DEPARTMENT OF HEALTH & HUMAN SERVICES

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Secretary's Advisory Committee on Infant Mortality (SACIM)
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August 18, 2014

The Honorable Sylvia M. Burwell
Secretary of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Madam Secretary:

In January 2013, the HHS Secretary's Advisory Committee on Infant Mortality (SACIM) submitted a report with six strategic directions and recommendations for a national plan to reduce the nation's infant mortality rate. In follow up, SACIM submitted a letter (August 2013) with more detailed advice about our first strategic direction, improving the health of women before, during, and beyond pregnancy. The purpose of this letter is to provide you with further recommendations for action related to our second strategic direction.

The second strategic direction defined by SACIM is to **ensure access to a continuum of safe and high-quality, patient-centered care.** The five core recommendations for this strategy are as follows:

2.A. Strengthen state leadership and capacity to improve birth outcomes and reduce infant mortality through the Health Resources and Services Administration (HRSA) Collaborative Innovation and Improvement Network (CoIIN).
2.B. Use Medicaid to drive quality and improve the health of women and infants.
2.C. Support quality improvement activities through other agencies of HHS, including the Agency for Healthcare Research and Quality (AHRQ) and Centers for Disease Control and Prevention (CDC).
2.D. Support health coverage for all newborns by requiring newborn coverage for all infants and making temporary coverage available to those who are uninsured at birth.
2.E. Maximize the investments in community health centers and workforce capacity.

Building on these core recommendations, we describe below a series of action items for consideration by HHS. These action items emphasize: access to care, continuity of care, and completeness of care.

- Access to care includes helping women and newborns both obtain and sustain care at any point across the perinatal continuum that they can enter the system. This requires linkages and communication about what resources are available.
- Continuity of care is especially important given the multiple transition points in the perinatal continuum (e.g., from pre-pregnancy into pregnancy, from prenatal care into a birth setting, from hospital discharge into well-child and well-woman care).

- Completeness of care encompasses issues related to safety, quality, patient-centeredness, and an intergenerational approach to the needs of families.

We believe HHS can take the following specific actions to improve access, continuity, safety and quality throughout the continuum of perinatal services.

1. The **Affordable Care Act (ACA)** remains essential for ensuring access, prevention, and quality. Thus we recommend the following regarding the ACA:

    a. Continue to leverage the ACA coverage and benefits that directly impact women of reproductive age, infants, and families.
    b. Continue public campaigns to inform and facilitate access for all women on their rights and benefits under the ACA and Medicaid (in all states regardless of expansion status).
    c. Monitor and report publicly on the status of ACA coverage mandates for preventive services, as well as mental health parity.

2. **Medicaid**, as a funder of more than half of all the nation's births, is critical to maternal and child health. We encourage HHS to continue to address access and quality for the Medicaid maternal and infant population with the following actions:

    a. Provide specific guidance and technical assistance from the Centers for Medicare and Medicaid Services (CMS) to states related to the challenging issues facing dually-eligible pregnant women under ACA and Medicaid. This is critical to avoid "churning" between different coverage and to ensure all covered pregnancy benefits are available.
    b. Require automatic newborn coverage eligibility under Medicaid for all infants who are born without an identified source of coverage.
    c. Support CMS perinatal quality measurements and encourage all state Medicaid agencies to routinely report on them.
    d. Develop partnerships to work on Medicaid approaches for measuring postpartum visit use, quality, and modernized payment strategies (e.g., unbundling payment).
    e. Fund additional cycles of CMS Strong Start demonstration projects targeting:
        i. Perinatal services in Accountable Care Organizations (ACO),
        ii. Regional perinatal care, to implement new joint ACOG/AAP guidelines and assure appropriate care at the time of birth
        iii. Interconception care,
        iv. Long acting, reversible contraceptive (LARC) at time of delivery,
        v. Postpartum visit content, timing, and payment, and
        vi. Intergenerational services (parent-child services, Centering Parenting, etc.)

