Secretary's Advisory Committee on Infant Mortality

Meeting Minutes of November 14–15, 2012

L'Enfant Plaza Hotel
Washington, DC

GENERAL SESSION

WEDNESDAY, NOVEMBER 14, 2012

CALL TO ORDER AND WELCOME

Hani Atrash, M.D., M.P.H., Director, Maternal and Child Health Bureau (MCHB)/Division of Healthy Start and Perinatal Services
Michael C. Lu, M.D., M.P.H., Associate Administrator for Maternal and Child Health (MCH), Health Resources and Services Administration (HRSA); Executive Secretary, SACIM

Standing in for Dr. David de la Cruz, Dr. Atrash called the meeting to order. Dr. Lu welcomed the participants to this historic meeting in which the Secretary's Advisory Committee on Infant Mortality (SACIM) will present its final recommendations for the first national strategy on infant mortality. He thanked the committee members for their service and leadership.

SUMMARY OF JULY 2012 MEETING

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

After summarizing the July SACIM meeting, Ms. Johnson noted the willingness of the Committee members to participate in a series of online meetings in August and September to hammer out the six strategic directions and their accompanying recommendations. The SACIM members introduced themselves.

HRSA UPDATE

Marcia Brand, Ph.D., Deputy Administrator, HRSA

Dr. Brand noted the formulation of the first national strategy to reduce infant mortality and address the persistent racial, ethnic, and income disparities associated with prematurity, low birthweight, and infant deaths. In 2010, the United States ranked 24th among other industrialized nations in infant mortality. She noted SACIM's determination to undertake its role in making recommendations to the Secretary within a very short framework, namely from June to November.

Dr. Brand listed SACIM's six Big Ideas for the national strategy, emphasizing the final goal of collaboration. She also mentioned a number of new initiatives launched this year and highlighted a few provisions of the Affordable Care Act (ACA), including three particular to HRSA: (1) expansion of the health center network, (2) expansion of the National Health Service Corps, and (3) opportunity for the implementation of the home visiting program.

STRATEGY TO ADDRESS INFANT MORTALITY
Howard K. Koh, M.D., M.P.H., Assistant Secretary, U.S. Department of Health and Human Services (HHS)

Dr. Koh explained that he is standing in for the Secretary today to hear SACIM's recommendations. As a former State health officer, he has been involved in the issue of infant mortality for a very long time. Infant mortality is a sentinel indicator for tracking global health, and affording children the best start in life is an indication of a Nation's values. He mentioned that he oversees Healthy People and works with a number of today's presenters. Dr. Koh thanked the Committee members for their passion regarding infant mortality. He ended his remarks by referring to Martin Luther King, Jr.'s call for "the sunlight of opportunity" for all people.

PRESENTATION OF RECOMMENDATIONS
Kay Johnson, M.P.H., M.Ed., Chairperson, SACIM

Ms. Johnson stated that the Committee's report is in the final stages of editing and should be ready soon after the meeting. SACIM sees the set of recommendations as action steps for the Department of Health and Human Services (HHS) and stands ready to partner with the Secretary and other leaders across HHS to implement the national strategy and engage many private and public partners.

Based on recent trends, SACIM proposes new targets for infant mortality, namely, "5-5 by 15" and "4-5 by 20"—that is, to reduce the infant mortality rate to 5.5 per 1,000 by 2015 and 4.5 by 2020. The national agenda should reflect a life course perspective, engage and empower consumers, reduce inequity and disparities, and ameliorate the negative effects of social determinants. The national agenda also should advance system coordination and service integration, protect the existing maternal and child health safety net programs, and leverage change through multisector public and private collaboration. The final principle for a national agenda is to define actionable strategies that emphasize prevention and are continually informed by evidence and measurement. The current SACIM reaffirms the need for Federal investments in the maternal and child health (MCH) safety net, including Medicaid; the Title V MCH Services Block Grant; Healthy Start; the Title X Family Planning Program; community health centers; the Maternal, Infant, Early Childhood Home Visiting (MIECHV) Program; and the WIC Supplemental Nutrition Program at the U.S. Department of Agriculture.

Ms. Johnson presented the following six Big Ideas or strategic directions and gave a detailed explanation of the recommendations that flow from each one:

1. Improve the health of women, before, during, and beyond pregnancy.
2. Ensure access to a continuum of safe and high-quality patient-centered care.
3. Redeploy key evidence-based, highly effective preventive interventions to a new generation of parents.
4. Increase health equity and reduce disparities by targeting social determinants of health through investments in high-risk communities and initiatives to address poverty.
5. Invest in adequate data, monitoring, and surveillance systems to measure access, quality, and outcomes.

6. Maximize the potential of interagency, public-private, and multidisciplinary collaboration.

OPPORTUNITIES TO IMPLEMENT SACIM CORE STRATEGIES

Ms. Johnson explained that SACIM will hear from its members and others about the six strategic directions.

Improving the Health of Women Before and Beyond Pregnancy

Arden Handler, Dr.P.H., SACIM Committee Member
Marianne Hillemeier, Ph.D., M.S.N., M.P.H., Associate Professor, Health Policy & Administration & Demography; Associate Director, Population Research Institute, Pennsylvania State University

Dr. Handler presented background information about the first strategic direction—improving the health of women. Care prior to pregnancy is part of well women's health care. In June 2005, the CDC Select Panel on Preconception Care issued a consensus definition of preconception care as "a set of interventions that aim to identify and modify biomedical, behavioral, and social risks to a woman's health or pregnancy outcome through prevention and management, emphasizing those factors which must be acted on before conception or early in pregnancy to have maximal impact." Focusing on women's health before pregnancy to prevent infant mortality is effective because many risk factors for infant death, preterm birth, and other adverse pregnancy outcomes are related to maternal health. In addition, experts have identified a wide array of evidence-based interventions that, if acted on before pregnancy, would benefit women and infants.

Dr. Handler stated that high-quality prenatal care is essential but not sufficient, and she suggested that prenatal care be added to the list of effective interventions to be redeployed. The emphasis on women's health provides opportunities to increase and focus on contraceptive access, reduce unintended pregnancies, and increase appropriate birth spacing. It also provides an opportunity to reduce risks for children and women and to change behaviors such as alcohol and tobacco use.

A reinvestment in women's health is necessary to reduce unintended pregnancies, increase appropriate birth spacing, and increase contraception access. Every woman should have a medical care home when she is not pregnant. Reproductive health care must be integrated with the rest of women's health care, depression and personal violence screening should be included in the guidelines for preventive health services visits, and a national campaign is needed to ensure that women take advantage of the preventive health services visit. Dr. Handler concluded her presentation by stating that women must be empowered to realize that they are entitled to health care and well women health care must be integrated with the anti-poverty strategy.

Improving Women's Health Prior to Pregnancy: A Key Strategy for Reducing Infant Mortality

Dr. Hillemeier began her presentation by stating that the life course perspective motivated her to see that reproductive outcomes are determined by what happens over the lifetime. The Central Pennsylvania Women's Health Study (CePAWHS), a community-based program of research to

improve women's health, focused on pre- and interconceptional women in low-income communities. The first phase of CePAWHS was data gathering through population-based surveys of reproductive-age women in central Pennsylvania. The researchers sought to establish the risk factors for adverse pregnancy outcomes prevalent in the population and to identify the subpopulations at greatest risk. Women ages 18 to 45 were surveyed regarding conditions or behaviors such as obesity, depression, nutritional deficits, alcohol use, and cigarette smoking. The women were elevated in all of the risk factors presented, including physical inactivity, gynecologic infections, and stress. The second phase of the study developed a behavioral intervention—Strong Healthy Women—that targeted the prevalent modifiable risk factors identified in Phase I. A randomized controlled trial tested the intervention with pre- and interconceptional women in low-income rural communities.

Dr. Hillemeier explained that the Strong Healthy Women intervention was delivered in small groups of 8 to 12 women and was designed to be implemented in community or clinical settings by lay facilitators. It targeted multiple risk factors simultaneously and was based on theories of behavior change. The idea was that the intervention would lead to increased knowledge, self-efficacy, and intention to make change, which in turn would lead to health behavior change and health status improvement and ultimately to improved pregnancy experiences and outcomes.

The intervention addressed multiple dimensions of risk, behavior change goals, learning objectives, and behavioral outcomes. After describing the intervention process, research design, recruitment, and eligibility, Dr. Hillemeier reported on the significant effects of the intervention, including increases in self-efficacy, behavioral intent, and behavior change. Strong Healthy Women also had significant dose-response effects among intervention participants, including at 6 and 12 months. It was found that pregnancy weight gain was more likely to be in the optimal range in the intervention group.

The researchers concluded that Strong Healthy Women improved attitudes and behaviors related to nutrition, folic acid supplementation, physical activity, and stress management; increased the internal locus of control regarding birth outcomes; lowered weight and body mass index; and lowered pregnancy weight gain. A conclusion is that Strong Healthy Women helped women manage their weight, including during pregnancy, and may be an effective obesity prevention strategy for women of reproductive age.

The next steps include research focused on low-income urban women in safety-net clinics, research focused on overweight and obese women, replication in other communities, and incorporation of Smart Phone and other technologies. The researchers believe that it is possible to significantly improve the health of high-risk women before pregnancy. Dr. Hillemeier concluded her presentation by stating that a comprehensive agenda to reduce infant mortality should incorporate preconceptional health promotion strategies, including behavioral health promotion interventions, as well as access to high-quality preventive services at each contact with the health care system.

Discussion

The presentations by Drs. Handler and Hillemeier prompted the following questions and comments:

- In response to questions from Dr. Miriam Labbok, Dr. Hillemeier stated that the study's numbers were too small to determine the impact of Strong Healthy Women on prematurity and Dr. Handler stated that paid maternity leave is addressed in the SACIM recommendations report.
- Dr. Ruth Shepherd asked about recruitment methods , including whether incentives were used to recruit women in the Strong Healthy Women study. Dr. Hillemeier explained that the study used a variety of recruitment methods, including flyers, talking with clinicians and faith leaders, notices in utility bills, and incentives such as gift cards.
- Ms. Johnson stated that the national Preconception Health and Health Care Initiative has compiled a bibiliography with abstracts and presented a webinar for sharing the study's findings.
- Dr. Sara Shields noted that knowledge and intention can be changed, but people do not always have access to healthy food, safe places to exercise, or smoking cessation programs. Dr. Hillemeier stated that the researchers attempted to strategize about the availability of grocery stores and transportation systems and facilitators identified resources in the communities and offered instruction in food preparation. In addition, participants in both the control and intervention groups were linked with care providers.
- In response to a statement from Dr. Fleda Jackson regarding the importance of addressing depression and stress, in particular subclinical depression, Ms. Johnson emphasized the importance of paying attention to emotional and mental health in reproductive health and health care.
- Dr. Iris R. Mabry-Hernandez asked about clinicians' addressing preconception care. Dr. Handler referred to the section of the report specifying that physicians should be trained and educated to use guidelines in preconception care. Empowerment of the group also is an important element, and structural changes must be made to the system for delivery. Regarding depression, Dr. Handler suggested revisiting the HRSA-funded intervention in which primary care physicians prescribed drugs with 24-7 backup on phone lines with psychiatrists.
- Dr. Mabry-Hernandez asked where the Strong Healthy Women sessions were held. Dr. Hillemeier responded that the sessions were often held in community centers or church basements. In addition, engagement and mutual support were encouraged through buddy systems within the groups.
- Dr. Milton Kotelchuck commented that different forms of continuity include intergenerational continuity. He added that the Strong Healthy Women program is a "pure" maternal resiliency, capacity, and empowerment program, and he asked about the concept of the internal sense of control over birth outcomes. Dr. Hillemeier explained that if a person feels there is nothing she can do about an outcome, then there is no reason to try to modify or change. The locus of control means that a person has it within herself to be able to affect her environment even though the outcomes might be partially determined by something outside herself.
- In regard to preconception care, Ms. Carolyn Gegor suggested that providers ask about

women's reproductive health intentions. They could then recommend folic acid supplementation, discontinued use of Accutane, etc. Ms. Johnson remarked that the Women's Preventive Services Guidelines call for the integration of preconception care in well women visits. Dr. Lu's book *Get Ready to Get Pregnant* covers topics such as nutrition, preconception health care, family planning, stress, and mental health to promote health over the life course.

