DEPARTMENT OF HEALTH

SPECIAL SUPPLEMENTAL NUTRITION PROGRAM

FOR WOMEN, INFANTS AND CHILDREN (WIC PROGRAM)

WIC STATE ADVISORY BOARD

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BEFORE: DR. DEBRA BOGEN, Chair
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Charlotte Dorsey, Member
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Katja Pigur, Member
Dr. Amaka Nnamani, Member
Miriam Seidel, Member
Brian Whorl, Member
Alex Baloga, Member

HEARING: Tuesday, February 11, 2025
11:03 a.m.

LOCATION: Videoconference

Reporter: Michele Ann McGinnis

A P P E A R A N C E S

ATTENDEES: NICHOLAS KIGER (BOARD COUNSEL), JOSEPH MCLAUGHLIN, MELISSA MOSS,

I N D E X

E X H I B I T S

Number	Description	Page Offered

NONE OFFERED

P R O C E E D I N G S

CHAIR: Good morning, everyone. Thanks for rescheduling with us and showing up today. I'm officially going to call this meeting to order. This is the Women Infants and Children State Advisory Board meeting, being held 11:00 a.m. on February 11th. For those of you who don't know me, I'm Dr. Deborah Bogen.

I'm the Secretary of Health for Pennsylvania Department of Health and I also have the honor of chairing this Board. Just a few reminders. This meeting is being recorded. By staying on, you are consenting to being recorded.

And secondly, this meeting is being transcribed by a stenographer, which is why it's important for all of us to introduce ourselves when we speak.

So that's why I introduce myself every time on these calls. So our first procedural issue matter is the attendance and roll call. So after I read your name and role, please acknowledge that you're present.

If you are not able to unmute, you can put a note in the chat that you are present and

at the end we can read those out. Dr. Kelly Kane, medical professional?

DR. KANE: I'm here.

CHAIR: Great. Lisa Sanchez, medical professional?

MS. SANCHEZ: Present.

CHAIR: Great. Miriam Seidel, food and security advocate? Miriam's not here today. Britney Zwergel, same, food and security advocate?

MS. ZWERGEL: Good morning.

CHAIR: Good morning, Britney. Katja Pigur, maternal child health advocate?

MS. PIGUR: Present.

CHAIR: Great. Thank you. Gerria Coffee, maternal child health advocate? Essence Cohen-Fields, current or former WIC participant? Raeni Yock, current or former WIC participant?

Bobbie Johnson, current former WIC participant? Charlotte Dorsey, WIC local agency rep?

MS. DORSEY: Present.

CHAIR: Thank you. Cathy Moffitt, WIC local agency rep?

MS. MOFFITT: Present.

CHAIR: Thank you. Theodore Deitman,

WIC local agency rep?

MR. DEITMAN: Present.

CHAIR: Thank you. Michael Howells, WIC authorized vendor or food merchant?

MR. HOWELLS: Here. Good morning.

CHAIR: Morning. Alex Baloga, WIC authorized vendor or food merchant? And Dr. Nnamani. I always get this wrong. Nnamani, breastfeeding expert.

Is there anyone who's added names in the chat, Sally, that we didn't hear from? Just for our - to make sure our stenographer has all the - I don't see any in the chat.

MS. ZUBAIRU-COFIELD: I think we're good. Raeni Yock was having some difficulties, but we should be good.

CHAIR: Okay.

Mr. Kiger, can you please confirm that we have a quorum for today's meeting?

ATTORNEY KIGER: Secretary, I only have eight, which is not a quorum. I'm going to advise that we can continue the meeting, but we will have to hold off on any voting matters, which I believe only includes the approval of the meeting minutes. So we can proceed, but we can't take any

official action this meeting.

CHAIR: And so if we get more people that come on to the call, then we can -.

ATTORNEY KIGER: At that point, we can continue. Yeah, sure.

CHAIR: All right. Well, I will try to keep track of if any others come in to change the total. All right, thanks so much.

