ADVISORY COMMITTEE ON INFANT
AND MATERNAL MORTALITY (ACIMM)

Social Drivers of Health Workgroup Meeting

Health Resources and Service Administration Building
5600 Fishers Lane
Rockville, MD 20857

Thursday, June 27, 2024
1:15 p.m. - 2:45 p.m.

1

2 00:00 - 00:31

3 Marie Elizabeth Ramas

4 While we're waiting on the virtual side, why don't we start
5 putting in the chat some reflections over the last couple days?
6 Ideas that may have resonated with you when it comes to social
7 determinants. and, you know, things that you would like to
8 discuss a little bit closer during our now hour that we have.
9 Does that sound like a plan for virtual folks as for sake of
10 time? I see a head nod.

11

12 00:33 - 00:38

13 Marie Elizabeth Ramas

14 Excellent. Thanks, Belinda.

15

16 00:41 - 01:04

17 Marie Elizabeth Ramas

18 I'm not sure, Belinda and team on site, how much you heard, but
19 I was just encouraging those who are virtual to put in the chat
20 any things that may have resonated over the last couple of days
21 as it relates to social drivers of health. Or any topics that
22 they would like to cover in this next hour.

23

24 01:10 - 01:11

25 Marie Elizabeth Ramas

26 Sherri, did you hear that?

27

28 01:14 - 01:15

29 Sherri Alderman

30 Yes.

31

1 01:18 – 02:06

2 Marie Elizabeth Ramas

3 Okay, I heard a whisper, from your end, so, I can see things are
4 coming in, okay. And, for those who are on virtually, just give
5 me a thumbs up to make sure that you heard my thoughts and --
6 for that matter, I see we have 23 participants now, it might be
7 helpful to give a brief introduction of who you are, so I can
8 know who's observing versus who is not. Okay.

9

10 02:08 – 02:10

11 Belinda Pettiford

12 Marie, we can hear you all now.

13 02:15 – 02:44

14 Marie Elizabeth Ramas

15 Awesome, Belinda, great. All right, well, with that, then,
16 Sherri and I want to thank you all for showing your interest in
17 the Social Drivers of Health group. I'm not sure if everyone had
18 access to our general summary pages, but I can put that and
19 share that on my screen, with some of the topics of discussion
20 that we had.

21

22 02:45 – 03:33

23 Marie Elizabeth Ramas

24 But before we do that, it looks like ShaRhonda had some
25 interesting readings on light pollution and its effect on
26 pregnant people, and I wasn't sure if anyone else had some take
27 home points, messages, or if you wanted to bring up any other
28 references or resources for myself and Sherry and subcommittee
29 to consider. So for now, let's, let's take -- if I may, let's
30 take the next five minutes or so just to have an open floor and
31 I'll trust Belinda and team to let me know who's able to engage
32 and speak versus those who are observing.

33

1 03:35 - 03:51

2 Marie Elizabeth Ramas

3 So I think probably the easiest thing would be to just come off
4 of mute, or you can raise your hand if you want. Just, like, to
5 say something. And ShaRhonda, if you want to go first, maybe
6 that'll help with stimulating discussion.

7

8 03:53 - 03:59

9 ShaRhonda Thompson

10 Hello. Am I just introducing myself or do you want me --

11

12 03:59 - 04:16

13 Marie Elizabeth Ramas

14 Yeah, ShaRhonda, if you if you want to start off with what you
15 wrote in the chat and for others, if you want to introduce
16 yourself in the chat and start thinking about, anything else
17 that may have resonated over the last couple of days as we are
18 discussing, to report back.

19

20 04:18 - 04:44

21 ShaRhonda Thompson

22 Oh, okay. My name is ShaRhonda Thompson, and I am a member of
23 the community. And I think that making sure that infants and
24 mothers get their best possible care will help brighten our
25 future for generations. So, that’s my goal -- I want life to be
26 better for my children and their children. So I have to start
27 here.

28

29 04:45 - 05:11

30 ShaRhonda Thompson

31 But, living in Saint Louis, you know, it's a lot of, heavily,
32 this light, you know, all over. And it became a topic of

1 interest for me because I don't know how it affects sleep.
2 Right? All of that light just everywhere. Street lights, all the
3 house lights -- everyone has lights around their houses, and I
4 know it affects sleep.

5

6 05:12 - 05:57

7 ShaRhonda Thompson

8 So it just made me think, well, if it affects sleep for people
9 who aren't pregnant, how does it affect those mothers that are
10 having -- that they are pregnant, you know, being surrounded by
11 light at all times? And so I did read up on it, and I found some
12 articles that, you know, they were suggesting that, okay, all of
13 that light, all of that unnatural light actually is causing
14 harm.

15

16 05:38 - 05:49

17 ShaRhonda Thompson

18 It may cause premature labor because the mother's not -- her
19 body's not sleeping properly, which means it's not healing
20 properly. And it just something that I thought was an
21 interesting topic, I think.

22

23 05:50 - 05:54

24 Marie Elizabeth Ramas

25 Thank you, Sharonda.

26

27 05:58 - 06:18

28 Marie Elizabeth Ramas

29 I'm not familiar with disparities related to the impact of light
30 pollution, but I'd be curious to know if there are any other
31 kind of environmental impacts that can lead to disparities.
32 Charleta? Are there...?

1

2 06:20 – 06:28

3 Charleta Guillory

4 I don't have answers to that question, but I was going to start
5 something else, so I will wait until that question is answered.

6

7 06:30 – 06:44

8 Charleta Guillory

9 I can tell you in the neonatal intensive care unit, we know that
10 light interferes with our baby supports so that many times we
11 have them, we have times when we cannot interrupt them with the
12 light. So it is important in the NICU.

13

14 06:45 – 06:52

15 Marie Elizabeth Ramas

16 That's interesting. And is it more so from a -- so I'm curious,
17 being a family doctor.

18

19 06:52 - 6:56

20 Marie Elizabeth Ramas

21 So can you speak a little bit more as to how that affects the
22 biology of a neonate?

23

24 06:58 – 07:17

25 Charleta Guillory

26 Well, it certainly has to do with the sleeping pattern of the
27 babies and interrupting them during their sleep, especially
28 their deep sleep patterns. So that's the major portion that I
29 know of. Noise, of course, is another pollutant that that's very
30 important.

31

07:17 - 07:29

Charleta Guillory

We actually have hearing, you know, hearing - it's for the babies that are in the NICU hearing all of the different alarms and opening up the isolates, et cetera.

07:31 - 07:32

Marie Elizabeth Ramas

Okay. That's helpful,

07:33 - 07:44

Charleta Guillory

But, anyway, my name is Charleta Guillory, and I'm a Neonatologist in Texas Children's Hospital and a Professor of Peds at Baylor College of Medicine.

