December 6, 2023

Social Determinants of Health Workgroup Transcript

DR. ALDERMAN: Well, welcome everyone. We were just going to start with introductions and then Sarah has some very helpful information about how this all works that I look forward to hearing, and then we will go into our discussion about social drivers of health as it relates to infant and maternal mortality among Black person, specifically.

So, I can start with introductions. My name is Sherri Alderman. I am located in Oregon. I am, by training, a developmental behavioral pediatrician with a special focus and passion for infant and early childhood mental health. I am endorsed, both in policy and clinical work in infant mental health and I am currently working full time at the Zero to Three organization, so I'm very excited about this topic and to have this opportunity to work together and come up with recommendations for how we can improve the health and wellbeing of Black babies and their moms and dads. So, I'll hand it off to Marie.

DR. RAMAS: Thank you, Sherri. My name is Marie Ramas. I am a family physician and have been practicing for about 15 years now. I have done extensive work, both in maternal and fetal care, practicing both C-sections and

maternal care since 2008.

I also currently sit on the American Academy of Family Physician Commission of Health for the Public and Science and have worked extensively on matters of health equity, both nationally and locally in the State of New Hampshire, and I am very much looking forward to serving as your co-chair for social determinants of health, social drivers for Black birthing parents and the infants that they care of. So, with that, let's go ahead and we will do a hot potato here. I see Felicia.

DR. COLLINS: Hi. Good afternoon, everyone. My name is Felicia Collins and I serve as the Deputy Assistant Secretary for Minority Health in the Department of Health and Human Services and the Director of Minority Health within the Office of the Secretary.

I am a pediatrician by training, but I spent most of my career as a policy and programmatic person within the Department and really excited to be here, and I'll pass it to Komani Burney who is working with me.

MS. MEYERHOLZ: I hate to jump in here but let me just get some context for this workgroup. We can definitely have Kimani come off of participant mode, but because this is open to the public only our workgroup members and some of our federal experts are able to actually speak.

DR. ALDERMAN: Can you introduce her just so she's

knows?

MS. MEYERHOLZ: Yes, she's fine. But when we go around for introductions just know not everyone will be introducing themselves.

DR. RAMAS: No worries. Sorry, as I'm learning the ropes here.

MS. MEYERHOLZ: No worries.

DR. RAMAS: So, Kimani Burney is a public health analyst within the Office of Minority Health who is new to our office and is our maternal health specialist, so she's the one that joining us also, so thank you. And let me pass it to Ashley, who is a friend from the past. I haven't seen her in a long time, so Ashley.

MS. BRYANT: I'm Ashley Bryant. I'm a senior scientist in the Office of Epidemiology and Research in Maternal and Child Health Care and I have background and training in prenatal epidemiology, GIS, and advanced research and outputs, so I provide a lot of data and analytic support to inform of planning and evaluation of the Bureau programs, specifically around infant mortality, Healthy Start, the Title V Program, and just try to conduct that research on perinatal trends and disparities when I can as well, so thank you for having me. I'm very interested in this topic and hopefully will share a little bit of the work that we're doing internally around SDOH as well.

DR. RAMAS: Thank you. I'll have ShaRhonda, Caroline, Golda, and Monique follow, who are a part of our internal group. ShaRhonda?

MS. THOMPSON: Hello. My name is ShaRhonda Thompson. I am a community member, voice of the community. I'll represent as best as I can, but I'm very anxious to get into the social determinants of health and hope that we can do something to stop other moms from experiencing some of the things that I experienced that didn't go quite right during my child birthing experiences.

DR. DUNN: Hi, I'm Caroline Dunn. I am an ex-officio representing USDA. I'm a social science analyst and I work directly with our WIC Program, which is the special supplemental nutrition program for women, infants, and children, which addresses hunger and nutrition security for pregnant and postpartum individuals and families with children up to age five, so happy to be here.

MS. PHILIP: Hi. My name is Golda Philip. I serve as the Senior Advisor for Equity for the Maternal and Child Health Bureau. I help all of the Bureau's divisions and offices further advance their equity-related goals for their programs. I'm a public health lawyer by training, and previous to this role, I served as the Deputy Director for HRSA's Office of Civil Rights Diversity Inclusion.

Previous to that, I was with the Department with

NIH, with CDC, so I've popped around HHS. Very glad to be with all of you today.

DR. FOUNTAIN HANNA: Good afternoon or good morning to those who are joining us today. My name is Monique Fountain-Hanna. I'm also with HRSA's Maternal and Child Health Bureau. I currently serve as our Chief Medical Officer in our Office of Home Visiting and Early Childhood Systems and I'm also serving right now in a detailed role in our Office of The Associate Administrator as our Perinatal Equity Liaison and Lead and Coordinator.

I'm a pediatrician by training for all of the pediatricians in the house I am representing and glad to be able to be here today to join the discussion.

DR. RAMAS: All right, thanks everybody. Appreciate you. So, with that, we will go forward and present our goals for the social drivers of health workgroup. And I believe, Sherri, you have something that you wanted to present.

DR. ALDERMAN: Yes, maybe for those who have not bene in this meeting, we had one preliminary meeting prior to this. We talked a little bit about what our focus is. And Marie, I think your fourth trimester concept, I think, is really valuable information to share with the group. Would you be interested in talking a little bit about that?