So a couple of quick reminders. Again, a quorum for the Board is 10 of 15 voting members. So everyone's presence, whether virtual or in person, in each meeting is important. There must be a quorum for the Board to conduct official business, such as voting as we just heard. I have a couple of quick reminders. Board members should make every effort to let us know ahead of time that they're unable to attend a specific meeting. They are expected to remain on camera during the meeting as much as possible. We're going to skip the order of business related to meeting minutes, but if you have additional - those were distributed, but we won't motion on those.

And then I'm going to turn things over to Sally. But again, thank you for your participation and presence on the Board and all your

volunteer work with us. So I'll turn things over to you, Sally.

MS. ZUBAIRU-COFIELD: All right.

Thank you, Dr. Bogen. And I'm going to jump down to our third order of business. Sorry, my screen is jumping all over the place. All right, I'll be moving on to our third order of business and we'll be providing a brief update on our Pennsylvania WIC fiscal year 2024 participation and closeout numbers.

So I'm going to hand this over to Mr. Joseph McLaughlin, who is our Director of Finance and Technology here at the state WIC agency.

MR. MCLAUGHLIN: Thank you, Sally. Good morning, advisory members. As Sally mentioned, my name is Joseph McLaughlin. I am the Director of Finance and Technology at the PA WIC Office. I'd like to take a moment to share an important update on the participation members for the PA WIC program.

As of the close of federal fiscal year, which spans October 1st, 2023 to September 30th, 2024. Excuse me. That was federal fiscal year '24. I am pleased to report that PA WIC served a total of 2,188,616 participants. This is a significant achievement and it reflects the

continued impact of our services across the Commonwealth. As we move into federal fiscal year '25 for this current year, there - we have participation numbers for four months and I'd like to share those with you right now. October 2024, we are reporting 186,568 participants. In November 2024, we reported 184,441 participants.

December of 2024, we reported 182,183 -. I'm sorry, 182,133 participants. And currently January numbers of January '25, we are showing 182,217 participants. While we are seeing a slight decline in the numbers as we move into the new federal fiscal year, as you know, we do remain committed to strengthening our outreach efforts and improving participation rates.

These numbers are a testament to the ongoing needs for WIC services and we'll continue working collaboratively to meet the needs of our communities. Thank you for your continued support and partnership as we work to ensure that more families across Pennsylvania benefit from WIC. I will now turn things over to Sally to go over the fourth order of business.

MS. ZUBAIRU-COFIELD: Thanks, Jeff. Thank you. And thank you to our Pennsylvania WIC

partners and communities. We definitely could not do this without you all.

So now for our fourth order of business, we're going to go over the healthcare provider's role and what we do here at WIC in providing nutrition education, just - Raeni's now here. And providing nutrition education, and that's tailoring the food package. We'll talk a little bit about the final food rule and what's more to come for Pennsylvania WIC.

Now, just a little brief overview. The WIC food package is designed so that we provide supplemental nutritious foods to our participants. The foods are specifically created so that we meet the unique dietary needs of pregnant and postpartum women, infants and children under the age of five.

For children, most importantly, it's really a jump start to get them prepared nutritiously in order to start kindergarten. In the WIC program, we provide fruits, vegetables, whole grains, dairy and dairy alternatives, proteins, including beans, eggs and peanut butter, and some fish to breastfeeding women and infant foods, the fruits, vegetables, meats, and then baby formula.

Now, the food package is tailored to

each participant's specific needs, and that's based on the nutritional status based on what they need, any medical conditions that may happen or have - they may have at that time. And we are constantly making updates and changes to our food package. Healthcare providers play a significant role in that. And in healthcare providers, we're talking about the doctors, nurses, nutritionists and dietitians. They are key partners in the WIC program and making sure that we provide the supplemental nutritious food for the participants.

The healthcare providers often work in collaboration with our WIC clinics to ensure that there's comprehensive care for the participants. It's very important to us here in the WIC program to make sure that we are always communicating with the healthcare providers in that team so that we are considering the whole health and making the best choices for the family. WIC provides food packages.

