Toward A National Strategy on Infant Mortality

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National Governors Association
Learning Network Conference:
Improving Birth Outcomes

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And today I’m pleased to announce my department will be collaborating in the next year to create our nation’s first ever national strategy to address infant mortality.

Secretary Kathleen Sebelius
Child Survival: Call to Action
June 14, 2012
Major National Initiatives to Reduce Infant Mortality

- ASTHO/March of Dimes’ Healthy Babies Initiative
- CMS/CMMI’s Strong Start
- HRSA’s Infant Mortality Collaborative Improvement & Innovation Network (CoIN)
- NGA’s Learning Network on Improve Birth Outcomes
Infant Mortality Rate, U.S.

Healthy People 2020 Target

Actual IMR
Projected IMR based on 2007-2010 average annual trend (-3.1%)
Secretary’s Advisory Committee on Infant Mortality

Charge & Purpose

- Advises the Secretary on Department activities and programs that are directed at reducing infant mortality and improving the health status of pregnant women and infants
- Provides guidance and attention on the policies and resources required to address the reduction of infant mortality
- Provides advice on how to coordinate the variety of Federal, State, local and private programs and efforts that are designed to deal with the health and social problems impacting on infant mortality
SACIM Members

• Kay Johnson, M.Ed. – Dartmouth Medical School (Chair)
• Mark Bartel, M.Div, BCC – Arnold Palmer Medical Ctr
• Sharon Chesna, M.P.A. – Mothers & Babies Perinatal Network of South Central New York, Inc.
• Robert Corwin, M.D., F.A.A.P – University of Rochester
• Raymond Cox, Jr., M.D., M.B.A. – Providence Hospital
• Phyllis Dennery, M.D. – University of Pennsylvania
• Carolyn Gregor, C.N.M., M.S. – Georgetown University
• Arden Handler, Dr.P.H., M.P.H. – University of Illinois at Chicago
• Fleda Mask Jackson, Ph.D., M.S. – Emory University
• Miriam Labbok, M.D., M.P.H. – University of North Carolina
• Joanne Martin, Dr.P.H., R.N. – Indiana University

• Monica Mayer, M.D. – Quentin N. Burdick Memorial Health Care Facility
• Tyan Parker Dominguez, Ph.D., M.S.W. – University of Southern California
• Virginia Pressler, M.D., M.B.A. – Hawaii Pacific Health
• Melinda Sanders, M.S.N., F.N.P. – Missouri Department of Health and Senior Services

• Ruth Ann Shepherd, M.D., F.A.A.P. – Kentucky Department for Public Health
• Susan Sheridan, M.I.M., M.B.A. – Consumers Advancing Patient Safety
• Sara G. Shields, M.D., M.S. – University of Massachusetts
• Adewale Troutman, M.D., M.P.H. – University of South Florida & President-Elect, APHA
SACIM Ex-Officios

- Assistant Secretary for Health
- Administrator for Children and Families
- Administrator for the Centers for Medicare and Medicaid Services
- Director of the Centers for Disease Control and Prevention’s Division of Reproductive Health
- Office of Minority Health
- Director of the Agency for Healthcare Research and Quality’s Center for Primary Care, Prevention, and Clinical Partnerships
- Assistant Secretary for Food and Consumer Services
- Department of Agriculture
- Department of Education
- Department of Housing and Urban Development
- Department of Labor
SACIM

Strategic Directions
for National Strategy on Infant Mortality

1. Improve the health of women before during, and beyond pregnancy
2. Ensure access to a continuum of safe and high-quality, patient-centered care.
3. Redeploy key evidence-based, highly effective preventive interventions to a new generation of families.
4. Increase health equity and reduce disparities by targeting social determinants of health through both investments in high-risk, underresourced communities and major initiatives to address poverty.
5. Invest in adequate data, monitoring, and surveillance systems to measure access, quality, and outcomes.
6. Maximize the potential of interagency, public-private, and multi-disciplinary collaboration.
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Strategic Directions for National Strategy on Infant Mortality
(Work in Progress)

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Preconception Health & Healthcare

- CDC/ATSDR Preconception Care Work Group & Select Panel on Preconception Care
- Office of Minority Health Preconception Peer Educators
- CMS Expert Panel on Interconception Care
- Affordable Care Act
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Opportunities for Quality Improvement

- Reduce elective delivery < 39 weeks
  - ASTHO/March of Dimes
  - CMMI
  - HRSA
  - National Governors’ Association
  - National Priorities Partnership
- Promote appropriate use of 17P
- Improve screening for asymptomatic bacteriuria or GBS
- Reduce central-line associated bloodstream infections in newborns
Percent Elective Deliveries <39 Weeks, Ohio Perinatal Quality Collaborative

The denominator is the number of scheduled deliveries 36 to 38 weeks gestation (number of scheduled delivery forms submitted). The numerator is the number of scheduled deliveries without indication documented.
Percent Elective Deliveries <39 Weeks, California Maternal Quality Care Collaborative

ELECTIVE DELIVERY <39 WEEKS (PC-01)

