February 8, 2024

Dr. Miriam E. Delphin-Rittmon
Assistant Secretary for Mental Health and Substance Use
Substance Abuse and Mental Health Services Administration
5600 Fishers Lane, Suite 18E01
Rockville, MD 20857

Submitted electronically via www.regulations.gov

Re: Request for Information, Questions From the Task Force on Maternal Mental Health

Dear Dr. Delphin-Rittmon:

Premier Inc. appreciates the opportunity to submit comments in response to the questions posed by the Task Force on Maternal Mental Health. Premier is dedicated to improving maternal outcomes across the country using data driven efforts. Through our intensive maternal health focused work including the PINC AI™ Perinatal Improvement Collaborative (PPIC), Premier has identified significant gaps in maternal care and is collaborating with our members to implement evidence-based care interventions. Premier has also conducted extensive research into substance use disorder (SUD) and has identified critical next steps to tackle the epidemic. This work has confirmed that broad collection and use of key data elements is the first step to effectively address maternal mental health and substance use disorders and will require a concerted effort across public and private sectors.

Premier's comments focus on three recommendations that can improve maternal mental health outcomes:

- Broader implementation of evidence-based practices
- Robust research designed to lead clinical action
- Redefining the maternal health condition to last year

In addition, Premier addresses the following issues raised in the RFI:

- Priority outcomes for pregnant and postpartum individuals with substance use disorder and/or mental health conditions
- Priority research questions and gaps related to maternal substance use disorder and/or mental health conditions that must be addressed to improve services and outcomes for individuals while pregnant and postpartum
- Successful efforts to support maternal emotional health, substance use and well-being during pregnancy and after and existing gaps in these areas
- Steps to ensure that approaches to detecting maternal emotional health issues and substance use challenges are culturally appropriate
- Key evidence-based intervention and treatment models that should be broadly implemented to address maternal mental health and substance use

I. BACKGOUND ON PREMIER'S LEADERSHIP IN INFANT-MATERNAL HEALTH

Premier is a leading healthcare improvement company and national supply chain leader uniting an alliance of 4,400 hospitals and approximately 300,000 continuum of care providers to transform healthcare. With integrated data and analytics, collaboratives, supply chain solutions, consulting and other services, Premier enables better care and outcomes at a lower cost. Premier's sophisticated technology systems contain robust standardized data gleaned from nearly half of U.S. hospital discharges, 812 million hospital

outpatient and clinic encounters and 131 million physician office visits. Premier is focused on raising the bar on quality, safety and cost of care for mothers and babies across the United States regardless of personal characteristics such as gender, race, ethnicity, geographic location and socioeconomic status.

To address this problem head-on, the Department of Health and Human Services (HHS) Office of Women's Health (OWH) through the Maternal Morbidity and Mortality Data and Analysis Initiative has tapped into Premier's extensive data to understand why disparate maternal outcomes occur. The HHS Perinatal Improvement Collaborative, a multi-year collaborative comprised of more than 225 hospitals from all 50 states and the District of Columbia, leverages standardized data and proven performance improvement methodology to scientifically identify root causes of maternal-infant mortality and morbidity. With these resources, the collaborative will implement and analyze evidence-based interventions to drive clinical quality improvement, advance health equity and help make America the safest place to have a baby.

In August of 2022, Premier responded to CMS' Maternity Care Action Plan with a commitment to collect population-specific data across the continuum of care to understand the scope of maternal and infant harm. Premier is conducting follow-up research to measure progress in maternal and infant social determinants of health (SDOH) data collection and publish outcomes to advance health equity and reduce healthcare-associated disparities.

In addition, Premier's maternal infant linked data set supports the ability to identify pregnant women with a mental health disorder such as bipolar disorder, depression, psychosis and substance use disorder while identifying the impact on the neonate such as Neonatal Abstinence Syndrome prematurity and infections.

II. RECOMMENDATIONS TO IMPROVE MATERNAL MENTAL HEALTH OUTCOMES

Premier appreciates the opportunity to provide input on this important topic. Unfortunately, the maternal mortality rates in the United States continue to be of grave concern. In 2021, the Centers for Disease Control and Prevention (CDC) reported U.S. maternal mortality rates were 32.9 deaths per 100,000 live births, up from 23.8 deaths per 100,000 live births in 2020. Maternal mortality rates also increased in correlation with maternal age as individuals 40 years of age and older experienced 138.5 deaths per 100,000 live births while individuals under age 25 experienced 20.4 deaths per 100,000 live births.

