Secretary's Advisory Committee on Infant Mortality

Meeting Minutes of July 10–11, 2012

Doubletree Hotel by Hilton
Bethesda, MD

GENERAL SESSION

TUESDAY, JULY 10, 2012

CALL TO ORDER AND WELCOME

David S. de La Cruz, Ph.D., M.P.H., Principal Staff and Designated Federal Official, Secretary's Advisory Committee on Infant Mortality (SACIM); Deputy Director, Maternal and Child Health Bureau (MCHB)/Division of Healthy Start and Perinatal Services (DHSPS)

Dr. de la Cruz called the meeting to order.

SUMMARY OF MARCH 2012 MEETING

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

Newly named chairperson of SACIM, Ms. Johnson summarized the March 2012 meeting. Before that meeting, SACIM had sent two letters to Secretary Sebelius advising and affirming SACIM's position on some of the budget issues from the Health Finance Commission and delineating the important elements in the Affordable Care Act (ACA). The workgroup on the national agenda presented a framework and the core elements of the national agenda. The committee also discussed the issue of quality of care. Ms. Johnson thanked the committee members for their work during the past 4 months.

Dr. Lu welcomed the SACIM members and congratulated them on the work they have done. He thanked Ms. Johnson for her leadership and stated the primary purposes for the meeting: to begin the work of developing a national strategy for infant mortality and to examine Healthy Start as a vehicle for addressing infant mortality.

HRSA UPDATE

Mary Wakefield, Ph.D., R.N., Administrator, Health Resources and Services Administration (HRSA)

After the members introduced themselves, Dr. Wakefield thanked Ms. Johnson for her willingness to accept the position of chair of SACIM, the members for their commitment to SACIM, and Dr. Lu for his leadership of MCHB.

Dr. Wakefield noted that Secretary Sebelius announced in June that the Department of Health and Human Services (HHS) would create a national strategy in the next year to address infant mortality. The strategy is at the beginning of development, and the individual and collective expertise of the SACIM members can help to advance this agenda. She added that, in relation to Healthy Start, the interconception care learning collaborative, and the infant mortality collaborative, the focus should be on performance improvement.

Dr. Wakefield commented on some of the provisions of the ACA. After the Centers for Medicare & Medicaid Services (CMS), HRSA is the second agency most affected by the provisions of the ACA. HRSA has been creating new programs and expanding existing programs as a result of the law. Before the Supreme Court decision, many new programs were implemented that have touched people in real and meaningful ways. Some of them are highly relevant to the populations about which SACIM cares most. For example, 54 million Americans can now receive preventive health services without copayments; health care coverage is extended to individuals younger than age 26, including women of child-bearing age; children younger than age 19 cannot be denied health care coverage because of preexisting conditions; and women cannot be charged more for their health insurance coverage because of their gender. These provisions of the ACA benefit children, infants, young women, and families.

HRSA is implementing programs authorized by the ACA: (1) community health centers, (2) the National Health Service Corps (NHSC), and (3) the home visiting program. Community health centers focus on preventing illness, keeping people healthy, and mitigating chronic disease. The patient base comprises 24.2 million people receiving primary care at 8,500 delivery sites. Women, infants, and children make up a significant proportion of people served, and women between the ages of 25 and 29 are the biggest cohort of people seen at community health centers, which provide prenatal care and primary care. The ACA also funds school-based health centers.

NHSC is expanding even more dramatically than the community health centers network. The ACA allocates $1.5 billion to ramp up the numbers of health care providers serving underserved areas. NHSC represents a range of disciplines, including dentists and mental health care providers, and provides scholarships, training, and loan repayment.

The ACA invested $1.5 billion in the home visiting program. Under this program, nurses, social workers, and other providers meet with pregnant women and work with young children residing in high-risk communities across the Nation. They provide intervention services and counseling and, based on evidence, deploy strategies known to improve health outcomes. States can choose from multiple models that must be evidence-based.

Dr. Wakefield underscored that, as an advisory body, SACIM should pivot off of all of the HRSA programs as a means of leveraging assets across agency programs to help reduce infant mortality nationwide.

Discussion

Dr. Wakefield's presentation prompted the following comments and questions from SACIM members:

- Ms. Johnson thanked Dr. Wakefield for sharing her perspective. She mentioned that SACIM sees the home visiting program as a means to improve pregnancy outcomes. Community health centers play a role in prenatal care and support for young families and can provide a model for preconception and interconception care.
- Dr. Arden Handler mentioned strategically aligned investments and asked about reaching out to communities beyond the medical model. Dr. Wakefield stated that, with the

Centers for Disease Control and Prevention (CDC), HRSA supports an investment in the Institute of Medicine's (IOM's) work to link primary care in the context of public health. The community health centers program requires the health centers to do extensive reviews of the need (poverty rates, infant mortality) in their communities in order to receive grants. HRSA works with community health centers to ensure that their work involves community-level engagement. HRSA partners with the Department of Housing and Urban Development (HUD), the Environmental Protection Agency (EPA), and the Department of Transportation to leverage community health center assets with an eye to meeting the needs of populations with compromised housing, transportation, etc.

- Dr. Adewale Troutman commented on the area of community safety as it relates to health and populations. Good relationships are needed between community health centers and public health departments in the delivery of services in various communities. Healthy Start centers can be the seeds for the community transformation grants to work specifically on the issues that support the work done on infant mortality reduction. Dr. Wakefield noted that HRSA is looking at its public health training assets through the Bureau of Health Professions to link traditional health professions education and other investments.
- Dr. Virginia Pressler noted that better measures of the social determinants of health are the critical components to making a difference in infant mortality.

MCHB UPDATE

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

Dr. Lu described MCHB as the one Federal program dedicated solely to improving the health of all women, children, and families in the Nation. It does its work with a staff of 160 and an annual budget of $1.2 billion. The budget covers three "big buckets": (1) the Title V MCH services block grant, (2) the home visiting program, and (3) several other distinct programs, including Healthy Start.

The Title V Maternal and Child Health Services (MCH) Block Grant involves funds for States, Special Projects of Regional and National Significance (SPRANS), and the Community Integrative Services System (CISS) set aside. Through, Title V, States serve 2.5 million pregnant women and 34.5 million children, including 2 million children with special health care needs. The block grants play an important role in improving maternal and child health in this country. MCHB is looking to improve the following areas: (1) ensuring access in the context of the ACA, (2) improving quality, (3) promoting systems integration, (4) achieving health equity, and (5) measuring progress. SPRANS supports oral health and sickle cell projects, training and workforce development, and translational research. It also funds the infant mortality Collaborative Improvement and Innovation Network (COiiN) in 13 Southern States, a program that will be scaled up to a national initiative by next year. CISS funds support the Early Childhood Comprehensive System (ECCS) grants, a vehicle for ensuring a comprehensive, integrative system for children and families in every State and jurisdiction.

The second "bucket," the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program is a significant investment in maternal and child health ($1.5 billion over 5 years). Two

new frontiers in the program involve quality improvement and systems integration. The program must be integrated into the comprehensive system of services for children and families in order to be effective.

The third "bucket" goes to support a variety of programs, including autism, sickle cell anemia, traumatic brain injury, universal newborn screening, emergency medical services for children, heritable disorders, Family to Family, and the Healthy Start program.

Discussion

Dr. Lu's update on MCHB prompted the following comments and questions:

- In response to a question from Dr. Handler about the CISS project, Dr. Lu explained that the idea is to ensure that the projects are not disconnected from each other and are well-integrated in comprehensive community systems. A significant amount of money goes to supporting ECCS in every State and jurisdiction as a vehicle to drive community systems integration and to better address the social determinants of MCH. Ms. Johnson explained the statutory origins of CISS, which has been repurposed several times since 1989.
- Ms. Sharon Chesna noted the continued decimation of vital public health services on the local level and asked about the role MCHB plays in ensuring access to those vital services. Dr. Lu stated that the potential of the block grant to improve the health of the Nation must be optimized. A great deal of flexibility exists across States and jurisdictions. Some States use the block grant to address gaps in primary and preventive services and services for children with special health care needs, picking up where Medicaid and CHIP leave off. The block grant also provides enabling services, population-based services, and infrastructure and systems-building services. The two-pronged challenge is to communicate what exactly the block grant does and to define the core elements of all block grants.
- Dr. Tyan Parker Dominguez noted that, historically, the focus has been on individually based health services, but a broader public health focus on social determinants is essential. She asked about emphasizing the larger fundamental drivers of inequality. Dr. Lu noted that some Title V block grant monies are being used for these purposes, but more can be done. Other Federal agencies can have a significant impact on MCH, for example, EPA, HUD, USDA, and CDC. The leadership challenge is to tear down silos, reach out beyond our comfort zone, and encourage agencies to work together to create better coordination and collaboration at the Federal level and build better integrative systems at the State and community levels.
- Dr. Raymond Cox asked how the work of the block grants helps individual practitioners to include population health in their focus. Dr. Lu referred to systems innovation and noted that MCHB is interested in creating systems of care that smaller practices can share.

U.S. STRATEGY TO ADDRESS INFANT MORTALITY
Michael C. Lu, M.D., M.P.H., Associate Administrator for MCH, HRSA; Executive Secretary, SACIM

Dr. Lu referred to Secretary Sebelius' comments on creating the first national strategy to reduce infant mortality. He noted that SACIM is an independent body that represents diverse interests and perspectives—public and private; Federal, State, and local governments; providers, consumers, and families; academia and public health; health plans, businesses, and foundations; and faith-based organizations. This diversity is needed to create a national strategy. However, Dr. Lu reminded the members to "check their agendas at the door," to listen and learn, and to remember what infant mortality means overall.

Dr. Lu stated that the "aspirational goal" of infant mortality reduction should be 5.5 infant deaths per 1,000 live births by 2015 and 4.5 infant deaths per 1,000 live births by 2020. This goal can be accomplished by (1) improving women's health before pregnancy through preconception health and health care, (2) promoting quality and safety by reducing early elective deliveries, (3) investing in prevention and promotion such as smoking cessation, safe sleep, breastfeeding, and COIN, (4) strengthening systems integration to avoid fragmentation and establish vertical (appropriate levels of care), horizontal (service coordination and systems navigation), and longitudinal (care continuum across the life course) integration, (5) mobilizing community transformation, and (6) supporting measurement and research.

In terms of vertical integration, perinatal regionalization involves both maternal and neonatal levels of care. Horizontal integration in prenatal care involves moving from an obstetrician-centered system of care, to wrap-around services, to a medical or health home model that includes mental health services, oral health services, specialty clinics, genetic counseling and prenatal diagnosis, an ultrasound center, etc.