Ensuring Safety and High-Quality Patient-Centered Services Along the Continuum of Perinatal Care

Virginia Pressler, M.D., M.B.A., FACS, SACIM Committee Member
Elliott Main, M.D., Medical Director, California Maternal Quality Care Collaborative; Chairman and Chief of Obstetrics, California Pacific Medical Center
David L. Lakey, M.D., Commissioner, Texas Department of State Health Services; Past President of the Association of State and Territorial Health Officers

Dr. Pressler asserted that it is acceptable to aim for zero harm and zero complications. In the absence of a national database, Kapi'olani Medical Center for Women and Children uses the Vermont Oxford Registry, the largest national neonatal database. Kapi'olani is also a member of the Institute for Health Care Improvement (IHI) Perinatal Collaborative and reports to the Joint Commission on Perinatal Core Measures. Notable progress has been made in improving the rates of elective deliveries before 38 weeks gestational age, cesarean section, preterm deliveries, and health care–associated blood stream infection. In addition, Kapi'olani is striving to improve the rates of newborns who are fed only breast milk and to reduce nectrotizing enterocolitis.

Dr. Main's presentation focused on the ability to have private-public partnering on the issues of quality of care and outcomes. California is a challenge, with about 38 million people and 500,000 births; however, California's infant mortality rate is the fourth lowest in the United States at 4.7, but 27th in the world. California's preterm birth rate of 9.8 percent earned a March of Dimes (MOD) score of B.

Data-driven quality improvement can improve maternal and neonatal outcomes through multistakeholder quality collaboratives, statewide perinatal outcomes databases, significant efforts to achieve data quality, and the use of transparent data to drive and incentivize care. New ideas are being tested in all of the States, but each State is "doing its own thing."

The California Perinatal Quality Care Collaborative (CMQCC) and the California Maternal Quality Care Collaborative (CPQCC) are quality collaboratives whose mission is to provide data-driven quality improvement for mothers and newborns. The California Maternal Data Center (CMDC) drives maternal care in California. CMQCC is a multistakeholder organizaton comprising State agencies, public groups, professional groups, and key medical and nursing leaders.

A number of current maternal QI projects are ongoing. One example is the perinatal regionalization for very low birthweight (VLBW) and very preterm infants. Regionalization of care for VLBW has diminished in the past decade despite strong evidence of benefit. California has large variation with major quality opportunities in urban areas and has turned the national

Healthy People goal into a hospital-level quality measure. The vision of CMDC is to build a statewide data center to collect and report timely maternity metrics in a way that is low cost, low burden, and high value for hospitals in order to drive quality improve and service line management. CMDC also will improve the quality of administrative data, facilitate reporting to national performance organizations, and publicly report a select set of robust measures to inform the decisions of childbearing women. Dr. Main described the data flow involved in the CMQCC maternal data center. The mantra is "If you use it (an administrative dataset), they (hospitals) will improve it."

Dr. Main explained that maternal data QI in California depends on standardizing the definitions; educating doctors, birth certificate staff, and coders; making system changes, improving data as a QI project, and creating value for maternal data QI for hospitals. The objectives of the "ReVITALize" Obstetric Data Definitions Project are to nationally standardize obstetric clinical data definitions; educate and advocate for national implementation of the standardized obstetric data elements and definitions in electronic medical records, birth certificates, and data registries; increase and improve performance measurement and implementation of the national obstetric data standards; and encourage data aggregation. Many stakeholders are involved in ReVITALize. Data quality reports identify discrepancies or missing data in birth certificate and discharge data files and are used to target data performance and QI. Opportunities exist for health equity at the hospital level rather than only at the public health office.

The recipe for improving care is to redefine the issues locally at the hospital and provider levels. Quality measures must be transparent through the use of public release or benchmarking to incentivize changes in the system. Financial incentives also are important to encourage change. Dr. Main stated that value-based purchasing has been an effective lever for change.

Roles for HHS include supporting measure development, widespread use, and data collaboratives; supporting public release and raising awareness of the measures; and reducing perverse incentives, exploring positive incentives, and engaging in value-based purchasing.

Dr. Lakey presented information about the improvement of safety and quality in Texas and improvements in other States. He began by explaining that several points of intervention exist for QI related to the health of mothers before pregnancy, maternal care, newborn care, and infant health. A major challenge in Texas involves obesity. Texas women fail to meet the Healthy People 2020 prenatal care goal, with a significant ethnic and racial disparity. Almost half of black women in Texas get no first-trimester prenatal care. Inductions have increased steadily in Texas and the United States. In 2010, one in four deliveries was induced in Texas. In fact, induction rates increased by 40 percent in Texas between 2000 and 2010. In 2010, almost 40 percent of single-birth inductions were performed before 39 weeks of gestation. Labor induction is associated with an increased risk of delivery by cesarean section. In addition, Texas is below 70 percent in reaching the Healthy People goal of 90 percent of all VLBW infants born in level III hospitals.

Dr. Lakey described Healthy Texas Babies (HTB), an initiative to decrease infant mortality in Texas. The goals of HTB are to (1) provide local partnerships and coalitions with major roles in shaping programs in their communities, (2) use evidence-based interventions, (3) decrease the

preterm birth rate by 8 percent over 2 years, and (4) save $7.2 million in Medicaid costs over 2 years. Legislation directed the Medicaid office to eliminate payment for elective (i.e., nonmedically indicated) inductions before 39 weeks. An outreach campaign was developed to promote fathers' involvement with children before birth, and a council was created to study neonatal intensive care unit regionalization. A total of $4.1 million in general revenue was appropriated for this effort, and 11 local coalitions were created.

The Texas Someday Starts Now initiative educates mothers-to-be about exercise and nutrition, and the Protect Two From the Flu initiative hopes to drive up immunization rates for influenza. Both initiatives use public service announcements (PSAs). Another initiative is working to reduce early-term births.

The goal of the ASTHO President's Challenge 2010 was to improve birth outcomes by reducing infant mortality and prematurity in the United States. So far, 49 States have publically committed to this initiative. The State strategies to improve birth outcomes include reducing early elective deliveries before 39 weeks, providing access to preconception and interconception care, encouraging smoking cessation, preventing SIDS, improving perinatal regionalization, and expanding access to 17-hydroxyprogesterone (17-P).

Dr. Lakey cited Louisiana, Texas, West Virginia, Indiana, and Kentucky as States where legislative action has called for the reduction of elective deliveries before 39 weeks. Georgia and Mississippi also are making significant improvements in this area. Oklahoma began recruiting hospitals for a voluntary "hard stop" effort in January 2011 and has enrolled 52 of its 59 birthing hospitals. Its Every Week Counts campaign has resulted in a 70-percent reduction in the rate of inductions before 39 weeks without a medical indication. States are using a variety of strategies for improvements in access to preconception and interconception care, smoking cessation, SIDS prevention, perinatal regionalization, and expansion of access to 17-P.

Discussion

The presentations by Drs. Pressler, Main, and Lakey prompted the following questions and comments from the participants:

- Ms. Chesna asked how well California is engaging providers in its initiatives. Dr. Main stated that provider-level statistics are being generated and are used internally within hospitals. A quality agenda is well-established in California, and payers, purchasers, and the public are involved. Starting in January 2014, the core measure set will be mandatory in hospitals with more than 1,100 births. Birth certificate data will be used for the generation of these metrics.
- In response to a question from Dr. Handler regarding health departments versus private entities, Dr. Lakey stated that the Texas Institute of Health Care Quality and Efficiency looks at a variety of health issues. State involvement in defining metrics is important, but the private sector also must be involved. Dr. Main stated that there is no one cookie-cutter approach. He asserted that CMQCC in California is a public-private collaborative of stakeholders involved in maternity care, not a quasigovernmental entity.
- Dr. Shields asked how out-patient–based quality measures are captured, including

prenatal and postpartum care, for example, breastfeeding support and depression screening. Dr. Main referred to 10 new provider-level metrics from the American Medical Association (AMA), a number of which refer to outpatient data collection done through HEDIS. Dr. Pressler added that measurements can be required through meaningful use measures for payments to physicians and through patient-centered medical homes and criteria required by health plans to be reported by providers.

- Dr. Joann Petrini asked whether the announcement by the Joint Commission that it will accept vital records data can serve as a launching step to increase collaboration. Dr. Main responded that this step values birth certificate data. An electronic version of the birth certificate is the next step.
- Dr. Lu lauded the efforts at QI on the State and local levels and asked what more the Federal Government can do to support the work. Dr. Lakey responded that States want to know when the Collaborative Improvement &Innovation Network **(**COIN) will be expanded. Another role will involve using the data to define other areas that need work, such as the cost of prescription drug abuse and use of newborn intensive care units. Dr. Main mentioned opportunities in payment structure reform at the hospital level and opportunities in value-based purchasing. Sharing information about States's activities is also very important. Dr. Pressler emphasized that efforts are needed at both the national and State levels and national standardized datasets are needed.
- Violanda Grigorescu noted that States have different ways of gaining access to hospital discharge data and linkages. Standardization is needed, and information should be shared between the States. The question is whether a way exists to link with hospital quality projects. Dr. Main noted that a number of States add fields to their birth certificates to obtain hospital discharge data. California is heavily linked with hospital-level quality projects and has a series of hospital engagement networks (HENs). He added that hospitals fund QI when, for example, they are required to report measures to CMS. Ms. Johnson stated that the CMS requirement for hospitals to report on elective deliveries is a good step but it is insufficient.
- Dr. Kotelchuck highlighted the innovation of both Texas and California in the use of the electronic birth certificate and noted that the e-birth certificate could be used more creatively. Many States are reluctant to collect hospital-specific data, for example, Massachusetts, but QI collaboratives forced the issue and made QI a vital direction for improvements in the State. Dr. Kotelchuck asked Dr. Lakey about the effectiveness of the hard-stop rule whereby Medicaid refused to reimburse elective deliveries before 39 weeks. Dr. Lakey explained the process whereby the hard-stop rule was formulated and implemented and noted that physicians are supportive of the rule that establishes the policy. Voluntary policies in other States are on the same path, and birth outcomes have been improved. Dr. Main pointed out that elective delivery is not a real outcome; it is a process measure. The real outcome is healthy babies.

Redeploy Key Evidence-Based, Highly Effective Preventive Interventions to a New Generation of Consumers and Their Providers

Miriam Labbok, M.D., M.P.H., SACIM Committee Member
Robert Mande Corwin, M.D., FAAP, SACIM Committee Member
Triesta Fowler-Lee, M.D., Medical Officer & Coordinator, National Child and Maternal Health Education Program (NCMHEP); Eunice Kennedy Shriver National Institute of Child Health and

Human Development (NICHD)
Yvonne T. Maddox, Ph.D., Deputy Director, NICHD
Marilyn Keefe, M.P.H., M.P.P., Deputy Assistant Secretary for Population Affairs, HHS
Susan B. Moskosky, M.S., R.N.C., Deputy Director, Office of Population Affairs, HHS

Breastfeeding

Dr. Labbok presented information on early and exclusive breastfeeding to reduce infant mortality in the United States. The message is that we must protect, promote, and support as well as inspire, educate, and empower. Misuse of formula and use of formula can be associated with increased infant mortality. Optimal infant feeding involves not only the immediate postpartum skin-to-skin or breastfeeding within 1 hour, and 6 months of exclusive breastfeeding, but also continued breastfeeding with appropriate complementary foods, and feeding for at least 1 year or up to 2 years and beyond. Optimal infant feeding also involves related maternal nutrition and care. In addition, optimal infant feeding entails antenatal counseling and preparation, avoidance of unnecessary invasive birthing practices, cord clamping delay, new complementary feeding guidance, and birth intervals of 3 to 5 years.

Dr. Labbok asserted that optimal breastfeeding approaches save lives. In the immediate postpartum period, breastfeeding within 1 hour could reduce neonatal mortality by 22 percent worldwide. In the neonatal period, possibly 55 to 87 percent of global neonatal mortality could be prevented with bresatfeeding. Furthermore, nonbreastfed infants are 25 percent more likely to die in the United States in the postneonatal period.

The systematic review and meta-analysis carried out by the Agency for Healthcare Research and Quality revealed that any formula use or lack of breastfeeding is associated with an increase in the risk of SIDS, severe lower respiratory tract infections, necrotizing enterocolitis, diabetes, and obesity. For mothers, lack of breastfeeding (or early cessation) is associated with an increased risk of type 2 diabetes, breast cancer, ovarian cancer, and maternal postpartum depression. The risks of exposure to formula include pyloric stenosis.

Breastfeeding reached a nadir in the late 1960s/early 1970s, especially in the white population. Today, about 75 percent of women initiate breastfeeding; however, exclusive breastfeeding for 3 months occurs at only about 35 percent and exclusive breastfeeding for 6 months is at less than 20 percent.

