

Secretary's Advisory Committee on Infant Mortality

Meeting Minutes of March 8–9, 2012

**Hyatt Regency Bethesda
Bethesda, MD**

GENERAL SESSION

THURSDAY, MARCH 8, 2012

CALL TO ORDER AND WELCOME

SUMMARY OF AUGUST MEETING

Kay Johnson, M.Ed., M.P.H., Acting Chair, SACIM

As new acting chair of the Secretary's Advisory Committee on Infant Mortality (SACIM), Ms. Johnson introduced Dr. Michael C. Lu, former chair of SACIM, as the new Associate Administrator for Maternal and Child Health (MCH) in the Health Resources and Services Administration (HRSA). Ms. Johnson expressed her optimism regarding SACIM's ability to affect the Nation's accomplishments in preventing and reducing infant mortality.

Michael C. Lu, M.D., M.P.H., Associate Administrator for Maternal and Child Health (MCH), HRSA; Executive Secretary, SACIM

Dr. Lu thanked the SACIM members for their time and effort spent on committee business since the August meeting and reaffirmed his commitment to the mission of SACIM in his new position. He expressed his gratitude to Ms. Johnson for serving as acting chair and noted her role as a leader in MCH policy during the past 25 years as well as her knowledge of Medicaid, children's health policy, immunizations, neonatal care, child development, and children's special health needs. Dr. Lu also thanked the chairs of the working groups: Dr. Raymond L. Cox, Dr. Arden Handler, Ms. Johnson, and Dr. Adewale Troutman.

MATERNAL AND CHILD HEALTH BUREAU (MCHB) UPDATE

Michael C. Lu, M.D., M.P.H., Associate Administrator for MCH, HRSA; Executive Secretary, SACIM

Dr. Lu presented an update from MCHB on the Bureau's major activities related to infant mortality.

Summit on the Infant Mortality Reduction Initiative

The Regions 4 and 6 Infant Mortality Reduction Initiative was launched in January 2012 with a successful Summit in New Orleans. Dr. David Lakey, president of the Association of State and Territorial Health Officials (ASTHO), opened the Summit by introducing the presidential challenge on reducing infant mortality by 8 percent over the next 3 years. Dr. Lu presented a report outlining some of the priorities identified by SACIM in August 2011, including quality and safety, pre- and interconception care, Medicaid innovations, Title V MCH programs, reform and financing, and health equity. A panel on Federal and State initiatives included Dr. Scott D. Berns from the March of Dimes (MOD) Foundation, who spoke about the Healthy Babies are Worth the Wait (HBWW) initiative; Dr. Wanda D. Barfield from the Centers for Disease Control and Prevention (CDC), who spoke about perinatal regionalization; and Dr. Marsha Lillie-Blanton from the Center for Medicaid and CHIP Services, who spoke about the quality measurements and innovative strategies that became

the Strong Start initiative. A panel on State and local initiatives included Dr. Ruth Ann Shepherd, who spoke about the HBWW initiative in Kentucky; Ms. Belinda D. Pettiford, who spoke about North Carolina's work in creating a statewide network of pregnancy medical homes; and Dr. Donald Shell, who spoke about Maryland's comprehensive approach to addressing infant mortality. The States drafted plans, which are now completed, on how to address infant mortality and prematurity. Dr. Lu added that in attendance at the Summit were State health officers, Medicaid directors, legislative staff from the governors' offices and State legislatures, and MOD and other foundations. The idea of working in silos to reduce infant mortality is not valid; instead, Federal, State, and local agencies; public and private partners; and business and community leaders must come together to work on the problem of infant mortality.

Maternal, Infant, and Early Childhood Home Visiting Program

Dr. Lu explained that the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program, which is part of the Affordable Care Act (ACA), is funded with \$1.5 billion over a 5-year period to influence six benchmark areas in MCH. All States intend to participate in MIECHV, and a total of 25 States have submitted their plans and are ready to begin home visiting. A national evaluation will be conducted, and the program will be integrated into comprehensive systems of care for mothers and young children.

Healthy Start

Healthy Start is in 105 communities with a budget of \$103 million a year to help close the gaps in infant mortality. The program is scheduled for reauthorization next year, and MCHB will be innovating and transforming Healthy Start by engaging the communities in the redesign. The National Healthy Start Association will meet next week to discuss Healthy Start 2.0. Dr. Lu asked that SACIM consider convening a work group to make recommendations on the redesign of Healthy Start 2.0 and to report at the next meeting this summer.

MCHB Budget

This year's budget is \$1.2 billion. A total of \$638 million is allocated for the MCH block grants, \$350 million goes to support the home visiting program, and the remainder supports eight other programs. The President's 2013 budget entails three major changes: (1) the block grant was increased by \$1.5 million, (2) home visiting increased by \$50 million to \$400 million, and (3) Family to Family was zeroed out because its legislative authority expired in 2012.

Overall Approach

Dr. Lu summarized his overall approach to his position at MCHB by citing the Five I's: (1) improvement, which entails an approach to the quality gaps evident in MCH care; (2) innovation through collaborative learning; (3) integration of the highly fragmented MCH system through an approach that is vertical (appropriate levels of care), horizontal (service coordination and systems integration), and longitudinal (the continuum of care across the lifecourse); (4) investment, including long-term and intergenerational investment in research and population health; and (5) impact, which necessitates reaching out to agencies such as the Departments of Education and Housing and Urban

Development (HUD), the Environmental Protection Agency, and others.

Dr. Lu noted that MCHB is recruiting for the positions of Director of Healthy Start and Deputy Director of MIECHV.

Discussion

In response to a question from Dr. Handler regarding changes to the Title V block grant formula, Dr. Lu explained that the MCH block grant has traditionally been calculated based on the percentage of children in poverty according to the census. Moving to the advanced data system (ADS) provides more up-to-date, annual estimates of children in poverty. The question involves what data to use—running averages or fluctuating data. To calculate the block grants, MCHB is attempting to determine the most current and reliable estimates of child poverty.

After the SACIM members introduced themselves, Dr. David S. de la Cruz, the Designated Federal Official for SACIM, called the members' attention to the bios and charter in the binder and mentioned that ex officio members have been added to the Committee at the members' request. Ms. Johnson read the Objectives and Scope of Activities section of the charter and pointed out the important role of SACIM in focusing on policies and programs affecting infant mortality.

SACIM'S PRELIMINARY RECOMMENDATIONS TO HHS SECRETARY SEBELIUS

Kay Johnson, M.Ed., M.P.H.

Ms. Johnson presented SACIM's preliminary recommendations to HHS Secretary Sebelius. She explained the framework for the national agenda to reduce infant mortality, including (1) the life course perspective, (2) access to a continuum of services from family planning to postneonatal care, (3) high-quality patient-centered care, (4) investments in the MCH safety net, (5) strategies to create health equity through the elimination of disparities and unequal treatment and to influence social determinants of health, and (6) the importance of interagency, public-private, and multidisciplinary collaboration.

Better health for women, including preconception, prenatal, birth, and interconception care, will result in improved infant and child health outcomes, such as improved birthweight distribution and reduced fetal mortality, preterm birth, birth defects, infant mortality, and infant and child morbidity. The continuum stretches to birth, newborn and neonatal care, and postneonatal care, and a complex network of elements work together to result in better health for women and better infant and child health outcomes.

Ms. Johnson explained that the committee reviewed prior SACIM documents and other Federal reports as well as President Obama's budget proposal for 2013. The earlier recommendations (2001 and 2006) focused intensively on research, especially etiologic research into the causes of low birthweight (LBW), preterm birth, and infant mortality. Ms. Johnson pointed out that the current SACIM continues to support research investments (from discovery to translation and dissemination) but recommends investments beyond etiologic research. Such investments can make a difference in reducing disparities in adverse pregnancy outcomes, including infant mortality.

Current SACIM Recommendations

After summarizing the strategies beyond research and mentioning the 2006 recommendations regarding the Deficit Reduction Act and Medicaid, Ms. Johnson stated that the current SACIM reaffirms the need for a continuum of prevention and intervention services to improve the health and well-being of women, infants, and families and an investment in an infrastructure that ensures access, quality and safety, and accountability for outcomes. SACIM also reaffirms the need for a lifespan (life course) approach to reducing infant mortality that recognizes the interaction of biologic, genetic, psychosocial, and environmental factors; the importance of the health of girls and women before, during, and beyond pregnancy; the contribution of social determinants of health; the imperative to create health equity and social justice; and the role of coordination and investments from multiple sectors and agencies within and outside HHS. In addition, SACIM reaffirms and reemphasizes the need for adequate standardized data, monitoring, and surveillance systems. The national vital statistics system is in need of repair, the Pregnancy Risk Assessment and Monitoring System (PRAMS) should be in every State, Medicaid perinatal data should be reported by every State, the Title V Information System (TVIS) should be maintained, and MIECHV data should be aligned with other systems. The National Immunization Survey (NIS) and quality measures for women and children from other agencies are also important.

The current SACIM emphasizes the importance of ACA in reducing infant mortality by extending access to care for mothers, infants, and families. SACIM also affirms the need for Federal investments in the MCH safety net, including investments in Medicaid, the Title V MCH block grant, Healthy Start, the Title X Family Planning Program, community health centers, the MIECHV program, prevention and public health, and the United States Department of Agriculture (USDA) WIC Supplemental Nutrition Program.

Medicaid. Between now and 2014, the initiatives of the Center for Medicaid and Medicare Innovation (CMMI) should be broadened. Strong Start is a good step, with its focus on prenatal care and the elimination of elective deliveries, but more must be done to reduce infant mortality (e.g., innovation grants for preconception and interconception care, newborn and regional perinatal care, and strategies for quality improvement). Automatic newborn eligibility for all infants is under discussion, as is encouraging Medicaid health homes for women of childbearing age with chronic conditions. Additional interconception care waivers should be approved, and the use of family planning State plan amendments should be encouraged. In addition, the Administration should push to collect Medicaid data on maternal and infant service utilization and outcomes in all States.

Title V MCH Block Grant. MCHB should be given the authority and resources to function effectively as the lead agency for maternal and child health and well-being in the United States because the block grant is the “bricks and mortar” of systems to ensure the health and well-being of women and children.

Healthy Start. Healthy Start needs continued and enhanced investment to reduce infant mortality and disparities in birth outcomes in the Nation’s highest risk communities. The emphasis should be on quality improvement, training, and technical assistance (TA).

Title X Family Planning Program. Title X’s capacity must be maintained to provide family

planning, preconception risk screening, sexually transmitted disease (STD) screening and treatment, and some elements of primary care. Title X ensures access to family planning education and services for millions of women, particularly low-income and young women.

Community Health Centers/Federally Qualified Health Centers. SACIM calls for maintaining the ACA multibillion dollar commitment to expansion of community health centers and federally qualified health centers (FQHCs), which provide care for 17 percent of births to low-income families and more than 5 million women of childbearing age.

MIECH Program. Funding for the home visiting program must be protected. It invests in an important evidence-based intervention strategy but does not replace the need for Title V or Medicaid.

Prevention and Public Health Fund. The prevention and public health fund should be protected and restored. The National Prevention Strategy can guide States and communities toward approaches for improving the health of women of reproductive age.

Ms. Johnson also mentioned SACIM's support of other ACA provisions, including those dealing with workforce capacity, delivery system structures, breastfeeding, teen pregnancy prevention grants, tobacco cessation for pregnant women, and postpartum depression. SACIM also supports the Department of Health and Human Services (HHS) endorsement of the Institute of Medicine recommendations for women's clinical preventive services covered without cost sharing for new, not grandfathered, plans.

In addition, SACIM is interested in creating health equity by eliminating disparities and influencing the social determinants of health. SACIM should be added to the list of HHS initiatives that aim to eliminate disparities and increase prevention as stated in the *HHS Action Plan to Reduce Racial and Ethnic Health Disparities*. SACIM emphasizes the importance of addressing the social determinants of health by focusing on poverty and income inequality as part of an infant mortality reduction agenda. HHS partnerships and coordination are essential to developing and implementing a common action agenda, measuring common outcomes, and supporting innovation and translation of research.

WORKGROUP PRESENTATIONS TO HHS SECRETARY'S OFFICE

Developing a National Agenda

Raymond L. Cox, Jr., M.D., M.B.A., Work Group Chair

Dr. Cox referenced Dr. Lu's comments on the Five I's, stressing the importance of investment. Clinical energy is translated into financial energy and back into clinical energy to reach the intended outcomes. The work group developed five items in a checklist, including (1) bidirectional communication, (2) equity and intergenerational focus, (3) patient-centered care in a life course framework, (4) quality and safety, and (5) neonatal and postneonatal survival

Health Care Financing

Arden S. Handler, Dr.P.H., M.P.H., Work Group Chair

Dr. Handler explained that her work group examined the possibilities regarding investments in health

care and discussed common outcomes and a common framework. Across HHS, MCHB is the only agency that continually looks at infant mortality, and the work group encourages other agencies in HHS to participate with MCHB in a “common outcomes-common results” framework. The vital statistics system is crumbling, and investments could be strategically used to shore up the system. The status of MCHB should be elevated to reflect its position as the leader on MCH issues. Dr. Handler mentioned recent increases in poverty, TANF’s reauthorization, the weakened safety net, and the need to reinvest in children and build assets in families. Dr. Fleda Mask Jackson added the importance of women having jobs, being educated, and being enabled to create their own businesses.