Infant mortality is more than just an accounting of infant deaths or an indicator of community health or social inequality. Ultimately, infant mortality is a measure of how much we fail to live up to our Nation's greatness as summed up in the Declaration of Independence.

Discussion

Dr. Lu's presentation prompted the following questions and comments from the SACIM members:

- Dr. Sara Shields wondered why the woman, instead of the medical home, is not at the center of prenatal care. Dr. Lu stated that he feels uncomfortable with the term "medical home" and prefers "family-centered health home."
- Dr. Joann Petrini commented that Secretary Sebelius's 2020 goal of 11.4 percent preterm births does not seem very ambitious. Dr. Lu encouraged SACIM to recommend to the Secretary the aspirational goal as he stated it.
- Dr. Handler pointed out that SACIM should indicate its interest, not only in the survival of small babies, but also in the reduction of prematurity and preterm delivery.

- Dr. Troutman noted that the aspirational goal should refer to the racial gap in infant mortality rates. Dr. Lu stated that no goal involving disparities exists in Healthy People 2020, but SACIM can recommend an aspirational goal involving disparities to the Secretary. Referring to Healthy People 2000, Dr. Troutman cautioned against two separate sets of goals.
- Dr. Miriam Labbok pointed out that the infant mortality rate among full-term babies in the United States is higher than in any other country in the world.

DISCUSSION OF THE NATIONAL STRATEGY AND THE ROLE OF SACIM
Kay Johnson, M.Ed., M.P.H., Chairperson, SACIM
Michael C. Lu, M.D., M.P.H., Associate Administrator for MCH, HRSA; Executive Secretary, SACIM

Ms. Johnson reminded the members that SACIM sent a letter to Secretary Sebelius applauding her for her commitment to developing the first national strategy for reducing infant mortality. The letter stated that success would require a multifaceted effort, including practice improvement by providers; changes in knowledge, attitudes, and behaviors of men and women of childbearing age; improved access to health care; empowered communities; health equity; and a serious commitment to prevention. The letter closed by saying that work on a national strategy is at the heart of the SACIM charter and a part of the personal mission of each member of SACIM.

SACIM has created a framework for a national agenda. The framework entails a life-course perspective, access to a continuum of services, high-quality patient-centered care, investments in the MCH safety net and data systems, strategies to create health equity through elimination of disparities and unequal treatment, and interagency, public-private, and multidisciplinary collaboration. SACIM reaffirms the need for a continuum of prevention and intervention services to improve the health and well-being of women, infants, and families and an investment in an infrastructure that ensures access, quality and safety, and accountability for outcomes.

SACIM's separate letter on health reform stated the committee's strong belief that the ACA offers major opportunities to reduce U.S. infant mortality. In terms of health coverage and the continuum of services, SACIM calls for promoting and monitoring coverage of clinical preventive services for women and infants; Medicaid involvement in clinical preventive services coverage, interconception care, health homes, chronic conditions, family planning, and breastfeeding; monitoring essential health benefits packages; addressing the need for behavioral, mental health, oral health, and obesity services among women; and automatic newborn eligibility for all infants.

Ms. Johnson delineated the topics involved in high-quality patient-centered care and listed efforts to maintain and protect Federal investments in the MCH safety net. In terms of health equity and disparities, SACIM should be added to the list of HHS initiatives addressing disparities; a strategy should be adopted to concentrate community development; income support should be addressed through the Temporary Assistance for Needy Families (TANF) program, tax policies, etc.; and social support, cultural competency, and the needs of families with young children should be emphasized. Adequate standardized data, monitoring, and surveillance

systems are needed, along with interagency public/private collaboration, for example, with the National Prevention Council.

Ms. Johnson ended her presentation by referring to the United Nations "Every Woman, Every Child" campaign and by stating that the first years of life lay the foundation to be healthy and thrive across the life course. Our wealthy Nation can and should commit to ensuring economic and social support to families sufficient to allow every baby to be born in optimal health and to enter the world wanted and loved.

Discussion

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

- Dr. Handler called for discussion of income distribution and TANF. What is needed is a universal program for poverty reduction on a national level. Dr. Fleda Mask Jackson agreed that economic inequality is key and that Healthy Start must be thought of as a major employer in low-income communities. The question is whether the number of community health workers can be increased to address and enhance employment opportunities. Dr. Dominguez called for promoting community development through economic development. A universal approach to addressing child poverty is critically important, and tax policy should be a topic of discussion.
- Dr. Iris Mabry-Hernandez asked about the structure for creating a national strategy and the transparency involved in doing so. Ms. Johnson stated that, regarding transparency, SACIM holds public meetings, engages with its respective networks of stakeholders, and is working toward consensus in a written document.
- Dr. Labbok noted that paid guaranteed maternity leave, which is lacking in the United States, would contribute significantly to infant mortality reduction. A high correlation exists between infant mortality and lack of paid maternity leave. Dr. Cox mentioned the unintended consequences of paid maternity leave in terms of opportunity for employment. The ultimate goal is to develop communities with inherent resilience, and using Healthy Start as a major employer is a way to impart resilience to a community. SACIM should think in terms of the importance of resilience in developing a sustainable model to address these issues.
- Dr. Kisha Davis mentioned nutrition and nutrition education in relation to the health of women and babies. A strategy of nutrition education is needed for these populations. Dr. Jackson called for increasing, improving, and enhancing the nutrition/weight management portfolio as a policy across socioeconomic groups. In addition, emotional health, fatigue, and depression in interconception care must be considered.
- Dr. Jackson asked how the United States fits in the global conversation about infant mortality. Dr. Lu stated that SACIM can learn from the global perspective, and Dr. de la Cruz noted that Secretary Sebelius announced the development of a national strategy on infant mortality at a USAID conference.
- Ms. Johnson reiterated that SACIM is tasked with making recommendations to the Secretary and is beginning to shape those recommendations. Over the next year, the national conversation about health will involve the ACA and what happens in the clinical world, instead of in communities, to adults rather than women of child-bearing age and

children. She asked the SACIM members about engaging their peer networks in the conversation.

- Dr. Pressler called for consensus and expectations about creating a health home in the pediatric environment and aligning reimbursements and other incentives with measureable outcomes.
- Dr. Cox stated that SACIM is responsible for speaking specifically to the needs of women and babies in the area of infant mortality. Preventive services, in particular interconception care, and the importance of developing communities and population health centers must be part of the recommendations to the Secretary.
- Dr. Milton Kotelchuck mentioned the continuity of prevention and treatment services. The clinical world is involved in improving the quality of clinical care, but its links to the public health world are seriously frayed. These two groups must be linked. For example, in regard to 39-week deliveries, women must be trained to argue with their obstetricians about their clinical care. Dr. Kotelchuck called for more attention directed to the continuity between prevention and treatment. Ms. Johnson mentioned the linkage needed between obstetricians and home care visitors and stated that extended care coordination and case management are needed.
- Dr. Cox reiterated that the issue involves the clinical/community interface and how it can be strengthened. For example, New York has developed regional perinatal networks that connect with community-based organizations. North Carolina has worked on patient-centered medical homes. Perinatal collaboratives are often community-based and have led to advances in clinical outcomes related to quality and safety. Healthy Start is another model that has worked very well. MCHB should work with large national organizations with good connections with clinical communities to address some of these issues. Several models can be used to develop a framework for community interface.
- Dr. Robert Corwin called for innovative methods of education for the public, clinicians, and legislators on topics such as immunization.
- Dr. Ruth Ann Shepherd noted that the ACA is targeted mostly at adults. Community transformation grants link clinical quality care with public health, but they are not connected with MCH issues. A community transformation grant should target these issues.
- Dr. Shields noted that the regional perinatal collaboratives focus mainly on hospital-based issues instead of outpatient, office-based, prenatal, postpartum, pediatric quality measures. Quality collaboratives are needed in those areas.
- Dr. Petrini noted that hospitals discourage readmissions by pushing patients out into the communities. The community transformation grants actually help the hospitals.
- In response to a remark by Dr. Handler noting that SACIM has a framework and a vision but needs to pinpoint recommendations for the Secretary, Ms. Johnson stated that SACIM can frame its principles in a written document, but a concrete, actionable list is more difficult given the timeframe. Dr. Joanne Martin called for broadening the constituency to talk about the social determinants of public health, in particular, regarding employers such as Goodwill, child care and education in the YMCAs and YWCAs, and faith-based communities.
- Dr. Labbok noted that perhaps SACIM should be asking about what can be done by existing mechanisms to achieve overarching goals such as health equity. Ms. Johnson stated that the list is meant to take SACIM in that direction.

- Dr. Troutman stated that the Ecuadorean constitution affirms the right to health and that the SACIM aspirational goal should include the right to health. He also stated that nontraditional partners, such as the YMCA, can expand the advocacy base and offer opportunities regarding policy.
- Dr. Corwin mentioned the importance of education and health literacy in decreasing the incidence of infant mortality.
- In response to a question from Dr. Petrini regarding process, Ms. Johnson stated that the following day's discussion will address that issue. If SACIM is to contribute to the development of the national agenda over the next several months, the committee must consider its opportunities.
- Dr. Mabry-Hernandez asked about the type of resources this initiative has, the networks or organizations that it wants to establish ties with, and alignments with other strategies such as the National Prevention Strategy. Ms. Johnson responded that SACIM has been involved in this work across its meetings with its ex officio members and other partners who have given presentations. Dr. Lu added that, as the Secretary accepts SACIM's recommendations, new resources will be devoted to implementing the national strategy and other Federal departments will be engaged to devote additional resources. What is needed is an actionable strategy. The acceptability of the recommendations is important.
- Ms. Chesna stated that a huge disconnect still exists between providers and the community. The focus should be on bringing people together, women must be more involved in their care and knowledgeable about the consequences of their decisions, and providers must be educated on public health perspectives.
- Ms. Johnson called for an inclusive, well-targeted set of actionable strategies to engage key partners outside Government in formal and informal ways in this conversation, for example, the American Congress of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP). Dr. Handler noted that key partners can be considered after the tangible pivot points are determined. Dr. Mabry-Hernandez agreed that a working document must come first, but key stakeholders should be determined to ensure their buy-in. Dr. Kotelchuck mentioned the need for a political will strategy and added that prioritizing the list is important.
- Dr. Troutman cited Healthy Start as an example of community involvement.
- Dr. Shields mentioned the 86-page National Prevention Council document and its appendixes and expressed her hope that SACIM's document will be more concise.
- In response to a question from Ms. Chesna, Ms. Johnson explained that in the development of actionable recommendations for the Secretary, SACIM might want to engage stakeholders. Dr. de la Cruz stated that as soon as the Secretary acknowledges receipt of the document, it can be disseminated to the public. Dr. Cox reiterated that political will supporting the document will ensure its acceptance by the Secretary.

