Secretary's Advisory Committee on Infant Mortality

Meeting Minutes of August 10-11, 2015

Webinar
Parklawn Building
Room 13-91
Department of Health and Human Services
Rockville, MD 20857

GENERAL SESSION

Monday, August 10, 2015

CALL TO ORDER AND WELCOME

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

Dr. de la Cruz welcomed participants to the meeting and reviewed the logistics for the webinar. He noted that all presentations would be uploaded to the SACIM website.

SUMMARY OF MARCH, 2015 MEETING

Kay Johnson, M.Ed., M.P.H., Research Associate Professor of Pediatrics, Geisel School of Medicine at Dartmouth; President, Johnson Group Consulting, Inc.; Chairperson, SACIM

Ms. Johnson welcomed meeting participants and provided a summary of the March 2015 meeting. She noted that committee members agreed in November 2014 that each meeting would focus on one of the six strategic directions that were presented to the Secretary in January 2013. The March meeting focused on Strategic Direction 4: Increase health equity and reduce disparities by targeting social determinants of health (SDOH) through both investments in high-risk, under-resourced communities and major initiatives to address poverty.

Ms. Johnson reviewed the agenda for this meeting. She noted that much of the meeting would focus on the PREEMIE Act, which requires the committee to provide a report to Congress on prevention of preterm birth. The committee would also review the draft letter to the Secretary on SDOH and health equity, with a goal of delivering the letter shortly after Labor Day.

Ms. Johnson stated that the report to Congress on the PREEMIE Act would have a short timeline. She would serve as lead writer and hoped to have a draft for review by September.

Ms. Johnson noted that the next SACIM meeting would focus on Strategic Direction 5: Invest in adequate data, monitoring, and surveillance systems to measure access, quality, and outcomes.

MCHB UPDATE

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

Dr. Lu provided updates from MCHB. Key points were as follows:

- Title V MCH Services Block Grant: The new guidance was issued on April 1. Grant applications were due on July 15, and the review began this week. The transformed block grant includes 15 national performance measures that apply to all states and jurisdictions. Grantees are required to submit an action plan and logic model for each performance measure. Standardized performance measurement and data collection will help MCHB tell a more compelling story about the impact of Title V.

- Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program: The program was reauthorized at $400 million per year for two years. MCHB is reviewing the competitive funding mechanism and will revamp performance measures for the program.
- Healthy Start 3.0: The revamped program was rolled out and is serving more families than ever. The program now focuses on women's' health, quality and safety, family resilience, collective impact, and accountability.
- National Collaborative Improvement and Innovation Network (COIIN) to Reduce Infant Mortality: Six national COIIN teams are addressing different aspects of infant mortality. MCHB held a learning session in Boston.
- Maternal Health Initiative: MCHB rolled out the 100,000 Mothers Campaign, led by the Council on Patient Safety in Women's Health. The goal is to prevent 100,000 maternal deaths and severe morbidity in five years by focusing on improving women's health before pregnancy, reducing low-risk cesarean deliveries, and improving the quality and safety of maternal care by implementing patient safety bundles in every birthing hospital and facility across the country in the next three years.
- 100,000 Kids Campaign: The campaign is led by the Child Safety Network, with a goal of preventing 100,000 child deaths and hospitalizations due to preventable injuries. National partners include the Centers for Disease Control and Prevention (CDC) and the Association of State and Territorial Health Officials (ASTHO). The campaign will use a COIIN approach to address safe sleep, opioid prevention, bullying, and traffic safety.
- Rural child poverty: MCHB is working on a new White House initiative to reduce child poverty in rural communities. Federal partners include HHS and the Departments of Commerce, Education, Labor, and Agriculture. MCHB is working with the American Academy of Pediatrics (AAP) to implement a two-generation bundle of services in a COIIN of 10 rural communities.
- Funding: The president's 2016 budget request proposed level funding for MCHB at $1.25 billion, including $637 million for the block grant. The Senate proposed a $500 million increase for the block grant, while reducing the budget for Special Projects of Regional and National Significance (SPRANS) by $25 million. SPRANS funding supports the COIIN, the maternal health initiative, the 100,000 Kids campaign, the rural child poverty initiative, and many other projects. The House proposed to increase the block grant by $100 million, while eliminating the Agency for Healthcare Research and Quality (AHRQ) and Title X family planning and reducing funds for many other HHS programs.

COMMITTEE QUESTIONS AND DISCUSSION

- Ms. Johnson noted that she conducted an analysis of infant mortality in rural America when Healthy Start was first proposed. She suggested that MCHB could update the data from that study to support the White House rural child poverty initiative.
- Raymond L. Cox, Jr., M.D., M.B.A., cited an article in the *New York Times* on intergenerational income elasticity, which reported that people in the bottom quintile have a lower chance of moving to the top quintile than if they lived in Canada or the United Kingdom. He expressed support for the interagency approach to address child poverty and asked how HRSA could strengthen its relationships with other federal agencies that address underlying issues that impact infant mortality.
- Dr. Lu urged the committee to continue its focus on the SDOH and its support for place-based initiatives that encourage communities to work across multiple sectors.

- Ms. Johnson suggested that the committee could reference the rural child policy initiative in its letter to the Secretary about health equity.
- Wanda Barfield, M.D., M.P.H, F.A.A.P., asked what HRSA would be doing to address neonatal abstinence syndrome.
    - Dr. Lu replied that MCHB began to work with ASTHO in 2013 to develop strategies for states to address this issue. CDC developed predictive models that identified 200 communities at highest risk for opioid use, clustering around the Appalachian states. The growing public health problem of opioid use will require efforts across multiple agencies.
    - Dr. Barfield agreed that there were opportunities to work together on prescription drug abuse and overdose and other areas. The issues Dr. Lu identified, including the risk of HIV infection, are very important.
- Arthur R. James, M.D., FACOG, asked how MCHB proposed to decrease generational poverty in rural communities and whether a template had been designed.
    - Dr. Lu said a template had not been designed yet. In 2014, MCHB launched a word gap initiative to address disparities in children's vocabularies. The rural child poverty initiative is developing a two-generation bundle that provides all of the services that are needed for children to thrive by age five. Many sectors are involved to address social determinants at the individual, interpersonal, and community level. The initiative will also look at policy levers to break the cycle of intergenerational poverty.
- Ms. Johnson stated that the loss of funding for SPRANS would have a significant impact. She asked Dr. Lu to provide an overview of how those funds are used.
    - Dr. Lu cited numerous examples of how MCHB has invested SPRANS funds to drive improvements and emerging issues in maternal and child health.
    - Milton Kotelchuck, Ph.D., M.P.H., noted that most of MCHB's budget goes directly to states. SPRANS is the Bureau's only flexible money, and loss of that funding would be a significant blow to the MCH community.

OVERVIEW OF SACIM WORK RELATED TO THE PREEMIE ACT
Kay Johnson, M.Ed., M.P.H., Chairperson, SACIM
Cynthia Pellegrini, Senior Vice President of Public Policy and Government Affairs, March of Dimes

Ms. Johnson noted that the PREEMIE Reauthorization Act authorized the continuation of the SACIM and outlined its role and duties. The legislation requires SACIM to provide advice and recommendations to the Secretary of HHS regarding:

- Programs that are directed at reducing infant mortality and improving the health status of pregnant women and infants
- Strategies to coordinate the various programs and activities with state, local, and private programs and efforts that address factors that affect infant mortality.
- Implementation of the Healthy Start program
- Strategies to reduce preterm birth rates through research, programs, and education.

The reauthorization also included assignments for the CDC and HRSA. The assignments for HRSA related to 1) telemedicine and high-risk pregnancies and 2) public and health care provider education. Those assignments should be included in the SACIM's plan.

The PREEMIE Act directs the SACIM to produce a plan for conducting and supporting research, education, and programs on preterm birth. The plan should: a) examine research and educational activities that receive federal funding in order to provide informed recommendations to reduce preterm birth and address racial and ethnic disparities in preterm birth rates; b) identify research gaps and opportunities to implement evidence-based strategies to reduce preterm birth rates among HHS programs and activities regarding preterm birth, including opportunities to minimize duplication; and c) reflect input from a broad range of scientists, patients, and advocacy groups, as appropriate. Ms. Johnson noted that the third aspect would require attention.

The SACIM intends to develop the plan in partnership with federal agencies and other partners. The process will include the following steps:

- Review recommendations from the Surgeon General's Conference on Preterm Birth (2008), the Institute of Medicine (IOM) 2006 report on preterm birth, and the professional literature
- Request input from federal agencies
- Request input from private organizations and individuals
- Prepare and submit a report to the Secretary.

Ms. Johnson asked MCHB to distribute the executive summary of the Surgeon General's conference and the IOM report to SACIM members.

Federal liaisons for the SACIM include numerous agencies within HHS as well as the Department of Agriculture, the Department of Education, the Department of Housing and Urban Development (HUD), and the Department of Labor.

In preparation for this meeting, the SACIM asked the liaison agencies to prepare a brief written narrative addressing the following questions:

- What are the primary activities that your agency or unit has undertaken related to preterm birth prevention? (Include activities currently underway or completed within the past three years.)
- What additional activities or projects are planned for the coming year? Are these activities part of formal plans or budgets?
- What are the major gaps your agency/unit has identified related to preterm birth prevention? Describe approaches that the federal government, particularly your agency/unit, could use to fill these gaps.

The SACIM needs to determine the best way to obtain private sector input. Efforts to date include a request to the March of Dimes, which provided written input, and a request for comments from ASTHO and the Association of Maternal & Child Health Programs (AMCHP). The March of Dimes response was circulated to committee members. AMCHP was unable to attend this meeting, but ASTHO was represented on the agenda.

The SACIM needs to determine how to obtain input from professional organizations and from consumers and families and their advocates.

The SACIM's plan will include elements from each of the six strategic directions.

Ms. Pellegrini stated that the legislation passed quickly, with strong bi-partisan support. There was a strong sense that the Congressional offices involved wanted a road map to advance the cause, with an emphasis on evidence-based strategies to focus and drive the federal effort.