Health Equity

Adewale Troutman, M.D., M.P.H., M.A., Work Group Chair

Dr. Troutman described his work group’s charge as shifting the frame from eliminating health disparities to focusing on the moral imperative of creating health equity, that is, optimizing the opportunities for good health for all people. Health equity rests on notions of human rights and social justice, with the social determinants of health as the primary driver. Healthy Start exists in 105 neighborhoods that could be turned into “opportunity neighborhoods” with guaranteed educational reform, strong housing, good transportation, good access to wholesome fruits and vegetables, jobs, and economic development. These neighborhoods could be looked at as a test case for change in communities and consequent change in health outcomes. The social determinants of health include education, occupation, income, the importance of place, and institutionalized, individually mediated, and internalized racism, all of which affect birth outcomes. Health equity principles should be used to reduce infant mortality.

Health Care Reform

Kay A. Johnson, M.Ed., M.P.H., Work Group Chair

Ms. Johnson reiterated the idea of Medicaid innovation, especially the issue of preconception and interconception care. At 60 days postpartum, most Medicaid-funded women lose coverage. Demonstration projects could monitor and measure preventive benefits for women regarding reproductive health and birth outcomes. Women must be educated and engaged before becoming pregnant. Both community health centers and the primary care workforce must be supported as fundamentally important opportunities to embed prevention and intervention for women, infants, and families.

REPORT AND UPDATE FROM THE SECRETARY’S OFFICE

Mayra Alvarez, M.H.A., Director of Public Health Policy, Office of Health Reform, U.S. Department of Health and Human Services (HHS)

Ms. Alvarez thanked SACIM for sharing its recommendations and noted that Ms. Johnson’s presentation echoes ideas presented by other agencies. She mentioned that this is the second anniversary of the ACA and expressed her desire to tell SACIM about how HHS is framing ACA for the American public.

ACA is the biggest piece of women’s and minority’s health legislation ever seen in this country; it addresses gender and ethnic/racial disparities. Because it allows young adults to stay on their parents’

health insurance until age 26, ACA has enabled 1.3 million young adults of color to access health insurance. In terms of free preventive services, 52 million people have been able to access key benefits such as mammograms so that the healthy choice is now the easy, affordable choice. Individuals are becoming more informed, empowered consumers of their health care.

These changes are just the beginning. In 2014, affordable insurance exchanges will be established and will provide Americans with transparent, easy-to-understand information regarding health insurance policies so that they can be informed, educated consumers. The result will be peace of mind and security. HHS also has invested in preventive health programs across the country in community health centers and in the health care workforce, focusing on primary care. Through the prevention fund, health improvements have been made in the public health sphere nationwide. The community transformation grant program required States and communities to work across different sectors to identify how to break down the existing silos to better utilize resources and influence individuals' health.

Discussion

Ms. Alvarez's presentation prompted the following questions and comments:

- Dr. Handler mentioned a *New York Times* article that reported that Texas is turning back Title X funds to prevent funds from going to Planned Parenthood. This tactic will leave women without access to care. She suggested bypassing intransigent States and going directly to communities by investing in community health centers. The infrastructure must exist for people to get good health care. Ms. Alvarez referred to the safety net for the most vulnerable individuals, the majority of whom will have health insurance under ACA. The future role of safety net providers must be discussed in terms of the impact of a more insured population. Family planning centers are an important source of preventive care for millions of women nationwide. Ms. Johnson mentioned that lessons learned regarding MCH can be found in the Medicaid managed care studies. These lessons involve Medicare-managed networks of services that provide comprehensive primary care. For example, offering a variety of opportunities for women to receive family planning services in different settings is very important. Women of different ages, different parity, and different life stage use those services differently.
- Dr. Cox noted that people tend to think in terms of health insurance reform rather than health care reform when considering the changes due to ACA even though many items in ACA address issues of quality. Interagency collaboration and innovation are required. Even with insurance access, workforce issues can exist. MCHB must be central to incentivizing or reconfiguring the workforce to ensure access to health care.
- Dr. Sara G. Shields echoed Dr. Cox's comment and emphasized that both training people in health centers and establishing a pipeline of primary care providers from medical schools and residencies are of primary importance. MCHB and the Centers for Medicare & Medicaid Services (CMS) should help to encourage physicians to go into primary care.

- Dr. Virginia Morriss Pressler commented on presumptive eligibility and gaps in care and continuity of care caused by requiring individuals to reapply for eligibility every year. These people must be able to access continuous care through FQHCs.
- Ms. Susan E. Sheridan commented on the importance of bidirectional communication, that is, having mothers and families inform SACIM. Ms. Alvarez commented that misinformation abounds about ACA, and HHS is embarking on a new public education effort to get the correct information into people’s hands. The 10 regional directors across the country bring very valuable information from their communities to HHS and establish a link with the Federal Government. She mentioned that Dr. Sebelius had a very successful discussion with women in Baltimore about the impact of health policies on their lives.
- Dr. Joann R. Petrini commented on residency training programs in primary care and stated that the safety net can be helped by funding FQHCs to establish residency training programs in medically underserved areas and keep residents for extended periods of time within those FQHCs. Ms. Alvarez stated that ACA created a teaching health center program that has been launched and is successful.
- Dr. Troutman noted that over the past decade local public health has been “getting out of the business of primary care” because of the existence of the safety net. As a result, waiting times have increased because of diminished capacity. The safety net does not have the required capacity, and public health might need to reconsider its decision to drop primary care. Ms. Alvarez noted that the National Prevention Council is currently discussing the integration of public health into more clinical work. Dr. Shepherd echoed that need and stated that a number of counties in Kentucky are not served by FQHCs and primary care centers. Ms. Melinda Dolan Sanders commented on the role of Missouri county public health departments in the provision of vaccinations and immunizations.
- Ms. Johnson stated that the role of public health involves much more than delivering clinical services. Its role includes distributing vaccines, collecting data on vital statistics, and ensuring that newborn screening systems function adequately. Public health “makes the connections and provides the bridge.”
- Dr. Rebekah Gee, Director of the Louisiana Birth Outcome Initiative, reported that Louisiana is working through the process of applying for a waiver for interpregnancy care. The process has been “bone breaking” and must be streamlined. Every State in Regions 4 and 6 should have a waiver. Women with unhealthy babies have chronic conditions that must be managed. State Medicaid programs do not have the staff to perform data analysis or carry out vital records work, and more TA is needed from Medicaid.

FINDINGS FROM HRSA’S REGIONAL SUMMIT ON INFANT MORTALITY

Cassie Lauver, ACSW, Director, Division of State and Community Health, MCHB

Ms. Lauver presented findings from the regional summit on infant mortality held January 12–13 in New Orleans. The summit focused on the 13 States in Regions 4 and 6, which represent the southern

part of the United States and have some of the highest rates of infant mortality and disparity in the country. Two years ago, energy from the States coming together and from HHS produced a “perfect storm.” Working together with ASTHO, the Association of Maternal and Child Health Programs (AMCHP), MOD, and other partners resulted in planning for the Summit. Seven members from each State met in State terms in New Orleans to move the infant mortality agenda forward.

The purpose of the Summit was to kick off a HRSA/MCHB national initiative to reduce infant mortality. The Summit was perceived as a pilot for future work with other regions to develop a national strategy on LBW and infant mortality. The Summit also provided an opportunity for collaboration with key national and Federal partners. The goal of the Summit was to improve birth outcomes and reduce infant mortality and prematurity in the United States. The Summit’s objectives included (1) to increase understanding of strategies to improve birth outcomes and infant mortality among Federal, State, and nonprofit partners, (2) to create synergy among State health officials, MCHB directors, and State partners to improve birth outcomes and reduce infant mortality through health and community systems development, (3) to identify clear strategies, outcomes, and their impact on reducing infant mortality in the States with special consideration of high-risk individuals, families, and communities, (4) to investigate the potential of one common strategy for States in the regions to reduce infant mortality and preterm birth, and (5) to create a unified message, building on best practices from around the Nation and the efforts from States in Regions 4 and 6, which can be adopted by other States and jurisdictions.

After describing the HHS regions, Ms. Lauver listed nine common priorities and strategies developed at the 13-State Summit: (1) increases in the appropriate use of 17P (17 hydroxyprogesterone), (2) preconception and interconception health care, (3) reductions in elective cesarean sections and inductions, (4) smoking cessation, (5) safe sleep, (6) data capacity, (7) regionalized perinatal systems, (8) home visiting programs, and (9) Medicaid waivers.

After offering examples from the various States, Ms. Lauver summarized the Summit outcomes: (1) increased understanding of strategies and resources, (2) increased synergy among State partners, and (3) creation of a 13-State blueprint for change in the States’ action plan drafts. Ms. Lauver stated that all 13 State action plans were collated and shared with the States. Printed resource materials are available at <http://MCHB.hrsa.gov/infantmortalitysummit>, and speaker presentations and videos can be accessed at <http://mchb.hrsa.gov/infantmortalitysummit.html>. Ms. Lauver reported that the Summit evaluations were very positive, with a high level of satisfaction among participants regarding the overall summit, individual presentations, State work group sessions, and the venue and facilities.

Dr. Lu emphasized that for this initiative to be successful MCHB and HRSA cannot work in a silo. In terms of next steps, Dr. Lu mentioned the States’ strong desire to learn from one another about applying for waivers, establishing networks, and so on. MCHB is considering supporting a collaborative, improvement, and innovation (COIN) network for this initiative. Teams would be established around each of the specific strategies, co-led by content experts from the regions, method experts, data experts, and so on. A face-to-face meeting in June would bring the teams together to spread the lessons learned from the collaborative. The idea is to transform the initiative from a regional initiative to a national initiative.

FROM THE NATIONAL PERSPECTIVE/OVERVIEW

Wanda D. Barfield, M.D., M.P.H., Director, Division of Reproductive Health, Centers for Disease Control and Prevention

Dr. Barfield began her presentation, titled “Infant Mortality: National Opportunities for Prevention,” by introducing the topics of (1) the problem of infant mortality, (2) tackling infant mortality by looking through the lens of maternal health, community health, and social determinants, and (3) CDC’s public health approach through community-based efforts to address infant mortality.

The Problem of Infant Mortality

Infant mortality in the United States reflects the health of the Nation. Although infant mortality rates have declined, they have become stagnant and racial disparity is still constant and persistent. Regarding the timing of infant death, Dr. Barfield pointed out that the neonatal period (< 28 days) accounts for two-thirds of all deaths, whereas the postneonatal period (28–364 days) accounts for one-third of all deaths. The drivers of death in the neonatal period are preterm birth, birth defects, maternal/newborn health, and risk-appropriate care. These deaths are moderately preventable given current knowledge. The drivers of death in the postneonatal period are SIDS/SUID, injury, and infection. These deaths are highly preventable with current knowledge. Dr. Barfield described the contribution of preterm birth and SIDS/SUID to infant mortality and pointed to the importance of understanding the causes of infant mortality in order to arrive at specific interventions in certain circumstances.