ADVISORY GROUP ON PREVENTION, HEALTH PROMOTION, AND INTEGRATIVE AND PUBLIC HEALTH

Jeffrey Levi, Ph.D., Executive Director, Trust for America's Health; Professor of Health Policy, George Washington University

Dr. Levi expressed his hope that SACIM and his advisory group could work together on developing the national strategy on infant mortality. He stated that the provisions of the ACA

relate to insurance coverage and the organization and financing of the health care delivery system and that the ACA also pushes us to think differently about health and public health. A two-pronged approach to health considers what happens in the health care system and what happens outside the health care system. What happens outside the clinic can have as much and possibly more impact on health outcomes. Therefore, nonhealth agencies, sectors, and organizations have an important role to play, and the challenge is to make the evolving system work.

The National Prevention Strategy was developed by the National Prevention Council, which is made up of 17 Cabinet agencies and offices. The goal of the National Prevention Strategy is to increase the number of Americans who are healthy at every stage of life. The four strategic directions are (1) healthy and safe community environments, (2) clinical and community preventive services, (3) empowered people, and (4) elimination of health disparities. The seven priority areas are (1) tobacco-free living, (2) preventing drug abuse and excessive alcohol use, (3) healthy eating, (4) active living, (5) mental and emotional well-being, (6) reproductive and sexual health, and (7) injury- and violence-free living. In an action plan released a month ago, the agencies agreed to certain cross-cutting activities: to improve healthy food choices in their environments, to establish tobacco-free campuses, and to begin to engage the concept of health impact assessments in their work. The National Prevention Strategy emphasizes the importance of policy and systems change, giving greater weight to social determinants, and assigning a new role to public health as a convener, leader, or catalyst.

Dr. Levi emphasized the importance of creating lasting relationships between those doing health and those who can affect health. The agencies must recognize the co-benefits of working together. Creating and identifying these opportunities, co-benefits, and closer working relationships entails the two advisory groups coming together to implement the strategy. A series of working groups could consider a number of issues during conference calls including the two advisory groups. The conference calls would discuss cross-cutting issues relevant to implementing the National Prevention Strategy and responding to the challenge of infant mortality.

Discussion

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

- Dr. Jackson asked how various agencies and groups can be convened around the issue of the social determinants of health; her concern involves the possibility of competition among the groups regarding who should lead the effort. Dr. Levi responded that the National Prevention Council can be the forum for these issues to come together. Competition among agencies will never be eliminated, but competition can be focused on achievement rather than on who is in charge.
- Ms. Chesna asked about the depth of the consensus among the 17 agencies. Dr. Levi stated that the strategy went through the clearance process in all 17 agencies, which indicates a genuine commitment. The goal is to integrate the interests of all of the agencies in a viable way. Despite the fact that culture change in agencies is very difficult, the commitment of the agencies' leaders will make the goal easier to achieve. When

Ms. Chesna asked specifically about policies involving breastfeeding, Dr. Levi stated that the strategy makes a specific commitment to breastfeeding and that advisory groups must reach out to one another to create working relationships.

- Dr. Troutman asked whether the concepts of health equity, antiracism, and health impact assessment are included in the National Prevention Strategy. Dr. Levi responded that these topics are included.
- Dr. Handler mentioned that only HHS and the Department of Labor expressed an interest in the topic of reproductive and sexual health. She asked whether SACIM encouraging more agencies to embrace that topic might enhance SACIM's charge regarding infant mortality. Dr. Levi responded that the working groups organized around the four strategic directions might be an effective way to lead to discussion around the topic of reproductive and sexual health.
- Dr. Cox remarked that the National Prevention Strategy is very global and very comprehensive. It might be possible for SACIM to focus its work on infant mortality in the larger context of the strategy. He inquired about the length of the vetting process for the 17 agencies. Dr. Levi referred to the statutory deadline, and Ms. Johnson noted that SACIM faces not a statutory deadline but a practical deadline. Dr. Levi mentioned that the strategy is very broad and entails several priorities. Before November, the advisory group will identify a handful of three to five "big things" to accomplish over the next 4 years whose measurable success would make a difference in health outcomes. He advised SACIM to prioritize elements in its document regarding infant mortality. Some of those priorities could be integrated into the work of the National Prevention Council.

HEALTHY START

Federal Perspective: An Overview of Healthy Start

David S. de la Cruz, Ph.D., M.P.H., Principal Staff and Designated Federal Official, SACIM; Deputy Director, MCHB/DHSPS

Dr. de la Cruz presented the HRSA and MCHB organization charts to indicate the position of the Division of Healthy Start and Perinatal Services. He explained that Title V helps to frame the work done in DHSPS and throughout MCHB. Title V aims to improve the health of all mothers and children, to provide and ensure access to quality MCH services, to reduce infant mortality, and to provide prenatal, delivery, and postpartum care.

Healthy Start is in 39 States and the District of Columbia and Puerto Rico, with a focus on indigenous populations, border communities, and new immigrants. It serves 142 counties and 163 project areas with a total of 105 grantees. The Healthy Start program, which is a specific line item in the budget each year, focuses on the factors that contribute to infant mortality, low birthweight, a community-based approach to delivery of services, and a comprehensive approach to women's health care to improve perinatal outcomes.

Healthy Start began in 1991 under the first President Bush. Its goals are to improve health care access and outcomes for high-risk women and infants and to promote healthy behaviors and reduce the causes of infant mortality. A strong focus is on reducing disparities by implementing innovative community-based interventions to support and improve perinatal delivery systems in project communities, ensuring that every participating woman and infant gains access to the

health delivery system and is followed through the continuum of care, and providing strong linkages with the local and State perinatal system. The target audience is families across the lifespan, particularly women of reproductive age and their infants. Healthy Start's activities focus on risk prevention and reduction, health promotion, infrastructure and systems building, and programmatic involvement of women, their families (including male partners), and communities in developing their health plans.

Healthy Start components include five core services (outreach, case management, health education, screening for depression, and interconception continuity of care) and four core systems-building elements (consumer and consortium involvement in policy formation and implementation, the local health system action plan, collaboration with Title V, and sustainability).

While describing each of these components in some detail, Dr. de la Cruz noted that many Healthy Start sites hire from within their own communities, are now at capacity, and serve the highest of the high-risk women. He also stated that case management is the lynchpin of Healthy Start and that community consortia help guide and advise the program.

Every year, Healthy Start sites must submit performance measures. Year 2010 data show that about 31,000 women were served, about 60 percent of whom were African American. About 38,000 live births occurred in 2010, 5,369 male participants were served, and about 29,000 women received interconception care services. Healthy Start provided the following direct health care services: prenatal care visits, well baby pediatric visits, postpartum clinic visits, women's health services, family planning services, and adolescent health services. The program provided about 75,000 families with enabling services, including breastfeeding education, pregnancy and childbirth education, parenting skills, transportation, housing assistance, job training, and translation. Infrastructure-building included consortia training and provider training.

At present, the Healthy Start infant mortality rate is below the U.S. infant mortality rate and is about even with the 2020 goal. However, significant disparities still exist, and more needs to be done in the communities.

DHSPS includes other programs and activities, such as the National Fetal and Infant Mortality Review Program, women's health initiatives, the Fetal Alcohol Spectrum Disorders Initiative, the First-Time Motherhood/New Parents Initiative, and the Community-Based Doula Program. DHSPS also developed a popular document titled "Taking Care of Mom: Bright Futures for Women's Health and Wellness" and took the lead in developing "The Business Case for Breastfeeding," a resource kit to improve lactation support in the workplace.

Discussion

The presentation by Dr. de la Cruz prompted the following questions and comments:

- Dr. Cox asked about care transitions for women who have recently delivered and are returning to the community. A cause for concern involves the interval between hospital discharge and the postpartum care visit at 6 weeks; it seems that the initial visit should

occur at 2 weeks. Dr. de la Cruz responded that a key component of Healthy Start is home visiting. Home visits occur well before the 6-week mark; in fact, they occur within days of the woman returning to her community.

- Dr. Shields asked about direct clinical health care in Healthy Start. Dr. de la Cruz responded that some Healthy Start programs provide direct clinical health care and that grant money is sometimes used to pay providers. The Healthy Start program can be molded to meet the unique needs of the community. Dr. Shields also asked whether any attempt has been made to determine the factors that make women choose to enroll in Healthy Start. Dr. de la Cruz stated that outreach workers now contact the most high-risk women because of the lack of open slots in the projects.
- Ms. Chesna also asked about the justification for direct health care services to Healthy Start women given the existence of other programs to fill that need. Dr. de la Cruz stated that the vast majority of women and families served by Healthy Start are Medicaid-eligible and some have been more successful than others at obtaining Medicaid-provided services. As a last resort, Healthy Start pays for direct clinical services as a gap-filling program. Ms. Johnson noted that a growing number of women do not have coverage for their prenatal care and cycle off Medicaid 60 days postpartum; therefore, Medicaid is not filling the gap.
- Dr. Dominguez referred to the outcome data in terms of infant mortality rates. A definite decrease in poor outcomes is seen among Healthy Start women, but the pattern of disparities has not changed. She asked how MCHB is addressing that fact in Healthy Start. Ms. Johnson noted that that question will be answered in subsequent presentations.

National Healthy Start Association: A Grantee Perspective
Alma Roberts, M.P.H., President and CEO, Baltimore Healthy Start, Inc.; President, National Healthy Start Association

Ms. Roberts stated that the National Healthy Start Association (NHSA) was founded in 1997 to galvanize the collective projects and to advocate for Healthy Start's work on the national level. The Federal Healthy Start initiative is a network of 105 projects with 20 years of experience in providing culturally authentic services to underserved and marginalized urban, rural, tribal, and border communities throughout the Nation. Active consortia comprise clients, providers, businesses, and churches engaged in local health systems planning.