07:45 - 08:20

Charleta Guillory

And in terms of social determinants of health, for me, I, when I heard your discussion earlier, my question that really resonated with me is where are we screening for social determinants of health? That was the first thing because we know the mothers come in for, you know, in prenatal care. But I also know that 20% of those babies are delivered end up in the NICU where we are talking about post-traumatic stress, right?

08:22 - 08:44

Charleta Guillory

But tend to 10 to 20% will end up being in our nurseries. And I know that depending on what sort of NICU you are, you may have higher -- if you are referral center, you may even have higher babies there. And I know that the mothers that are in the NICU,

you have higher incidence of postpartum depression, they have high incidence --

08:45 - 09:03

Charleta Guillory

We call the nursery a food desert, in the sense that they are not prepared to be there. It's very expensive to get food, and we don't serve food in the nursery. So this is really a food desert for our parents. So that's one of the things I was thinking --

09:03 - 09:05

Unknown

Charleta, can you hear me?

09:06 - 09:07

Charletta Guillory

Yes.

09:08 - 09:12

Unknown

Okay, can you pause just one second? We're working on getting, we have an audio issue in here. We could hear you, and it just stopped. So give me just one second.

09:13 - 09:14

Charleta Guillory

No problem.

09:16 - 09:21

1 Belinda Pettiford

2 Marie, just continue the conversation while we work on our issue
3 on this end.

4

5 09:22 - 09:23

6 Marie Elizabeth Ramas

7 Thank you. Belinda.

8

9 09:24 - 09:29

10 Marie Elizabeth Ramas

11 Charleta, the floor is yours again. Thank you for your patience.
12 Is it Charleta or Charleta?

13

14 09:29 - 09:30

15 Charleta Guillory

16 Oh, it's Charleta.

17

18 09:31 - 09:33

19 Marie Elizabeth Ramas

20 Okay. Thank you.

21

22 09:34 - 09:46

23 Marie Elizabeth Ramas

24 The floor is yours again if you had any additional comments,
25 because I think that this is a unique perspective that's
26 centered on the period -- the postnatal period.

27

28 09:46 - 09:48

1 Marie Elizabeth Ramas
2 So I'd love to hear a little bit more from you.
3
4 09:48 - 10:08
5 Charleta Guillory
6 Well, just -- and again, as you guys spoke today, you had -- I
7 love the fact that you were thinking out the box in terms of
8 social determinants of health, but for me, I'm still at the
9 baseline. You know, for years we thought the NICU was, how can I
10 say that, that we didn't have racism.
11
12 10:08 - 10:34
13 Charlotta
14 Nobody could possibly mistreat babies, right? So for years,
15 people thought that when you went into the nursery, you had no
16 problems. And but now we realize that's absolutely not true. And
17 so as we look at social determinants of health, we're at the
18 process of how do we screen our moms. We know they're at high
19 risk. We know that this is a special subgroup of moms who need
20 transportation, who needs food.
21
22 10:35 - 11:01
23 Charlotta
24 Just basic things during this time. That's -- it's a very
25 expensive venture. and, we have to really step forward to make
26 sure that they are taken care of during this time. And not only
27 that, we have a major responsibility when they leave the NICU in
28 terms of it, used to be follow up care. Now we're talking about
29 how do we follow through to the next section.
30
31 11:01 - 11:18
32 Charlotta

1 So all of these things are sort of important to me. But these
2 are basic things. You know, these are things you're thinking at
3 this level. And I'm still here at this level, just the basic
4 things that our parents need. That's all. Thank you.

5

6 11:19 – 11:25

7 Marie Elizabeth Ramas

8 That's not all. That's a very pregnant, you know, aspect to
9 consider.

10

11 11:26 – 11:55

12 Marie Elizabeth Ramas

13 And, and I'm curious to hear from folks. So, you know, this
14 opens up some thoughts of, you know, parents that may not have
15 the luxury of taking time off from work, for instance, in order
16 to be present with their infant that's in the NICU. And how does
17 that work with creating the bonding that is so important for a
18 child that's in the NICU?

19

20 11:56 – 12:36

21 Marie Elizabeth Ramas

22 And I'm also thinking about parents that have multiple children,
23 and how that might affect the parents' availability and
24 understanding of what's happening internally in the, in the NICU
25 itself. So I'm curious, does anyone on the call have any other
26 thoughts? Do you think this aspect of social determinants as it
27 relates to risk of perceived needs or material needs, if there
28 is a complication postpartum postnatal, would that be something
29 that we as a subcommittee should look into further?

30

31 12:39 – 12:45

32 Marie Elizabeth Ramas

1 And I don't see many people that are on the screen, but I'd love
2 to hear your thoughts here.
3
4 12:56 - 13:15
5 ShaRhonda Thompson
6 I think that we -- that is something we should look at. I do
7 agree that that is it's a major concern. It's a major concern
8 for the mom while she's pregnant, so knowing that, okay, I may
9 not be able to take off work or have to take off work, which
10 means I'm going to have this issue, that issue.
11
12 13:16 - 13:29
13 ShaRhonda Thompson
14 I'm already living check to check, I can't save money to be off
15 for six weeks. So I can see how that can lead to a lot of stress
16 that can cause issues during pregnancy.
17
18 13:30 - 13:36
19 Marie Elizabeth Ramas
20 Yeah, and it sounds like a to-do. Charleta, Dr. Charleta had
21 mentioned is --
22
23 13:37 - 13:38
24 Charleta Guillory
25 Please, call me Charleta.
26
27 13:39 - 13:58
28 Marie Elizabeth Ramas
29 Thank you. Charleta. I had mentioned that, one, our social
30 drivers of health being used consistently across the board in

1 the perinatal period. And then two, how is that documented so
2 that it's -- there's continuity of care postnatally.

3

4 13:59 - 14:23

5 Marie Elizabeth Ramas

6 And, that might be an area, team now that the, now that the on-
7 site team can hear us, that might be an area for us to get some
8 insights in. I don't know if there's, from a technology
9 standpoint, EHR standpoint, if there are any advancements
10 occurring as far as documentation. I know that there's billing
11 for social drivers of health.

12

13 14:24 - 14:39

14 Marie Elizabeth Ramas

15 That's not necessarily reimbursed, but it's helpful for these
16 kind of population health concerns. But then how is it
17 transferred from the maternal chart or the birthing person's
18 chart to the infant's chart? Caroline.

19

20 14:40 - 14:46

21 Caroline Dunn

22 Just some insights, kind of from the WIC side of things, because
23 this is something that we've been sort of working through in
24 terms of food security.

25

26 14:47 - 15:12

27 Caroline Dunn

28 And there are several, innovative approaches that are happening
29 across the country. In North Carolina, specifically, Wake Forest
30 hospital system actually has a very interesting one where the
31 WIC system and physicians are able to communicate through notes
32 in the EHR system. And that is definitely not unique, but again,
33 an example of screening for and addressing social determinants

of health within the medical system and also having
communication from some of those programs back and forth.

