

**Secretary's Advisory Committee  
on Infant Mortality**

**Meeting Minutes of  
July 7–8, 2005**

**The Wyndham Washington Hotel  
Washington, D.C.**

# **GENERAL SESSION**

**THURSDAY, JULY 7, 2005**

## **CALL TO ORDER**

*James W. Collins, Jr., M.D., M.P.H.*

*Chairperson, Secretary's Advisory Committee on Infant Mortality*

*Associate Professor of Pediatrics, Northwestern University Medical School*

## **WELCOME AND INTRODUCTIONS**

Dr. Collins welcomed participants to the meeting of the Secretary's Advisory Committee on Infant Mortality (SACIM). The participants and observers introduced themselves, and the minutes from the last meeting were approved. Dr. Collins announced that the subcommittees would meet later in the day; Betty Tu, M.D., M.B.A., would be absent from the meeting because of a death in her family; and public comments, if any, would be heard during the afternoon session. He also mentioned that as a liaison member of the Advisory Committee on Heritable Disorders and Genetic Diseases in Newborns and Children, he will keep SACIM abreast of that committee's activities.

## **RACISM AND ITS IMPACT ON HEALTH**

*Camara P. Jones, M.D., M.P.H., Ph.D.*

*Research Director on Social Determinants of Health*

*National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention*

Dr. Jones, who gave her presentation by speaker telephone, stated that the initiative to eliminate health disparities requires an examination of the fundamental causes of racial health disparities. "Race" is only a rough proxy for socioeconomic status (SES) in this country, a rougher proxy for culture, and meaningless with regard to genes. However, "race" precisely measures the social classification of people in this race-conscious society and profoundly affects the life experiences and life opportunities of individuals. Many scientists hypothesize racism as a fundamental cause of racial disparities in health.

## **Definitions of Racism**

In a global sense, racism is a system of structuring opportunity and assigning value based on the social interpretation of a person's phenotype (how people look), or "race." This system has three impacts:

- It unfairly disadvantages some individuals and communities.
- It unfairly advantages other individuals and communities.
- It saps the strength of the whole society through the waste of human resources and human potential.

The goal of a national campaign against racism is a society in which all people will be able to know, and develop to, their full potential. The global definition of racism elucidates the system of power that underlies racism in this country.

To understand the effect on health, one can define three levels of racism: (1) institutionalized, (2) personally mediated, and (3) internalized. *Institutionalized racism* is the system of structures, policies, practices, and norms that result in differential access to the goods, services, and opportunities of society, by race. This type of racism does not require an identifiable perpetrator; in fact, it often manifests as inherited disadvantage. It is institutionalized in laws, practices, and policies and has an impact on material conditions and access to power. Examples of institutionalized racism are differential access to quality housing, an excellent education, equal employment opportunities, or equal income at the same levels of employment, all of which affect health. Institutionalized racism also manifests as differential access to medical facilities or a clean environment. In addition, institutionalized racism affects access to health information and resources as well as an individual's "voice," for example, representation in government or on school boards.

Dr. Jones addressed the question of the distribution of social class in the United States by race. It is not just a happenstance. The overrepresentation of Blacks in poverty has its initial historical roots in the injustice of slavery. Contemporary structural factors perpetuate that initial historical injustice and are part of institutionalized racism. Institutionalized racism explains the association between SES and race in this country. It differentially shunts people of color into a low SES, and it must be understood and dealt with when addressing health disparities. Merely dealing with social class is not enough; the mechanisms in structures, policies, practices, and norms must be addressed to deal with racial disparities. Furthermore, acts of omission and commission are part of institutionalized racism.

Dr. Jones addressed a question from Yvonne Bronner, Sc.D., R.D., L.D., about the impact of current national policy that decreases funding for education. Dr. Jones' personal belief is that No Child Left Behind strategies have had unintended negative results. At the Centers for Disease Control and Prevention (CDC), recent informal discussion of 100-percent high school graduation as an adolescent health goal indicates a recognition that improvements in public health will result in part from partnering across sectors (education, labor, justice, and transportation). As the Nation's public health agency, CDC can identify important interventions outside a narrow health boundary.

*Personally mediated racism* involves differential assumptions about the abilities, motives, and intents of others, by race, and differential actions based on those assumptions. This level of racism entails prejudice and discrimination and includes police brutality, physician disrespect, shopkeeper vigilance, waiter indifference, and teacher devaluation. Personally mediated racism can be unintentional or intentional, and, like institutionalized racism, it can manifest in acts of omission and commission.

*Internalized racism* is acceptance by the stigmatized races of negative messages about their own abilities and intrinsic worth. Internalized racism can affect health through self-devaluation, "the

White man's ice is colder" syndrome, resignation, helplessness, and hopelessness. Internalized racism involves acceptance of the limitations to full humanity.

### **The Allegory of the Garden**

After presenting these brief definitions of the three levels of racism and examples of their impact on health, Dr. Jones illustrated the levels of racism with her allegory of "A Gardener's Tale" ("Levels of racism: A theoretic framework and a gardener's tale. *American Journal of Public Health* 2000;90(8):1212–1215). Dr. Jones described planting seeds in two separate pots, one containing new, rich, fertile potting soil and the other containing old, poor, rocky soil. Most of the seeds in the first pot develop into strong and vigorous flowers, and even the weak seeds become middling-height plants. In contrast, only about half of the seeds planted in the old soil develop into flowers. The weak seeds die, and the strong seeds struggle to attain even a middling height. The image presents a picture of the importance of environment.

To extend the allegory, a gardener is introduced who is aware of the condition of the soil in the flower boxes. The gardener plants two types of seeds, one that will produce pink blossoms and one that will produce red blossoms. Because the gardener prefers red over pink, she puts the red seeds in the rich, fertile soil and the pink seeds in the poor, rocky soil. After 3 weeks, all of the red seeds, both strong and weak, sprout into either tall, vigorous flowers or middling-height flowers, respectively. In the poor, rocky soil, the weak pink seeds die, and the strong pink seeds struggle to get to a middling height.

The next year, after the flower boxes have gone to seed, the same thing happens, and year after year the pattern is repeated. Ten years later, the gardener looks at the flower boxes and proclaims, "I was right to prefer red over pink." This part of the allegory illustrates how institutionalized racism works. The initial historical injustice, coupled with structural barriers, inaction in the face of need, societal norms, biological determinism, and unearned privilege, results in institutionalized racism.

To illustrate personally mediated racism, Dr. Jones described how the gardener plucks off the pink blossoms before they can even go to seed. If she notices that a pink seed has blown into the rich, fertile soil, she plucks it out before it can establish itself. This part of the allegory depicts several elements of personally mediated racism, including its intentional and unintentional qualities, acts of omission and commission, the maintenance of structural barriers, and that personally mediated racism is condoned by societal norms.

In the allegory, internalized racism is illustrated by describing how the pink flowers struggle while bees collect nectar and pollinate the flowers. The pink flowers resist pollination with nectar from the red flowers. This part of the allegory reflects a system of privilege and societal values and depicts the erosion of an individual sense of value and the undermining of collective action.

