutrition education that focuses on Maternal, infant needs and topics
    - ✓ OHSU
    - ✓ Cea Doula
3. Create Interprofessional education to HCP to increase awareness and collaboration on nutrition
    - ✓ Institute for Natural Medicine
4. Create 2-minute developmental health message for general public/micro webinars (culturally adapted and linguistically)
    - ✓ Cea Doula
    - ✓ OHSU
5. Foster space to share successes, best practices that are replicable
    - ✓ AMCHP
    - ✓ CDC Foundation
    - ✓ HRSA
    - ✓ NACCHO
6. Leverage Existing trainings (i.e.: WIC Peer Counselor Training) to other CBO Staff

CROSS CUTTING GOALS aligned with this Priority and Organizations that are already working on them:

3) Reduce racial disparity in pregnancy and childbirth outcomes.

a. Identify and expand programs that improve health disparities.

- ✓ HRSA
- ✓ NACCHO
- ✓ OHSU

4) Prioritize community-driven and community-centered messaging and solutions.

e. Develop and use simple, community-centered nutrition messages and education strategies. ***Micro Webinars***

- ✓ ACOG

- ✓ Cea Doula International
- ✓ NACCHO
- ✓ Institute for Natural Medicine

POLICY AND INTERVENTION GOALS aligned with this Priority and Organizations that are already working on them:

1. Ensure high-quality and culturally competent clinical care.

1a. Provide culturally sensitive interventions.

- ✓ AMCHP
- ✓ Cea Doula
- ✓ HRSA
- ✓ NACCHO

1b. Require cultural competence, implicit bias, and anti-racism training for providers.

- ✓ Cea Doula
- ✓ NACCHO
- ✓ OHSU

1. Expand nutrition education across healthcare professional training programs and mandate some degree of competency in Continuing Medical Education-related or board renewal activities.

- ✓ ACOG AV
- ✓ CDC Foundation
- ✓ Cea Doula
- ✓ CHLPI
- ✓ Vitamix

1a. Set meaningful requirements for nutritional knowledge in professional colleges.

- ✓ AMCHP
- ✓ CDC Foundation
- ✓ Cea Doula
- ✓ CHLPI
- ✓ HRSA
- ✓ OHSU
- ✓ Vitamix

WHERE ARE OUR BEST OPPORTUNITIES FOR COLLABORATIVE ACTION?

Collective Monitoring & Shared Learning 	Add developmental Health content to the "Teaching Kitchen Collaborative" initiative ✓ CEA Doula ✓ OHSU ✓ Vitamix Develop and implement and use interprofessional nutrition education that focuses on maternal and infant needs and topics ✓ CEA Doula Create interprofessional education to HCP to increase awareness and collab on nutrition ✓ Institute for Natural Medicine Create 2-minute Developmental Health message for general public/micro webinars; culturally adapted and linguistically ✓ CEA Doula ✓ OHSU Develop and use simple, community-centered nutrition messages and education strategies; micro webinars ✓ ACOG ✓ CEA Doula ✓ NACCHO ✓ Institute for Natural Medicine Identify and expand programs that improve health disparities ✓ HRSA ✓ NACCHO ✓ OHSU
Coordinate & Strengthen Existing 	Screening and referral ✓ CHLPI ✓ OHSU Expand nutrition education across healthcare professional training programs and mandate some degree of competency of Continuing Medical Medication-related or board renewal activities ✓ ACOG ✓ CEA Doula ✓ CHLPI ✓ OHSU

	✓ Vitamix Create inter-professional ed (expand awareness of nutrition providers) ✓ CLHPI ✓ Institute for Natural Medicine ✓ NACCHO Provide culturally sensitive interventions ✓ AMCHP ✓ CEA Doula ✓ HRSA ✓ NACCHO Leverage existing training to other CBO staff (i.e. WIC peer counselor training) Set meaningful requirements for nutritional knowledge in professional colleges, including all education levels (K-12, community college, undergraduate, etc.) ✓ CDC Foundation ✓ CEA Doula ✓ CHLPI ✓ HRS ✓ OHSU ✓ Vitamix Foster space to share successes, best practices that are replicable ✓ HRSA ✓ NACCHO Require cultural competence, implicit bias, and anti-racism training for providers ✓ NACCHO ✓ OHSU Provide culturally sensitive interventions and cross-generational ✓ AMCHP ✓ CEA Doula ✓ HRSA ✓ NACCHO ✓ PB, NWA Require cultural competence, implicit bias, and anti-racism training for providers ✓ CEA Doula ✓ NACCHO ✓ OHSU

Explore Innovation & New Opportunities 	(1st Group) Set meaningful requirements for nutritional knowledge in professional colleges, including all education levels (K-12, community college, undergraduate, etc.) ✓ AMCHP ✓ CDC Foundation ✓ CEA Doula ✓ CHLPI ✓ HRSA ✓ OHSU ✓ Vitamix (1st Group) Expand nutrition education across healthcare professional training programs and mandate some degree of competency of Continuing Medical Medication-related or board renewal activities ✓ ACOG ✓ CDC Foundation ✓ CEA Doula ✓ CHLPI ✓ OHSU ✓ Vitamix (2nd Group) Create 2-minute Developmental Health message for general public/micro webinars; culturally adapted and linguistically ✓ AMCHP ✓ CEA Coula ✓ India Hinton, HRSA (interested) ✓ Liana, OHSU ✓ DS, OHSU (2nd Group) Develop and use simple, community-centered nutrition messages and education strategies; micro webinars ✓ ACOG ✓ Black Food Sovereignty Coalition ✓ CDC Foundation ✓ CEA Doula ✓ Institute for Natural Medicine ✓ NACCHO

WHAT DO WE COMMIT TO DO?

