Secretary's Advisory Committee on Infant Mortality

Meeting Minutes of April 24–25, 2013

Webinar
Parklawn Building
Conference Room 16-49
Department of Health and Human Services
Rockville, MD

GENERAL SESSION

WEDNESDAY, APRIL 24, 2013

CALL TO ORDER AND WELCOME

David S. de la Cruz, Ph.D., M.P.H., Principal Staff and Designated Federal Official, SACIM; Deputy Director, Maternal and Child Health Bureau (MCHB)/Division of Healthy Start and Perinatal Services

Dr. de la Cruz called the meeting to order and welcomed the participants to the first meeting of the Secretary's Committee on Infant Mortality (SACIM) to be conducted over Adobe Connect. He explained that SACIM Chairperson Kay Johnson is involved in a family medical emergency and will most likely not be able to participate in the meeting.

SUMMARY OF THE NOVEMBER 2012 MEETING

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, Health Resources and Services Administration (HRSA); Executive Secretary, SACIM

Dr. Atrash presented an overview of the November 2012 SACIM meeting at which SACIM presented its final recommendations for the first national strategy on infant mortality. He noted that the SACIM report has been submitted to the Secretary.

Dr. Lu welcomed the participants to SACIM's first virtual meeting and announced that the focus of the day's discussion will be improving women's health. The second day of the meeting will focus on updates from MCHB and its Federal and State partners involved in reducing infant mortality. Dr. Lu thanked the SACIM members for their leadership and service in improving the health of mothers, babies, and families in our Nation.

HRSA UPDATE

Mary Wakefield, Ph.D., R.N., Administrator, HRSA

Dr. Wakefield thanked the SACIM members for their important work on the development of recommendations to the Secretary for action and as the framework of a national strategy to reduce infant mortality. The recommendations are clear and informative and align with HRSA priorities: (1) to strengthen the primary care workforce to better meet the health care needs of the Nation and (2) to improve access to high-quality primary care services in the context of an integration of primary care with public health and population health.

The first strategic direction, which focuses on improving the health of women before, during, and beyond pregnancy, aligns with Affordable Care Act (ACA) benefits, which have already been achieved or will be later this year. The second strategic direction—to ensure access to a continuum of safe and high-quality patient-centered care—is another important focus for HRSA that is beginning to crystalize thanks to the ACA and the expansion of community health care

centers. Dr. Wakefield mentioned the focus on quality of health care services, the achievement of medical home recognition by community health care centers, the adoption of electronic health care records, the increase in the number of clinicians in the National Health Service Corps (NHSC) program, and the funding for school-based health centers. The third strategic direction, which focuses on highly effective evidence-based interventions, is reflected in HRSA's Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program created by the ACA and run at the State level. Dr. Wakefield mentioned the success of text4baby.org, which offers free text messages on prenatal care, baby health, and parenting. The fourth strategic direction focuses on increasing health equity and resonates across much of HRSA's work involving delivery of care to underserved populations. The ACA provides new tools and opportunities, such as expanding eligibility for Medicaid and expanding the NHSC. The fifth strategic direction—investing in adequate data, monitoring, and surveillance systems to measure access, quality, and outcomes—is important in defending and explaining programs and funding. Regarding the sixth strategic direction, HRSA works closely with the Centers for Disease Control and Prevention (CDC) and other Federal and private partners on a number of studies involving integrating primary care and public health. HRSA is working to forge alignments of its programs and to collaborate with private partners.

Dr. Wakefield reiterated the utility of the information SACIM shared in its recommendations. The strategic directions compliment HRSA's priorities and prompt HRSA to do even more work in those key areas. The directions proposed for the issue of infant mortality are mutually reinforcing; they affirm HRSA's focus and point to the need for continued work to drive access to quality health care.

STRATEGY TO ADDRESS INFANT MORTALITY

Caya B. Lewis, M.P.H., Counselor to the Secretary for Science and Public Health, U.S. Department of Health and Human Services (HHS)

Ms. Lewis mentioned that the Secretary appreciates the work of SACIM and will use the framework laid out by SACIM to inform efforts throughout HHS. Ms. Lewis has worked on women's health issues, reproductive health issues, and health disparities issues. The issue of infant mortality is a difficult one to understand and solve. Ms. Lewis mentioned the National Prevention Strategy and the Racial and Ethnic Health Disparities Action Plan. The ACA makes prevention affordable and accessible; the annual well-woman visit will be offered without a co-pay. Ms. Lewis encouraged feedback and advice from SACIM members regarding the issues under discussion.

Q&A and Comments

Ms. Lewis called for questions or comments from the Committee members:

- Sara Shields, M.D., M.S., asked about the measurement of well-woman preventive services. Ms. Lewis stated that current services are measured through Medicare and Medicaid. How to do that in the private insurance market is unknown at present. Ms. Lewis will get back to SACIM on that question. Wanda Barfield, M.D., M.P.H., stated that CDC uses population-based surveillance systems as an opportunity to examine the issue. Ms. Lewis called for collecting, monitoring, and measuring this information.

- Raymond Cox, M.D., M.B.A., asked about the way in which health insurance exchanges would be monitored regarding preventive services for women. He noted concerns about reductions in revenue related to the sequester. Ms. Lewis replied that overall the expectation is that more people will be insured and receive care. She noted concerns regarding the safety net for the most vulnerable, working with providers on outreach and enrollment, and implementing health reform.
- Dr. Atrash noted that MCHB has been working with the Office on Women's Health (OWH), the Office on Minority Health, and the American Congress of Obstetricians and Gynecologists (ACOG) to develop guidance on well-woman care visits. A discussion will occur soon with Federal and professional partners, and SACIM will be kept posted on the planning committee's deliberations.
- Fleda Mask Jackson, Ph.D., M.S., asked about the level of commitment and amount of investment to eliminate disparities in infant mortality. Ms. Lewis referred to the present as a transformational time in health care in the United States. The team and leadership understand and want to reduce health disparities. She mentioned the Strong Start initiative in the Center for Medicare & Medicaid Innovation (CMMI). The leadership is very aware, concerned, focused, and dedicated to addressing the issue.

IMPROVING THE HEALTH OF WOMEN
SACIM Committee Member: Arden Handler, Dr.P.H., M.P.H.

Standing in for Ms. Johnson, Dr. Handler referred to SACIM's first strategic direction—improving the health of women before, during, and beyond pregnancy. She listed the recommendations that flow from that direction: (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 for women. Dr. Handler called for broadening, deepening, and strengthening these recommendations and developing additional pivotal strategies for action.

Improving the Health of Women
Jeanne Conry, M.D., Ph.D., President-Elect, American Congress of Obstetricians and Gynecologists; Assistant Physician in Chief, North Valley Kaiser Permanente

Dr. Conry noted that women's health is the focus in this Year of the Woman. With the passage of the ACA, well-woman health care, preconception health, reproductive health, and prenatal care are covered benefits. The ACA is an investment in women's health and newborn health; therefore, it is an investment in the next generation. In fact, an investment in infant outcomes requires an investment in women's health and maternal outcomes.

Dr. Conry noted that maternal mortality in the United States is two to three times higher than in western European nations, Japan, Canada, and Australia. Preconception care involves addressing obesity and overweight, hypertension, smoking, and aerobic activity. Severe maternal morbidity currently affects more than 50,000 women annually, an increase of 75 percent over the past decade. In addition, postpartum hospitalizations and postpartum mortality doubled in the past

decade.

The top priority in ACOG's national agenda is reproductive choice, that is, every pregnancy should be a planned pregnancy. The national agenda also addresses obesity, including weight gain during pregnancy and weight loss after pregnancy. The postpartum visit should address weight gain and plans for another pregnancy. The health of women should be addressed before conception, particularly with chronic conditions management programs (e.g., obesity, hypertension, diabetes). Quality measures must be set specifically for women of reproductive age, with goals that are different from those of other individuals with chronic medical conditions.

Dr. Conry ended her presentation by stating that she would like to see SACIM give rise to SACIMM—the Secretary's Advisory Committee on Infant and Maternal Mortality and Morbidity.

Discussion

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

- Dr. Cox voiced his concern about standardization of definitions and metrics regarding vital statistics data. Dr. Conry responded that ACOG is working to standardize terminology and address national quality forums. She recommends the adoption of standardized levels of A1c and blood pressure for women of reproductive age.
- Milton Kotelchuck, Ph.D., M.P.H., asked about the approach at the postpartum visit regarding chronic conditions. Dr. Conry called for a complete redesign of the postpartum visit, taking into consideration the most common complications of prenatal care and pregnancy (e.g., preeclampsia and thyroid disease). The timing and frequency of visits have not been resolved. The redesigned recommendations are on the Preconception Health Council of California Web site at everywomancalifornia.org.
- Dr. Handler asked about the difficulty of getting women to participate in the postpartum visit. Dr. Conry mentioned that Kaiser Permanente works with a Medicaid patient population and 90 percent of the women participate in the postpartum visit, which is incorporated into all of the expectations and becomes a focus even before delivery.
- Dr. Shields mentioned the challenge, especially regarding chronic medical conditions, of having insurance coverage end 6 weeks postpartum. Dr. Conry stated that the hope is that the ACA will allow for continuous coverage for a larger number of women than seen in the past. The postpartum visit should be redesigned to be a very effective visit in which women are coached to optimize their continued access to health care.
- Dr. Kotelchuck commented about the mindset that the postpartum visit is the end of the pregnancy instead of the beginning of a well-woman lifecourse of health. The ACA should be used to think more broadly and creatively about coverage for only one postpartum visit. Dr. Conry agreed and mentioned the idea of a medical home for obstetrics.

Improving the Health of Women Before Pregnancy: Preconception Care
*Merry-K. Moos, B.S.N., M.P.H., FAAN***,** Professor (retired), Department of Obstetrics and Gynecology; Consultant, Center for Maternal and Infant Health, University of North Carolina at Chapel Hill

Ms. Moos began her presentation with a definition of preconception health—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 that must be acted on before conception or early in pregnancy to have maximal impact. She quoted *Born Too Soon: The Global Action Report on Preterm Birth,*which defines preconception care as "any intervention provided to women of childbearing age, regardless of pregnancy status or desire, before pregnancy, to improve health outcomes for women, newborns, and children." Ms. Moos pointed out that this second definition clearly underscores that improving women's health status is a good unto itself and implies that some pregnancies may not be planned.

The traditional prenatal paradigm is unequal to today's health challenges, as pointed out by Robert Dillard, who wrote that "as attractive and relatively inexpensive as prenatal care is, a medical model directed at a 6- to 8-month interval in a woman's life cannot erase the influence of years of social, economic, physical, and emotional distress and hardship." Ms. Moos stated that in obstetrics, most outcomes and known contributors to poor outcomes (such as chronic disease) are already present before doctors meet with their pregnant patients. Over time, it has come to be recognized that prepregnancy health status and preconception health care provide pathways to the primary prevention of many poor pregnancy outcomes beyond those opportunities available through traditional prenatal care, which is largely ineffective in meeting the primary prevention needs of pregnant women and unborn children. Affecting the health of this generation and future generations requires new prevention approaches through an emphasis on women's health and the lifecourse perspective.

Women's health in this country has evolved into a categorical disjointed series of services that address a woman's current reproductive status instead of her general preventive health needs. A continuum of care makes sense both for women and the efficiency of services. Furthermore, nearly 50 percent of pregnancies in the United States are categorized as unintended. Over the past decades, many projects have been undertaken to break down the silo walls to transform categorical services to a focus on preventive services, including preconception health promotion for "every women, every time." Opportunistic care takes advantage of all health care encounters to stress prevention opportunities throughout the lifespan, addresses conception and contraception choices at every encounter, and involves all medical specialties and subspecialties, not only those directly involved in reproductive health.

To answer the question of who should deliver preconception health care, Ms. Moos stated that all health care workers who take care of women of reproductive age should be actively involved, including community health workers and nurse practitioners. To answer the question of how preconception health care should be delivered, Ms. Moos described a three-tier approach: (1) social marketing for public awareness, (2) routine preventive services, and (3) specialty care for women with known high-risk factors.

Ms. Moos described issues in consumer awareness. Few professionals, patients, men, future grandmothers, etc. understand how important the earliest weeks of pregnancy are. In addition, women most in need of preconceptional health promotion are often those least likely to have intended conceptions. The objective of CDC's Show Your Love program is to increase preconception knowledge, awareness, and behavior among women of childbearing age. The basis of the campaign includes the idea that women need to love themselves by taking care of their health.

Ms. Moos described ways in which providers are helped to incorporate a preconception orientation to routine preventive services. The data demonstrate that a majority of women receive health care services every year but are not experiencing basic health promotion/disease prevention emphases in their encounters. The ACA is projected to increase the number of women seeking and receiving routine primary care. Providers are already overwhelmed by all of the demands on content to be included in routine care. The Kellogg Foundation elected to provide support to move the need for clinical guidance forward. The Toolkit Steering Committee did not want to focus on high-risk women, but rather on the majority of women, and it did not want to frame preconception health promotion as a new silo in women's preventive health care. The toolkit will provide guidance to primary care providers on how to address the core components of all primary care. The specific content of the toolkit builds on existing resources and will be available at www.beforeandbeyond.com.