The healthcare provider supports the overall health of the participants and makes sure that the relationships between both systems is vital for achieving positive health outcomes. Over the past 50 years, the WIC food package has changed and we celebrated 50 years last year. So we are excited

about that and it continues to evolve. As Pennsylvania WIC rolls out several updates, I'm going to turn things over to our state agency nutrition and training coordinator and Melissa Moss is here.

She's a little under the weather so please bear with her, but she's going to talk a little about how we're implementing these changes that have been proposed in our final food rule and how Pennsylvania WIC is becoming more aligned with the current nutrition science. So Melissa?

MS. MOSS: Thank you. So the WIC program is undergoing significant updates to its food packages. The final food rule issued by USDA aims to improve the nutritional quality of foods provided by WIC while promoting healthful eating habits. These changes reflect an overall shift towards supporting healthier eating patterns and addressing emerging concerns around diet-related health issues. And I do have a quick video to show. Let me just share my screen.

(WHEREUPON, VIDEO WAS PLAYED.)

MS. MOSS: So some of the key

elements of the final food rule include, as I mentioned, increased access to whole grains. Seventy-five (75) percent of the breakfast cereals must be whole grains. We're also - which is increased from the 50 percent. We're also increasing the expanded whole grain options to include quinoa, wild rice, pita bread, English muffins, bagels and naan, just to name a few. We took advantage of a recent survey we sent out on our nutrition services to gather feedback from participants on those additional whole grain options and what they would like to see.

We plan to prioritize the most popular selections and reach out to those manufacturers. They're also increasing the variety and protein sources. So as I mentioned, they're adding canned fish to additional food packages, including pregnant women and children. Currently only are fully breastfeeding women and those pregnant with multiples receive the canned fish.

And we're also looking at expanding the WIC-allowable varieties. Again, we utilized the most recent survey to gather participant feedback on whether they'd like to see options in addition to what we currently have, which is tuna, salmon and

sardines. So we did ask if they would like to see Chub mackerel and Atlantic mackerel added.

USDA is also providing legumes and peanut butter as allowable substitutes for eggs. And they've also allowed alternate nut and seed butters as substitutes for peanut butter. They've increased the fruit and vegetable amounts and varieties. The increase in cash value benefits amounts are now permanent. This just ensures continuity of a change that we've already made. They're also allowing additional CVB as a substitute for juice at a rate of about $3 for the entire 64 ounce container of juice.

And they're also allowing the cash value benefit dollars to purchase whole fruits and vegetables in exchange for the jarred infant fruits and vegetables. So with the increase in popularity of the baby-led weaning approach and general interest in making homemade baby foods, we think this is going to be well-received.

USDA also improved dairy options. They've increased the yogurt substitution amount for milk. Because the final rule established a Vitamin D standard for yogurt, we do anticipate, based on what's currently available in the marketplace, some

challenges finding products to meet the newly-established criteria. But USDA did give us until April of 2027 to implement the Vitamin D standard in yogurt so that manufacturers had time to update their products.

USDA is also allowing one year old children to purchase whole or low fat yogurts at the store. Right now they normally can only receive the whole fat yogurt.

They've also focused on reducing sugar, so they've established an added sugars limit in plant-based milk substitutes, yogurt and breakfast cereals. They've allowed additional allowances to accommodate those with allergies and/or diet preferences. So they have allowed plant-based yogurts and plant-based cheeses. We do expect some issues with these. Right now there's not a lot on the marketplace that meets USDA's recommendations.

And then lastly for infant formula, they allowed additional formula to be permitted in the first month for the partially breastfeeding infants. Currently we have a one can rule in place and with the new food rule, this is going to allow up to approximately four cans.

So that's some of the changes that we will be working on over the next several months here.

And I will now turn things over to Dr. Kelly Kane who will be discussing the healthcare provider perspective and starting solvents.

DR. KANE: Good morning, everybody. I just - part of the reason why I wanted to join this group was to be able to impact nutrition in our - in our kids. And I feel as though the way that we create nutrition in infants really affects how kids feed their bodies. And so I think it's really an important thing.