The question arises of what can be done to set things right in the garden. Internalized racism can be addressed by calling for "power to the pink," but that strategy will not change the conditions under which the pink flowers find themselves. To address personally mediated racism, a

conversation is held with the gardener (a workplace multicultural workshop) to ask the gardener to stop plucking the pink blossoms. However, even if the gardener does as requested, the conditions under which the pink flowers live will not change. To set things right in the garden, institutionalized racism must be addressed by breaking down the boxes and mixing up the soil or by enriching the rocky soil until it is as rich as the fertile soil. When that is done, the pink flowers will flourish and might be even more beautiful than the red flowers because they have been selected for survival and strength. If the inequality of the soil is addressed in this way, that intervention also might address internalized racism. Similarly, the intervention might address personally mediated racism. Ultimately, the gardener's children will be less likely to prefer red flowers.

The most important question raised by the allegory involves the identity of the gardener, who has the power to decide and act and who also controls the resources—all elements that amount to self-determination. Perhaps government is the gardener. Perhaps the rich people behind government are the gardeners. Or perhaps we can become our own gardeners in our communities. Dr. Jones pointed out that it is especially dangerous when the gardener is allied with one group and is not concerned with equity. With the current articulated commitment to eliminating health disparities, the main question involves how to make the gardener own the entire garden.

### **CDC's Measures of Racism**

Dr. Jones described CDC's work on measures of racism. The "Reactions to Race" module, a telephone survey comprising six questions, was piloted on the 2002 Behavioral Risk Factor Surveillance System (BRFSS) by California, Delaware, Florida, New Hampshire, New Mexico, and North Carolina. It is now available to all 50 States, the District of Columbia, and 3 territories that participated in BRFSS.

Dr. Jones then presented the six questions and reported on data derived from the responses to the first two questions in the 2002 pilot survey.

Question 1: "How do *other* people usually classify you in this country? Would you say White, Black or African American, Hispanic or Latino, Asian, Native Hawaiian or Other Pacific Islander, American Indian or Alaska Native, or some other group?" This question involves the social interpretation of how a person looks versus the question of self-identity. In terms of general health status, three groups were identified: (1) those who self-identify as Hispanic and are usually classified by others as Hispanic; (2) those who self-identify as Hispanic, but are usually classified by others as White (20 percent); and (3) those who are usually identified by others as White and self-identify as White. The data show a marked difference in the number of people who report excellent or very good health versus fair or poor health, depending on their socially assigned race. For Hispanics, socially assigned White race does matter. Data on American Indians/Alaska Natives reveal the same situation. Dr. Jones pointed out that these data present compelling evidence that socially assigned race (how you are classified by others) makes a difference even within a self-identity category. Dr. Jones perceives this situation as an elementary illustration of the impact of racism on health.

Bernard Guyer, M.D., M.P.H., mentioned that “Hispanic” is not a homogeneous category in the United States and infant mortality rates differ among various Hispanic groups in the country. He asked how the Hispanic data distribute across different ethnicities in groups that call themselves Hispanic. Dr. Jones explained that Hispanic ethnicity does not exist in BFRSS, but three States (Florida, New Mexico, and North Carolina) have sizable Hispanic populations. The differences among these groups might entail the way that others classify them.

Question 2: “How often do you think about your race? Would you say never, once a year, once a month, once a week, once a day, once an hour, or constantly?” Dr. Jones noted that the frequency with which people think about their race is a combination of the racial climate of a given place and time (a contextual measure of the pertinence of race) and a person’s personal “racialized” history. About 57 percent of White respondents said they never think about their race, and 2.5 percent said they think about their race constantly. About 35 percent of Black respondents said they never think about their race, and 40 percent said they think about their race at least once a day. About 20 percent of Hispanic respondents said they never think about their race, and about 50 percent said they think about their race at least once a day. In terms of variability across the States, Whites have a fairly uniform racialized experience. Black respondents showed slightly more variability, and Hispanic respondents showed a significant amount of variability. Dr. Jones commented that the distributions tap into something about the racial climate in a given place and time.

Dr. Jones stated that she is developing a measure of racial climate based on looking at the differences between the distributions. Racial climate measures the pertinence of race as a basis for classification. Racial climate also concerns the rules for racial classification, including the number and names of the categories and the sorting rules. Another element of racial climate is the opportunities and value accorded the different racial groups. Finally, racial climate affects how often people think about their race. Dr. Jones also is interested in the question of how often people think about their race on an individual level. Thinking about race monthly is associated with excellent or very good health status for both Whites and Hispanics. For Blacks, a different pattern emerges, one in which increasing reports of excellent or very good health occur when thinking about race up to once a day and drop off slightly when thinking about race constantly.

Dr. Jones read the remaining questions and remarked that the data associated with the answers raise questions for further research:

- Question 3: “Within the past 12 months at work, do you feel you were treated worse than, the same as, or better than people of other races?”
- Question 4: “Within the past 12 months when seeking health care, do you feel your experiences were worse than, the same as, or better than for people of other races?”
- Question 5: “Within the past 30 days, have you felt emotionally upset, for example angry, sad, or frustrated, as a result of how you were treated based on your race?”
- Question 6: “Within the past 30 days, have you experienced any physical symptoms, for example, a headache, an upset stomach, tensing of your muscles, or a pounding heart, as a result of how you were treated based on your race?”

Other data involving general health status by education level showed that if the distribution of education by race were not uniform, Black/White disparities would still exist. Institutionalized racism causes a maldistribution of education or income. To intervene concerning health disparities (in particular, Hispanic infant mortality rates), even if the Hispanic and White rates were the same at each education level, as long as infant mortality depended on education and a maldistribution of education exists, then there will be an excess of Hispanic infant mortality.

CDC is considering measuring institutionalized racism. Doing so would involve scanning for racial disparities in various areas. Routinely monitoring outcomes as well as opportunities and exposures by race would be necessary. The question to be asked is, “Could racism be operating here?” In addition, the mechanisms of racism must be identified. Structures and written policies must be examined, and unwritten practices and norms must be queried. The question to be asked is, “How is racism operating here?” Dr. Jones referred to this as the most important question in terms of workplaces, schools, and communities. Once the structures, policies, practices, and norms are identified, targets for intervention become apparent.

CDC has identified four classes of policies of interest: (1) policies allowing segregation of resources and risks, (2) policies creating inherited group disadvantage, (3) policies favoring the differential valuation of human life by race, and (4) policies limiting self-determination. The first set of policies involves the funding of public education by local property taxes. The second class of policies involves poor social security for children and the existence of inherited wealth. The third set of policies includes curricula that fail to recognize the contributions of all groups of people. The fourth class of policies includes limitations to voting rights.

Public health officials and citizens in this society face three tasks:

1. Put racism on the agenda. Racism must be named as a force that determines the distribution of other social determinants of health. Routine monitoring is needed for differential exposures, opportunities, and outcomes by race.
2. Ask, “How is racism operating here?” The mechanisms of racism must be identified in structures, policies, practices, and norms. Both what exists and what is lacking must be addressed.

Organize and strategize to act. Citizens should join in grassroots efforts that organize around the conditions of people’s lives, identify the structural factors creating and perpetuating those conditions, and link with similar efforts across the country, around the world, and across scientific disciplines.