Congress expects a plan that provides concrete, measurable steps to reduce the preterm birth rate. The requirement to address racial and ethnic disparities presents a powerful opportunity for the SACIM to identify gaps and state how they should be addressed.

The March of Dimes recommends that the plan address seven key priority areas:

- Elevate preterm birth as a national priority
- Increase research into preterm birth
- Improve data collection, analysis, and dissemination
- Work to eliminate social inequities
- Improve access to quality health care
- Train health professionals
- Increase public education about preterm birth.

Ms. Pellegrini stated that the March of Dimes would use the plan to:

- Focus efforts and energies
- Drive appropriations (i.e., increasing accounts and fending off cuts)
- Impel administration agencies going forward
- Provide material for state advocacy
- Galvanize other stakeholders into action
- Shape the next reauthorization.

COMMITTEE QUESTIONS AND DISCUSSION

- Dr. Cox suggested that the March of Dimes 2010 TIOP III report could inform the committee's plan. The committee's policy work should provide incentives for people at the local level to implement and spread best practices.
- Dr. Cox emphasized the need for a way to analyze existing data and disseminate the information in a way that people can use it.
    - Ms. Pellegrini stated that the March of Dimes was approached by groups that want access to data at the Census tract level. It would be helpful to have recommendations in that area.
    - Dr. Cox agreed that granularity is extremely important. For example, Hilton Head, South Carolina is considered to be rich and healthy, but block-level data show pockets with high levels of substance abuse and uninsurance.
- Dr. Barfield asked what the March of Dimes was doing to address early preterm birth.
    - Ms. Pellegrini replied that early preterm birth was an intractable problem, with rates that have not changed in 20-25 years. She hoped that March of Dimes

prematurity research centers would be able to identify risk factors and causal factors to understand what is happening.

- Dr. Kotelchuck noted that Ms. Pellegrini did not address secondary prevention of infant mortality, such as treatment to improve the health of preterm babies.
    - Ms. Pellegrini stated that a large percentage of women do not receive interventions that are known to be effective for secondary prevention. Recommendations regarding how to use federal policies to promote those interventions would be a major asset.

SPECIAL FEDERAL PRESENTATIONS: WHAT ARE THE PRIMARY FEDERAL ACTIVITIES RELATED TO PREVENTING PRETERM BIRTH?

Health Resources and Services Administration

Hani Atrash, M.D., M.P.H., Director, Division of Healthy Start and Perinatal Services, MCHB, HRSA
Sue Lin, M.S., Director of Quality Division, Office of Quality Improvement, Bureau of Primary Health Care, HRSA

Dr. Atrash outlined MCHB's approaches to improving pregnancy outcomes, as follows:

- Title V MCH Services Block Grant: Transformed to reduce burden, maintain flexibility, improve accountability, and document impact.
    - Performance measure domains: women's/maternal health, perinatal/infant health, child health, adolescent health, children with special health needs, and cross-cutting or life course.
    - Performance measures related to prematurity: Well-woman visit, low-risk cesarean delivery, adolescent well visit, and smoking during pregnancy. Outcome measures include first trimester prenatal care entry, severe maternal morbidity, infant outcomes, early elective deliveries (EED), and infant mortality.
- Women's Preventive Services Guidelines: Well-woman visits; screening for gestational diabetes; human papillomavirus testing; counseling for sexually transmitted infections; counseling and screening for human immune-deficiency virus; contraceptive methods and counseling; breastfeeding support, supplies, and counseling; and screening and counseling for interpersonal and domestic violence
- National Maternal Health Initiative (MHI): Goals are to improve women's health across the life course and improve the quality and safety of care. Priority areas are surveillance and research, state and community public health systems, quality and safety of clinical care, public awareness, and women's health.
- Alliance for Innovation on Maternal Health (AIM): A national partnership funded by MCHB to promote implementation of evidence-based maternal safety bundles to ensure consistent maternity care. Safety bundles address obstetrical hemorrhage; severe hypertension/ preeclampsia; prevention of venous thromboembolism; support for intended vaginal birth; reduction of peripartum racial disparities; and standards of care for the interconception/postpartum visit.
- Infant Mortality COIIN: Public-private partnership in 58 states and jurisdictions to reduce infant mortality and improve birth outcomes. Structured into six strategy teams: Safe Sleep; Smoking Cessation; Social Determinants; Preconception/Interconception Care; Prevention of Preterm and Early-Term Births; and Perinatal Regionalization.

- National Healthy Start Program: Redesigned in 2014 to reflect best practices and SACIM recommendations. The revised program has five strategic priorities: improve women's health; promote quality services; strengthen family resilience; achieve collective impact; and increase accountability. Healthy Start serves 100 communities in 37 states and the District of Columbia.
- MIECHV: Provides evidence-based home visiting services to pregnant women and families of young children, with a focus on those in highest need Eight of the 17 evidence-based models address pregnant women. In 2014, 27 percent of enrolled households included pregnant teenagers.

Ms. Lin provided an overview of the Bureau of Primary Health Care (BPHC), as follows:

- BPHC has slightly more than 1,200 health center grantees that operate approximately 9,000 service delivery sites. In 2013, health centers served 21.7 million patients; one-quarter of those patients lived in poverty, and one-sixth were uninsured.
- BPHC's key strategies are to: increase access to primary health care services for underserved populations; modernize the primary health care safety net infrastructure and delivery system; improve health outcomes for patients; and promote a performance-driven, innovative organization culture.
- Health centers consistently exceed the Healthy People 2020 (HP 2020) goal for low birthweight, but early entry into prenatal care remains below the goal of 77.9 percent. BPHC will provide technical assistance (TA) to help health centers meet that measure.
- The health center program exceeded the HP 2020 goals for tobacco use screening and tobacco cessation counseling in 2013. Nearly all health center patients were screened for tobacco use, and nearly two-thirds received tobacco cessation counseling.
- Health center data for 2014 from the Uniform Data System (UDS) are available at http://bphc.hrsa.gov/uds/datacenter.aspx. However, such data do not provide much detail regarding maternal and infant health services.

Medicaid

Lekisha Daniel-Robinson, M.S.P.H., Coordinator of the Maternal and Infant Health Initiative, Center for Medicaid, CHIP, and Survey & Certification, Centers for Medicare and Medicaid Services (CMS)

Ms. Daniel-Robinson highlighted key CMS activities related to prevention of preterm birth:

- Strong Start for Mothers and Newborns Initiative
    - Launched in 2012, with two areas of focus: 1) a public-private partnership and awareness campaign to reduce the rate of EED, and 2) a funding opportunity to test the effectiveness of specific enhanced prenatal care approaches to reduce the frequency of premature births.
    - Preliminary data show lower rates of preterm birth and low birthweight, lower rates of cesarean section, and higher rates of breastfeeding among participants. They also show greater psychosocial needs than anticipated (e.g., depression, domestic violence, food insecurity, unstable housing, and transportation needs).
    - CMS will look at ways to reach targeted enrollment and will incorporate patient satisfaction feedback into service delivery. They will also explore ways to work more closely with managed care organizations for the next phase of Strong Start.

- Quality measurement efforts and data capacity building
    - CMS is training six new states, plus an initial cohort of 12 states, to increase capacity to link vital records with Medicaid and other data and improve state monitoring and reporting on specific measures in Medicaid core sets.
    - Adult Quality Measure grants were awarded to 25 states in 2012 to improve data capacity and reporting on the core sets and to link core set measures to quality improvement (QI) measures, such as early elective delivery and postpartum care.
    - Children's Health Insurance Program Reauthorization Act (CHIPRA) Quality Grants: Florida and Illinois have focused on creation of a perinatal-prenatal risk assessment tool, maternity care, coordination guidelines for transitions, and other primary activities.
    - CMS used the adult and child core measures to create a maternity core set that includes postpartum care, antenatal steroids, cesarean delivery rates, low birth weight, frequency of ongoing prenatal care, behavioral risk assessment, and well-child visits. CMS has reported data on the child core measures for the past several years and hopes to have data from enough dates to report on the low birthweight measure by September 30.
- Maternal and Infant Health Initiative
    - Launched in July 2014 to improve postpartum care and increase effective contraception use among women in Medicaid and CHIP.
    - Eleven states participated in a rapid cycle QI project for postpartum care.
    - CMS plans to award a grant to support states in collecting and reporting data on contraceptive utilization for birth spacing and planning.
- Smoking cessation
    - CMS is collaborating with CDC and other HHS offices on a program to reduce smoking during pregnancy and increase utilization of existing resources.

Ms. Daniel-Robinson identified the following gaps:

- Data infrastructure to improve collection of information on gestational age, preterm birth, and registry-level data
- Direct funding to support state-level collaboratives or other QI activities directly targeted to birth outcomes.

National Institute of Child Health and Human Development

Catherine Y. Spong, M.D., Deputy Director, Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD), National Institutes of Health (NIH)

Dr. Spong described NICHD's research and outreach related to infant mortality in preterm birth and low birthweight babies.

NICHD funds researcher-initiated studies related to infant mortality in preterm birth and low birthweight babies as well as targeted clinical studies conducted by interdisciplinary networks:

- Maternal-Fetal Medicine Units (MFMU) Network: Established in 1985 to perform clinical trials to improve pregnancy outcomes, with a focus on decreasing preterm birth.

- Neonatal Research Network (NRN): Established in 1985 to conduct observational and interventional studies to improve neonatal health outcomes.
- Nulliparous Pregnancy Outcomes Study-Monitoring Mothers-to-be (NuMOM2b): Aims to identify mechanisms and early predictors of adverse pregnancy outcomes. The study pool includes 10,000 racially, ethnically, and geographically diverse women in their first pregnancy.
- Intramural Perinatology Research Branch: Conducts laboratory and clinical research on maternal and fetal diseases that are responsible for infant mortality, focusing on mechanisms of preterm labor and delivery, with an emphasis on inflammation and infection.
- Genomics and Proteomics Network for Preterm Birth Research (GPN): Created to use genomic and proteomic strategies to uncover mechanisms of spontaneous preterm birth.

NICHD aims to build an evidence base that can be translated into practice guidelines to improve patient outcomes.