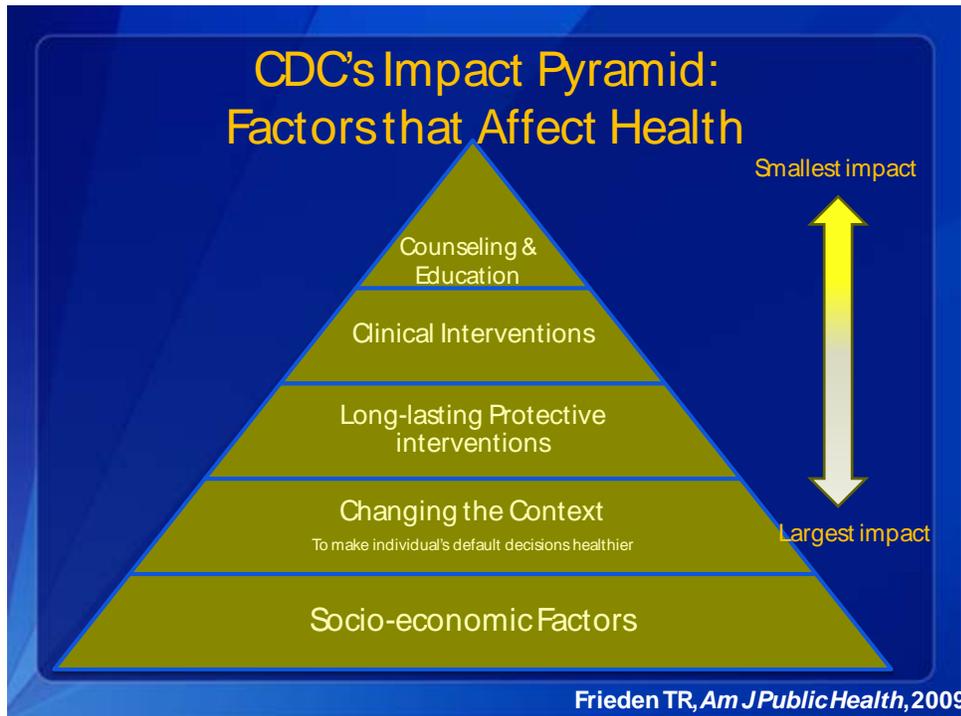
Tackling Infant Mortality

Maternal health, community health, and social determinants present ways in which to tackle infant mortality. Numerous factors influence the health of communities. The circle of influences on the fetus or infant includes the health of the mother, the health of the family, and the health of the community over the lifecourse. The health of women is declining, as can be seen in the prevalence of risk factors and chronic conditions among adult women of reproductive age. PRAMS data reveal that obesity, lack of physical activity, smoking, high cholesterol, and high blood pressure have increased from 2001 to 2009. The leading cause of maternal death in the United States is chronic disease. To tackle infant mortality, these factors must be addressed.

CDC’s Public Health Approach Through Community-Based Efforts To Address Infant Mortality

CDC’s Division of Reproductive Health has established three priority areas to address infant mortality issues in the context of the social determinants of health: (1) pregnancy health, (2) women’s health, and (3) infant health. The focus is on maternal mortality and complications of pregnancy, teen pregnancy prevention, SIDS/SUID prevention, preterm birth prevention, family planning, and chronic disease prevention in women of reproductive age. CDC’s National Center for Chronic Disease Prevention and Health Promotion has established three action areas: (1) public health infrastructure, (2) healthy communities, and (3) healthy care environments. Dr. Barfield introduced CDC’s impact pyramid of factors that affect health (see below) and presented potential prevention strategies such as improving women’s health, treatment of diabetes in pregnancy, long-acting

reversible contraception for birth spacing, safe infant sleep and injury prevention, new models of care such as centering, preventing nonindicated late preterm and early term births, perinatal regionalization, and health insurance and employment.



What We Can Do Together To Address Issues of Infant Mortality

Dr. Barfield stated that she sees opportunities to work across agencies. Data must be used to address social determinants. For example, PRAMS has rich contextual data, as does the Behavioral Risk Factor Surveillance System (BRFSS). State longitudinal data linkage is important, as is the Perinatal Periods of Risk (PPOR), Maternal Mortality Surveillance System (PMSS), SUID Case Registry, and perinatal collaboratives.

CDC has developed clinical guidelines for contraception to prevent unintended pregnancy, provide adequate child spacing, provide effective and safe treatment for women with chronic medical conditions, and complement preconception and interconception care. Dr. Barfield also presented information about the community transformation grants (CTGs). In addition, the provision of risk-appropriate care, “Right place, right time,” involves CDC’s meta-analysis of 30 years of data on perinatal regionalization. The data clearly demonstrate that birth outside a level III facility increases the risk of death.

Dr. Barfield ended her presentation by asking SACIM to work on the actionable items. She stated that, with the current evidence, important steps can be taken to reduce infant death now.

The Challenge and Opportunity To Improve Maternal and Infant Health

Marsha Lillie-Blanton, Dr.P.H., Director, Division of Quality, Evaluation & Health Outcomes, Center for Medicaid and CHIP Services, CMS

In her presentation titled “Medical Initiatives To Improve Maternal and Infant Health,” Dr. Lillie-Blanton described the role of the Center for Medicaid and CHIP Services (CMCS) in achieving the three-part aim for mothers and children in Medicaid, that is, providing (1) better care, (2) better health, and (3) more affordable care. CMS’s overarching goal is to ensure that, regardless of how a woman comes into the health care system, she has the highest quality care that the health care system can provide. At least two of three women covered by Medicaid are in their reproductive years, and Medicaid now finances about 40 percent of all births and offers prenatal and postpartum care, gynecological services, and testing and treatment of STDs. Medicaid also now covers about one-third of all children younger than 18 years of age.

Much of the focus in health care has been on the payment and purchase of medical care, but Medicaid is now broadening its focus to include personal behavior and economic and social resources and conditions. This change brings a significant challenge for the health care delivery system overall. Extending into the other arenas necessitates creating collaborations and fostering connections both within and outside Government.

Dr. Lillie-Blanton highlighted a few of the efforts undertaken by Medicaid to improve maternal and infant health. Medicaid has funded pilots of the Neonatal Outcomes Improvement Project in Arkansas, North Carolina, and Ohio. Medicaid also held the Perinatal Outcomes Symposium in June 2011. Jointly sponsored by CMCS and CMMI, this major symposium profiled interventions to improve perinatal outcomes and identified key elements of the agenda to advance perinatal health. In addition, Medicaid conducted two webinars: “Patient Safety in Neonatal Intensive Care Units” and “Improving Birth Outcomes in Medicaid: Healthy Babies, Lower Costs.”

New Ideas

Quality Improvement Efforts. CMS has now moved to a system of voluntary State reporting of measure sets. CMCS was required to identify an initial core set of quality measures for children in Medicaid/CHIP, and ACA required Medicaid to identify an initial core set of quality measures for adults in Medicaid. Each of those measure sets include measures that focus on maternal and infant health. The core set of measures for children includes frequency of ongoing prenatal care, timeliness of prenatal care, cesarean rate for low-risk first-birth women, percentage of live births weighing less than 2500 grams, and pediatric central-line–associated bloodstream infection rates. The core set of measures for children was first collected last year; therefore, fiscal year 2010 data are now available. However, the data collection is voluntary for States, and the collection and reporting requirements are challenging. CMS has launched an effort to support States in collecting and reporting these data. The adult core measure set is not required to be reported until December 2013. Quality improvement efforts are underway.

Testing of Promising Practices. CMS is working with the Strong Start initiative to test approaches to eliminate early elective deliveries before 39 weeks. It also is working with Strong Start to test

enhanced models of prenatal care that address medical and social factors contributing to prematurity-related poor birth outcomes. CMS also is working to evaluate State-specific initiatives to improve maternal and infant health identified in health care delivery system report 1115 waiver applications. CMS has approved 28 family planning waiver applications. Dr. Lillie-Blanton stated that CMCS is putting together “tips of the trade” that will allow States to learn from the successful Georgia waiver application.

Encouraging and Supporting Use of Evidence-Based Maternity Care Practices. CMS wants to be a vehicle whereby States can share successful experiences of State Medicaid agencies with other States (e.g., the Breastfeeding Issue Brief released in January 2012). CMS will offer awards and/or financial incentives to State Medicaid agencies that achieve improvements on a national set of performance measures for maternal and infant health. CMS also is working to create opportunities for Medicaid agencies to implement models of care or interventions that show promise in bridging multiple determinants of pregnancy outcomes (e.g., medical, social, nutrition). In addition, CMS is encouraging States to include maternity care performance measures in their Medicaid managed care contracts.

Dr. Lillie-Blanton closed her presentation by requesting SACIM’s input regarding how Medicaid/CHIP should target its resources to improve maternal and infant health. A new transparency rule encourages communication between States and CMS. Ideas can be submitted to MedicaidMeetings@cms.hhs.gov, with the subject line: Improving Perinatal Outcomes.

Discussion of Federal Staff Presentations

The presentations of Drs. Barfield and Lillie-Blanton prompted the following questions and comments:

- Dr. Jackson cited the challenge of bridging the social determinants in clinical practice. The psychosocial factors must be measured and assessed, and the assessments must be enhanced in a culturally specific way. The gap must be bridged to connect agencies involved in social determinants, such as housing and nutrition, with the medical side. Dr. Lillie-Blanton responded that States have begun to take baby steps in the direction noted by Dr. Jackson. For example, States now have case management services that cover nurse home visiting programs, but those programs are narrowly structured, not well funded, and vary widely from State to State. The Strong Start initiative is attempting to acquire stronger evidence about the impact of this package of services before it can become part of a Federal benefit package. Until that evidence accrues, it will remain a State-by-State undertaking. Dr. Barfield added that clinicians and other health providers must be trained differently before the social determinants issue can be integrated.
- Dr. Troutman stated that a closer alignment is needed between the education of medical professionals and public health professionals. Social determinants are well vested in the public health community but not in the clinician community. Opportunities to accomplish that crossover are frequently blocked and should be encouraged by comment from the President or the Surgeon General. The two disciplines of public health and medicine must be brought closer together in terms of education regarding social determinants.

- Dr. Handler mentioned that the National Children’s Study is experiencing a time of upheaval and confusion in determining next steps. The National Institutes of Health (NIH) has spent a significant amount of money on data collection that could be better directed to infrastructure. Can NIH be encouraged to help support CDC’s infrastructure, such as PRAMS, by investing in PRAMS in the States to improve vital statistics information? NIH should be integrated with the rest of the public health community.
- Dr. Petrini asked Dr. Barfield what she would like to see happen next regarding regionalization of care. Dr. Barfield responded that the data show missed opportunities regarding term infants with significant problems and children with congenital anomalies. Individuals in the public health sector must bring this situation to light. A clearly effective intervention should be available to these children.
- Ms. Sheridan asked whether infant mortality occurs at home or at the hospital. Dr. Barfield responded that infant mortality occurs largely in the first day of life and in the hospital and involves very preterm infants. Ms. Sheridan also asked whether the programs dedicate time and money to educating mothers about the risks of elective induction. An initiative such as Strong Start requires an informed and involved mother in the creation of the program. Dr. Lillie-Blanton responded that a major component of Strong Start works with MOD to ensure communication with mothers and families. Dr. Barfield added that partnerships are important. In addition, hospitals must educate mothers about levels of care so that they understand potential risks. Dr. Lillie-Blanton stated that an HHS initiative called Text4Baby is an effort to improve communication with families.
- Dr. Shields noted that one-third of infant deaths occur at 37 weeks or later and that the United States has a higher infant mortality rate among term babies than several countries in Europe. Breastfeeding, newborn screening, and quality issues are important in dealing with term infant mortality, which should also be addressed. Dr. Barfield responded that this point relates to the issue of having systems in place that allow care, that is, having appropriate resources in appropriate places. These systems have huge benefits to term infants.
- Dr. Wendy DeCoursey expressed her interest in the data elements under consideration and the broader model of dissemination and translation. She asked whether Medicaid is considering systems or process variables in conjunction with outcomes variables or maternal care variables. Ms. Johnson added that the continuum of data is also important. Dr. Lillie-Blanton noted that part of the challenge resides in the data systems that exist for State Medicaid agencies. These data systems, known as legacy systems, will be upgraded to allow linkages and population segmentation. The Medicaid Management Information Systems (MMIS) use broad categories, but retrieving information about a pregnant woman or newborn is very difficult. Through the Strong Start effort in a few States, CMS will work to support an infrastructure so that the States can track the populations they serve. Within a year, the MMIS should be working better.
- Ms. Connie Burke from the Delmarva Foundation commented on the success of coordination of effort. In terms of 39-week deliveries, the Joint Commission has required that physician

performance data be included in credentialing, MOD has an initiative to reduce late preterm deliveries, and the Maryland Patient Safety Center in 2009 launched an initiative to reduce the number of elective deliveries at less than 39 weeks, resulting in a 91-percent reduction in elective inductions less than 39 weeks and an 80-percent reduction in cesarean sections less than 39 weeks. All of the hospitals in the area participated in a coordinated effort to effect these reductions. Dr. Lillie-Blanton noted that the Delmarva Foundation is an external quality review organization and a very good model of what can and should be done.

NATIONAL ORGANIZATIONS

David Lakey, M.D., Commissioner, Texas Department of Health Services; President, Association of State and Territorial Health Officials (ASTHO)

Dr. Lakey's presentation on healthy babies initiatives began with an explanation of how Region 4 and 6 State health officials meet biannually to share their successes and challenges. Data on infant mortality and preterm births from the southeast part of the United States is significantly different from data from the rest of the Nation. Ethnic and geographic disparities compound the issue. The States discovered that they needed to develop a learning community. Federal partners were able to help facilitate that learning community, and the State health officers from the 13 States decided to make this effort their top priority.