### ***Discussion***

- Maxine Hayes, M.D., M.P.H., FAAP, pointed out that SACIM has traditionally looked at the content of care, but Dr. Jones’ work encourages looking at the context of care. Consideration of the impact of preconception care on infant mortality and the cumulative impact of racism on maternal health can lead to new interventions to prevent poor outcomes. Dr. Jones called for “taking the long view”; interventions might not show results in the short term. A generation might be needed before the positive results of an important intervention can be seen.

- Mary Lou de Leon Siantz, Ph.D., R.N., FAAN, added that part of the long view must be integrating this information into the health professional curriculum in the formation of the next generation of health care professionals.
- Kevin Ryan, M.D., M.P.H., reiterated the ideas of Drs. Hayes and Jones by stating that 9 months of prenatal care will not correct the lifetime or intergenerational effects of poor health care.
- Dr. Bronner thanked Dr. Jones for a very challenging and intellectually detailed addressing of the topic. Dr. Jones offered to present an update of her work at a future meeting.
- Deborah Frazier, B.A., R.N., asked whether the States involved in BFRSS have used the information to implement any policy or service-delivery changes and, if so, whether there are plans to track any of those changes with health outcomes by race. Dr. Jones replied that North Carolina has worked with the data and part of CDC's work will be to distribute the information to the other States.
- Dr. Guyer asked about the interaction between race and class in the way the data are interpreted. The disparity in infant mortality rates across social class shows that the gap is even greater at higher SES than lower SES. Dr. Guyer asked how Dr. Jones' analysis and thoughts about racism relate to that problem. Dr. Jones stated that racism is another caste marker in this society. Race is caste based on phenotype, whereas in India caste is based on birth. The reality is that poverty is not the only thing poor Black and White people have in common. They also have in common that they live in a racist society that treats them differently. In some ways, racism is one of the tools for perpetuating class differences.
- Joyce Roberts, C.N.M., Ph.D., asked Dr. Jones to elaborate on the policies related to health outcomes. Dr. Jones mentioned the local property tax policies related to funding public education. Communities should have the power to act and control resources as opposed to setting up agencies to do that for communities. CDC should make monies available to communities that have already tried interventions instead of funding new demonstration projects. CDC also should fund evaluations of ongoing interventions and invest for 20 years instead of 3 to 5 years in research projects, thereby enabling communities to work with ideas and control the resources over an extended period of time.

## **MEDICAID REFORM AND MATERNAL AND CHILD HEALTH**

### **Medicaid at a Crossroads**

*Cindy Mann, J.D.*

*Research Professor, Center for Children and Families, Georgetown University Health Policy Institute*

Ms. Mann explained that her presentation would touch on the current status of Medicaid reform, the pressures facing Medicaid, the track records of Medicaid and the State Children's Health Insurance Program (SCHIP), and Medicaid at the Federal level.

Medicaid's role for children and pregnant women involves both coverage and support for related programs. Only 25 percent of children whose families fall into the \$33,000 annual income range have employer-sponsored health insurance, compared with 81 percent for higher income children. Medicaid is designed and has been used increasingly over the years, both at the Federal and State levels, to fill that insurance gap. For all children, Medicaid and SCHIP represent about 27 percent of the source of coverage. For low-income children (those below 200 percent of the Federal poverty level [FPL]), about one-half are covered through Medicaid or SCHIP. Medicaid also supports other systems of care for children, such as foster care and child welfare programs, early intervention programs, special education, and child care and Head Start. In fact, Medicaid is often the financing mechanism for the health assistance piece of these other services for children. Medicaid changes will have an indirect effect on other services for children and pregnant women because Medicaid is the largest single source of Federal support to States.

Regarding coverage and access to care, Medicaid's track record shows that it is a success. Trends in the uninsured rate of low-income children from 1997 to 2003, when there was an economic downturn, reveal a one-third drop in the rate of uninsured children. Marked improvements also have been noted in terms of access to care. However, State fiscal pressures, such as higher health care costs, sinking State revenues, and more people needing publicly funded health insurance, have prompted changes. States have taken cost-containment measures, particularly relating to drugs, or have cut or frozen rates, with implications for access to care. Some States have reimposed enrollment barriers, six States closed enrollment in SCHIPs, and other States cut eligibility and benefits for adults. Some States have proposed far-reaching waivers. For example, a waiver proposal from South Carolina would eliminate the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit coverage requirement. Washington State was a leader in simplifying its program and encouraging access to coverage for children, but participation plummeted when verification requirements were reinstated and recertification rules were changed to eliminate the 12-month eligibility rule. A current reversal in Washington State will no doubt show an increase in the enrollment of low-income children.

Ms. Mann described the Federal budget components of Medicaid reform, including the President's proposal, Congress's budget resolution and reconciliation, the role of the governors, and the appointment of a White House commission. The commission is tasked with making a first set of recommendations to Congress on the Medicaid program by September 1, 2005, and a broader set of recommendations by December 2006. The congressional reconciliation called for \$10 billion in cuts, aimed largely at Medicaid, over 4 years (2006 to 2010). The administration's policy proposals include: (1) changing the rules for how States are paid, (2) instituting changes that would result in Federal and State savings, (3) increasing Federal and State spending through initiatives, (4) "modernizing" Medicaid, and (5) moving up SCHIP reauthorization.

The National Governors Association (NGA) issued a preliminary report on June 15, 2005, and testified before the Senate Finance Committee on the following recommendations: (1) drug benefit and pricing changes, (2) long-term care eligibility changes, (3) more flexibility for States to make changes in the program regarding cost sharing and benefits, (4) less judicial intervention in the program, (5) other initiatives to reduce the need for people to turn to Medicaid, (6)

operational and information technology improvements, (7) waiver reform, and (8) “clawback” payments.

Ms. Mann focused on the issues of cost sharing and benefits because they have the most significance from the maternal and child health perspective. The NGA policy leads to many open questions about the broadly stated proposal. The NGA identifies SCHIP as the model to be used and generally proposes to allow cost sharing (e.g., premiums and copayments) as long as total costs do not exceed 5 percent of total family income, or perhaps 7.5 percent, for those with incomes above 150 percent FPL.

A question arises about whether SCHIP is the appropriate model in terms of cost sharing and whether the NGA proposal appears to provide even less protection than SCHIP. Ms. Mann reviewed the differences between the SCHIP rule and the NGA proposal. Because SCHIP applies only to children with incomes above Medicaid, it has an implicit income exemption. SCHIP is layered on top of Medicaid; very low-income children and pregnant women are not eligible for the program. In contrast, the NGA proposal does not include any income exemption. Another difference exists in the cost-sharing caps allowed by SCHIP (5 percent) and the NGA proposal (7.5 percent). Medicaid covers a much broader group of people; the more medically needy children tend to be in the Medicaid program, not in the SCHIP program. Ms. Mann reiterated that most children and parents covered by Medicaid have very low incomes. About 80 percent of all children covered by Medicaid have incomes below 100 percent FPL (for children older than 6 years of age) or below 133 percent FPL, and about 60 percent of pregnant women/parents have incomes below 133 percent FPL. The intensity of participation is clearly at the lower income level.