3. **Community health centers** (CHCs) play a pivotal role in increasing access under the ACA to some of the nation's most vulnerable young families. We recommend continuing to support expansion of CHCs, especially in relation to perinatal services and the need for neighborhood-based, culturally-sensitive, comprehensive, longitudinal care for such families. Specifically, SACIM recommends that HHS:

a. Support continuation of the trust fund for CHCs set to expire in 2015.
b. Implement the new family planning guidelines jointly issued by the CDC and Office of Population Affairs (OPA) in all CHCs through HRSA's Bureau of Primary Health Care (BPHC).
c. Fund demonstration projects in CHCs for perinatal medical homes that connect both maternity and pediatric medical homes in a comprehensive and integrated way.
d. Adopt additional and/or alternative perinatal measures for the Uniform Data Set (UDS) that CHCs report on annually.
e. Offer BPHC's technical assistance to CHCs regarding reproductive health, perinatal health, pre/interconception care, and best practices for maternal and infant care.
f. Support and report on linkages between CHCs and federally funded Maternal, Infant and Early Childhood Home Visiting (MIECHV) sites and Healthy Start grantees.

4. **Home visiting** programs have the potential to improve coordination, integration, and linkages among an array of perinatal services. SACIM encourages ongoing HHS support for the MIECHV program which can have significant impact on use of services across the perinatal continuum. SACIM also recommends that HHS require community-level collaboration among federally funded programs (e.g. MIECHV, Healthy Start) to avoid duplication, foster integration, and strengthen local service capacity.

5. Across federal agencies, both within HHS and beyond, many programs that address maternal and child health could be strengthened through collaboration and/or focus on specific challenges. SACIM recommends that HHS:

   a. Use Substance Abuse and Mental Health Services Administration (SAMHSA) resources and expertise to develop effective perinatal substance abuse (including opioids) and perinatal mental health programs.
   b. Fund additional National Institutes of Health (NIH) research on the issues such as perinatal smoking, breastfeeding, nutrition, and maternal stress and depression.
   c. Collaborate with the Department of Education (DOE) to increase federal funding for the Individuals with Disabilities Education Act (IDEA), Part C Early Intervention Services Program, which has impact on infant survival and long term disability.
   d. Work with the Department of Labor to offer paid maternity leave of at least 18 weeks as part of disability insurance.

6. **Information technology (IT)** and electronic records can support linkages, but much remains to be done to move from concept to real-time, practical tools. SACIM recommends that HHS take the following steps to improve linkages across the perinatal continuum:

   a. Support integration across disparate platforms of electronic health records, and "Meaningful Use" measures that reflect this need for integration.
   b. Within HRSA, align measures related to perinatal health to avoid duplication (e.g. Healthy Start, MIECHV, Title V, CHC, and Medicaid perinatal measures).
   c. Fund IT projects to aid linkages between maternal and infant health records, such as the work that CDC and CMS link vital statistics and Medicaid claims data.
   d. Clarify HIPAA/FERPA requirements and reduce barriers to linked records for the parent/young child dyad, and for longitudinal child health and education records.

7. We recommend that HHS take the following actions related to **quality and safety**:

    a. Provide federal funding to support a Perinatal Quality Collaborative in every state.
    b. Support the implementation and continuation in all states of the HRSA Infant Mortality CoIIN.
    c. Support the work of the HRSA CoIIN, the CDC, and others working with states to improve perinatal regionalization.
    d. Continue the MCHB-HRSA role as a partner in the Maternal Health Initiative to monitor maternal morbidity and mortality and to promote the adoption of safety "bundles" for care at the time of birth.
    e. Continue work at AHRQ on teamwork training (TeamSTEPPS) as part of inpatient maternity safety and system integration across inpatient and outpatient settings

8. **Patient centeredness** also includes patient engagement and empowerment. With an eye to promoting shared decision-making and parental resiliency, we recommend that HHS:

    a. Collaborate with the Patient Centered Outcomes Research Institute (PCORI) to facilitate and fund perinatal research projects.
    b. Continue to promote the use of group models such as Centering Pregnancy and Centering Parenting, which can increase patient empowerment and improve outcomes.

Assuring quality across the continuum of perinatal care is critical to reducing infant mortality. We still have far to go toward assuring that all women and infants receive quality care as defined by the Institute of Medicine, that is, safe, timely, effective, efficient, equitable, and patient-centered.

We respectfully submit these recommendations for action and stand ready to assist in their implementation. SACIM would welcome your participation in our next meeting, September 29-30, when we will focus on reducing disparities and increasing health equity.

Sincerely yours,

/s/

Kay A. Johnson
Chairperson, SACIM

/s/

Sara G. Shields, MD, MS, FAAFP
Chair, SACIM Work Group on Strategy 2