The States developed an economic argument to show the dollars saved by reducing infant mortality by 8 percent. In Texas, 55 percent of all births are paid by Medicaid; in Oklahoma and Louisiana, it is about 70 percent. A significant cost is related to this situation, and infant care costs are growing by about 10 percent per year. Dr. Lakey mentioned possible points for policy intervention through the lifecourse to decrease the rates of prematurity through attention to maternal health, maternal care, newborn care, and infant health.

Texas used some of its Title V funds to jumpstart an initiative to decrease infant mortality. The goals of the Healthy Texas Babies initiative are (1) to provide local partnerships and coalitions with major roles in shaping programs in their communities, (2) to use evidence-based interventions, (3) to decrease the preterm birth rate by 8 percent over 2 years, and (4) to save about \$7.2 million in Medicaid costs over 2 years. An expert panel was formed comprising 68 committed individuals from MOD, State agencies, health partners, private industry, advocacy and community organizations, and the military.

The Texas legislature appropriated \$4.1 million in general revenue funds to the Texas Department of State Health Services to fund the Healthy Texas Babies initiative. Dr. Lakey reported on three related perinatal health bills passed by the legislature. In addition, as president of ASTHO, Dr. Lakey described the ASTHO presidential challenge to improve birth outcomes by reducing infant mortality and prematurity in the United States. Specific objectives are to (1) focus on improving birth outcomes as State health officers and State leadership teams work with State partners on health and community system changes, (2) create a unified message that builds on best practices from around the Nation, and (3) develop clear measures to evaluate targeted outreach, progress, and return on investment. The "8 by 14" challenge is to have the States reduce preterm births by 8 percent by 2014.

After describing one roadmap to reducing prematurity by 8 percent by 2014, Dr. Lakey commented

on the HRSA Region IV and VI Summit on Infant Mortality that developed regional strategies to reduce infant mortality and prematurity, including (1) implementing State policy change to eliminate elective inductions and cesarean sections before 39 weeks gestation, (2) improving access to care for all women of reproductive age, including 17P as clinically indicated, (3) developing and implementing a regional campaign to address certain aspects of women's health (life course health, smoking cessation, chronic conditions, and influenza immunizations for pregnant women), and (4) promoting safe sleep.

Since the summit, the State teams are continuing their work and are meeting together to develop and implement next steps. A State summit is in the works in Oklahoma, and the States are sharing practical tools such as economic impact calculation formulas, hospital policies, and legislative language. ASTHO continues to work through its committees and strong collaboration with several entities. ASTHO's Web site will soon include a matrix of emerging promising and best practices.

Scott D. Berns, M.D., M.P.H., FAAP, Senior Vice President, Chapter Programs, March of Dimes (MOD) Foundation

Dr. Berns began his presentation on March of Dimes initiatives by citing the mission of MOD: to improve the health of babies by preventing birth defects, premature birth, and infant mortality. His presentation focused on two initiatives for reducing infant mortality and preventing early term and preterm birth: (1) Toward Improving the Outcome of Pregnancy: Enhancing Perinatal Health Through Quality, Safety, and Performance Initiatives (TIOP III) and (2) Healthy Babies are Worth the Wait (HBWW).

TIOP III

Dr. Berns explained that TIOP III is the third iteration of Toward Improving the Outcome of Pregnancy. This iteration is focused on quality improvement across the spectrum of perinatal care. TIOP III is an action-oriented monograph that highlights proven principles, methodologies, evidence-based practices, and selected quality improvement programs that significantly improve perinatal outcomes. The monograph illustrates strategies and interventions that incorporate robust process and systems change. It is a call to action, with the goal to reach a more efficient, more accountable system of perinatal care.

Dr. Berns pointed out that preterm birth rates have declined to just under 12 percent now. Cross-cutting themes in the monograph include (1) ensuring the uptake of quality improvement and safety initiatives, (2) creating equity in perinatal care, (3) empowering women and families, (4) standardizing the regionalization of perinatal services, and (5) strengthening the vital statistics system. MOD also launched the Prematurity Prevention Network to look at quality improvement and improving outcomes in perinatal care. MOD's action agenda includes ensuring that quality improvement and safety programs are put in place to improve the health of mothers and babies.

Healthy Babies are Worth the Wait (HBWW)

MOD is using HBWW in its community programs, hospital quality improvement efforts, and consumer education campaign. HBWW is a MOD chapter-led, community program aimed at

reducing preterm birth. Partnership in this program exists among four key entities: (1) MOD chapters, (2) health departments, (3) clinics and hospitals, and (4) communities. HBWW includes the following critical elements: clinical and public health interventions, provider/patient education, and community awareness. Efforts are focused on results and include process and pregnancy outcome measures. Programs exist in Kentucky, New Jersey, and Texas.

“Elimination of Nonmedically Indicated (Elective) Deliveries Before 39 Weeks Gestational Age” Toolkit. The Big 5 Initiative covers the five States with the largest numbers of births in the country: California, Florida, Illinois, New York, and Texas. Close to 40 percent of births nationwide occur in those five States. The States convened in 2007 to discuss how they have leveraged their partnerships and relationships to reduce preterm birth. Using data-driven quality improvement, California stepped forward and created a toolkit whose components include reducing the demand for nonmedically indicated deliveries through provider/staff education, patient education, and public awareness. The key change tactics involve implementing a scheduling process and increasing physician and nursing leadership. The Big 5 group decided to tackle the problem of < 39 week nonmedically indicated deliveries. With the toolkit as the foundation of the project, 25 hospitals were selected to implement it beginning in early January 2011. A secure Web-based data portal collects the data and reports monthly and quarterly progress to eliminate elective deliveries < 39 weeks. Preliminary data indicates a dramatic decrease in those births.

MOD Service Package. Dr. Berns also touched on the topic of regionalization and announced that MOD has created a quality improvement service package of professional education, online services such as webinars and access to experts in the field, public education, and access to the Web-based data portal. The service package will be made available at no cost to hospitals. The goal is to partner with 100 hospitals to bring them the service package.

Dr. Berns urged SACIM to examine TIOP III, continue the momentum around reducing preterm birth and infant mortality, and support Strong Start and the Partnership for Patients.

Discussion of National Organizations’ Presentations

The presentations by Drs. Lakey and Berns prompted the following comments and questions:

- Dr. Barfield asked Dr. Lakey to explain his role as a State health officer. Dr. Lakey stated that State health officers are in a unique position to be able to bring diverse groups together. For example, the expert panel comprises leaders from many different fields. The ability of State health officers, through ASTHO, to speak with a unified voice across the Nation is very significant.
- Dr. Lu remarked on the synergy between Federal and State agencies and organizations and called for a discussion to enlighten SACIM on these connections. Dr. Lakey stated that, because it enhances understanding, a unified voice with a consistent theme results in legislators’ willingness to fund certain projects.

- Ms. Johnson asked Dr. Berns for information about the Partnership for Patients. Dr. Berns explained that a number of hospitals have committed to improving outcomes. Dr. Lillie-Blanton explained that Partnership for Patients fosters two major objectives related to improving patient safety: (1) to reduce all-cause harm by 40 percent, including obstetric harm, and (2) to reduce readmissions by 20 percent, including an effort to improve care coordination especially for aged and disabled patients.
- Brent Ewig from AMCHP stated that confusion can result when a number of initiatives are presented that seem to be duplicative instead of complementary. For example, the creation of the new home visiting program has been used as a rationale to cut back on MCH block grants. SACIM can be helpful in suggesting to the HHS Secretary that funding not be supplanted in this way. Mr. Ewig emphasized that sustainability is important regarding the initiatives to create systematic change.
- Dr. Handler remarked on the perinatal regionalization issue. Neonatal intensive care unit (NICU) dollars are substantial for hospitals. In some cases, action on recommendations involving decreasing NICU admissions might close hospitals. Ms. Johnson noted that this topic would be held for discussion.
- Ms. Johnson posed a question about what can be learned from the 1980s regarding infant mortality initiatives. Ms. Lauver mentioned that a primary recommendation from the 1980s involved prenatal care but without attention to the current concept involving the social determinants of health. Ms. Johnson stated that when more people have health coverage, quality of care and ways to influence the social determinants will surface as important. Dr. Berns stated that change will occur one community at a time. For example, HBWW in Newark empowers the community and addresses questions regarding poverty and nutrition. He reminded SACIM that five States are committed to a pilot regarding regionalization.
- Dr. Troutman insisted that the local nature of the work addressing and attacking the social determinants of health is evident, but the work must also be regional and national. “Winnable battles” start above the base of social determinants of Dr. Frieden’s pyramid. Dr. Troutman asked whether CDC is committed to winnable battles at the baseline, that is, battles involving socioeconomic status and access to education, housing, and transportation. Dr. Barfield stated that CDC is attacking the problems at the base; for example, teen pregnancy prevention entails the creation of educational opportunities for teens. However, much more needs to be done. The key is to work with other organizations to improve those areas. Dr. Troutman mentioned a trip to India during which he observed an infant mortality reduction campaign that involved women’s empowerment issues. The focus on infant mortality reduction began with microentrepreneurial development. In a matter of years, the infant mortality rate dropped to 14 or 15 from more than 100 per 1,000 live births. Ms. Johnson added that a policy and programmatic framework must be in place to support change; it does not happen community by community.
- Dr. Lakey stated that very important work must take place community by community, but States’ ability to make policy changes with a huge impact in this area should not be overlooked. States have specific levers, such as getting additional funding from the legislature, setting Medicaid

policy, and ensuring that funds are applied to areas of need such as health disparities. State health departments can make those changes, but States and communities must work together.

- Ms. Allison A. Kretz stated that one of HUD’s strategic goals is to use housing as a way to improve quality of life. HUD is planning a Father’s Day kickoff event for an initiative to improve children’s outcomes. Partnering with local public housing authorities might help to discover ways to remove some of the legal barriers to allowing fathers on leases in public housing.
- Dr. Lillie-Blanton reiterated that Medicaid delivers 40 percent of babies nationwide. Ensuring healthy births is an important way to make inroads on social determinants. Medicaid covers 12 percent of women in their reproductive years but delivers 40 percent of babies. Disproportionately, children born in this country are poor. The work of CMS does deal with the base.

FROM THE STATE PERSPECTIVE

Ruth Ann Shepherd, M.D., FAAP, SACIM Member; Director, Division of Maternal and Child Health, Kentucky Department for Public Health

Dr. Shepherd’s presentation, “Community-Based Prematurity Prevention: The Kentucky Experience,” described the HBWW initiative in Kentucky. Five years ago, the rate of preterm births in Kentucky was rising, and a community-based initiative to prevent preterm birth was begun. HBWW uses a real-world, ecological design with bundling of evidence-based interventions in different health care settings (academic, private, and clinic based). It is an innovative, multidimensional intervention program designed to prevent “preventable” preterm birth in subgroups of the population where interventions have a likelihood of success in a reasonable period of time.

HBWW was launched in Kentucky because its rate of preterm birth was rising twice as fast as it was nationwide. Three hospitals became the intervention sites and were paired with comparison hospitals. Dr. Shepherd presented information about the keys to community-based prematurity prevention by discussing the material in the following framework: (1) from data to action, (2) from research to real world, (3) from silos to systems, (4) from the medical model to the ecological model, and (5) from relationships to results.

From Data to Action. The research question was “Do we know enough now to make a difference?” The data determined the focus, and it was discovered early on that late preterm birth was driving the increase in preterm birth rates. The data were developed through consumer and provider surveys, focus groups, an American College of Obstetricians and Gynecologists (ACOG) survey, and policy and environment surveys. The researchers found at each of the sites that data quality matters; data definitions and consistent collection became issues. It was learned that local data drive improvement. An education card titled “Brain Growth Matters” was among the materials developed for professionals.

From Research to the Real World. Evidenced-based practice from grand rounds, ACOG guidelines, and other sources was not being translated to the real world. For example, it was determined that evidence-based smoking cessation interventions were not being regularly implemented. In July 2005,

the National Institute of Child Health and Human Development (NICHD) held a workshop on near term/late preterm births, defined late preterm birth, and reported striking information about the brain. Research was cited on the development of the human brain through gestation and on brain development in the last 4 to 6 weeks of pregnancy. As a result, concerns were raised about late preterm brain development and its potential impact.

From Silos to Systems. HBWW in Kentucky convened the partners, described best practices, determined the gaps, and asked what could be done better. Dr. Shepherd described the prematurity data from the hospital engagement networks (HENs) program and cited the importance of improving referral linkages. For example, dentists were recruited to accept pregnant Medicaid patients, and co-location of services in every site improved access to oral health services and substance abuse services.

From the Medical Model to the Ecological Model. HBWW disseminated community messages to inform women that full term is about 40 weeks and that, absent medical complications, women should try to carry pregnancy to a full 40 weeks because much of brain development happens in the last 4 to 6 weeks of pregnancy. Another message was that preventing prematurity improves the lives of families and communities.

