**DEPARTMENT OF HEALTH AND HUMAN SERVICE**

Secretary's Advisory Committee on Infant Mortality (SACIM)
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August 15, 2013

The Honorable Kathleen Sebelius
Secretary of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Secretary Sebelius:

In November, 2012 the Secretary's Advisory Committee on Infant Mortality (SACIM) presented to you six broad strategic directions, and followed in January, 2013 with a report to you detailed recommendations to reduce U.S. infant mortality and the ongoing disparities in maternal and infant health. The purpose of this letter is to discuss in greater detail recommended actions to improve the health of women and mothers, in particular.

As you may recall, the first strategic direction listed in our report is to: **improve the health of women before, during, and beyond pregnancy.** The four core recommendations for this strategy are to:

1. Monitor coverage and promote use of women's clinical preventive services;
2. Partner with professionals to develop clinical guidelines for well-woman visits;
3. Use Medicaid innovation, demonstrations, and flexibility to offer states new avenues for delivering effective, evidence-based interventions to women; and
4. Increase efforts to ensure mental/behavioral health and social support services.

SACIM believes that improving the health of women across the reproductive life course is a key strategy for improving the health of families and communities, reducing disparities, and improving the well-being of the next generation. Improving the health of women before, during, and after pregnancy not only benefits women directly but also has major potential to reduce infant morbidity and mortality, particularly for the most vulnerable populations, women of color, and women of limited financial means.

Efforts to link improvements in the health and well-being of women of reproductive age to improvements in reproductive and birth outcomes must include approaches that enable and support women to: have planned and/or intended pregnancies, enter pregnancy in good health, gain access to high quality prenatal care, have a safe and positive birthing experience, address

chronic conditions or conditions, and use postpartum and well woman visits that promotes their physical and mental health over their life course.

Building on our four core recommendations (as noted above), we delineate below a series of related actions for consideration by DHHS. These timely and evidence-informed actions build on the efforts of the Obama Administration to improve women's health through implementation of the Affordable Care Act (ACA).

1. **Build on DHHS public-private partnerships to support a call by the American College of Obstetricians and Gynecologists (ACOG) for 2013 to be the Year of the Woman and Women's Health. Use this momentum to improve well-woman care.**

    a. Delegate the Health Resources and Services Administration's Maternal and Child Health Bureau (HRSA/MCHB) to support development of clinical guidelines for well-woman visits, as suggested in the ACA women's health amendment, through a process similar to the development of "Bright Futures" clinical guidelines for well-child visits through which HRSA/MCHB engaged professional organizations (e.g., American Academy of Pediatrics). This effort should be aimed at defining the content of visits and promoting their implementation, and it should include attention to women's mental health and psycho-social needs.

    b. Include OB-GYNs in the list of providers eligible for Medicaid primary care incentives payments. As many as half of women of childbearing age consider their OB-GYN to be their primary provider or medical home. Permitting OB-GYNs to receive primary care incentive payments through Medicaid will help to maintain access.

2. **Continue to support efforts that ensure women are able to plan their pregnancies and prevent unintended and unwanted pregnancies and births.**

    a. Provide continued support for the Title X Family Planning Program both for women who will remain uninsured after implementation of the ACA and because of the role Title X plays in providing clinical infrastructure for family planning.

    b. Develop and implement a public education and engagement campaign that provides information about contraceptive coverage available to women without cost sharing through the ACA women's clinical preventive services guidelines.

3. **Provide explicit support for preconception/interconception care activities, both new initiatives and existing initiatives that need expansion.**

    a. Accelerate implementation of the DHHS guidelines for women's clinical preventive services for well-woman visits without cost-sharing, through efforts to integrate postpartum visits, well-woman visits, and interconception care.

    b. Continue support of Medicaid financing for interconception care, through flexibility in Medicaid state plan amendments, waivers, and other mechanisms. In particular, health

homes for individuals with chronic conditions and integrated delivery systems offer important opportunities to improve the health of women who had a prior adverse pregnancy outcome (e.g., preterm birth, infant death).

c. Endorse the 2013 Action Plan of the National Preconception Health and Health Care Initiative. Supported by the Centers for Disease Control and Prevention (CDC) and engaging five other units of DHHS, as well as more than a dozen private partners (e.g., March of Dimes, ACOG), this Initiative works to implement the 2006 CDC recommendations and its public-private sector Action Plan released in 2012.