Many challenges are connected with breastfeeding. For the consumer, convenient time and place, paid maternity leave, unbiased information and education, and skilled support are lacking. Consumers also lack an understanding of the differences beween optimal breastfeeding, human milk feeding, and formula feeding; social support; and inspiration, education, and empowerment. Providers need training; reimbursement; hospital structures, protocols, and policies; funding to study, change, and implement; and definitions. In terms of policy, support is lacking for breastfeeding, health worker education, full reimbursement for lactation consultants, and paid maternity leave, among others.

A cost-benefit calculation reveals $3.5 billion in savings if breastfeeding were supported. For every dollar spent, there would be $1.66 in savings. If all the women who are not currently

exclusively breastfeeding for 3 weeks were enabled to, the infant mortality rate would be reduced from 6.05 to 5.75. Medicaid should cover lactation services beyond 2 months in every State, and States should be encouraged to reimburse lactation services, use available billing codes for lactation consultation, and conduct projects with managed care plans to reduce variation in practice.

Immunization

Dr. Corwin presented information about the successes and challenges of immunization and ways to continue the protection of the population. Vaccines save $10 in health care costs for every dollar spent on them. The success of the vaccine program has created a country in which parents do not worry about polio, fear measles, or until recently know what pertussis looks like. The challenges are that each year brings more than 4 million live births in the United States, with each infant susceptible to a long list of vaccine-preventable diseases, but some of the newer forms of vaccines do not have the same level or length of protection as the old whole-cell vaccines. Also, severe vaccine shortages have occurred, increasing numbers of States permit philosophical exemptions to vaccine administration in addition to medical or religious exemptions, and increasing numbers of parents refuse to allow their children to receive immunizations. A lack of trust among parents about vaccine safety and vocal antivaccine movements populate numerous Internet sites that deliver misinformation, unsubstantiated information, flawed data, conspiracy theories, etc.

Dr. Corwin offered two vignettes to highlight the situation and mentioned herd immunity (i.e., the need to immunize a sufficiently large proportion of the population to protect those who are not immunized). Parents, legislators, and the public must be informed, educated, and convinced about the need to preserve and enhance the vaccine program. Attitudes, beliefs, and experiences must be considered; messages must be tailored to all groups, including the hard-to-reach; and newer technologies such as social media must be used to deliver the messages. The risk of real disease exists, and the benefits of vaccines far outweigh the risks of the illnesses. SACIM is asking the Secretary to redeploy strong messages about the need for immunization using new communication technologies.

Safe Sleep

Dr. Fowler-Lee presented information about the Safe to Sleep program and the National Child and Maternal Health Education program. The Back to Sleep (BTS) campaign launched in 1994 involved an intensive outreach program to African Americans, American Indians/Alaska Natives, and health professionals. Since the launch of the BTS campaign the overall U.S. SIDS rate has declined by 50 percent across all racial and ethnic groups, and the rate of back sleeping among infants has increased by 40 percent. However, data show that risk factors for SIDS and infant mortality go beyond back sleeping and include features in the sleep environment.

The Safe to Sleep program resulted in a new logo, determined by focus group testing, and two new campaign collaborators, CDC's Division of Reproductive Health and the American College of Obstetricians and Gynecologists (ACOG). After describing the Safe to Sleep campaign materials, Dr. Fowler-Lee explained that the campaign outreach plans include a Web site launch and a video on safe infant sleep. A SIDS/infant mortality conference was held in Jackson, MS, in October, and an Arkansas SIDS outreach project will be launched this month. In addition, a Safe

to Sleep Champions Initiative will be launched on a national level in 2013, and campaign outreach materials will be updated.

The National Child and Maternal Health Education Program (NCMHEP) is NICHD's first national education program. It was created as a forum for reviewing, translating, and disseminating new research in the field of maternal and child health. This outcome will be achieved through a coalition of the Nation's most prominent health care provider associations, Federal agencies, nonprofit MCH organizations, and other partners. NCMHEP will address one maternal and child health issue at a time for a period of 12 to 18 months. The program's first focus area is late preterm birth. Elective deliveries before 39 weeks gestation also are part of the focus area, and health care providers are the audience for this initiative. In 2011, NCMHEP launched a CME in partnership with Medscape for all maternal and child health providers to alert them to the impact and effects of late preterm birth and of inducing delivery for nonmedical reasons before 39 weeks. The CME resulted in 20,000 readers and 10,000 certificates. "Is It Worth It?" is a video produced by NCMHEP.

Dr. Yvonne Maddox emphasized the value of partners as campaigns and initiatives are developed.

Family Planning

Ms. Keefe explained that the Office of Population Affairs (OPA) at HHS oversees the Title X program, which provides needed preventive care services that are the backbone of the publically funded family planning system in the United States. Childbirth went from being a serious risk for women and children at the beginning of the 20th century to being a relatively safe experience, thanks in part to many improvements in public health including the advent of modern contraception. U.S. maternal and infant mortality decreased substantially between 1900 and 2010.

A link exists between pregnancy intention and pregnancy outcomes, with women who experience an unintended pregnancy being more likely than women with an intended pregnancy to have poor maternal and infant outcomes. Nearly half of all pregnancies in this country are unintended, one of the highest rates in the industrialized world. Unintended pregnancies are by definition unplanned, and unplanned pregnancies are correlated with late entry to prenatal care, elective abortions, low birthweight, and child abuse and neglect.

Ms. Keefe pointed out that the intendedness of births varies by race and ethnicity in the United States as well as by income. The negative consequences of unplanned pregnancy are especially important for teens, with 7 percent of teens giving birth each year and four of five of these pregnancies unplanned. The social and economic consequences of teen childbearing are clear, and teens have higher perinatal and infant mortality rates than adults.

Family planning allows individuals and couples to anticipate and attain a desired number of children and spacing and timing of births. Pregnancies that occur too early, too late, or too frequently can have negative consequences. After a live birth, the recommended interval before the next conception is at least 18 months to reduce the risk of adverse outcomes.

The Title X family planning program is dedicated to increasing access to contraception and related services. Title X provides contraceptive counseling, services, and supplies primarily to low-income individuals. Unlike Medicaid, Title X provides grants to agencies and is not a fee-for-service reimbursement program. It provides care for those patients who are not eligible for Medicaid and further helps to support the public health infrastructure by providing funding for training, staff, etc. Title X projects also provide breast and cervical cancer screening; STD screening, counseling, and treatment; HIV screening, referral, and linkage to care; screening for anemia, diabetes, and hypertension; pregnancy testing and counseling and referral; and other preventive health services related to contraception. In 2008, Title X services were estimated to prevent about 1 million unintended pregnancies, which would have resulted in about 400,000 unintended births and an equal number abortions.

Title X agencies also provide preconception care and family planning. Family planning centers are an important source of women's preventive health services. Family planning providers screen for chronic conditions that affect maternal and infant morbidity and mortality. Title X also has expanded its focus on preconception care and reproductive life plans. In addition, OPA and CDC are developing evidence-based clinical guidelines that include preconception as a key component.

Another Title X program priority is to increase the accessibility and affordability of long-acting reversible contraception (LARC). LARCs are extremely effective, but they are not always available because of cost. They include Implanon and Nexplanon and intrauterine devices such as Mirena and ParaGard.

After commenting on the Affordable Care Act (ACA) and family planning in terms of women's preventive health services and Medicaid expansions, Ms. Keefe stated that family planning fits into SACIM's strategy as a key evidence-based intervention. OPA will expand its efforts to provide high-quality information and services that can help reduce unintended pregnancy, increase access to highly effective contraception, and provide preconception care as a core part of family planning services.

Discussion

The presentations related to the third SACIM strategic direction prompted the following comments and questions:

- Dr. Joanne Martin asked about attempts to reach out to manufacturers of infant bedding. Dr. Maddox replied that the SIDS/SUIDS working group is in contact with some manufacturers and that the Consumer Product Safety Commission is a member of the working group.
- Dr. Shields asked about the rates of disparities in vaccine refusal. Dr. Corwin responded that the rates are much higher among well-educated families. For example, in high-income communities in the State of Washington, the immunization rate has dropped by 30 to 40 percent. Another concern involving disparities concerns access.
- Dr. Labbok mentioned that cosleeping is part of optimal breastfeeding and asked how it is addressed in the new NICHD materials. The response was that bed-sharing is strongly

discouraged by NICHD, which is attempting to promote the idea of a safe sleep environment. NICHD recommends room-sharing as opposed to bed-sharing. Dr. Labbok expressed concern.

- Ms. Johnson mentioned a project at George Washington University in which a study team is examining family planning in community health centers and the relationship to Title X and Medicaid. An important finding from the study is the role of Title X in assisting community health centers in delivering family planning services not only as a source of funding but also for the effect of the guidelines on support, training, etc.
- Dr. Nadine Garcia noted that the initiation rate for breastfeeding among African Americans is at 58 percent, significantly lower than the 75 percent rate overall. Targeted strategies are needed to end this disparity. Dr. Labbok mentioned that support systems work and empowerment and inspiration are key to targeting the populations that are least likely to breastfeed. She added that conflicting information about safe sleep must be dealt with.
- Dr. Troutman called for the passage of local ordinances and policies to increase access to places for breastfeeding. Dr. Labbok stated that most States now acknowledge that breastfeeding in public is not indecent exposure and barriers are being broken down. The business case for breastfeeding from HRSA has been an effective tool. Breastfeeding-friendly worksites are needed.
- Dr. Shields mentioned the Baby Friendly Hospital Initiative. Baby-friendly hospitals have higher breastfeeding initiation rates and lower supplementation rates. She asked whether SACIM can issue a national statement about promoting hospitals becoming baby friendly. Dr. Labbok responded that hospitals are being certified as baby friendly by CDC, and Dr. Barfield added that CDC is also supporting community efforts for breastfeeding outside of hospitals.
- Dr. Lu noted the centrality of family planning to any national strategy on infant mortality. He asked what the Federal partners and partners at the State and local levels can do to help promote family planning. Dr. Susan Moskosky responded that family planning involves more than conception; it helps individuals plan and space pregnancies. The preconception component of the family planning program should be made much more visible through guidelines and information-sharing. SACIM can promote the idea that family planning is involved in preconception health and family planning visits are an important opportunity for providing preconception messages and care that can result in healthy pregnancies. Ms. Keefe added that although family planning has been controversial in the political arena, women do use contraception in overwhelming numbers. Opportunities to coordinate and collaborate at the Federal level exist, and cooperation at the State and local levels has always been high.
- Ms. Johnson asked whether an immunization campaign is in the offing, and Dr. Corwin replied that no such campaign is on the horizon. Redeployment of the messages is under discussion, but funding in New York State ran out before an immunization campaign could produce materials for dissemination. The question is how to redeploy existing funds to programs that could better serve the population at risk.
- Dr. Handler asked about OPA's message regarding Title X in connection with the ACA. Ms. Keefe responded that Title X entails more than merely money for direct services; it enables the infrastructure to exist. Under the ACA, providers are needed who are capable of delivering services to people who are privately insured, insured through Medicaid, or

uninsured. Title X provides care to all comers, including people who will not be eligible under the ACA.

- Dr. Handler mentioned the controversy surrounding bed-sharing and back to sleep, both of which involve parental decision-making. The messaging lacks subtlety. SACIM's report should mention the need for empowering people to make good decisions with good information regarding safe sleep and immunization.
- Dr. Wendy DeCourcey suggested that the Early Head Start National Resource Center would be a useful partner for NICHD. She asked about the potential danger of losing the effect of the Back to Sleep campaign by introducing controversial additional ideas in the Safe Sleep program. Dr. Fowler-Lee replied that a great deal of discussion went into how to incorporate the new ideas; as a result, it was decided to give the campaign a new direction.
- Dr. DeCourcey asked about the Migrant and Seasonal Head Start program, which requires children to be immunized. Families often have lost their records, and Head Start does not have a cross-State data system. Information for parent decision-making would be helpful.
- Ms. Chesna stated that private practice providers do not effectively discuss family planning with their patients. Dr. Moskosky stated that, along with CDC and others, OPA is studying the evidence base for family planning and in spring 2013 will release the family planning guidelines for a broad audience.
- Ms. Johnson reiterated that messages must be well-coordinated and science-based, but providers who are well-informed and prepared to deliver those messages also are needed. Also needed are access to clinically based services and QI mechanisms.