15:13 – 15:20

Caroline Dunn

And I'm happy to provide some insights on kind of what those evaluations have looked like, if that's something that this group would be interested in.

15:23 – 15:40

Marie Elizabeth Ramas

Yeah, we can put that on our, sandbox as well. in our, recommendations and I did want to also give opportunity for, is it Zsakeba? Miss – Dr. Henderson to --

15:41 – 15:45

Zsakeba Henderson

Hi, I'm sorry. Yes. Zsakeba.

15:46 – 15:55

Marie Elizabeth Ramas

Zsakeba, thank you. So I think you brought up a really interesting point as well, and I'd love to hear from you. And Melissa.

15:55 – 16:10

Marie Elizabeth Ramas

And Melissa -- I do see -- Dr. Fries, I do see you as well. Would you like to talk a little bit further, regarding this, and then we'll get Dr. Fries' comments and then we can turn it over to our summary document to look into a little further.

1 16:11 - 16:14

2 Zsakeba Henderson

3 Yes. I just wanted to raise the issue.

4

5 16:15 - 16:48

6 Zsakeba Henderson

7 I, just to introduce myself, I'm Zsakeba Henderson, an
8 obstetrician gynecologist and, founder and principal consultant
9 with Equity, Safety and Well-Being consultants and also Senior
10 Health Advisor for the National Institute for Children's Health
11 Quality, based in Boston. And I am, part of the work that I do,
12 there's a very - it's deeply invested in the work around
13 improving equitable care and maternity care, but also very
14 involved in the work around, safe sleep and improving,
15 preventing, SUED and SIDS deaths.

16

17 16:49 - 17:14

18 Zsakeba Henderson

19 And one of the things that came to my attention in a way that I
20 never anticipated was the impact of, you know, we know that
21 substance use and mental health are issues, you know, and
22 maternal health outcomes, but never really paid attention of the
23 impact of those diagnoses and experiences on, the child and on
24 the engaging with child welfare.

25

26 17:15 - 17:36

27 Zsakeba Henderson

28 I had a specific encounter with a family who experienced the
29 SIDS death and, and subsequent to that, it was, of course, drug
30 screened and found to have a positive drug screening and all of
31 their other children, were taken away, by the state. And the
32 impact on the mental health of that mother was substantial.

33

1 17:37 – 18:12

2 Zsakeba Henderson

3 And, I think the onus on us as health care providers and public
4 health practitioners to recognize the impact of certain policies
5 on health and outcomes that we may not even consider. And that
6 was one thing that I hadn't considered. And after, having
7 direct, you know, interaction with the family who experienced
8 it, realizing that the, the impact of the, the intermittent drug
9 use was much less than the impact of that intervention by the
10 state and removing the children on that mother and family's
11 health. And wondering what role can we play?

12

13 18:13 – 18:25

14 Zsakeba Henderson

15 And, you know, our efforts to improve outcomes for moms and
16 infants on making sure that the policies that are in place that
17 supposedly are to protect children are actually harming families
18 and can be quite destructive.

19

20 18:26 – 18: 56

21 Marie Elizabeth Ramas

22 Right. So poignant. And, you know, depending on the workforce in
23 each state as well, that can definitely lead to
24 misappropriation, just to move people along through the system,
25 whether it's necessary or unnecessary.

26

27 18:57 – 19:01

28 Marie Elizabeth Ramas

29 And so, I'm hearing some opportunity to dig a little further.
30 Maybe the school to jail pipeline starts much more upstream than
31 we anticipate.

32

33 19:02 – 19:27

1 Zsakeba Henderson

2 Yes. And there are huge disparities, I mean, clearly, on which
3 families are impacted in this way. And there's also geographic
4 disparities, as I've looked into more certain states that have
5 some of the worse outcomes, have the most, punitive, policies
6 against mothers and families, that, one have experienced drug
7 use, especially those that, have, you know, issues around drug
8 use and mental health.

9

10 19:28 - 19:41

11 Zsakeba Henderson

12 And, it's quite alarming. that I'm figuring out what families
13 are experiencing, particularly families that are poor and don't
14 have the resources to fight to keep their families together.

15

16 19:42 - 19:46

17 Marie Elizabeth Ramas

18 So thank you so much. And Dr. Fries? or Fries?

19

20 19:47 - 19:48

21 Melissa Fries

22 Yes. Hello? Can you hear me?

23

24 19:49 - 19:50

25 Marie Elizabeth Ramas

26 Yes.

27

28 19:50 - 19:55

29 Melissa Fries

1 Thank you. I appreciate the opportunity to speak. My name is
2 Melissa Fries.

3

4 19:56 - 20:25

5 Melissa Fries

6 I'm a clinical geneticist and high-risk obstetrician. So I had
7 the privilege of actually sitting on both the infant and the
8 maternal mortality committees here in the District of Columbia.
9 And that's given me a very interesting perspective on the impact
10 of the social determinants of health in terms of the infant
11 mortality concerns. We have, is described as continuing concern
12 for pre-term birth and congenital anomalies.

13

14 20:26 - 21:10

15 Melissa Fries

16 But astonishingly, a large number of sleep-related births that I
17 think are potentially preventable through better housing
18 situation. These are babies that die because they are bed
19 sharing, often with 2 or 3 siblings and siblings differ from
20 parents who may have some awareness of the vulnerability of the
21 baby, but sibs don't. And so there is this concern that if there
22 were a different housing setting for these -- these are people
23 in maybe in hotel housing or in HUD houses that have two
24 bedrooms for seven children.

25

26 21:11 - 21:51

27 Melissa Fries

28 All of these issues relate back to the disparity and the need
29 for different housing accommodations. It was surprising to me,
30 how rare those kind of overlay issues are with people who have
31 can actually afford a three bedroom house. So just, a major
32 comment in that regard. And in terms of maternal issues, I think
33 that we really have to comment on the challenges of how mothers
34 balance their other children's needs with the needs of their
35 newborn and their pregnancy.

21:52 – 22:26

Melissa Fries

As a geneticist, I often see mothers who prioritize the child that they have rather than the potential child, because that's what they can care for. It's a lose-lose situation for them making it so that they can't come to the nursery. They don't have a place to stay when they come to the nursery. Many women choose to go back to work from their babies in the nursery so that they can then have that time off when the baby comes home, but that prevents them from bonding there in the nursery.

22:26 – 22:57

Melissa Fries

So many of those issues could be impacted by altering our capacity with our nurseries to accommodate people overnight and have places for siblings to stay. Also, to have some legislation that could address issues related to the unique feature of a nursery baby and how that would impact on its downstream life care by having family attendance. So comments along those lines.