Premier's recent analysis, published in JAMA and reported in CNN, shows the rate of pregnant women dying of delivery-related causes in the hospital appears to have declined significantly – a 57 percent decrease from 2008-2021. However, this decline only reflects in-hospital maternal deaths, not the nation's overall maternal mortality rate, which has been on the rise. More comprehensive research is needed to understand what factors are leading to this increase in maternal mortality rates outside the walls of the hospital, including the possibility that maternal health issues and substance use disorders are contributing to this crisis.

Premier's research, data analysis and on the ground member efforts are all working together to understand what elements are leading to these horrific outcomes and what we can do to address them. Although there is more work to be done, early indicators point to several areas where improvements can be made.

Evidence-based practices need to be broadly implemented. When our Premier team looked at inpatient readmission for psychiatric treatment within one year of delivery, we found that 51 percent of patients did not have a mental health condition documented during the delivery visit (4,134 out of 8,060 readmissions). [1]

Comprehensive research that is critical to tackling these issues cannot be done without proper mental health condition screening and coding as a start. Recommendations from professional societies such

[1] Premier Healthcare Database, 2023

as the American College of Obstetricians and Gynecologists (ACOG)[2] need to be implemented to create the accurate data we so sorely need.

Comprehensive research can spur effective clinical action. Greater intelligence and a willingness to take evidence-based actions can help relieve strain on healthcare systems and improve patient care. PINC AI™ data is fueling leading research to understand the impact of maternal health and SUD interventions and support better outcomes.

Premier data shows that women delivering between 23-33 weeks experienced nearly twice the rate of readmission for psychiatric treatment compared to those women delivering after 33 weeks. This data can assist with clinical considerations such as enhancement of maternal mental health assessments while the baby is in the NICU - some NICUs have implemented best practices to formally assess the mother with a validated tool, once per visit. Incorporating the emergency department (ED)/pediatric care providers into referring/securing response to maternal distress is also an option.

Maternal health should not be considered a 28-day condition. The Diagnostic and Statistical Manual of Mental Illnesses (DSM-5) only includes pregnancy/post-partum related conditions (which are extremely limited in scope) through 28 days post-delivery (this is inclusive of any pregnancy conclusion - miscarriage, termination, still birth or live birth at any gestation). It is estimated that among pregnancy-related deaths, about 53 percent have occurred seven to 365 days postpartum, according to the CDC.[3]

Since treatment recommendations, as well as payment by healthcare providers, are often determined by DSM classifications, the 28-day limit needs to be updated to a one-year period, given the most up-to-date data.

III. RESPONSE TO SAMHSA QUESTIONS

The remainder of Premier's comments are in direct response to the questions posted in the request for information.

i. What are the priority outcomes for pregnant and postpartum individuals with substance use disorder and/or mental health conditions?

Premier recommends starting with clinical outcomes such as mortality and morbidities for both mothers and infants, miscarriages, live birth and birth defects. In addition, healthcare resource utilization (HRCU) and cost outcomes such as number of all-cause and mental health related inpatient hospitalizations/outpatient visits, and costs associated with the inpatient and outpatient services are also important outcomes to assess in this population.

Furthermore, the differences in the clinical, HRCU and economic outcomes by race/ethnicity, regions, insurance payors, and social vulnerability level are critical for health equity search. All the outcomes mentioned above can be derived from the PINC AI™ Healthcare Database (PHD). Premier offers a mother-infant linkage which provides access to unique data source enabling research on the association between mother's mental health/substance use status and infant outcomes. For example, newborns born to maternal patients with documented substance use and/or mental health condition are 1.2 - 2.8 times more likely to be readmitted compared to newborns born to maternal patients without a documented substance use and/or mental health condition. This same newborn population are 1.65 - 2.22 times more likely to succumb to a mortality event compared to those newborns born to mothers without a documented mental health and/or substance use condition.

[2] https://www.acog.org/programs/perinatal-mental-health/patient-screening

[3] https://www.cnn.com/2023/06/22/health/maternal-deaths-hospital-complications

ii. What are the priority research questions and gaps related to maternal substance use disorder and/or mental health conditions that must be addressed to improve services and outcomes for individuals while pregnant and postpartum?