d. Expand the National Preconception Health and Health Care Initiative's *Show Your Love* campaign. The campaign encourages women to become as healthy as possible for themselves and children they may want to have in the future.

e. Encourage dissemination of a preconception care clinical toolkit to the health care provider community, such as that created under the leadership of the National Preconception Health and Health Care Initiative. This work focuses "*All Women, All the Time*" or "*Every Woman, Every Time*" to achieve the triple aim of assuring safe and high quality care, improving population health, and reducing costs.

f. Support states in the collection of the recommended preconception health indicators, developed and piloted by eight states, supported by CDC, and disseminated by the Association of State and Territorial Epidemiologists.

**4. Provide renewed attention to the access to, content of, and quality of prenatal care.**

a. Provide continued support for implementation of effective innovations in prenatal care such as those being demonstrated through Strong Start.

b. Convene a process regarding the Content of Prenatal Care. Twenty-five years after the 1989 *Caring for Our Future: The Content of Prenatal Care Report* of the USPHS Expert Panel on the Content of Prenatal Care, there is a need to reconsider the newest evidence with respect to the number and content of prenatal care visits.

c. Request that the National Center for Health Statistics (NCHS) resume regular reporting of prenatal care utilization data in the annual NCHS brief "Births". These data are now only reported in special issues.

d. Launch a public awareness campaign to promote early entry into prenatal care. The nation is well below its goal of 90% of women entering prenatal care in the first trimester and renewed efforts are needed. With implementation of ACA, many pregnant women will face coverage transitions with likely negative impact.

e. Ensure aggressive monitoring of implementation of the ACA mandate for smoking cessation during pregnancy as state implementation of this mandate varies. Prenatal visits are an important means for connecting women to evidence-based smoking cessation approaches.

**5. Invest in initiatives to reduce maternal morbidity and mortality through risk appropriate, high-quality maternity care, particularly for higher risk mothers.**

a. Support the HRSA/MCHB Maternal Health Initiative to ensure the safety and quality of maternal health care. Importantly, through partnerships with private sector organizations, the next generation of prevention strategies is emerging.

b. Adopt the actions called for by the Centers for Medicare and Medicaid Services (CMS) by the Expert Panel on Improving Maternal and Infant Health Outcomes related to the quality and appropriateness of maternity care for pregnant women covered by Medicaid, as well as related topics including: reduced C-sections, improved postpartum visits, use of progesterone (17 – OHP), reduced impact of chronic conditions, and accelerated use of new models of care such as doulas and Centering Pregnancy.

c. Adopt a unified, national process for reporting maternal deaths, including a confidential system for review of maternal deaths and severe maternal morbidity.

d. Increase efforts to strengthen states' regionalized perinatal care systems so that high-risk women and infants receive the appropriate level of hospital (birth facility) care during pregnancy and labor and delivery.

**6. Use the tools and leverage of DHHS programs to focus on a continuum of reproductive health services following pregnancy into the postpartum and interconception periods.**

a. Support the concept of a "two-generation" investment and ensure that DHHS programs and initiatives such as Healthy Start and the Maternal and Child and Infant Health Home Visiting (MIECHV) Program continue to focus on both infant and women's health and social needs in the postpartum/interconception period.

b. Create a CMS innovations project focused on improvement in postpartum care. This could build upon current state efforts (e.g., California, Louisiana, Ohio) to redesign the timing and content of postpartum visits based on evidence.

c. Build on proposals by the CMS Expert Panel, ACOG, and others to unbundle the prenatal care payment from the postpartum care payment in Medicaid and other publicly subsidized plans so as to increase incentives to provide postpartum visits.

d. Support expansion of Centering Parenting and similar program models that focus on women's physical and mental health and social needs in the postpartum period.

e. Monitor implementation of ACA provisions and Department of Labor regulations that require employer action to support breastfeeding in the workplace, as well as state action to use Medicaid financing to promote use of breastfeeding.

We stand prepared to discuss any or all of these initiatives with you in detail and look forward to working with DHHS staff to implement those efforts that you believe fit best with your current priorities. Thank you for your consideration.

Sincerely yours,

/S/

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Chairperson, SACIM

/S/

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Chair, SACIM Women's Health Work Group