DR. RAMAS: The goal of our social drivers of

health is to take a more universal approach, looking at the full spectrum of the birthing parent and infant neonatal dyad, so our focus will be to develop, (1) what are the basic definitions of social drivers of health; (2) what are emerging social drivers that may be of actionable support in the work that the Secretary is doing. And then, also to identify conduits and social drivers that help promote postnatal and perinatal care within the material and infant dyad.

So, we have seen, and we heard yesterday of work that is surrounding the fourth trimester and we have a group that's talking about that inter-partum aspect; however, we feel that the social drivers of health are really the thread that connects all of the experiences particularly for our Black birthing parents and the disparities that they face.

So, our hope is to develop an acumen here from our experts regarding the emerging concepts from social drivers and then highlight any best practices that may be current within the United States to put as examples of further research. So, that's the general overview of our work here in this workgroup and we're excited to see so many that are interested today. Felicia?

DR. COLLINS: I just want to be sure I understand the charge. So, is the charge to identify areas for further research or does the charge also include the disseminations

you're saying of best practices and programs and policies?

DR. RAMAS: Thank you. So, we're trying in this iteration of our group to create salient and actionable recommendations that could be utilized in the shorter term, Felicia. However, we also recognize that not all community members and policymakers may understand what the evolution of social drivers of health have been and what current programs are available, so our hope is that we can provide (A) an overview of current states and the through evolving information, subject matter experts that we hear from in the workgroup, then provide salient recommendations form a policy level or recommendations on potentially considering scaling current best practices. I hope that makes sense.

MS. MEYERHOLZ: That's a great question. And our timeline is that we will be merging this work that we do in this workgroup with the other two and create an overall report and submit by January of 2025. So, that is our timeline at this point. We will be finding the most powerful recommendations in our group four or five recommendations and be adding those recommendations to the other workgroup's four or five recommendations that we then submit to HRSA for review. So, that's at kind of a broad level the timeline and what the focus is.

It seems logical, to me anyway, that we look at what are the causes of death among Black moms and babies.

From that, we look at what social drivers of health impact that, and then we can make recommendations. And as Marie said, it could be new recommendations as we begin to understand the field or underscoring recommendations or actions that are already taking place that could be enhanced to address those issues.

DR. COLLINS: Excellent.

DR. RAMAS: Any other questions or clarifications?

(No response)

DR. RAMAS: Sherri?

DR. ALDERMAN: Again, we're just getting started in this and we're very interested in your expertise as well, but when we follow that logic, I put together, and this is just a draft, and I will share my screen here, of looking at what social drivers of health have been considered in some of the literature. And again, this is in the very beginning stages and from what sources are for us to take a look at together here.

So, do you see there on that table there that I have this pulled together here.

DR. RAMAS: Can you just zoom in a little bit, Sherri?

DR. ALDERMAN: Yes.

DR. RAMAS: Thank you.

DR. ALDERMAN: So, before I go into the table, I

just wanted to point out that based on one article that was shared by one of the members of this workgroup, and thank you very much, that what the top four causes of maternal mortality among Black birthing parents there, and is actually is reflective of that population circumstances specific, so we have that information, which is different from the Caucasian population.

And still have some work here to find what the causes are of Black fetal and infant mortality, so that is incomplete and yet undetermined. Several sources that have come to our attention as it relates to social drivers the White House Domestic Policy Council.

DR. RAMAS: We can make available the references as well after our meeting if that makes it easier.

DR. ALDERMAN: And that is the focus, specifically, on social drivers and what most -- that we have. So, you there you can see our reference in -- .

A second source was a publication and here is that, addressing social determinants of health in federal programs -- mentions food and nutrition, transportation, education, financial strains or economic, and environment --

And then the Surgeon General reports that is specific to social isolation and -- and the important impacts factor in impacting health and (audio unintelligible)

MS. MEYERHOLZ: Sherri, I'm sorry. I'm having a

lot of trouble hearing you. If you maybe just speak a little louder.

DR. ALDERMAN: Okay.

MS. MEYERHOLZ: Oh my gosh, that's so much better. Thank you.

DR. ALDERMAN: I think my speaker was locked. Thank you so much for telling me, Sarah.

So, I'm not sure where I dropped off, but De Lew's a document published in JAMA Health Forum and there is some overlap with the White House Report with the addition of environment as being a factor also, a social driver of health.

And then the Surgeon General Advisory has published documentation document that actually speaks specifically to social isolation and loneliness as having an impact on health, which was also mentioned in the White House Report. I'm just going to scroll down here so you can get a glance of Braveman. This documentation which was published just a few weeks ago in the Frontiers on Reproductive Health explaining the white/Black disparity in preterm birth, consensus statement on multiple disciplinary scientific workgroups convening by the March of Dimes mentions social drivers or determinants of health as well and shows significant overlap with the White House Report as well, and also includes environment, which was mentioned in that De Lew

article.