The benefits of a systematic approach to women's wellness are that addressing women's wellness "every woman, every time" will achieve better "before and between" pregnancy health status, higher levels of women's wellness before pregnancy will result in healthier pregnancy outcomes, and higher levels of women's wellness will result in healthier women across the lifespan, thereby affecting "beyond pregnancy." Advancing the health and well-being of women of reproductive age will promote lifelong wellness, desired and healthy future pregnancies, and healthy future offspring.

Q&A and Discussion

The presentation by Ms. Moos prompted the following questions and comments:

- Dr. Conry commended Ms. Moos on her work on the toolkit. Joanne Martin, Dr.P.H., R.N., FAAN, echoed the sentiment and expressed her hope that the role of home visitors will be addressed so that they understand the importance of preconception care and encourage the women they work with to get the care they deserve and need. Ms. Moos mentioned her hope that strategies for community health workers will be created to support women in meeting their desires about their future health and well-being. Dr. Lu commented that HRSA's MIECHV is aware of this need.
- Melinda Sanders, M.S.N., R.N., administrator of Title V and director of the Missouri Department of Health and Senior Services, asked about the role of grandmothers in helping to solidify the importance of the postpartum visit. Ms. Moos stated that grandmothers' influence is sometimes underrecognized and mentioned the grandmothers' role in the Back to Sleep campaign.
- Carolyn Gegor, C.N.M., M.S., FACNM, voiced her concern about translating

information about preconception care to providers so that they understand the critical importance of their role and use the information in their clinical practice. Ms. Moos stated that the idea is to "work smarter, not harder," which requires marketing to providers. The idea is to distribute primary prevention information and assessment across a practice.

- Tyan Parker Dominguez, Ph.D., M.P.H., M.S.W., commented on the promotion of lifelong wellness and women's mental health by developing strong partnerships with allied health professions, paticularly in vulnerable communities.
- Dr. Cox asked about the timing of the postpartum visit. Ms. Moos noted the inadequacy of the 6-week timing. It should be more individualized, and other models should be examined.

Improving the Health of Women During Pregnancy
SACIM Committee Member: Arden Handler, Dr.P.H., M.P.H.

Dr. Handler presented information about the role of prenatal care as a women's health strategy to reduce infant mortality. Despite ongoing considerations of its efficacy, prenatal care is still considered a key public health strategy to prevent adverse pregnancy outcomes. Prenatal care as an infant mortality intervention strategy fell out of favor in the aftermath of the Medicaid expansions, which increased prenatal care utilization but did not simultaneously lead to a decrease in low birthweight and preterm delivery. The result of what some might consider a "policy failure" was the recognition that the 9 months of pregnancy is insufficient to make a difference on its own and led to the movement for well-woman's health care, preconception care, and interconception care. That movement also led to a simultaneous decreased emphasis on prenatal care.

The approach (until recently) of abandoning prenatal care as an important intervention strategy failed to take many factors into consideration: (1) Medicaid payment for delivery does not equal Medicaid payment for prenatal care, (2) the women at highest risk were not affected by the Medicaid expansion, and (3) the quality and content of prenatal care was minimally addressed by the Medicaid expansion. Furthermore, studies of prenatal care effectiveness are routinely plagued by selection bias.

Given this history, the question is whether improvements in prenatal care can make a difference in infant mortality rates. Dr. Handler asserted tht if all women of all racial/ethnic groups have access to early high-quality prenatal care, there will be an impact on infant mortality. High-quality prenatal care can reduce behavioral risks (e.g., smoking, alcohol, substance abuse, weight gain); reduce the impact of preexisting morbidities; provide social support to reduce stress; link to the high-risk delivery system and appropriate levels of care for delivery; and link to postpartum care, interconception care, and family planning. The three components of prenatal care are (1) early and ongoing assessment of a woman's risk status, (2) ongoing health education and health promotion, and (3) interventions to address risk factors and any health problems that are discovered.

Dr. Handler reviewed the Healthy People 2010 objectives. The goal was for 90 percent of women to receive prenatal care in the first trimester and 90 percent of women to receive early

and adequate prenatal care compared with the 1998 baseline of 83 percent and 74 percent, respectively. Dr. Handler explained that the measurement of prenatal care utilization on birth certificates changed and the change affected the conclusions drawn from the data. The first trimester prenatal care entry and percentage of women with late or no prenatal care were far from the Healthy People 2010 objectives, and racial and ethnic disparities remained pervasive. Recognizing that the metric had changed, the Healthy People 2020 objective was changed. The target for prenatal care beginning in the first trimester is 77.9 percent and for early and adequate prenatal care, it is 77.6 percent. Dr. Handler pointed out that no inforamtion is routinely collected on content and quality of prenatal care.

Dr. Handler listed pivotal points for action with respect to prenatal care: (1) increasing women's entry into care during the first trimester, (2) revisiting the visit schedule, (3) addressing the content and quality of prenatal care, (4) eliminating the differential focus and reimbursement of prenatal care components beyond "medical," (5) resuming reporting on prenatal care in the national vital statistics reports, (6) developing, testing, and expanding new models of prenatal care and prenatal care enhancements, (7) increasing women's voice in the delivery of prenatal care, and (8) improving the delivery of high-risk maternal health care.

Dr. Handler concluded her presentation by stating that, although prenatal care is not sufficient to improve perinatal outcomes and reduce rates of infant death, it is an essential component of the continuum of reproductive/perinatal care that continues to deserve attention.

Q&A and Comments

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

- Dr. Kotelchuck remarked that it has been 25 years since a national meeting occurred to talk about the content of prenatal care. Dr. Handler remarked that SACIM can make a specific action recommendation for such a conference to take place. Joann Petrini, Ph.D., M.P.H., added that a SACIM report might be another way to address this issue.
- In response to a question from Ms. Sanders, Dr. Handler referred to the graph in her presentation describing the visit schedule for women with first-time versus subsequent pregnancies.
- Dr. Cox referred to the structure of prenatal care, caring as an aspect of prenatal care, and its effect on return visits and compliance.

Keisher Highsmith, Dr.P.H., Director of Special Initiatives and Program Planning and Evaluation, Division of Healthy Start and Perinatal Services, MCHB/HRSA (maternal health)

Dr. Highsmith presented information about the National Maternal Health (NMH) initiative, which is in development to become a comprehensive collaborative strategy to reduce maternal morbidity and mortality in the United States. Maternal mortality is considered a rare event in the United States; however, the lifetime risk of maternal death is greater in this country than in 40 other countries. In 2007–2008, maternal mortality increased from 12.7 to 15.5 deaths per 100,000 live births. The leading causes for maternal mortality are preeclampsia, obstetric hemorrhage, embolisms, and cardiovascular disease. African American women have a 3 to 4 times higher risk of dying from pregnancy complications than non-Hispanic whites and Hispanic

women. Dr. Highsmith reviewed 2010 data on selected maternal morbidities and risk factors (chronic diabetes, gestational diabetes, chronic hypertension, pregnancy-associated hypertension, and eclampsia) in pregnancy by race/ethnicity.

Severe maternal morbidity or "near-miss" increased by 75 percent for deliveries in hospitals and 114 percent in postpartum hospitalization. Indicators for severe maternal morbidity include blood transfusion, hysterectomy, and eclampsia. Adequate control of diabetes and hypertension before and during pregnancy can reduce the risk of maternal morbidity and mortality, spontaneous abortion, fetal malformation, intrauterine fetal death, and neonatal morbidity. Dr. Highsmith reported on the economic burden of maternal morbidity and mortality in the United States.

The mission of HRSA is to improve health and achieve health equity through access to quality services, a skilled health workforce, and innovative programs. The mission of MCHB is to promote and improve the health of women and children across the Nation. The agency has multiple investments in programs to achieve its mission. The NMH initiative offers a comprehensive approach to reducing maternal morbidity and mortality in the United States. The vision of the NMH inititative is "healthy women, healthy mothers, healthy babies."

The mission of the NMH initiative is to develop and implement a national comprehensive initiative to strengthen State and local systems capacity and infrastructure to promote, protect, and improve maternal health by strengthening State maternal morbidity/mortality surveillance, ensuring quality and safety in maternity care, supporting State and community-based strategies that improve access to care, and providing a platform conducive to collaborative learning and sharing best practices. This mission is accomplished through coordination and collaboration within HRSA, across HHS agencies, and with proessional and private organizations.

The overarching goal of the NMH initiative is to improve women's health across the lifecourse and to improve the quality and safety of maternity care. The five priority areas are (1) surveillance and research, (2) State and community public health systems, (3) quality and safety of clinical care, (4) public awareness, and (5) women's health. The guiding principles for a NMH strategy are (1) collaboration and coordination, (2) translation, (3) disseminatioin and education for action, and (4) training and capacity building.

Dr. Highsmith concluded her presentation by announcing that MCHB is planning a town hall meeting on maternal health in September 2013 to kick off the NMH inititative.

Q&A and Comments

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

- Dr. Martin asked about the statistic that 94 percent of hospital deliveries have some type of complication. She asked what the main types of complications are because that number seems high. Dr. Highsmith responded that the information came from the 2011 Agency for Healthcare Research and Quality (AHRQ) study. Later in the public comments box, Dr. Highsmith clarified that the 94 percent of women hospitalized for pregnancy and delivery had complications such as premature labor, uninary infection, anemia, diabetes, vomiting, bleeding, laceration of the area between the vagina and anus during delivery,

abnormal fetal heart rate, advanced maternal age (older than 35 years), and hypertension and eclampsia (a condition associated with high blood pressure that can involve swelling and seizures). The report can be accessed at http://www.hcup-us.ahrq.gov/reports/statbriefs/sb113.jsp.

- Dr. Shields asked about the increase in maternal morbidity and mortality over the past two decades and the caesarean section epidemic. She inquired whether the NMH initiative will work on the variability in caesarean section rates among low-risk women. Dr. Highsmith stated that those working on the initiative will take that point into consideration as they move forward.

Improving the Health of Women Following Pregnancy: Interconception Care
SACIM Committee Member: Milton Kotelchuck, Ph.D.

Dr. Kotelchuck began his presentation by stating that improved maternal and child health outcomes result from improving the knowledge base, social strategy, and political will. He mentioned the CDC Safe Motherhood conference in 2001 and the CDC national summit on preconception care select panel meeting in 2005, which defined preconception care in part as including care between pregnancies (commonly known as interconception care). The four goals of the summit included reducing risks indicated by a prior adverse pregnancy outcome through interventions in the interconception (interpregnancy) period that can prevent or minimize health problems for a mother and her future children. Interconception care traditionally stopped at the 6-week postpartum visit, but it should be considered more broadly. The 6-week postpartum visit should be conceptualized not as the end of a pregnancy but as the beginning of a new women's longitudinal health initiative. Dr. Kotelchuck explained that in lifecourse terms, interconception care represents not only longitudinal continuity of maternal care but also intergenerational continuity of care. Interconception care can be thought of as a strategy to address women's health, to enhance the health of the parent and caregiver, to reduce subsequent infant mortality, and to reduce racial disparities in birth outcome.

Interconception health and health care (like preconception health and health care) is a subset of lifecourse health, but they are intrinsically linked concepts. Interconception health care implies an intergenerational continuity; that is, mother's health and child's health are not totally separable. It should be seen as mother and child health, not mother versus child health. The timeframe for interconception care (like preconception care) is debatable. The challenge is to move lifecourse forward from theory to practice. The three basic ways of improving reproductive health are (1) clinical care and systems interventions, (2) social determinant interventions, and (3) maternal/family–focused resilience and responsibility interventions.

Currently, clinical health care is the principal sector of interconception programs and intervention. There is room for much improvement in interconception health care. Existing interconception health care is a dramatic and preventable source of the creation of future reproductive health disparities. People on Medicaid get substantially fewer postpartum care visits than those in the private sector. The majority of women with gestational diabetes mellitus do not get postpartum followup.

Dr. Kotelchuck stated that interconception health care programs should be easier to create than

preconception care programs because virtually all births and mothers are known and easy to locate. They also are more operationally feasible via current public health and clinical care programs. Interconception care programs are not widespread because both clinician supply and consumer demand are low. Developing interconception health care programs involves nine pressing issues, including eligibility criteria for women, content of care, timing/frequency of care, provider of care, payer source, motivation to participate, community involvement, public health policy and infrastructure support, and research and monitoring databases. Many innovative interconception health programs are being implemented, including the Healthy Start initiative, the California Black Infant Health Program, Collaborative Improvement & Innovation Network (CoIIN) initiatives, chronic illness followup clinics in obstetric programs, quality improvement programs to enhance 6-week postpartum visits, pediatric family care initiatives, and many others.

Dr. Kotelchuck pointed out that the social determinants of health also must be addressed along with resilience enhancement interventions such as parenting support groups, maternal empowerment initiatives, centering parenting, teen parenting support programs, fatherhood initiatives, family planning, and many more. A knowledge-base social strategy is needed in this area. Interconception care programs are not currently widespread, but in the future, interconception care will seem as normal as prenatal care is today. When women demand it, it will happen.