So a brief history of introducing solids. The - you know, prior to the invention of formula, breastfeeding was a must. And there were wet nurses that often supplied babies with milk and they sometimes lived in with families, but sometimes the babies lived in with the wet nurses. Once commercial formulas were developed, they also had the advent of homemade formulas with the use of condensed milk, which was canned and shelf-stable.

Over time, formula production has been updated and really the science behind it is to contain as many nutrients that are often found in

breast milk. Just trying to simulate what we know is nature's best product. Once formulas became mass produced and distributed, people began to use them more often. Depending on the culture and the times in history, solid introduction was done either very soon or later. Initial commercial baby food started in the U.K. and the U.S. as basically broth-based soups.

And those have progressed over time. When the purchase of commercial baby food became more prevalent, so did the production of baby foods. And today there's a variety of baby, toddler and child foods that exist in the marketplace.

Over time mothers have used cues from their babies to determine when to start solids. A common theme is night waking. So as babies continue to wake at night or cluster feed, that might be a time whenever a mother considers starting solids.

Also, if mothers start to have milk production problems outside of the neonatal phase, that's also been another time when mothers consider starting solids. So a lot of times I'm asked whether feeding a cereal snack or cereal in a nighttime bottle would help. And my experience and studies show that it doesn't help. That sometimes

that leads to increased digestion and more irritability. So my personal narrative is that I was breastfed. And according to my baby book, I was started on homemade single food purees at six weeks of age.

The nutritional guidance that my mother was given was not evidence-based in any way, shape or form. As I grew up, I was fortunate to have family meals for breakfast and dinner. And no substitutions were made at mealtime for my feeding preferences. And snacks were not readily available in our home. So the meals were really important for my nutrition and growth.

When I went to medical school and into residency, the way that we were taught were to feed standard purees or homemade purees. And at that time infants were seated at the table and they were to be single food and introduced one at a time and vegetable before fruit and green before yellow and three days in a row. And the idea behind it was to prevent a sweet taste preference and to identify allergies.

As my practice evolved, my private practice, identified some issues with doing this. There really wasn't any evidence to base this plan.

Allergies were increasing despite this plan and gastroesophageal reflux was increasing. Children after their infant feedings became more texture-averse and protein and iron intake were lacking. This also led to a separate meal for family and babies.

And babies were not receiving modeling from family members because they were having separate foods, oftentimes at separate times because they needed to feed the baby and the baby's feeding was a priority over the family. Families seemed to want to do what other families were doing and some worried about food waste and wanted child-friendly meals. And they needed convenience in their busy schedules. So my thoughts of how I was going to recommend doing things and also looking at evidence brought me to a few key points.

First of all, was that development has everything to do with when babies should start solids. So typically at the four month appointment, I talk to families about sitting the baby at the table during mealtime, so that we can see what they do and what their level of interest is. So then I assign the babies three chores. They need to watch the bites, open for bites and reach for the food.

And in sitting them at the table, we can start to see those developmental milestones occur. And we can also model what feeding is supposed to like - look like for babies.

I think that the other thing is that when we're talking about feeding solids, it has to be easy. So I really recommend feeding from the table when the babies are ready to start eating. And there are advantages to that in that it can be easy for the families. The babies are more likely to receive a balanced diet and to receive foods that are - are iron-rich. And we can also introduce the more allergenic foods on a timetable where the babies might have a lessening of allergies, because of earlier introduction, before their immune system starts building IGE - IGEs to certain things.

So with this being a topic of discussion, there are sort of two groups mainly that have come out with their - their theories and their ideas. So baby-led weaning is typically you just - you put whole foods on the baby's tray and the baby figures out how to, over time, pick them up and then eat.

In the BLISS feeding, they talk more about the structure of the food, that it should be

in slabs that are as wide as the baby's fist. And it should always be supervised feeding. You don't want to let the baby alone with hunks of food on her tray. And they evaluated what happens with traditional purees.

So when they looked at choking, because that's always a mother's concern, the BLISS was the best at preventing choking. And baby-led weaning and purees were comparable in the percentage of people that had choking episodes with their babies.