And then yesterday we heard a presentation about the Title V measures, changes that will be coming up and that social drivers or determinants of health that were mentioned in that presentation were housing discrimination and healthcare access, so those specific two Title V measures. So, that's just a beginning to look at how social drivers or social determinants of health are spelled out, itemized, and where there is constancy across publications and presentations and where there are somewhat unique to that. All right, back to Marie.

DR. RAMAS: Before we open up, there was a question in the comments that I wanted to answer. So, ShaRhonda just wanted to get clarity on some of those medical terms that she shared from the document. So, preeclampsia is toxemia of pregnancy. That's typically evident by high blood pressure in the mom or in the delivering parent, protein in the urine, and if it is severe then can also lead to elevated liver enzymes and is one of the leading causes of perinatal death in our delivering populations.

And then we have also I believe there was preterm labor as well, and that is defined as labor that happens spontaneously before 39 weeks. There's higher risks of morbidity and mortality, both for the delivering parent and baby in preterm deliveries and outcomes, length of stay in

ICU, and complications are higher and more prevalent within Black and Brown populations compared to their White counterparts.

And we saw yesterday in one of our presentations that regardless of financial income or education these disproportionate effects on delivering parents and their infants that are delivered are still maintained.

And then I believe there was one more that was identified as well in the document that was shared with the group, embolism, and cardiomyopathy, so postpartum heart failure is cardiomyopathy, air embolism or placental embolism is when there are particles or substances that do not belong within the lung anatomy. It happens sometimes after delivery and that can cause imminent death for the birthing parent, and, of course, obstetric hemorrhage, which is one of the leading causes of death as well for maternal mortality. And depending on the documentation and the reports the definition of the severity of hemorrhage varies, so hopefully that helps.

I'm going to open the floor for our subject matter experts. Obviously, social determinants of health span is a huge area and cascade of a patient's experience and sone, one, I'd love to hear from our subject-matter experts on what are some key areas that you think would be impactable based on the summary that was provided by Sherri with the

documentation that we have seen. What might be missing and what are some evolving areas that we might consider as a workgroup getting further clarification on? So, I'll open up the floor.

DR. ALDERMAN: And before we do that, I would just like to circle back and say that those causes of death they occur in non-Black birthing parents as well. What is significant is that there are more deaths among Blacks attributed to those causes than other segments of the population. And we don't know yet if it is because of an increase of frequency of those adverse events, potentially fatal events, or if the death itself is associated with the medical care that is received in response to the occurrence of the event, so we still have a lot yet to understand about that, but this is a beginning. So yes, we can open it up now.

MS. MEYERHOLZ: Thank you, both, to our co-leads. I want to ask Ashley Hirai actually to go first. She is a special guest from Office of -- is Evaluation and Research, Ashley? There are so many acronyms, OER, be she might have just helpful information about what the Bureau is doing. And then I also just want to acknowledge Juanita Chen has joined us, Nima Sheth, and Belinda, who are members of our workgroup as well. And you all have been given the ability to unmute and turn your video on if you would like to speak. Ashley, I'll turn it to you.

DR. HIRAI: Thank you, Sarah. I'm just pulling up my screen here. Let me see if I can share that. Can we see this slide.

MS. MEYERHOLZ: Yes.

DR. HIRAI: So, at the Bureau, we've started trying to put together a framework for perinatal equity that links both the distal and proximate contributors to the dyad of maternal and infant outcomes, so there are a lot of existing frameworks.

And I do want to acknowledge, I think Dr. Joia Crear Perry was attending this and we drew heavily from her work in restoring the root cause framework, so really linking the structural and the social determinants to these outcomes. And then also the work by Paula Braveman that Sherri had already put in that paper on contributors to the preterm birth inequity.

So, we wanted to build on those by really adding both the maternal and infant piece, so broadening beyond preterm birth to look at maternal fetal infants' death due to disparity that would not exist if there were no inequities in those outcomes.

And then really looking at those proximate drivers, like you had mentioned about the cardiomyopathy and cardiovascular components, for example, as well as those more mid and upstream, but structural and social determinants.

And so, our goal in putting this together was really hopefully map our investments and see where the gaps are and where partners could help contribute to helping to achieve equity and redress those longstanding disparities.

So, it's definitely more in a developmental phase. This isn't finalized. We've been trying to get feedback from partners as well. So, here is this slide that shows the framework in its current state and so it borrows a lot, as I said, from Paula Braveman and Matt, the March of Dimes article that Sherri had shared and having those upstream and structural determinants, midstream and social determinants, so the experiences of economic, environmental exposures that are driven by those broader policy and structural determinants, segregation and what not.

And then the downstream is how that gets under the skin and the stress responses and coping mechanisms that link to those proximate drivers that we have listed here and ultimately those deaths due to disparity that we need to eliminate to achieve equity. And in those proximate drivers, we looked at available data to look at underlying causes of death for infants, for mothers, and we also drew from what you had mentioned, Sherri, too, I think Mary McDorman's article, the PMSS Pregnancy Mortality Surveillance System that categorizes causes.