Rebekah Gee, M.D., Medicaid Medical Director, Louisiana Department of Health and Hospitals, (Interconception care, Medicaid, & CoIIN)

Dr. Gee presented information about the Collaborative Improvement & Innovation Network (CoIIN). The aim of CoIIN is to modify Medicaid policies and procedures in five to eight Southern States by December 2013 in order to improve access to and financing of postpartum visits and interconception care case management for women who have experienced a Medicaid-financed birth that resulted in an adverse pregnancy outcome. The strategy is to increase use of interconception care for women in Medicaid. The goals of the CoIIN are to reduce the impact of chronic disease and other reproductive health risk factors, improve the outcome of any subsequent pregnancies, and enhance fulfillment of a woman's reproductive plan and successful use of birth control to optimally space pregnancies.

Dr. Gee reviewed the changes needed in the Federal Centers for Medicare & Medicaid Services (CMS) and other rules and policies to assist States. Providers should be enabled through policies and incentivized through payment structures to change their attitudes and practices. In addition, women should be empowered and supported to seek interconception care to improve their health status. In terms of challenges, 50 to 70 percent of women who have a Medicaid-financed birth lose coverage at 60 days postpartum. Currently, even women with identified risks and continuing coverage do not receive appropriate services. Care is not focused on reproductive health and birth spacing—almost half of all pregnancies in the United States are unintended. Like chronic disease management, this situation requires intensive, tailored case management. Core approaches include interconception care waivers to serve an expanded eligibility group, use of strategies such as primary care case management and medical home, Medicaid targeted case management or administrative case management, and enhancements to the use or design of the

postpartum visit.

Dr. Gee explained that States have been asked to measure the percentage of target women who receive a postpartum visit and the number/percentage of women enrolled in the interconception care waiver and/or served in the interconception care project by December 2013. After describing the Medicaid interconception care project pathways and ways to change provider practice, Dr. Gee stated that outreach to women should begin before discharge from the delivery hospital and the gateway should be through the postpartum visit or the pediatric care visit.

Dr. Gee reported on Louisiana's interconception care initiative, which was built on an existing 1115 waiver in the Hurricane Katrina–affected Greater New Orleans area. The Greater New Orleans Community Health Connection (GNOCHC) waiver adds interconception case management services, and recipients must meet the eligibility criteria for both the GNOCHC demonstration and the family planning waiver.

The ultimate goals of the CoIIN are to (1) reduce women's chronic conditions and reproductive health risks by modified health access and care models, (2) reduce costly repeat adverse pregnancy outcomes among Medicaid beneficiaries, (3) improve delivery structures and provider capacity to provide interconception care, and (4) implement available evidence-based strategies via policy and practice.

Q&A and Comments

The presentations on interconception care by Drs. Kotelchuck and Gee prompted the following questions and comments:

- Dr. Cox commented on the free and charitable clinics network across the country, many of which are in the Southeast. He voiced one of the concerns with expanded eligibility and the ACA, which is whether all of the patients can be seen given the current infrastructure. Dr. Gee remarked that increased access to care will involve the exchanges. It will be necessary to transmit data to free care clinics that can provide ongoing care to women. The issue of lack of providers, creating teams of health care workers, training medical students in interdisciplinary leadership—all are crucial challenges nationwide.
- Sharon Chesna, M.P.H., asked about requiring waivers for the postpartum visit in the CoIIN and about tools for redesigning the postpartum visit. Dr. Gee mentioned a case management tool that she will share and called for innovative payment approaches for the postpartum visit to engage and incentivize providers. Dr. Conry added that the Kaiser Permanente system has about 90 to 95 percent postpartum visit participation for regions with Medicaid. Changing the bundling and rewarding the postpartum visit with higher payment were used to increase participation in Delaware. Dr. Gee mentioned that best practices should be translated quicker between the CoIINs. States need technical assistance in this regard. Dr. Kotelchuck added that quality improvement can have a significant effect in raising the participation rates for the postpartum visit. Dr. Gee stated that the CoIIN will continue its intensive focus on elective delivery and then turn its attention and energy to the postpartum visit.
- Dr. Handler stated that case management of high-risk women as part of the waiver raises the question of how to integrate services. Dr. Gee responded that the bigger challenge

involves selling the program to people and then following through.

- Dr. Shields asked about the reporting of postpartum visit rates as part of grant reporting. Perhaps SACIM could make this recommendation for the collection of data.
  Dr. Kotelchuck agreed and noted that different reporting systems should focus on the postpartum visit.

COMMITTEE DISCUSSION

Dr. Handler called for the SACIM members to begin to formulate deeper recommendations and specific strategies for the Secretary, for example, recommendations and strategies related to postpartum paticipation rates, the structure of prenatal care, payment issues, the NMH initiative promulgated by HRSA, and interconception and postpartum care.

Dr. Cox stated that the presentations were very high quality and very informative. He expressed his concern with the implementation of the ACA and the impact on the health infrastructure in those States that are not expanding Medicaid. Some significant challenges will result. SACIM's recommendations should take into account the impact and struggles of those States to maintain their current health care infrastructure.

Dr. Martin stated her endorsement of efforts to link the MIECHV program with interconception care, paticularly for the signifcant proportion of women with chronic health conditions, for at least 2 years postpartum. Home visitors can play a real role in supporting the care that these mothers need.

Dr. Atrash commented that some people are assuming that interconception care is not being given enough attention. MCHB focuses heavily on interconception care implementation programs in Healthy Start communities as well as the CoIIN States, including better defining the content of interconception care. Dr. Handler suggested that SACIM could be supportive of that activity in its recommendations.

Dr. Shields raised the question of who should be targeted for interconception care. Interconception care should be broadened to include women with any maternal or infant poor outcome and should address interconception contraception needs because of unintended pregnancies. Dr. Atrash stated that interconception care is care between pregnancies and MCHB programs target everybody. Dr. Kotelchuck reiterated that interconception care should apply to all women; however, some case management programs focus exclusively on women with poor birth outcomes. Dr. Atrash added that the majority of women who have complications or poor pregnancy outcomes began their pregnancies as low-risk, healthy young women. Every woman is at risk; therefore, every woman should be targeted.

Dr. Kotelchuck stated that, from a lifecourse perspective, reproductive health and home visiting should be linked much more concretely and screening should involve both maternal and infant issues. Dr. Handler noted the challenges to that idea. Dr. Martin suggested David Willis, M.D., as a speaker on this issue. Dr. de la Cruz stated that he will add Dr. Willis, director of Home Visiting and Early Childhood Systems for HRSA, as a future speaker.

ENGAGING AND EMPOWERING WOMEN

Patient Centered Care

SACIM Committee Member: Sara Shields, M.D., M.S.

Dr. Shields presented information about empowering and engaging women in patient-centered care. She pointed out places in the SACIM Executive Summary related closely to patient-centered care in terms of core principles (engage and empower consumers; life course perspective) and strategies (new care models, maternity medical homes, social marketing, etc.). Using a story about one of her patients, Dr. Shields framed the information about patient-centered care related to SACIM's stated strategies involving infant mortality. She referred to ways of relating to and communicating with patients by understanding the experience, understanding the context, finding common ground, prevention and wellness, and longitudinal relationships. The traditional maternity system is provider centered, technology centered, and fetus centered, but woman-centered care is patient-centered, family centered, and relationship centered. Pregnancy should be framed as a healthy life event, not a disease, diagnosis, or illness. The idea is not to medicalize pregnancy. The woman-centered approach considers a woman's strengths, such as her age, multigenerational connections, family's community ties, and community health center ties. Community health centers are accessible because they are located in communities, open to patient voice through consumer participation on boards, and act as cutural "brokers" because staff are from the local communites. Future challenges involve funding cuts, recruitment and retention of staff, and information technology infrastructure.

Dr. Shields described the standards for a patient-centered medical home and noted that group care gives women the opportunity to become engaged and empowered in labor and to speak up and learn from one another. She tackled the question of whether evidence-based maternity care can be paient centered and mentioned the use of a labor companion with labor-support training, nonsupine positions for birth, and early skin-to-skin contact. In terms of patient-centered care and behavioral health, Dr. Shields mentioned skill sets needed to deal with behavioral change, integrated behavioral health teams, motivational interviewing skills, the patient-centered clinical method, decision support tools, and longitudinal relationship and trust to be able to discuss sex, weight, depression, and domestic violence.

The next question involves how quality improvement can be more patient centered. Dr. Shields noted that patient-centeredness is not yet central. Quality collaboratives must really engage and empower women and families. Longitudinal patient care in multigenerational families calls for linkages across the reproductive life spectrum, and well-woman care starts with well-girl care.

Woman-centered care must involve teams comprising community-based workers, outreach, and the longitudinal relationship or lifecourse. Mothers and families must be included in developing quality outcomes, and tracking must occur to determine what happens to a family after a loss. Self-assessment/empowerment tools include group care tools and motivational interviewing, birth plans and reproductive life plans, and parenting support through childhood and adolescence. Multifactorial solutions take into account poverty reduction, healthy food sources, and mental health services.

Listening to Mothers
Maureen Corry, M.P.H., Executive Director, Childbirth Connection

Ms. Corry previewed select results from Childbirth Connection's national survey, *Listening to Mothers III.* The full report will be released in May. A postpartum followup survey report, *New Mothers Speak Out,* will be released in early June.

Childbirth Connection is celebrating its 95th anniversary this year. Ms. Corry pointed to broad variations in care, noting that caesarean section rates vary from hospital to hospital across the Nation, from a low of 10 percent to a high of 70 percent. The Tranforming Maternity Care Project resulted in the publication of two direction-setting papers, "2020 Vision for a High-Quality, High-Value Maternity Care System" and "Blueprint for Action." In addition, two major policy reports were issued in January and February 2013. Both reports can be found at www.transform.childbirthconnection.org.

In 2002, Childbirth Connection launched its Listening to Mothers initiative, which was devoted to understanding the experiences and perspectives of new mothers and using the knowledge to improve maternity care policy, practice, education, and research. The surveys allow for comparing actual experiences of childbearing women, values and preferences, evidence-based care, optimal outcomes, and protections granted by law. The *Listening to Mothers III* survey involved 2,400 women, 18 to 45 years of age, who gave birth to a single baby in U.S. hospitals beween July 1, 2011, and June 30, 2012. Data were adjusted to reflect the target population and propensity to be online.

Ms. Corry reported on selected survey results involving a comparison between women whose primary source of payment was Medicaid and the Children's Health Insurance Program (CHIP) (37 percent) and women with private insurance. When asked to list the top three factors in their choice of the maternity care provider or group for their recent prenatal care, both Medicaid and privately insured women cited the following factors: (1) the provider accepted their health insurance, (2) was a good match for what they valued and wanted, and (3) attended births at the hospital they liked. The greatest gap between the two groups involved whether the provider was assigned to them as their maternity care provider, which was a much more common factor among the Medicaid beneficiaries. Eighty-one percent of Medicaid women used Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) services compared with 23 percent of privately insured women, and Medicaid women enrolled earlier than privately insured women. Medicaid mothers indicated a greater need than privately insured mothers in the need for and use of special services, especially help with food. The majority of women in both payer groups had access to the Internet. Participation in childbirth education was fairly low overall and lower in the Medicaid group than in the privately insured group. Six percent of women in both groups had a labor doula, and 36 percent of Medicaid women, compared with 19 percent of privately insured women, had never heard of doulas.

About 6 in 10 mothers agreed that the birth process should not be interferred with unless medically necessary. Ms. Corry pointed out that the proportion of women agreeing with this proposition has steadily increased over the past several decades. Overall, 25 percent of women who actually had labor induction reported pressure from health professionals to have labor

induction compared with 8 percent who did not have induction. Overall, 8 percent of mothers who did not have a cesarean section experienced pressure for surgery versus 25 percent of mothers who did have a cesarean. Nearly half of the Medicaid women reported that their provider tried to induce labor, which was somewhat higher than women with private insurance. The reasons for labor induction were comparable across the two groups.

Other survey questions involved mothers' knowledge of labor induction and cesarean complications. Overall results of questions involving women's knowledge of labor induction complications indicate that women are not aware that a suspected large baby is not an indication for induction. Mothers who had a cesarean were no more likely to be correct about the increased chance of future placental problems after cesarean but were much more likely to identify newborn breathing problems as a complication of cesarean section. Another question involved mothers' knowledge about the safe gestational age for babies to be born. Only 21 percent chose 39 weeks or beyond. Ms. Corry mentioned the need to reach women with correct information concerning this very important topic.

In terms of the mode of birth by payer, Ms. Corry stated that there was no difference between the vaginal birth rate and cesarean rate among mothers, and it appears that vaginal birth after cesarean (VBAC) access might be worse for women covered by Medicaid.

Ms. Corry reported on questions involving shared decisionmaking after cesarean. Women with one or two prior cesareans were more likely to be told about reasons to have repeat surgery rather than reasons not to have it. About 62 percent of caregivers presented Medicaid women with the framework for choice involving how to give birth in this situation versus 81 percent of privately insured women; 87 percent of caregivers made a recommendation, which overwhelmingly was for repeat cesarean. Thirty percent of mothers with Medicaid versus 9 percent of privately insured mothers felt the decision to have a cesarean had been the provider's, and fewer Medicaid mothers said they would definitely go with the same decision if they had it to do over. There was high concordance between what the caregivers recommended and the type of birth that the women had.

Other survey questions involved breastfeeding intention and infant feeding 1 week after birth, hospital support for breastfeeding, and new-onset physical problems in the first 2 months and at 6 or more months postpartum. Ms. Corry pointed out a few results regarding variation in demographics, prenatal experiences, and intrapartum and postpartum experiences by race and ethnicity.