And this didn't necessarily - it wasn't defined as they needed to have the Heimlich maneuver. It was just a parent-reported tool. You know, when you're talking about introducing solids, the WIC platform prefers purees, except for with the new rule. And without any WIC intervention, baby-led weaning and BLISS might be more economical.

So I think that with the cash value benefit, that could - this could really benefit families. The nutrition, you know, oftentimes the purees and the cereals are fortified, but the bioavailability of some of the nutrients is questionable and the protein and fat content is low. And this is a time when children need more fat for

their brain growth and development.

When they're looking at ease of use, opinions vary. But if the child's eating what the family's eating, everybody's nutrition could improve. So I have some families that they kind of are ordering pizza three times a night. And that can't continue to happen if they want their baby to have good nutrition. And so when they get to the point where they need to start modeling for their baby, it could mean that everybody's nutrition gets better.

My experience is that texture aversion is worse with purees in its development. And what the studies say is that it looks like there's a window of texture acceptance and I call it plasticity to occur. So if you are waiting until after nine months to give more texture, a lot of times those babies will be texture-averse and less willing to try.

Another point that I wanted to get across is that WIC is important not just for the babies, but it's also important prenatally. And there are studies that show that the fetuses are affected by what the mother eats. So what if we put focus on maternal eating driven by family-style

meals? What if we teach these mothers how to put together good, balanced, nutritious meals? There were - there were studies about garlic intake that mothers who ate garlic during their pregnancy, their babies had a preference to that.

And you know, with infants, the milk that their mother gives them when they're breastfed also programs them for taste. So modeling allows for the kids to be part of the family, to have multiple tries, to develop a preference, but not one that becomes inflexible.

And seasoning for taste that's preferred by the family means that they can behave more like a unit. When you feed separate meals, it inhibits the natural progression for babies to use modeling and multiple tries to develop.

So my - my proposal is that WIC enrollment drops after a year of age because the families don't know how the benefits from the solid part of the program can be utilized. And if we offer flexible education and ensure discussion about whole solids, we may be able to retain babies and children better in the program. Thanks for your attention.

MS. ZUBAIRU-COFIELD: Thanks Dr.

Kane. I appreciate that and echo. And I know personally here at WIC we do understand the importance of teaching healthy meals. We're working a lot, especially now more than ever, around making sure that we have a variety. Because a big part of that is families not understanding what to prepare, not being familiar with the foods on our food package.

So we're making sure that they not only have access to foods, but access to foods that are familiar to their country of origin, access to foods that they understand how to cook. We're also providing cookbooks in the WIC clinics. We're working together with lots of our partners to make sure that the participants also have a hand in the recipes that we provide, always making it a practice to share what we learn and experiences from other participants with participants all over.

So I do thank you and appreciate that. And we do hope to see people stick with WIC as the child ages off of one. And it's not just the no longer needing formula or no longer breastfeeding, but we do understand it's - people don't understand. I mean, there's lots of times where families would say, this is a whole lot of

milk or I don't need that much cheese. So just teaching them what they can do and different recipes that they can come up with things that they cook all the time is very helpful and resourceful. So thank you for that presentation.

I'm now going to turn things over to Britney and Charlotte, the vice chair and secretary for the Advisory Board, and they're going to walk us through the fifth order of business.

MS. ZWERGEL: Thank you, Sally, and thanks, Dr. Kane, for that presentation. We appreciate the time you put into that. Charlotte and I are tasked to talk a little bit about the determining a food package.

Charlotte, do you want to kick us off or do you want me to start?

MS. DORSEY: You can go ahead and start.

MS. ZWERGEL: Okay.

So I wasn't sure how much information folks wanted to know about this, so as far as we could start with what happens - how food packages are determined. It's based on - Sally kind of went into this as well. So Sally, just give us the cut when we're good with this topic.

Food packages are supplemental and not intended to cover everything that a participant may need each month. Participants are educated on how to best utilize WIC and their SNAP benefits together when they receive both. We know that WIC and SNAP can really partner well together to improve food security for the families that we are serving. Specific products under each food category are determined by WIC-eligible or determined by what's WIC-eligible by the USDA and then also the State as well, using the federal guidelines.