22:57 – 22:58

Melissa Fries

I appreciate the opportunity to speak.

23:09 – 23:10

Unknown

You're muted. Marie.

23:15 – 22:36

1 Marie Elizabeth Ramas

2 Thank you. That's a great point. I'm not aware -- and this might
3 be an area of opportunity for the subcommittee to see what is
4 available as far as education for parents that have children
5 that are in nursery settings or NICU settings and what that
6 might look like, how to access resources.

7

8 22:37 - 24:04

9 Marie Elizabeth Ramas

10 As a delivering -- as a family doctor that delivered babies and
11 took care babies in tertiary settings, I know I incorporated the
12 potentiality. If there were complications, this is what you
13 might encounter, but I'm not sure of any resources that goes
14 into the depth that you are talking about, Dr. Fries. So I
15 appreciate that.

16

17 24:05 - 24:53

18 Marie Elizabeth Ramas

19 So I appreciate these additional insights. I believe before you
20 today, you're able to see our work group summary, of
21 recommendations thus far. Sherri, did you have any since I can't
22 see you well, did you have any additional thoughts before we go
23 into our summaries? And the hope here is that we can either
24 highlight some of these recommendations as things that we as a
25 subcommittee should go into a little bit deeper versus adding
26 additional recommendations like the two that were or the three
27 that were suggested today as well.

28

29 24:54 - 25:03

30 Marie Elizabeth Ramas

31 So, Sherri, did you have any additional thoughts before we kind
32 of go through these recommendations here for the last 30
33 minutes?

34

1 25:07 - 25:12

2 Sherri Alderman

3 Let me just adjust...

4

5 25:14 - 25:17

6 Marie Elizabeth Ramas

7 No, I can't hear you. Okay.

8

9 25:38 - 25:40

10 Belinda Pettiford

11 Can you hear this one?

12

13 25:41 - 25:43

14 Marie Elizabeth Ramas

15 Yep. Thank you.

16

17 25:46 - 26:16

18 Sherri Alderman

19 Okay, so there we go. We got it figured out. Now, I'll -- we'll
20 share, thanks Belinda. I just wanted to say that the purpose of
21 this meeting today is -- it's a great opportunity to get that
22 diversity of voices and perspectives that we have in this
23 virtual meeting and that we have been, you know, having people
24 come and speak to this subcommittee over the last several
25 months.

26

27 26:17 - 27:00

28 Sherri Alderman

29 And we have been drawing from those experiences, those learned
30 experiences to begin to formulate draft recommendations that

that will ultimately result in being a part of the report that goes to the Secretary. and we are charged with making recommendations for a tremendously broad topic, as we hear every time we hear your voices in this process, and also limiting the number of recommendations that will be merged with the other three subcommittees, in the report.

27:01 – 27:25

Sherri Alderman

So we -- today is, an opportunity to kind of throw out a wide net. And then and as with the in the spirit of this is a draft and we will be working with this information to optimize the recommendations that eventually appear in the report. And so I just want to say I'm very grateful for this opportunity.

27:26 - 27:41

Sherry Alderman

And we already have some laid down here in this draft that Marie can go through to give you a sense of where we are at this point and so that we can build on that. So, thank you, Marie.

27:48 – 28:18

Marie Elizabeth Ramas

Awesome and keep the ideas coming in the chat, while we're discussing. So, to Sherri's point, here are some recommendations and thoughts that we had after having multiple presentations. One of the things that were very clear to us, as we started our workgroup sessions for Social Drivers of Health, was the concept of nutrition and disparities in access to optimized nutrition support.

28:19 – 29:07

Marie Elizabeth Ramas

And the -- beyond having information from WIC, we were able to invite again, this Mother of Fact platform, group, where they have created, a means to provide telehealth services for nutrition for both inpatient and outpatient, expectant patient -- people, who have high-risk, diagnoses during gestation. And so, very interesting opportunities here where they have a working document, research document that will be published soon that talks about their measure of impact.

29:08 - 29:34

Marie Elizabeth Ramas

They are able to help support both the institutions, and also with billing the institution with billing of these services, which also helps. And then they're able to also connect pre and postnatal. So that's one area of recommendation. Again how do we leverage technology in order to help support those who are high-risk?

29:35 - 30:06

Marie Elizabeth Ramas

And we all know that it's been -- it's difficult to get access to reliable sources of quality care, in a culturally sensitive manner, which this group has done. Does this seem to resonate as far as the nutrition support and optimizing technology as it comes to nutrition support? Does that resonate with the group, and are there any other groups or best practices that you think we should also look into going into this next phase here?

30:07 - 30:16

Marie Elizabeth Ramas

So -- and feel free to come off of mute folks. I think we're a small enough group that we can do that.

30:17 - 30:46

1 Melissa Fries

2 Okay, I like the connections with WIC, but the other – there are
3 connections with potentially increasing food delivery services
4 and meal delivery services. For those -- specifically for
5 pregnant women and for diabetic patients. I think that those are
6 extraordinarily useful for people who have children and who
7 maybe struggle with hunger who would utilize food resources.

8

9 30:47 – 31:08

10 Marie Elizabeth Ramas

11 Okay. So food resources and that -- I think about geo mapping,
12 which can vary depending on state geo mapping of services that
13 are local. Any other thoughts, folks, regarding incorporation of
14 nutrition services?

15

16 31:10 – 31:16

17 Caroline Dunn

18 Yeah, this is Caroline. I just wanted to point out, just as a
19 quick from the USDA perspective, WIC is definitely not the only
20 program that pregnant and postpartum people would be eligible
21 for.

22

23 31:17 – 31:24

24 Caroline Dunn

25 So I would just caution us to expand beyond WIC and think of
26 SNAP and other nutrition support programs as well.

27

28 31:27 – 31:29

29 Marie Elizabeth Ramas

30 Thank you, Caroline.

31

31:33 - 31:50

Marie Elizabeth Ramas

Anyone on site have any insights that they'd like to bring? Dr. Fries, you may -- you have your hand up. I'm not sure if that is, a new hand or if it's from your previous comments.

31:51 - 31:56

Melissa Fries

I apologize. I don't have a new comment.

31:58 - 32:14

Marie Elizabeth Ramas

Okay, great. All right. So, moving on to the next recommendation that we had was evidence of reimbursement for nurse led or community health worker led, home visit programs.

32:15 - 32:31

Marie Elizabeth Ramas

And Sherri, I'm not sure if you have any comments regarding the Family Connects program or any clarifying or content, contextual points that you want to bring about the Family Connects program for the group.

32:33 - 32:46

Sherri Alderman

Hi, sure. Just very briefly, Family Connects is a universally offered home visiting program that families can opt to take advantage of.