In terms of benefits, the approach of the NGA proposal is to target benefits and give them to the neediest populations, but the proposal would have a significant impact by eliminating EPSDT. One issue is that the group most affected by the proposal would be children (including those with special health care needs), pregnant women, and very low-income parents. Second, it must be recognized that savings can be achieved only by not covering services or treatments people need and that are now covered by Medicaid. Another issue is that tiered benefits could make the program very complicated and costly to administer and could result in difficulty for beneficiaries and providers.

Ms. Mann called for identifying the problems with Medicaid and aiming constructive solutions at those problems. The real issues facing the Medicaid program involve: (1) the State revenue system and added pressures during downturns, (2) broader issues relating to health care costs and coverage, (3) the cost of dual eligibles and the aging population, and (4) the existence of millions of uninsured people, including 9 million children. Ms. Mann concluded her presentation by emphasizing the following points: (1) Medicaid expenditures per person have grown more slowly than private insurance costs, (2) children account for almost half of Medicaid beneficiaries but less than 20 percent of expenditures (about 42 percent of total Medicaid spending is for Medicare beneficiaries), and (3) the right balance must be found between meeting Federal standards and allowing State flexibility.

## **Infant Mortality and Medicaid Reform**

*Shelly Gehshan, M.P.P.*

*Senior Program Director, National Academy for State Health Policy*

Ms. Gehshan's presentation covered the accomplishments and challenges in infant mortality prevention and focused on the effect of two reform proposals on infant mortality prevention efforts. The Medicaid program has resulted in several accomplishments regarding infant mortality prevention. The infant mortality rate has dropped steadily. The Medicaid enhancements enacted in the late 1980s were embraced by the States. Smoking rates dropped from 20 percent in 1987 to 12 percent in 2002. Neural tube defects are down because of the folic acid campaign, and breastfeeding is up.

As of 2002, only 10 States extended Medicaid coverage to pregnant women at minimum levels, 27 States offered the coverage between 134 and 199 percent FPL, 9 States covered at 200 percent FPL, 4 States covered above 200 percent FPL, and Medicaid paid for 37 percent of all births. In 1985, States could choose to provide enriched services to low-income pregnant women, including health education, nutrition counseling, and case management. In 1986, States were given the option to use presumptive eligibility and to drop the barrier of the asset test. In 1990, continuous eligibility was established through 60 days postpartum and 1 year for newborns. In addition, Medicaid provides 61 percent of all family planning monies. Ms. Gehshan pointed out that this last factor should be an important consideration in any reform proposals. Fewer family planning dollars means more unintended pregnancies.

The challenges in infant mortality prevention outnumber the accomplishments:

- Twenty percent of pregnant women lack insurance at some point during their pregnancies, most often at the beginning of pregnancy.
- Employer-based insurance is eroding steadily.
- African American women have a 13.6 infant mortality rate compared with a 6.9 rate in the overall population, and a 13 percent low birthweight rate compared with 7.7 percent overall.
- Pregnant women enrolled in Medicaid are twice as likely to smoke as others.
- The percentage of women not practicing family planning is small but rising.
- The percentage of women with no prenatal care is rising.
- Only seven States have Medicaid dental coverage for adults.

After mentioning the challenges in the South and the interplay between low birthweight and poor oral health, Ms. Gehshan turned to two reform proposals: the National Academy for State Health Policy (NASHP) "Making Medicaid Work" (MMW) proposal and the NGA Medicaid reform proposal. The NASHP MMW report contains the following recommendations: (1) cover all people below poverty level, regardless of category; (2) continue to require States to cover children and pregnant women below poverty level but allow expansions; (3) simplify eligibility based on income alone; (4) make comprehensive benefits available for mandatory groups and less comprehensive benefits available for optional groups; (5) discontinue block grants and change the countercyclical nature of the financing formula; (6) support an enhanced match such as SCHIP for expansion groups; and (7) coordinate with employer-sponsored insurance without a waiver.

The NASHP system would affect infant mortality because poor women of childbearing age would have coverage before, during, and after pregnancy. They would not lose eligibility 60 days postpartum. However, in States that chose the minimum level, pregnant women under 100 percent FPL might lose coverage.

In terms of eligibility, the NASHP system has some striking possibilities. States would continue to have the option to waive the asset test. The enrollment process would be simplified, and States would face fewer expenses to process eligibility. The simpler process could expand the options for enrollment, resulting in less “churning” on and off the system.

In terms of financing, the absence of block grants would mean no cap and no waiting lists, and more people could be covered as they became eligible. Eligibility by income means continued individual entitlement. Continuous eligibility could mean fewer delays and earlier entry for prenatal care. More planned pregnancies and fewer unplanned pregnancies might result from access to family planning services. More consistent care would offer opportunities for education, prevention, and intervention. One insurance source for low-income families might lead to a medical home for those families.

In terms of benefits, the NASHP system raises some concerns. Medicaid works well for pregnant women partly because of services for which most insurance companies do not pay. Ancillary, enabling services, such as translation services, might not exist in the NASHP plan. Higher income pregnant women also might have fewer benefits than they need. On the other hand, States might be successful in tailoring their benefits packages for pregnant and postpartum women.

The NGA Medicaid reform proposal reveals that the governors seek enforceable cost sharing (5 percent to 7.5 percent of family income). The system offers flexibility to tailor benefit packages to populations. It also offers a simplified waiver process and the right to manage optional populations without court intervention. In terms of infant mortality, cost sharing in this system might cost more money than it brings in. Cost sharing impedes enrollment and receipt of services among low-income people, and copayments reduce the utilization of preventive services and raise costs among people with chronic diseases. In addition, premiums and copayments for low-income pregnant women could raise costs, and waiver authority in the States sometimes is used to create less coverage for people.

In conclusion, Ms. Gehshan reiterated that high costs in Medicaid come largely from the disabled, institutionalized population, not from children. It is hoped that Medicaid reform will not impair the ability of States and providers to care for pregnant women and young children. Medicaid is the vehicle for health care programs in the States.

### *Discussion*

- Robert Hannemann, M.D., thanked the speakers for the update and reminder about Medicaid issues. He commented that Medicaid costs are not increasing at the same rate as private insurance costs in part because private insurance is “subsidizing” the Medicaid program.

Providers frequently charge more for their private insurers to offset the decreased reimbursement from Medicaid. Dr. Hannemann also referred to the SACIM report to the Secretary and a report by a multiagency workgroup, which made recommendations for research on the problem of preterm birth and low birthweight in the African American population. The reports' recommendations have not been implemented. Dr. Hannemann asked whether data exist on the cost of low birthweight/preterm birth to the Medicaid program. Ms. Mann replied that her comments on Medicaid costs compared with costs of private insurance were meant to point out that Medicaid costs are not out of control, more people need Medicaid and many of those people are very sick, and Medicaid might actually be paid too low per person. She also referred to a study on the distribution of spending within Medicaid; 25 percent of Medicaid enrollees account for 75 percent of the spending. To find a solution, the focus must be on high-cost cases and delivering better care at reduced costs. Ms. Gehshan added that known issues, such as lack of insurance, lack of access to high-quality care, smoking, and substance abuse, should be addressed to remedy the current disparities in care. Dr. Hannemann mentioned that SACIM recommended to the Secretary that the antismoking program be continued, the level of prenatal care be maintained, and nutrition education not be downgraded. The need continues for basic science to examine the reasons behind preterm birth and low birthweight.