To summarize the overall survey results, Ms. Corry expressed concerns about care not supported by best evidence or best practice: (1) a high rate of adjusting the due date at the end of prgnancy (mostly moving it forward), (2) a large proportion of labor induction for nonmedical reasons, and (3) considerable caregiver support for labor induction and cesarean section for a suspected large baby. Other concerns involve failing to present VBAC as an option for many women with one or two prior cesareans; a considerable proportion of care providers and hospitals unwilling to offer VBAC; and considerable experience of caregiver pressure to have induction, cesarean, or epidural. Also, most women with an episiotomy did not have a say in it.

Ms. Corry noted that the *Listening to Mothers* surveys are viewed as guideposts that can help accelerate improvement. The survey results can be used to close gaps between actual and more optimal experiences through policy, practice, research, and education. A clear need exists to expand clinical, public health, performance measurement, quality improvement, and family support policies at all levels. Attention must be focused on enhancing the ability of the maternity care system to protect, promote, and support physiologic childbirth for this largely healthy population of women and their fetuses and newborns. A concerted effort must be made to engage and activate childbearing women to become informed, understand their rights, and make wise deisions. Mothers need access to skills and tools to take these steps forward, including knowledge about quality maternity care, high-quality decision aids and shared decisionmaking processes, critical appraisal skills, and help in navigating the maternity care system.

Ms. Corry concluded her presentation by stating that Childbirth Connection is optimistic about opportunities to improve care because it sees, on a daily basis, high-performing providers and facilities that are showing the way to better care and improved outcomes. Multistakeholder collaborative efforts are the way to these improvements.

Q&A and Comments

The presentation by Dr. Shields prompted the following questions and comments:

- Dr. Barfield asked about the challenges involved in the medical home regarding teenagers. Dr. Shields noted that the question involves whether a teen mother should be in a pediatric medical home or an adult medical home. The answer might be that specialists should be co-located. Dr. Cox mentioned that a centering-parenting model, particularly for young parents, can be helpful, and Dr. Shields suggested that "well-mother, well-baby" groups might be the answer.
- Dr. Kotelchuck raised the topic of resilience and empowerment built into patient-centeredness. Programs that empower women are needed. Dr. Shields reiterated that women's voices must be considered and that questions of adherence call for an examination of the circumstances women are dealing with and better strategies to hear women's voices.

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

- Phyllis Dennery, M.D., asked when the survey was conducted in light of the ACOG recommendation about not inducing before 39 weeks. Ms. Corry responded that the survey results demonstrate that challenges still exist in this regard.
- Dr. Shields asked about State Medicaid programs that cover doula support. She suggested that SACIM might want to form a recommendation for doula support as an evidence-based practice. Ms. Corry mentioned Minnesota and Oregon and will share other information on the topic.
- Dr. Barfield asked about perceptions of home birth. Ms. Corry stated that the survey did not ask any attitude or knowledge questions related to home birth.
- Dr. Handler mentioned that in Chicago, Lamaze or parenting support classes are rare. She also asked about questions related to provider type. Ms. Corry responded that about 90 percent of the survey respondents had obstetricians and the rest had family practice physicians and midwives. She also stated that since the surveys began in 2002 fewer

women have taken childbirth classes. Lamaze International might be a source for further information on the topic. Ms. Corry also stated that the number one source of information cited by women was their provider or caregiver and that Childbirth Connection is interested in integrating the shared decisionmaking process into the clinical setting.

IMPLEMENTING THE ACA TO IMPROVE WOMEN'S HEALTH AND PREGNANCY OUTCOMES
Nancy C. Lee, M.D., Deputy Assistant Secretary for Health—Women's Health; Director, Office on Women's Health, HHS

Dr. Lee's presentation covered the promise of the ACA regarding women's health in the United States. She began by stating her agreement with the idea that healthy babies require healthy mothers.

Dr. Lee began by citing the leading causes of death for reproductive-age women in 2010. In the 15- to 24-year-old age group (7,800 deaths), the three top causes of death were accidents, suicide, and homicide and only 2 percent of deaths were due to pregnancy. Among 25- to 44-year-old women, the three leading causes of death were cancer, accidents, and heart disease. Dr. Lee pointed out that the leading causes of death among women are clearly tied to the social determinants of health, including sex, income, and education. She cited a study by Kindig and Cheng in which the authors examined the change in female mortality by county from 1992 to 2006 and found that female mortality worsened. The pattern of female hardship is clearly linked to socioeconomic factors.

The ACA is an important initiative to improve the health of women through prevention. Preventive services will be covered by private insurance plans without copays. Covered preventive services for women include blood pressure, cancer screening, cholesterol, depression, diabetes, osteoporosis, sexually transmitted infections (STIs) and HIV/AIDS, alcohol abuse screening and counseling, dietary counseling, obesity counseling, tobacco cessation interventions, and immunizations. Other covered preventive services for women include HPV DNA testing, Food and Drug Administration (FDA)-approved contraceptive methods and sterilization, screening and counseling for interpersonal violence, and at least one well-woman visit annually. The ACA also will cover services for pregnant women without cost-sharing, including screening for various conditions, breastfeeding counseling, and the cost of renting breastfeeding supplies.

More than 47 million women will be eligible for preventive services without cost-sharing under the ACA. The law also protects women. In 2014, women cannot be charged more for the same coverage as men, insurers will not be able to deny coverage to women because of preexisting conditions and insurers will not be able to impose a lifetime cap on coverage. By 2016, 13 million women will gain insurance coverage; in 2014, 8.7 million women with individual insurance plans will gain maternity coverage.

The MIECHV program will be funded over 5 years at $1.5 billion. Grants go to almost all States. The program goals are to improve maternal and newborn health, prevent child abuse and domestic violence, improve school readiness, and improve economic self-sufficiency. Nurses and social workers will meet with families in their homes and connect the families to needed

assistance. Seventy-five percent of funding goes to program models that have been proven effective.

Beginning on October 1, 2013, individuals, families, and small-business owners in every State will gain access to affordable, quality health insurance through the new Health Insurance Marketplace. Coverage will begin in January 2014. Dr. Lee described the characteristics of the Marketplace. About 49 million Americans are currently uninsured, and 13.5 million women will get insurance through the ACA. After reviewing eligibility requirements for the Marketplace, Dr. Lee stated that every health insurance plan in the Marketplace will offer essential health benefits, including preventive services, in 2014. The essential health benefits include maternity and newborn care, behavioral health treatment, and prescription drugs. A catastrophic plan will be available to individuals under 30 years of age.

The Marketplace is a new way to find and buy health insurance from private companies. Individuals and small businesses will be able to shop for insurance that fits their budget. People with limited income will receive financial help, and assistance will be available to help people get the best coverage for their needs. Employer-based coverage will continue, and insurance will continue to be sold outside the Marketplace. Purchase from the Marketplace is not required, but the Marketplace is the only place to get access to the new premium tax credits and cost-sharing reductions.

Dr. Lee concluded her presentation by stating that the ACA and its benefits will help women and their families. To learn more about the ACA, Dr. Lee urges individuals to go to womenshealth.gov and healthcare.gov.

Q&A and Comments

Dr. Lee's presentation prompted the following question:

- Miriam Lubbok, M.D., M.P.H., asked about the need for detailed definitions of the preventive services under the ACA, including contraception, home visits, and dental care. Dr. Lee stated that HHS is only interested in providing broad guidance to providers, health care plans, and States regarding how to set up Marketplaces. HHS will work with other professional organizations on recommendations concerning, for example, the well-woman visit. Dr. Lee noted that in the past several groups offered similar recommendations regarding Pap screening. With the ACA, clinical judgment and knowledge will be left to providers.

Strong Start
*Erin Smith, J.D.***,** Patient Care Models Group, Center for Medicare & Medicaid Innovation (CMMI), 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 before 39 weeks for all populations and (2) testing enhanced prenatal care models to reduce preterm births for high-risk women enrolled in Medicaid and CHIP.

Ms. Smith described three components of the first strategy: (1) promoting awareness, (2) rapidly spreading best practices, and (3) promoting transparency. Media outreach involved television, radio, print, in-store audio, search engine marketing, and waiting room television. In addition, a WebMD consumer page is scheduled to launch in May. To spread best practices, CMS has successfully worked with Medscape and WebMD on early elective delivery continuing medical education (CME) opportunities and is working with the Partnership for Patients, including the participating hospital engagement networks (HENs). The evaluation data indicate success in spreading best practices involving elective deliveries. To promote transparency, in the fiscal year 2013 Inpatient Prospective Payment System final rule, CMS finalized the addition of a new measure to the Inpatient Quality Reporting (IQR) program, which involves elective delivery before 39 completed weeks of gestation.

Regarding the second strategy, Ms. Smith explained that awardees will test enhanced prenatal care through evidence-based models. The four prenatal care models to be evaluated are (1) centering/group care, (2) birth centers, (3) maternity care homes, and (4) home visiting. CMS awarded 27 cooperative agreements on February 15, 2013. The Strong Start awardees will serve women in 32 States, Puerto Rico, and the District of Columbia at 181 health care sites, including more than 80,000 women in Medicaid and CHIP over 3 years. The areas served by the Strong Start awardees are those with the highest preterm birth rates and infant mortality rates.

The evaluation strategy is still developing. Methods include baseline comparison, contemporaneous comparison group, site visits, interviews, and linking State Medicaid and vital records data. The outcomes to be examined are reduced preterm birth measured through gestational age and birthweight, reduced cost of care for women and infants, frequency of ongoing prenatal care, timing of prenatal care, appropriate use of antenatal steroids, delivery, elective delivery before 39 weeks, appropriately timed postpartum care, and patient experience during care.

Q&A and Comment

Ms. Smith's presentation prompted the following question and comment:

- Dr. Kotelchuck asked whether the evaluation would be done in-house. Ms. Smith responded that a national evaluation will be carried out through a contractor. Dr. Kotelchuck remarked that linking Medicaid and vital statistics data will be beneficial on a national level.

COMMITTEE DISCUSSION ON RECOMMENDATIONS FOR IMPROVING THE HEALTH OF WOMEN AND MOTHERS

Before the committee discussion began, Dr. de la Cruz confirmed that the following committee members were not participating in this day's webinar: Drs. Corwin, Pressler, Mayer, and Troutman. Dr. Handler summarized the meeting's presentations and listed potential strategies that SACIM might want to endorse, including supporting ACOG's Year of the Woman, dissemination of preconception/interconception toolkits for providers, a new approach to the postpartum visit, linking the postpartum visit and interconception care to MIECHV, Medicaid coverage for doula support, support for centering parenting, and several others. (See appendix A

of these meeting minutes for Dr. Handler's summary of ideas for HHS action to support improvements in women's health.) Kay Johnson, M.Ed., stated her endorsement of all of the ideas in the list and added some refinements.

Dr. Handler mentioned the tension between targeting women with chronic conditions versus targeting all women. Ms. Johnson pointed out that the preconception focus should be on all women, but the interconception piece involves women with a prior adverse pregnancy outcome. This distinct focus requires intense case management and SACIM should support it. Dr. Handler pointed out that women as well as infants can suffer from an adverse pregnancy outcome.

Dr. Jackson cited this as an opportune time to ask women what would make it attractive for them to participate in the postpartum visit. Two areas go beyond chronic conditions: weight and emotional health. Dr. Jackson asked whether the home visit includes intensive information about diet, nutrition, and exercise. Ruth Ann Shepherd, M.D., FAAP, added that home visiting should be linked to the medical home. She also suggested adding to the list the importance of women accessing preventive services without copays. According to the Bureau of Primary Care (BPC), individuals served at community health centers must pay a nominal fee or a sliding scale fee. Dr. Shepherd stated that SACIM should consider challenging HRSA's BPC to align with the ACA, particularly for low-income populations, to offer care without cost to patients.

Dr. Lubbock suggested that SACIM offer advice about intervention areas and what is included in all of the preventive services. Dr. Handler stated that numerous groups are already working on this issue, and Ms. Johnson added that this suggestion does not fit with SACIM's charge. The emphasis should be on the role of HHS in developing detailed and specific guidelines like those in Bright Futures for Children. SACIM's recommendation is for HHS through HRSA to empower MCHB to do the same for women. Key stakeholders should be convened to move that work forward.

Dr. Atrash stated that MCHB is already working on interconception care in Healthy Start sites. ACOG and OWH are beginning the process of developing guidelines for well-woman care, and HRSA's role is to facilitate that process. Dr. Handler pointed out that part of SACIM's mission is to support work that is ongoing in HHS; SACIM should likewise support the Maternal Health Initiative in MCHB. Regarding the interconception care piece, SACIM can endorse the idea of linking medical health care support to the social determinants of health. Dr. Atrash mentioned the clinical guidelines regarding the content of well-woman visits during different stages of life. He reported that meetings have occurred with representatives from professional organizations such as ACOG and Federal agencies. Dr. Lu added that he recognizes the importance of the need for guidelines regarding home visiting; however, there are limits to what can be done presently under current legislative authority in terms of enhancement to the existing models. The potential expansion and reauthorization of MIECHV is linked to ways in which to strengthen the program, and support from SACIM would be helpful.