Healthy Start projects represent the melting pot of America. They serve vulnerable African American, Hispanic, Native American, Alaska Native, Pacific Islander, White, and Asian populations and operate in urban, rural, tribal, and border communities. The mission of NHSA is to be our Nation's voice in providing leadership and advocacy for health equity services and interventions that improve birth outcomes and family well-being. The role of NHSA is to educate, provide technical assistance (TA), promote and increase public awareness, identify strategies and common factors that affect MCH, develop strategies to sustain projects, and collect and analyze community health data. NHSA activities include the Best Babies Zones, Male Involvement—Where Dads Matter, and the preconception health and health care initiative. NHSA also provides TA materials for Healthy Start projects along with a number of publications.

For more than 20 years, Healthy Start projects have been able to transition the theory of life course to practice. Healthy Start started and continues with a focus on the social determinants of health. It has led community engagement and transformation with strategies involving consortia and health systems action plans. Healthy Start is a repository for a wealth of community health data that is only just beginning to be mined, a laboratory for effective training and employment of community health workers, and a cost-effective model.

Ms. Roberts continued her presentation with an overview of Baltimore Healthy Start, whose mission is to reduce infant mortality by using a life course perspective for improving the health and well-being of women and their families through the provision of comprehensive, supportive services in the communities where they live. Baltimore Healthy Start is one of the original 15 Healthy Start projects and has served more than 14,000 pregnant and postpartum women over 21 years. It has been certified under the Maryland Nonprofits' Standards of Excellence, and it created the Cradle of Hope Campaign for Healthy Babies. Initially, Baltimore Healthy Start was able to have a 95-percent penetration rate in the geographical areas in which it was located. However, with reductions in funding, the penetration rate has fallen to about 77 percent.

Ms. Roberts explained that the projects are aligned along the life course. The Perinatal Monitoring Intervention Model includes a recruitment team, in-center services, clinical services, interview and entitlement work, and in-home services. The program cares for the most vulnerable of women in the most vulnerable of communities. The Baltimore Healthy Start team comprises a recruiter, interviewer/entitlement specialist, care coordinator, neighborhood health advocate, early childhood development team, high-risk nurse, certified registered nurse practitioner, and social worker. All of these individuals are supported by a rigorous training program and comprehensive data collection.

The model of care evolved from a sole focus on the social determinants of health. In 1999, the perinatal monitoring intervention component was implemented. Ms. Roberts mentioned the evidence-based tools in use, the quality dashboard, and the Standards for Excellence before she described the successful Healthy Start outcomes involving low birthweight, very low birthweight, and preterm birth. She ended her presentation with a summary of why the Healthy Start model works—because of its use of community health workers, operation based on time-tested protocols, use of evidence-based tools, data-driven approach, adaptability, extensive community collaborations, and cost-effectiveness.

Central Hillsborough Healthy Start Project: A Grantee Perspective
Estrellita Berry, M.A., President and CEO, REACHUP, Inc.; Project Director and Principal Investigator, Central Hillsborough Healthy Start Project

Ms. Berry explained that the organization called REACHUP, Inc. (Respond, Educate, Advocate, Collaborate for Health in Underserved Populations) believes that families have an inherent ability to nurture and take care of themselves and sees itself as a conduit for that process.

In her remarks about the genesis of the national Healthy Start movement, Ms. Berry pointed out that Healthy Start was founded upon the successful World Health Organization Infant Mortality Reduction Model. Healthy Start systems-building efforts involve the idea of a community

consortium that includes male involvement and consumer participation. The consortium of Central Hillsborough Healthy Start (CHHS) includes a high percentage of recipients of services who take leadership roles, address policy, assist in hiring, and actively participate in evaluation and research with the University of South Florida. Ms. Berry described the local health systems action plan and collaboration with the State Title V agency and touched on the sustainability plan and continuous quality improvement.

CHHS and REACHUP focus on four major areas: (1) increasing civic engagement, (2) fostering resiliency in communities, (3) increasing employment and strengthening the health care workforce, and (4) leveraging resource opportunities.

Ms. Berry described the effectiveness of the CHHS project, which reduced the level of low birthweight and preterm delivery by about 30 percent among service recipients compared with nonrecipients. The struggle was to find an evaluator who could understand the value of community-based participatory research. Ms. Berry shared some of CHHS's clinical outcomes regarding the infant mortality rate (from 19.2 in 1998 to 9.4 in 2010) and low birthweight (from 16.7 in 1998 to 13.4 in 2010). Touching on the strategies, interventions, and tenets for effectiveness, Ms. Berry emphasized the life course movement and the importance of the ACA. CHHS works with three local clinics, four community resource centers, a county Medicaid waiver partnership, Strong Start for Mothers and Babies, and the Best Baby Zones initiative. It looks forward to establishing a partnership with the Federally Qualified Health Centers (FQHCs).

Healthy Start believes in achieving health equity by building a social movement, investing in ideas, executing tasks, and returning results. It links women to health, power, and love across the lifespan. The Life Course Practice Network will transform how Healthy Start–lead agencies restructure themselves and link various social and clinical practices to improve MCH. Since December 1, 2010, CHHS has been looking toward a vision of creating opportunities for "on the ground" training around the life course perspective.

Ms. Berry mentioned the next steps for discussion: (1) lead a strategic movement toward health equity for all, (2) co-create a standard service delivery to support families throughout the lifespan, (3) broker, forge, and nurture key partnerships toward a shared vision, (4) partner with SACIM to further improve infant mortality health outcomes, (5) strengthen network ties between Healthy Start sites nationwide, and (6) leverage funding for a robust Healthy Start evaluation.

Discussion

The presentations by Ms. Roberts and Ms. Berry prompted the following questions and comments:

- In response to a question from Dr. Davis about initiatives to engage fathers, Ms. Roberts stated that Baltimore Healthy Start works with the Center for Urban Fathers on job development. Fathers also are involved in prenatal care, breastfeeding activities, and a prenatal stress reduction program and have an active role in the consortium. Ms. Berry stated that CHHS includes male involvement components such as intergenerational

mentorships, a male mentoring peer support group that meets monthly, and a speaker's bureau.

- Referring to the gap in Healthy Start programs in the southwest United States, Ms. Chesna asked whether the number of projects is adequate. Ms. Roberts responded that more programs are needed. In response to another question from Ms. Chesna about the tenure of peer mentors and advisory board members, Ms. Berry stated that CHHS consortium members attend at least four meetings per year and participate on at least two subcommittees. They tend to be very active for 2 years on average. Most of the outreach workers stay with the program for about 7 years. Ms. Roberts stated that 15 of 70 employees of Baltimore Healthy Start have been with the program for more than 18 years.
- Dr. Troutman asked what percentage of women receive services given the limited resources. Ms. Roberts stated that the Baltimore Healthy Start penetration rate fluctuates because of reductions in funding, with caseloads currently at capacity. Ms. Berry stated that Hillsborough County has about 18,000 births a year. The project area served by CHHS includes 7,000 of those births. Of those 7,000 women, CHHS interfaces with about 2,300, only 500 of whom are case-managed per year.

The History of Healthy Start

Milton Kotelchuck, Ph.D, M.P.H., Senior Scientist, Center for Child and Adolescent Health Policy, Massachusetts General Hospital for Children

Dr. Kotelchuck stated that his presentation would consist of reflections on the history of Healthy Start. He pointed out that Healthy Start builds off of three prior improved pregnancy outcome programmatic initiatives of MCHB in 1965, 1978, and 1987. A Federal interagency White House Task Force to Reduce Infant Mortality in 1989 included Healthy Start as one of its proposals. Healthy Start was the final programmatic initiative of the second national era of infant mortality reduction. The central idea behind Healthy Start was that improved access to comprehensive prenatal care would reduce infant mortality and disparities.

Dr. Kotelchuck described what he called the Healthy Start Initiative 1.0, which had both a rocky and an auspicious beginning. The rocky start included an initial conflict over the source of Healthy Start funding, no unified vision of how to reduce infant mortality, and problems with governance by the consortia. Unintended consequences included a diminished broader focus on reproductive health in MCHB and partial abdication of Federal programmatic content leadership. On the positive side, Healthy Start was a successfully implemented program with strong local support. It began to replicate itself with smaller levels of funding and more modest interventions. The national evaluation showed successful implementation and improved prenatal care but limited impact on birth outcomes or disparities. Dr. Kotelchuck listed the major findings from the Healthy Start national evaluation.

Healthy Start 2.0 evolved from a strategic assessment (the Kotelchuck and Fine Healthy Start Report) that studied the notions of poor conception, poor implementation, and poor measurement. The assessment report offered 38 recommendations. No compelling science or overall theory of how to improve reproductive health existed; instead, the emphasis was on what should be implemented in every high-risk community in America. A key new developmental

idea was to extend Healthy Start's focus from conception through 2 years of age. The programmatic initiatives were organized around three core ideas: (1) ensure access and utilization of high-quality comprehensive health services for all Healthy Start participants, (2) strengthen local health systems, and (3) bring a consumer or community voice to efforts to improve MCH. The program evolved within that three-part framework. Dr. Kotelchuck considers Healthy Start 2.0 as a transition model. It continues to lack a strong science base, the implementation of the three core programmatic recommendations is mixed, and the national evaluations have not been used for quality control. MCHB has lost much of its leadership role on reproductive health, and Healthy Start appears to be an isolated program with mixed partnership development.

Dr. Kotelchuck stated that Healthy Start faces several opportunities. Healthy Start 3.0 should refocus on the three programmatic recommendations in the Kotelchuck and Fine Healthy Start Report, emphasize its great strengths in ensuring access and utilization of comprehensive health services, reconceptualize local health systems action plans as place-based community systems integrative initiatives, and better ensure and assess community voice.

National Evaluation of Healthy Start
Deborah Walker, Ed.D., Vice President, Abt Associates, Inc.

Dr. Walker began her presentation by stating that Healthy Start projects need a vital Federal/State partnership and a very strong State systems partner to be successful. She presented an overview of the Healthy Start evaluation, highlights of descriptive results from the project directors' survey, and next steps and recommendations.

The logic model for the National Evaluation of Healthy Start continues to evolve. The evaluation questions involve the (1) implementation of the nine program components across all Healthy Start projects, (2) subcomponents implemented by Healthy Start projects, and (3) function of consumer participation and leadership in Healthy Start.

The 2010 project directors' survey revealed that all 104 Healthy Start projects implement all five of the service components (outreach, case management, health education, perinatal depression screening, and interconception services). Between 66 percent and 99 percent of Healthy Start projects reported implementation of the four required systems components (consortium, local health system action plan, collaboration with Title V, and a sustainability plan.