INVEST IN ADEQUATE DATA, MONITORING, AND SURVEILLANCE SYSTEMS NATIONWIDE (NATIONAL, REGIONAL, STATE, AND LOCAL LEVELS) TO MEASURE ACCESS, QUALITY, AND OUTCOMES

Joann Petrini, Ph.D., M.P.H., SACIM Committee Member
Marian F. MacDorman, Ph.D., Statistician and Senior Social Scientist, Division of Vital Statistics, National Center for Health Statistics, Centers for Disease Control and Prevention (CDC)
Wanda Barfield, M.D., M.P.H., Captain, U.S. Public Health Service; Director, Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion, CDC

Dr. Petrini reviewed Strategic Direction 5, which involves the need for many types of data systems. The data systems must be complete, high-quality, timely, and coordinated. This strategic direction calls for investing in the National Vital Statistics System, which is the most important source for mortality prevention. The lack of universal adoption of the 2003 revised birth certificate is an issue. The fifth strategic direction also calls for incentivizing reporting of uniform Medicaid perinatal outcome measures for each State, expanding PRAMS to every State, systematically using quality measures that are both desseminated and incentivized, and continuing support for other related data systems that fill voids.

Vital Statistics

Dr. MacDorman stated that the reason it took longer to adopt the revised birth certificate in 2003

than in 1989 was because in 1989 the certificate was paper. By 2003, States had electronic reporting systems, and adopting the e-certificates was costly. The National Center for Health Statistics (NCHS) had little money to support the change.

Dr. MacDorman began her presentation on recent declines in infant mortailty in the United States by reporting that vital statistics infant mortality data are based on birth and death certificates filed in State vital statistics offices and transmitted to NCHS, where they are made into national data files on birth, death, and linked birth/infant death data. The more detailed data in the linked data set facilitates infant mortality analysis and is currently available through 2008. A recent reengineering of the vital statistics data processing systems led to problems with timeliness. A recent catch-up program for birth and death data files has been successful; however, the linked and fetal death data sets still lag behind.

After significant declines throughout the 20th century, the U.S. infant mortality rate plateaued from 2000 to 2005. In 2005, the infant mortality rate was 6.86 infant deaths per 1,000 live births. Since 2005, there was a substantial decline in the U.S. infant mortality rate from 6.86 in 2005 to 6.05 in 2011. From July 2011 to June 2012, the U.S. infant mortality rate was 5.9.

After citing statistics for the percentage of preterm births and infant deaths from 2000 to 2011 and infant mortality rates by gestational age in 2008, Dr. MacDorman stated that the overall infant mortality rate can be partitioned into two key components: (1) the distribution of births by gestational age and (2) gestational age–specific infant mortality rates. Preliminary modeling suggests that both must have declined to yield the current infant mortality rate.

In terms of racial and ethnic differences, Dr. MacDorman cited infant mortality rates in 2008 for non-Hispanic black women as 12.67, which is 2.3 times the rate for non-Hispanic white women at 5.52. Rates for American Indian and Puerto Rican women were higher than for non-Hispanic white women, whereas rates for most other Hispanic origin groups were similar to or lower than those for non-Hispanic white women. A high rate of perterm births accounted for the higher infant mortality rate for all Puerto Rican women and for most non-Hispanic black women. In contrast, higher gestational age–specific infant mortality rates primarily at 34 weeks or more accounted for most of the higher infant mortality rate for American Indian women.

Dr. MacDorman described statistics on the leading causes of infant death: congenital malformations, short gestation and low birthweight, SIDS, maternal complications, and unintentional injuries. Dr. MacDorman stated that from 2005 to 2011, infant mortality declined most rapidly for non-Hispanic black women (-16 %), followed by non-Hispanic white and Hispanic women (112% and -9%, respectively) based on mortality file data. Infant mortality declines were largest for states such as Louisian, Georgia, the Carolinas, and DC with large African American populations and previously high infant mortality rates.

Dr. MacDorman explained the recent decline in preterm birth, which appears to be widespread across maternal race/ethnic groups, maternal age groups, and States and for both single and multiple births. Some factors to consider in the changes to the overall rate are the recent decline in teen births, leveling out of multiple-birth rates, and changes in obstetrical management of pregnancy.

PRAMS

Dr. Barfield presented information about the Pregnancy Risk Assessment Monitoring System (PRAMS), a large CDC surveillance system housed in the Division of Reproductive Health at the National Center for Chronic Disease Prevention and Health Promotion. An invaluable source of information on mothers and infants, PRAMS is a population-based surveillance system with self-reported maternal behaviors and experiences around the time of pregnancy. It supplements birth certificate information and includes State and near-national estimates. After providing backgound information about PRAMS, citing its goals, and describing its participants, Dr. Barfield described the PRAMS survey and the way in which the data is collected in phases that last about 3 to 5 years. Phase 6 data for 2009 to 2010 are currently available for analysis, and phase 7 data for 2012 are currently being collected.

Key long-term PRAMS topics include the adequacy, barriers, and content of prenatal care; breastfeeding; contraceptive use; infant sleep position; Medicaid and WIC participation; physical abuse; and unintended pregnancy. Data go back to 1988 for some States. New topics for phase 6 include cesarean section/labor induction, chronic disease, health insurance coverage, infant 1-week checkup, influenza vaccination, obesity, preconception health, and postpartum depression.

The PRAMS scientific work group is a multidisciplinary group of specialists in maternal and child health, chronic disease, public health, survey methods, and clinical practice. Its purpose is to provide guidance to PRAMS on ensuring that PRAMS data maintain high quality to affect policy and programmatic effort, craft new questions given the renewed focus on science translation and possible use of PRAMS for quality assessment, and generate constant and greater awareness of PRAMS and its value.

PRAMS is used in the area of special populations; for example, the South Dakota Tribal PRAMS survey was conducted in 2007 and addressed the experiences and behaviors before, during, and after recent births by women in South Dakota. PRAMS also looks at emerging health issues and priority topics; for example, the PRAMS Influenza Questionnaire Supplement assesses seasonal influenza vaccine coverage among pregnant women. A third activity of PRAMS is program evaluation; PRAMS works with the Kellogg Foundation to focus on vulnerable populations, enrollment in WIC and Medicaid, breastfeeding rates, home visitation, and the opportunity to engage in the medical home. Work with State partners includes modifying State sampling, modifying the PRAMS questionnaire to capture target indicators, developing new community partnerships, developing and testing new data collection methods, and anayzing data for Kellogg program evaluation use. Another component involves chronic disease prevention; PRAMS data can monitor and evaluate screening and diagnosis of chronic disease conditions among women of reproductive age. In addition, PRAMS offers an opportunity for data linkages; for example, live birth certificates can be linked to data systems on birth defects, Medicaid, WIC, hospital discharge, and newborn screening. Finally, PRAMS is a method for assessing service quality and satisfaction.

Discussion

The presentations on vital statistics and PRAMS prompted the following comments and questions:

- In response to a statement by Ms. Johnson that PRAMS should be a national system, Dr. Barfield cited the opportunity PRAMS gives to sample from a known population, and she noted the possibility of synergy between PRAMS and the Behavioral Risk Factor Surveillance System.
- Ms. Chesna asked about the response rate for PRAMS and the possibility of the survey being electronic. Dr. Barfield stated that the response rate in general is very high; for many States, it exceeds 70 percent. She remarked that the use of cell phones or computers for survey response raises the question of access and literacy, in particular for low-income women and noted that the phone survey works well especially for Latinas.
- Dr. Jackson asked whether the lower birth rate is a factor in the decline in infant mortality in the southern States. Dr. MacDorman responded that NCHS has not looked at that specific possibility. In general, the decline was seen more for the non-Hispanic black population than for the other populations. A much higher proportion of non-Hispanic black infant deaths are due to preterm-related causes of death. A decline in preterm births would have more of an impact in the non-Hispanic black population. Dr. Jackson added that the birth rate for well-educated African American women is declining and might contribute to that statistic. Dr. Kotelchuck stated that Georgia, North Carolina, South Carolina, and DC have recently experienced surges in Latino immigration, which might be driving the African American population out of those areas. Dr. MacDormand noted that the non-Hispanic black infant mortality rate has been declining faster than other populations, but the data have not been examined State by State.
- Dr. Barfield stated that the revised birth certificate can look at the therapies and decreases in elective term delivery that might be contributing to the decline in infant mortality. She called attention to a PRAMS report on CDC's winnable battles.

HEALTHY START UPDATE
Hani K. Atrash. M.D., M.P.H., Director, MCHB/Division of Healthy Start and Perinatal Services
Fleda Jackson, Ph.D., M.S., Chair, SACIM Healthy Start Work Group

Federal Perspective
Dr. Atrash presented information on the background of Healthy Start, explaining that it was established as a presidential initiative in 1991 to reduce infant mortality disparities in high-risk populations through community-based interventions. A total of 163 local sites operate under 105 grants in 39 States plus DC and Puerto Rico. The Healthy Start objectives are to implement evidence-based practices and innovative community-driven interventions to promote and improve the quality of health care for women and infants. The approach is to work collaboratively with stakeholders and consumers in the community to leverage existing assets at both the service and system levels to ensure continuity of care from pregnancy through 2 years following delivery. The core program goals are to reduce racial and ethnic disparities in access to and utilization of health services, improve local health care systems, and increase consumer or community voice in health care decisions.

The National Healthy Start Program has nine core components. Five components are focused on services: (1) outreach and participant recruitment, (2) health education, (3) case management, (4) maternal depression screening, and (5) interconception care services. Four components are focused on systems-building: (1) implementation of a consortium, (2) development of local health system action plans, (3) development of sustainability measures, and (4) collaboration and coordinatiion with Title V. In 2010, more than 90 percent of all Healthy Start sites were implementing all nine core components. Sites report on both services and outcomes.

Statistics from 2010 reveal that Healthy Start has done an outstanding job in improving outcomes in terms of total number of infant deaths, babies with low birthweight, and babies very low birthweight. However, Healthy Start serves only a tiny proportion of women; in fact, Healthy Start serves less than 1 percent of babies born nationally.

The transformation of Healthy Start is based on a responsibility to demonstrate effectiveness with a focus on health outcomes, demonstrate sustainability and impact on systems, and scale up and disseminate interventions to serve the larger population. Updated goals include (1) ensuring access to health care across the life course continuum, (2) promoting resilience, (3) improving quality, (4) enhancing systems integration, and (5) driving community transformation. The last goal refers to taking a place-based, systems approach, which includes the health system, educational system, economic system, and community system. The five goals are referred to as the five pillars of Healthy Start 3.0. Reinventing Healthy Start approaches involves assessment, blueprint, capacity-building, development, and evaluation and QI.

Dr. Atrash stated that Healthy Start must build on what it already has. The current literature must be reviewed along with advice and guidance from key stakeholders. In addition, a Healthy Start transformation taskforce must be convened. The taskforce should be a multidisciplinary group with diverse backgrounds and expertise whose input will be highly respected and accepted. The current thinking is that Healthy Start needs standardized components and practices, a place-based systems approach, common benchmarks focused on the five pillars, a strong evaluation platform that is scientifically rigorous and evidence-based, and QI.

Healthy Start Work Group

Dr. Jackson reported on the work of the Healthy Start Work Group over the past few months. The work group objectives were to make recommendations for Healthy Start, for the evaluation plan created by the past group, and for responses to Healthy Start 3.0 as well as the language for reauthorization. The work group process involved discussions about the nature of Healthy Start; its contribution to the national agenda for achieving equitable birth outcomes and "moving the needle" for infant deaths; support for its new function and design, its target, community transformation, stress reduction, and resilience; and lessons learned and future vision.

The work group discussed the following ideas and approaches:

- Healthy Start should be a national priority with its presence in every community plagued by the tragedy of disproportionately high infant death rates among the most vulnerable.
- Healthy Start should become patient-centered community health homes for women, children, and families seamlessly integrated with public health and clinical services for

both delivery of services and evaluation of outcomes.
- Healthy Start should participate as an expert panelist for the design, implementation, dissemination, and evaluation of a national agenda setting the policies and practices for advancing equitable birth outcomes.
- Metrics should be developed to show the difference in a relatively short time, proximal to the intervention method, and to show the long-term life course impact of Healthy Start through quantitative and qualitative methods.

The Healthy Start Work Group recommendations are as follows:

- HHS should continue Healthy Start as a priority initiative to improve perinatal outcomes in project areas with high rates of infant mortality.
- HHS should give approval for Healthy Start grantees to become patient-centered, community-based health teams for women, children, and families.
- HHS should support new performance standards, evidence-based practices, and system-building strategies in every Healthy Start community.
- New data and evaluation should be acquired to demonstrate the effectiveness of Healthy Start's patient-centered, community-driven, strength-based, and culturally competent model.
- Healthy Start should be re-reviewed as an evidence-based home visiting program with new data.
- HHS should consider Healthy Start as the hub for coordinating new place-based initiatives to improve the health of women during their childbearing years and to reduce infant mortality.