And then our families are educated on ways to introduce and incorporate those foods into their diets. Some of the food packaged factors include the participant type, any kind of medical need and their participant preference as well.

Charlotte, do you want to jump in with any specifics from your experience with the food packages?

MS. DORSEY: Yeah, I think, as Sally already alluded to, a lot of what we do in the - in the clinic setting, we - when we are completing our nutrition interviews with our families, we're collecting medical information, like diagnosis for each individual that we're setting up food packages

for. So that plays into what we're able to offer.

So if someone reports like lactose intolerance, we're more than likely going to give them lactose-free milk versus regular cow's milk. Other things that we're able to do, too, is we are able to adjust food packages based off of preferences as well. So if we have, for example, a Hispanic family who eats a lot of beans, we'd be able to offer beans rather than peanut butter. So it's - we're collecting a lot of that information during our interview.

And then when we get to the food package, we're asking those additional questions to make those food packages not only medically appropriate, but also culturally appropriate for each of the individuals.

MS. ZWERGEL: And if a participant doesn't know about these substitutions, a lot of that, as Charlotte said, comes out during the conversations and the interviews. But something everyone can do is help remind and educate WIC participants that they have some flexibility that they can speak up and share, you know, oh, that, you know, we're not going to eat that.

We don't want to give food to folks

just to contribute to the food waste, if we can avoid it. So advocating for themselves and saying, no, we're not going to have that if there's an alternative that we can use. So another great spot for this advisory as well.

MS. DORSEY: And that is something - that's another thing that we talk about in clinic, too, is if -. Because we're actually capable of being able to see what particular food products that each participant is purchasing at the store, so we can kind of see like their typical patterns of grocery shopping.

But that also gives us an opportunity to notice what things that they're not purchasing. So those are conversations that we're having with our participants, like, oh, like why aren't you purchasing this particular item and then providing education on how to maybe utilize that food product? Because there are food products that we aren't able to adjust and we want to be able to provide all the nutrition that we're able to. And sometimes that includes offering some type of education with that family to be able to utilize those products.

MS. ZWERGEL: And I know that at Dojo Health and I know MFHS, we also have teaching

kitchens in our WIC spaces, so that we can not only tell you and give you a recipe, but if you come to a class, you can learn how to incorporate those WIC foods right into your everyday meals. So we're very, very fortunate to have that space in our clinics for sure.

MS. DORSEY: Yeah, I wish we had those.

MS. ZWERGEL: Space is a factor.

MS. DORSEY: Yeah. Yeah, we try to partner with our local nutrition links. So that's kind of like our version of that. So they're able to still get like hands-on learning even if it's virtual. So yeah, it's really good to - if you don't have the capability or size to be able to do that, you might want to reach out to your extension offices to see if maybe they provide an opportunity like that to collaborate.

MS. ZWERGEL: And your SNAP program partners as well, they're also able to do that work with you. Does anyone have any questions for us about the food package? And Missy, do you want to tackle that question?

Okay.

MS. MOSS: Yeah. I was just going to

say the things that I was talking about are future changes. So these are things that we're going to be making changed here potentially in the next year. So like that CVB for the juice, that's coming.

DR. NNAMANI: Sorry. What is CVB?

MS. ZUBAIRU-COFIELD: I was going to -.

MS. MOSS: Yeah. Cash value benefits. So it's the dollar amount that they can use for the fruits and vegetables, and that they're going to be able to use eventually to replace the juice, if they would want to. Part of USDA's regulations were that we make the changes all at one time for each of the participant types.

So - and that doesn't necessarily mean we have to wait for all of them. But we can't just make a change for like, you know, the substitution for the CVB for juice for the children and not do it for the women or, you know, decrease the milk for one and not the other. So we're just going to be working on doing everything at one time and we're working on our timeline right now as to when those changes will occur.

DR. NNAMANI: I think Dr. Kelly has a question. I'll let you go and then I'll ask my

question.

DR. KANE: What about the purees, substituting those for solids?

MS. MOSS: Yeah, all of those are going to be coming here in the next year.