And so, you can see we have a causal maternal

morbidity, prematurity that really has these cardiovascular, metabolic roots, obstetric hemorrhage, infection, congenital anomalies for infants, mental health conditions, and injury for safe sleep. And I have another slide. I'm not sure if it's easy for me to share it, but I do have a slide that shows really on the infant side it's predominantly prematurity and SIDS. ON the maternal side, it's predominately those cardiovascular conditions, about half of those excess deaths or deaths through disparity can be attributed to cardiovascular underpinnings and hemorrhage as kind of definitely patient safety quality of care driver. So, this is something we've been working on.

And then, I will share too that Golda -- and I can't really see if there's hands raised if people want to comment on this, but Golda did ask us to then have as our next step out office to help prioritize align the key social determinants of health in our work in the Bureau to be able to really pick maybe one or two that are most contributing to these inequities that we could prioritize as a Bureau throughout all of our programs. That's kind of the general idea and we thought maybe that could be helpful for you to hear in your work to identify gaps and priority areas for action.

So, what we are trying to do is do a needs assessment prioritization exercise and first selecting and

defining the social determinants of health, which Sherri had that nice table that looked across different resources. There's also Healthy People, WHO, Community -- Services Taskforce. And so, looking at those PSDOH that we want to drill further into.

And then, really selecting the criteria of how we would prioritize those drivers, so looking at prevalence, trends, disparities, and then impact on outcomes. So, that's really looking at the literature to see what kind of effects the social determinants are having and then combined with prevalence you really are getting population attributable factions for these outcomes.

And then looking at availability of effective interventions. These ability interventions, do we have the levers, existing programs, partners? Could we make that happen and then ultimately acceptability across the spectrum from community members, stakeholders, policymakers.

And then there are different strategies, so this is going to take us probably six months to really drill down into the literature, especially on the impact and effectiveness of interventions, but I think you can do more quick scans of the literature there. And then, we are planning to determine weights for each of these criteria and then score the social determinants of health further impact on -- MCHR comes more broadly, so we are looking more at the

Bureau that would also include child adolescence and special healthcare needs, but in case that's helpful those kinds of criteria are thing you might consider to help identify prominent drivers, gaps in the literature, et cetera.

DR. RAMAS: Thank you, Ashley. Golda, if you're still on the call, would you like to add any additional comments before opening up for a couple of clarifying questions?

MS. PHILIP: Thanks so much, Ashley. I think Ashley covered it very well. And in case it's helpful, just to summarize the key ideas here, I think about it in terms of two main components when we're trying to do this thinking around how do we impact SDOH, thinking about it in terms of the levels of interventions, so there's levels all the way from, as you can see from this slide, from the proximates like the individual experience.

As you push up to the downstream, midstream, and upstream, you start to get more systems. You start to push into systems that impact the individual outcomes and so we can think about interventions at each of those levels. So, that's one really important component. And the second component that Ashley talked about the Bureau doing thinking around prioritizing is within the different types of SDOH, so this is where we get to housing, environment, food access. There are ways to think about which of those levers we should

prioritize.

And so, I think it's both of those categories of thinking that we at the Bureau are trying to do, and I think we offer our thinking on both of those components if it will help inform the work of the Committee.

DR. RAMAS: Thank you. Just organically, it appears to be more common to hear the maternal aspect of the effects of disparities and social determinants and one of the things that we would also like to highlight within the workgroup setting is the impact on infants. So, it's great that particularly prematurity and SIDS is going to be highlighted.

I'm curious to know if low birth weight or very low birth weight is also going to be considered within the social drivers that affect infants as well? Is that something that, on a clinical level, is seen quite often as well.

DR. HIRAI: So, that is in there. It's lumped with maternal morbidity. It's those kinds of drivers that are linked to actual experience of prematurity, spontaneous labor, or kind of indicated delivery because of cardiovascular and other conditions.

DR. RAMAS: Great. In the work that you're looking at, we have our traditional drivers. Thank you for sharing this chart. It's very helpful to have a visual.

Some of those things that both Sherri and myself have seen are some emerging information around social isolation, loneliness, and how that can also affect the delivering parent, infant dyad. With emerging ideas or concepts around social determinants also be factored into your review within the Bureau?

DR. HIRAI: Yes, definitely. Did you say social support?

DR. RAMAS: Social support and isolation, specifically, that was also identified within the chart that Sherri shared that was most recently published. And so, we recognize that as we go deeper into trying to operationalize the work there is become more nuance regarding a patient experience in the environmental, structural, and systemic effects on the individual. So, I'm just curious, how do you incorporate some of the emerging information as you're working through the frameworks. That would be helpful for us as well as we're trying to identify potential blind spots that have not necessarily been addressed historically.

DR. ALDERMAN: And if I could just jump in, the way that it's looking is that loneliness and social isolation as it impacts health in the current times, especially coming out of COVID this has become really pronounced, but that factor has been at some of the core aspects of public health going back a century and what we're seeing is that actually

some of the current programs to support young families are looking at address that. Home visiting is a classic and DULA is another classic during the prenatal and perinatal period.

So, I could see that it could cut through all of the levels that you're talking about, and I appreciate you pointing out how the levels can also be a way of organizing this information and the complexity that it holds. It could be at the system level, it could be at the individual level, it could be at the community level and so that impacts the health and wellbeing of infants and families. So, that's the question that I have as well, is how do we capture that, even though it's not a typical social determinant of health?