Current discussion and next steps involve the target or timetable for achieving equitable birth outcomes; stress, resilience, and thriving; community transformation; and data and evaluation.

Discussion

The presentations on Healthy Start prompted the following comments and questions from the participants:

- Ms. Chesna stated that her impression of Healthy Start is that it concerns resiliency and engaging and empowering women, which is perhaps not measureable. Dr. Atrash stated that measurements for resilience and empowerment probably do exist.
- Dr. Troutman stated that the Louisville Healthy Start program had limited resources and the most important measure to evaluate was the same demographic without access to the program. He asked about the current status of funding and stated that funding should be expanded for existing long-term programs. Ms. Johnson noted that the details involved in sequestration reveal that no program is safe and that Title V and Healthy Start are not well-protected from the fiscal cliff. Dr. Atrash mentioned outcomes that could be measured besides infant deaths, such as hospital admissions, maternal complications, and behavioral modifications.
- Dr. Shepherd addressed the question of why Healthy Start has not been replicated. Three reasons are that (1) outcomes and process measures are not forthcoming, (2) evidence-based practices have not been reported on, and (3) the program is not cost-effective.

Dr. Atrash responded that project managers in the field and at the Federal level bear the burden of making the information available.

- Dr. DeCourcey compared Head Start with Healthy Start as a community-driven program with a growing need for performance standards. The individualization of the programs based on the communities and the differing emphasis on the core components make the box of services difficult to define and measure in a standardized manner. Implementation evaluation and breaking down the processes in terms of lessons learned might help to further an understanding of the processes that work across those boxes and the core components. QI is a critical part of this process in communities. Ms. Johnson noted the discussion at a previous SACIM meeting about the similarity of Healthy Start to Head Start and Community Health Centers, all of which are community-driven, family-centered Federal programs that focus on serving vulnerable populations.
- Dr. Martin noted that looking at outcomes should extend to the entire service area, not just the women who receive Healthy Start services or nurse-family partnership services. Healthy Start must collaborate with other programs in communites with poor birth outcomes so that everyone can work together to achieve the anticipated outcomes.

WRAP-UP AND ADJOURN FOR THE DAY
Kay Johnson, M.P.H., M.Ed., Chairperson, SACIM
Michael C. Lu, M.D., M.P.H., Associate Administrator for MCHB, HRSA; Executive Secretary, SACIM

Ms. Johnson announced that the terms of a number of SACIM members will end on January 1. She acknowledged the transitioning of the following members and thanked them for their contributions: Ms. Sharon Chesna, Dr. Robert Corwin, Dr. Phyllis Dennery, Dr. Tyan Dominguez, Ms. Carolyn Gegor, Ms. Melinda Sanders, and Ms. Susan Sheridan.

Dr. Lu also expressed his gratitude to those whose terms are ending. He mentioned the potential of the recommendations to reduce infant mortality and disparities. The meeting adjourned for the day at 5:20 p.m.

THURSDAY, NOVEMBER 15, 2012

SUMMARY OF DAY 1 & OVERVIEW OF DAY 2
Kay Johnson, M.P.H., M.Ed., Chairperson, SACIM

Ms. Johnson summarized the previous day's meeting, listing the speakers and panels that presented information linked to the strategic directions. After reviewing the day's agenda, she turned the meeting over to Dr. Palmer for public comment.

PUBLIC COMMENT PERIOD

Dr. Palmer announced one submission for public comment from the National Healthy Start Association. Ms. Deborah Frazier stated that the Federal Healthy Start initiative is a cost-effective, community-driven model of care that will play a major role in the ACA. The ACA's efforts to build quality, comprehensive, statewide early childhood systems for pregnant women,

parents, caregivers, and children from birth to 8 years of age fit the Healthy Start model. The 104 Healthy Start sites are shovel-ready to assist and improve the quality of health care, enhance disease prevention, and strengthen the health care workforce.

The ACA will bring a greater focus on prevention; the social determinants of health; and racial, ethnic, and socioeconomic inequality. A well-tested, successful delivery system of care, Healthy Start will assist and implement the key provisions of health care reform and health equity promotion in a timely and efficient fashion. Federal Healthy Start is committed to continuing the work it has started and desires to maintain its partnerships with local, State, and national partners to achieve success for both current and new Healthy Start sites.

Reviewing the core components of Healthy Start, Ms. Frazier described home visiting, education, systems delivery, risk reduction services, and screening. She also mentioned evaluation, community corsortia, collaborative relationshps, and local health system action plans. She continued by restating that Federal Healthy Start represents a shovel-ready network with experience and cultural authenticity to assist in serving the newly insured and the marginally served in at-risk communities nationwide. As health care reform rolls out, 32 million newly insured persons will need access to health care. Ms. Frazier ended her comments by stating that Healthy Start is positioned and ready to continue its work with its partners in addressing the needs of vulnerable populations and improving the health care of women and children.

Discussion

The public comment session prompted the following comments and questions:

- Dr. Handler asked Ms. Frazier where Healthy Start will be in 5 years. Ms. Frazier stated that Healthy Start is ready to move in the direction of a life course model; in fact, Healthy Start programs have always followed that model. Healthy Start welcomes the opportunity to measure resilience and expand programs and partnerships with existing programs. Healthy Start has always been a gap-filler.
- Dr. Handler asked about expanding Healthy Start to other sites versus using it as a hub for existing place-based initiatives. Ms. Frazier responded that whichever alternative fits the community is the right answer. Ms. Johnson added that using Healthy Start as a hub for place-based initiatives is one recommendation along with helping to implement community-based strategies through the ACA.

COMMITTEE BUSINESS: DISCUSSION AND NEXT STEPS
Kay Johnson, M.P.H., M.Ed., Chairperson, SACIM

Ms. Johnson asked members to submit additional comments and thoughts on the draft document over the next week so that it can be revised and forwarded to HRSA during the week of November 26 and then sent from HRSA to the Secretary by the end of November. Ms. Johnson asked for questions and comments.

Dr. Kotelchuck suggested adding prenatal care to the list of five topics under the redeployment strategic direction. Ms. Johnson questioned whether the level of effectiveness of prenatal care is

borne out by the available evidence. Dr. Handler stated that research demonstrates that enhanced, high-quality prenatal care has a proven impact on birth outcomes. Ms. Johnson pointed out that in the background information section of the document, prenatal care is paired with regionalized perinatal care, and Dr. Shields suggested that prenatal care might belong in the safety and quality piece. Dr. Kotelchuck stated that regionalized perinatal care is a system of care, whereas prenatal care is not. In an era of life course, prenatal care becomes more important and fetal environment is a central concept. The content of prenatal care should be reexamined, and clear evidence exists for its effectiveness. Dr. Kotelchuck reiterated his suggestion that prenatal care be included in the strategic direction regarding redeployment.

Ms. Johnson stated that both prenatal care and regionalized perinatal care are processes that have been extremely effective and should not be underrepresented in the document. Dr. Labbok called for emphasizing the attention to maternal care because of problems caused by perinatal practices. Dr. Handler remarked that the mention of prenatal care in the document is insufficient. Ms. Johnson asked which section prenatal care should be included in, the quality section or the improving women's health section. Dr. Shepherd stated that she sees the issue as one involving quality, and she recommended that prenatal care be included in the redeployment section of the document, citing the fact that an ACOG guideline on elective delivery was issued in 1979 and has not been followed. Dr. Lu agreed that prenatal care is a package of services, along with breastfeeding support and family planning, and is different from preventive services. A good place for it is in the first strategic direction about improving women's health because placing it there would provide an opportunity to rethink prenatal care not only as a strategy to improve birth outcomes but also as part of comprehensive women's health care across the continuum of the life course, which will be a game-changer for addressing infant mortality nationwide.

Dr. Kotelchuck expressed his opinion that the third strategic direction is not as strong as it should be. It correctly emphasizes a series of well-known evidence-based initiatives that should be increased, but the focus should be on strengthening the capacity for the resiliency of women as a leading force for improving birth outcomes. Dr. Labbok agreed that the first strategic direction should be strengthened, but she stated that the list of rcommendations involved in the third strategic direction deserves to be more fully defined. Ms. Johnson agreed that the list needs amplification and suggested adding an explanatory sentence or two to each of the bullets.

Ms. Johnson also mentioned cost-benefit and return on investment and suggested adding a text box highlighting each of the items on the list. Dr. Kotelchuck mentioned another topic, namely the electronic birth certificate and its linkage with other public documents. He suggested adding information to the section on the fifth recommendation under Strategic Direction 5 encouraging further efforts to link the vital statistics system to some of the other data systems.

Ms. Johnson mentioned the lack of a focus on Native American and tribal issues. Dr. Handler remarked that injury prevention is key to preventing postneonatal mortality in the Native American population and perhaps should be included in the redeployment section of the document.

Dr. Shields raised the issue of malpractice reform and suggested that it might belong in the workforce section. Ms. Johnson suggested that it be added in the general narrative, and she asked

the participants for feedback on this suggestion. Dr. Handler suggested that the approach should be more forceful and consistent, but Dr. Kotelchuck disagreed and stated that he does not recommend the choice of a single model. Dr. Handler stated that the Government should have a common framework for disparities and mortality, and Ms. Johnson mentioned that the Prevention Council offers such a framework even though it is confusing.

Dr. Martin called for an overarching statement about the interrelatedness of all of the strategic directions and recommendations.

Ms. Johnson asked the members to reexamine the executive summary and consider including the substrategy recommendations. The document reflects the macroprocess, that is, SACIM's recommendations for HHS action. It also recognizes that the the Prevention Council and the Disparities Council have both an HHS action plan and a national strategy, which is a public-private set of ideas. When they reread the document, Ms. Johnson asked that the members consider whether it makes clear that SACIM stands prepared to be the entity that combines the public and private ideas into a national strategy if the Secretary desires that SACIM take on that role. Dr. Handler asked whether SACIM is supposed to inform the national strategy. Dr. Lu stated that the recommendations will inform the national strategy, and Dr. McGraw stated that the building of the national strategy to improve infant mortality starts with SACIM. Dr. Handler asked whether SACIM should make recommendations about who should be at the table. Ms. Johnson responded that SACIM should be the entity, including all of the ex officios. Dr. Atrash stated that SACIM's report is a useful document that will give guidance to agencies.

Ms. Johnson reiterated that the work undertaken by the Prevention Council and Disparities Council involved two processes—action steps and a national strategy. Dr. Lu clarified that SACIM will make recommendations to the Secretary about the national strategy. She could accept all, some, or none of the recommendations. These powerful recommendations will be worthy of consideration toward the national strategy. Dr. Kotelchuck raised the question of research, which is buried in the section on collaboration. Research belongs in the data section and is needed on every one of the six topics.

Ms. Johnson raised the question of whether the public health investment strategy section is clear and strong enough. She questioned whether the public health infrastructure workforce message is effectively stated. She asked the members to consider this question as they review the document.

In another piece of committee business, Ms. Johnson reminded the members about the annual ethics training for committee members.

Further discussion occurred toward the end of the meeting. See page 37.

FEDERAL UPDATES
Michael C. Lu, M.D., M.P.H., Associate Administrator for MCHB, HRSA; Executive Secretary, SACIM
Erin Smith, J.D., Strong Start Project Team, Center for Medicare and Medicaid Innovations, CMS
Stephen Cha, M.D., Chief Medical Officer, Center on Medicaid and CHIP Services, CMS

Update From MCHB
Dr. Lu provided brief background information about MCHB before describing the Title V MCH Services Block Grant; the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV); and Healthy Start.

The overall Federal-State Title V program is a $6 billion enterprise every year. Title V is the country's best vehice for driving improvements in access, quality, integration, accountability, and equity, which are the five vertices of the MCH pyramid. The pyramid itself includes direct health care services, enabling services, population-based services, and infrastructure-building services.

Describing the five vertices of the pyramid, Dr. Lu stated in regard to access that the ACA will guarantee that millions of uninsured women will get health care coverage, including coverage for clinical preventive services without copay. Also needed are outreach and enrollment, care coordination and case management, translation and transportation, family voices, cultural competency, and community trust—all things that Title V does very well. In terms of quality, Dr. Lu stated that in 2013 he wants all Title V programs to be driving QI in MCH in their States, and regarding integration, Title V programs must drive systems integration in MCH, including vertical (appropriate levels of care), horizontal (service coordination across systems), and longitudinal (continuum of care across the life course) integration. In terms of accountability, Title V must measure results and deliver returns on investment in MCH. Equity is the overarching goal—gaps must be closed in MCH and disparities must be eliminated. Dr. Lu stated that another goal of Title V is to translate research from bedside to curbside and from practice to policy.