NICHD health education and outreach efforts related to infant mortality include:

- Safe to Sleep® Campaign: The rate of back sleeping has increased by 200 percent and the rate of sudden infant death syndrome (SIDS) has declined by 50 percent since the campaign was introduced in 1994. The focus has expanded beyond back sleeping to promote a safe sleep environment. Outreach includes a video for grandparents, improved promotion of breastfeeding with safe sleep messaging, and fatherhood outreach training.
- National Child and Maternal Health Education Program (NCMHEP): Uses a coalition of healthcare provider organizations, federal agencies, non-profits, and other partners to review, translate, and disseminate new research in MCH.
- *Is it Worth It?* Initiative: Created educational videos for pregnant women and their families to reduce elective deliveries before 39 weeks and a Medscape continuing education program for clinicians.
- *Know Your Terms* Initiative: Explains the new term pregnancy definitions and describes the risks at each gestational age between 37 and 42 weeks. Materials are available in Spanish and English.

Future NICHC projects include:

- Human Placenta Project (HPP): Launched in 2014, the overarching goal is to understand human placental development and function in real time. Most prior research focused on the placenta after the baby develops. Three Requests for Application (RFAs) should be awarded by the end of the current fiscal year. SACIM members are encouraged to attend a free workshop in April 2016.
- PregSource-Crowdsourcing to Understand Pregnancy: The project will use an interactive mobile app to detail the natural history and variations of human pregnancy, provide accurate information, and let pregnant women know about opportunities to participate in research. NICHD hopes to launch a beta test in fall 2015.

Administration for Children and Families (ACF)

Moushumi Beltangady, M.S.S.A., M.P.P., Senior Policy Analyst, Office of Early Childhood Development

Wendy DeCourcey, Ph.D., Social Science Research Analyst, Office of Planning, Research, and Evaluation (OPRE)

The speakers provided an overview of ACF programs and evaluations related to preterm birth and infant mortality.

Early Head Start (EHS)

- EHS grantees nationwide provide early care and education to infants and toddlers, from birth to age three as well as pregnant women. Approximately 150,000 children and 15,457 pregnant women were enrolled in the 2012-2013 program year.
- EHS grants assist women to access comprehensive prenatal and postpartum care. Grantees must provide pregnant women and family members with prenatal education, including fetal development and risks from smoking, labor and delivery, and postpartum recovery, including maternal depression.
- A national descriptive study (BABY FACES, 2009) found that most families who enrolled in EHS during pregnancy did so during their second trimester.
- The Office of Head Start provides TA and support for EHS grantees that serve pregnant women, including a national resource center that can be accessed online.
- A research brief, "Women and Families Enrolled in Early Head Start during Pregnancy," will be released in fall 2015 (http://www.acf.hhs.gov/programs/opre).

Mother and Infant Home Visiting Program Evaluation (MIHOPE)

- National evaluation of the MIECHV program, mandated by legislation. Components include a state needs assessments analysis, a random assignment impact study, a multi-level implementation study, and a cost effectiveness study.
- The study will measure the effects of four evidence-based models funded by MIECHV: EHS home visiting, Parents as Teachers, Nurse-Family Partnerships, and Healthy Families America.
- Collection of baseline family data began in 2012 and will continue through 2015; follow-up data will be collected from 2014 to 2017. Implementation data will be collected from 2012-2017. A report with baseline data and information on the programs and types of families involved in the study was submitted to Congress in February 2015. Final reports on the implementation and impact of MIECHV will be submitted in 2018.

MIHOPE-Strong Start (MIHOPE-SS)

- Looks at the impact of Strong Start nonmedical prenatal interventions on health outcomes, healthcare use, and healthcare costs.
- Testing four interventions: centering/group visits, birth centers, maternity care homes, and home visiting.
- Underway since 2012, with several reports submitted to date.

MIECHV Tribal Home Visiting Program

- A set-aside program for Indian tribes, consortia of tribes, tribal organizations, and urban Indian organizations.

Focus on implementing high-quality, culturally relevant, evidence-based home visiting programs in American Indian and Alaska Native (AI/AN) communitiesAdolescent Pregnancy Prevention (APP)

- Personal Responsibility Education Program Innovative Strategies (PREIS)
  - Focus on new and promising approaches to prevent pregnancy.
  - Targets youth ages 10-19 who are homeless, in foster care, live in rural areas or geographic areas with high teen birth rates, or come from racial or ethnic minority groups, and pregnant and parenting youth under age 21.
- Competitive Personal Responsibility Education Programs (CPRES)
  - Discretionary projects implemented by community-based organizations in 10 jurisdictions.

ACF programs targeting fathers

- Responsible Fatherhood and Pregnancy Demonstration Grant program
- Home visiting Approaches to Father Engagement and Fathers' Experiences: a qualitative study that will include pregnancy outcomes.

COMMITTEE QUESTIONS AND DISCUSSION

- Dr. James noted that most Healthy Start sites are also in communities that have community health centers (CHCs). Health centers that do not provide prenatal care do provide preconception and interconception care. There is an opportunity for different federal programs to demonstrate synergy and work together to enhance and improve outcomes for women from under resourced neighborhoods.
  - Dr. Atrash replied that MCHB places a major emphasis on collective impact. They expect grantees to coordinate efforts and collaborate with other providers to ensure alignment, avoid duplication, and ensure good preventative care. MCHB encouraged CHCs to apply for the most recent round of Healthy Start grants.
- Arden S.Handler, Dr. P.H., M.P.H. asked if Ms. Lin could provide data on rates of low birthweight by race and ethnicity and factors that might be responsible for a decline in those rates, if any. She also asked what BPHC was doing to increase early entry into prenatal care.
  - Ms. Lin stated that the BPHC Uniform Data System (UDS) is a grants reporting system, with limited capability to disaggregate data by race and ethnicity. BPHC has asked the national and state-level organizations with which it has cooperative agreements to identify TA strategies to address low birthweight and encourages grantees to create synergy among programs. BPHC conducted a cross-walk to help health center grantees and Healthy Start grantees determine how they could work together to impact the community at large.
- Dr. Cox stated that access to granular data was essential in order to identify the needs of sub-populations. He noted that the programs described by Ms. Lin and Dr. Spong made effective use of social marketing tools that helped to reduce elective early term delivery. He asked how those efforts could be revised to reach critical populations that might not be aware of those tools.
  - Dr. Spong acknowledged that communications strategies do not always reach the groups that are most important. The Safe to Sleep Initiative targeted some

states, such as Alabama, for outreach to sororities, local organizations, and local churches. There is always room for improvement.
    - Ms. Lin stated that HRSA was working with health centers to develop a mechanism to fully receive data from electronic health records and hoped to be able to provide more granular data in the future. She noted that HRSA invested in applied research networks that would allow health centers to harmonize their data. A recently issued expanded services funding announcement allocates 20 percent of the budget to enabling services, such as outreach to additional populations.
- Diane Ashton, M.D., M.P.H., asked if the random assignment impact study of the MIHOPE evaluation was looking at birth outcomes and if there was any overlap between the populations for the MIHOPE and the MIHOPE-SS studies.
    - Dr. DeCourcey replied that both evaluations include randomized controlled trials and both contain measures on pregnancy. MIHOPE-SS is designed to examine pregnancy outcomes in particular and can pick up perinatal impacts that MIHOPE cannot identify. The MIHOPE-SS sample only includes participants who enrolled at 32 weeks of pregnancy (to allow time for the influence of home visiting before birth). It examines two home visiting models that previously demonstrated impacts on pregnancy outcomes.
- Dr. Cox asked Dr. Spong about the impact of cortisol on placental clock and expressed a hope that future studies would include transgenerational research that might help to clarify the epigenetic focus of preterm delivery.
    - Dr. Spong replied that NICHD would support a transgenerational if one was proposed. The HPP is focused on the placenta in real time, during that pregnancy. One initiative that will be funded this fiscal year will look at environmental impacts, and factors such as stress or cortisol could be incorporated into that study.
- Dr. Kotelchuck asked if the goal of the 100,000 Mothers Campaign was realistic.
    - Dr. Atrash clarified that the goal was to prevent 100,000 maternal morbidities and 1,000 maternal deaths over three years, representing a reduction of 20 to 30 percent. The goal should be achievable if other states could replicate what California has done.
- Ms. Johnson noted that the SACIM's letter about social determinants discussed the role of Temporary Assistance to Needy Families (TANF) in pregnancy, and she hoped it would also be included in the PREEMIE Act plan. She asked the ACF representatives to provide information on that issue in the future.
- Dr. James observed that Ms. Pellegrini highlighted the need to develop action steps to eliminate social inequities. He asked if the letter to the Secretary would be sufficient, or if the committee should develop a full report on equity.
    - Ms. Johnson stated that the letter would identify the need for specific strategies and was the most feasible option at this point. A full report would require significant time and energy, and it would only be delivered to the Secretary. It is important to determine the right audience for that message.
- Sam B. Cooper III, L.M.S.W., asked where the committee could obtain more information about the preliminary results of the Strong Start initiatives. He also asked

if CMS could provide information on the states that were involved in the first and second cohorts of the data linkage initiative.
    - Ms. Daniel-Robinson provided a link to the evaluation report for the committee's use. The draft report on the data linkage initiative was not publically disseminated, but she offered to provide information on the cohorts. She noted that CMS was trying to leverage the data linkage activity and the contraceptive utilization measure with the COIIN.
- Dr. Handler asked if there was any research on the infectious process in preterm delivery. She also commented that the SACIM should be mindful of the challenges facing many state Title V directors when it develops its plan.
    - Dr. Spong replied that the microenvironment of the placenta and the vaginal floor was an important area for research.
- Dr. Ashton asked Ms. Daniel-Robinson to expand on her comments regarding the gap in the data infrastructure and the need for more information on preterm birth.
    - Ms. Daniel-Robinson replied that one gap was the lack of information on prior preterm births in registry data. Another gap was the lack of linked data for some states. A continuous linkage is important for monitoring and QI.
    - Ms. Johnson emphasized that more than half of the births in the United States are covered by Medicaid, and data regarding the outcomes of those births should be a priority. She noted that the committee's recommendations report identified additional areas of research into key facets of infant mortality prevention for subsequent phases of Strong Start.