Iris Mabry-Hernandez, M.D., M.P.H. from AHRQ asked about the issue of prioritizing in regard to recommendations to the Secretary. Dr. Handler and Ms. Johnson responded that SACIM does not make recommendations regarding clinical content but does make recommendations regarding policy, administrative action, and implementation. Ms. Johnson stated that SACIM comprises

thoughtful people who generate new ideas and make specific recommendations regarding maternal health.

Dr. Barfield asked about the issues of primary care and medical home. Dr. Atrash stated that the plan is to have ACOG, as a coordinator or organizer, meet with other organizations to discuss the role of primary providers.

Dr. Martin asked whether the list of actions for HHS could be made available to the SACIM members for consideration. Dr. de la Cruz responded that the list will be available through the transcript and the meeting minutes. Dr. Handler volunteered to provide the list at the next day's meeting.

Dr. Lubbock mentioned the Institute of Medicine report, *Clinical Preventive Services for Women: Closing the Gaps*, as a source of information on prevention and treatment. Dr. Handler will add it to her list. Dr. Lubbock also mentioned reproductive health cycles and the continuum of care as covered by the American Academy of Family Physicians.

Dr. Dominguez mentioned that the list compiled by Dr. Handler seems very long and involved. To flesh out the women's health strategies, SACIM should organize or prioritize the information for presentation to the Secretary. Dr. Handler stated that the Women's Health subcommittee would flesh out the ideas and organize them.

Dr. Kotelchuck mentioned that there was consensus about developing clinical guidelines for interconception care. He encourages MCHB to engage in ways to increase demand for interconception care and to discover from the woman's point of view what would be helpful. He added that in addition to clincial care and social determinants, the discussion involves maternal resilience. SACIM should encourage HRSA and MCHB to include social determinant factors that affect the health of women and families.

WRAP-UP AND ADJOURN FOR THE DAY
SACIM Committee Member: Arden Handler, Dr.P.H., M.P.H.
Michael C. Lu, M.D., M.P.H., Associate Administrator for Maternal and Child Health, HRSA; Executive Secretary, SACIM
David S. de la Cruz, Ph.D., M.P.H., Principal Staff and Designated Federal Official, SACIM; Deputy Director, MCHB/Division of Healthy Start and Perinatal Services

Dr. de la Cruz thanked the participants for the day's discussion, and Dr. Atrash praised the presenters for the informative presentations and thanked SACIM for its input. Dr. Lu noted the leadership and support from HRSA and other Federal partners, including CDC, OWH, and CMS, as well as leadership at the State level and in the private sector. He thanked the SACIM members for their dedication and energy.

Dr. de la Cruz reviewed the second-day agenda before adjourning the meeting at 5 p.m.

THURSDAY, APRIL 25, 2013

WELCOME AND CALL TO ORDER

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

Dr. de la Cruz welcomed the participants to the second day of the meeting and called the meeting to order.

PUBLIC COMMENT PERIOD

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

Dr. de la Cruz explained that the public comments are usually submitted a week in advance so that they can be included in the public record, but because of problems with the Federal Registry, the notice was published after the deadline for submission for this meeting. He asked the meeting paticipants to type in their comments in the Public Comments box of Adobe Connect. They will be submitted to the official record. (See appendix B of this summary for a compilation of the public comments.)

FEDERAL UPDATES

Healthy Start

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

Dr. Atrash thanked SACIM for its continuing support of Healthy Start and confirmed the commitment of HHS to continuing work to improve pregnancy outcomes.

In terms of Healthy Start expectations, the program was established in 1991 to look for communitywide commitment and unconventional approaches. The Government commitment is to provide resources and develop usable model programs that work. The Federal program was established to attract new support from State, local, and private sources for sustainability, replication, and dissemination. Dr. Atrash described the initial Federal investment in 1991 and additional funding through 2001. Today Healthy Start supports 105 grantees in 39 States. An evaluation report states that in 2010, more than 90 percent of Healthy Start sites were implementing all nine core components of the program. Most Healthy Start sites offer the following services: home visiting, breastfeeding support and education, smoking and other tobacco use cessation, healthy weight services, male and family involvement, domestic/intimate partner violence screening, and child abuse screening or services.

Dr. Atrash reported that significant progress has been made in reducing infant mortality and very low birthweights. The number of infant deaths in Healthy Start communities was reduced by 48 percent. Improvement also has been noted in the percentage of babies born with low birthweight and very low birthweight. Other successes have been noted in specific Healthy Start sites. For example, in the Westside Healthy Start program in Chicago, the percentage of participants who received prenatal care in the first trimester rose from 64 percent in 2007 to 72 percent in 2011, and the percentage of participants who initiated breastfeeding rose from

46.6 percent in 2009 to 60.6 percent in 2012.

After 22 years of Healthy Start, the question is whether the program has lived up to the expectations of communities and lawmakers. A 1997 congressional hearing titled "Healthy Start Program: Implementation Lessons and Impact on Infant Mortality" inquired about the impact of Healthy Start initiatives on the leading causes of infant mortality and the effectiveness and sustainability of community action to improve the health of at-risk infants. Dr. Atrash described the challenge and noted that Healthy Start has made only a small dent in solving the problem of infant mortality and low birthweight. The 30,759 pregnant women served by Healthy Start represent only 0.78 percent of the almost 4 million women who gave birth in 2010. The 19,273 babies born in Healthy Start communities represent only 0.49 percent of the almost 4 million babies born nationally in 2010. The 90 infant deaths in Healthy Start sites represent 0.37 percent of the almost 25,000 infant deaths nationally in 2010.

Dr. Atrash stated that Healthy Start has a responsibility to demonstrate the effectiveness of its programs with a focus on health outcomes, to demonstrate sustainability and impact on systems, and to scale up and disseminate interventions to serve the larger population. Dr. Atrash also stated the need, for moral, ethical, and legal reasons, to respond to critics and acknowledge the need to change.

The two themes of Healthy Start are (1) doing the right things and (2) doing things right. In terms of "doing the right things," Healthy Start has a unique role to play in communities that goes far beyond infant mortality prevention. Five Healthy Start guiding principles are (1) informing policy to ensure access, (2) promoting resilience through education, skills-building, and employment, (3) ensuring cultural and linguistic competency, (4) ensuring consumer engagement and involvement, and (5) promoting health equity. Five critical elements of Healthy Start are (1) community-based service delivery, (2) comprehensive health care, (3) care coordination, (4) systems integration, and (5) quality improvement and evaluation. In terms of "doing things right," the Healthy Start program must move from demonstration to replication. To do so, the following actions are needed: (1) identification and documentation of objectively proven effective interventions, (2) uniformly implemented interventions, (3) monitoring of interventions and outcomes, (4) ongoing evaluation of activities and their impact at the local and national levels, (5) feedback for action, and (6) documentation of interventions and outcomes.

Healthy Start is planning to build on lessons learned over the past 22 years, to develop clear evidence-based tools and practice guidelines for all interventions at all levels, and to ensure a skilled workforce at all levels. To be seen as experts in infant mortality reduction, it will take a strong infrastructure and competent management and guidance; knowledgeable, skilled, competent, passionate, and hard-working individuals at all levels; a feedback loop, including collection, analysis, dissemination, and use of relevant data; a strong consortium and meaningful collaboration with Title V and other relevant organizations; and intense documentation.

Next steps will involve an internal strategic plan from the Division; input, advice, and guidance from key stakeholders; and strategic planning principles reflected in the guidance for funding in the future.

Update From MCHB
Michael C. Lu, M.D., M.P.H., Associate Administrator for Maternal and Child Health, HRSA; Executive Secretary, SACIM

Dr. Lu provided an overview of MCHB and its activities related to infant mortality. The mission of MCHB is to improve the health of all children and families in the Nation, and the President's 2014 proposed budget continues to support that mission. Dr. Lu highlighted some of the key programs related to infant mortality: the Title V block grant, the Heritable Disorders in Newborns Screening Program, and the MIECHV program.

Q&A and Comments

The presentations by Drs. Atrash and Lu prompted the following questions and comments:

- Ms. Judy Wilson asked whether Healthy Start will continue to link women with nutrition services and programs such as WIC. Dr. Atrash stated that Healthy Start grantees are expected to connect women with their local services, and Healthy Start will initiate a stronger focus on doing so. Healthy Start is the hub that brings together all providers in the community to meet clients' needs.
- Dr. Jackson asked whether Healthy Start will be given the resources to provide the needed documentation, and she stressed that research must be integrated with services. Dr. Atrash stated that he does not see documentation as a separate process from service delivery. Resources are available for grantees to report on their activities, but reporting also should include maternal morbidity and hospital admissions, that is, items beyond low birthweight and infant mortality.
- Dr. Jackson asked about the number of Healthy Start projects that might be added as the demonstration phase closes. She also asked about Healthy Start being elevated to a level that recognizes its expertise. Dr. Atrash responded that after 22 years Healthy Start should be leading other nationwide activities, such as the CoIIN. The problem is that Healthy Start is not well known; the program must better define what it does—from providing basic services, to providing mentoring or training activities, to establishing consortiums to leverage resources and information, to providing comprehensive care to all women in their communities. Dr. Jackson added that some of the issues related to Healthy Start's lack of presence concern equity.
- Ms. Sanders mentioned the collaborative work in Missouri on coordinating MIECHV with the three Healthy Start sites there, where each site uses a different model for home visits. She asked about a possible movement to get Healthy Start sites to convert their home visiting model to an evidence-based model. Dr. Atrash responded that interventions must be defined and provided to grantees, and evidence-based approaches for home visiting do exist. Some grantees do outreach whereas others do home visiting. Outreach requires a basic knowledge of breastfeeding, etc., and referral to proper services. Expected best practices that have been tested are required.
- Mark Bartel, M.Div., asked how HRSA and Healthy Start can coordinate and collaborate with other groups to increase the number of women and communities served. He mentioned that competition seems to exist among the home visiting groups. Dr. Atrash stated that both MIECHV and Healthy Start exist in the same Bureau and the expectation

is that Healthy Start grantees will work closely with other programs. Dr. Lu mentioned the absense of significant overlap between Healthy Start and MIECHV. As home visiting expands, a broader, more comprehensive vision of the work will be needed. Healthy Start is more than just a program to reduce infant mortality; rather, it should be the first rung on the ladder of opportunity for family support programs. It should not be in competition with other programs.

- Dr. Kotelchuck referred to the goals of the transformation of Healthy Start, in particular, the concept of resilience. Healthy Start's work involves coordination with health care, but it also affords women the capacity for resilience, which should be measured. Healthy Start also addresses the social determinants of health. Dr. Kotelchuck agrees with Dr. Lu that coordination, not competition, with MIECHV is needed. Dr. Atrash referred to the highlights he presented of Healthy Start's strategic plan, which includes priorities and strategies for interventions and outcomes. Coordination is the key to avoiding duplication of services. Dr. Lu added that resilience is a critical factor. Referring to the work of Nobel laureate economist James Heckman, Dr. Lu stated that success in America today depends on three capacities formed early in life: cognitive, noncognitive, and health. The noncognitive capacity involves social/emotional skills, or what many call "resilience." Healthy Start can be viewed as a backbone organization in communities to promote parenting education and is uniquely positioned to serve its communities with a collective impact. Healthy Start sites have an important leadership role in their communities as a comprehensive early childhood and family support system.

Update From CMS

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

Dr. Lillie-Blanton presented an update on some of the efforts underway at CMS and CHIP. Medicaid and CHIP now cover about 40 percent of births in the United States. CMS is currently engaged in three separate but related efforts: (1) the Expert Panel on Improving Maternal and Infant Outcomes in Medicaid and CHIP, (2) measuring and tracking care, and (3) the quality of care.

Dr. Lillie-Blanton explained that the expert panel is co-chaired by Dr. James Martin, former president of ACOG, and Dr. Mary Applegate, Ohio's Medicaid medical director. They are working with a distinguished and engaged group of thought leaders, clinicians, and advocates charged with identifying strategies that can be implemented in the short term. The expert panel is divided into four workgroups: (1) effective reproductive enablers, (2) enhanced maternal care management, (3) data and reporting, and (4) payment strategies. The groups will issue a report, and the panel will present its strategies to CMS.

CMS also is working to better measure and track care. The agency has identified a set of child and adult core measures. The maternity core set includes eight measures; a ninth measure involves well-child visits for infants up to 15 months of age. CMS also has been working with CDC and a subcontractor to analyze birth outcomes in Medicaid and privately insured women. In addition, CMS is collaborating with Medicaid directors on a project on early elective deliveries and is working with HRSA to strengthen ties to establish better linkages to vital records.

In terms of quality of care, CMS is engaged in two efforts funded through the Children's Health Insurance Program Reauthorization Act (CHIPRA) and the ACA. These efforts are focused on several maternal and child health outcomes and will drive improvements in quality of care. A quality improvement webinar series will focus on maternal and infant health. Dr. Lillie-Blanton announced that Lakisha Daniel-Robinson, M.S.P.H., who is very knowledgeable in the area of maternal and infant health care, will be coordinating these efforts.