- Fredric Frigoletto, Jr., M.D., referred to reports of fraud and abuse in the Medicare and Medicaid programs. Ms. Gehshan stated that the fraud and abuse reports concern provider billing, not individuals misusing the program. Ms. Mann added that the fraud and abuse rates in Medicare and Medicaid are actually quite low. She mentioned that States might use financing mechanisms (intergovernmental transfers) to draw down Federal Medicare dollars without contributing the State share, but this is not fraud and abuse because the States adhere to current Federal rules when they engage in this practice.
- Dr. Hayes commented on the MMW recommendations and stated the importance of the continuity of preconception care. She asked about the White House commission on Medicaid and whether SACIM has the ability to recommend someone for the commission who has a broad understanding of the issues. Ms. Mann explained that the legislation involving the commission contained clear guidelines on the goals, composition, and voting of the commission; however, that legislation was not adopted. The Administration called for nominations and will choose commission members and run the commission. Ms. Mann reiterated that the NASHP proposal calls for all people to be covered at least up to the poverty line and to receive full Medicaid benefits, which is a significant change from the current system. On the other hand, the NGA proposal does not address the need for Medicaid to cover more parents and childless adults at lower income levels. However, the view must be one that considers a broad restructuring proposal, not just a look at specific recommendations. The NASHP proposal would increase, not decrease, Federal spending. Dr. Hayes referred to a larger return on investment if the long view is considered. Ms. Gehshan remarked that the biggest beneficiaries of the NASHP proposal would be men.
- Dr. Ryan remarked on the complexity of the NASHP proposal, especially in terms of equity issues. If the States and the Federal Government have to pay so much more to cover the uncovered populations up to 100 percent FPL, many States will drop to 100 percent or 130

percent for pregnant women and infants and children. Ms. Mann mentioned that the NASHP financing system would push most of the burden of the additional coverage on the Federal Government, not on States. Dr. Ryan pointed out that the Federal Government can run a deficit, but the States cannot. Ms. Mann raised another issue, namely, that States have different fiscal capacities and different burdens. Insofar as there is a national interest in improving access to health care coverage, more of that obligation should be financed nationally so the burdens can be distributed more equitably across the country. Dr. Ryan noted that the NASHP proposal might be an incremental step toward a universal single payer system. Ms. Gehshan referred to the huge cost to society of the uninsurance problem and the often overlooked costs associated with loss of productivity.

### **HEALTHY START UPDATE**

*Maribeth Badura, M.S.N., R.N.*

*Director, Division of Healthy Start and Perinatal Services, Maternal and Child Health Bureau, Health Resources and Services Administration*

Before she began her update, Ms. Badura stated that she hoped to be able to report on the first phase of the national Healthy Start evaluation at the next SACIM meeting. Healthy Start was established as a Presidential initiative in 1991 to improve health care access and outcomes for women and infants, promote healthy behaviors, and combat the causes of infant mortality. Authorized in 2000 as part of the Children's Health Act, the program is expecting reauthorization this year. Healthy Start is an initiative to reduce the rate of infant mortality and improve perinatal outcomes. It makes grants for project areas with high annual rates of infant mortality. The legislation mandates a partnership with statewide systems and with other community services funded under the maternal and child health block grant. A community consortium made up of various individuals and organizations provides overall direction for the project. A total of 94 percent of the funds go to community-based projects.

After presenting information about funding various grants addressing racial and ethnic disparities (74 grants) and focusing on the border, Alaska, and Hawaii (3 grants), Ms. Badura provided information about recompeting grantees as well as grants on improving screening and treatment for perinatal depression, high-risk interconceptional care, and family violence. Phase one of the national evaluation, which is a descriptive analysis of activities in the sites, will be completed this year. The second phase of the evaluation will include case studies of selected sites and a participant survey. Healthy Start also supports three technical assistance contracts in the following areas: (1) perinatal depression, (2) domestic violence, and (3) breastfeeding.

The overall strategic approach of the Department of Health and Human Services (HHS) Closing the Health Gap on Infant Mortality initiative is to (1) focus on research coordination, risk reduction, and collaboration; (2) build on existing programs and pilot test evidenced-based interventions in high-incidence States and communities; (3) partner with organizations; and (4) initiate a communication campaign. Healthy Start contributes some funding to the pilot communities in Illinois, Michigan, Mississippi, and South Carolina. It also participates in the perinatal collaborative and the media campaign. Healthy Start's goal is a healthy Nation through healthy women, infants, families, and communities.

## ***Discussion***

- Dr. Hayes asked about the backup plan should Healthy Start not be reauthorized. Ms. Badura responded that Healthy Start is in the President's budget for 2006.
- Dr. Bronner inquired about the estimate on the impact of Healthy Start on infant mortality. Ms. Badura replied that some projects are reporting no infant mortality among their program participants. Other communities report very dramatic decreases, but the decreases are not consistent across all of the communities. Ms. Badura added that Healthy Start has received increasing requests to cover medical services as well as enabling services, such as transportation and child care.
- Ms. Frazier asked whether the evaluation will include information about successful interventions addressing racial disparities. Ms. Badura responded that information on that topic might come from the final impact reports submitted by the projects. Ms. Frazier commended the Healthy Start program for its reports on lessons learned, which have been very helpful to new projects.

## **MATERNAL AND CHILD HEALTH BUREAU UPDATE**

*Peter C. van Dyck, M.D., M.P.H.*

*Associate Administrator for Maternal and Child Health, Health Resources and Services Administration*

*Executive Secretary, Secretary's Advisory Committee on Infant Mortality*

After confirming that there would be no public comments, Dr. Collins introduced Dr. van Dyck, whose presentation included topics of interest to SACIM as well as supplementary information on the Closing the Gap initiative.

Previous HHS Secretary Thompson asked the Health Resources and Services Administration (HRSA) and the National Institutes of Health to organize the HHS Interagency Coordinating Council on Low Birth Weight and Preterm Birth (Coordinating Council) and develop a department-wide research agenda on low birthweight and preterm birth. The topics of sudden infant death syndrome (SIDS) and racial disparities were added to the initiative later. Duane Alexander, M.D., Director of the National Institute on Child Health and Human Development (NICHD), and Dr. van Dyck were the cochairs of the Coordinating Council, which included 20 representatives from 12 agencies in HHS and 2 liaison members from SACIM, Drs. Hannemann and Frigoletto. The group met for 2 years. Its report, which was submitted to the Secretary on June 3, 2005, currently is in the clearance process. It includes 24 recommendations for research priorities on low birthweight, preterm birth, and SIDS. Some examples of the research priorities are to (1) study the mechanisms of the initiation of labor with an emphasis on better biomedical, social, and behavioral indicators of risk for preterm delivery; (2) assess and improve measurement or surveillance methods for monitoring trends in preterm delivery risk; and (3) accelerate the development of innovative ways to introduce research advances into practice and study their effectiveness.