From Relationships to Results. Dr. Shepherd stated that results come from relationships. The researchers met frequently to share and celebrate their findings. They noticed that small wins add up and that making a difference motivates. Compared with surrounding States, Kentucky had the largest drop in preterm birth and late preterm birth by the end of the second year of the program. The intervention sites have sustained that effect even though the projects have ended; better systems of care have been built. The comparison sites were brought on in 2010, and they also experienced drops in preterm birth and late preterm birth.

Rebekah Gee, M.D., M.P.H., FACOG, Director, Louisiana Birth Outcome Initiative

Dr. Gee's presentation on improving birth outcomes started with a comment about coordination for change through a credible array of policy solutions, the political will, and the major problems of prematurity and infant mortality. Louisiana has the highest cesarean section rate in the country—almost 40 percent. Louisiana is also ranked very low in children's health and birth outcomes. Therefore, Louisiana has an opportunity to have an impact. Seventy percent of births in Louisiana are Medicaid financed; therefore, changing the structure of care women receive in Medicaid changes maternity care for the State.

Louisiana strives to improve health and health care by using the lifecourse theory, motivating and building the will for change, and building consensus. To build consensus, the mantra must be "community first." Five statewide action teams represented community partners, consumers, advocates, public health professionals, clinicians, hospital administrators, and insurers. Success follows from engaging stakeholders from the very beginning.

Louisiana Perinatal Collaboratives. Interventions to improve birth outcomes include prenatal, birth, and postpartum and interconception interventions. Louisiana is the first State in the Nation to partner with the Institute of Healthcare Improvement (IHI) to create a statewide quality improvement

collaborative to address elective deliveries before 39 weeks. Fifteen of Louisiana's largest birthing hospitals participated in 2011, and the collaborative will expand to up to 40 hospitals in 2012. Hospitals have tracked down in their rates of deliveries before 39 weeks.

Data and Measurement. Louisiana is interested in creating transparency, accountability, and a quality improvement infrastructure for perinatal quality improvement measurement and reporting. Although vital records is an incredibly rich data source, it is not used generally for quality improvement. Louisiana has modified its electronic birth certificate form to include measurement of reasons for deliveries before 39 weeks. This step will enable real-time quality improvement.

Behavioral Health. To streamline referrals for tobacco, alcohol, and drug abuse treatment during prenatal care, Louisiana created La HART (Louisiana Health Assessment, Referral, and Treatment), a Web-based screening and referral tool for drug and alcohol abuse, smoking, depression, and violence. To be launched this month, La HART includes enrollment forms for tobacco cessation services provided through the Department of Health and Hospitals quitline. Alcohol and drug use referrals are made to a 1-800 number and coordinated through Louisiana's behavioral health management organization.

Interpregnancy Care. Louisiana will work to provide interpregnancy care to all Medicaid-eligible women through its managed care plans. A four-parish pilot program will be established for interpregnancy care modeled after the Grady Memorial Hospital interpregnancy care program and conducted in conjunction with Healthy Start New Orleans. The details are being finalized.

Dr. Gee stated that racism, poverty, and lack of education are at the heart of the problem of infant mortality. Economic development, educational development, community development, and health development can work together to produce better birth outcomes. New Orleans is one of four communities selected to be a "Best Babies Zone."

Belinda D. Pettiford, M.P.H., Interim Head, Women's Health Branch, North Carolina Department of Health and Human Services

Ms. Pettiford presented information about North Carolina's pregnancy medical home (PMH) program. The State's most recent infant mortality data show that the infant mortality rate is the lowest in the State's history at 7 per 1,000 live births. North Carolina has seen a 19.6 percent reduction in the African American infant mortality rate; however, there is still a twofold disparity. PMH is one of numerous efforts focused on birth outcomes, but this effort is focused on the medical community, specifically around pregnancy and the medical home. The program is a partnership among the Division of Medical Assistance (DMA), Division of Public Health, Community Care of North Carolina (CCNC), and providers across the State. DMA provides program coordination and health policy support. Fourteen CCNC networks across the State recruit and support maternity care providers. Local health departments contract with CCNC to provide pregnancy care management. The PMH program takes a population management approach to improving birth outcomes; it is provider driver, voluntary for women and providers, and based on a quality improvement framework with outcome-driven metrics.

PMH is charged with improving birth outcomes in the North Carolina Medicaid population by

providing evidence-based, high-quality maternity care to Medicaid patients and focusing care management resources on those women at highest risk for poor birth outcomes. PMH also is charged with improving the stewardship of limited perinatal health resources. In this program, quality improvement goals are aligned with cost-savings goals, that is, reducing NICU admissions and avoiding associated expenses. In year one, PMH must be cost neutral.

In the North Carolina Medicaid population, the focus is on low birthweight. About two-thirds of women are covered by Medicaid while pregnant but are not Medicaid-eligible outside of pregnancy. Medicaid coverage for pregnant women ends on the last day of the month in which the 60th postpartum visit occurs. Presumptive eligibility provides temporary coverage while the Medicaid application is processed.

Pregnancy Medical Home Initiative Goals. PMH goals are to (1) improve the rate of LBW by 5 percent in the first and second years, (2) move the primary cesarean section rate to 20 percent or lower, and (3) focus on preterm birth prevention by creating interventions for the multiple clinical and psychosocial risk factors that contribute to preterm birth. The goals will be accomplished through a quality improvement focus for PMH practices to identify outliers and work with them to improve performance. Four physician performance measures will be put in place: (1) no elective deliveries < 39 weeks, (2) offering and providing 17P to eligible patients, (3) maintaining the primary cesarean section rate at or below 20 percent, and (4) coordinating a standardized initial risk screening of all obstetric patients with local health department care managers. Pregnancy care management is the key intervention to improve the rate of LBW and preterm birth.

Pregnancy Medical Home Responsibilities. One of the responsibilities of a PMH is to provide comprehensive, coordinated maternity care to pregnant Medicaid patients. The PMH also must allow chart audits for evaluation purposes for quality improvement measures. In addition, PMHs must collaborate with public health pregnancy care management programs to ensure that high-risk patients receive care management. The postpartum visit must include, at a minimum, depression screening using a validated screening tool, discussion of a woman's reproductive life plan, and connecting the patient to ongoing care if it will not be provided in the PMH practice. Another responsibility of the PMH is to provide information on how to obtain Medicaid during pregnancy, WIC, and Medicaid family planning waiver postpartum.

Pregnancy Medical Home Incentives. PMH incentives for providers include incentive payments for completion of the initial risk screening (\$50) and completion of the postpartum visit (\$150). An increased rate of reimbursement for vaginal delivery makes the reimbursement roughly equal to the cesarean section rate. Providers also can bypass the preauthorization requirement for obstetric ultrasounds. In addition, practices are supported by a CCNC obstetric team consisting of an obstetric physician champion and nurse coordinator who provide education, TA, and best practices. The data-driven approach to perinatal quality improvement entails access to multiple data sources through the CCNC Informatics Center regarding Medicaid claims, birth certificate data, and real-time hospital utilization data.

Priority Risk Factors. After referring to a list of the priority risk factors that focus on preterm birth prevention, Ms. Pettiford presented information about their prevalence. In the 9 months from April to December 2011, 60 percent of pregnant Medicaid patients received risk screening. Of the 60 percent,

70 percent of the patients had at least one priority risk factor, including tobacco use, late entry to prenatal care, or a chronic condition complicating pregnancy such as mental illness, asthma, hypertension, or diabetes.

PMH Program Status at the End of 2011. By the end of December 2011, approximately 300 PMH groups existed, which represent about 1,000 physicians. In North Carolina, between 350 and 400 groups could apply to become PMHs, and efforts continue to recruit all Medicaid obstetric providers. Between the program launch in April 2011 and the end of the year, more than 23,000 Medicaid patients had the initial risk screening. In the first 3 months alone, 11,000 patients received the initial risk screening statewide.

Next Steps. North Carolina's PMH program will continue its efforts to improve processes to identify the priority population, including new data on hospitalized patients. Enhanced techniques will be used to improve patient engagement in care management services, including new marketing materials such as a patient brochure, patient contact letters, and telephone contact scripts for care managers. Motivational interviewing training will be developed for care managers to promote patient engagement, behavioral change, and health promotion. The program also is exploring opportunities to address system gaps and enhance care coordination for patients needing behavioral health and substance abuse services, patients receiving care at tertiary center high-risk obstetric clinics outside their home communities, and patients with antenatal hospitalizations. In addition, the PMH program is further developing program evaluation and examining factors associated with gestational age at entry to prenatal care and other medical factors.

Discussion of the State Perspective Presentations

The presentations of Drs. Shepherd and Gee and Ms. Pettiford prompted the following questions and comments:

- Dr. Pressler asked whether Louisiana and North Carolina have been successful in integrating mental health services into care given the problems connected with protected health information and the difficulty in making it part of the embedded medical home. Ms. Pettiford responded that North Carolina has been able to embed mental health in many of its practices by using licensed clinical social workers who are often employed by local public health agencies and have the ability to bill Medicaid for their services. Attempts are being made to broaden mental health care with private providers. The challenge is not in screening but in guaranteeing that women have an appropriate place for treatment. Dr. Gee stated that Louisiana had no behavioral health system until 7 days ago when a new system came into existence. Dr. Shepherd added that in Kentucky, ACA money for home visiting is being used to pilot a program for cognitive behavioral therapy in the home setting.
- Dr. Jackson noted that, in dealing with traumatic stress during the aftermath of Katrina, groups of community-based organizations or programs were trained to perform initial assessments and were successful in getting victims to acknowledge their mental health conditions. Dr. Gee noted the importance of bringing community coalitions into this work to deal with cultural differences such as resistance to talking about mental health. To break down

these barriers in Vietnamese and African American communities, trusted resources must be brought into the home, for example, through the efforts of Best Babies Zone.

- Ms. Sharon M. Chesna asked how the North Carolina program is being “sold” to women. Ms. Pettiford stated that the PHM program has been incentivized for providers but not for women. However, the program has conducted training in cultural competency and made efforts to guarantee access to providers. In addition, the program is developing some marketing tools and discussing a series of statewide focus groups. Ms. Pettiford explained that, beginning in the early 1980s, North Carolina had a statewide Medicaid program for pregnant women called Baby Love. Pregnancy care management began in North Carolina in April 2011 when the Baby Love program officially ended. As a result, the average woman now probably does not even realize she is participating in a PMH.
- In answer to another question posed by Ms. Chesna, Ms. Pettiford stated that if a woman does not want to be involved in the PMH program, she probably will not be assigned a pregnancy care manager, but she will continue to be provided with care. Ms. Chesna also asked who performs risk assessment screenings in a practice. Ms. Pettiford stated that the screenings can be carried out by the nurse, the physician, the nurse practitioner, the nurse midwife—whoever the patient sees on the first visit. The risk screens are entered into the Case Management Information System where it should be easy to include information about the person performing the screen. Ms. Chesna also asked about motivational interviewing. Ms. Pettiford stated that primary care management using motivational interviewing has seen positive results. The PMH training for care managers is a yearlong commitment in which trainees are paired with coaches who get additional support from the trainers. During the first year, 1,600 people will be trained.
- Ms. Johnson noted that a commonality among all three of the States is connecting the providers, payers, and public health and that a community engagement piece underlies the work. She asked what accounts for the success of the programs: is it the carrots, the sticks, the nurturing relationships and partnerships, or the role of structured, evidence-based guidance? Dr. Gee noted that all of these elements are important, along with the urgency of the issues, and that once the connection is made among the stakeholders, barriers are broken down. The Strong Start grants create the structures and the relationships between payers and providers needed for a successful medical home, and cross-cutting initiatives are important. Dr. Shepherd added that communities are the catalysts for making the entities come together and share ideas and that the evidence-based piece is important in establishing what is known to work and setting a vision for what is possible. Relationships are the key. Ms. Pettiford concurred with Drs. Gee and Shepherd and mentioned that North Carolina has become more data driven as a result of the PHM program.
- Ms. Chesna asked about the decision to invest in new initiatives. Ms. Pettiford restated that the PMH program in North Carolina must be cost neutral in the first year. The pregnancy care management piece, which was a fee-for-service model, is now being converted into a per member-per month (PMPM) model. Each county gets a different PMPM each month. Dr. Gee stated that in Louisiana a champion in the Department of Health and Hospitals provided the

money, but existing funds were redirected and partnerships have been leveraged for a common purpose. Dr. Shepherd added that the Kentucky project existed at the community level, sustained by the energy of the people involved with it.