Update From the Agency for Healthcare Research and Quality
James B. Battles, Ph.D., Social Science Analyst for Patient Safety, Agency for Healthcare Research and Quality (AHRQ)
LTC Shad Deering, M.D., FACOG, Assistant Dean for Simulation Education, Uniformed Services University of the Health Sciences (USUHS); Deputy Medical Director, USUHS Simulation Center; Chair, Central Simulation Committee

Dr. Battles stated the objectives of the AHRQ presentation: (1) to update SACIM on the current AHRQ and Department of Defense (DoD) collaboration and projects to improve maternal and fetal morbidity and mortality and (2) to understand the critical importance of patient safety on the labor and delivery unit.

Dr. Deering pointed out that childbirth in the United States accounts for 4 million hospitalizations per year. In terms of patient safety in obstetrics, two patients may potentially be injured with every case. Perinatal adverse outcomes affect women, children, and families and can have lifelong consequences for survivors or can lead to premature death. Pointing to the incidence of severe maternal morbidity trends, Dr. Deering stated that major complications for mothers giving birth in U.S. hospitals increased 75 percent in the decade ending in 2009. The complications include shock, acute renal failure, heart attack, thrombotic embolism, and need for hysterectomy.

Quality Patient Care in Labor and Delivery: A Call to Action was endorsed by seven national organizations. These organizations recognized that structured systems help to optimize communication about and response to rapid changes in patient status. Communication tools and training in principles of crew resource management are critical to ensuring best outcomes. In addition, drills and simulations are necessary to prepare for emergencies. Dr. Deering explained that labor and delivery is the unit of change and improving intrapartum care improves outcomes for mothers and babies. Furthermore, mistakes during labor can last a lifetime, and multiple evidence-based strategies are now available to accomplish goals.

Dr. Deering stated that evidence demonstrates that simulation training decreases brachial plexus injuries fourfold, can shorten time to delivery for cord prolapse cases by nearly 10 minutes, and can result in better care with eclampsia cases. Likewise, operation room safety checklists decrease morbidity and mortality by 30 to 40 percent. In addition, teamwork training improves the adverse outcome index (AOI) by 37 percent when combined with simulation and leads to a decrease in medication and transfusion errors. Current evidence also demonstrates significant decreases in malpractice payments and the number of sentinel events.

DoD initiatives include the Mobile OB Emergencies Simulator, a simulation-based package used on the labor and delivery unit and funded by AHRQ, which uses an obstetric birthing mannekin. All DoD hospitals have this program and the ability to conduct emergency simulations. Another initiative is the Safe Cesarean Section Checklist. In addition, TeamSTEPPS and simulation training were integrated into a combat support hospital and resulted in a significant decrease in medical and communication errors.

Dr. Deering explained the comprehensive obstetric patient safety program. A new focus on implementing patient safety programs in a comprehensive manner (i.e., including all programs under one umbrella) leads to improved oversight and efficacy and improved patient safety. The components of the program include education and training, teamwork and communications, outcomes and evaluations, and systems evaluation and improvement. Implementing a comprehensive obstetric patient safety program led to a significant decrease in mean annual malpractice payments from $27 million to $2.5 million. Sentinal events between 2000 and 2009 decreased from 1.04 per 1,000 to 0.0 per 1,000 deliveries.

Dr. Battles described major programs in patient safety and medical liability. AHRQ funds seven demonstration projects, with two of those programs in labor and delivery. One project is with the Ascension Health Care System, which implemented perinatal care bundles and simulation training. The results demonstrate decreases in elective inductions, operative delivery rates, and birth tauma rates. The primary cesarean rate remained unchanged at 22.5 percent, and no medical liability cases have been reported to date in participating hospitals. The other project, with the Fairview Health Services and Premier, combines perinatal care bundles, TeamSTEPPS, and in situ simulation. The results demonstrate a 23-percent reduction in preventable birth traumas, a 38-percent reduction in preventable newborn intensive care unit admissions, and a 12-percent reduction in the rate of preventable birth-related maternal complications.

The Perinatal Safety Intervention Program (PSIP) spreads lessons learned from AHRQ and DoD efforts nationwide. PSIP is geared toward hospital-based labor and delivery health care teams and is designed for use by perinatal teams across various hospital types, geographic locations, and staffing and resource levels. Training and implementation support is provided. PSIP implementation involves (1) building a core team, (2) providing teamwork, communication, and safety training, (3) selecting PSIP components for general obstetrical care and for obstetric emergency prevention and response, (4) implementing PSIP, and (5) evaluating and learning. Combining TeamSTEPPS and simulation is what drives the change.

Dr. Battles explained that PSIP field-testing will begin in summer 2013 and will include DoD institutions. AHRQ is in the process of recruiting institutions, States, health systems, and HENs to participate. The PSIP toolkit will be available on the Web in early 2014.

In summary, Dr. Battles stated that AHRQ and DoD are working together to improve outcomes for mothers and babies and that focusing on the labor and delivery unit will produce the largest return on investment in many areas. Programs are separate but closely integrated. Dr. Deering added that the evidence regarding positive outcomes for mothers and babies must be disseminated.

Q&A and Comments

The presentations from Dr. Lillie-Blanton and Drs. Battles and Deering prompted the following questions and comments:

- Dr. Cox mentioned that Dr. Deering is one of the pioneers in developing obstetric simulation. Simulation has been used at Ascension for about 8 years, and disclosure and rapid resolution training have led to a decrease in malpractice events, a significant reduction in primary cesarean section rates, and a reduction in a number of birth trauma events. Dr. Cox thanked AHRQ and DoD for their leadership in making labor and delivery units across the country much safer.
- Dr. Shields commented that since 1991 she has been involved with the Advanced Life Support in Obstetrics (ALSO) program, which teaches obstetric emergency simulation to family physicians. She asked how the program described by Drs. Battles and Deering overlaps or integrates with the ALSO program. Dr. Deering noted that the ALSO course provides the same type of tools but both medical knowledge and teamwork/communication are important. In situ simulation involves teams and facilities that cannot be duplicated in a course. Dr. Battles mentioned discussions with the leadership of ALSO about integrating teamwork into the program.

STATE ACTION TO IMPROVE BIRTH OUTCOMES

National Governor's Association

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

Mr. Osberg presented an update on the Learning Network on Improving Birth Outcomes. The first of three Learning Networks is underway in four States: Kentucky, Connecticut, Michigan, and Louisiana. The four States will be brought together at a Learning Network conference on May 17 to discuss their progress and to hear from experts and officials regarding this effort. The Learning Network program, which is sponsered by HRSA and the Association of State and Territorial Health Officers (ASTHO), helps States to coordinate and streamline current efforts like Strong Start and the CoIIN.

A number of applications have been received, round two applications are due April 26, and third round applications are scheduled for this fall. The Learning Network involves in-State planning sessions, consultation, and a networking conference. A high level of involvement exists at the State level and in the private sector, but data systems are a common challenge. Issues raised involve preconception and interconception care and early elective deliveries.

The National Governor's Association is undertaking other maternal and child health activities. The annual survey this year will focus on improving birth outcomes, a recent webinar focused on children's health disparities, a policy paper is forthcoming on maternal and child health and health reform, and a brief will be issued on improving birth outcomes for the Medicaid population. Information on health care issues can be found at http://state policyoptions.nga.org.

Association of State and Territorial Health Officers (ASTHO)
Ellen Pliska, M.H.S., C.P.H., Family and Child Health Director
Monica Valdes Lupi, J.D., M.P.H., Senior State Public Health Advisor

Ms. Pliska announced that all 50 States have taken the pledge to reduce prematurity by 8 percent by 2014. ASTHO is developing a health equity index with the United Health Foundation and a national expert panel. A tool will be developed for setting "goodness" and "fairness" goals using the best available data. The tool will show disparities that are driving the index number for the States, including health outcomes and subpopulations. ASTHO also is involved in a Medicaid payment study to determine the impact of payment policy changes on selected perinatal outcomes. A natural experiment observation study will address this point in four States: Louisiana, Mississippi, Oklahoma, and Texas.

ASTHO also is tracking Medicaid payment and early elective delivery legislation and regulation as well as Michigan's infant mortality reduction plan. In Michigan, the governor's 2014 budget puts $2.5 million towards infant mortality reduction. The infant mortality plan for 2012–2015 aims to reduce racial and ethnic disparities. Various measures are publicly monitored on a dashboard of Michigan health indicators, which can be found at www.michigan.gov/midashboard. In addition, ASTHO is monitoring the Ohio Perinatal Quality Collaborative, which has shown significant success in a 3-year period.

Ms. Pliska reminded the SACIM members about the contents of the ASTHO Healthy Babies Web site (www.astho.org/healthybabies). She noted that information on health equity and health policies also can be found on the ASTHO Web site.

Association of Maternal and Child Health Programs (AMCHP)
Michael Fraser, Ph.D., C.A.E., Chief Executive Officer

Dr. Fraser shared some updates from AMCHP. He referred to CDC's National Center for Health Statistics (NCHS) report on the 12-percent decline in infant mortality and the 16-percent decline in infant mortality among African Americans since 2005. He asked how SACIM will amplify and leverage that good news and recommended a congratulatory letter to the Secretary with a call for excelerated progress. The data show how the improvement has occurred but they do not explain why. The answer is that the collective work of many individuals and groups has lead to the good news about infant mortality.

Dr. Fraser noted the importance of adding women's health and the lifecourse perspective to maternal and child health. He also noted that the President's 2014 budget proposes flat funding for most maternal and child health programs as well as an increase in the expansion of MIECHV. He suggested that SACIM send a note of thanks to the administration for the expansion of MIECHV. On the other hand, AMCHP is worried about the impact of cuts in HHS work because of the sequester. Dr. Fraser stated that the HHS strategy for dealing with the cuts has not been shared widely with States and local partners, who are interested in specific suggestions and guidance regarding Title V.

Dr. Fraser praised SACIM's national strategy's comprehensive recommendations and asked

about the process to finalize the recommendations. He reiterated that AMCHP would be glad to vet the recommendations among State leaders at an appropriate time to seek buy-in about what will be needed for implementation.

CityMatCH
Chad J. Abresh, M.Ed., Executive Director

Mr. Abresh presented an overview of CityMatCH's three infant mortality initiatives: (1) the Institute for Equity in Birth Outcomes, (2) Perinatal Periods of Risk (PPOR), and (3) Best Babies Zone.

The Institute for Equity in Birth Outcomes project (Equity Institute) applies a scientific focus to the work of reducing inequities in birth outcomes. Teams implement and evaluate a local project aimed at producing measurable improvements in inequities. A high-visibility national summit will showcase results and impacts. The first cohort of Equity Institute training includes Baltimore, West Palm Beach, San Francisco, and Dayton. In the coming months and years, the Equity Institute will produce curriculum content, project launch reports, and the first Equity Institute summit in summer 2015. Mr. Abresh announced that CityMatCH in Ohio has entered into an agreement to launch the Ohio Institute for Equity in Birth Outcomes in eight cities.

PPOR has been adapted for use in urban communities as an analytic framework and community process for investigating and addressing local causes of fetal/infant mortality. It helps communities to determine how best to allocate limited resources for maximum return and is a community engagement and empowerment project. This year, CityMatCH is partnering with MCHB to deliver a new PPOR training in three selected Healthy Start sites.

Best Babies Zones in New Orleans, Oakland, and Cincinnati uses three main strategies: (1) taking a neighborhood or zonal approach, (2) working toward collective impact change across four domains (education/early childhood, economic development, health services, and community systems), and (3) cultivating a public health social movement to support and advance real change.

CityMatCH has a twofold scope of work in 2013: (1) coordination, training, oversight, and implementation of work at the three Best Babies Zone sites and (2) design and development of the *BBZ Guide*, a step-by-step workbook for building a Best Babies Zone.

Mr. Abresh concluded his presentation by stating that CitymatCH's initiatives are aligned to demonstrate an achievable path forward for reducing longstanding inequities.

HRSA/MCHB Collaborative Improvement and Innovation Network (CoIIN) on Infant Mortality
David S. de la Cruz, Ph.D., M.P.H., MCHB CoIIN Coordinator; Principal Staff and Designated Federal Official, SACIM

Dr. de la Cruz presented information about the way in which CoIIN uses the science of quality improvement and collaborative learning to reduce infant mortality. A CoIIN is a team of self-

motivated people with a collective vision, enabled by the Web to collaborate in achieving a common goal by sharing ideas, information, and work. Cyber teams communicate through webinars, telephone conferences, and email. The model requires that everyone be part of the solution. CoIN has been adapted to CoIIN (an added I) to reflect the focus on both innovation and improvement. Dr. de la Cruz presented highlights of the history and vision of CoIIN, which started in the Southern States in 2012 and was born out of previous State-level work by ASTHO and the March of Dimes. A nationwide expansion is planned. Dr. de la Cruz emphasized that CoIIN is team driven and State driven and is not HRSA led.

The CoIIN design revolves around five common strategies for Regions IV and VI: (1) promote smoking cessation, (2) expand interconception care in Medicaid, (3) reduce elective deliveries, (4) enhance perinatal regionalization, and (5) promote safe sleep. The five strategies became the five strategy teams, which were expanded to work at the State level. Each State has indentified its aims and strategies, and at present measures are being selected to track progress toward the aims over the next 12 to 18 months. The plans will begin to be implemented at the State level.