Inductions and Cesareans before labor among uncomplicated 37 and 38wk gestations (JC, CMS, NQF)

Elective Delivery <39 Weeks Rate

Target: <5.0%

Percent Elective Deliveries <39 Weeks, Healthy Texas Babies

Courtesy: David Lakey, MD, MPH
System Integration

- Vertical
- Horizontal
- Longitudinal
Prenatal Care 3.0

Medical Home

High Risk OB

OB Hospitalist

Genetic Counseling & Prenatal Diagnosis

Ultrasound Center

Preconception & Interconception Care

Primary & Preventive Services

Health Education

Prenatal Care

Family Planning

Family Support & Social Services

Specialty Clinics

Dietitian & WIC

Mental Health

Oral Health
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Opportunities for Prevention & Promotion

- Missed opportunities
  - smoking cessation
  - safe to sleep
  - breastfeeding
  - Immunization
  - family planning

- New Workforce
  - Health educator
  - Home visiting nurse
  - Community health worker or doula

- New Platform
  - Group prenatal care

- New Technologies
  - Social media
  - Text messaging
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Health Equity

• Overarching goal of the national strategy
  • Need aspirational goal for the gap?

• Life-Course Perspective as a Guiding Framework
  • Place-based initiatives working across multiple sectors (e.g. transformation of Healthy Start)
  • Policy changes (e.g. inclusion of anti-poverty programs such as TANF reauthorization as part of the national strategy to address infant mortality)

NOTE: Neonatal is less than 28 days; Postneonatal is 28 days to less than 1 year. *Includes persons of Hispanic and non-Hispanic origin.

Black-White Disparity Trends

Black-White Rate Ratio of 2.4 from 2000 to 2007, just dropped to 2.3 in 2008

Infant deaths per 1,000 live births


Non-Hispanic Black
Non-Hispanic White
Closing the Gap
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Surveillance & Research

• Strengthen Surveillance
  • Standardize vital records
  • Improve data linkage capacity
  • Promote quality improvement using real-time data

• Support translational disparities research
  • T1 to T2 (bench to bedside)
  • T2 to T3 (bedside to curbside)
  • T3 to T4 (curbside to policy)
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Collaborative Improvement & Innovation Network (COIN) to Reduce Infant Mortality

- Partnership among HRSA, ASTHO, AMCHP, CDC, CityMatCH, CMS, March of Dimes, NGA, NPP, and the States
- Began in the 13 Southern States in January 2012
- States developed their state plans to reduce infant mortality

COIN: Strategies & Structure

5 Strategy Teams

1. Reducing elective deliveries <39 weeks (ED);
2. Expanding interconception care in Medicaid (IC);
3. Reducing SIDS/SUID (SS);
4. Increasing smoking cessation among pregnant women (SC);
5. Enhancing perinatal regionalization (RS).

Teams
- 2-3 Leads (Content Experts);
- Method Experts
- Data Experts
- Shared Workspace
- Data Dashboard
Regions IV & VI Infant Mortality COIN AIMS

• By December 2013,
  • Reduce elective delivery < 39 weeks by 33%
  • Reduce smoking rate among pregnant women by 3%
  • Increase safe sleep practices by 5%
  • Increase mothers delivering at appropriate facilities by 20%
  • Change Medicaid policy and procedures around interconception care in at least 5-8 states
Non-Medically Indicated Early Term Deliveries Among Singleton, Term Deliveries

25% total decline translating to ~50,000 early, elective deliveries averted since 2011 Q1

* Based on provisional birth certificate data; excludes women with pre-existing conditions
Non-Medically Indicated Early Term Deliveries Among Singleton, Term Deliveries*

<table>
<thead>
<tr>
<th>Region</th>
<th>Average State Change 2011 Q1 – 2013 Q2 or Q3*</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Region IV</td>
<td>-23.3%</td>
<td>(-38.9%, -4.4%)</td>
</tr>
<tr>
<td>Region VI</td>
<td>-28.2%</td>
<td>(-36.4%, -12.3%)</td>
</tr>
<tr>
<td>Combined</td>
<td>-25.2%</td>
<td>(-38.9%, -4.4%)</td>
</tr>
</tbody>
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- 5 States have already met the team aim of a 33% reduction in early, elective deliveries by December 2013

* Relies on latest available data for a given State
Smoking During Pregnancy*

8% total decline translating to ~8,000 fewer women smoking in pregnancy since 2011 Q1

* Based on provisional birth certificate data reflecting smoking in any trimester; 3 States using unrevised birth certificate; 1 State excluded that did not report 2013 data
## Smoking During Pregnancy

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<tbody>
<tr>
<td>Region IV</td>
<td>-6.4%</td>
<td>(-22.2%, 4.8%)</td>
</tr>
<tr>
<td>Region VI</td>
<td>-4.6%</td>
<td>(-17.2%, 15.0%)</td>
</tr>
<tr>
<td>Combined</td>
<td>-5.7%</td>
<td>(-22.2%, 15.0%)</td>
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</table>

- 9 States have already met the team aim of a 3% reduction in smoking during pregnancy by December 2013.