STRONG START FOR MOTHERS AND NEWBORNS

Valinda Rutledge, M.B.A., Director, Patient Care Models Group, Center for Medicare and Medicaid Innovation, CMS

Ms. Rutledge explained that the Center for Medicare and Medicaid Innovation (CMMI) was established under the ACA with \$10 billion of funding for FY 2011 through FY 2019. The purpose of the center is to test innovative payment and service delivery models to reduce program expenditures under Medicare, Medicaid, and CHIP while preserving or enhancing the quality of care furnished. Once CMMI identifies new models of care delivery and new payment models, its charge is to test, evaluate, and scale them. The opportunity exists to “scale up,” that is, to recommend that the HHS Secretary expand successful models of payment to the national level. CMMI also has authority to apply waivers. The center’s measures of success are better health care, better health, and lower costs.

The Strong Start Initiative. Strong Start is a partnership between CMMI and the Center for Medicaid and CHIP Services, which provides health coverage for nearly 60 million Americans and finances about two of every five births in this country. The Strong Start initiative has two different but related strategies to improve birth outcomes: (1) reducing early elective deliveries and (2) delivering enhanced prenatal care. The first strategy entails a test of a nationwide public-private partnership and awareness campaign to spread the adoption of best practices that can reduce the rate of early elective deliveries before 39 weeks for all populations. The second strategy presents a funding opportunity for providers, States, and other applicants to test the effectiveness of specific enhanced prenatal care approaches to reduce preterm births in women covered by Medicaid.

Eric Fennel, Specialist, Centers for Medicare and Medicaid Services

Mr. Fennel elaborated on the strategy of reducing early elective deliveries. The issue must be addressed from the perspectives of both health and economics. Critical brain and lung development occurs between 37 and 39 weeks. However, despite 20 years of advocacy, early elective deliveries still account for up to 15 percent of all deliveries, and poor outcomes drive high costs. The question became what CMS could do to help achieve the goal of reducing early elective deliveries. It was determined that CMS could be helpful in three areas: (1) promoting awareness to mothers and clinicians, (2) spreading best practices rapidly, and (3) promoting transparency. Regarding a broad-based awareness effort, CMS decided to partner with advocacy and professional organizations. Regarding best practices, Mr. Fennel mentioned the Partnership for Patients, a public-private partnership of more than 3,900 hospitals committed to specific improvements in patient safety and reductions in all-cause harm, including reductions in obstetric harm. A total of 26 hospital engagement networks (HENs) work to provide TA to achieve the specific agreed-upon goals. Regarding transparency, efforts are underway to adopt measures to collect and publicly report data on early elective deliveries.

Ellen-Marie Whelan, Ph.D., N.P., R.N., Senior Advisor, CMMI, CMS

Dr. Whelan presented information about the second strategy—delivering enhanced prenatal care.

This strategy entails a funding opportunity for providers, States, managed care organizations, and conveners to test evidence-based approaches that deliver enhanced prenatal care. These approaches must improve health outcomes for mothers and infants in Medicaid. The specific outcome of interest is reducing prematurity.

Medicaid currently finances approximately 40 percent of all U.S. births. Compared with women with private insurance, women enrolled in Medicaid are more likely to have multiple risk factors for adverse birth outcomes and higher rates of complications, poor outcomes, and preterm birth. The Institute of Medicine estimates that complications from prematurity cost the Nation \$26 billion each year. According to the objective of this Strong Start strategy, CMMI must demonstrate the ability to achieve better care, improved health, and reduced costs for high-risk pregnant Medicaid beneficiaries and their newborns. The focus is to examine the impact of nonmedical prenatal interventions provided, in addition to evidence-based clinical care, to reduce rates of preterm births for at-risk women.

The improvement opportunity involves the enhanced prenatal care model, which entails three evidence-based approaches: (1) enhanced prenatal care through centering or group care, (2) enhanced prenatal care at birth centers, and (3) enhanced prenatal care through maternity care homes. An additional approach, which is not funded by Strong Start, is enhanced prenatal care through home visits, which will be coordinated with HRSA and the Administration for Children and Families (ACF). After describing the four approaches in some detail, Dr. Whelan delineated the eligible applicants: (1) State Medicaid agencies, (2) providers of obstetric care, (3) managed care organizations, and (4) conveners in partnership with other applicants. Nonprovider applicants must partner with providers, and non-State applicants must partner with States.

In terms of model design, to detect statistical change in prematurity, Strong Start needed to enroll 30,000 women in each of the 3 models over the 3-year period of participation. The evaluation will then continue for an additional year after the program period to collect the medical costs of infants through the first year of life. The evaluation plan is to compile a matched sample as a control group, preferably from the same State. A similar valuation of the home visiting program will occur in collaboration with HRSA/ACF. Many data challenges exist, including diversity in State data collection, capacity linking clinical data with vital records, helping States with resources required for these activities, and collecting data from managed care organizations. Dr. Whelan stated that Strong Start is up for the challenge. She concluded her presentation with a description of the award timeline and noted that the performance period will begin in September 2012. The project email address is StrongStart@cms.hhs.gov.

Discussion

The presentation on Strong Start for Mothers and Newborns prompted the following questions and comments:

- Ms. Johnson expressed her appreciation for the Strong Start program but stated that interconception care seems to have “fallen through the cracks.” Dr. Lillie-Blanton stated that CMCS has approved at least one Medicaid waiver that includes interconception care and

information about applying for interconception waivers will be on the Web site within a month. She emphasized that Strong Start is a CMMI initiative to test models. Dr. Whelan explained that to examine how to reduce preterm births and demonstrate cost savings, 30,000 pregnant women were needed. The question is how many women would have been needed to study preconception care and at what expense. Ms. Johnson insisted that interconception care is ripe for interventions and that the opportunity has been missed to study interconception care in a targeted group of women with identified risks where Georgia has shown savings.

- Dr. Handler stated that she supports the prenatal care piece and hopes that “the right test” can be used this time. She also mentioned that the guidance around the data and evaluation must be streamlined and clarity must be brought to the issue of risk factors for outcomes and reductions in disparities. She noted that a specific fix for a specific population might not involve reducing disparities. Mr. Fennel remarked on the balance of effort between the two strategies and stated that the second strategy will address the issue of disparities. Dr. Shepherd noted that in Kentucky the focus was on preterm birth but the goal was to build better systems of care in communities, thereby improving care for everyone. Late preterm and early term are the low-hanging fruit that got people’s attention—the hook that brought them in so that other discussions could be had about how to make systems work better to improve care for everyone.
- Dr. Lillie-Blanton remarked on early elective deliveries as one of the cost drivers in the health care system. If costs go up in any part of the system, that situation detracts from the ability to fund other projects. Ms. Rutledge emphasized Strong Start’s testing of the use of private-public partnerships to adopt best practices. The Partnerships for Patients infrastructure consists of 3,600 hospitals that have committed to improving quality and decreasing readmissions. They have been designated through 26 HENs, which disseminate best practices. Obstetric harm is one of the areas that will be looked at generally, but SACIM could have discussions with Partnerships for Patients and the HENs about other initiatives to help hospitals and physicians to adopt best practices.
- Dr. Troutman asked about other disproportionate rates among poor women when it comes to late preterm delivery. Dr. Barfield remarked on the lack of disparity in late preterm births and noted that the Back to Sleep campaign, for example, entailed education and cultural effectiveness. She mentioned late preterm infants who experience educational challenges. The question is whether late preterm infants born in poor communities have different challenges. Ms. Johnson mentioned an analysis done by Medicaid in Illinois that can be shared with the committee.
- Commenting on the issue of interconception care, Dr. Shields mentioned a centering parenting curriculum that involves group mother and baby visits in the first year of life and added that this setting might be an effective place for interconception care. Dr. Whelan stated that some applicants have mentioned this type of centering activity and its effectiveness can be noted in a rapid-cycle evaluation.

- Dr. Joanne B. Martin asked how CMMI will control for the fact that some of the individuals in the matched sample might be participants in other programs, such as Healthy Families or Natural Family Planning, or that participants receiving care at a center might also be involved in home visitation. The opportunity is great for a collective impact, but the possibility of overlapping impacts will complicate the data collection and analysis. Dr. Whelan responded that the overlap cannot be avoided in all of the models and that this situation is one of the challenges of Strong Start.
- Dr. Lu cited data on late preterm birth from the National Center for Health Statistics. In 2006, non-Hispanic black mothers were about 50 percent more likely than non-Hispanic white mothers and one-third more likely than Hispanic mothers to have a late preterm delivery. What is not clear is whether excess late preterm birth is due to elective deliveries or medically indicated preterm deliveries. Dr. Petrini cited a “nagging concern” that the rate could potentially fall to 10 percent and that the perception will be that the problem is solved, which is an undesirable message.
- Dr. Paul Jarris from ASTHO noted that the Strong Start paradigm is clinical. He encouraged CMS to consider leadership from public health departments, which could be conveners to assemble multiple partners and bring policy to the table without having a financial stake in the system. Dr. Whelan noted that the funding opportunity announcement (FOA) for Strong Start mentions the importance of partnering with public health. In fact, the criteria include a preference based on working with public health departments. Specific to the first strategy, Mr. Fennel mentioned that Strong Start is actively looking for partners for all three activities (creating awareness, promoting transparency, and spreading best practices).
- Dr. Tonse Raju from NICHD commented on the importance of working across agencies to affect late preterm birth. A 2005 workshop organized by NICHD shifted the paradigm on this issue so that research on late preterm delivery came to be published. Momentum from the workshop changed the designation from “near term birth” to “late preterm birth,” and the change in terminology changed the thinking. However, evidence-based research must be connected with implementation. The accumulation of data lead to excellent work among partners. A concern at NICHD involves the possibility that a desire to reduce nonmedically indicated preterm deliveries might result in a failure to deliver those that are indicated. NICHD is very interested in funding research in this area and is collaborating with ACOG to tackle this issue.
- Carolyn Aoyama stated that she works in the Indian Health Service (IHS) with American Indians and Alaska Natives, among whom preterm birth is not as significant a problem as postneonatal death. Noting that most of the babies in this population are delivered by midwives, Ms. Aoyama encourages testing a midwifery model of care, which is the model of care used in IHS. Ms. Oyama noted that the main focus of tribal health care delivery systems is the community. A nurse-family partnership program in Alaska reduced postneonatal mortality in Anchorage by 50 percent in a 12-month period. Central to serving underserved families are nurse practitioners and public health nurses. At the State level, nurses drive the public health system.

GENERAL DISCUSSION

- Dr. Jackson called for more discussion about community. She also expressed concern that when prevention, diabetes, and hypertension are discussed, the emphasis is on medical interventions. If an intervention involving nutrition or exercise is needed, how is that intervention supported? Can SACIM push the Nation in ways other than medical care, such as partnerships with YMCAs? How can emotional and mental issues be addressed within the systems of health care, and what community-based partners might be involved in that effort? What can be done about stress, obesity, and hypertension as risk factors for poor birth outcomes in terms of nonmedical interventions?
- Ms. Sheridan urged SACIM not to forget what is already known about screening, immunization, and fundamentals about preventing death in newborns. Ms. Johnson noted that SACIM recommendations for the CMS innovations center include regional perinatal care and newborn care.

PUBLIC COMMENT PERIOD

David S. de la Cruz, Ph.D., M.P.H., Principal Staff and Designated Federal Official, SACIM

Dr. de la Cruz opened the meeting to public comment. The Federal Register Notice gives individuals who cannot attend the meeting an opportunity to submit comments ahead of time. Comments from the Society for Maternal-Fetal Medicine (SMFM) are included in an appendix to this summary. SMFM wrote in support of the work of SACIM, encourages working more closely with NICHD, expresses excitement about the Strong Start initiative, recognizes the work of CHIP, and encourages a focus on preterm birth, hypertension, and diabetes. SMFM stands ready to assist SACIM as it moves forward.

Ellen Schmidt from the Education Development Center remarked on the Children's Safety Network project, which works on injury and violence prevention and is funded by MCHB. She added to the list of issues around mental health the issue of suicide. In terms of accessing groups at risk, she mentioned the Head Start project as another area with access to at-risk mothers.

WRAPUP AND ADJOURN FOR THE DAY

Kay Johnson, M.Ed., M.P.H., Acting Chair, SACIM

Ms. Johnson reviewed the agenda for the following day and thanked Drs. Lu and de la Cruz for their efforts in planning the meeting.

Michael C. Lu, M.D., M.P.H., Associate Administrator for MCH, HRSA; Executive Secretary, SACIM

Dr. Lu thanked the speakers for their input into the meeting and stated that he looks forward to hearing actionable recommendations for the Secretary from the committee regarding health care reform, financing, health equity and ways to improve quality and safety, address disparities, and

reduce infant mortality.

The meeting adjourned at 4:45 p.m.

SECRETARY'S ADVISORY COMMITTEE ON INFANT MORTALITY

FRIDAY, MARCH 9, 2012

The following individual work groups met during the morning in breakout sessions:

- Developing a National Agenda
- Health Care Financing
- Health Care Reform
- Health Equity

WELCOME AND REMARKS FROM HRSA

Sarah Linde-Feucht, M.D., Chief Public Health Officer, HRSA

Dr. Linde-Feucht conveyed greetings from Dr. Mary Wakefield of HRSA and mentioned that Dr. Lu's presence at HRSA is emblematic of the importance that the agency places on the issue of infant mortality and the work of SACIM. She thanked the HRSA staff for the work they do in supporting maternal and child health.