32:47 - 33:11

1 Sherri Alderman

2 If the at -- in the hospital at the time of birth, if they
3 choose to opt in, they receive typically one but sometimes up to
4 three home visits about three weeks after the birth of the
5 child. And that is an opportunity for a nurse, in this case, in
6 this model, a nurse to come to the home to engage with the
7 family.

8

9 33:12 – 33:58

10 Sherri Alderman

11 Again, this is a brief, intervention and but very broad list of
12 topics that they engage with the family, to talk about that. The
13 concept is that every birthing family can benefit from a
14 connection. It can help address a sense of isolation when you go
15 home with that baby in-arms. It can also be a non-stigmatized
16 approach to engaging with the early childhood system,
17 specifically home visiting, especially for families who may be
18 reluctant to do so because it is universally offered for
19 everyone.

20

21 33:59 – 34:24

22 Sherry Alderman

23 There are no criteria other than having a baby to qualify for
24 this brief intervention. And then in the case that longer-term
25 home visiting would be of benefit to a family if they opt in,
26 they are referred, a warm handoff, to an available home visiting
27 program for longer-term engagement.

28

29 34:27 - 35:04

30 Marie Elizabeth Ramas

31 Excellent. Awesome, awesome. Thoughts here being put in the
32 chat, so thank you, keep them coming. I see you, Monique,
33 regarding expanding home visits and who's included? There's a
34 great point. Sometimes we can be too narrow, from a state policy

1 or even a federal policy level. And we miss opportunities for
2 other very qualified individuals that do not need to necessarily
3 be medicalized, but we can get reimbursement for those services.

4

5 35:05 – 35:25

6 Marie Elizabeth Ramas

7 So we'll add that to the, to the recommendations. And I
8 apologize, I'm on one screen. So, if I can have someone on site
9 perhaps looking at the chat for me, so that way we don't miss
10 out on these, that'll be helpful as well. Charleta?

11

12 35:27 – 35:39

13 Charleta Guillory

14 Two quick things. The -- if you participate in this program,
15 will you still be able to see your pediatrician or family
16 practice physicians for the babies?

17

18 35:41 – 35:44

19 Charlotta

20 That's in addition to, correct?

21

22 35:46 –35:42

23 Sherri Alderman

24 Yeah, this is Sherri. That’s absolutely, it's -- in that way,
25 it's like other home visiting programs.

26

27 35:43 – 35:44

28 Charleta Guillory

29 Okay.

30

1 35:45 – 36:12

2 Sherri Alderman

3 It’s for ideally greater connectivity between home visiting
4 program and the primary care services that are provided to both
5 the birthing person and the baby. That is it because one does
6 not preclude the other.

7

8 36:14 – 36:27

9 Charleta Guillory

10 And the only other question I had is, as we expand the number
11 one where we expand delivery of meals, et cetera, just -- and we
12 talked about diabetics. Please keep in mind the breastfeeding
13 mother.

14

15 36:33 – 36:46

16 Marie Elizabeth Ramas

17 Yeah, I think you bring a great point. We, both Sherri and I,
18 there's a healthy tension between the Social Determinants of
19 Health, Social Drivers of Health and the Interconception group.

20

21 36:47 – 37:13

22 Marie Elizabeth Ramas

23 I think that is a great example of encouraging breastfeeding and
24 that fourth trimester time, how important it is to have the
25 appropriate support. And that is a overlapping kind of
26 intersection between prenatal, perinatal, and interconception as
27 well. So I appreciate you pulling that out, and I'll make a note
28 of that.

29

30 37:16 – 37:17

31 Marie Elizabeth Ramas

32 All right.

1

2 37:18 – 37:19

3 Sherri Alderman

4 Hand is up.

5

6 37:22 – 37:26

7 Marie Elizabeth Ramas

8 Oh, please, you can go off mute. Again, I'm on one screen, so
9 thank you so much.

10

11 37:27 – 37:49

12 Nima Sheth

13 Hi. This is Nima from SAMHSA. I know that we presented on the
14 maternal mental health strategy, but I -- as I'm looking at some
15 of these recommendations, I see a lot of overlap with the
16 strategy. So I just wanted to point out, any way that we could
17 sync on some of this together because we also talk about, home
18 raising programs and especially reimbursement.

19

20 37:50 – 38:28

21 Nima Sheth

22 And then I know we talked about this, but like the dyadic care
23 and reimbursement for dyadic care, or like multi-generational
24 care, so that is addressing some of this. I do think we could go
25 -- we could do more in the strategy around SDOH. So I'd love to
26 connect with the appropriate folks, I guess down the road? So I
27 guess the action item or recommendation would be to maybe sync
28 with the strategy or as we create it or implementation tracker
29 to see what we could help implement through the strategy that
30 would also align with what this group wants to get done here,
31 kind of pull that work in together.

32

38:29 - 38:39

Marie Elizabeth Ramas

That sounds like that might be an opportunity to return. and we can maybe do more of a working session around those specifics.

38:41 - 38:49

Nima Sheth

That would be great. Yeah. So we can have our schedulers actually reach out to you all. Would that be the best way to just -- or maybe you'll get back to us on action steps for this, but then we can follow up.

38:50 - 38:57

Nima Sheth

But yeah, a working session on kind of reviewing the tracker and going through some practical steps, would be great, yeah.

39:03 - 39:06

Belinda Pettiford

This is Belinda. I don't know if you can hear me or not. Marie.

39:07 - 39:08

Marie Elizabeth Ramas

Yes.

39:09 - 39:20

Belinda Pettiford

Okay. I just want to make sure we are mindful, the focus of this work group around those non-medical or social drivers of health

and the focus on a Black African American maternal and infant health.

39:21 - 39:43

Belinda Pettiford

And for us to be bold, and by no means does Belinda have an issue with home visiting, but we just had a presentation yesterday where millions and millions of dollars are going into home visiting. So is that a recommendation that we want to keep supporting knowing that it is moving forward, or do we want to think broader? Think something outside of the box?

39:44 - 40:02

Belinda Pettiford

And I think we all need to think about that when we're thinking about these social drivers, these social determinants of health. What is it that we know families need or benefit from that isn't occurring already? And so I think we need to make sure that is part of this conversation with this workgroup.

40:03 - 40:51

Sherri Alderman

This is Sherri. I appreciate your comments, Belinda. And reminding us to be bold and to not just underscore what's already happening and, and, and if I could add to that. In terms of Family Connects most recently, MCHB at HRSA has made the determination that they would only be, through MIECHV dollars, they would only be supporting long-term home visiting programs, such as nurse-family partnership, etc. and that Family Connects as a very brief intervention is not something that they are actively funding and, and have shared that they do not plan to fund.

40:52 - 41:09

1 Sherri Alderman

2 So I agree that we need to think more broadly than home
3 visiting. I also feel that we're pushing the envelope, with
4 HRSA, by saying that Family Connects does have value, even
5 though it is a brief intervention, not a long-term intervention.