DR. RAMAS: Thanks. I see ShaRhonda and Nima from SAMHSA. ShaRhonda, you can go ahead and unmute and the Nima can follow.

MS. THOMPSON: Okay, so I was looking at the chart, the lower stream, midstream, downstream and so I'm thinking about environmental stresses or stressors. I think it might fit in both the mid and down, but I'm not sure. When I think of environmental stressors, I think of someone who lives in a high-crime area. We call it toxic stress here in St. Louis, but I'm not sure if that's really the right terminology for it, but I do know the environmental stressors, what going on around them that they can't control. I know that does also affect the maternal stress levels as

well. So, I just wasn't sure because I saw the toxic environmental stress, but then I also saw just chronic stress, so I'm not sure which that would fit under.

DR. RAMAS: Would that be considered like weathering as well, the concept of a person of color experience racism, the isms, the structural effects and how that can affect them from a biological standpoint? Is that similar to what the toxic environment?

DR. HIRAI: Yes, I would think so. And ShaRhonda, I think that you had it right, that it's the environments, the adverse environmental exposures that then influence the individual experience of stress and weathering and that was in the downstream. So, the downstream is the individual experience and the midstream is your immediate environments and upstreams are those structures and policies that created those adverse environments.

And then, just to the point about the social isolation and this is really definitely more deficit framed here as the drivers of these adverse outcomes, but I would think of social support as more of that buffer against the chronic stress and definitely more solution-oriented framing would certainly be the doulas. I think group prenatal care, for example, and those are more affecting the individual and are needed from a policy perspective to promote more access to those tools, for sure.

DR. RAMAS: Thank you, Ashley. I do recognize Nima, who's joining us from SAMHSA. Nima, do you have any thoughts of any current states that that's occurring through SAMHSA?

DR. SHETH: Sure. So, I think in terms of thoughts, I don't know if we're talking about solutions yet, but in terms of some of the things that SAMHSA focuses on that I think have proved helpful have been a little bit of a focus on peers and community health workers.

I think in this space if we were looking at addressing multiple social determinants of health, I think there's some many things upstream that needed to be fixed that we're not going to be able, especially in a timely way. But I think we were thinking about things that could be immediately impacted.

It could be some pieces around access and socio-education. So, for example, like preeclampsia, eclampsia, carcinomatosis, a lot of times there are compounding factors with the fact that people of color often have that there's more hospitals closing in communities that have people of color. That there's not maternal wards in those areas. I had women when I was treating that would literally give birth on the street because they couldn't get a cab fast enough to get all the way to GW and they lived in Southeast or Southwest D.C.

And so, I think, one thing that we're looking at trying to do more of is create programs that have liaisons and serve in liaison roles that include almost like mobile teams or community-based teams that could serve as different things. I mean, an element of case management to give education, empowerment, connection to community, so just even saying, okay, what are things around preeclampsia that you could do. If you have pre-eclampsia, what are things you could do.

I mean, medically, there's a lot of things that underlay preeclampsia, but in terms of management, I mean, a BP machine at home, right? Like how often to use that, how to use it, why is it important to monitor at home and what to do. Who to call if it's going up, right? Same with gestational diabetes or things like that.

Even in places that have high-end care like Georgetown or Hopkins, the people they send you to really intervene once in a while, right? Like you go to a dietician, and they tell you what to do and they have these follow-up visits, but it's very minimal. There is not a rapport formed, per se, that would help people to follow through who might understand the true health impacts behind these things going untreated. So, having an emphasis on community health workers and peers support workers like mobile teams of a combination of clinicians and peers and

community health workers and therapists. I mean there are some therapists within mental health, but medically it can also be case management that go to people's homes too, right, just to improve access and then serve as a liaison.

So, if it's a transportation issue, having funds built in to say, okay, if you call me, we can arrive with transportation to take you to the Emergency Room. I have patients where I'm literally on the phone with them at 8:00 p.m. and I'm like you need to go to the ER. Can you get a lift? These are the situations that are happening day in and day out and it's like there's only so much bandwidth that providers have to answer their patients' calls at 8:00 p.m., right? Like that's going to depend on us individually and I think -- I'm sorry.

So, I think that we need to just think about if there's a way to think about both types of interventions that could address multiple social determinants of health that, at least for the time being until these more upstream factors could be thought of, just a recommendation to see we could think more about that. I'm happy to connect to think through some of the stuff, to share some of stuff that SAMHSA has been working on. And I'm sure HRSA has programs like that as well., so I'll pause there.

DR. RAMAS: Thank you. I'm recognizing Felicia and Monique, if you can share your thoughts that you put in

the chat, curious to hear your thoughts.

DR. COLLINS: So, yes, I appreciate what others have said already and I think somewhat piggybacking off of both Ashley and Nima, what we're doing within the Office of Minority Health is we have a really big focus on community-based organization in the community base who are trusted messengers within the communities and so we take, if you will, Ashley, your social determinants of health, the different factors and we're thinking about who are the individuals in the communities that can provide those services to women, infants across the life span that then would support better health outcomes.