DR. NNAMANI: A couple questions. One is, I'm just curious and I don't know, this may not be a question for you guys, but I'm wondering why we're recommending like juice at all. I know as a pediatrician I don't recommend juice at all. The only beverages you really need are water and milk. So I'm just wondering why it is part of the food package.

Is it something that's beyond your control or is it something that we're educating parents on? Because I know for certain populations, juice starts at six months and I do a lot of education around that. Like really nobody ever really needs juice, but it could be a treat, Birthday parties and things. But just wondering what WIC is doing with regards to like juice recommendations. Question number one. I'll let you answer that.

MS. DORSEY: Okay.

I can kind of talk about, like, the

education piece of that. So for juice, one, we don't offer infants juice, and we actually don't recommend starting juice until they turn one year of age. So typically that's the conversation we're typically having with our parents. Like don't start that until they turn one.

And then after that point, the amount of juice that we currently provide on the food packages equates to four ounces per day, which is the recommended like max amount that a child could drink of juice each day. We do include juice in like a fruit and vegetable serving. So I think that was sort of the idea behind the reason why we were offering juice, because it could be a form of serving in a fruit or vegetable.

But I think that's one of the suggestions that our families have said, because they're like, well, we don't typically drink juice. Like can we switch it out for more fruits and vegetables?

MS. ZUBAIRU-COFIELD: Thanks, Charlotte, and I can jump in as well. But yeah, as far as the education, we do make sure that we don't offer it before they're one and we provide education with it. We even tell the families to try to dilute

the juice with water when they can.

But as far as why we offer juice, it is a USDA recommendation. And the WIC program nationally offers juice to toddlers for a lot of different reasons. Most of it is based on the nutritional and developmental needs, Vitamin C and nutrient supplementation in the juice. We only offer a hundred percent fruit juice. And trying to get the participants to make sure that the kids have a source of essential vitamins and minerals in the juice, and trying to offer an option for when the toddlers are transitioning from either breast milk or formula.

We do encourage water. We encourage a lot more water than we do juice, but also does provide a convenience source for the families of Vitamin C, which may be a little difficult for the families to get from other sources of food. So more for Vitamin C supplementation and providing that option to WIC families.

Anyone else on our team want to offer anything? I mean, we've talked a lot about it at USDA level, but it's really for the variety. And there's also that stigma. Because I'm on WIC, that means I can't get juice. So we want to offer it in

moderation. But yeah, remembering and keeping at the forefront of our minds that WIC provides supplemental nutritious food. And you know, we are the premier nutrition education program.

So we're providing these WIC education alongside it. And you know, our hope is, with the support of you all, and the community partners, that message will get passed along to the participants. But there are specific guidelines on how much juice that we offer. Up to four ounces a day for children between one and two years old.

Appropriate consumption, not having the juice rest on their teeth. So lots of education goes behind it and we only offer a hundred percent juice. So just hoping that - you know, it can't make everybody happy, but we're going to try to do our part when we can. And Dr. Bogen has her hand raised.

CHAIR: Yeah. Thanks for this interesting and important conversation. I really appreciate Dr. Kane, you putting in dental health as an issue. So I just want to make sure that our educational materials, even when we tell people to dilute the juice and add water, that walking around all day with a sippy cup full of water, even with a

drop of juice contributes to cavities are the number one chronic disease of childhood.

And so just making sure that when we're providing that education to families, you know, my rule of thumb was kids only had - they're going to walk around with something to drink, it's a cup of water with not even a drop of juice in it. And they can sip that all day long, but they can't sip juice all day long, because it'll contribute to their cavity formation.

So I know you all pay attention to that, but I also think it's an important part of the conversation that often gets dropped. And again, people forget cavities, number one cause chronic disease in childhood, above and beyond. I think if you combine all the chronic diseases of childhood, cavities may add up to more of them than all the others combined. So thanks so much. Can't take the pediatrician out of me. Sorry.