Dr. Walker provided information from the survey concerning the location or setting of Healthy Start core services; referrals offered through case management; the educational and professional background of staff providing health education services, case management services, and outreach services; the percentage of Healthy Start projects that used selected outreach and client recruitment strategies; and targeted outreach for cultural or ethnic groups in the community. She referred to expanded service components implemented by Healthy Start projects, including home visiting, male involvement, breastfeeding support and education, healthy weight components, and tobacco use and smoking cessation opportunities.

In terms of systems components, Dr. Walker reported that all of the projects have consortia to mobilize key stakeholders (policymakers and consumers). However, only 68 percent of the projects have a local health system action plan. Dr. Walker also provided information on the percentage of Healthy Start projects that reported benefits received from coordination with State Title V and the percentage of projects collaborating with service-related organizations. Only 66 percent of the projects reported that they have a sustainability plan.

Dr. Walker called for more emphasis on helping local projects with evaluations. Local evaluations can be improved in the future by using available data to enhance evaluation designs; partnering with State and academic institutions, State agencies, and researchers at universities; and creating a network of Healthy Start researchers to encourage standardization of methods and approaches and to encourage peer learning.

Interconception Care Learning Collaborative
Kay Johnson, M.Ed., M.P.H., Chairperson, SACIM

Ms. Johnson reported on the goals and structure of the Interconception Care Learning Collaborative (ICCLC) developed by MCHB to engage all Healthy Start grantees in learning. The ICCLC project goals are to advance the quality and efficacy of Healthy Start interconception care components, address identified gaps in the provision of interconception care in Healthy Start, and develop a toolkit to guide maternal and child health programs with their interconception care activities. Another goal is to build skills around quality improvement (QI) among grantees.

The project leaders of ICCLC were learning community members and Healthy Start grantee teams. A total of 105 teams were organized into 16 learning collaboratives over a 3-year period. The Healthy Start teams conducted QI work, and each Healthy Start team selected a topic area and a change concept for each cycle. More than 750 individuals participated in team work. The ICCLC core content topics are case management, family planning and reproductive health, healthy weight, interconception screening and assessment, maternal depression, and primary care linkages.

After reviewing the evidence of improved community action through the ICCLC, Ms. Johnson described the "Model for Improvement" and the characteristics of the Institute for Healthcare Improvement's collaborative model for achieving breakthrough achievement. The framework for ICCLC change included strengthening linkages and partnerships, advancing the use of objective tools and data collection methods, and improving Healthy Start staff skills and protocols. Each team identified measures to fit its unique change project and used common measures specific to its learning collaborative.

Ms. Johnson touched on the results and conclusions of the ICCLC. A readiness assessment showed a high proportion of individual willingness and organizational readiness for change. A total of 102 ICCLC Healthy Start teams in cycle one demonstrated improvement in their chosen topic areas. The overall results show improvements in (1) grantee capacity to use QI, (2) staff knowledge of topics, (3) use of evidence-based tools, (4) number of program participants

counseled on family planning, healthy weight, and interconception risks, (5) completed referrals and followup by participants, and (6) strength of linkages and partnerships.

Project team recommendations were related to QI and interconception care. In terms of QI, Healthy Start should continue to focus on QI, provide robust TA to grantees using varied methods, emphasize measurement and provide TA to grantees, encourage peer learning and sharing, increase dissemination opportunities for grantees, and involve program participants in QI. In terms of interconception care, Healthy Start should standardize the components, encourage grantee self-assessment, and strengthen ties to community resources such as FQHCs.

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

Dr. Lu stated that Healthy Start represents the Nation's best hope to close the infant mortality gap. He pointed out that strategies to reduce infant mortality are not necessarily the same ones to close the infant mortality gap. For example, reducing early elective delivery may be an effective strategy for reducing neonatal intensive care unit (NICU) admissions and infant deaths, but it may not be a sufficient strategy for closing the infant mortality gap. The question is how to deliver on the full promise of Healthy Start. To reinvent Healthy Start, it must be improved, innovated, and transformed into Healthy Start 3.0.

Healthy Start should be reinvented because of new science, new opportunities, and "the same old gap." Dr. Lu focused on the same old gap. Healthy Start 3.0 builds on Healthy Start 1.0 and Healthy Start 2.0 and improves on their features. The 3.0 version would add five functionalities to improve Healthy Start's ability to close the gap: (1) ensuring access, (2) promoting resilience, (3) improving quality, (4) enhancing systems integration, and (5) driving community transformation.

Access to health care across the life course must be ensured, but coverage does not automatically translate to access. Outreach and care coordination, translation and transportation, cultural and linguistic competency, and community engagement and trust are needed. Healthy Start provides the ACA with a ready-made infrastructure to increase health care access in the 105 most underserved communities in the Nation. It must be redesigned so that it becomes a gateway to health care access across the life course.

The second added functionality of Healthy Start 3.0 is to promote resilience, the ability to bounce back in the face of stress. Resilience may be one of the most protective factors against adverse birth and child health outcomes. Healthy Start 3.0 can promote positive coping skills (relaxation exercise, mindfulness, transcendental meditation, and positive psychology), financial literacy, interpersonal communication, parenting skills, and father involvement, and it can use faith and social capital as sources of community resilience. Dr. Lu stated that Healthy Start must be reinvented as a cradle of resilience in communities.

The third added functionality of Healthy Start 3.0 is to improve quality. QI has a role in improving outcomes in hospitals, but disparities are rooted in clinics and the community;

therefore, QI must be moved from the bedside to the curbside, from health care systems to community systems and public health systems. Dr. Lu stated his belief that Healthy Start's deep roots in the community can make it a driver of perinatal QI in the community.

The fourth added functionality of Healthy Start 3.0 is to enhance systems integration. Healthy Start can act as the navigator or integrator helping to connect community health centers to other important preconception and perinatal health services. However, not all communities have community health centers. In those communities, Healthy Start must be a systems navigator, integrator, and shared resource for perinatal health care.

The fifth added functionality of Healthy Start 3.0 is community transformation. A place-based systems approach would bring together health development, educational development, economic development, and community development. Healthy Start can be reinvented to become a driver of community transformation.

Dr. Lu ended his presentation by stating that this vision of Healthy Start 3.0 needs more focus and clarity and that partners must work together to redesign Healthy Start. A series of town hall meetings with Healthy Start programs and grantees was held to get help and guidance in improving, innovating, and transforming Healthy Start to fully deliver on the promise of closing the infant mortality gap.

Discussion

The presentations by Ms. Johnson and Drs. Kotelchuck, Walker, and Lu prompted the following questions and comments:

- Dr. Jackson stated that the concept of thriving should be added to the construct of resilience.
- Ms. Chesna asked about the reaction to Healthy Start 3.0 from currently funded programs, inquired whether this plan to transition existing programs also includes a plan to expand to new communities, and asked about a cost analysis. Ms. Roberts responded that Healthy Start grantees are excited about the prospect of reinventing the program. The grantees agree about the need for enhancement and want to be part of the change.
- Dr. Shields asked about the history of funding for Healthy Start. Dr. Lu stated that, under current budgetary constraints, vast expansion of appropriations for Healthy Start programs in the next few years is very unlikely. The additional functionalities will require investment strategies and difficult choices. The hope is that full implementation of Healthy Start 3.0 will demonstrate a return on investment (ROI) that will result in funding for many more Healthy Start programs. Ms. Johnson stated that effective training in consistently high-quality performance data is needed and that the transformation of Healthy Start is fundamental to its long-term existence. Showing an ROI could lead to greater long-term investment.
- Dr. Peter Ashley mentioned that sending community health workers into homes is an opportunity to look at the home environment, specifically lead paint levels.
- Dr. Kotelchuck stated that the Healthy Start communities were very resistant to outcome-oriented evaluations, which has proved problematic over the years. Improvement is

needed to demonstrate impacts. Dr. Jackson noted that, at the beginning, Healthy Start did not have conversations about community-based participatory research. Now a platform exists to talk about such research and evaluation, and programs have forged partnerships based on trust. Ms. Berry stated that the great majority of projects understand the relevance of and desire to move toward more rigorous evaluation; however, funding for evaluation does not exist. Ms. Johnson called for more conversation on these topics.

- In response to a comment by Dr. Handler that Healthy Start 3.0 should be a universal program that coordinates all of the various initiatives, Dr. Roberts noted that Healthy Start is working on core performance standards that can be applied across different programs and sites.
- Dr. Labbok noted that a medical home with woman-centered care is needed. Dr. Troutman agreed that the construct is appealing, but the question is how to define the optimal community and health equity. Delores Acevedo-Garcia's idea of "opportunity neighborhoods" defines the elements of an optimal community, and Healthy Start can be a guide in that direction.
- Dr. Kotelchuck asked where Healthy Start fits into the full national strategy. He added that perhaps infant mortality should not be used as the outcome measure in the success of Healthy Start because it is unrealistic to ask small sites with limited funds to solve the problem of infant mortality. Penetration, or reaching all of the women in a community, is a much more important issue and will be more helpful to Healthy Start. Dr. Jackson stated that a recommendation to the Secretary could be to raise the visibility of Healthy Start. It should be represented on SACIM.
- Dr. Lu referred to the Richmond/Kotelchuck model regarding effective social change to improve MCH outcomes in this country. Three elements are needed: scientific knowledge, social strategies, and political will. The question is how to create political will to enable Healthy Start 3.0 to carry out these functions. The discussion must go beyond just talking about the strategies to talking about how to generate the political will to support the approach embodied in the Healthy Start projects.
- Dr. Dominguez stated that SACIM should champion Healthy Start and examine how to improve it; however, it must be noted that Healthy Start does not seem to affect disparities. In terms of a national infant mortality agenda around improving infant health nationwide and decreasing infant mortality, the ideas from Healthy Start 3.0 map to the National Prevention Council ideas. In an effort to make a formal connection with the National Prevention Council, SACIM can recommend improvements to Healthy Start to address the persistent gap that drives our Nation's poor ranking internationally; at the same time, SACIM can think about a national strategy to improve overall health.
- Ms. Johnson reflected on a parallel between Head Start and community health centers. Both programs had variable early evaluations about their effectiveness and were thought to be overly involved in community empowerment. Doubts were raised about what the evaluations measured and about the core components of each program. Questions also were raised about data from the programs and the amount of variability among sites. Nevertheless, both programs experienced tremendous success in transforming themselves, adjusting to a changing world, and monitoring their own performance through convincing evaluations. Both programs also grew and built political will. In addition, both Head Start and the community health centers exhibited strong performance

standards, obtained sufficient funding, established clear structures and opportunities for support and evaluation, used their political clout, and built greater political will to support themselves through a transformation and period of growth. Healthy Start will do the same.