In 2004, HHS implemented the Closing the Health Gap on Infant Mortality initiative, a major cross-agency initiative aimed particularly at the African American and American Indian and Alaska Native populations. The initiative takes a three-part approach: (1) research coordination among HHS agencies, (2) communication through a public education campaign titled Know What to Do for Life, and (3) risk reduction efforts in communities in Illinois, Michigan, Mississippi, and South Carolina on SIDS, low birthweight, and preterm birth.

Dr. van Dyck provided some detail about the Know What to Do for Life campaign, which focuses on reducing infant mortality among African Americans. A second campaign planned for this fall will focus on SIDS in African American and American Indian and Alaska Native populations. The goal is to raise awareness in the communities among individuals and providers.

An effort related to the work of HRSA and the Indian Health Service in the Closing the Gap initiative involves the Bureau of Primary Health Care (BPHC), which has implemented the Perinatal and Patient Safety pilot using the highly successful framework of the Health Disparities Collaborative's program. BPHC-funded community health centers in Illinois, Michigan, Mississippi, and South Carolina are participating in this 12-month pilot project. The Health Disparities Collaborative program is a national effort to achieve strategic system change in the delivery of primary health care. An innovative health initiative, it seeks to (1) generate and document improved health outcomes for underserved populations; (2) transform clinical practice through new evidence-based models of care; (3) develop the infrastructure, expertise, and multidisciplinary leadership needed to improve health status; (4) and build the strategic partnerships needed to make the program work. These collaboratives originally focused on chronic diseases such as diabetes and have since spread to other topic areas.

The Perinatal and Patient Safety pilot is unique because it is the first collaborative of teams composed of health centers working together with their community hospitals to improve the quality of care of mothers and infants along the continuum of care from the first prenatal visit through postpartum followup. Patient safety issues, such as improved communication between the health centers and hospitals, are an important part of the pilot program. After the pilots are evaluated, a perinatal care model will emerge as the guiding framework to be shared with all of the community health centers across the Nation.

The Institute of Medicine's (IOM's) Committee on Understanding Premature Birth and Assuring Healthy Outcomes was convened in March 2005 to define and address the health-related and economic consequences of premature birth. The broad goals of this study are to (1) describe the current state of the science with respect to premature birth; (2) address the broad costs (economic, medical, social, psychological, and educational) for children and their families; and (3) establish a framework for action in addressing the range of priority issues, including a research and policy agenda for the future. The study will last about 18 months. Sponsors include the Maternal and Child Health Bureau (MCHB), CDC, NICHD, and other organizations with a clear interest in this area. The report will be ready in about 2 years.

Dr. van Dyck also reported that data from the National Survey of Children's Health are now available. The survey included 100,000 children, approximately 2,000 from each State. Data collection ended in summer 2004. The survey results include information about demographics,

physical and mental status, health insurance, health care utilization, access to a medical home, family functioning, parents' health, and neighborhood characteristics. Survey domains include the effect of child characteristics, family-level influences, and neighborhood and community influences on child health and child outcomes. The survey also contains a number of positive indicators to track youth development, such as family strengths, family relationships and behavior, family processes, and household routines. In addition to measuring the physical, emotional, and dental health of children, the survey includes information about medical homes for children's health care, school activities, family activities, and neighborhood activities. Data from the survey are available to SACIM, parents, the public, and health care researchers. Dr. van Dyck urged SACIM members to visit <http://www.nschdata.org> to access the survey data. The Children's Special Health Care Needs survey also can be accessed at <http://www.cshcndata.org>. These Web sites contain information about the prevalence of obesity, breastfeeding, and asthma across States. Visitors to these sites also can access data on the number of children by age who have medical homes, how many children by age have a personal doctor, and how many children by age are in child care. In addition, the Web sites reveal data about parents' health practices related to children's health status, parents' reading to children related to children's mental or behavioral health status, and the safety of neighborhoods and schools according to parents.

### *Discussion*

- Ann Miller, Ph.D., asked how the public will be informed that this information is available on the Web. Dr. van Dyck replied that a brochure will describe the availability of the data. He added that Family Voices and other constituents know about the Web sites, and a press release will announce the existence of the Web sites when they are fully functional.
- Dr. Ryan suggested that faculties at the schools of public health across the Nation be informed about the Web sites. Dr. van Dyck remarked that information will be disseminated to all the grantees.
- Dr. Hannemann asked whether the implementation or initiation of the LBWCC recommendations for research will be delayed by the IOM committee work. Dr. van Dyck responded that the two reports are not related, and the Secretary is not obligated to wait for the second report before initiating funding for research grants. Dr. Hannemann asked whether it would be appropriate for SACIM to recommend to the Secretary that he initiate action on the LBWCC recommendations as soon as possible because of the urgency of the problem. Dr. van Dyck agreed that such an action is in the purview of the Committee and would be appropriate as a Committee-initiated function.
- Dr. Hayes noted the importance of emphasizing collaboration to improve the health status of children. The recent summit on preconception care also recognized that everyone has potential involvement in this opportunity.

Ann Koontz, C.N.M., Dr.P.H., announced that each SACIM member was given a folder containing three sets of materials:

1. Travel reimbursement forms (due July 12, 2005)
2. Ethics forms (due August 1, 2005)
3. New pay system information (payday July 15, 2005)

#### **TASKS FOR SACIM AND SUBCOMMITTEES**

*James W. Collins, Jr., M.D., M.P.H.*

*Chairperson, Secretary's Advisory Committee on Infant Mortality*

Dr. Collins directed SACIM members to their subcommittee meetings to continue the work begun at the previous SACIM meeting. The three subcommittees (Eliminating Health Disparities, Improving Clinical and Public Health Practice, and Maternal and Child Health Funding and Financing) were asked to narrow down their tasks to two to four issues and to appoint a member to report back to the full Committee on the following afternoon.

**FRIDAY, JULY 8, 2005**

#### **COMMITTEE BUSINESS: SUBCOMMITTEES' REPORT-OUT AND DISCUSSION OF SUBCOMMITTEES' DIRECTION**

*James W. Collins, Jr., M.D., M.P.H.*

*Chairperson, Secretary's Advisory Committee on Infant Mortality*

After several hours of subcommittee meetings, the groups reassembled to hear the reports on their work. Before that discussion began, Dr. Hannemann proposed a motion to recommend that the Secretary encourage action on the research agenda proposed by the Coordinating Council. Dr. Hannemann mentioned that the motion as written could be modified to indicate a greater sense of urgency, if the group so desires.

The motion is as follows: SACIM recommends that the Secretary initiate action on the research programs outlined by the Coordinating Council in its report submitted on June 3, 2005. In addition, SACIM requests that the SACIM Chair and/or designee be included in future discussions involving such research.

Dr. Guyer seconded the motion, and Dr. Collins called for discussion.

- Dr. Guyer noted that the motion raises the question of how SACIM communicates with the Secretary. He suggested the letter sent to the Secretary should express a sense of urgency.
- Dr. Hayes mentioned that the March of Dimes has had an audience with the Secretary on the topic of prematurity. Perhaps the SACIM Chair could be included in followup meetings. Dr. Hayes also reported that the State Health Officer in Florida, John O. Agwunobi, M.D., M.B.A., M.P.H., recently was nominated to be Assistant Secretary for Health, HHS. As a pediatrician, Dr. Agwunobi would understand the relevance of the issues and might be very receptive to attending the SACIM sessions.