SPECIAL FEDERAL PRESENTATIONS: WHAT ARE THE PRIMARY FEDERAL ACTIVITIES RELATED TO PREVENTING PRETERM BIRTH? (CONTINUED)

Centers for Disease Control and Prevention (CDC)

Wanda Barfield, M.D., M.P.H, F.A.A.P., Director, Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP)
Cynthia Moore, M.D., Ph.D., Director, Division of Birth Defects and Developmental Disabilities, National Center for Birth Defects and Developmental Disabilities

Dr. Barfield noted that the Division of Reproductive Health has three priority areas: women's health, pregnancy health, and infant health. The Division administers the Safe Motherhood Program, through which CDC works with states and other governmental and nongovernmental partners to promote safe motherhood before, during, and after pregnancy. More information is at http://www.cdc.gov/reproductivehealth/.

CDC activities addressing the PREEMIE Act include:

- National Vital Statistics Surveillance (NVSS) system
- Investigating social, biological, environmental, and clinical factors that put women at risk for preterm birth and racial disparities
- Improving national data to better define and track preterm birth
- Improving understanding of indications for late preterm birth and early term birth and translate findings into public health action.

Preventing preterm birth requires a comprehensive research initiative. CDC's work is focused in four areas: 1) strengthening the national data system to track the burden of preterm birth; 2) advancing prevention of late preterm birth; 3) uncovering the causes of early preterm birth; and 4) moving science to practice.

Dr. Moore noted that preterm birth and birth defects have overlapping outcomes and shared risk factors. She presented an overview of the National Birth Defects Preventions Study NBDPS research on preterm births and infant mortality among infants with and without birth defects:

- National Birth Defects Preventions Study (NBDPS)
    - Multi-state, population-based, case-control study of preterm birth and small-for-gestational age among infants with and without birth defects
    - Includes research on preterm birth among controls (infants without birth defects).
- Opportunities for reducing infant mortality due to birth defects
    - Appropriate and timely treatment addressing disparities in care and survival
    - Prevention through preconception health.
- Inclusion of birth defects in plans to reduce infant mortality.

COMMITTEE QUESTIONS AND DISCUSSION

- Dr. Cox asked whether the investments to improve information technology (IT) systems would make it possible to get more real-time NVSS data. He emphasized the need to find ways to correlate demographic data and clinical co-morbidities in subpopulations, both of which are available in the administrative data set.
    - Dr. Barfield stated that it was important to encourage local analysis of data to increase granularity and identify details that are lost in national datasets. The state-based perinatal quality collaborative has emphasized the importance of timely and relevant data. CDC is helping states increase data reporting, because the NVSS is only as fast as the slowest state.
- Dr. James asked if the data showed any association with earlier findings regarding early pregnancy losses prior to viability and whether it was possible to discern any factors that might contribute to differences in infant mortality and preterm birth rates across states.
    - Dr. Barfield noted that the issues of viability and stillbirth overlap. Stillbirth is an important issue to address, because rates have not changed substantially in recent years. NICHD has done a great deal of work on viability, and the Stillbirth Collaborative is helping to gain a better understanding of early pregnancy losses. CDC would like to conduct a pilot project under PRAMS to address that issue, but the first priority is to get PRAMS in all states. Factors that impact differences in preterm birth rates across states include variations in demographics, and hence risk, and variations in practice. Clinical decision making about delivery and continuity of care could also be factors. The early work of the COIINs about drivers of infant mortality has helped states improve their rates.
- Merry K. Moos, RN, FNP, MPH asked if CDC was directing any research at the issue of interpregnancy intervals (IPI).
    - Dr. Barfield stated that several studies have shown a correlation between IPI and disparities in preterm birth. Several HHS agencies are looking at improving birth spacing for the populations they support.

Indian Health Service (IHS)

Carolyn Aoyama, C.N.M., M.P.H., Senior Consultant for Women's Health

Ms. Aoyama provided an overview of Indian health care systems and noted that tribes are beginning to take control of their own health care, including hospitals and health centers. Nearly half of the 29 hospitals operated by IHS provide maternity services, and many of those are critical care hospitals.

Background and context:

- AI/AN are the most impoverished minority group in the U.S.
- Historical trauma and intergenerational trauma are major SDOH.
- Risk factors for poor pregnancy outcomes include high rates of smoking, alcohol consumption, substance abuse, domestic violence, teen pregnancy, obesity, poverty, and under-employment; low rates of education; and late entry into prenatal care.
- AI/AN have the second highest rates of infant mortality, post-neonatal mortality, and preterm birth of all racial and ethnic groups in the U.S., and the pre-term related mortality rate and neonatal mortality rate are rising.

Key initiatives:

- IHS Baby Friendly Hospital Initiative (BFHI): Brings together federal agencies, communities, and tribes to increase breastfeeding among AI/AN mothers and end the epidemic of childhood obesity in Indian Country within one generation. All 13 IHS maternity hospitals are designated Baby Friendly.
- Centering Pregnancy: Evidence-based approach to reduce preterm birth and enhance birth weights at all gestational ages. One IHS hospital has been approved as a site, one will be trained in 2016, and four hospitals have been funded to begin planning.
- Family Spirit Program: Home visiting intervention delivered by tribal community health workers to support AI/A parents from pregnancy to three years post-partum.
- CHOICES Program: Brief motivational intervention to assess alcohol use and contraceptive use; provide counseling on the consequences of alcohol use in pregnancy; and provide reproductive health education and contraceptive services, focusing on long-acting reversible contraceptives (LARC). Bifurcated funding is a challenge, because tribes have substance abuse funds, and IHS has funds for medical services.
- Domestic Violence Prevention Initiative: Promotes the development of culturally appropriate evidence- and practice-based prevention and treatment approaches to domestic and sexual violence.
- Methamphetamine and Suicide Prevention Initiative: Promotes the development of culturally appropriate, community-driven, evidence- and practice-based prevention and treatment approaches.
- Integrating Behavioral Health and Primary Care: Three IHS clinics are incorporating behavioral health and substance abuse specialists into their primary care teams.

Agency for HealthCare Research and Quality
David Meyers, M.D., Chief Medical Officer

Dr. Meyers stated that AHRQ's efforts to address preterm birth prevention focus on data, quality, evidence, and implementation.

Data on preterm birth:
- *National Quality and Disparities Report*
- *AHRQ Statistical brief* using Healthcare Cost and Utilization Project (HCUP) data www.hcup-us.ahrq.gov/reports/statbriefs/sb163.pdf.

Quality measures:
- AHRQ is developing a comprehensive set of quality measures for health care for children
- First measure set pertaining to services aimed at healthy birth and preventing premature birth is focused on receipt of behavioral risk assessment for pregnant women.

Evidence:
- Systematic evidence reviews
- Support for the independent U.S. Preventive Services Task Force

Implementation:
- AHRQ *Safety Program for Perinatal Care* (currently being tested)
- AHRQ Innovations Exchange (https://innovations.ahrq.gov/).

COMMITTEE QUESTIONS AND DISCUSSION
- Dr. Barfield asked if HIS was addressing access to care in remote locations where births occur.
    - Ms. Aoyama said the most important variable in access to care was having a healthcare provider. Recruitment, retention, and staff shortages are constant challenges for HIS, especially for midwives and obstetrical nurses.
- Dr. Cox noted that AHRQ provides excellent data, but many audiences are frustrated because they need tools to address disparities.
    - Dr. Meyers replied that AHRQ tools focus on what healthcare systems can do. Clear answers are beginning to emerge, such as the importance of screening for alcohol, smoking, and intimate partner violence as part of the first prenatal visit and programs to increase early entry to prenatal care.
    - Ms. Aoyama stated that IHS engaged in broad-based stakeholder partnerships with tribes to address sexual assault and domestic violence, because tribal communities have their own behavioral health and justice systems. The program requires constant training of providers.
- Dr. Atrash asked if any tribal communities were involved in COIIN activities.
    - Ms. Aoyama replied that she received an invitation to participate in a COIIN. She forwarded it to IHS headquarters and recommended participation. To her knowledge, IHS was not involved at this time. She could not speak for the tribes.
    - Dr. Barfield stated that the CDC's assignee in Wyoming involves tribes in some COIIN activities. She did not know the extent of those activities.

- Dr. James expressed concern about possible suppression of data that might document the adverse influence of budget cuts to safety-net programs. He asked how the SACIM could help states address that issue.
- Dr. Handler asked how the programs described by the speakers are coordinated across agencies and whether the SACIM should advocate for links if they do not exist.
    - Dr. Meyers stated that AHRQ makes every effort to coordinate and align activities, avoid duplication, and accelerate implementation. For example, the perinatal safety program includes advisors from HRSA and CDC. He encouraged the SACIM to focus on identifying the most important priorities; the Secretary would determine which agencies have the right expertise to address them.
- Ms. Johnson noted that nearly all of the liaison agencies have public education campaigns. She asked what factors were involved in determining which agency is responsible for public education regarding a particular issue.
    - Chazeman Jackson, Ph.D., stated that the national awareness campaign launched by the Office of Minority Health (OMH) was focused on racial and ethnic disparities in infant mortality, because that target was correlated with the OMH mission.
    - Dr. Spong stated that key factors are an agency's area of interest and the availability of staff to take on a campaign. NICHD had a long-standing interest in SIDS and had significant evidence to support the Safe Sleep campaign.
    - Ms. Aoyama stated that IHS does not generally conduct large public education campaigns. She noted that many messages are not tailored to native audiences. IHS would like to partner with agencies to target their messages for Indian people.
    - Dr. Meyers noted that AHRQ's education efforts are targeted at hospitals and primary care providers. It is important to include the full range of expertise across HHS, along with their networks and the communities they reach.
- Dr. James noted that none of the speakers had mentioned the Preterm Labor Assessment Toolkit (PLAT) developed by the California March of Dimes. He asked if it was making a difference in the preterm birth rate and whether the SACIM should advocate for more wide-spread adoption of its use.
    - Dr. Meyers asked whether the PLAT had been evaluated and noted that an AHRQ evidence grant could be used for that purpose.
    - Ms. Aoyama replied that she had advocated for use of the PLAT, and some IHS sites were using it.
- Mr. Cooper asked if the Secretary determines how to coordinate or balance public education activities across HHS.
    - Dr. Meyers replied that all public education campaigns must be submitted to and approved by the Secretary's office, which is responsible for coordinating and aligning those efforts.
- Dr. Handler noted that she could not find data on prenatal care in the *2014 National Quality and Disparity Report* asked what data AHRQ used to track that measure.
    - Dr. Meyers replied that access and use of early prenatal care is a standard measure, using data from CDC. It is reported at the national level, in the state snapshots, and in the discussion of disparities.

OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH

Office of Minority Health
Chazeman Jackson, Ph.D., M.A., Health Science Advisor

Dr. Jackson stated that OMH has two strategies for preterm birth prevention:

- Promote preconception health as a key intervention to improve birth outcomes
- Partner strategically with community, health, and healthcare organizations to eliminate the disproportionate burden of infant mortality among racial and ethnic minority groups.

Key activities include:

- A Healthy Baby Begins with You: National campaign to raise awareness about infant mortality, with an emphasis on the African American community.
- Pre-conception Peer Educators (PPE) Program
    - PPE training and certification of on college campuses
    - Three site models (state, campus, community-based organization).
- Baby Buggy Walk in the Park: OMH Resource Center collaborates with the National Healthy Start Association to raise awareness of infant mortality among low-income women of color and their families.

Office of Adolescent Health (OAH)
Evelyn M. Kappeler, Director

Ms. Kappeler provided an overview of OAH programs and activities to prevent preterm birth.

Teen Pregnancy Prevention Program (TPP)

- Supports a range of programs across the country.
    - Tier 1: Replication of program models that have been proven effective through rigorous evaluation.
    - Tier 2: Demonstration programs to develop and test additional models and innovative strategies.
- AOH announced 81 new grantees in July 2015 that will serve close to 300,000 youth each year and 1.2 million youth over five years.

Pregnancy Assistance Fund (PAF)

- Established by the Affordable Care Act as a competitive grant program for states and tribes, with funding authorized at $25 million per fiscal year from 2010 through 2019.
- Provides a comprehensive network of evidence-based, culturally and linguistically appropriate services for expectant and parenting teens, women, fathers, and their families and increases public awareness about those services.
- Improves services for pregnant women who are victims of domestic violence, sexual violence, sexual assault, and stalking.
- Currently funds 17 grantees (14 state agencies and three tribal agencies). Grants for three new projects were awarded this year, and a third cohort will be funded in 2017.
- Program activities emphasize health, education, and social services. All services are evidence-based or evidence-informed and culturally and linguistically appropriate.

- Grantees disseminate information about the availability of and eligibility for health coverage under federal and state programs and to assist participants with application and enrollment.
- Grantees are expected to demonstrate collaboration among relevant state agencies and leverage existing resources and services.

OAH is collecting a common set of performance measures, conducting grantee-level evaluation, and planning a federal evaluation for the TPP and is developing a sustainability plan for PAF grantees.

Additional information is available at www.hhs.gov/ash/oah.

Office of Population Affairs (OPA)
Susan B. Moskosky, M.S., W.H.N.P.-BC, Acting Director

Ms. Moskosky noted that family planning can prevent preterm births by preventing unintended pregnancies, spacing births, and improving preconception health. She outlined OPA's role in contributing to the prevention of preterm births and described current and potential collaborative efforts.

Title X Family Planning Program
- Provides direct services for 4.5 million low-income women and men each year through 90 grantees with sites in 75 percent of U.S. counties.
- Services are confidential, voluntary, and free or low-cost.

Quality Family Planning (QFP) recommendations
- Issued by OPA and CDC in 2014 to define what services should be offered in a family planning visit and how to do so; support consistent application of quality care across settings and provider types; and translate research into practice.
- The intended audience is all providers of family planning services.

Proposed clinical performance measures for contraceptive services
- Currently being developed by OPA, CDC, and other organizations
- Moving toward endorsement by the National Quality Forum and inclusion in HP 2020.

OPA-funded Family Planning National Training Centers provide a wide range of resources (http://www.fpntc.org).

Collaborative opportunities
- Collaboration with the CMCS Maternal and Infant Health Initiative to develop performance measures for contraceptive use, including CMCS funding for states to report on the measures.
- Partnership with COINN's preconception health strategy, with a focus on birth spacing and pregnancy prevention and performance measures.

COMMITTEE QUESTIONS AND DISCUSSION

- Dr. Kotelchuck asked what kinds of programs were available to address the role of men in teen pregnancy and family planning and what was being done to increase parity between men and women, which is important to prevent prematurity.
    - Ms. Moskosky replied that OPA and CDC spent a great deal of time discussing the role of men in family planning and preconception health services. There is increasing emphasis on ensuring that family planning providers are welcoming to men. A grantee in Corpus Christi, Texas that received targeted funding to provide services to men demonstrated compelling results, including an increased number of both men and women. Public awareness campaigns highlighting the role of men in preventing preterm pregnancy would be helpful.
    - Dr. Kotelchuck requested information on the grantee in Corpus Christi. Dr. de la Cruz asked Ms. Moskosky to send that information to his attention.
    - Ms. Kappeler noted that the PAF serves young men and fathers. TPP Tier 2 includes a partnership with the CDC Division of Reproductive Health to test interventions that are specifically tailored to the needs of boys and young men, and serving boys and young men is a priority for the new cohort of TPP grantees.
    - Dr. Jackson noted that 93 percent of PPE participants are female. The advisory group for the program raised the issue of parity and the need to target messages to men. That will be a focus area in the coming fiscal year.
    - Ms. Johnson stated that parity is needed in contraceptive methods as well as services.
- Dr. James asked if there was a fatherhood curriculum specifically designed for teen fathers or fathers-to-be.
    - Ms. Kappeler said OAH does not currently have a curriculum for teens or teen fathers. The partnership with CDC will test curricula targeting young men between the ages of 15 and 24.
- Ms. Johnson asked the speakers to identify areas they would like to address if resources were available.
    - Ms. Moskosky replied that financial resources are always a challenge. Significant funding for Colorado and Iowa had a dramatic impact on the level of unintended pregnancies in those states. OPA has quite a bit of flexibility within Title X to support innovative approaches, such as an "Avoid the Stork" media campaign on college campuses in Iowa.
    - Ms. Kappeler noted that funding for the PAF will expire in 2019. It is the only federally funded program that provides seamless support for young families through work with states and tribes. Reducing and preventing teen pregnancy is an important strategy to avert preterm births.
    - Dr. Jackson emphasized that implementation and dissemination must be tailored if people are to respond to messages and change behaviors. It is challenging to demonstrate the impact of public awareness programs, because behavior change takes time.
- Dr. James asked if any studies showed a clear correlation between effective implementation of family planning and population-wide improvement in infant mortality.

- Ms. Johnson said there was a 30-40 year history of studies showing that family planning reduces unintended pregnancies and improves birth outcomes, both directly and indirectly.
- Ms. Moskosky stated that all states with Medicaid family planning waivers were required to demonstrate cost savings and improvements in outcomes. She offered to send a list of studies to Dr. de la Cruz.
- Ms. Daniel-Robinson said she would provide information on a study conducted in North Carolina.

WRAP-UP AND ADJOURN FOR THE DAY

Kay Johnson, M.Ed., M.P.H., Research Associate Professor of Pediatrics, Geisel School of Medicine at Dartmouth; President, Johnson Group Consulting, Inc.; Chairperson, SACIM
Michael C. Lu, M.D., M.P.H., Associate Administrator for Maternal and Child Health(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/Division of Healthy Start and Perinatal Services

Dr. de la Cruz thanked committee members, ex officio members, and speakers for their participation.

Ms. Johnson thanked the liaison agency staff for their support for the SACIM's work and reviewed the agenda for the second day of the meeting. She asked committee members and ex officio members to review the draft letter regarding SDOH to ensure that it addressed all of the issues that were discussed at the March meeting.

TUESDAY, AUGUST 11, 2015

SUMMARY OF DAY 1 AND OVERVIEW OF DAY 2

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

Ms. Johnson welcomed SACIM members and federal liaison staff, reviewed the discussions of the previous first day, and provided an overview of the agenda for Day 2.

UPDATE FROM THE MARCH OF DIMES

Diane Ashton, M.D., M.P.H., Vice President for Health Equity & Deputy Medical Director March of Dimes; Member, SACIM

Dr. Ashton provided an update on prematurity prevention at the March of Dimes. Key points were as follows:

- The third national Prematurity Prevention conference would take place on November 17 and 18 in Arlington, Virginia. The goals of the conference are to enhance prematurity prevention efforts through sharing information, disseminating findings on evidence-based practices, and engaging stakeholders. A call for abstracts was issued. Registration opened on August 1.
- The 2015 Prematurity Report Card will be released in November, to coincide with Prematurity Month. The report card will reflect the change in gestational dating from last menstrual period to the obstetrical estimate. As a result of that change, the U.S. met the 2020 preterm birth goal in 2014. However, prematurity is the leading cause of infant mortality, and the U.S. has one of the highest infant mortality rates among high-income countries. The data will be more granular than in the past. Instead of assigning a grade for each state, a grade will be assigned for each city with a population of 100,000 or more, and those grades will be compared to the overall preterm birth rate for the state. County data will be used for states that do not have large cities. Cities will be ranked according to their preterm birth rate. The report card will include a preterm birth disparity index, using a methodology developed by the National Center for Health Statistics (NCHS). The reference point will be the racial or ethnic group with the lowest preterm birth rate in the state. The distance from the reference rate will be measured as a percentage, and the differences will be combined into an average summary measure. The disparity index will be used to provide a ranking for each state.
- The March of Dimes developed new preterm birth goals of 8.1 for 2020 and 5.5 for 2030, since NCHS data for 2014 show that the 2020 goal of 9.6 has been met. Achieving that goal would move the U.S. from among the worst high-income countries to the best 10 percent. It would result in an estimated 1.3 million fewer preterm births and associated savings of $70 billion in health and societal costs. The new goal also calibrates with the new 2030 Global Sustainable Development goals.
- The March of Dimes is involved in a wide range of advocacy efforts at the state and federal level relevant to infant mortality, prematurity, birth defects, and other birth outcomes. Top priorities at the federal level are passage of the Protecting Our Infants Act, which would focus on prevention of drug exposure in utero, particularly opioid exposure; the proposed Food and Drug Administration (FDA) rule regarding liquid nicotine; and a forthcoming FDA rule regarding e-cigarettes and other novel tobacco

products. Priorities at the state level include tobacco prevention and cessation, drug exposure in utero, childhood immunizations, and adding Pompe Disease to the Recommended Uniform Screening Panel (RUSP) for every state, since it was approved at the federal level in March of this year.