6

7 41:12 - 41:15

8 Belinda Pettiford

9 Thank you. I just want to make sure that it has value for Black
10 and African American individuals.

11

12 41:16 - 41:24

13 Belinda Pettiford

14 That's what I want to see, the data, the research to support
15 because that's where our focus is. So thank you for that
16 information.

17

18 41:26 - 42:00

19 Sherri Alderman

20 And I would add to add to that too, thank you for reminding me,
21 that in conversation with Family Connects' Executive Director,
22 she pointed out that because this is a universal model and
23 offered to everyone, that it can capture Black birthing persons
24 who are of higher socioeconomic class who are at increased risk
25 that we were hearing over and over again for, infant and/or
26 maternal mortality and morbidity.

27

28 42:01 - 42:14

29 Sherri Alderman

30 So, it can reach everyone -- it has the potential to reach
31 everyone, including, Black birthing people that that are -- do
32 not qualify for other home visiting programs.

42:17 - 42:49

Marie Elizabeth Ramas

One of the aspects that I think is potentially bold is making these universal requirements, right? Right now we have spotlights and we have bright spots across the country. We have certain programs that are demonstrating good outcomes. But for entities like FQHCs, for instance, Title X, for instance, where there are auditory requirements that need to be done in order to receive funding.

42:50 - 43:14

Marie Elizabeth Ramas

That might be that extra boldness that we're talking about, if we are not standardizing is best practices, then we're left at the discretion of the individual at hand to make the decisions of who warrants and who merits the access in some regard. So that might be another thing that I can add to the document.

43:15 - 43:16

Marie Elizabeth Ramas

Franchesca, your hand’s up.

43:27 - 43:29

Marie Elizabeth Ramas

Franchesca, I can't hear you.

43:32 - 43:36

Belinda Pettiford

You may want to come back to it because she's, she looks unmuted, so she may just be having technical issues.

1

2 43:39 - 43:35

3 Marie Elizabeth Ramas

4 Thanks. All right, so, I should start --

5

6 43:35 - 43:58

7 Sherri Alderman

8 Could I point out a comment that came in the chat, and invite
9 Ashley to talk a little bit more? She's making reference to a
10 document specific to Black maternal and infant health.

11

12 43:59 - 44:06

13 Sherry Alderman

14 Ashley, would you like to come off mute and say what this
15 document is that you're pointing out for us?

16

17 44:15 - 44:44

18 Ashley Hirai

19 Yeah, I don't have a whole lot more to add. But I do think that
20 came up yesterday. Sherri, you actually mentioned that that
21 housing does seem like an opportunity that can be both, social
22 driver with health-related social needs and screening. And
23 Sherri, actually, you were talking about something that Oregon
24 was doing around that and having a Medicaid waiver to be able to
25 pay for housing, and support that.

26

27 44:45 - 45:15

28 Ashley Hirai

29 And then, you know, broader policies around zoning and other
30 ways of encouraging mixed income and more integrated
31 neighborhoods. So there could be an opportunity to have, like,

1 policy experts in housing, maybe speak to this group. Matthew
2 Desmond at Princeton, he runs the Eviction Lab. And I know
3 there's a lot of research on that in terms of maternal and
4 infant health outcomes.

5

6 45:16 – 45:48

7 Ashley

8 Jason Reese is on that paper I just put in the chat, from the
9 Kerwin Institute, in Ohio. And, yeah, I think there definitely
10 are a lot of opportunities in the housing sphere because it is
11 the largest expense in our families, budget and typically
12 accounts for more than half, and is a major source of
13 intergenerational wealth inequality as well.

14

15 45:49 – 45:56

16 Franchesca Saulson

17 If this is a good time to share what my thought was.

18

19 46:00 – 46:03

20 Franchesca Saulson

21 Can you guys hear me now?

22

23 46:04 – 46:06

24 Belinda Pettiford

25 Yes, we can hear you, Franchesca.

26

27 46:06 – 46:27

28 Franchesca Saulson

29 Okay, perfect. So I heard a lot about housing as well as mothers
30 that have babies that are in the NICU and, just coming from a

1 place of -- I never had a baby that was in the NICU. But I do,
2 have had three high risk pregnancies.

3

4 46:28 – 46:57

5 Franchesca Saulson

6 And I've had family members as well as friends that have gone
7 through similar situations or have had C-sections and babies
8 that had ended up in the NICU. And I've seen that, a lot of the
9 time -- I also heard that there is a food issue, but also a lot
10 of those mothers want to breastfeed their children.

11

12 46:58 – 47:27

13 Franchesca Saulson

14 And if they have to commute from home back to the hospital if
15 they've had a C-section, and that makes it a little bit rougher
16 because they have to take care of theirself and the healing
17 process. I've seen that some hospitals that have children, that
18 have to stay in the hospital, like I had known a mother and her
19 daughter had got meningitis.

20

21 47:28 – 48:17

22 Franchesca Saulson

23 And I know this is a completely different scenario, but, there
24 was -- her daughter was in a room where she was able to stay
25 with the daughter, and there was, laundry facility as well as a
26 place where she could shower so that she was able to stay with
27 her daughter. And I think if something like similar to that was
28 put in place into hospitals for high-risk mothers that may have
29 gone through a C-section or, their, their child is very high-
30 risk and needs to stay in the neck for a little bit longer, that
31 maybe that would help the food shortage, because the mother
32 would be able to supply the milk to the child.

33

34 48:18 – 48:46

1 Franchesca Saulson

2 You wouldn't have to have formula on hand, because with the
3 mothers that I know that had C-sections and had to go home and
4 come back, and they could only make it on certain days, their
5 milk supply would dry up before they could get back to their
6 child. So they weren't able to breastfeed their child, so they
7 would end up having to buy a formula. And one that takes money
8 from the hospitals.

9

10 48:47 - 49:13

11 Franchesca Saulson

12 But it also takes money from the family. And it also, I think it
13 also increases the recovery rate for the mother and the child if
14 they're able to be together right after birth. So the longer
15 that they're able to have the skin to skin and have the ability
16 to breastfeed and be close to their child and child be close to
17 mother.

18

19 49:14 - 50:03

20 Franchesca Saulson

21 That is just a thought to put out there that if there was an
22 ability to have the mother stay a little bit longer in the
23 hospital with the child that, the rates of mortality might go
24 down too, because, their immune system might be a little bit
25 better because they were able to have been supervised by the
26 hospital as well as being breastfed by mother to get the
27 nutrition from the breast milk, as well as extra bonding time,
28 because I know if I wasn't able to be with my kids straight out
29 of the hospital and I had to commute to the hospital and back,
30 it would be very difficult for me.