The last activity of Day 2 was for each of the Top 3 Priorities to establish some actionable steps over the next six months. Participants were encouraged to identify quick wins or opportunities for immediate action, and discuss what it would take to produce a collaborative plan that could lead to transformative impact. Some groups discerned that more in-depth action planning will be required to produce an informed, coordinated approach. All noted the need to connect with other potential partners. In the timeline below, some agencies are listed as leading work. Otherwise, see the "Where are our best opportunities for collaborative action?" section in each Priority above for all agencies that indicated intent to partner for action.

	June	July	August	September	October	November
PRIORITY 1: **Presence of food and nutrition security and access to healthy foods**	Establish a list of workgroups members Establish what groups need to be invited	Asset-mapping from current & not yet invited groups Establish a list of curriculums and learning courses related to food and nutrition security	→		Create guidelines for funding that is equitable/can include/prioritize community-based organizations	Look for existing/new funding to collaborate Gather success stories and determine next steps for promotion/identifying model practices
PRIORITY 2: **People with lived experience co-create nutrition in pregnancy systems of care in partnership with organizations at all levels**		Model community members in leadership roles	Develop principles for equitable engagement of community and people with lived experience	Leverage the power of personal stories (not facts) to communicate key messages		

PRIORITY 3: Emphasis and resources devoted to nutrition education for all medical and health professionals		Foster space to share successes, best practices that are replicable (CDCF will set up call) ✓ ACOG ✓ AMCHP ✓ CDC Foundation ✓ NACCHO	Add Developmental Health content to the "Teaching Kitchen Collaborative" initiative ✓ CEA Doula ✓ OHSU ✓ Vitamix	Create 2-minute Developmental Health message for general public/ micro webinars Develop and use simple, community centered nutrition messages and education strategies ✓ ACOG ✓ Black Food Sovereignty Coalition ✓ CDC Foundation ✓ CEA Doula ✓ Institute for Natural Medicine ✓ NACCHO	**Steps:** Step 1. (July) Agree on audience, platform; editorial calendar (topics) Step 2. (July) Who, type Step 3. (August) Timeline for recording Step 4. (Sept-Nov) Editing, distributing Amy, OHSU Michell, Institute for Natural Medicine Chuck, Black Lives Matter Alejandro – CEA Doula India – Healthy Start Ellisa, AMCHP Rachel, CDC Foundation	

**NOTE: Participants recommended assessing events that many group members may be attending, like regularly scheduled conferences, as opportunities to meet in person and leverage work time together. For example, in October/November the FNCE and ANDP are happening.*

CLOSING:

Attendees inquired about the coordination, support and resources this would type of systems impact plan would require, and what the potential structure of this group might evolve to become. The conference hosts/sponsors expressed intent to provide backbone support for the next six months, noting the desire for the groups to reassess at that time and discern best course of action with the clarity of developed proposals.

Participants described what a fulfilling coordinated effort might include, considering various levels of involvement such as:

- ✓ **Collective Monitoring & Shared Learning** – this might include meeting a few times a year virtually, shared accountability, and technology to support connection and access to information.
- ✓ **Coordinate & Strengthen Existing** – this might include agreed upon shared rules of engagement to build trust workgroup progress monitoring and updates, hosting an environment that is safe and curious, and leveraging in-person events for ongoing collaboration.
- ✓ **Explore Innovation & New Opportunities** – this might include sharing resource accountability, including more community members, methods to communicate urgency of this work, intentional practices to share learnings and not hoard information, being invited into each other's work for cross-pollination and expanding systems views, and formalizing the group's structure to ensure support, financing and sustainability.

The group further discussed the possibility of become an 'action network' or 'coalition' -yet to be determined- and invited participation into an interim steering committee that would further explore that and related sustainability. Currently this group includes OHSU, CDC Foundation and Vitamix; and three additional persons indicated willingness to contribute: Michelle Simon, Institute for Natural Medicine; India Hinton, HRSA; and Tylea Davenport, HRSA Community Participant. Anyone interested in joining this group should contact Mandy Burns (OHSU) at burnsma@ohsu.edu.

Event Co-Facilitators noted that the report documentation from this event would be distributed via OHSU within a few weeks, and further instructions about launch would be coming soon. Questions regarding the process or resulting work products may be directed to the Co-Facilitators: Shelby Pierce (shelby@pierceporterfacilitation.com) or Maya Chilese (drmaya@blueagatecollaborative.com)

All other questions or communication about this conference should be directed to the OHSU staff:

Kent Thornburg, Ph.D. - Conference Chair
OHSU Moore Institute for Nutrition & Wellness | thornbur@ohsu.edu

Mandy Burns - Conference Co-Chair
OHSU Moore Institute for Nutrition & Wellness | burnsma@ohsu.edu

Liana Haywood, M.P.H. - Communications Manager
OHSU Moore Institute for Nutrition & Wellness | haywoodl@ohsu.edu

Leslie Myatt, Ph.D., FRCOG - Director
OHSU Moore Institute for Nutrition & Wellness | myattl@ohsu.edu

Bernadette Battilega - Project Coordinator
OHSU Moore Institute for Nutrition & Wellness | battileg@ohsu.edu