- SACIM members are encouraged to join the March of Dimes advocacy efforts at www.marchofdimes.org/advocacy.

COMMITTEE QUESTIONS AND DISCUSSION

- Ms. Johnson asked if the SACIM could assume that the topics in its preterm birth plan would be included in the prematurity prevention conference, if the plan is approved by the Secretary and published prior to the conference.
    - Dr. Ashton stated that the March of Dimes could accommodate that request.
- Dr. Cox asked if the March of Dimes had previously published disparities indices and said he thought another agency had published a disparities index for perinatal care.
    - Dr. Ashton said this was a new undertaking for the March of Dimes. She was aware of a disparities index for cardiovascular disease in adults.
    - Dr. Cox said that a similar index for perinatal care would be a significant contribution.
    - Dr. Ashton said the March of Dimes index was focused on the preterm birth rate, and she described how the disparities score was calculated for each state.
    - Ms. Johnson noted that the March of Dimes index was aligned with the committee's concern about the need for data to be broken out by populations.
- Dr. Moore asked if there would be any attempt to look at very early preterm births, versus preterm births in general. She noted that the risk of birth defects is much greater among very early preterm births, and the rate has not changed significantly.
    - Dr. Ashton replied that the March of Dimes focuses primarily on late preterm births because they are more amenable to intervention. However, their transdisciplinary research centers are doing a great deal of research on very early preterm births.
- Ms. Moos asked about strategies to maintain support for this issue in Congress when the 2020 goal has already been met and resources are shrinking.
    - Dr. Ashton replied that the new goals for 2020 and 2030, the fact that the U.S. has a long way to go to be in the top 10 percent of very high-income countries, and the wide disparities in preterm birth would help to keep the issue on the radar.
- Dr. Spong noted that there are many situations where preterm birth is optimal for both the mother and baby. The current rate is unacceptable, but the goal should not be zero.
    - Dr. Ashton said Dr. Spong's point was well taken, and she stressed the need to understand the issues around early preterm birth.
    - Ms. Moos stated that this was an important point that should be included in the report. She agreed that the goal should not be zero.
- Dr. Kotelchuck suggested that reframing preterm birth as a social justice issue could help to keep it relevant.
    - Dr. Ashton agreed and stated that the disparities index was one way to do that.

COMMITTEE DISCUSSION OF FEDERAL ACTIVITIES RELATED TO PRETERM BIRTH

Committee members discussed the issues that emerged on Day 1. Key points were as follows:

- Impressive amount of information about activities.
- How do we make the case for investment in preterm birth prevention when we have made progress and reached the HP 2020 goal?
- Coordination and duplication
    - Advantages of duplication of effort for subpopulations
    - Need to encourage coordination of key activities
    - Some might see duplication, excess cost.
- Prevention is key, but it is also important to acknowledge secondary prevention (e.g., neonatal intensive care unit [NICU, care for families).
    - What can we do to improve outcomes, including around the time of birth, intrapartum (e.g., steroids, 17 alpha hydroxyprogesterone caproate [17P], preterm labor, California example)?
- Did not hear enough about activities and linkages to preterm birth regarding:
    - Obesity
    - Chronic disease
    - Stress
    - Interpregnancy interval
    - Fathers
    - Opioid use, neonatal abstinence syndrome: need adequate behavioral health and substance abuse services for women (and men), including those who are not pregnant
    - Linking maternal health to preterm birth, intergenerational issues, epigenetics
    - Need to acknowledge the difficulty for federal staff to determine what is critical to cover in their presentations; they may, in fact, have activities in these areas.
- The remarkable work of OPA/CDC on QFP guidance is not reaching private practice (e.g., primary care), not holding people accountable, etc.
    - Opportunity to promote this work.
- Dissemination
    - Encourage use of social media strategies to disseminate preventive health messages, think about innovation and new ways to communicate
    - Encourage Google and others to detect women's activity and interests in pregnancy
    - Struck by big data look
    - Concern about reach to populations most in need
    - Difficult to capture information about who is being reached
    - Need federal resources to generate opportunities
    - Need public-private partnerships
    - Gabby (avatar) for preconception health counseling
    - Need evidence that social marketing works to improve health and outcomes.
- Data issues
    - Granularity
    - Capitalize on investment in IT: where is the return?

    - CMS/Medicaid data: Need data about births financed by Medicaid, which are more than half of all births.
- New mechanisms (e.g., placenta research).
- How to get this to the top level (e.g., Million Hearts initiative)?
- Focus on professional development
    - Learning centers and collaboratives: Is information getting translated into action?

COMMITTEE DISCUSSION OF PREEMIE ACT REPORT

Committee members discussed the PREEMIE Act report. Key points were as follows:

General comments

- Praise good work that is being done
- Discuss how to translate federally funded knowledge/evidence into state and local action and how to translate private initiative into federal action
    - Build the infrastructure: encourage perinatal quality collaboratives in every state.
    - Spread and implement change
    - Should extend beyond hospitals and clinics
    - Population health focus from health system and institutions
    - Incorporate into the COIIN
- Communicate the important role of HUD and other agencies in SDOH.

Outline for plan/report

- What is the problem?
- Why does it matter?
- What is going on now in terms of federal agencies?
- What are the gaps that need to be addressed?
- What is the recommended plan for HHS action?

Framework

- Use continuum diagrams?
- By agency
- By program
- Richmond-Kotelchuck model
    - Knowledge base/evidence (e.g., risk factors that merit more study are listed and enumerated)
    - Social strategies, intervention programs (e.g., health, SDOH, agency issues)
    - Political will: Need more attention, buy-in, investment, professional support, interagency collaboration.
- Three buckets: Research (including gaps and recommendations)/clinical services/performance monitoring, measurement, data/consumer education.

IOM framing

- IOM causes
    - Behavioral and psychosocial

    - Socio demographic and community
    - Medical and pregnancy
    - Biological and gene-environment interactions
    - Environmental toxicants.
- Need actionable recommendations
- Include cross-cutting, interagency activities
- Issues related to coordination and duplication of effort.

Making the case: In the face of success, why does this matter?

- Epidemic: We have made some progress, but as with cancer, we do not stop because we have had some success.
- Prematurity is a leading cause of infant mortality.
- We are reducing preterm births and infant mortality, but our ability to close the gap to achieve equity has not happened. (Focus recommendations.)
- We have not made improvements for a significant percent of the population (need the number).
    - Costs associated with this failure include productivity, health care, education, etc.
- Improving birth outcomes can yield cost savings across the lifespan (e.g., chronic disease and disability).
    - *"Preterm birth is associated with expenditures across a wide range of public programs, including those for health care, education, and income support. Public investment in reducing the rate of preterm birth has the potential to result in large cost savings, not only to society as a whole but also to the public sector."* (IOM report)
- We do not compare favorably internationally.
- Some success is an artifact of data collection.

Secondary and tertiary prevention

- Highest rate of survival for preterm infants, but we have too many (celebrate what we have achieved, but primary prevention is important)
- Care and intervention for infants and children who experience preterm birth (life course, long-range outcomes, clinical-social-developmental)
    - Clinical interventions that limit harm at time of birth (NICU and other infant health care)
    - Interventions with families that minimize harm (e.g., depression screening, home visiting)
    - Longer-term services
        - Early intervention to reduce disability
        - Other long-term supports (Supplemental Security Income, foster care)
- Recommendations to improve transitions from secondary to tertiary
- HHS could make a difference.

Overall focus

- Primary focus: preventing preterm birth
    - Primary prevention: focus on woman's health to avoid this pregnancy outcome

    - Secondary and tertiary prevention: focus on optimizing outcomes of preterm infants, also requires attention to parents' function and needs
- What you would do differently if the focus is on the woman or the baby.
- Both may happen in parallel.

Policy environment

- Make the best case for investment, without regard to the budget environment
- Acknowledge that we are in a difficult budget and political environment
- Be realistic and practical in recommendations.

Role and opportunities of the Affordable Care Act

- Stay the course – it solves issues related to preterm birth.
- Coverage – especially Medicaid expansion
    - States with the highest preterm birth rates in the South are those that have not expanded Medicaid, for the most part. Compare to some states in Midwest that did adopt expansion.
- Women's clinical preventive services
    - Prematurity prevention includes preconception care for 40-70 million women
    - Need preconception care and well-woman visit coverage in Medicaid
    - Center for Medicare and Medicaid Innovation (CMMI) could conduct research in this area.
- Community transformation grants (CTGs), prevention grants, other CDC (what is the status?).

Other key topics

- Demographic and statistical background
    - Need sufficient data to show general trends and disparities
    - Use CDC data prepared for SACIM
    - Include State-level information, if available (HRSA).
- Race versus racism
- Mention historical circumstances, institutional racism, and SDOH that drive disparities
- Interconception/interpregnancy care, preventing subsequent preterm birth.

Recommendation ideas

- Against preterm birth, prevention is critical
- Support the PREEMIE Act and future reauthorization
    - Comment favorably on work the Act supports
    - Highlight as necessary and focus recommendations
    - Suggestions on how the next version could facilitate data, research, interventions, communication, etc.
    - Restore funding (e.g., CDC, NICHD, HRSA?).
- Begin with March of Dimes recommendations and enrich them with SACIM perspective
    - Elevate preterm birth as a national priority
    - Increase research into preterm birth
    - Improve data collection, analysis, and dissemination

    - Work to eliminate social inequities
    - Improve access to quality health care before, during, and between pregnancies
    - Train health professionals
    - Increase public and provider education about preterm birth.
- Coordination of federal efforts is an important addition.
- How to get providers to implement evidence-based services, provide quality care that is culturally competent and appropriate (e.g., as powerful as interventions such as 17P)? Treating everyone equally often results in inequity (IOM *Unequal Treatment*).
- Preterm birth and very low birth weight are windows into maternal health, life course, and intergenerational risks. Focus on the health of the woman.
- Must be evidence-based; we do not want to cause harm.