31

32 50:05 - 50:41

33 Franchesca Saulson

1 Just not only physically, but emotionally. And I know that, with
2 one of the mothers that I know and these are all Black mothers
3 as well, she had, she had weight issues before she had the baby.
4 So her C-section was getting infected. It wasn't healing
5 properly because, of course, every day she was trying to get up
6 and drive herself to see her daughter, but she couldn't drive
7 herself, so she still had to get into the car, walk up and down
8 stairs and go through all of these things.

9

10 50:42 – 51:04

11 Franchesca Saulson

12 But, I think that -- just a thought to put out there, that maybe
13 that would help benefit families and also maybe take off of some
14 of the food issues surrounding newborn babies.

15

16 51:05 – 51:45

17 Marie Elizabeth Ramas

18 Thanks, Franchesca, all excellent points. And, as we're -- we
19 have 15 more minutes, before we have to transition. I'm hearing
20 this, a need possibly I wrote down here, to look at potential
21 economic impacts of some interventions. One to Belinda's point,
22 you know, how do we guarantee potential income or credits or
23 protect parental leave so that one can promote and have paid
24 parental leave so that one can promote bonding?

25

26 51:46 – 52:22

27 Marie Elizabeth Ramas

28 And then I heard Franchesca from you, examine potentially,
29 what's the risk benefit of allowing for extended hospital stays
30 for birthing individuals? And providing nutrition, potential
31 travel vouchers, what have you so that they can manage, that
32 peripartum phase. if their child is in a NICU setting or with
33 complications. Did I miss anything, Sherri, or, are there any
34 other thoughts or areas that we need to highlight that I may
35 have missed something?

1

2 52:24 - 52:27

3 Sherri Alderman

4 No, I think you covered it really well, thanks. Yeah.

5

6 52:29 - 52:58

7 Marie Elizabeth Ramas

8 Okay. So I'd love for us to take the last 15 minutes to expand
9 on this concept of going bolder. So I think in some permutations
10 we've heard about transportation, we've heard about documenting
11 for social drivers of health and for, for even race in EHR
12 systems in a more consistent way.

13

14 53:00 - 53:46

15 Marie Elizabeth Ramas

16 We've heard about the importance of nutrition and various
17 permutations. We have some best practices that we've identified
18 and some groups that we've identified in our previous sessions.
19 I invite us today, to think a little bit beyond what the
20 baseline structure is. My hope with that is that as we're
21 starting to think about recommendations and crafting our
22 recommendations, we really want to stretch what we currently
23 have available so that, so that the common denominator is going
24 to be, yes, we need to have EHRs that talk to one another.

25

26 53:47 - 54:17

27 Marie Elizabeth Ramas

28 We need to make sure that, you know, there are policies and
29 practices that allow routine screening for all individuals and
30 hence Black individuals to, you know, to have access. I'm
31 wondering, just taking the mental health aspect because that
32 seems to be a more ubiquitous concept as well. What would be a
33 recommendation?

1

2 54:18 – 54:55

3 Marie Elizabeth Ramas

4 Or in a utopian world, an environment or an archetype of a
5 birthing patient and infant dyad that does have complicating
6 factors as a Black birthing patient, what would be the picture
7 of that? So I'd like for us to think about this in multiple
8 aspects. Just looking at mental health screening, if we can
9 think about it as, when the person first becomes pregnant.

10

11 54:56 – 55:28

12 Marie Elizabeth Ramas

13 To how do you manage various mental health aspects during the
14 pregnancy to screening for potential post, postnatal
15 complications with mental health, and then access and follow up
16 for both the individual and the infant. So let's just use this
17 next couple of minutes to be iterative, and talk about – we have
18 some best practices, what’s the next step?

19

20 55:29 – 55:49

21 Marie Elizabeth Ramas

22 What’s the 2.0? Recognizing certainly at this point, there are
23 many places that we still haven't gotten off the ground yet. So
24 let's put that aside and kind of think about a little bit more
25 broadly for the next couple of minutes. And I'm leaving this
26 purposefully open so that we can have some measure of
27 creativity.

28

29 55:50 – 55:55

30 Marie Elizabeth Ramas

31 Franchesca, do you have thoughts? Or is that hand from your
32 previous comment? Or?

33

1 56:00 – 56:02

2 Franchesca Saulson

3 That was from my previous comment. My apologies.

4

5 56:03 – 56:54

6 Marie Elizabeth Ramas

7 No problem. Qin Li, I see what is—two people, what's the
8 recommendation on promoting perinatal mental health and healthy
9 relationships, preventing violence. So, let's talk about that. I
10 know that we have some, both ACOG, AAFP and AAP have recommended
11 screening measures, both in the hospital setting when patients
12 are delivering and then postnatally, Qin, would you, would you
13 care to unmute and share a little bit more about what you might
14 perceive to promote in a bold way, perinatal mental health?

15

16 56:55 – 57:41

17 Qin Li

18 Oh, thank you. Thank you for the invitation. I want to use early
19 home visiting as the example I remember your report talking
20 about healthy relationships education was evaluated in the study
21 on early home visits. However, the existing component in the
22 early home visiting curriculum hasn't been comprehensive and
23 standardized. So that's a key issue. So how to break the gap
24 breach report in other discipline?

25

26 57:42 – 58:20

27 Qin Li

28 So family psychologists very -- family therapist really working
29 on those issues. So they already developed comprehensive and
30 standardized curriculum. I hope in Maternal and Child Health
31 Bureau, those early home built-in programs can integrate
32 existing evidence-based practice really develop to break the
33 gap, the boundary practices claim.

1
2 58:22 - 58:55
3 Marie Elizabeth Ramas
4 Thank you so much for that comment. And you know, we do -- we
5 have heard and we've heard presentations of the merits of the
6 home visiting programs. just to be a devil's advocate, not every
7 culture accepts people, random people coming to their home. And
8 not every culture is open to specifically talking and screening
9 about mental health concerns, in that kind of a setting.
10
11 58:56 - 59:22
12 Marie Elizabeth Ramas
13 And so I'm inviting folks in on the call here. If we want to
14 talk about home visits, how can we make sure that we have
15 culturally sensitive and appropriate home visits? And how can we
16 incentivize the right workforce to do the home visits? That
17 could be a potential tertiary recommendation that we can submit.
18 Charleta, you came off mute.
19
20 59:26 - 59:46
21 Charleta Guillory
22 Not necessarily home visits, but I think it can be applied to
23 that. We have an app screening for our mothers in the NICU. The
24 reason we did that is because I think what Dr. Henderson said is
25 the high rate of -- if we picked up a mother that was positive
26 being referred to CPS.
27
28 59:47 - 01:00:10
29 Charleta Guillory
30 So what we did is develop an app where the mother can screen
31 herself, depending on the numbers, it then gives her the
32 resources and plans so that it's a way of screening mothers. But
33 yet it sort of leaves the onus on them to follow through with

1 it. And we really was able to look at the data we presented at
2 Spro recently.