- Dr. Bronner stated her support of the idea of an audience with the Secretary and encouraging future periodic communications. Dr. Guyer suggested that the letter to the Secretary contain a concluding sentence welcoming him to a Committee meeting at a future date to engage in an interchange with the members. Dr. Collins voiced his support of this suggestion.
- In light of the large number of Federal advisory committees, Dr. Ryan stated that Dr. Hayes's suggestion involving the new Assistant Secretary of HHS might be an advantageous avenue to pursue. Dr. Bronner thought the point should be to obtain an audience with someone who can allow the communication flow to move forward on the report as well as the Committee's work.

Dr. Collins called for a vote on the motion. The motion was approved.

### **Report of the Subcommittee on Eliminating Health Disparities**

Dr. Bronner reported on the subcommittee's work and its acknowledgement that infant mortality has been lowered without closing the disparities gap. Over the past 100 years, while infant mortality has decreased, the gap has not closed. Therefore, the subcommittee focused on the continuum that starts with preconception, goes on to conception and pregnancy, and ends with the postpartum period. The subcommittee encourages an emphasis on the environmental and contextual issues. The subcommittee discussed three issues:

1. To link interventions, such as lessons learned from Healthy Start and the Community Health Centers, to develop and financially support a multilevel model (one that would work at the community level, institutional level, and individual level) of implementable elements. The implementable elements include (1) education on the appropriate birth interval; (2) promotion of family mental health, in particular, the male role; (3) acknowledgment and strengthening of the resilience factor; (4) stress management (partner support and spirituality); (5) risk factors involving smoking, diet, physical activity, substance abuse, and violence; and (6) neighborhood context (e.g., violence, racism). These elements can be implemented and then evaluated, monitored, and iterated upon to solve problems.
2. To develop, disseminate, and financially support family health promotion messages at multilevels. The lessons learned must reach the people who are at risk and must be culturally relevant and appropriate.
3. To expand the research agenda examining effects of racism, social, economic, and environmental/contextual factors on family health and infant mortality. A cost-benefit analysis component should be included so the findings can be applied in policy solutions.

Dr. Bronner mentioned that the subcommittee members did interim work that allowed them to work from an evidence base in their deliberations.

## ***Discussion***

- Dr. Hayes asked whether family health promotion would be targeted or population-based. Dr. Bronner stated that the subcommittee did not address the question from that perspective. She noted that the emphasis on family health promotion rose from the subcommittee's discussion of the early emphasis on family formation. Robert Sapien, M.D., FAAP, added that the subcommittee discussed the lack of male involvement in many high-risk situations.
- Dr. Guyer remarked that it might be more accurate to say that we don't know how to reduce the gap as quickly as we would like. He then indicated that the absolute difference between Black and White infant mortality was reduced from 9.7 per 1,000 to 8.1 per 1,000 from 1990 to 2002. Therefore, the health disparities gap is decreasing. Black infant mortality is now 2.4 times White infant mortality. However, as the overall denominator decreases, the gap relative to the denominator increases. This artifact of the numbers belies the fact that the absolute difference between Black and White infant mortality is going down. Dr. Bronner commented that the gap remains at more than 100 percent. Dr. Collins added that there has not been a dramatic, significant decrease in disparity. Dr. Guyer noted that the effort to make a real impact on the difference requires going well beyond current strategies. Dr. Hayes called for underscoring the importance of the social determinants of health in the preconception stage. Dr. Ryan reiterated the need for accuracy in describing the health disparities gap. He pointed out that the magnitude of the gap (the difference in the numbers) has declined, but the ratio has not declined. Dr. Collins and others supported this statement and reiterated that methods to improve infant outcome are known, but the disparity ratio (between 2 and 2.8) persists. Research is needed to understand the mechanisms underlying the gap.
- Dr. Frigoletto remarked that Dr. Hayes's statement about the social determinants of health was a pillar of the subcommittee deliberations.

## **Report of the Subcommittee on Improving Clinical and Public Health Practice**

Dr. Ryan reported on the subcommittee's deliberations and its three main areas of interest.

1. *Considering preconceptional health with a lifespan approach.* The paradigm in use in the late 1980s and 1990s was that the key to improving birth outcomes was better access to prenatal care, earlier initiation of prenatal care, and better content of prenatal care. Now the emphasis should be on the gains derived from promoting better health throughout the lifespan of girls and women. The paradigm shift aims to achieve optimal health before pregnancy through a healthy girlhood and to stress the life cycle approach to better birth outcomes. A lifetime of poor health behaviors cannot be corrected during prenatal care, and primary prevention should take precedence over a rescue-approach mentality. Nutrition, physical fitness, chronic disease prevention or care, sexually transmitted disease avoidance, and social and emotional wellness must be addressed. The mindset about what is needed to achieve a good birth outcome must be changed. Promoting healthy girlhoods is the key to promoting healthy pregnancies and positive birth outcomes. This issue relates to personal behaviors, clinical practice, family support, and community infrastructure. Improving care

should occur in the context of social determinants of health. Practical steps to reaching these goals might include: (1) bringing expert panel advice on preconception care to SACIM, (2) strategizing about ways to engage a broad spectrum of clinical providers in this initiative, and (3) establishing tasks and timelines following the expert panel discussion.

2. *Reengineering vital statistics for the 21st century.* The major limitation of the current biostatistical system is its lack of timeliness. There is a 2-year delay in reporting final annual reports of deaths, infant births, and birthweight-specific mortality. Other limitations of the current system involve (1) a lack of uniformity that results from each State making its own decisions about items on birth and death certificates and (2) the development of separate registries for various neonatal conditions that are not integrated or linked to the birth registration files. The subcommittee would approach this topic as a short-term task. It would inform itself about current efforts in the area, seek to understand the barriers, and lend support to the best efforts to resolve the issues. The subcommittee believes that funding must be provided to States and municipalities to provide the instruments and electronic medical record systems to generate high-quality, accurate, and complete perinatal information.
3. *Improving quality of care.* Incorporation of demonstrated evidence-based practices into everyday clinical activities will improve birth outcomes. Much of the work in this area must concentrate on the dissemination of already identified evidence-based practices in the practice arena. Providers' behaviors must be changed, and timely data are a critical component of quality improvement. Incentivized high-quality care is important, and effective practical strategies must be identified. Information from the following sources would be helpful: (1) the Perinatal and Patient Safety Collaborative of the BPHC, (2) the California hospital-based perinatal system, and (3) the Centers for Medicare and Medicaid Services (CMS) pay-for-performance initiative. The subcommittee also would benefit from input from entities interested in change (such as private payers, professional organizations, and Government agencies). These groups could help us identify what is necessary to move practice, what are the motivators, and what strategies might ultimately be successful. In addition, the subcommittee discussed birth-specific areas in which quality can be improved, such as progesterone, periodontal health, family planning services, and risk-appropriate intrapartum care.