Dr. Lu explained that the MIECHV Program is authorized under the ACA to provide home visits to at-risk families throughout pregnancy and in the first years of life. For 2013, two new frontiers for home visiting are going to be QI and systems integration. By March next year, a COIN of the first 10 to 12 States will be launched to drive quality improvement in home visiting.

In 2013, MCHB will continue the effort to improve, innovate, and transform Healthy Start. MCHB will convene an expert panel to advise about the transformation of Healthy Start and will consider the SACIM Healthy Start Work Group recommendations. The transformation must emphasize standardized interventions, common benchmarks, and scientifically rigorous evaluation while continuing to be about families, communities, and systems.

Dr. Lu concluded his presentation by stating that to reduce maternal mortality and morbidity in the United States, MCHB must improve women's health before pregnancy and improve the quality and safety of maternal health care. The goal is to launch a new national movement on

maternal health by next year.

Update From the Centers for Medicare & Medicaid Services (CMS)

Ms. Smith presented information about the Strong Start for Mothers and Newborns initiative, which has two different but related strategies: (1) reducing early elective deliveries and (2) delivering enhanced prenatal care. The first strategy involves promoting awareness, spreading best practices, and promoting transparency. Strong Start is partnering with advocacy and professional organizations such as the March of Dimes and ACOG. This broad-based awareness effort includes "baby showers"; six events spread out across the country will encourage pregnant women to wait 39 weeks before delivery. Press coverage around these events will ensure that the message is being disseminated. In addition, WebMD will launch a consumer page on 39-week delivery, and a Strong Start webinar targeting payers and providers is scheduled for November 28. To rapidly spread best practices, Strong Start works with HENs at 3,700 hospitals to create policies involving early elective deliveries. Initial results are very positive. Work is also ongoing with Medscape, which has created some continuing education products for doctors and nurses focused on the benefits of not scheduling early elective deliveries. To promote transparency, Strong Start encourages hospitals to report on early elective deliveries.

Strategy 2 is based on findings from studies demonstrating that enhanced prenatal care approaches improve outcomes. Medicaid and CHIP populations have problems with access to care, social determinants of health, and other issues that often go unaddressed. Common elements of enhanced prenatal care approaches with demonstrated efficacy include addressing psychosocial needs, providing augmented approaches to care, and improving the delivery of clinical services.

The second strategy includes a funding opportunity for providers, States, managed care organizations, and conveners. Strong Start funds three models for the interventions: (1) centering and group care, (2) birth centers, and (3) maternity care homes. A fourth approach will be the MIECHVprogram. The result will be an evaluation of four different approaches to prenatal care. The awards date will be announced soon.

Dr. Cha presented an overview of the general approaches to delivery system reform and then presented detailed information about the specific work on infant mortality at the Center on Medicaid and CHIP Services (CMCS). The overall idea is to seek new opportunities and pathways through partnerships to achieve the three-part aim of improving health of populations, improving patient experience of care, and reducing costs. Integrated care model letters were sent in July to State Medicaid directors with the goal of leveraging comprehensive, patient-centered care oriented toward outcomes as the unifying principle. Letters also will be produced on shared savings and a quality framework for delivery system reform approaches.

Dr. Cha stated that the problem of access to care is multifactorial and must be unpacked as CMCS rolls up its sleeves and takes pathways forward toward 2014 and beyond. Likewise, collaborations with partners and with COIN will help to leverage the effort to move forward regarding interconception care.

Dr. Cha also mentioned the work group on tobacco cessation for pregnant women; uptake on implemention has been variable across the country. Dr. Cha also described an expert panel that considers policies to leverage best practices over time. Medicare and Medicaid directors are key partners involved in unpacking the ideas around standardized performance in outcomes measurement. The three frameworks involve (1) standardizing performance in outcome measurement, (2) the best Medicaid coverage and payment policies, and (3) methods to drive the best practices. The maternity core measures must be moved forward from a QI framework. The expert panel has made suggestions about how to focus the ideas, for example, streamlining access to family planning services, improving chronic health conditions, engaging and empowering women through education, enhancing models through synergy, and identifying best practices in contraception policy.

Discussion

The presentations by Ms. Smith and Dr. Cha prompted the following comments and questions:

- Ms. Johnson commented on the impressive quality of leadership, level of innovation, and change in direction at CMS. She stated that SACIM reaffirms the need for Federal investments in the MCH safety net, including Medicaid, and referred to two of the six strategic directions reviewed during the previous day's meeting. The first strategic direction—to improve the health of women before pregnancy—calls for using Medicaid innovation, demonstrations, and flexibility to offer States new avenues for delivering effective, evidence-based interventions to women. The second strategic direction—to ensure access to a continuum of safe and high-quality patient-centered care—calls for using Medicaid to drive innovation, quality, and change.
- Dr. Kotelchuck mentioned the close working ties between Title V and Medicaid in the 1970s and 1980s, including a technical advisory working group (TAG) between MCHB and Medicaid. He encouraged Medicaid to integrate and align at the Federal level with other agencies that deliver services. Dr. Cha responded by saying that the model structured by Medicaid is bidirectional. Ms. Johnson stated that the expert panel is a modernized version of TAG. It recognizes health plans, providers, and consumer advocates who must be brought into the conversation, and it seeks to strengthen partnerships with the States, but it does not have the same force as the TAG.
  Dr. Kotelchuck referred to the two-step process outlined by Ms. Johnson involving Government and private partners and stated that the Government plan is less clear and both strategies are needed. The Government does not speak with one voice on some key issues. Internal barriers to collaboration must be examined, and QI must be explored.
- Dr. Shepherd asked whether the materials developed for the Strong Start public awareness campaign are available on the Web so that they can be distributed at the State level. Ms. Smith responded that MOD has produced the creative materials for the print campaigns and the television PSA, and they are available online.
- In reponse to a question by Dr. Jackson regarding psychosocial factors, Ms. Smith stated that CMMI is asking providers and health systems what services they can add, with funding from CMS, to fix the problem. The psychosocial services have not been defined, but they are often referred to as "wraparound" services. Ms. Johnson added that a goal will be to demonstrate and evaluate the delivery of those services connected to what

Medicaid and CHIP fund. Ms. Smith reiterated that everything will be integrated with Medicaid and CHIP services, and continuous quality improvement is expected over the 3-year interventions.

- Dr. Kotelchuck stated his opinion that behavioral/mental health problems often are not covered. Ms. Smith remarked that applicants are proposing what they think are the best ways to approach situations involving low-level problems such as stress management. Dr. Cha mentioned the coordination and delivery of services for women without a maternity medical home. The problem often involves access to services, and care coordination ensures that a person's needs are met. Ms. Johnson added a clarification—that the applicants are defining these approaches, not CMS.
- Dr. Handler posed a question about ineffective providers, often referred to as "storefront docs" or "doc in a box," and asked how can Medicaid can be used to ensure good care. She stated that women should have access to "organized settings of care" in urban areas. Dr. Cha responded that QI has to take place in two phases: (1) exemplifying and innovating best practices and (2) ensuring that quality is increased across the board for all providers. As a Federal/State program, Medicaid must work with all of its partners across the country, recognize why problems exist, and reimburse for outcomes. The question is how to help States along this pathway and how to improve the Medicaid claims base. He described funding opportunities, including one for enhancing data, and mentioned the problems surrounding measures and systems. Providers must be held accountable for the care they give.
- Ms. Johnson asked about women's clinical preventive services for the current population and requested that CMS respond in light of the fact that the ACA does not require it.

HRSA COLLABORATIVE IMPROVEMENT &INNOVATION NETWORK (COIIN) TO REDUCE INFANT MORTALITY

Reem Ghandour, Dr.P.H., M.P.A., Public Health Analyst, MCHB/Office of Epidemiology and Research

Dr. Ghandour provided background information about the HRSA COIIN on infant mortality as well as some new information about the direction that COIIN activities will be taking over the next couple of months.

COIIN is an initiative designed to bring the science of QI and collaborative learning to bear on the challenge of infant mortality and poor birth outcomes starting in 13 States in Regions IV and VI. It is grounded in a model of collaboration developed by Dr. Peter Gloor. The key elements of a COIN are that (1) the work is done in cyberspace by a cyberteam, (2) innovation comes through rapid and ongoing communication across all levels, and (3) work is characterized by both transparency and meritocracy. Gloor's COIN model has been adapted to include a focus on improvement as well as innovation. The initiative is designed to address stated needs that came out of the January 2012 Infant Mortality Summit in New Orleans, including the need to work outside of State boundaries. It is a 12- to 18-month program and has been implemented from the start in partnership with ASTHO, AMCHP, MOD, CityMatCH, CMS, CDC, and other public and private partners. The effort is entirely driven by the individuals doing the work on the teams in the States.

HRSA's COIIN comprises State teams and strategy teams to promote smoking cessation, expand interconception care in Medicaid, reduce elective deliveries, enhance perinatal regionalization, and promote safe sleep. The five strategy teams were asked to establish QI aims for each strategy, to identify State-level opportunities to achieve aims, and to select measures to track progress towards aims.

Dr. Gandhour described activities that are being proposed under each of the aims. The Safe Sleep Team has developed strategies to foster infant caregiver knowledge, attitudes, and beliefs (KABs) and practices, establish standardized training within provider systems, and form strategic alliances. The Interconception Care Team is examining Medicaid eligibility policy, program design and innovation, and administrative processes and is considering provider KABs and practices and consumer KABs and utilization. The Perinatal Regionalization Team focuses on data, maternal care, policy and incentives, and guidelines for levels of care. The Smoking Cessation Team emphasizes changing provider and consumer KABs and practices and exploring Medicaid policy. The Elective Deliveries Team is focused on building leadership and maintaining momentum.

Over the next 6 months, COIIN will work on the draft aims, strategies, metrics, and driver diagrams; ensure that the strategies can be implemented at the State level; track process and outcome measures; plan for the second face-to-face meeting; and expand to Region V and other Regions.

Dr. Ghandoor summarized her presentation by stating that COIIN is a new MCHB-HRSA partnership to accelerate improvements in infant mortality. It is designed to help States innovate and improve their approaches to reducing infant mortality and improving birth outcomes through communication and sharing across State lines and using the science of QI and collaborative learning to improve birth outcomes. COIIN is part of a portfolio of public/private and MCHB efforts to improve birth outcomes.

Discussion

Dr. Ghandoor's presentation prompted the following comments and questions:

- Dr. Labbok asked about dollars for implementation. She also questioned why 39 weeks is the standard and whether immunization and breastfeeding might be included in COIIN in the future. Dr. Ghandoor responded that after the January meeting, the States developed their infant mortality plans, and MCHB examined the common themes in those plans. Some States have already been able to leverage additional dollars to do their infant mortality work. Money is starting to flow into these efforts. In regard to the 39-week question, the States designated this timeframe, and the team is probably grappling with this issue. Regarding immunization and breastfeeding, other Regions will no doubt take on these issues.
- Dr. Shields asked for a definition of adverse birth outcome and whether it can be expanded to include lack of breastfeeding, postpartum depression, and cesarean section. Ms. Johnson responded that the States define what they mean by an adverse birth outcome and decisions are being driven by the availability of Medicaid funding.

UPDATE FROM THE HHS HEALTH DISPARITIES COUNCIL: ALIGNING SACIM'S PRIORITIES WITH THE HHS ACTION PLAN TO REDUCE RACIAL AND ETHNIC HEALTH DISPARITIES
J. Nadine Gracia, M.D., MSCE, Deputy Assistant Secretary for Minority Health (Acting), HHS

Dr. Gracia's presentation included an overview of the HHS Action Plan To Reduce Racial and Ethnic Health Disparities, an explanation of the implementation and evaluation of the HHS Disparities Action Plan, and some comments on the synergy beween SACIM and the HHS Disparities Action Plan.

The Office of Minority Health (OMH) is leading the implementation of the Disparities Action Plan through its five core functions of awareness; data; partnerships and networks; policies, programs, and practices; and research, demonstration, and evaluation. OMH has three strategic priorities: (1) to support the development and implementation of the provisions of the ACA that address disparities and equity, (2) to lead the implementation of the HHS Action Plan to Reduce Racial and Ethnic Health Disparities, and (3) to coordinate the National Partnership for Action To End Health Disparities and the National Stakeholder Strategy for Achieving Health Equity.

The vision of the Disparities Action Plan is "a nation free of disparities in health and health care." The Disparities Action Plan represents the largest Federal commitment on disparities reduction and achieving health equity, and leverages provisions from the ACA for a coordinated and impactful effort. The HHS Disparities Council oversees the Disparities Action Plan implementation.