WRAP-UP AND ADJOURN FOR THE DAY

Kay Johnson, M.Ed., M.P.H., Chairperson, SACIM
Michael C. Lu, M.D., M.P.H., Associate Administrator for MCH, HRSA; Executive Secretary, SACIM
David S. de la Cruz, Ph.D., M.P.H., Principal Staff and Designated Federal Official, SACIM; Deputy Director, MCHB/DHSPS

The meeting adjourned for the day at 5:38 p.m.

SECRETARY'S ADVISORY COMMITTEE ON INFANT MORTALITY

WEDNESDAY, JULY 11, 2012

SUMMARY OF DAY 1 AND OVERVIEW OF DAY 2

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

After the minutes of the March meeting were approved unanimously, Ms. Johnson summarized the topics covered on the previous day. In response to a question about the National Prevention Council from Dr. Handler, Ms. Johnson stated that the council is congressionally mandated and will continue unless the ACA is repealed. Dr. Cox recommended that the SACIM members read Jeffrey Sachs' *The End of Poverty* and pointed out the importance of clinical economics or cost-benefit analysis of the work recommended by SACIM. Dr. Troutman pointed out the need to deal with health inequities, the role of race and racism in health outcomes, and broader issues involving social determinants and institutionalized racism.

COMMITTEE DISCUSSION OF PRIORITIES OF THE NATIONAL AGENDA

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

Ms. Johnson opened the discussion on the national agenda by referring to her use of the impact and feasibility grid and the fact that it did not work in this instance. The people who submitted their scores graded the impact items high, with more variability in the feasibility scores but few items falling out. Tallies, averages, and charting the individual items did not result in valuable information. Other methods are available for voting, scoring, and rating, but more discussion is needed on the life course approach, key action areas, and short-term actionable items.

Ms. Johnson asked the SACIM members to state their top priorities so that they can eventually be clustered in a document. SACIM developed the following list of top priority areas for the Secretary over the next 1 to 2 years:

- Focus on ways to reach the aspirational goal
- Social marketing phase/campaign on preconception health
- Consistent standardized data
- TANF to address poverty
- Evidence-based interventions that reduce infant mortality and ensure they are properly incorporated into all programs (breastfeeding, family planning, home visiting, preconception care, smoking cessation, immunization, SIDS/SUID prevention, WIC, comprehensive sexual/reproductive health education from K–12 with life planning, regional perinatal care)
- Important evidence-informed areas (social support, nutrition, obesity prevention)
- Clinician-to-community interface, care transitions, innovative approaches to improving linkages for maternal and infant populations (e.g., discharge planning as a condition/standard of participation for hospitals in Medicaid)
- Building on Bright Futures for Women and IOM recommendations and HHS-approved women's clinical preventive services (e.g., postpartum visit, interconception visit)
- Increased workforce (e.g., nurse midwives, physicians, community health workers) through education and training funds
- Focus on improving health of women before, during, and beyond pregnancy (interconception care and opportunities in the ACA)

- MCHB responsibility for infant mortality strategy of HHS and the Nation. Support States and communities in coordinating resources for reducing infant mortality and improving perinatal care and other outcomes.
- Innovative educational programs using new communication technologies for infant mortality reduction strategies (e.g., immunization, breastfeeding, SIDS/SUID)
- Expand funding for mental health and substance abuse for pregnant and postpartum women as a percentage of spending on prenatal/maternity care, maximizing use of new ACA resources related to maternal depression, evidence-based tools and models
- Public health/HRSA support for coordinated, enhanced training of clinicians in public health/cross-training
- Transformation of Healthy Start and expanded funding with additional responsibilities in systems integration, quality improvement, improved evaluation, and performance monitoring
- Concentrate resources in communities with a high infant mortality rate; place-based initiative building on Healthy Start and Best Baby Zones to improve health equity and reduce disparities in pregnancy outcomes and infant mortality (maybe community transformation grants, co-location, and coordination of other Federal resources from HUD, DOE, ACF, HRSA-BPHC, etc.)
- Develop "shared resources" or "utilities" at the State and community levels that support maternal and infant care providers (community health teams, Help Me Grow–type technological resources, breastfeeding [ZIPMilk], telephonic/Internet resource lines for providers)
- Increase the number of States that offer preconception care in well-women visits through Medicaid (defined benefits, provider incentives, billing codes)
- Increase the number of States that finance interconception care for women with a prior adverse pregnancy outcome in Medicaid
- Automatic presumptive eligibility for all newborns
- Continue efforts to improve regional perinatal care and reduce elective preterm deliveries before 39 weeks and otherwise improve the safety and quality of care around the time of birth
- Increase funding for translational research, particularly related to health equity
- Promote a better balance between high-tech and low-tech interventions. Keep the current emphasis on high-tech interventions (NICU technology), but also invest in low-tech interventions (risk-appropriate care)
- Alignment with the National Prevention Strategy
- Include a focus on MCH populations, maternity and infant groups in particular, in ACA grants (community transformation grants and innovation grants). Recognize the role of early life in the prevention of chronic disease and promotion of lifelong health (life course perspective).
- Make infant mortality a winnable battle for HHS, including CDC and HRSA in particular
- Secretary to make statements for infant mortality and other months dedicated to related issues

Ms. Johnson remarked that the list must be synthesized into a narrative document. In the next 4 to 6 weeks, a document will be produced that represents the best thinking of the group and frames the thoughts into concrete actionable items for the Secretary. The goal will be to transmit the document to the Secretary in September, which is Infant Mortality Month. Ms. Chesna inquired whether SACIM's document should be aligned with the five strategies outlined by Dr. Lu. Dr. Lu remarked that a draft of the document could be vetted to the various public and private stakeholders, but doing so would compress the timeline even more. Ms. Johnson agreed that the ideas must be vetted with

partners to ensure that the professional organizations and other stakeholders have the opportunity to give SACIM feedback. Because of the timeline, the recommendations will be written first. Dr. Lu encouraged the development of very specific recommendations (who, what, where, when, how) that are actionable. Dr. Martin suggested that a request be made regarding documents in progress that might be helpful in creating the SACIM document. Dr. Mabry-Hernandez suggested that webinars with organizations might result in buy-in and helpful feedback from stakeholders and partners. Ms. Johnson agreed that SACIM can make effective use of online meetings for that purpose.

Ms. Johnson asked the members to think about the possibility of aligning the SACIM document either with the four National Prevention Strategy categories presented by Dr. Levi or with the topics presented by Dr. Lu. SACIM could organize all of its ideas under the four categories of the National Prevention Strategy. Another possibility is to use the framework that is the composite of Dr. Lu's categories and SACIM's categories and then, at some point, include a table in the document that crosswalks the framework with the National Prevention Strategy to indicate the overlap.

WORKGROUP PLANNING

Ms. Johnson referred to the following list of work groups:

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

The Healthy Start workgroup, which will discuss the transformation of Healthy Start and the concept of place-based initiatives, will include Drs. Jackson, Kotelchuck, Handler, Petrini, Shepherd, and Shields. Dr. de la Cruz stated that the reauthorization of Healthy Start is to take place in October 2013, and the Healthy Start projects have a June 1, 2014 start date.

Ms. Johnson stated that the National Agenda workgroup has done its work. Dr. de la Cruz mentioned that seven of the current SACIM members will rotate off the committee in January 2013; seven others will rotate off in January 2014, and seven more in 2015. Based on a suggestion from Dr. Handler, the National Agenda workgroup will create a table to integrate SACIM's ideas with those in the National Prevention Strategy.

In terms of the Health Care Financing and Health Care Reform workgroups, Dr. Handler stated that a more accurate name for the Health Care Financing workgroup would be the Budget Priorities workgroup and that, with the Health Care Reform workgroup, it has morphed into the bigger agenda. Ms. Johnson asked whether the Health Care Finance budget-focusing workgroup should merge with the Health Care Reform workgroup. Dr. Handler responded that the Health Care Financing workgroup should be renamed and should continue separate from the Health Care Reform workgroup.

Regarding the Health Equity workgroup, Dr. Cox stated that it should continue until equity is achieved. Ms. Johnson suggested that the workgroup have a future conference call to further discuss

the national strategy. A table should be created that links to the disparities plan and helps to flesh out the core concepts.

Dr. de la Cruz stated that each workgroup has a DHSPS staff person assigned to it. A staff person for the Healthy Start workgroup will be identified, and that person will work with the chairperson to schedule conference calls. Dr. Jackson will chair the Healthy Start workgroup.

INFANT MORTALITY COLLABORATIVE AND COIN

Michele Lawler, M.S., R.D., Deputy Director, MCHB/Division of State and Community Health
Reem Ghandour, Dr.P.H., M.P.A., Public Health Analyst, MCHB/Office of Epidemiology and Research
Paul E. Jarris, M.D., M.B.A., Executive Director, Association of State and Territorial Health Officials

Ms. Lawler presented an update on the State Title V infant mortality initiative, which is an ongoing partnership between HRSA, State Title V MCH grantees and other State public health partners, Association of Maternal and Child Health Programs (AMCHP), Association of State and Territorial Health Officials (ASTHO), March of Dimes (MOD), CityMatCH, and Federal partners in CMS and CDC. The ultimate goal is to develop and implement a national strategy to reduce infant mortality. The infant mortality initiative was launched in Region IV and Region VI in January 2012. State infant mortality teams were formed, and each of the 13 States developed an infant mortality action plan. The States continue to refine and implement their plans.

A review of the State infant mortality action plans revealed five common strategies: (1) reduce elective delivery at less than 39 weeks, (2) expand access to interconception care through Medicaid 1115 waivers, (3) promote smoking cessation among pregnant women, (4) prevent SIDS/SUID by promoting safe sleep, and (5) improve perinatal regionalization.

The Region IV and Region VI States expressed a desire to learn from one another. As a result, the Region IV and Region VI Collaborative Improvement and Innovation Network (COIN) was created. Its purpose is to facilitate collaborative learning across the 13 States. Action teams for the five identified strategies will meet in Washington on July 23 and 24.

The work done in the Region IV and Region VI COIN will serve as a model for expanding the State infant mortality initiative to other HHS regions. Region V State health officials and Title V MCH directors will participate in the Region IV and Region VI infant mortality collaborative meeting in Washington. In addition, a 2-hour COIN orientation and TA training on QI and principles and practices related to infant mortality will be provided at selected regional directors' meetings in conjunction with the August 2012 State Title V MCH block grant reviews.