It will be important to consider the overlap (or coincidence of occurrence) of SUD and/or mental health needs with other social drivers of adverse outcomes (including personal safety/housing security/food security).

For example, based on a PINC AI analysis, we know that patients with a SUD diagnosis were more likely to live below the poverty line than those without SUD (e.g., 66.9 percent versus 40.8 percent of ED outpatients and 47.5 percent versus 21.4 percent of inpatients were on Medicaid or uninsured). While pregnant and post-partum patients face unique challenges, they would certainly be subject to the significant demographic disparities that exist for the general population.

iii. What is lacking and what is working to support maternal emotional health, and substance use and well-being during pregnancy and after?

Identifying patients with high risk of adverse outcomes and urgent needs for mental healthcare would be key for improving care. To improve care and outcomes, real-world evidence gained from observational database studies should be used to guide the educational/improvement programs in healthcare facilities.

Based on the risk factors identified from the retrospective analysis, a clinical decision support system can be integrated in the electronic medical record systems in healthcare facilities with high needs.

It is well documented[4] that perinatal mental health conditions are underrecognized and undertreated, which is reflected in the clinical setting by the lack of related coding and documentation. We cannot conduct real-world observational studies if this gap is not solved. The latest recommendations also emphasize screening for bipolar disorder before initiating pharmacotherapy for anxiety or depression – this is now a hard stop during the inpatient admission process and measurement for implementation is an opportunity.[5]

There is also a reluctance of care providers to identify patients with need for support services secondary to scarcity of resource availability. There is a scarcity of: mental health providers in most communities; inpatient units that support the active detoxification process of pregnant patients who choose this treatment during pregnancy; inpatient units that support the detoxification process of postpartum patients; and dual-trained perinatal care/psychiatry providers (obstetrician, family practice or mid-level nursing providers with training and licensure in psychiatry and/or addiction medicine).

Compounding these gaps are the limitations on insurance coverage of perinatal mood disorder/mental health counseling visits/treatment. Co-pays are often a financial burden for families that are now without the income of the pregnant/delivered person.

iv. What steps should be taken to ensure that approaches to detecting maternal emotional health issues and substance use challenges are culturally appropriate?

Premier's work with our hospital members has shown several approaches can be beneficial to discovering underlying issues:

[4] Perinatal mental health: a review of progress and challenges (nih.gov) and Treatment and Management of Mental Health Conditions During Pregnancy and Postpartum | ACOG
[5] Treatment and Management of Mental Health Conditions During Pregnancy and Postpartum | ACOG

- Incorporation of multicultural patients with lived experience
- Healthcare provider (all levels) education on impact of mental health and/or SUD on outcomes
- Implicit and explicit bias education
- Transition support after discharge for patient by community member with lived experience and training
- Training to address the stigma surrounding pharmacologic treatment for mental health and SUD conditions

v. What are key evidence-based intervention and treatment models that should be broadly implemented to address maternal mental health and substance use?

In general, retrospective studies should be conducted to identify gaps and risk factors using real-world data. The findings from retrospective studies could be used to inform interventions in health systems. Educational programs, clinical decision support alerts for those with high risks and coordination of follow-up care are some of the interventions that can be targeted to patients with highest unmet needs.

ACOG has specifically noted that "screening is insufficient and should occur within systems that promote progression down the full mental health pathway, including detection, assessment, triage and referral, treatment access and initiation, symptom monitoring, and measurement-guided treatment adjustments until symptoms remit." [6]

IV. CONCLUSION

In closing, Premier appreciates the opportunity to submit comments regarding the policies, effectiveness, promising practices, and limitations related to prevention and treatment of maternal mental health conditions and substance use disorders. Premier looks forward to continuing our work in this space and collaborating with the Substance Abuse and Mental Health Services Administration in addressing the critical issue of maternal mental health.

If you have any questions regarding our comments, or if Premier can further serve as a resource to the Agency, please do not hesitate to reach out to me at soumi_saha@premierinc.com.

Sincerely,

Soumi Saha, PharmD, JD
Senior Vice President of Government Affairs
Premier Inc.

[6] ACOG Practice Guideline Number 4, June 2023