After presenting a snapshot of the agencies participating in the Council and listing the OMH directors, Dr. Gracia enumerated the five goals of the Disparities Action Plan: (1) transforming health care; (2) strengthening the Nation's health and human services infrastructure and workforce; (3) advancing the health, safety, and well-being of the American people; (4) advancing scientific knowledge and innovation, and (5) increasing the efficiency, transparency, and accountability of HHS programs. Dr. Gracia highlighted the actions implemented to date in each of the goal areas.

Some examples of key disparities measures delineated in Appendix C of the HHS Disparities Action Plan include the percentage of the U.S. nonelderly population with health coverage, the percentage of people who have a specific souce of ongoing medical care, the percentage of infants born at low birthweight, and the percentage of adults and adolescents who smoke cigarettes. The Health System Tracking Project will enable HHS to do some of this tracking on access to care, population health, etc.

Dr. Gracia concluded her presentation by describing the ways in which a subgroup of the Health Disparities Council offered input to SACIM regarding the strategic directions and recommendations in its national strategy document. In the area of improving the health of women, the subgroup offered comments regarding preconception health care as well as breastfeeding. Council members expressed an interest in the fourth strategic direction regarding racial and ethnic disparities. A broad social determinants framework is needed to address this issue, and campaigns must be focused on the differences between various racial and ethnic

groups. Regarding data monitoring and surveillance systems, partnerships can help to look at smaller populations in State and local areas. In the area of optimizing interagency and multidisciplinary collaboration, HHS can provide support and technical assistance.

EQUITY, DISPARITIES, AND SOCIAL DETERMINANTS IN INFANT MORTALITY
*Adewale Troutman, M.D., M.P.H., M.A., CPH***,** SACIM Committee Member
Tyan Parker Dominguez, Ph.D., M.P.H., M.S.W., SACIM Committee Member

Dr. Troutman reported on the work of the SACIM Health Equity Social Justice Committee. He stated that "creating health equity" is a stronger way to frame the idea than "eliminating health disparities." How you frame an issue determines the questions you ask, your analysis of the issue, how you prioritize it, your policy choices, and resource allocation. It also can determine your allies and your enemies, and you can frame an issue narrowly or broadly. Some issues ripe for reframing are health versus health care, individual versus population health, market justice versus social justice, rights versus privileges, biological/behavioral determinants versus social determinants, and creating health equity versus eliminating health disparities.

Health equity is the realization by ALL people of the highest attainable level of health. Achieving health equity requires valuing all individuals and populations equally, and entails focused and ongoing societal efforts to address avoidable inequalities by ensuring the conditions for optimal health for all groups, particularly for those who have experienced historical or contemporary injustices or socioeconomic disadvantage. Health inequities are systemic, avoidable, unfair, and unjust differences in health status and mortality rates and in the distribution of disease and illness across population groups. They are sustained over time and generations and are beyond the control of individuals.

Dr. Troutman listed the World Health Organization's social determinants, which include stress and the social gradient. He also listed the social determinants of health from his own perspective, including socioeconomic status, which entails occupation, education, income, racism (individualized, internalized, and institutionalized), discrimination, housing, and political power. Health can be viewed as a resource to attain education, economic security, and access to goods and services, but the social determinants are a resource to attain health. The notion of residential segregation is that "the metropolitan areas with the highest segregation levels have the most unequal geographies of opportunity." Opportunity neighborhoods are characterized by sustainable employment, high-performing schools, access to high-quality health care, adequate transportation, high-quality child care, neighborhood safety, and institutions that facilitate civic engagement.

Dr. Dominguez spoke on promoting health equity in the National Strategy on Infant Mortality. The United States ranks behind 24 other countries in infant death. Persistent disparities in health have been called a "biologic expression" of persistent social inequalities, related to fundmental social inequities—socioeconomic, racial, and ethnic. SACIM's fourth strategic direction is to reduce racial/ethnic and income disparities, influence social determinants, and increase health equity through investments in higher risk communities and programs to reduce poverty and racism. Dr. Dominguez pointed out that this strategic direction is not new. A 2006 SACIM report on eliminating health disparities called for a plan that recognized biopsychosocial determinants,

examined disparities in the sociological context of race, understood lifelong accumulation of risk due to poverty and racism, and recognized the need for major investments in place-based, community-driven, multisector initiatives such as Healthy Start.

The 2012 SACIM report calls for a national strategy to reduce infant mortality that includes sustained commitment to addressing social determinants of health in order to increase health equity. The recommendations involved in health equity include convening an interagency expert panel to set goals for closing infant mortality gaps; supporting and transforming Healthy Start and maximizing its potential to reduce infant mortality, eliminate disparities, and increase health equity; using Federal interagency collaboration to address social determinants of health by concentrating investments in place-based initiatives with Healthy Start sites as the hub; addressing and alleviating poverty through enhanced use of income supports; and adding SACIM to the list of HHS initiatives aiming to eliminate disparities and increase health equity. The HHS Action Plan To Reduce Racial and Ethnic Health Disparities and the ACA afford key opportunities to implement the SACIM recommendations.

Dr. Dominguez concluded her presentation by stating that health equity is a Big Idea that is an Old Idea based on a founding principle of our country.

Discussion

The presentations by Drs. Gracia, Troutman, and Dominguez prompted the following comments and questions:

- Dr. Pressler noted that education level is a significant factor in health outcomes and asked about the need to address education equity along with health equity. Dr. Gracia stated that Healthy People recognizes the important connection between education and health, as does OMH and the President. Dr. Troutman mentioned the Harlem Children's Zone, which is based on educational attainment, overall health, and community sustainability.
- Dr. Kotelchuck asked about the role of promotores and community health workers. Dr. Gracia explained that the HHS Promotores Steering Committee comprises 15 individuals who are leaders of various promotores networks nationwide. They serve as experts guiding HHS on how to promote the use of community health workers to engage in health outreach and education. CDC, OMH, and the National Heart, Lung, and Blood Institute have been working with community health workers through a variety of programs to address particular diseases such as diabetes and heart disease and to reduce health disparities.
- Dr. Kotelchuck asked about Healthy Start and the replication of the same model for various diseases and conditions. Dr. Gracia responded that information is being shared to address the problem of duplication of efforts.

UPDATES FROM PARTNER ORGANIZATIONS

Brian Osberg, M.P.H., Program Director, Health Division, Center for Best Practices, National Governors Association
Paul E. Jarris, M.D., M.B.A., Executive Director, Association of State and Territorial Health Officers
Cindy Pellegrini, Senior Vice President of Public Policy and Government Affairs, March of Dimes
Michael Fraser, Ph.D., CAE, Chief Executive Officer, Association of Maternal and Child Health Programs

National Governors Association

Mr. Osberg reminded the SACIM members that at the July meeting he presented information about the initiative on improving birth outcomes. NGA's role is to facilitate, convene, and coordinate current efforts and assist governors in adopting best practices regarding preterm birth and infant mortality. NGA is developing a Learning Network, sponsored by HRSA and ASTHO, on improving birth outcomes.

The State Learning Network involves the issuing of requests for applications to States. More than 20 States were involved in a bidders' conference in early November. Three sequential Learning Networks, in groups of four, will start in December, followed by March and June. The Learning Network will complement and support Strong Start and the COIN collaborative to help position States to be successful in this area. An in-State planning session will be held, with consultation and a networking conference in March.

NGA also is involved in other MCH activities, including an annual MCH survey, webinars on children's health, a policy paper on MCH and health reform, an issue brief on improving birth outcomes for the Medicaid population, and a health policy Web site (statepolicyoptions.nga.org).

Association of State and Territorial Health Officers

Dr. Jarris presented an update from ASTHO, including ASTHO's bottom line, promising approaches, and initiatives. The bottom line is that ASTHO will continue to be engaged in the area of infant mortality and prematurity. A total of 49 States have taken the pledge under ASTHO's Healthy Babies Presidential Challenge to reduce preterm birth by 8 percent by 2014. Three States (Alaska, New Hampshire, and Vermont) have already met the targets. Dr. Jarris described the life of the President's Challenge. In 2011, ASTHO began work in the area of promoting health equity to reduce disparities, and Healthy Babies began in 2012 as an outgrowth of that work. In 2013, the Presidential Challenge involves the integration of public health and health care. In 2014, the Presidential Challenge will likely involve prescription drug abuse with a focus on neonatal abstinence.

Ongoing efforts include a powerful group—the National Quality Forum's National Priorities Partnership—which brings together many public and private-sector groups to share information about initiatives. A vaccine initiative has met with success across the country and includes the National Medical Association and the National Hispanic Medical Association. America's Health Rankings Collaboratives are focused on obesity, diabetes, tobacco, and infant mortality, with a particular emphasis on health equity and a "goodness and fairness" goal. ASTHO also is

participating on the CMCS Expert Panel on Improving Maternal and Infant Health Outcomes in Medicaid and CHIP and is active on the NGA expert panel and in the MOD prematurity campaign.

After describing the successes enjoyed by Georgia and Maryland, Dr. Jarris mentioned future areas to address, including a standardized methodology for ensuring goodness and fairness, the COIIN, Medicaid waivers, rural and geographic disparities, disparities in the Native American population, and maternal smoking.

March of Dimes

Ms. Pellegrini presented information about MOD initiatives. She referred to last year's preterm birth report card, which was produced using 2009 final birth data. Only Vermont received a grade of A. The 2011 preliminary data reveal that the national rate of preterm birth dropped from 12.0 to 11.7 percent, the fifth consecutive year of decline from a peak of 12.8 percent in 2006. Four States earned an A: Vermont, New Hampshire, Maine, and Oregon. Declines were achieved in 45 States, DC, and Puerto Rico, but challenges still exist in the deep South. Three States saw slight increases in their preterm birth rates: Louisiana, Arkansas, and Idaho, while Kentucky and Kansas held steady. The Premature Birth Report Card also includes information on the latest rates of uninsured women, women smoking, and late preterm birth by State. Ms. Pellegrini also reported that media coverage has involved a number of national outlets. Strong Start is executing about $1 million in media buys during November, which is Prematurity Awareness Month, for MOD early elective delivery PSAs and print ads.

The PREEMIE Act was passed initially in 2006 and created the first real focus on coordinating, increasing, and supporting preterm birth activities; directed convening of the Surgeon General's Conference on Prevention of Preterm Birth; and expanded CDC activities on preterm birth. The PREEMIE Act is due for its 5-year renewal. The Act protects Federal research into the causes, prevention, and treatment of prematurity. Ms. Pellegrini also stated that World Prematurity Day (November 17) will see activities in dozens of countries. In addition, MOD is petitioning to Light the White House Purple on January 3, 2013, to celebrate the 75th anniversiy of MOD.

Association of Maternal and Child Health Programs

Dr. Fraser explained that AMCHP is the organization representing State Title V directors and leadership, and he offered initial feedback on the SACIM strategic directions and recommendations. He referred to 2012 as a banner year for initiatives. The SACIM strategic directions and recommendations are consistent with the seven recommendations in the AMCHP Compendium on Improving Birth Outcomes.

Dr. Fraser mentioned, in particular, the SACIM recommendation on place-based initiatives under Stratetic Direction 4. He stated that, for the most part, States know what to do to reduce infant mortality. Title V should be thought of as a safety net provider plus a locus for leadership on MCH issues at the State level. Chronic disease programs, injury prevention programs, medical home expansion, MCH epidemiology, and other nondirect services work are supported through the block grant.

States lack resources, and Dr. Fraser called for the report to suggest that issuing recommendations without a call for sustained investment will not advance the call to action. The true success of SACIM's recommendations will rest primarily on the sixth strategic direction, which involves interagency collaboration and partnership between public and private entities. Dr. Fraser concluded his presentation with an offer that SACIM work through AMCHP and its partners to share the recommendations with the States. Feedback from the States at a town hall meeting can provide a reality check from individuals in the field.