The ultimate goal is to advance the national strategy to reduce infant mortality by establishing State teams and convening infant mortality summits in additional HHS regions, beginning in Region V. The Title V infant mortality initiative also hopes to build on the recommendations and action strategies developed in Region IV and Region VI and to provide States in all 10 HHS Regions with the opportunity to develop effective strategies for addressing infant mortality in their States and to participate in structured QI COINs that will ultimately lead to reduced rates of infant mortality nationwide.

Dr. Labbok noted that immunization and breastfeeding are not emphasized in the Title V infant mortality initiative. Ms. Lawler responded that, in addition to the five common strategies that emerged from a review of the State action plans, other topics are being addressed by some of the States' individual action plans.

Dr. Ghandour provided additional information about the work of COIN. A COIN, or collaborative innovation network, is a cyberteam whose innovation comes through rapid and ongoing communication across all levels. A COIN describes how individuals work and learn collaboratively to develop, implement, and evaluate strategies to reduce infant mortality. On Dr. Lu's suggestion, the COIN definition was adapted to reflect a focus on both innovation and improvement.

The COIN initiative was born out of the January 2012 infant mortality summit in New Orleans for Region IV and Region VI. It was designed to meet the stated needs related to common evidence-based strategies to reduce infant mortality and to enable sharing and collaborative learning and action across States. The first meeting was held in March 2012. COIN was initiated as a mechanism to support the adoption of collaborative learning and QI principles and practices to reduce infant mortality and improve birth outcomes. The work was developed in partnership with ASTHO, MOD, CityMatCH, CMS, and CDC.

Five strategy teams focus on common State-identified priorities, and the work is being done by teams led by two to three topical experts with data and methods experts, two staff, and self-selected members from each of the 13 States. Teams average between 25 and 30 members. The lifespan of a COIN is envisioned to be 12 to 18 months, supported by a contract through MCHB, with team-driven foci, activities, and outcomes.

The challenges faced by the COIN teams include logistics; regional, interstate, and intrastate differences; strategy-specific challenges; and adoption of collaborative practices under challenging logistical circumstances. The strengths of the COIN teams are their people, commitment, partners, and momentum.

COIN's work to date is entirely team driven and focused on defining the scope and nature of the problem, developing an aim statement, identifying possible action strategies, and identifying related metrics to track progress. The launch, which will take place in Crystal City, VA, on July 23–24, will include learning sessions on existing efforts to reduce infant mortality and improve birth outcomes, collaborative learning and working, and QI. The core of the meeting will be work time for the teams.

To summarize, Dr. Ghandour stated that COIN was developed in response to stated needs among the 13 States in Region IV and Region VI. It is designed to help States use the science of QI and collaborative learning to improve birth outcomes over the next 12 to 18 months. It is participant driven. Finally, it is part of a much larger portfolio of efforts to improve birth outcomes, and it works in partnership with those efforts.

Dr. Paul Jarris presented information about the ASTHO Healthy Babies Initiative and infant mortality. The purpose of the initiative is to affect health outcomes in Region IV and Region VI, areas of the country with the highest rates of infant mortality and preterm births and the greatest health disparities. In spring 2010, State health officials in the South committed to a regional effort for infant mortality and prematurity. In October 2011, Dr. David Lakey issued ASTHO's Healthy Babies Presidential Challenge to improve birth outcomes by reducing infant mortality and prematurity in the United States. The challenge went nationwide, with a total of 44 States pledging to reduce preterm births by 8 percent by 2014.

The initiative's Web site (www.astho.org/healthybabies) is organized around four stages (preconception, prenatal, birth to 28 days, and first year) and six categories of interventions (policy resources, community resources, organizational resources, health information technology, health care provider resources, and self-management resources).

Ideas from the January summit on infant mortality are being spread all over the country, and States are sharing their interventions with one another. ASTHO is playing a connector role between State Hospital Engagement Networks (HENs) and Medicaid. Dr. Jarris offered examples of the work that has been done in Louisiana, Oklahoma, and West Virginia.

Recommendations include capitalizing on common goals and strategies of multiple national initiatives; actively engaging executive leadership from business, hospitals, health care providers, public health, Medicaid, insurance, and associations; calculating true savings while improving care; continuing to leverage partnerships; and improving goodness and fairness. Dr. Jarris encouraged SACIM to recommend to the Secretary to set a specific target for closing the gap in infant mortality.

Discussion

The presentations by Ms. Lawler and Drs. Ghandour and Jarris prompted the following questions and comments:

- Ms. Johnson stated that, especially in health policy, States are the drivers, leaders, and innovators.
- Dr. Kotelchuck offered a historical reflection, mentioned the MCHB Improved Pregnancy Outcome (IPO) initiatives, and stated that the Southern States were the drivers in Medicaid expansion to address infant mortality. He asked why ASTHO chose an 8-percent reduction in preterm births as its goal. Dr. Jarris explained that ASTHO and MOD collaborated to arrive at that number, which was thought to be realistic and doable.
- Dr. Dominguez reiterated the importance of closing the gap as well as decreasing the overall infant mortality rate. She asked about the five strategies and how the idea of closing the gap is integrated into them. Dr. Jarris responded that the integration is not satisfactory, but that Medicaid waivers (getting people into Medicaid quicker and extending care after delivery) would help. The measurement system must be changed to guarantee goodness and fairness in each of the interventions, specific goals must be set for closing the gap, and goodness and fairness measures should be included for every Healthy People goal.

- Dr. Shields asked about the timeframe for expanding the initiative nationally. Dr. Jarris responded that ASTHO launched the initiative nationally in September 2011; however, the gravitational pull back to Region IV and Region VI is very strong, which is a challenge. Dr. Ghandour stated that the groundwork for expanding the COINs will be laid in the next 2 years. Ms. Lawler added that the TA pieces done in conjunction with the block grant reviews in Region II, Region X, and California are introductory sessions, but the hope is that they will build to the infant mortality summits. Dr. Jarris noted that the Title V directors are engaged across the country.
- Ms. Johnson mentioned the general concern about State uptake around Medicaid.. She expressed her optimism about States adopting Medicaid expansions over the next 2 years. Dr. Jarris mentioned that examining the waivers across the country would be helpful, especially in terms of MCH, and Ms. Johnson stated that that work has been done.
- Dr. Cox expressed his admiration for the work of the COIN strategy teams, but he cautioned that face-to-face meetings, either regionally or at the State level, have value. He recommends a periodic schedule of in-person meetings in addition to the cyber work. Dr. Ghandour noted a built-in capacity for as many as three face-to-face meetings in the first set of COIN activities.
- Ms. Chesna asked whether the collaboratives are targeting their strategies to areas of States with the highest rates of infant mortality. Dr. Ghandour responded that this point depends on the State representatives sitting on the strategy teams.

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

Dr. Lillie-Blanton stated that CMS sees itself involved in both care delivery and population health. She presented an update on two major CMS activities: the Strong Start initiative and the Expert Panel on Improving Maternal and Infant Health Outcomes.

Strategy one of Strong Start focuses on reducing early elective deliveries. A major part of the strategy is a public-private partnership involving MOD, ACOG, and other major organizations. An ad campaign targets families and mothers. The Partnership for Patients, which works through the HENs, is another part of the strategy, along with an education campaign that will engage clinicians in reducing early elective deliveries.

Strategy two also is moving forward with a funding opportunity announcement (FOA) involving retrieving and analyzing data on birth records and birth outcomes. Some pushback involves privacy laws that prohibit States from releasing data. The new FOA entails CMS taking the lead to work with the States to ensure that the data needed for evaluation is available. Applicants must be able to demonstrate that they have some baseline data to be used in a strong evaluation.

Dr. Lillie-Blanton stated that eight maternity care performance measures within CMS help States and CMS monitor performance. Five of the measures are in the child core set, and the others are in the adult core set. CMS is in the beginning stages of working with States to collect those data. At least three of the measures require linkage of birth certificates and Medicaid claims data, for example, data on caesarean sections, low birthweight, and elective deliveries. An effort has been

launched with CDC to help improve the ability of CMS to work with States to do those linkages. A detailee from CDC is working with CMS full-time to train the States regarding those linkages. The States' capacity to do the linkage will improve their self-monitoring.

CMS has launched the Expert Panel on Improving Maternal and Infant Health Outcomes. Over the course of the next year, the expert panel will break into two workgroups: (1) Preconception, Postpartum, and Interconception Care and (2) Pregnancy and Delivery. The expert panel is lead by Drs. Mary Applegate and James Martin. The intent of the expert panel is to identify the opportunities that Medicaid should be engaged in to make a difference. CMS's intention is to give guidance and direction to its leadership, but Dr. Lillie-Blanton pointed out that giving direction to CMS leadership means going to the States. Within the course of a year, CMS plans to create some concrete action steps for guidance.

The two workgroups overlap to some extent with COIN and will meet monthly with the charge of identifying action steps for CMS. Overlap with some of the COINs and members of SACIM will help CMS to coordinate this work. A concerted effort will be needed to ensure alignment and coherence in the expert panel's work. CMS has brought together the national players in the field and will coordinate with COINs in Region IV and Region VI. Federal partners are participating as well.

Discussion

The presentation by Dr. Lillie-Blanton prompted the following comments and questions:

- Ms. Johnson noted that SACIM will make substantial recommendations to the Secretary related to Medicaid. SACIM believes that the money spent on innovation must be extended beyond Strong Start; the prenatal enhancements are necessary but not sufficient.
- Dr. Kotelchuck mentioned the MCH Medicaid TAG (Technical Assistance Group), a committee that met during the 1980s and 1990s. He suggested that the committee be reestablished as a mechanism to make innovations, for example, in financing and purchasing. Dr. Lillie-Blanton noted that a quality TAG and an oral health TAG exist now. An outgrowth of the expert panel might be to institutionalize or reinvigorate an MCH TAG to continue the work of the expert panel.
- In response to a comment by Dr. Handler about the corporate health care nature of the list of the Center for Medicare and Medicaid Innovation (CMMI) grantees, Dr. Lillie-Blanton noted that the independent reviewers of Strong Start grantees must understand the fields, people, communities, and issues involved in enhanced prenatal care within birthing centers, medical homes, and centering. The review panels must be as knowledgable as the people who designed the program. Ms. Johnson noted that workers in public health must keep up with the transformations occurring in clinical medicine.
- Dr. Kotelchuck asked where the eight maternity core performance measures are listed and whether CMS reports on them in a public document. Dr. Lillie-Blanton stated that the collection of data for a number of the measures that require linkage has not been satisfactory and the data are not publicly available at present. Some of the data will be available in the September 2012 report. Ms. Johnson added that the expert panel meeting involved discussion of how different measures are carried out at different levels, micro-

QI data, and simple administrative data sets.