The health of America's children and the ongoing challenge of infant mortality are a high priority for President Obama and Secretary Sibelius. Several provisions of ACA are aimed directly at infant mortality: guidelines to ensure that women receive preventive health services at no additional cost, the MIECHV program, and the priority in awards of funding in the CDC Community Health Workers program. ACA also addresses the role of social determinants in birth outcomes and the expansion of the primary care safety net. The Administration is continuing to focus on expanding access to primary health care, increasing the health care workforce, focusing on prevention, and shoring up health care in the safety net for the most vulnerable populations, including mothers and children. Dr. Linde-Feucht stated that HRSA will continue to support SACIM's work, and she asked for SACIM's advice, candor, and expertise.

REVIEW OF RECOMMENDATIONS FROM PREVIOUS COMMITTEE MEETINGS

Kay Johnson, M.Ed., M.P.H., Acting Chair, SACIM

Ms. Johnson explained that SACIM has followed up on Dr. Wakefield's request to review the committee's recommendations. A narrative document will be produced that captures all of the information presented in the slides and fills in some of the details.

A detailed summary of Ms. Johnson's review of the slides can be found on pages 4–6. The current SACIM reaffirms the need for a continuum of prevention and intervention services to improve the health and well-being of women, infants, and families as well as investment in infrastructure that ensures access, quality and safety, and accountability for outcomes. SACIM also reaffirms the need for a lifespan approach to reducing infant mortality and adequate standardized data, monitoring, and surveillance systems. In addition, SACIM affirms the importance of ACA in access to care for mothers, infants, and families and the need for Federal investments in the MCH safety net, including Medicaid, the Title V MCH block grant, Healthy Start, the Title X family planning program,

community health centers, the MIECHV program, prevention and public health, and WIC. SACIM should be added to the list of HHS initiatives aiming to eliminate disparities and increase prevention, thereby creating health equity. Poverty and income inequality must be considered to address the social determinants of health. HHS partnerships and coordination are needed in all of these efforts.

Ms. Johnson asked the work group chairs to summarize their groups' work.

- *Developing a National Agenda.* Dr. Cox stated that his work group felt the need for addressing Dr. Lu's Five I's: innovation, integration, implementation, investment, and impact. Within that framework, integration of leadership through interagency collaboration will result in improved efficiency. SACIM must be able to innovate, to have an impact on these services, and to change the cost curve on infant mortality.
- *Health Equity.* Dr. Troutman stated that the primary focus on the impact of the social determinants of health includes areas such as education, income, housing, neighborhood, and racism. The stand on social determinants is an affirming, empowering stand, rather than the deficit stand of health disparities. The work group discussed multiagency interaction through the Prevention Council to attack infant mortality.
- *Health Care Financing.* Dr. Handler stated that the work group focused on the fact that infant mortality is everyone's problem. The "common results-common outcomes" framework is a valuable approach. Breaking down the silos, community transformation, place-based initiatives, and investing in the crumbling vital statistics structure are of special importance. The work group applauds the use of Text4Babies and is interested in health education. A recommendation might be to target initiatives that bypass States and instead deal directly with communities.
- *Health Care Reform.* Ms. Johnson stated that the work group tried to arrive at particular areas to support. A significant concern involves women's preventive services and the Bright Futures benefits. The question is how to let the public know about new benefits. One of the tendencies in implementing health reform strategies that concern the whole population is that children get lost. Because many people think that the problem has been solved, it is important to ensure that the message about protecting the most vulnerable is not lost. HRSA can help in this task.

Dr. Linde-Feucht thanked the work groups for the impressive amount of work they have done and remarked that the recommendations are in line with HRSA's activities. The agency concurs on the data issue, on MCHB's willingness to assume a leadership role, and on the transformation of Healthy Start. Dr. Linde-Feucht urged SACIM to continue to advise the Secretary on actionable items.

Discussion

- Dr. Handler remarked that MCH funds have been threatened in the past year. She asked what SACIM can specifically do to ensure, in the face of ACA, that MCHB will take the lead in reducing infant mortality. Dr. Linde-Feucht mentioned the efforts of Dr. Lu to reach out

across the agency, and she encouraged SACIM to continue to do its work and advise the Secretary. Dr. Lu added that being able to articulate a clear vision of what the MCH block grant does in the era of ACA would be tremendously helpful. It is important to dispel the misperception that home visiting can replace the block grant. Outside voices on the importance of the block grant will be important.

- Dr. Cox stated that SACIM has some very definite ideas about how infant mortality should be addressed and needs the involvement of MCHB and other Federal agencies to achieve its goals. Those goals must be robust enough to be administration proof; that is, they should be immune to damage caused by a change in administration. Dr. Cox asked for advice on ensuring that SACIM's recommendations will be sustained and supported regardless of who is in power. Ms. Johnson asked about the overall structure of HRSA regarding an interagency agenda. What components of HRSA can be used to advance SACIM's agenda? Dr. Linde-Feucht cited evidence of Dr. Wakefield's dedication to the mission of HRSA in the establishment of the position of chief public health officer. In that role, Dr. Lindi-Feucht serves as internal ambassador at HRSA, connecting and convening individuals on high-level issues in the agency. The National Health Service Corps of primary care providers is an entity and resource that SACIM can take advantage of. The HIV/AIDS Bureau has a network of AIDS education training centers. The Office of Rural Health Policy funds the State offices of rural health. Dr. Lindi-Feucht pointed out that interfacing goes on at the community level, and HRSA has a broader reach than merely the MCH and health center grantees. Public health training centers funded by the Bureau of Health Professions received an enormous boost through ACA. Those groups are already interfacing and crossing over with traditional MCH stakeholders, but many other connections can be made.
- Ms. Johnson mentioned another area of reach—the regional offices and their capacity to help create synergy and carry forward messages to States regarding maternal and child health. Do opportunities exist for messages about the core strategies around infant mortality prevention to be disseminated to regional offices. Dr. Linde-Feucht cited the regional offices and the Office of Regional Operations as an important resource.
- Ms. Johnson reiterated the idea of place-based initiatives, synergy in communities, and building on the work of the Nation's 105 Healthy Start communities with the highest infant mortality rates. Dr. Linde-Feucht endorsed this idea and noted the importance of linking primary care and public health. The Healthy Weight Collaborative is a quality improvement initiative to prevent and treat obesity in children and families through the use of quality improvement science. It links the clinical/public health world and the community.
- Dr. Shields stated that obesity and diabetes are among the chronic diseases faced by women that can contribute to poor birth outcomes. The Healthy Weight Collaborative should emphasize that treatment of obesity is related to infant mortality reduction. Dr. Linde-Feucht cited the Web site address collaborateforhealthyweight.org and stated that a resource center will disseminate lessons learned.

QUALITY IMPROVEMENT RESEARCH

Raymond L. Cox, Jr., M.D., M.B.A., SACIM Member; Senior Vice President for Medical Affairs and Chief Medical Officer, Providence Hospital

Dr. Cox presented information about the “Maryland Patient Safety Center Perinatal Collaborative and Learning Network.” The aim of the Perinatal Collaborative is to reduce infant and maternal harm inside the walls of the hospital through the implementation and integration of systems improvements and team behaviors into maternal-fetal care. The collaborative is an initiative to test, adopt, and implement evidence-based improvement strategies in the labor and delivery units of hospitals in Maryland and the District of Columbia.

The collaborative’s change package includes mandatory parts of the program, such as use of common language from NICHD in electronic fetal monitoring; training in team coordination, team communication, and teamwork behaviors; improvement in staff performance during high-risk events, specifically centered on simulation; and revision and application of recommended practice guidelines. Success in the program is measured by use of the Adverse Outcome Index (AOI), the The Agency for Healthcare Research and Quality (AHRQ) Hospital Survey on Patient Safety Culture, process measures related to hospital-specific interventions, and improvement stories. So far, AOI has not been highly sensitive for measuring change. There was a 25.6 percent decrease in NICU admissions. The AHRQ culture survey showed an improvement in 9 of 12 dimensions on labor and delivery units. Since January 2009, elective induction rates have decreased by 91 percent and cesarean section rates have decreased by 80 percent.

Perinatal collaboratives have had significant impacts in relatively short periods of time and have a tremendous impact not just on mortality but on morbidity and overall safety and reliability. In terms of clinical economics, savings do exist in many of these systems, but proving where they fall out is difficult. Savings do not necessarily accrue to the hospital; they accrue to the insurance company or the community.

Dr. Cox explained that in the collaborative network, the reduction in infant mortality occurs across all races, with a significant reduction among African Americans. Reducing unintended variation in quality and safety may be most important to vulnerable populations. As policy and safety initiatives develop, the most vulnerable populations benefit most. Therefore, it is important to ensure that hospitals that are most likely to serve those populations are given the resources they need to address and implement the quality and safety programs.

Dr. Cox explained that, after the Perinatal Collaborative was developed, the Neonatal Learning Network was created, and then the two were combined. Ms. Connie Burke is the program director.

Dr. Cox listed the elements of a successful change strategy: (1) creating the burning platform, (2) engaging leadership, (3) borrowing shamelessly, (4) establishing non-negotiable mutual respect, (5) practicing relentless persistence, (6) creating ongoing opportunity for discussion, and (7) constantly measuring and adjusting programs.

Excellence in Obstetrics: A Multisite AHRQ Demonstration Project

Dr. Cox continued his presentation with a description of an AHRQ-funded demonstration project to reduce medical liability through patient safety. In June 2010, Ascension Health received a grant for the Healing without Harm multisite demonstration project to develop new models for medical liability and improve patient safety. Five very diverse sites are involved in the Healing without Harm project. The five study hypotheses involve (1) a decrease in shoulder dystocia injury rates and infant harm when the “bundle” is introduced, (2) change in delays of treatment when fetal distress occurs, (3) reduction in the frequency and severity of claims when full disclosure is implemented, (4) an increase in reporting of serious safety events when five elements of high reliability have been adopted, and (5) a decrease in all birth trauma events and rates.

More than 1,800 nurses and physicians have been trained thus far on multiple interventions, and more than 8,000 mothers have consented as of January 2012. The average consent enrollment rate at the five sites is about 80 percent. The project involves a very racially and ethnically diverse population. Associates have been trained in electronic fetal monitoring, shoulder dystocia, simulation, cause analysis, and disclosure. The plan is to spread the program to the other 38 hospitals in the Ascension Health system that deliver babies. Dr. Cox ended his presentation by emphasizing that the purpose of quality and safety is its equitable distribution.

Discussion

Dr. Cox’s presentation prompted the following questions and comments:

- In response to a question from Ms. Johnson, Dr. Cox explained that Ascension Health, the largest nonprofit health care system in the country, is a Catholic system with 70 hospitals nationwide and 75,000 births a year. Most of the hospitals are in the Midwest, but they exist in 26 States across the country.
- Ms. Chesna asked what accounts for “moving the dime” on disparity in the Ascension system. Dr. Cox reiterated that the point of quality science is to raise all boats. The question is whether it raises all boats equitably. Dr. Cox thinks that quality science raises more vulnerable boats more rapidly because they are much more prone to suffer the effects of unintended variation. Quality improvement efforts do affect health disparities. Studies done on centering practices show significant reductions in LBW specifically in the African American community when that model is used. A science on how to close the gap is under development, but more effort is needed.
- Dr. Petrini noted the fear that reductions in NICU admissions can close hospitals. Is there evidence that these funds are really what keep hospitals open? Dr. Cox responded that hospitals work on thin margins, and the NICU might be considered what makes the difference in keeping a positive margin. However, most hospitals understand that NICU reductions are an important community benefit. Furthermore, reductions in NICU use in Maryland did not threaten any of the hospitals. On the other hand, the losses are not inconsequential. Instead of worrying about “being a victim of our own success” in regard to NICUs, Dr. Cox stated that

he worries about how all of the changes with ACA will affect risk-based payment systems, value-based purchasing, CMS bundling, and accountable care organizations (ACOs).