Discussion

The presentations by the partner organizations prompted the following comments and questions:

- Dr. Handler clarified that SACIM considers Title V not as services but as systems. Title V can be viewed as an infant mortality safety net because of the infrastructure it provides.
- Ms. Johnson pointed out that the document will be finalized, submitted, and accepted and then a town hall meeting can be planned. She reiterated that SACIM is recommending an actionable set of strategies for HHS.
- Dr. Jackson commented on the need for reasonable targets and stated the importance of measuring equity, that is, looking at systems and programs and gauging whether they are equitable in their process and outcomes. She mentioned successful initiatives in southwest Georgia working with churches on obesity and nutrition, but she also mentioned that the area has a civil rights history and the question is whether those two elements will merge in terms of a health conversation. Regarding measures, Dr. Jarris stated that measurement is necessary for reporting and for improvement. A goal for improvement is needed along with a measurement for that goal and then an intervention. Being specific about how to create improvements is critical.
- Dr. Labbok asked about age-group control in the MOD data for Louisiana. Ms. Pellegrini replied that tremendous variation existed in the States and communities within States, so age-group control was not possible. Ms. Johnson pointed out that both age and race are driving forces. Ms Pellegrini agreed and stated that Louisiana's rates went up despite a significant effort over the past 2 years to drive the rates down.
- Dr. Barfield asked the partners to comment on issues of health equity and opportunities to address health inequities. Dr. Jarris stated that health equity is not a separate issue from decreasing infant mortality—it is one issue. The two elements must be brought together. Health equity has been elevated to ASTHO's strategic map. Dr. Fraser added that infant mortality is a health equity issue and States know that an additive approach from national, State, and community leadership is needed to close the gap. Strategies to reduce health inequities from a clinical standpoint are very different from the general community standpoint; the science behind the clinical closing of the gap is known, but the process of eliminating racism from communities is unknown. Dr. Jarris pointed out that most plans cannot capture race, ethnicity, and income levels from claims data, which is another problem that must be solved. Ms. Pellegrini stated that our current understanding of disparities or inequities is unsophisticated; without knowing the causes, we cannot create interventions to correct them. Mr. Osberg mentioned the need to address the question of inequities especially in the Medicaid population.

- Dr. Kotelchuck stated that new technologies such as fertility treatments can increase or decrease the evidence of disparities and that disparities change depending on technology.
- Dr. Troutman asked whether the partners have worked with the National Association of County Health Officials (NACHO) or with CityMatCH. Dr. Jarris stated that ASTHO has engaged NACHO in the effort to develop the goodness and fairness measure. Dr. Troutman added that the health status of the Native Hawaiian population is a major issue in Hawaii.
- Dr. Handler mentioned that partnerships must be developed with groups that are willing to take on the issue of poverty because infant mortality will not be reduced until the problem of poverty is solved. Health is determined by access, but there is no substitute for money. Dr. Jarris noted that we must be more refined in how we look at the inequities, including socioeconomic inequities. "Operating out of one's lane," for example, mixing public health with education, can be a political problem. Dr. Pressler reiterated that the fundamental issue is education.

COMMITTEE BUSINESS: DISCUSSION AND NEXT STEPS (CONTINUED)
Kay Johnson, M.P.H., M.Ed., Chairperson, SACIM
Michael C. Lu, M.D., M.P.H., Associate Administrator for MCHB, HRSA; Executive Secretary, SACIM
Hani Atrash, M.D., M.P.H., Director, MCHB/Division of Healthy Start and Perinatal Services

Ms. Johnson mentioned an exchange of emails among SACIM members involving the target for closing disparities and progress over trends. A bullet in the report notes that the Secretary should appoint an individual to look at target-setting, but SACIM perhaps should reevaluate that recommendation. An opportunity exists to add information in the opening comment about health equity. Ms. Johnson asked the members to reexamine that recommendation so that they can reach consensus about it.

Ms. Chesna asked about editing versus making additions to the document. Ms. Johnson stated her sense that the document contains a good consensus but a few areas require greater clarification and improvement. Some fine-tuning is necessary, and members should give feedback about important omissions.

Dr. Martin expressed her concern that the next week does not allow enough time to consult with individuals who could help determine the target goals for eliminating disparities. Ms. Johnson suggested that SACIM could notify the Secretary that this topic needs further exploration and that SACIM intends to do more work on it.

Members announced upcoming meetings, including an Institute of Medicine workshop on research issues into the assessment of birth settings and the eighth annual meeting on women's perspectives on breastfeeding to be held in March. The committee will receive further information about both events.

Dr. Shields asked about next steps after the report is submitted at the end of November. Ms. Johnson will confer with Dr. de la Cruz for clarification on next steps. The report is submitted to MCHB, sent through HRSA, and then on to the Secretary. The process can take a

number of days.

The next meeting agenda will be determined in December and January. Several ideas are on the table.

Dr. Lu thanked his staff, the speakers, and the committee members. He stated that the strategic directions and recommendations are strong and actionable and will have an impact as the Nation moves forward in addressing infant mortality and closing the infant mortality gap. Dr. Lu acknowledged the following committee members who are leaving SACIM and thanked them for their service and leadership: Ms. Sharon Chesna, Dr. Robert Corwin, Dr. Phyllis Dennery, Dr. Tyan Dominguez, Ms. Carolyn Gegor, Ms. Melinda Sanders, and Ms. Susan Sheridan.

Dr. Atrash commented on the rich discussion and useful information given in the meeting. He lauded the clear efforts among many groups to coordinate and collaborate, avoid duplication, and work effectively and efficiently. The speakers addressed infant mortality not as a health outcome issue but as a socioeconomic issue whose solution extends far beyond ensuring availability and accessibility to health services—it requires education, employment, and community transformation. SACIM's strategic directions and recommendations will help guide HRSA's actions to reduce the gap and improve the rates of infant mortality.

The meeting adjourned at 3:13 p.m.

PARTICIPANT LIST

Advisory Committee Members

Kay A. Johnson, M.P.H., Ed.M.
Mark Bartel, M.Div., BCC
Sharon M. Chesna, M.P.A.
Robert Mande Corwin, M.D., FAAP
Tyan A. Parker Dominguez, Ph.D., M.P.H., M.S.W.
Carolyn L. Gegor, C.N.M., M.S., FACNM
Arden Handler, Dr.P.H., M.P.H.
Fleda Mask Jackson, Ph.D., M.S.
Milton Kotelchuck, Ph.D., M.P.H.
Miriam Harriet Labbok, M.D., M.P.H.
Joanne B. Martin, Dr.P.H., RN, FAAN
Joann R. Petrini, Ph.D., M.P.H.
Virginia Morriss Pressler, M.D., M.B.A., FACS
Ruth Ann Shepherd, M.D., FAAP
Sara G. Shields, M.D., M.S.
Adewale Troutman, M.D., M.P.H., M.A., CPH

Ex Officio Members

Wanda Barfield, M.D., M.P.H.
Stephen Cha, M.D., CMS (representing Dr. Marsha Lillie-Blanton)
Wendy DeCourcey, Ph.D., ACF
J. Nadine Gracia, M.D., MSCE, OMH
Iris R. Mabry-Hernandez, M.D., M.P.H., AHRQ

Advisory Committee Staff

Executive Secretary
Michael C. Lu, M.D., M.S., M.P.H.
Associate Administrator
Maternal and Child Health Bureau
Health Resources and Services Administration

Staff Assistant
Michelle Loh
Division of Healthy Start and Perinatal Services
Maternal and Child Health Bureau
Health Resources and Services Administration

Presenters

Hani Atrash, M.D., M.P.H.
Director
MCHB/Division of Healthy Start and Perinatal Services

Wanda Barfield, M.D., M.P.H.
Captain, U.S. Public Health Service
Director, Division of Reproductive Health
National Center for Chronic Disease Prevention and Health Promotion, CDC

Marcia Brand, Ph.D.
Deputy Administrator, HRSA

Stephen Cha, M.D.
Chief Medical Officer
Center on Medicaid and CHIP Services, CMS

Robert Mande Corwin, J.D., FAAP
Clinical Professor of Pediatrics
University of Rochester School of Medicine and Dentistry

Tyan Parker Dominguez, Ph.D., M.P.H., M.S.W.
Clinical Associate Professor
School of Social Work
University of Southern California

Triesta Fowler-Lee, M.D.
Medical Officer and Coordinator
National Child and Maternal Health Education Program
NICHD

Michael Fraser, Ph.D., CAE
Chief Executive Officer
Association of Maternal and Child Health Programs

Reem Ghandour, Dr.P.H., M.P.A.
Public Health Analyst, Office of Epidemiology and Research
Maternal and Child Health Bureau

J. Nadine Gracia, M.D., MSCE
Deputy Assistant Secretary for Minority Health (Acting), HHS

Arden Handler, Dr.P.H.
Professor of Community Health Sciences, Maternal, and Child Health
School of Public Health
University of Illinois at Chicago

Marianne Hillemeier, Ph.D., M.S.N., M.P.H.
Associate Professor
Health Policy and Administration and Demography
Pennsylvania State University

Fleda Mask Jackson, Ph.D., M.S.
Senior Scientist
Rollins School of Public Health
Emory University

Paul E. Jarris, M.D., M.B.A.
Executive Director
Association of State and Territorial Health Officials

Kay Johnson, M.Ed., M.P.H.
Chairperson
Secretary's Committee on Infant Mortality

Marilyn Keefe, M.P.H., M.P.P.
Deputy Assistant Secretary for Population Affairs, HHS

Howard K. Koh, M.D., M.P.H.
Assistant Secretary, HHS

David L. Lakey, M.D.
Commissioner
Texas Department of State Health Services

Miriam Labbok, M.D., M.P.H.
Professor of the Practice of Public Health
Gillings School of Public Health
University of North Carolina at Chapel Hill

Michael C. Lu, M.D., M.P.H.
Associate Administrator for Maternal and Child Health
Health Resources and Services Administration

Marian F. MacDorman, Ph.D.
Statistician and Senior Social Scientist, CDC

Elliott Main, M.D.
Medical Director, California Maternal Quality Care Collaborative
Chairman and Chief of Obstetrics
California Pacific Medical Center

Brian Osberg, M.P.H.
Program Director, Health Division,
Center for Best Practices, National Governors Association

Cynthia Pellegrini
Senior Vice President of Public Policy and Government Affairs
March of Dimes Foundation

Joann Petrini, Ph.D., M.P.H.
Director, Clinical Outcmes and Health Services Research
Danbury Hospital

Virginia Pressler, M.D., M.B.A., FACS
Executive Vice President
Hawaii Pacific Health

Erin Smith, J.D.
Strong Start Projuect Team
Center for Medicare and Medicaid Innovations, CMS

Adewale Troutman, M.D., M.P.H., M.A., CPH
Director of Public Health Practice and Leadership
Colege of Public Health
University of South Florida

Other Attendees

Chad Abresch
CityMatCH

Kwamme Anderson
Office of Minority Health, HHS

Carolyn Aoyama
IHS

Sundal A i
HHS

Benita Baker
HRSA

Danielle Barradas
CDC

Erin Bonzon
AMCHP

Kathy Buckley
NFIMR/ACOG

Kirby Bumpus
HHS

Carlos Cano
HRSA

Kevin Concannon
USDA

Andria Cornell
AMCHP/JHSPH

Kim Deavers-Sherman
HRSA/MCHB

Christopher DeGraw
HRSA/MCHB

Juliann DeStefano
HRSA/MCHB/DHSPS

Johannie Escarne
HRSA/MCHB/DHSPS

Brent Ewig
AMCHP

Deborah Frazier
National Healthy Start Association

Allison Goodman
Department of Labor

Violanda Grigorescu
CDC

Isadora Hare
HRSA/MCHB

Kenn Harris
Community Foundation for Greater New Haven

Kimberly Hawley
HRSA/MCHB

Angela Hayes-Toliver
HRSA/MCHB/DHSPS

Keisher Highsmith
HRSA/MCHB/DHSPS

Anna Hyde
ACOG

Barbara Lee Jackson
National Healthy Start Association

Chazeman Jackson
HHS/OMH

Kathleen Kilbane
HRSA

Lisa King
HRSA/MCHB

Vanessa Lee
HRSA/MCHB

Brenda Lisi
USDA

Ruth Lubic
Developing Families Center

Yvonne Maddox
NICHD

Kate Marcell
HRSA/MCHB

Marlene Matosky
HRSA

Carolyn McCoy
AMCHP

John McGovern
HRSA

Kate Meyer
Planned Parenthood

Susan Moskosky
HHS/OPA

Florence Odongkara
HRSA

Brea Onokpise
AWHONN

Corey Palmer
HRSA/MCHB/DHSPS

Diane Pilkey
HHS/ASPE

Uma Reddy
NICHD

Madelyn Reyes
HRSA/MCHB

Makeva Rhoden
HRSA/MCHB

Alma Roberts
National Healthy Start Association

Patrick Simpson
Kellogg Foundation

Laura Snebold
NACCHO

Michelle Sternthal
March of Dimes

Natalya Verbirsky-Savitz
Mathematica Policy Research

Ellen Volpe
HRSA/MCHB

Raynard Washington
Healthy Start

Kathy Watters
HRSA/MCHB

Kristen Wan
ASTHO

Vanessa White
HHS/OPA

Emil Wigode
March of Dimes