- Dr. Cox asked how CMS interacts with the Medicaid and CHIP Payment and Access Commission (MACPAC). Dr. Lillie-Blanton replied that CMS does not interact with MACPAC in a formal way; CMS attends meetings and discusses the agendas. MACPAC issues regular reports on CHIP and Medicaid that are available online.

Referring to Dr. Jarris's presentation, Dr. Jackson asked whether SACIM's recommendations will declare a target for closing the gap. Ms. Johnson stated that the Health Equity workgroup will address that topic. She also stated that the committee will have opportunities to weigh in on the draft report that she will write.

UPDATES FROM PARTNER ORGANIZATIONS

Cynthia Pellegrini, Senior Vice President of Public Policy and Government Affairs, March of Dimes Foundation
Lauren Raskin Ramos, M.P.H., Director of Programs, Association of Maternal and Child Health Programs
Brian Osberg, M.P.H., Program Director, Health Division, Center for Best Practices, National Governors Association

The March of Dimes Foundation

Ms. Pellegrini presented information about the MOD initiatives. MOD is engaging in three activities to reduce infant mortality and prevent early-term and preterm birth: (1) Toward Improving the Outcome of Pregnancy: Enhancing Perinatal Health Through Quality, Safety, and Performance Intiatives (TIOP III), (2) Prematurity Prevention Network, and (3) Healthy Babies Are Worth the Wait (HBWW) program. TIOP III is the MOD major roadmap for QI in maternal and infant health care. Regionalization is a long-time interest of MOD, and increasing utilization of antenatal steroids when medically indicated also presents significant opportunities for improvement. The Prematurity Prevention Network continues to serve as a key forum for prematurity data, programs, and information-sharing. MOD maintains and updates the network, which currently has more than 4,300 registered users and averages more than 500 visits per month. The HBWW community program uses multiple interventions in multiple settings to reduce preterm birth rates in the community at large. The program is expanding to sites in Texas and New Jersey. A CMMI grant was not funded, but MOD is pursuing other options for maintaining the momentum of the initiative. In addition, MOD has launched a QI service package that accompanies the HBWW toolkit. The service package includes grand rounds, online services, public education, and a Web-based data portal. A total of 100 hospitals have been selected to participate in the service package at no cost.

MOD is continuing its ongoing partnership with HHS to advance the goals of Strong Start. Patient materials on 39-week elective delivery issues produced by MOD are cobranded with HHS and ACOG and are being distributed across the country. MOD also is collaborating on media coverage, and HHS is planning media buys in November. In conjunction with Strong Start, Partnership for Patients promotes QI through HENs. MOD is reaching out to the HENs to offer a menu of options to reduce elective deliveries before 39 weeks.

MOD is partnering with ASTHO on its initiative to reduce States' preterm birth rate by 8 percent by 2014. MOD chapters are reaching out to State health officers to offer assistance and resources, and MOD has created a new award for States that meet the challenge. MOD also sits on the National Governors Association (NGA) Design Team on Improving Birth Outcomes that supports the ASTHO challenge. In addition, MOD is working to ensure that perinatal quality measures are developed and incorporated, as appropriate, in a consistent way into various measure sets and initiatives.

Ms. Pellegrini concluded her presentation with a reference to the five main findings of the Born Too Soon report on global prematurity: (1) 15 million babies are born too soon every year, (2) preterm birth rates are rising, (3) prevention of preterm birth must be accelerated, (4) premature babies can be saved now with feasible, cost-effective care, and (5) everyone has a role to play to meet the stated targets. The United States is ranked sixth among the world's countries in preterm births.

Association of Maternal and Child Health Programs

Ms. Ramos presented an update on a variety of AMCHP projects and activities. AMCHP is a national resource, partner, and advocate for State public health leaders and others working to improve the health of women, children, youth, and families, including those with special health care needs. AMCHP supports State Title V MCH programs and provides national leadership on issues affecting women and children. Its role in improving birth outcomes involves advocating for MCH programs, communicating information, disseminating best practices, providing direct TA, connecting States in peer-to-peer sharing, and forging partnerships.

AMCHP's infant mortality compendium document is a comprehensive report on what States can do to improve infant mortality and birth outcomes. AMCHP pulled together seven recommendations and concrete action steps supplemented by specific State examples. The document will be available on the AMCHP Web site next week.

AMCHP's database of best practices is known as Innovation Station. SACIM members can use it as a resource and can also help to populate it. AMCHP also is supported by the Kellogg Foundation in a project focusing on the areas of preconception health, breastfeeding promotion, preterm birth, and life course indicators. Tools and resources on these topics will be forthcoming later this year. With support from CDC, AMCHP will release a State infant mortality collaborative toolkit in September, which is the result of a five State collaboration to pilot analytic strategies for investigating direct contributors to infant mortality. Another project is the Partnership to Eliminate Disparities in Infant Mortality, which addresses racism in infant mortality. AMCHP also partners in the Best Babies Zone project.

Ms. Ramos concluded her presentation with an update on the Title V MCH Block Grant funding, which AMCHP is working hard with others to ensure. The fiscal year (FY) 2012 appropriations process is underway, with the expectation of deep cuts from the House. The fiscal policy procedure of sequestration, by which automatic spending cutbacks take place, will result in an across-the-board cut of 8 to 10 percent. During FY 2014, intense scrutiny is expected on the Title V MCH block grants because of questions about duplication with the ACA.

National Governors Association

Mr. Osberg presented information about the National Governors Association's (NGA's) involvement in the issue of premature birth and infant mortality. The NGA's Center for Best Practices involves best practices in education, homeland security, transportation, and health care. Mr. Osberg stated that half the births nationwide are funded through Medicaid and CHIP, which makes infant mortality both a major cost issue and a major quality-of-life issue.

NGA realigned its agreements with ASTHO on its State health leaders' initiative and its arrangement with HRSA in the Alliance for Information on Maternal and Child Health Services (AIM) to focus on improving birth outcomes. The ASTHO and HRSA agreements put NGA in a position to help 12 States meet the challenge of reducing premature births by 8 percent by 2014. An expert design team includes HRSA, CMS, MOD, and ACOG to direct NGA in helping the 12 States by coordinating programs and resources that already exist. In addition, NGA is developing a Web portal to help governors' offices on health care policy options in general.

Discussion

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

- Ms. Chesna referred to the need for community leaders to be involved in areas with high rates of infant mortality and asked about the governors' level of commitment to the issue. Mr. Osberg stated that the governors are very concerned about how to more effectively provide health care services. He reiterated that 44 States have signed ASTHO's pledge and that infant mortality will doubtless be a high-profile issue for the governors' offices.
- Ms. Johnson referred to SACIM's charge to make recommendations to the Secretary on how to reduce infant mortality and asked the panel members for their opinions about the most important actions to recommend. Ms. Pellegrini responded that the Secretary should link already existing organizations and programs for easier understanding, access, and implementation. All of the programs and resources should be aligned and not in conflict. MOD is involved in quality measures because it is trying to ensure that the same measures are being used in the hospitals, Medicaid programs, and CHIP programs. Likewise, it is hoped that the exchanges will adopt the same measures on perinatal health. What is needed is connection, simplification, and links to shared resources.
- In response to Ms. Johnson's question, Ms. Ramos stated that full funding for MCH programs is needed and the Secretary can help model the behavior across agencies and departments, think broadly and support comprehensive approaches instead of just pregnancy, and strike a balance between evidence and innovation.
- Mr. Osberg called for coordination at the department level and a clear message about the importance of reducing infant mortality to the administration and the country.
- Ms. Johnson mentioned that the Secretary's statement about a national strategy to reduce infant mortality was made in the context of a global meeting. She asked Ms. Ramos what she sees as the role of Title V in helping with some of the data linkage challenges. Ms. Ramos responded that Title V collects data on MCH indicators every year, but that fact is not widely known. Not all States have the same capacity for data collection, infrastructure support is needed, and sharing data should be made easier.

- Dr. Kotelchuck reiterated that NGA was the key agency during the last major period of infant mortality initiatives in the country in the 1980s and 1990s. It sponsored all of the national meetings at which States shared with one another the best practices. Ms. Johnson added that the COIN strategy in the Southern States modernizes the methods used previously.
- In response to a statement by Dr. Jackson questioning the current state of affairs in the South, Ms. Johnson stated that the focus in the earlier time period was on what happened in a pregnancy, not on what happened in the lives of families. The emphasis should be on improving the health of women before, during, and beyond pregnancy. Dr. Jackson pointed to the compartmentalization of the concerns—into pregnancies and families—and noted the absence of a marriage of the two. Dr. Handler stated that access was the focus, but women who got expanded Medicaid access were not the highest risk women. The content of prenatal care was not part of the discussion. Currently, many very high-risk women are still disenfranchised.
- Ms. Johnson pointed to new opportunities, the evolution of the health care system, and the role of partners and sharing.

PUBLIC COMMENT PERIOD
David S. de la Cruz, Ph.D., M.P.H., Principal Staff and Designated Federal Official, SACIM; Deputy Director, MCHB/DHSPS

No public comments were submitted.

COMMITTEE BUSINESS: DISCUSSION AND NEXT STEPS
Kay Johnson, M.Ed., M.P.H., Chairperson, SACIM
Michael C. Lu, M.D., M.P.H., Associate Administrator for MCH, HRSA; Executive Secretary, SACIM
David S. de la Cruz, Ph.D., M.P.H., Principal Staff and Designated Federal Official, SACIM; Deputy Director, MCHB/DHSPS

Ms. Johnson stated that the writing of the document for the Secretary will begin immediately, with emphasis on a version of the recommendations in a narrative format and organized according to priorities. The draft will be circulated to SACIM members and then to a small number of selected partners. During that vetting process, the background and framework will be written to support the recommendations and put them in the context of health equity and quality. The goal is to send the document to the Secretary in September, which is Infant Mortality Month.

Dr. de la Cruz suggested the tentative dates of November 14 and 15 for the next SACIM meeting. He explained that seven members will rotate off SACIM in January 2013. New members will be identified, and current terms can be extended 180 days if necessary. The Secretary also can extend terms. Ms. Michele Loh will send a list of term expirations to members.

Ms. Johnson stated her appreciation to the ex officio members of the committee for their participation in the meeting.

The meeting adjourned at 2:55 p.m.

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Benita Baker
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