And so, as was said, community health workers are one of the groups that we're working with, but we've noticed that within the Department there can be a lot of focus on the medical aspect, on the providers and helping the providers have needs assessments and community liaisons, all of which is very important, but it's appearing to us that the rate-limiting step is you do all of that great work and then you refer to the community and the community-based organizations don't have the capacity to do the work that then addresses those social determinants of health long term or even in an intermediate term to then impact outcomes. So, I'll just pause there, but happy to share more at a later time.

DR. RAMAS: I think that'll be really helpful for us to get a clear line of sight. It sounds like it was just part and parcel to how things work typically is that there are lots of work that is in alignment happening in silo spaces. I'm curious to know how we can perhaps create a picture of similar activities are happening across different entities and that could potentially support further progress and expedite work as well.

Felicia, I'm wondering with the Office of Minority Affairs, I know on the industry side, from a payer perspective, trying to create and justify the investment of capital and resources with more community-based programming is a hot topic in the industry right now. We know that there is value. How do we show the monetary value and the value in a way that can speak to our policymakers and to our other stakeholders? Has there been any work around that aspect?

DR. COLLINS: There has. So, we were just meeting earlier this week with colleagues at CMS and their CMMI, their model center and I'm blanking on the acronym, but there's actually a -- and I just sent an email to get a follow up from them because I have some thoughts there could be a connection.

But short story is there is a model that they worked on called The Accountable Health Communities, in which they were trying to actually demonstrate the impact of all of

this effort focusing on environmental, focusing on the social needs assessment, and its linkages to services, et cetera. And they expected that they were going to see either cost savings or improved health outcomes and they to some degree.

With all of this work upfront, they did see decreased Emergency Department visits, so they documented that in their work, but again, I think what I concluded from hearing from them is that there weren't sufficient community-based services. It's almost like they geared the patients and the individuals up to receive services that weren't actually available and so then you didn't see the full impact.

Within the Office of Minority Health, I can actually share a link. We're doing currently a demonstration grant that's looking at or encouraging -- well, not really encouraging. The expectation is for organizations to create a comprehensive perinatal system of care in which community-based organization services are integrated within the medical care model.

So, we just made those awards and it's a four to five-year grant, but that's exactly what we're trying to do to be able to document that when you bring these community-based services into the broader system and if they are supported and funded approximately that you see improved health outcomes and hopefully decrease costs, but health

outcomes we hope to see first.

DR. RAMAS: Thank you.

DR. ALDERMAN: I'm curious as we begin to really tackle this together that we break through the medical model, per se, and look at the bigger picture that definitely includes the medical model, but also with social drivers and determinants of health that that does open up the opportunity to do that. And also, I think about ShaRhonda's comment and how the hematologic system is impacted by environment and social constructs, et cetera, and how that impacts the mental health which impacts the body and are very much interconnected and what are the opportunities for us to be able to perhaps, if not break through the medical model, but broaden the medical model to include the social drivers of health and the psychological aspects that the system impacts and ultimately impacts the health and wellbeing of that population. Is there work in that area going on?

DR. RAMAS: That sounds like that might be an opportunity for us to look deeper into within the workgroup setting.

DR. COLLINS: I think there is work. I don't think it is articulated as well as the medical model and so I do think that could be an opportunity for this group.

DR. RAMAS: Monique, you had mentioned this workgroup space being an opportunity of highlighting

additional ways of looking at social determinants of health. So, there is evidence and then there are stories and patients' stories, and particularly, for Black maternal fetal health.

I know there have been campaigns in highlighting the stories of patients to make these concepts more real. Does the group here think that that might be another way that we can demonstrate value in the social determinants? And I recognize that some of the work has been done through CDC and other groups. Do you think that that's something that our workgroup should explore?

DR. FOUNTAIN HANNA: Well, I want to be careful not to answer that question and let the group decide. The part that I will just response to, I'm trying to toe the line as one of the federal representatives on this or not, help you give us recommendations. But I do think that there is a unique space that you all have to be able to lean into as Ashley outlined the framework that we've been working on very diligently and being able to bring in some -- when we talk about evidence, I think we need to broaden our idea of what evidence is and where evidence comes from. And so, even thinking about and including ideas like social isolation on the back end of a pandemic and thinking about how that may influence health, overall wellbeing, mental health, wellness.

I mean we know the trajectory of what happens when

a mom had anxiety, depression, all of those things and how that social isolation ca be a part of that compendium of things that are impacting birth and the ultimate trajectory of the infant. And so, I want to applaud you for even introducing that there are these concepts and these opportunities that may also come alongside of the three, five, ten-year, twenty-year evidence base that we know impacts, while also creating some space for some of that way of learning and what we're on the journey to learning, so thank you for that.

DR. RAMAS: Thank you, Monique. And that's helpful as well as possible opportunities that we can help contribute to.

So, in transitioning, thank you for the rich discussion here. In our report, there are a couple of questions that our workgroup will need to discuss, and Sarah graciously put those in the comments, the chat for us.

I’m going to tackle the last one first for those who are interested in continuing in the workgroup setting, which is the cadence and frequency of our workgroup meetings. Again, these are public meetings and part of the purpose of these meetings is to gather information so that we can, hopefully, within the next six to nine months be able to really articulate the why and the specific areas that we would like to highlight in the full report.