MS. ZUBAIRU-COFIELD: Appreciate it. It's necessary. Thank you. And we do provide dental oral health education and try to incorporate that in every stage of development, every milestone that the child reaches. And when they're coming in for their med certification appointments, we do try

to educate as often as we can. So thank you. But it's not unnoticed.

At this time I'm going to just jump back up to our second order of business. And that was our meeting minutes. You all have received the meeting minutes from October, November and December. We got all the transcripts and sent it to you all. Any edits that needed to be made. I think there was only one edit. We made those edits and shared you all that version. So I'm going to pass it - hand it over now to Dr. Bogen, so she can just either approve - we can approve those minutes.

CHAIR: For our stenographer and for our minutes, I just want to recognize that we've had former members of the Board join the call. So we can now conduct official business because I think we have a quorum. But we've added Miriam Seidel, Raeni Yock, Alex Baloga, and Dr. Nnamani.

So if anyone else joined the meeting who wasn't - responded to the original roll, can you please let me know if I missed somebody? Okay.

So Mr. Kiger, do we now -.

MR. WHORL: Brian Whorl is here as well. I joined a little late as well. Sorry.

CHAIR: Wonderful. Thank you, Brian.

So Mr. Kiger, can you confirm that we now have a quorum to take a vote on our meeting minutes?

ATTORNEY KIGER: We do have a quorum, but just for the record, it does look like we've lost Raeni Yock, but we still have a quorum, regardless.

CHAIR: Okay.

Great. So you've all previously been sent the meeting minutes for the meeting held on November 12th and December 10th. So two of them. I hope you've had a chance to review them. There were no requests to edit. So at this time I would make a motion to approve the meeting minutes for the November 12th Board meeting.

Do I have a motion?

DR. KANE: I move to approve the minutes.

CHAIR: Thank you, Dr. Kane. A second?

MR. HOWELLS: I second. Mike.

CHAIR: Mike Howells, for the stenographer. And all in favor, say aye or unmute and say aye.

AYES RESPOND

CHAIR: Any nays? Any abstentions?

Great.

Let's do the same for the December 10th meeting minutes. Do I have a motion to approve the December 10th meeting minutes?

MS. SEIDEL: So moved.

CHAIR: Who was that?

MS. SEIDEL: Miriam Seidel.

CHAIR: Thank you, Miriam. A second, please.

MR. DEITMAN: Theodore Deitman. Second.

CHAIR: Great. Thank you so much. All in favor, say aye, please.

AYES RESPOND

CHAIR: Any nays? Any abstentions? All right. So I think we have now officially approved the minutes for November and December. Thank you for your patience. And I'll turn things back over to Sally.

MS. ZUBAIRU-COFIELD: Thank you, Dr. Bogen. And thank you all. Raeni's back. All right, thank you again, Dr. Kelly Kane, for your presentation. And thank you, Britney and Charlotte. Thanks, everyone, for the engagement. I'm going to move to our sixth and final order of business, and

that's providing the public with an opportunity to participate in today's meeting.

So I'll open the floor for any comments, questions from the public. See if I see anything in the chat. And I don't see anything in the chat. So thank you all for attending today's meeting. This meeting officially will not - no longer be monthly, so we'll keep that in mind. Again, my apologies for technical difficulties last month.

We pray that doesn't happen again, but we will be meeting quarterly now. Our next meeting is going to be April 22nd, and that meeting is going to be at 1:00 p.m.

All right. Meeting adjourned.

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MEETING CONCLUDED AT 11:55 A.M.

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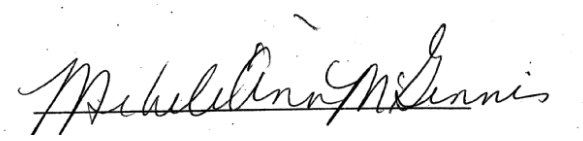
CERTIFICATE

I hereby certify that the foregoing proceedings, a hearing held before Chair Bogen, was reported by me on February 11, 2025 and that I, Michele Ann McGinnis, read this transcript, and that I attest that this transcript is a true and accurate record of the proceeding.

Dated the 3rd day of March, 2025



Michele Ann McGinnis,

Court Reporter