- Referring to “perverse incentives,” Dr. Pressler stated that her hospital in Hawaii loses money on maternity care and relies on the NICU as a source of funds. Hawaii Pacific Health is working vigorously with its payers to change the method of compensation as the hospital moves toward ACO value-based purchasing. Dr. Pressler mentioned a 2-year project plan to establish an ACO with the major payer to ensure compensation during the transition to ACA. To be an ACO in maternity care, the hospital would have to go to a bundled payment so that compensation would be higher for good outcomes than bad outcomes. Dr. Cox cited North Carolina’s patient-centered medical home model, which is the front door to the ACO and mentioned that ACOG has pushed for women-centered ACOs. Over time, fairly narrow spectrum risk-based models will exist for women, the developmentally disabled, the chronic care population, and so on. Companies will specialize in particular types of ACOs because risk cannot be managed across the entire spectrum. The hospital rightfully will become the back door, rather than the front door, to health care. A way must be found to develop the incentives that pay for that system accordingly. In particular, money must not be driven out of the system before the changes are made.
- Dr. Handler asked about regional perinatal care in Maryland. Dr. Cox explained that there are two level 4 hospitals (Johns Hopkins and the University of Maryland), an array of level 3 hospitals around the State, and a smaller group of level 1 and level 2 hospitals. A perinatal standards advisory committee is responsible for setting the standards for each of those levels of care. The regionalized system in Maryland is fairly tight.
- Dr. Lu asked about quality improvement as applied to inpatient settings (labor and delivery) versus the greater impact, especially around disparities, of what occurs in outpatient settings. Can quality improvement be taken from the bedside to the curbside to apply it to the outpatient setting? Dr. Cox explained that ACOG’s Perinatal Quality and Improvement Committee recently developed an ambulatory care program for outpatient safety. Nevertheless, the answer lies in developing a system that coordinates care across the continuum.
- Dr. Lu requested that the health care reform work group concern itself with the improvement of children’s health in an ACO. How does the work group deal with the issue of the design of the women and children’s ACO as a potential vehicle for addressing infant mortality? Dr. Cox reiterated that systems must be developed that are very good at a particular level or type of care. SACIM will provide instruction for moving forward to develop a continuum of care for women and infant’s health. Along with the positive aspects of Dr. Lu’s leadership, several other systems issues must be addressed, such as care transition, workforce access, public education and empowerment, social determinants, and hospital safety.
- Dr. Pressler mentioned that bundled payments based on outcomes for both mothers and children must include followup to guarantee complete accountability and incentives for healthy outcomes for babies and mothers.

- Ms. Burke explained that Maryland followed the IHI breakthrough model for rapid-cycle improvement, which included a significant amount of “touch,” meaning that hospitals were contacted every day. The cost was low—perhaps as little as \$500,000 per year covered the entire State of Maryland. Regarding the outpatient side, discharge is coordinated in the hospital with the focus on the transition and ensuring communication with parents. A patient-centered approach educates the parent, and hospital followup calls ensure that patients keep their appointments. For the neonatal program, the American Association of Pediatrics approved the maintenance of certification; pediatricians who meet the certification requirements for the program accrue credits toward recertification.
- Ms. Chesna mentioned that improved teamwork, enhanced communication, and a patient-centered approach taken together help to reduce disparities. Dr. Cox stated that the solutions are complex and IHI’s bundled concept works to improve outcomes.
- Ms. Catherine Ruhl, director of women’s health programs for the Association of Women’s Health, Obstetric and Neonatal Nurses (AWHONN), noted the importance of quality improvement and stated that nurses and midwives are integral parts of the continuum to outpatients. Connections with quality improvement projects and centering programs have made a significant difference. Health systems that use midwives are an important avenue to quality improvement and patient safety. Ms. Johnson noted that the person who most represents the perspective of midwives on SACIM, Ms. Carolyn L. Gegor from Georgetown University, was unable to attend the meeting. SACIM needs her perspective.
- Dr. Tyan A. Parker Dominguez mentioned rising rates of maternal mortality and the gap regarding disparities. Quality improvement related to mothers means that maternal outcomes are as important as infant outcomes. Mothers with chronic conditions affect the health and well-being of babies.
- Dr. Raju cited the need for research and data on patient safety. An NICHD workshop last year on patient safety and newborn care was followed by an FOA inviting research proposals. The FOA will be active for the next 2 years.
- Dr. Cox thanked the committee for allowing him to speak and quoted from a 1981 paper by Dr. David Nagey on “The Content of Prenatal Care” (*Obstetrics and Gynecology*; 74:525). Dr. Nagey concluded that “the art of caring” must enhance obstetric practice.

COMMITTEE BUSINESS: DISCUSSION AND NEXT STEPS

Kay Johnson, M.Ed., M.P.H., Acting Chair, SACIM

Michael C. Lu, M.D., M.P.H., Associate Administrator for MCH, HRSA; Executive Secretary, SACIM

David S. de la Cruz, Ph.D., M.P.H., Principal Staff and Designated Federal Official, SACIM

Ms. Johnson presented a preliminary list of topics, and committee members added items for future meeting presentations. The list of future SACIM meeting agenda items is as follows:

- Presentations from mothers and consumer organizations
- Information and communication strategies with consumers
- Model community-based organizations
- Place-based, housing (HUD), community strategies
- Healthy Start (interconception care learning community, evaluation, transformation)
- Medicaid update
- Alignment with Prevention Strategy/Council
- Alignment with the Disparities Action Plan
- Update from NICHD/NIH
- Interconception care
- Workforce/community health centers/primary care/public health/safety net
- Vital statistics infrastructure
- Title V 5-year assessments

Discussion

Dr. Lu suggested that the committee consider what it needs to learn to be able to develop a set of informed recommendations that the Secretary can act upon. Ms. Johnson stated that SACIM has set itself a very ambitious timeline. In the next few weeks, the committee will produce a narrative document that captures the slide presentation on recommendations from previous committee meetings. In the next few weeks, a conference call will review a matrix of specific action items based on their potential impact, feasibility, and alignment with HHS and the Obama Administration priorities. In the next month, SACIM will send an initial set of recommendations to the Secretary.

As discussed in the morning session, members must think in terms of a long-term and a short-term recommendation in a priority area as an actionable item for the Secretary. Dr. Lu pointed out that the Secretary was impressed by the Ohio experience in reducing elective deliveries and SACIM's input was instrumental in the establishment of Strong Start. Healthy Start reauthorization will be considered in 2013, and the issue will be how to improve, innovate, and transform the program. SACIM's collective wisdom and experience will be useful to HHS in setting the stage for Healthy Start's reauthorization. The MCH workforce issue is also a priority for the Secretary and the Administrator.

Issues related to newborn screening, especially those related to patient safety and quality, could be on the SACIM agenda. The current focus of the Secretary's Advisory Committee on Heritable Disorders in Newborns, which is housed within MCHB, has been to review the evidence base screen by screen. Newborn screening may not be a primary focus of this committee, but it would be appropriate for SACIM to make a carefully worded recommendation that the committee consider recommendations concerning quality and safety issues. SACIM could present itself as reinforcing the committee's work and commitment while realizing that variability in newborn screening due to State law and financing cannot be fixed at the level of an advisory committee.

HHS comprises more than 100 Secretary's advisory committees. SACIM is concerned with disparities work, the Prevention Council, and heritable disorders. In terms of authority and

jurisdiction, health policy decisions made by States, such as Medicaid payment rates, are outside the purview of the Secretary. SACIM can use HRSA staff as a resource for any questions about what is within the purview of the Secretary. The Secretary might also respond to recommendations about how she can use her bully pulpit to get the message out. Executive orders might be another avenue by which to align priorities. The Secretary's logo means that an item has gone through the clearance process.

SACIM members could benefit from a model recommendation, one that could guide them in terms of specificity, diplomatic wording, and actionability. Examples will come with the narrative based on the slides. Drs. Cox, Troutman, and Handler have offered to help Ms. Johnson to turn the slides into narrative; Drs. Jackson, Shields, and Shepherd also volunteered to help with this project.

Dr. Lu thanked the committee members for their participation in the meeting. Dr. de la Cruz remarked that the members are bringing their expertise and their energy to the mission of the committee. He reminded them that their bios will need to be updated. Participants will receive copies of all of the slides presented during the meeting. Recommendations for new members are welcome from current members. A nomination package is with the Secretary now for a full-time chair and another new general member so that SACIM will be back up to 21 members by the next meeting in July 2012. Another meeting will take place in November 2012. Dr de la Cruz will send out a list of members and their individual terms.

Ms. Johnson thanked the SACIM members for their participation. The meeting adjourned at 2:45 p.m.

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APPENDIX

Public Comments to the Secretary's Advisory Committee on Infant Mortality March 8-9, 2012

**Submitted by: Society for Maternal-Fetal Medicine
M. Kathryn Menard, MD, MPH, President**

On behalf of the Society for Maternal-Fetal Medicine (SMFM), I am pleased to offer brief written public comments to the Secretary's Advisory Committee on Infant Mortality (ACIM). Established in 1977, the Society for Maternal-Fetal Medicine (SMFM) is dedicated to improving maternal and child outcomes; and raising the standards of prevention, diagnosis, and treatment of maternal and fetal disease.

Maternal-fetal medicine specialists, also known as MFM specialists, perinatologists, and high-risk pregnancy physicians, are highly trained obstetrician/gynecologists with advanced expertise in obstetric, medical, and surgical complications of pregnancy and their effects on the mother and fetus.

The most common medical illnesses managed by MFM's include hypertension, diabetes, seizure disorders, autoimmune diseases, and blood clotting disorders. We also provide care for women who are at increased risk for preterm birth, including multiple gestations, women with cervical insufficiency who may require a surgery to prevent preterm birth, and women with placental problems such as bleeding from premature separation. In addition, MFM specialists are often responsible for the management of preterm labor, premature rupture of membranes, and other complications during labor that have the potential to impact newborn and long-term infant outcomes.

The ACIM will hear about the many activities that the federal government is engaged in surrounding infant mortality, and SMFM commends the US Department of Health and Human Services and the various agencies involved collectively for making this important issue a priority.

SMFM supports the Eunice Kennedy Shriver National Institute for Child Health and Human Development (NICHD) at the National Institutes of Health (NIH), which has made great strides in the area of pre-term birth (birth before 37 weeks' gestation). Overall, NICHD's commitment to basic, clinical and translational research has led to new ways to treat and improve the health of pregnant women and infants. One of the most successful approaches for testing research questions is the NICHD Maternal-Fetal Medicine Units (MFMU) Network which allows researchers from across the country to coordinate clinical studies to improve maternal, fetal and neonatal health. The studies to date have not only identified new therapies and evaluated technologies used in maternal fetal medicine, but also have helped to abolish practices that are not useful.

Additionally, the new Strong Start Initiative, announced by the Center for Medicare and Medicaid Innovation, is very promising. This multi-agency partnership will certainly apply to all of the issues being discussed today surrounding infant mortality – specifically how we can improve the health status of infants and mothers as well as factors affecting the continuum of their care. SMFM assisted in the development of this program, along with other key stakeholders. A public awareness campaign and the testing of innovative ways to reduce the rate of preterm births for women at-risk for pre-term

birth who are covered by Medicaid will have an impact infant mortality and women's health nationwide.

Finally, efforts advanced by the Centers for Medicare and Medicaid Services through Medicaid and the Children's Health Insurance Program (CHIP) quality measures will also be helpful to reducing infant mortality. The maintenance and overhaul of perinatal quality measures by the National Quality Forum is currently underway. Recommendations will soon be sent to CMS for inclusion in Medicaid and CHIP quality improvement programs, which may be used as guidance to states on how to improve the care of pregnant women and newborns.

However, there is always more work to be done. For example, the special problems faced by some mothers may lead to death, short-term or in some cases life-long problems for their babies. For example:

- *Pre-term birth* (birth before the fetus is at 37 weeks' gestation). Over half a million children are born preterm each year. Preterm infants are at high risk for a variety of disorders, including mental retardation, cerebral palsy, and vision impairment. These infants are also at risk for long-term health issues, including cardiovascular disease (heart attack, stroke, and high blood pressure) and diabetes. The annual cost to society (medical, educational, and lost productivity) of preterm birth is at least \$26 billion (in 2005 dollars).
- *Hypertension*. High blood pressure during pregnancy endangers the health of both the mother and the baby and is increasingly common as women delay pregnancy until they are older, and as they are more frequently overweight. Chronic hypertension complicating pregnancy is associated with a risk of fetal growth restriction and a risk of preterm birth. Hypertension in pregnancy is also the 2nd leading cause of maternal death in the United States.
- *Diabetes*. The hormonal changes of pregnancy often bring about a diabetic state (gestational diabetes) in predisposed women or can seriously worsen preexisting diabetes. Whether diabetes mellitus existed before conception or gestational diabetes develops during pregnancy, maternal glucose intolerance can have significant medical consequences. Poorly controlled diabetes is associated with miscarriage, congenital malformations, abnormal fetal growth, stillbirth, obstructed labor, increased cesarean delivery, and neonatal complications.

Each of these areas should be explored further.

To conclude, SMFM urges the ACIM to ensure that all of these activities are coordinated to achieve the maximum impact on maternal and child health. SMFM stands ready to assist the ACIM as well as the federal agencies in any way possible to achieve the goal of reducing infant mortality.

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