Public input in plan development

- SACIM meeting
- Professional/ organizations request
    - e.g., AMCHP, ASTHO, ACOG, AWHONN, ACNM, CityMatCH, NHSA, NAMD, APHA, AAP, AHA, AAFP
    - Use three questions, similar to those asked of federal agencies
- Parent organizations
    - Ask Libby Bianchi, Sue Sheridan, March of Dimes patient website, National Premature Infant Health Coalition, Moms Risking, National Partnership, National Perinatal Association consumer network, and others to help
- Blogs, Twitter, other social media

Ms. Johnson stated that her goal was to have the report completed and published prior to the March of Dimes prematurity prevention conference in November. She would circulate a preliminary draft for comments in the next few weeks, at which point committee members could develop sections in their areas of expertise.

Ms. Johnson asked the federal liaisons to provide additional information about research gaps and to comment on the draft.

Ms. Johnson asked how the SACIM should obtain public input for the plan. Dr. de la Cruz said there were several options. He noted that no public comments had been submitted for this meeting and encouraged SACIM members to assist in obtaining input for the plan.

Dr. de la Cruz stated that once the report has been accepted by the Secretary, it can be disseminated widely. He noted that SACIM members could speak about the plan as private individuals; if they were to speak on behalf of the SACIM, there would be some restrictions.

TOPIC-SPECIFIC PRESENTATIONS FROM PARTNERS

Preterm Birth Prevention: Association of State and Territorial Health Officials (ASTHO)
Lisa Waddell, M.D., M.P.H.., Chief Program Officer, Community Health and Prevention

Dr. Waddell informed the committee that ASTHO represents chief health officials of U.S. states, territories and freely associated states, and public health agencies in the District of Columbia.

The organization tracks, evaluates, provides TA, and advises on the impact and formation of public and private health policy.

ASTHO's immediate past president, Dr. David Lakey, used his presidential challenge to galvanize the country around addressing infant mortality and reducing preterm births. He established the Healthy Babies Challenge initiative and, in collaboration with partners, established a goal to reduce preterm birth by eight percent by 2014. The Healthy Baby clearinghouse on ASTHO's website provides resources for the initiative.

With ASTHO's support, states have implemented a wide range of strategies to reduce preterm births, including: issuing the Healthy Baby Challenge, participating in the National Infant Mortality COIIN, increasing access to 17P, reducing EED, reducing tobacco use, increasing access to LARC immediately postpartum (IPP), addressing NAS, and an ASTHO position statement on Improving Birth Outcomes. Engaging leadership and fostering partnerships are key elements of ASTHO's efforts in this area.

Key points:

- Effective and evidence-based strategies exist to reduce preterm birth and infant mortality
- State health departments play an important role in implementing these strategies
- Leadership, partnership, and policy changes are critical in advancing systems-level changes
- ASTHO is a resource to federal, state, and local partners.

Health Equity and Preterm Birth: Association of State and Territorial Health Officials ASTHO

Ellen Pliska, M.H.S., C.P.H., Director, Family and Child Health

Ms. Pliska described ASTHO's strategic map and its impact on health equity goals, ASTHO policy regarding health equity, and ongoing coordinated projects.

The central challenge of ASTHO's strategic map for 2013-2015 is to strengthen the effectiveness, value, and relevance of state and territorial public health in promoting health equity and improving health outcomes. The proposed overarching goal for the 2016 strategic map goes a step further to state that ASTHO will improve health equity and population health outcomes through transformational leadership. ASTHO aims to better support its members to effectively lead health equity change within their states.

ASTHO's incoming president, Dr. Edward Ehlinger, will launch the President's Challenge on Health Equity in September 2015. The challenge identifies three areas of opportunity:

- Expand the understanding of what creates health
- Promote a health in all policies approach with health equity as the goal
- Strengthen the capacity of communities to create their own healthy futures.

The Access Policy Committee (APC) houses ASTHO's work on access to health services, particularly for vulnerable and at-risk populations. Its position statement on Access to Health Services provides structure for statements related to maternal and child health, including Access

to Reproductive Health Services; Improving Birth Outcomes; and Maternal Mortality and Morbidity.

The APC's Healthy Babies Subcommittee aims to reduce infant mortality and morbidity in the U.S. through comprehensive system change. Reducing health disparities is one of four core goals. The subcommittee will use a health disparities lens to address maternal and child health issues and an SDOH lens to improve policies in all sectors.

ASTHO issued eight recommendations for state and territorial health agencies regarding smoking cessation for women before, during, and after pregnancy. One recommendation is to implement evidence-based tobacco control policies, including working with housing agencies to promote smoke-free home policies, especially in multi-unit housing, and promoting smoking bans in worksites, public spaces, environments affecting pregnant women and new mothers, and commercial and home-based daycare settings. Pueblo, Colorado is one example of how smoking bans can effectively reduce the odds of maternal smoking and preterm births.

ASTHO's goals for state and territorial health officials to achieve health equity include: partner with multi-sector agencies, providers, and communities; develop a culture of improving the health and closing gaps between groups; create a unified message; and develop clear measurements to evaluate targeted progress. Ms. Pliska cited efforts in Georgia and Maryland to reduce disparities in infant mortality.

Questions to advance health in all policies, strengthen capacity for communities, and create a culture of change include:

- What health impacts can we anticipate, and who will experience these impacts?
- What do we know about the impact (outcome) versus the intent of the policy?
- Who is/is not at the decisionmaking table, and who has the power?
- Who is being held accountable, and to whom or what are they accountable?

Social Determinants of Health: Infant Mortality COIIN

Lauren Smith, M.D., M.P.H., Executive Project Director, National Institute for Children's Health Quality (NICHQ)

Dr. Smith provided an update on the National Infant Mortality COIIN. She noted that the agenda of the COIIN is to have more infants celebrate their first birthday.

The COIIN includes six collaborative learning networks that were developed in collaboration with states:

- Improve safe sleep practices (selected by 37 states)
- Reduce smoking (selected by 21 states)
- Pre/interconception care (selected by 29 states)
- Social determinants of health (selected by 23 states)
- Prevent pre- and early term births (21 states)
- Perinatal regionalization (selected by 14 states).

All of the learning networks are relevant to preventing pre- and early term birth, with the exception of safe sleep practices. States can participate in more than one network.

Dr. Smith highlighted activities in the Pre and Early Term Birth Learning Network, which aims to reduce the prevalence of preterm and early term singleton births by July 2016. The overall aim includes three components: 1) Decrease non-medically indicated births between 37 0/7 and 38 6/7 weeks of gestation by 20 percent; 2) Increase the percent of pregnant women on Medicaid with a previous preterm birth who receive progesterone to 40 percent; and 3) Achieve or maintain equity in utilization of progesterone by race/ethnicity. Primary drivers of its work are:

- Support providers in timely, reliable, and effective screening, identification, and prevention of preterm birth
- Eliminate barriers to access, administration, and adherence to progesterone
- Increased patient, family, and community understanding of and demand for progesterone and carrying to full term
- Public and private payment policies aligned with aims
- Build capacity of and support for hospitals and providers to reduce EED.

Each primary driver has an array of secondary drivers. A detailed chart showing the number of states working in each area was included in the presentation slides.

Each learning network has a lead TA organization. The March of Dimes provides TA for the Pre and Early-Term Birth learning network.

The SDOH learning network is focused on innovative strategies rather than QI. Its primary focus is innovation and spread of evidence-based policies, programs, and place-based strategies to improve SDOH and equity in birth outcomes. The 20 recommended strategies are built on the World Health Organization framework for tackling SDOH. A detailed chart was included in the presentation slides. States can choose from among 20 potential strategies to improve SDOH.

The COIIN held its second learning session in Boston in July. The SDOH World Café discussed what the SDOH learning network is trying to achieve, identified a number of ways to motivate change, and identified the types of partnerships that are needed, including cross-agency connections with government.

COMMITTEE QUESTIONS AND DISCUSSION

- Dr. Cox asked if Louisiana used incentives to align the disparity between where 17P was given and where it was needed.
    - Dr. Waddell stated that Louisiana implemented pay-for-performance for women on Medicaid receiving 17P.
    - Ms. Pliska stated that Louisiana implemented a multi-faceted strategy that included pay-for-performance, opening the payment mechanisms for all forms of progesterone, a QI project for hospitals, and incentives.
    - Dr. Waddell added that currently, only five percent of eligible women receive 17P. The state set a goal of 20 percent, which will increase over time. Medicaid reimbursement will be reduced by $250,000 for hospitals that do not achieve that goal within a certain time period.

- Dr. Cox asked how savings from reduced EED would be used.
    - Dr. Waddell stated that some states chose to reinvest the savings into strategies related to birth outcomes. For example, South Carolina used the savings to increase the number of baby-friendly hospitals, which offset other rate reductions.
    - Ms. Pliska added that the state of Washington would increase the Medicaid reimbursement by 1 percent for hospitals that reduce their EED rate and meet other QI benchmarks.
    - Dr. Cox stated that increasing the reimbursement rate was an appropriate incentive, because hospitals lose money if NICU admissions decrease.
- Dr. Barfield asked what opportunities were available to increase community engagement, especially with regard to SDOH, now that funding for CTGs is no longer available.
    - Dr. Waddell stated that most states participating in the Infant Mortality COIIN have engaged partners such as March of Dimes and local medical societies and hospital associations. ASTHO is sharing best practices for partnerships so states can learn from each other.
    - Ms. Pliska said several states have worked directly with communities to implement health equity activities. In Connecticut, the state health department implemented an assessment of persistent and significant disparities in health outcomes. They worked with community groups and organizational partners to explore how racism impacted pregnant women and their babies and how the state could support community groups to make the necessary changes.