Dr. de la Cruz briefly reviewed the aims and strategies involved in each of the five common strategies and then described next steps over the next 6 months. The Regions IV and VI strategy teams will continue to refine the metrics, and the strategies will be implemented at the State level. Process and outcome measures will be tracked, and plans will be made for the second face-to-face meeting. The CoIIN will be expanded to Region V in March 2013 and to other Regions. Region V possible strategies might involve the social determinants of health, sudden infant death syndrome and sudden unexpected infant death (SIDS/SUID), and preconception care.

Dr. de la Cruz concluded his presentation by stating that CoIIN is designed (1) to help States innovate and improve their approaches to reducing infant mortality and improving birth outcomes through communication and sharing across State lines and (2) to use the science of quality improvement and collaborative learning to improve birth outcomes. He reiterated that these activities are State and Region led, not directed by HRSA, whose role is to provide guidance and support for the work being done at the State and regional levels. It is hoped that CoIIN will expand to all of the Regions by the end of this year.

Q&A and Comments

The presentations from the National Governor's Association, ASTHO, AMCHP, CityMatCH, and Dr. de la Cruz prompted the following questions and comments:

- Dr. Cox stated that CoIIN tactics reveal interesting work done "on the ground." He asked whether there is a way to catalogue those tactics from the communities. Dr. de la Cruz stated that documentation and collection of data and work that is being done are strong components of CoIIN. As lessons are learned, they will be shared. Dr. Cox noted that sharing tactics and strategies in low-volume hospitals or communities can be difficult.
- Ms. Sanders mentioned that Missouri has the lowest tobacco tax in the country, with huge smoking rates, and she asserted that the CoIIN strategy in Tennessee helps to reframe an approach to the problem.
- Dr. Handler suggested that a grid, map, or organizing framework could provide some

guidance about potentially duplicative efforts in the States and localities. Dr. de la Cruz acknowledged her concern.

- Dr. Shepherd mentioned that the CoIINs are cataloguing their main strategies and tactics along with their successes. She agrees that some sort of framework should be devised so that States can be aware of and select from all of the ongoing activities.
- Dr. Cox remarked that resilience takes place at the neighborhood and ZIP Code levels. Mr. Abresh stated that CityMatCH relies on communities to provide local data and that crossover does occur among the three initiatives he discussed. Dr. Cox added that high-risk communities need particular attention and resources.

IT'S ONLY NATURAL: MOTHER'S LOVE. MOTHER'S MILK.
Suzanne Haynes, Ph.D., Senior Science Adviser, Office on Women's Health

Dr. Haynes announced the recent launch of It's Only Natural, a campaign to raise awareness among African American women of the importance of and benefits associated with breastfeeding. The campaign comprises radio PSAs, a Web site, and collateral materials.

Breastfeeding rates for African American women are significantly lower than those for Caucasian women. About 80 percent of Caucasian women indicate that they want to initiate breastfeeding compared with only 55 percent of African American women. The It's Only Natural campaign was developed because of the disparity. A comprehensive Web site delivers information to women at womenshealth.gov/itsonlynatural. The Web site includes seven sections, written at a 6th- to 8th-grade level, and a variety of videos and materials. The seven sections include (1) planning ahead, (2) overcoming challenges, (3) addressing breastfeeding myths, (4) finding support, (5) fitting it into your life, (6) my breastfeeding story, and (7) resources (including a poster, factsheets, and a facilitator's guide).

Dr. Handler asked whether focus group testing was conducted for the videos and mentioned that the women in the video seem to be upper or middle class. Dr. Haynes replied that the videos comprise a mixture of middle and lower class women and focus groups were held around the country. The focus groups discovered that women get information from the Internet and from peers. Dr. Barfield asked whether any scenarios depict women with premature infants because the evidence shows that mother's milk is best for these infants. Dr. Haynes replied that premature infants are not addressed specifically in the videos, but many of the focus group mothers had had premature infants.

Dr. Haynes stated that one of the most frequently voiced concerns among women is that they do not know if their babies are getting enough milk. This concern and breastfeeding myths in the African American community are addressed on the Web site as are topics such as breastfeeding in daily life and handling stress. Personal stories of breastfeeding women and a father are testimonials, and a poster can be downloaded along with factsheets.

Dr. Haynes described some special projects in States with the lowest breastfeeding rates, including Louisiana and Mississippi. Raising Our Sisters Everywhere (ROSE) in Atlanta conducted a summit last summer for breastfeeding advocacy. Another summit will be held this summer.

UPDATE ON MONITORING INFANT MORTALITY AND BIRTH OUTCOMES DATA

CoIIN Elective Delivery Team: Plan To Measure Success

William M. Sappenfield, M.D., M.P.H., Professor and Department Chair, Department of Community and Family Health, University of South Florida

Dr. Sappenfield presented information about the CoIIN's monitoring of early elective deliveries and the work done to reduce them. Three possible measurement options were considered: (1) hospital reporting of Joint Commission measure PC-01, (2) early linked hospital discharge and birth certificate reporting, and (3) birth certificate reporting. Because of major problems with the first two measurement options, the third option was chosen.

Birth certificate measurement overestimates elective delivery rates because of a limited number of conditions and underreporting of conditions. However, the data are available in all States on a timely basis with electronic birth cerificate reporting, and State public health agencies can provide provisional reporting on a quarterly basis. An algorithm was developed to compare the old and new birth certificate reporting format. In addition, States could monitor regional and hospital progress. The birth certificate measurement confirmed a decrease in the elective delivery rate with a concomitant decrease in the early-term rate.

The measurement methods were limited to singleton term births to in-State residents in nonmilitary delivery hospitals. The births had to be early term, by induction or cesarean, with no spontaneous labor and no birth certificate conditions identified by the Joint Commission. The number of elective deliveries was divided by the number of early-term deliveries.

The provisional data through the fourth quarter of 2012 indicate a decline in the percentage of nonmedically indicated deliveries among singleton early-term deliveries in Regions IV and VI and a similar decline in the percentage of early-term deliveries among singleton term deliveries. Plateauing is beginning to take place. Dr. Sappenfield provided some State data as well. For example, the patterns indicate that the reduction in Mississippi is not very substantial compared with the reductions in Alabama and Kentucky.

Dr. Sappenfield cited some initial conclusions. State trends in the singleton elective delivery rate and early-term birth rate are similar. Since 2009, progress can be seen across most States in reducing elective delivery rates. State progress appears to have plateaued in 2012. If possible, these finding should be confirmed by other data sources.

Dr. Sappenfield shared some information from an unpublished national survey on hospital hard-stop policies. A phone survey was conducted of obstetric nurse managers or charge nurses in all U.S. labor and delivery hospitals between July 1, 2012, and August 31, 2012. The survey asked about the presence of a hard-stop policy on elective deliveries before 39 weeks. Responses were obtained from 2,312 of 2,641 hospitals (an 87.7-percent response rate). Among other information, the data show that the use of nurse-midwives in New Mexico has had considerable impact, with fewer early elective deliveries in those hospitals.

The implications are that initial efforts to reduce elective delivery appear to be successful in the 13 States. However, further efforts should focus intensely on the remaining issues in hospitals building on current successes.

Dr. Sappenfield thanked the State vital statistics bureaus and maternal and child health epidemiology units that provided the provisional data.

Q&A and Comments

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

- Dr. Cox noted that Florida has a number of hospitals with hard-stop policies, hospitals with nurse-midwives tend to have lower early elective delivery rates, and other States (e.g., Maryland and California) have shown remarkable reductions in early elective delivery as well. He pointed out that, in particular, larger hospitals report dramatic reductions. His concern involves rural hospitals with fewer than 1,000 deliveries per year that either do not monitor or do not adopt hard-stop policies or understand the importance of reducing early elective deliveries. Dr. Sappenfield responded that hospitals with fewer than 500 deliveries per year are more likely to perform early elective deliveries and primary and repeat cesareans. The March of Dimes pilot showed that rural hospitals experienced difficulty in establishing a hard-stop policy perhaps because their few obstetric providers resisted adopting the policy. This area of challenge needs extra focus because smaller hospitals continue to have higher rates of early elective delivery.
- Dr. Barfield asked Dr. Sappenfield to comment on changes in cesarean rates. Dr. Sappenfield noted that the changes in cesarean rates are smaller, and he predicts little change in that situation.

Medicaid Data and Quality Improvement Measures
Mary Applegate, M.D., Medicaid Medical Director, Ohio; Co-chair, CMS Expert Panel on Maternal and Child Health Outcomes

Dr. Applegate stated that Ohio is one of the few States that has a Perinatal Quality Collaborative. Because of those quality improvement efforts, the Medicaid program sees the value of vital statistics in its work as the single major payer of maternity and infant care. Once mothers at risk are identified, specific services can be provided to prevent preterm births and ensure improved outcomes for families. The connectivity of the data sets adds value. A consortium of Medicaid medical directors can share the methodology involved in early elective deliveries, collect the information from every State, and add the link to Medicaid claims information. Applied analysis can result in a deeper understanding of outcomes.

The hard stop is an example of a policy with a dramatic impact. Ohio used a collegial approach through its Perinatal Quality Collaborative, which was better on the front end, and discovered that when systems work together the result is better outcomes and a higher level of success. Dr. Applegate mentioned that other measures might be up for consideration. The first efforts focused on working closely with vital statistics and then analyzing the data to discover the path for moving forward.

In July, the CMS Expert Panel on Maternal and Child Health Outcomes will comment on the guidance suggested from a wide array of stakeholders and subject matter experts. The guidance will range from data and measurement, to specific clinical details, to systems issues. One subject will be the connectivity and value of birth certificates as a source of data for clinicians or practices as well as hospitals. The overall message relates to the connectivity and value of vital statistics and Medicaid data sources.

Q&A and Comments

Dr. Applegate's presentation prompted the following comment:

- Dr. Kotelchuck asked whether other topics will be explored once the linked data set is created from Medicaid to vital statistics. Dr. Applegate replied that some analysis has been done about which variables might be most closely connected to poor outcomes. Continuing work will help inform which variable to consider next, depending on which variable has the greatest impact. She asked for suggestions. Dr. de la Cruz stated that HRSA will facilitate communication between Drs. Kotelchuck and Applegate on this point.

Recent Trends in Infant Mortality and Infant Mortality Risk Factors
T.J. Mathews, M.S., Demographer, Division of Vital Statistics, National Center for Health Statistics (NCHS), Centers for Disease Control and Prevention (CDC)

Mr. Mathews began his presentation with a reference to the April 2013 data brief on recent declines in infant mortality in the United States between 2005 and 2011. The vital statistics infant mortality data are based on all birth and death certificates filed in State vital statistics offices and transmitted to NCHS. The national data files currently available are the birth data, mortality data, and linked birth/infant death data set The linked file provides more accurate data by race and ethnicity than the mortality data.

After a plateau from 2000 to 2005, infant mortality declined substantially from 2005 to 2011. The decline was largest for non-Hispanic black women at 16 percent and smallest for Hispanic women at 9 percent. Mr. Mathews explained that in the information provided in his presentation, the white, black, and Hispanic infant mortality rates for 2010 and 2011 are projected by applying the race/ethnic–specific percent decline from the mortality file to the 2009 race/ethnic–specific infant mortality rates from the linked file. He pointed out that projected data is not as accurate as directly reported data.

Mr. Mathews described the public health impact of the 2005–2011 infant mortality decline. An estimated 3,250 fewer infant deaths occurred in 2011 than if the 2005 infant mortality rates had been in effect. In 2011, 54 percent of all U.S. births were to white women and 15 percent were to black women, yet white and black women had equal numbers of infant deaths averted.

Mr. Mathews further explained this historic infant mortality decline. 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. The statistics show that recent attempts to reduce early elective deliveries may be working. The Kitagawa analysis method was used to

quantify the relative contribution of changes in the two components to the 2005–2009 decline in infant mortality. The analysis was done separately for the total population and for white, black, and Hispanic women.

Mr. Mathews summarized by saying that after the plateau from 2000 to 2005, the U.S. infant mortality rate declined 12 percent from 2005 to 2011. From 2005 to 2011, the infant mortality rate declined by 16 percent for non-Hispanic black, 12 percent for non-Hispanic white, and 9 percent for Hispanic women. In 2011, preliminary data reveal 23,910 infant deaths. There were about 3,250 fewer infant deaths in 2011 than there would have been had the 2005 infant mortality rate been in effect that year. Only 15 percent of U.S. births in 2011 were to black women; however, 42 percent of the infant deaths averted were to black women.

After more than two decades of increase, there was a 9 percent decrease in the preterm birth rate from 2006 to 2011. Preterm births decreased for spontaneous vaginal, induced vaginal, and cesarean deliveries. Black women have higher rates of preterm birth and preterm-related infant mortality; therefore, the recent decline in infant mortality had a bigger impact for black women. For black women, two-thirds of the 2005 to 2009 infant mortality rate decline was due to declines in preterm births. For white and Hispanic women, the majority of their infant mortality declines were due to declines in gestational age–specific infant mortality rates.