## ***Discussion***

- Dr. Frigoletto asked which aspect of care is lacking—the traditional medical care or the ancillary care. Dr. Ryan responded that the subcommittee did not focus its attention on this aspect of the issue. He also pointed out that the periodicity of prenatal care is not evidence-based; it is derived from tradition.
- Dr. Collins noted the clear overlap between the group studying improving quality of care and the group studying disparities. In terms of the dissemination of information, the latter group focused on providers, health professionals, and receivers of care. The former group should focus on disseminating information to health care providers. SACIM should conduct further discussions about which group should make the dissemination of information to the community its primary focus. Dr. Hayes stated that SACIM should be grounded in the

concept of preconception and care over the lifespan to bridge some of the gaps in birth outcomes. Dr. Ryan explained that his subcommittee thinks of this issue as a paramount area in which gains can be made in improving birth outcomes.

### **Report of the Subcommittee on Maternal and Child Health Funding and Financing**

Robyn Arrington, Jr., M.D., stated that the subcommittee decided its approach overall should be to serve as the moral authority on the most important and priority-oriented issues based on the expertise of the group, stressing the care that should be maintained or the areas that should receive priority funding. The subcommittee recommended four priority areas:

1. To maintain the core functions of the Medicaid program, which has provided a safety-net to women and children and has had a positive impact on the infant mortality rate. This includes but is not limited to health education components that relate to maternal health and EPSDT. In addition, explore ways that Medicaid can incorporate evidence based practices.
2. Develop strategies to preserve the MCH Block Grant (Title V).
3. Promote the medical home concept for expectant families and infants.
4. Improve health and information technology for MCH services.

### ***Discussion***

- Jennifer Cernoch, Ph.D., offered a point of clarification on the second subcommittee recommendation, namely, that the reference to the block grant was to the maternal and child health block grant.
- Dr. Hayes asked whether the subcommittee discussed the SACIM recommendation to the Secretary about the benefit package to ensure better outcomes and the pay-for-performance proposal. She also suggested SACIM make recommendations on infant mortality and enter the conversation about accountability and return on investment. Dr. Arrington explained that the subcommittee wanted to bring its initial assessment back to the full Committee for its input. Dr. Hayes reiterated that the connection should be made between funding and the clinical pieces as they relate to quality. Quality, not money, should be the driver. SACIM should take advantage of the momentum in the Secretary's office concerning some of these issues.
- Ronald Finch, Ed.D., commented on the subcommittee's discussion of maintaining the core value of providing service but restructuring the benefits around evidence-based care. This approach includes the pay-for-performance issue.
- Dr. Cernoch added that the subcommittee discussed the preservation of core values, services, and functions that the CMS currently provides, such as the EPSDT program, prenatal care, and immunizations. While CMS is engaged in reform, these core services should be preserved to continue their positive impact on infant mortality. Dr. Hayes stated that SCHIP is an opportunity to bring preconceptional care to women.
- Dr. Ryan reemphasized the idea of supporting and incentivizing evidence-based practices, for example, smoking prevention and cessation services.

## Future Directions for Subcommittees

Dr. Collins asked the participants to turn their attention to the subcommittees' future directions. He summarized the issues to be considered by each group as follows:

- *Eliminating Health Disparities.* This subcommittee will focus on (1) implementation issues and (2) setting a new research agenda. The aspects of dissemination to the public will be handled with implementation issues. Other dissemination issues associated with providers will be included in the work of the Improving Clinical and Public Health Practice Subcommittee. Attention to the contextual facets of preconception care will be included in item (1).
- *Improving Clinical and Public Health Practice.* This subcommittee will focus on (1) improving quality of care, including educating providers; (2) reengineering electronic vital records; and (3) preconception health and the lifespan approach.

Note: the first two groups will each work on the issue of preconceptional health and the lifespan approach, refining which components will be addressed by each (see Discussion below).

- *Maternal and Child Health Funding and Financing.* This subcommittee will focus on the moral authority for targeted priority issues. This work will include four components: (1) the values of Medicaid, (2) the maternal and child health block grant, (3) the medical home, and (4) information technology.

## Discussion

- Dr. Roberts expressed concern about losing the postpartum component of the lifespan approach. The continuum of care that goes beyond pregnancy is critically important in terms of sustained smoking cessation and dealing with mental health. She also suggested there might be overlap between funding health information technology and reengineering of vital records.
- Dr. Finch pointed out that an essential element in maintaining the core values of Medicaid is ensuring a movement to evidence-based care.
- Dr. Hayes mentioned a business imperative that the private sector is beginning to recognize—the biggest users of their dollars are women in the reproductive age group. Therefore, investments in women's health are wise investments. The question involves what women should expect in terms of coverage and what employers should expect in terms of evidence-based return on investment. This business imperative exists outside Medicaid and Government.
- Dr. Finch added that absences due to pregnancy and family leave result in high disability costs. Large employers can afford exceptional prenatal programs, lactation-at-work

programs, maternal depression programs, and so on. However, those programs are not standardized across all businesses. Small- and medium-sized employers are limited in their funds and do not have the resources to put those programs in place. Business coalitions are examining what can be done in this context.

- Dr. Ryan explained that his subcommittee's consideration of the topic of vital records would not be a long-term endeavor. Work on that issue can be concluded quickly.
- Dr. Hayes mentioned that specific tasks could not be delineated on the preconception issue until the subcommittee receives some grounding in the issue. Dr. Bronner referred to the overlap between the two subcommittees on this issue. Yvonne Moore, M.D., suggested the Improving Clinical and Public Health Practice Subcommittee take the lead on the issue of preconceptional health across the lifespan. Dr. Bronner asked about the difference between approaching the topic from the point of view of medical care (the clinical side of the issue) versus social, contextual, and environmental factors (the community side of the issue). Tentatively, Dr. Bronner's subcommittee will deal with the latter and Dr. Ryan's subcommittee the former. Dr. Hayes pointed out that, for quality of care, the work on this issue should take into consideration inequality. Dr. de Leon Siantz commented that the clinical side of the issue includes nurses, community aides, and the whole spectrum of health care providers in the clinical area.

Dr. Collins noted some potential speakers for the next meeting, including Vijaya Hogan, Ph.D., who would speak about modeling and a life course perspective, and a member of the expert panel on preconception. The next SACIM meeting will take place on November 29 and 30, 2005. The meeting was adjourned at 3:10 p.m.

## **PARTICIPANT LIST**

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Renee T. Barnes, M.S., R.N.  
Yvonne Bronner, Sc.D., R.D., L.D.  
Jennifer M. Cernoch, Ph.D.  
Mary Lou de Leon Siantz, Ph.D., R.N., FAAN  
Ronald Finch, Ed.D.  
Deborah L. Frazier, B.A., R.N.  
Fredric D. Frigoletto, Jr., M.D.  
Bernard Guyer, M.D., M.P.H.  
Robert E. Hannemann, M.D.  
Maxine Hayes, M.D., M.P.H., FAAP  
Ann Miller, Ph.D.  
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**Other Attendees**

Yako Allen  
ASIP

Carolyn Aoyama  
HRSA

Benita Baker  
MCHB, HRSA

Lori Cooper  
ASIP Project IMPACT

Chris DeGraw  
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David de la Cruz  
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