3

4 01:00:11 - 01:00:27

5 Charleta Guillory

6 And what it did do is we had a higher incidence of women of
7 color doing the testing because they were able to do it, and it
8 was more private, does that make sense? And they did not have to
9 have any worry about any repercussions. That's all.

10

11 01:00:28 - 01:00:37

12 Marie Elizabeth Ramas

13 Asynchronous, I like that. And how about you getting paid for
14 the completion of that, from a fee for service standpoint?

15

16 01:00:38 - 01:01:12

17 Marie Elizabeth Ramas

18 Right. So I you know, and Belinda, I wonder sometimes what I'm
19 hearing and this is the friction, and we'll need to dig into
20 this a little bit more as co-chairs, maybe the simplest things
21 need to be considered as bold because they haven't been
22 ubiquitously implemented yet. So I'm -- we'll have to like,
23 think about, you know, why do these themes continue to come up
24 and why are they not universally implemented?

25

26 01:01:13 - 01:01:27

27 Marie Elizabeth Ramas

28 And how can we incentivize some of those behaviors that we know
29 work? That was a rhetorical question, but definitely has got me
30 thinking. So we have a couple more minutes remaining, Sherri.

31

32 01:01:28 - 01:01:32

1 Belinda Pettiford
2 You've got a hand up. Juanita’s hand was up.
3
4 01:01:33 - 01:01:34
5 Marie Elizabeth Ramas
6 Thank you, Juanita?
7
8 01:01:37 - 01:01:59
9 Juanita Chinn
10 Hi, home visits. One, they can be seen as surveillance. So
11 beyond the cultural appropriateness of them, you know,
12 surveillance among low income or low SES status households, is
13 not always welcomed, and it can be seen as a way for Child
14 Protective Services.
15
16 01:02:00 - 01:02:36
17 Juanita Chinn
18 As we talked about housing inadequacies and number of rooms per
19 household member, and how those things can impact child well-
20 being. Those types of screenings may not be something that is
21 welcome for certain populations. The other regarding
22 interpersonal violence, NIH has issued this fiscal year two
23 notices of funding opportunity for trainings of people that have
24 maternal health expertise, but not IPV expertise.
25
26 01:02:37 - 01:02:59
27 Juanita Chinn
28 These are two as we know, homicide is the number one cause of
29 maternal death. but these are two disciplines that typically are
30 not interconnected. So it's taking those who are experts in
31 interpersonal violence and educating those that are experts in
32 maternal health.

1

2 01:03:03 - 01:03:30

3 Juanita Chinn

4 The other thing I wanted to add on that also is that these types
5 of programs and things that we talk about with maternal health
6 interventions typically are with the victim, and don't involve
7 the perpetrator. And so it's important when we think about all
8 interventions on maternal health, particularly homicide during
9 the pregnant and postpartum periods, that we think about
10 interventions with the perpetrator.

11

12 01:03:34 - 01:03:35

13 Marie Elizabeth Ramas

14 Thank you.

15

16 01:03:38 - 01:03:55

17 Marie Elizabeth Ramas

18 Well, I want to thank everyone for their robust engagement here.
19 We'll be picking up hopefully these resources and saving the
20 chat as well. Sherri, do you have any?

21

22 01:03:57 - 01:04:00

23 Belinda Pettiford

24 This is Belinda. I'm sorry for interrupting you. Can you hear
25 me?

26

27 01:04:00 - 01:04:01

28 Marie Elizabeth Ramas

29 Yes, I can.

30

1 01:04:01 - 01:04:11

2 Belinda Pettiford

3 I'm sorry. I think we forgot about a presentation on social
4 isolation that someone was supposed to be given as part of this
5 session.

6

7 01:04:12 - 01:04:19

8 Belinda Pettiford

9 I just got a text about it. That's what I think. We might have
10 forgotten it. Or was it for a different group?

11

12 01:04:21 - 01:04:24

13 Sherri Alderman

14 I -- that's right. I thought it was supposed to be in this
15 group.

16

17 01:04:26 - 01:04:29

18 Ms. Ahmed

19 Hi, I'm just coming off mute. If folks can hear me. Hi, yes.

20

21 01:04:30 - 01:04:43

22 Belinda Pettiford

23 We're down to like four, five minutes now. So are you good
24 narrowing down your presentation? Apologies on our end for
25 forgetting that you were presenting in this session.

26

27 01:04:44 - 01:04:54

28 Ms. Ahmed

29 I am happy to maybe present at another time -- there is a good
30 amount of research literature that would be really great to

1 share with you all. but, yeah, so it’s a really, great
2 discussion, and I figured you would just, table topics that we
3 weren't able to cover at this time.

4

5 01:04:56 - 01:05:17

6 Marie Elizabeth Ramas

7 I do apologize, that that has escaped my awareness. And Ms.
8 Ahmed, and I would definitely appreciate to hear from you, my
9 apologies.

10

11 01:05:18 - 01:05:19

12 Ms. Ahmed

13 Of course, no problem.

14

15 01:05:27 - 01:05:44

16 Sherri Alderman

17 Okay. I apologize as well. And we do have a Social Determinants
18 of Health, Social Drivers of Health subcommittee meeting coming
19 up. And we will very much make sure and appreciate it if you are
20 available to present at that time.

21

22 01:05:49 - 01:06:21

23 Marie Elizabeth Ramas

24 Excellent. Again, I do appreciate everyone's input. We certainly
25 have some more work to do. I've been actively adding to our
26 document as we've been discussing and, both Sherri, myself,
27 Belinda and team will consolidate some of the suggestions and
28 recommendations, just to be make sure -- will we have the chat
29 also saved so that we can refer to it?

30

31 01:06:22 - 01:06:36

1 Marie Elizabeth Ramas

2 Okay. Thank you. Belinda. And Ms. Ahmed, we will get in touch
3 with you as well to see if you have time to return for our
4 subcommittee meeting to talk about isolation. Thank you.

5

6 01:06:37 - 01:06:38

7 Ms. Ahmed

8 Sounds great.

9

10 01:06:41 - 01:06:48

11 Marie Elizabeth Ramas

12 At the end of our meeting, we'll have the dates, I believe, of
13 our subcommittee meetings for those that would be interested.

14

15 01:06:49 - 01:07:02

16 Marie Elizabeth Ramas

17 So, please stay tuned. If not, that will be communicated as well
18 in our follow-up communications. So I appreciate you. We'll give
19 you one minute back before we go back to our main session for
20 you.

21

22 01:07:04 - 01:07:12

23 Belinda Pettiford

24 Thanks, everyone. We actually start back our main session at
25 3:00. So it gives us time to transition. Thank you all.

26

27 01:07:13 - 01:07:14

28 Marie Elizabeth Ramas

29 Excellent, Belinda. Thank you.

30