Sherri and I were discussing, as far as cadence meeting bimonthly. That would potentially give us opportunity to do asynchronous work in between meetings and also have enough time to get further information from subject-matter experts and interim updates of work that is ongoing. So, we were going to start in the month of January and essentially odd months to meet as a workgroup together. Anyone have objections to that frequency?

(No response)

DR. RAMAS: Hearing none, we will start meeting and we were thinking, as far as availability is concerned, having meetings that were towards the end of the workday for our East Coast members, around 4:00 p.m. And hopefully, with that being bimonthly we can block schedules effectively for one hour to meet. Would that one-hour block at about 4:00 p.m., Eastern Time, 1:00 p.m., Pacific Time, on Tuesday, third or fourth Tuesday of the month? I know that's very specific, but just throwing that out there. Would anyone have overt conflicts at this time that you can think of?

MS. MEYERHOLZ: Are you looking at starting January 16th or January 23rd?

DR. RAMAS: Probably January 23rd because I believe the 16th is – well, it doesn't matter. That's the Tuesday after Martin Luther King Day, so it's not a federal holiday.

Sherri, I think you said the 23rd or the 16th would work with you. Correct?

DR. ALDERMAN: Yes. The 23rd would work better than the 16th. I'll be traveling on the 16th, so that would be the fourth Tuesday of the month.

MS. MEYERHOLZ: We'll send a hold to you guys and everyone else who is considered an official member of this workgroup. And if there's other folks that you want to invite to that meeting or future meetings, we can go from there. But I'll just go ahead and send a recurring appointment for that time, the fourth Thursday every other month, right, 4:00 p.m., Eastern.

DR. RAMAS: Fourth Tuesday.

MS. MEYERHOLZ: Sorry, Tuesday. Yes, I can do that.

DR. RAMAS: Thank you. We can check that off. And in our discussion, we have looks like some opportunities to identify any other additional data or resources that we would need, or we would like to hear more information on for the future meetings. This could be a running list, but any thoughts, at this point, of what additional information might be helpful for our workgroup?

(No response)

DR. RAMAS: I personally would be interested to know if there are any care and medical type extenders,

meaning that in the behavioral health, particularly substance abuse disorders that we have behavioral health technicians who aren't necessarily therapists, but they can help with intermediary supports for patients and it seems to be a model that is emerging more within the substance abuse disorder space and I wonder if there are other types of extenders of the medical home or environmental, maternal environment that could lends towards that.

Certainly, community health workers are a known entity and support, but I'm wondering if there might be other frameworks or programs that have used creative models of addressing the needs of pregnant persons and infants? What are thoughts regarding that?

DR. SHETH: Hi, it's Nima. I hope it's okay to unmute. I think one thing was integrated care. I know there's a few programs that have actually psychologists or therapists embedded within the queues, for instance, and it's like through a time buy-out model, like 30 percent or 40 percent of their time go in. And so, we've been thinking a little bit about things like this, although there's issues with grant authorities and sort of thing, so we have to be mindful of that. Like integrated care in L&D settings, high-risk settings within even Pediatrics, OB/GYN clinics and that kind of thing, but I mean for mental health that makes sense and you could put mental health folks there, but for

general support, case management. Like somebody gets flagged with a medical diagnosis or their gene testing comes back positive from screenings, ultrasound, or whatever and there's a problem that somebody is there immediately to take over or talk about form psychologically to health interventions what that person could do.

We have some integrated care programs that are successful, but I don't know how much in the community that model has been used and I definitely know that OB/GYN is going use that support and Pediatrics because I think there's a sense of like, oh, this person just told me there's -- at home this or that. Other than giving them a pamphlet of resources, I don't know what else to do. There's no warm handoff to someone else. So, using someone like behavioral health technicians that are similar for health-related things and for psychological health.

DR. RAMAS: Thank you. And that just made me think about -- I know in New Hampshire and in other spaces the Academy of Family Physicians have created geo-mapping software where you could put up, based on zip code, social resources that are available for patients. Would that be something from a non-political systems level that is either being investigated in a deeper level or something that we might want additional information on as a workgroup? As that been considered for our subject-matter experts in the call?

Yes, Nima?

DR. SHETH: I think one thing to be wary of is when thinking about recommendations or interventions is like this idea of resources because I think, in practice, there's a lot of resources everywhere and if we are creating more mechanisms to hand resources without the ability of doing actual follow up and warm handoff and connection -- I don't know exactly what the literature says on this, but I know that in practice it's not very effective because the likelihood of follow up is so low if it falls on that individual patient who's already going through lots of things.

I think also to give providers more places to refer to is helpful, but without additional assistance in the healthcare systems that we're in now and how bogged we get with insurance and paperwork and patient caseloads, I don't think that that's also going to be effective, so I think it has to be something that offloads some of the work for both providers and also for patients and creates a third entity that would pick up on some of that. So, I would just caution against things that are just going to create more mechanisms by which to get resources, even if it's an app or something you can link.

People look at it and then they're like, okay, this is like I don't know the other person that's going to

answer the call. I don't know if I can trust them. I don't know if they'll be a live person or a recording.