COMMITTEE DISCUSSION ON DRAFT LETTER REGARDING STRATEGIES TO PROMOTE HEALTH EQUITY AND REDUCE INFANT MORTALITY

Ms. Johnson reviewed the recommendations in the draft letter and asked whether any items needed to be added or removed:

1. Expand implementation of the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS).
2. Build on the HHS Disparities Action Plan.
3. Collaboration between the HHS, Department of Labor, and Internal Revenue Service to broaden the reach of key tax credits – includes EITC and CTC.
4. Improve the responsiveness of the TANF program to families having babies.
5. Continue and expand the federal role in community-level, place-based initiatives.
6. Support the continued funding and evaluation of the Healthy Start program.
7. Support the continuation of key initiatives of the MCHB – includes COIIN and health equity plan.
8. Continue and expand funding to the National Institute of Child Health and Human Development (NICHD-NIH) for research.
9. Expand the Preconception Peer Educators program of the Office of Minority Health.
10. Stimulate action using the National Quality Strategy six priorities.
11. Initiatives related to increasing the minimum wage and pay equity for women.

Committee members discussed the recommendations.

- Dr. Kotelchuck asked how the list was developed and whether it included input from all committee members.
    - Ms. Johnson replied that the subcommittee met four times and the list reflected the presentations and discussions of a full committee meeting in March 2015, which was dedicated to this topic. She would welcome suggestions regarding the list and the body of the document, particularly if something was missing.
- Dr. Kotelchuck suggested adding paid maternity leave to the third recommendation, adding a recommendation about fathers, and adding a recommendation to encourage community-based organization around SDOH and reproductive health, such as mothers' clubs and neighborhood initiatives.
    - Dr. Barfield expressed support for federal funding for community-based interventions.
    - Ms. Johnson asked how to make the distinction between the recommendation regarding place-based initiatives and the one for Healthy Start.
    - Dr. Kotelchuck stated that only the top tier of Healthy Start grantees are required to develop a Community Action Network (CAN). The SACIM could encourage expanding the CAN approach for all programs.
    - Ms. Johnson added a new draft recommendation: "Federal funding for community-based organizations, community engagement—encourage CAN in all programs, social networking, mothers' clubs, empowerment, voice of communities (every community)."
    - Dr. Ashton stated that the SACIM could express support for community-based participatory research.
    - Mario Drummonds, M.S. L.C.S.W., M.B.A., offered to cull points from his paper on how to mobilize residents in local communities to address the SDOH. He noted that the president recently put forth a policy on two-year colleges to raise people out of poverty.
- Ms. Moos emphasized the concerns Dr. Cox raised regarding granularity of data. The county-by-county comparisons in Georgia were an excellent example.
    - Ms. Johnson replied that she would like to use those examples in the next letter, which would address data.
    - Dr. Cox suggested adding a recommendation regarding the need to build data capacity. The recommendation would also lay the groundwork for the next letter.
    - Ms. Johnson added a new draft recommendation: "Build data capacity to permit specific assessment of disparities, measure unequal treatment, and monitor performance toward achieving health equity."
- Dr. Cox noted that the recommendations did not include anything that would help practitioners direct their communications to improve health equity. Kaiser and the American Medical Association developed good vignettes to demonstrate the importance of culturally appropriate communication, but they have not been updated. The IOM report, *Unequal Treatment*, includes a discussion of the impact of cognitive dissonance.
    - Ms. Johnson asked if the first recommendation would address that concern.
    - Dr. Cox replied that only two of the CLAS standards deal with cultural appropriateness. That aspect needs to be emphasized.

    - Ms. Johnson added "and measure" to the beginning of Recommendation 1 and added the phrase, "giving particular attention to cultural appropriateness and cultural congruity" to the end of that recommendation.
- Dr. James expressed support for expanding data capacity and noted the importance of ensuring that data are used to inform the work that is being done. He asked if the concept of "proportionate universalism" had been addressed sufficiently in the recommendation regarding place-based initiatives.
    - Ms. Johnson replied that a discussion of proportionate universalism was more relevant to the body of the document and said she would strengthen that section.
- Mr. Smith asked if Recommendation 11, which addresses the minimum wage and pay equity, could be combined with Recommendation 3, which addresses tax credits.
    - Ms. Johnson said she would prefer to keep them as separate recommendations, although they could be moved closer together.
    - Mr. Drummonds suggested referencing the movement to increase the minimum wage for fast food workers to $15 per hour Recommendation 11.
    - Ms. Johnson moved Recommendation 11 to follow Recommendation 3 and revised it to read: "Presidential initiatives related to increasing the minimum wage for workers, achieve pay equity for women, require paid family leave, and support community college attendance." (Women being served, childbearing, low-income women).
- Dr. Kotelchuck proposed adding a paragraph about the need to make infant mortality part of the national civil rights agenda and the social justice movement around the country, which would help the Secretary articulate the link between infant mortality, SDOH, and the larger political context.
- Dr. Ashton noted that addressing the SDOH could also be framed as a QI activity.
- Dr. Kotelchuck proposed three possible approaches: use the WHO framework to link SDOH and the quality of healthcare; focus on empowering communities and changing social stratification; and focus on changing the environment. He suggested that the letter should emphasize what we are doing well, and highlight where we could go farther.
- Dr. Cox recommended emphasizing five or six recommendations where HHS could have the most impact, with a separate list of other priorities that do not fit within those ideas. His top priorities would be communications at the patient-provider level; measurement and data; CLAS standards; and measures to address poverty (e.g., tax credits, TANF, miminum wage, and pay equity).
    - Dr. Johnson said she believed there was consensus around a list of 10 or 12 recommendations, but there would not be a consensus regarding a list of five.
- Mr. Drummonds suggested framing the letter around key themes that capture the current social and political environment (e.g., income inequality, structural racism, criminal justice reform, and reproductive justice).
- Dr. de la Cruz noted that the committee would receive a more specific response from the Secretary if the letter includes clear and specific requests.
    - Dr. Kotelchuck stated that the SDOH are not amenable to specific requests. He expressed strong support for a recommendation to allow women to receive TANF income for three to six months following the birth, which would be concrete and actionable. In his view, this letter should provide the Secretary with a framework

through which to view existing work. It is premature to offer the type of targeted recommendations the SACIM developed for other strategic areas.
    - Dr. James stated that the SDOH team within the COIIN encountered a similar problem. He noted that Dr. Smith's emphasized the need for more inter-agency collaboration at the federal level and more inter-system collaboration outside of the federal sector.
    - Dr. Kotelchuck suggested that the committee look at the difficulty of framing specific recommendations for SDOH as an opportunity rather than a problem. One presenter suggested that the committee could help the Secretary support innovative ideas and encourage the evolution of work in this area.
- Ms. Johnson suggested focusing the letter on the following five areas:
    - Expand implementation of the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS)
    - Collaboration between the HHS, Department of Labor, and Internal Revenue Service to broaden the reach of key tax credits – includes EITC and CTC.
    - Improve the responsiveness of the TANF program to families having babies.
    - Federal funding for community-based organizations, community engagement—encourage CAN in all programs, social networking, mothers' clubs, empowerment, voice of communities (every community).
    - Presidential initiatives related to increasing the minimum wage for workers, achieve pay equity for women, require paid family leave, and support community college attendance." (Women being served, childbearing, low-income women).

The letter could encourage the Secretary to support and build upon the remaining items in the list, which provide more specific details.

- Dr. James suggested that, in addition to the letter, the committee should produce a report regarding the impact of SDOH on infant mortality.
    - Ms. Johnson said it was unlikely that the committee would be able to produce a report, given members' time constraints, the requirements to produce a report to Congress, and the need to address the Strategic Directions 5 and 6. She suggested that a subgroup of committee members who are interested in this issue could work with colleagues outside of the committee to develop a journal article.
    - Dr. Kotelchuck noted that on several occasions, a subgroup of committee members developed a report on a topic of interest to them. The SACIM is the most influential voice on issues related to infant mortality.
- Mr. Kotelchuck stated that place-based initiatives should be included among the key issues. The reproductive health community has not been as active in that area.
- Deborah Frazier asked how SACIM members viewed place-based as different from Healthy Start.
    - Dr. Kotelchuck replied that place-based work involves bringing many sectors together to create collective impact. Healthy Start has the capacity to do that, but its current focus is on providing services to women and families and its funding is not sufficient to do transformational work. However, some of the best place-based work has occurred in communities such as Harlem, where Healthy Start served as the backbone for additional organizations. In the new model, Level Two and Three grantees have the responsibility to build zones. That will require an infusion of funds for infrastructure, community development, and labor.

- Ms. Johnson stated that the discussion of place-based initiatives in the letter would emphasize that funding a number of discreet programs (e.g., Promise Neighborhood, Safe Neighborhood, Healthy Start) does not add up to the level of federal investment that is needed. The letter would urge HHS to require programs to work together across sectors within the community, supported by community development resources.

Ms. Johnson said she would circulate a revised draft of the letter reflecting this discussion, with a deadline for comments.

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

Ms. Johnson outlined next steps, as follows:

- Circulate a revised draft of the SDOH letter
- Develop a draft outline of the preterm birth report
- Plan the meeting to address Strategic Direction 5.

Ms. Johnson noted that the first two activities would entail a great deal of work over the next two months. She asked members to let her know if the next meeting should also include Strategic Direction 6.

Dr. de la Cruz emphasized the importance of a clear timeline for comments and feedback on the letter and the preterm birth report. He stated that MCHB would reach out to partner organizations for input on the report and could put a notice in the *Federal Register* to request public comments.

Dr. de la Cruz stated that the committee would meet in person during the first quarter of fiscal year 2016. Due to turnover on the committee, the date could not be finalized until the Secretary approves enough new committee members to achieve a quorum.

Ms. Johnson noted that her term as SACIM chair would expire early in 2016. She urged committee members to consider serving in that position or to recommend candidates for consideration by MCHB.

Dr. de la Cruz thanked committee members and federal liaisons for their work and commitment.

The meeting was adjourned at 2:50 p.m.