Q&A and Comments

The presentation by Mr. Mathews prompted the following questions and comments:

- Dr. Dennery asked about an explanation for the change in infant mortality especially in the African American population. Mr. Mathews pointed out that two-thirds of the decline is due to fewer preterm births.
- Dr. Petrini asked about the adoption of the 2003 birth certificate by the States, which SACIM recently recommended to the Secretary. Mr. Mathews reported that all States will be using the new birth certificate by January 1, 2014. At the present time, 80 percent of the States have adopted the revised birth certificate.
- Dr. Barfield noted that more work is still needed on reducing birthweight-specific infant mortality. The role of perinatal regionalization and the work of the CoIIN might address some of those issues.
- Dr. Kotelchuck stated that if black women deliver more babies in urban hospitals compared with white women and efforts at reducing early elective deliveries take place in the larger urban hospitals, then a proportionately higher percentage of late preterm births in the black community are being treated differently than previously because of deliveries in urban hospitals. Referring to the graph showing the percentage of contribution of two components to the decline in the U.S. infant mortality rate, 2005–2009, by race/ethnicity, Dr. Kotelchuck asked about the unexpected effect of changes in practice and the possibility of stratifying the data by size of hospital. Mr. Mathews responded that stratification by size of hospital is not an element in the national data.
- Dr. Sappenfield remarked on the preterm distribution and suspects that mortality improvement is due to the smaller babies, not to those near the 37-week cusp, which shows a remarkable pattern. Dr. Dennery agreed and stated that most of infant mortality is due not to the very late preterm but to the very small preterm. The question is whether

the granularity of the data might reveal what is happening to prevent preterm birth at the earlier stages. For example, is there better screening for preeclampsia? Mr. Mathews referred to the public health message about the importance of carrying babies to term.

- Dr. Shields repeated the question about whether the change in preterm birth in black women involves early preterm births rather than late preterm births, which might reflect early elective delivery policies or some unknown factor. Mr. Mathews referred to the graph that shows the percentage distribution of births by gestational age and noted that the information by race and ethnicity ends at 2009 not 2011. More up-to-date information will be forthcoming.
- In response to a question from Dr. Barfield, Mr. Mathews stated that Native American data is not included in the report. The smaller numbers make an accurate analysis difficult.
- Dr. Cox asked about the possibility of getting more real-time data instead of 2- to 3-year-old data. Mr. Mathews stated that NCHS is aware of that problem.

UPDATE FROM CDC
Wanda Barfield, M.D., M.P.H., Director, Division of Reproductive Health, CDC

Dr. Barfield's presentation covered CDC's impact pyramid for infant mortality prevention, updates on CDC activities, and opportunities for future collaboration.

Dr. Barfield explained how the public health pyramid can be applied to infant mortality. Infant mortality prevention strategies include improving women's health before conception, treatment of chronic conditions in pregnancy, long-acting reversible contraception, safe infant sleep and injury prevention, new models of care such as centering, improving the quality of perinatal care, perinatal regionalization, and health insurance and employment.

Prenatal smoking occurs in 11.5 percent of all U.S. live births, and smoking in pregnancy accounts for 23 to 34 percent of deaths due to SIDS and 5 to 7 percent of deaths from preterm-related causes. CDC's Office of Smoking and Health is currently engaged in the Tips From Former Smokers campaign for smoking cessation to prevent premature birth. Another strategy for infant mortality prevention is newborn screening for critical congenital heart disease (CCHD). CCHD represents about 25 percent of all congenital heart disease, and an estimated 300 or more infants with unrecognized CCHD are discharged yearly from U.S. newborn nurseries with risk for serious complications, including death, shortly after birth.

CDC is funding State Perinatal Quality Collaboratives in California, Ohio, and New York to disseminate the work done in the States. In terms of SIDS/SUID, Dr. Barfield described an initiative to create a standardized SUID investigation form for medicolegal investigators to more clearly identify the causes of death. CDC also is promoting preconception health through the Show Your Love campaign. In addition, the Core State Preconception Health Indicators Working Group established several domains in preconception health, with the Pregnancy Risk Assessment Monitoring System (PRAMS) as one of the sources for the core indicators.

CDC also is working to develop selected practice recommendations for contraceptive use to offer guidance for health care providers on common yet complex issues in the management of

contraception. In addition, CDC is partnering to reduce teen pregnancy through the Winnable Battle campaign. Dr. Barfield emphasized the importance of partnerships for CDC's success.

Further opportunities for future research and collaboration exist with the CoIIN, the Maternal Mortality Initiative, Surveillance of Preventive Services, Tips From Former Smokers campaign, and CDC's National Assisted Reproductive Technology (ART) Surveillance System. ART is a significant contributor to multiple gestation, very preterm infants, and low birthweight infants. CDC is linking ART with vital records.

COMMITTEE BUSINESS: DISCUSSION AND NEXT STEPS
Michael C. Lu, M.D., M.P.H., Associate Administrator for Maternal and Child Health, HRSA; Executive Secretary, SACIM
David S. de la Cruz, Ph.D., M.P.H., Principal Staff and Designated Federal Official, SACIM

Dr. Lu commended and congratulated the committee for another informative meeting with very thoughtful presentations and discussions. He mentioned next steps for SACIM and noted that the group will not come together again for several months. The important work of the committee should continue between meetings, and the timing is critical on a number of issues. Regarding women's health, he encouraged the committee to summarize the discussion and provide some input for the Secretary. He also encouraged the committee to continue its effort and flesh out recommendations for a national strategy on women's health and maternal morbidity. Dr. Lu also encouraged SACIM to advise the Secretary on Healthy Start's transformation and the strategic plan. In addition, Dr. Lu called for support for the implementation of the ACA. SACIM should play a role in informing the Secretary about strategies to address infant mortality.

Dr. Handler stated that it is not exactly clear that the Secretary will endorse SACIM's recommendations and strategy. The women's health group will flesh out some of the ideas from yesterday's presentations and discussions. Regarding Healthy Start, Dr. Handler restated the importance of the social determinants and the case management role of Healthy Start, both of which might not be possible to carry out in an effective way. She suggested that Healthy Start 3.0 not try to make Healthy Start "be all things to all people." Instead, Healthy Start should be thought of as a backbone organization, not a case management organization.

Dr. de la Cruz reported that he will follow up with Dr. Wakefield's office to get specific direction about what SACIM's next steps should be. He will have information for SACIM on that subject very soon. Dr. Lu assured SACIM that its recommendations will be used to inform HRSA's future actions. He reiterated that SACIM's work is very important.

Dr. Cox referred to all of the ground covered in the past 2 days. Next steps should involve charting out all of the activities affecting infant mortality to see how the pieces fit together and how the synergy can be maximized among all of them. Another point involves the tremendous opportunity afforded by the ACA to improve women's health across the country, but Dr. Cox expressed his concern about the States that have opted out of forming their own insurance exchanges. A third issue involves the way in which to improve the accuracy of data and metrics and to make it available in real time. Waiting 2 or 3 years for data is very inefficient.

Dr. Jackson called for further discussion of mental and emotional health as part of interconception care. In particular, more serious work must be done on weight management and obesity. Women in the postpartum period are the most captive audience for further screening for chronic diseases, etc. Dr. Jackson also would like to hear from Healthy Start directors about the strategic direction of Healthy Start before the final document is completed. Dr. de la Cruz stated that the SACIM group on Healthy Start will be asked for its feedback and guidance during this process. Dr. Atrash stated that the draft document exists and input from individuals will be solicited, but the first focus will be on critics of Healthy Start. When a close-to-final plan is produced, it will be circulated to some individuals and then collective input will be solicited.

Dr. Petrini stated her support for the recommendation regarding the availability and delivery of more timely data at the national level, particularly vital statistics. SACIM should make this issue a priority in its recommendations to the Secretary. A letter could be drafted to Dr. Frieden regarding SACIM's discussion and prioritization of this issue. A tangible next step is needed on this issue. Dr. de la Cruz recommended that Dr. Petrini work directly with Ms. Johnson on this suggestion.

Dr. Kotelchuck suggested that SACIM encourage NCHS to look into exploring the electronic birth certificate as a means of supplying advanced national information. He also suggested extending SACIM meetings an hour or two to facilitate more discussion among the members, and he asked whether a list of attending SACIM members could be made available. In addition, Dr. Kotelchuck mentioned that Dr. Lu's idea of developing parenting education as a focus of MCHB can be seen as being linked to interconception care and home visiting.

Dr. Martin mentioned her confusion about the difference between preconception and interconception care. She also stated that parenting education and developing the reflective function of mothers are at the core of the home visiting programs' work. However, more could be done to improve the health status of mothers enrolled in Medicaid, many of whom have chronic conditions and fail to understand the importance of taking care of their own health. Home visitors are capable of developing trusting relationships, and the opportunity to reach women through home visiting programs should not be missed.

Dr. Dominguez reported that SACIM will have an opportunity to present its recommendations to the Secretary on the national infant mortality strategy during the APHA Maternal and Child Health session of the meeting in Boston in November. Ms. Johnson will provide an overview at the beginning of the session, and certain topics have been selected for discussion.
Dr. Dominguez called for SACIM members who are interested in being on the panel to sumbit abstracts and learning objectives.

Dr. Kotelchuck suggested that Vijaya Hogan, Dr.P.H., be asked to speak to SACIM on the topic of interconception care and mental health–related issues.

Dr. de la Cruz mentioned that seven SACIM members' terms expired in January but were extended 6 months. The nomination process is continuing.

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

Dr. de la Cruz thanked the SACIM members and stated that they will be contacted soon about next steps. The meeting adjourned at 3:30 p.m.

Appendix A

Summary of Ideas for HHS Action To Support Improvements in Women's Health Based on SACIM Meeting, April 24, 2013

Potential Recommendations of SACIM to the Secretary:

1) Endorse ACOG's Year of the Women and ACOG's call for ob-gyns to be considered primary care providers
2) Endorse the preconception-interconception focus: *All Women All the Time*
    a. Preconception care: all women
    b. Interconception care: women with morbid events during pregnancy and with adverse pregnancy outcomes (including fetal deaths)—see below for additional ICC recommendations
    c. Support dissemination of toolkits for providers at all levels to deliver preconception/interconception care at every opportunity
3) Focus on new approach to postpartum visit—timing, site/location, provider type
    a. Build on interconception care COIN efforts related to unbundling prenatal care payment from postpartum (PP) care payment
    b. Support measurement of PP visit use in all possible datasets
    c. Develop strategies that provide incentives to providers to directly link prenatal care-delivery care-PP care and make the case for the value of PP care for women
    d. Make improvements in PP care the next focus of QI initiatives—next focus beyond "39 weeks initiative"
4) Interconception care—Build on the ACA and the IOM Report on Clinical Preventive Services to make the link between PP care, interconception care, and well-woman health care
    a. Build on both the PP visit and the Maternal, Infant, and Early Childhood Home Visiting program. This dual focus will allow for attention to both the medical and social needs of women in the interconception period
    b. Support HRSA's Interconception Care Initiative and the work of Healthy Start with respect to interconception care
    c. Empower HRSA to develop the "Bright Futures" for PP care/interconception care/well-women health care
    d. Expand interconception care focused strategies within Medicaid (building on ICC COIN)
    e. Support centering parenting and similar program models that focus on both woman and child's health and social needs in the early and extended PP periods

5) Prenatal Care

    a. Call for a Content of Prenatal Care Summit—25 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
    b. Call for consistent reporting of prenatal care utilization in the annual NCHS brief "Births."
    c. Provide continued support for new models of prenatal care (e.g., centering pregnancy)
6) High Risk Maternity Care
    a. Support/Endorse HRSA's Maternal Health Initiative
7) Labor and Delivery
    a. Support the implementation of shared decision-making protocols for elective inductions and VBACs versus C-section endorsed by Childbirth Connections
    b. Support CMS Expert Panel on Medicaid's (likely) endorsement of Medicaid reimbursement for doula care during labor and delivery (expand to doula support during prenatal and postpartum periods)

Appendix B
Public Comments

Debra Bingham: AWHONN's Women Health and Perinatal Nursing Care Quality draft measures are now open for public comment. You can access the document and respond to the survey by going to www.awhonn.org. AWHONN welcomes your feedback. You can provide us feedback using the online survey.

Mrs. Judy Wilson: I want to share information about a new initiative from FNS-USDA that addresses peri-conceptual nutrition among the WIC population. This is a collaboration between FNS and the UCLA. Below is a summary and link to the web site that provides information about specific projects. The Role of the WIC Program in Improving Peri-conceptional Nutrition: A Small Grants Program. The University of California at Los Angeles (UCLA) is managing a small-grants research program, funded by the Food and Nutrition Service of the U.S. Department of Agriculture. Through a competitive process, UCLA awarded seven grants in June 2012. The two-year projects to academic researchers, in partnership with WIC agencies, focus on the role that the WIC program is playing and can play in improving nutrition in pre-conceptional and peri-conceptional (between pregnancies) periods. FNS and UCLA anticipate that the grants will foster future collaboration and additional outside funding, along with findings that can inform WIC program development. FNS and UCLA anticipate that the grants will foster future collaboration and additional outside funding, along with findings that can inform WIC program development and nutrition education nationwide. For a list of funded projects under this collaboration, go to http://www.fns.usda.gov/ora/menu/DemoProjects/WICPericonceptional.htm.

Kelly Bellinger: Thank you all for the stimulating discussion and information. We plan to incorporate many of these thoughts into our local planning in San Antonio for our Local Health System Action Plan for reducing infant mortality and using the AMCHP compendium as a guideline. Great to be invited as a guest!

Shelby Weeks: Thanks for extending an invitation to Healthy Start project staff to listen in on this meeting. It has been a fascinating and very informative experience.