So, I just want to be wary of that and think through in terms of recommendations or actions like things that we could do to utilize what already exists, but utilize them better, I guess.

DR. RAMAS: That sounds like an ask. Can we come up with a more comprehensive list of current resources and programs that are offered and identify if there's overlap or gaps. Is that something we might be able to put on the list as well, Sarah? Thank you.

ShaRhonda, I see your note about environmental stress. You touched on it a little bit earlier, is there anything else specifically you'd like to pull out from that suggestion?

MS. THOMPSON: Actually, I raised my hand for something else.

DR. RAMAS: Okay.

MS. THOMPSON: But for that, for me, if we could find anything basically like even crime or even toxic lighting. I know that's a thing as well, too much light, not enough light. All of those things can also be environmental stressors on the body and mentally as well, as Sherri brought up earlier.

So, honestly, any toxic environmental stressors,

if there's any detail on those, I would love to get that. I know I see a neurologist. I have a genetic disorder and right now my pneumatic system is all out of whack because of environmental stressors, so I know that that can cause a lot of issues during pregnancy and also with your mental health as well.

But I raised my hand, as I was listening to Nima, one of the things I've noticed that we're doing here in St. Louis for helping is they began incorporating social workers, especially clinics have begun incorporating more social workers into their environment and those social workers are actually being actual hands-on with their clients.

They'll get recommended to the social worker and the social worker will, even to the point of, oh, you need to go to the hospital, here I come to take you to the hospital and here I come to take you to your doctor's appointment. We started getting to the degree of helping patients. And I don't know if any other states are doing anything similar to that, but I know it's been helping a lot here in St. Louis.

DR. RAMAS: Thank you. A couple of things I just want to highlight. And thank you, Caroline, for the review. That's helpful. So, we talked about access as being a sticking point.

The other side of access for these non-medical programs is actually finding the workforce to support it.

And I'm curious to know, at least in New Hampshire there has been monies set aside specifically for community health workers and increasing the workforce and support of community health workers, but there's been a dearth of eligible candidates to fill those paid positions. Is that something that, from the social determinants of health aspect, would be beneficial for us to investigate as a workgroup or do we need more information potentially, regarding workforce and how to creatively increase?

Another thing that came to mind, yesterday we had discussions about culturally and linguistically appropriate systems and organizations. There is a huge program that centers around maternal/infant care regarding linguistic equity and wondering if it would be beneficial for the workgroup to hear specifically regarding that kind of programming, which is already available, but maybe not as universally utilized within the system. Would that be something that folks would be interested in hearing more about?

(No response)

DR. ALDERMAN: I would also like to mention that some of the areas of thought in this conversation really do call for changes in Medicaid coverage to be able to integrate behavioral health or mental health in primary care to be able to fund community health workers out in the community and

many others. Those are available through a Medicaid waiver in some states, but not all states, so payment is another consideration.

MS. MEYERHOLZ: While others are thinking, I did want to note that Ada had her hand up. She's representing the CDC DRH. I don't know, Ada, if you want to add anything.

DR. DIEKE: Thank you. Hi, everyone. I'm sorry that I'm late. I was coming from another meeting, and I jumped in, but I picked up on a little bit of the context and just wanted to raise up thoughts about that workforce that would support social resource finding and someone that you can trust to do that social resource finding.

I don't know where things are with patient navigators for the Affordable Care Act, but I remember that that was a big push, a big effort and I'm wondering if there could be some thought with utilizing whatever efforts there were to grow the navigators to help for the Affordable Care Act and in supporting this.

DR. RAMAS: Duly noted. Any other opportunities? I'm hearing a couple of themes from our discussion over the last 90 minutes. One is investigating frameworks and how are we defining social determinants of health, what are the specific frameworks of prioritizing the work that might help support decision making and allocation of resources. I hear opportunities in identifying current state and current

programs that are available and funding available for more community and non-clinical supports for patients.

We talked about, as well, identifying any community-based efforts that seem to meet the needs of high-risk patients as well, and we had examples of community health workers and now patient navigators and social workers to be integrated and how that can be leveraged and more closely fashioned so we can make sure that there's adequate follow up.

And then I heard about access, and to that point workforce development. I think in Massachusetts there were some innovative strategies to recruit and train maybe non-traditional candidates to work in health systems and that might be outside of our purview within social determinants of health, but I think to the point of identifying trusted voices within communities and thinking about ways that current systems are structured that limit access for potential candidates to join in the work might be something for us to consider. But again, I would defer to the workgroup to see if that would be something we want to think about. Did I miss anything, Sherri, Sarah?

MS. MEYERHOLZ: I don't think so. I've been taking notes, so I will send them to you, Marie, and Sherri, for you to take a look at before the report out at 2:00. If there's nothing else from Sherri, I did put a link in the

chat to the main room if folks want to go over there. Any panelists who have the ability to speak on -- should have received a separate link from LRG from Emma Kelly, this morning. So, if you have any questions at all, I'm happy to navigate you to the correct place; otherwise, Marie, Sherri, you'll hear from me very shortly.

DR. RAMAS: Excellent. Thanks everybody for a robust conversation. We're looking forward to working together.

DR. ALDERMAN: Thank you.

(Whereupon, the meeting was adjourned)