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Preconception Care:

Achieving Healthy Communities

HANI ATRASH: Good afternoon, and thank you very much for this opportunity to speak to you about preconception health and healthcare. Actually, we do preconception care, but it's, we always consistently now refer to it as preconception health and healthcare. Just as a context, as a background, could you tell me, raise your hand, if you have seen or read the recommendations on preconception health and healthcare? Oh, that's great, so I don't need to worry about details. Now this is going to be brief.

Well, let me start by saying that I'm here speaking to you on behalf of the over 200 individuals, including many of you in the room, who have helped develop and carry forward this initiative on preconception health and healthcare, that we, as I said in the morning, we simply coordinate and just make sure it keeps going. We have a steering committee, with representatives from CDC, March of Dimes, HRSA, MCHB, ACOG, AMCHP, CityMatCH, and Kay Johnson, is our consultant, has been with us for three years now. I just realized, six members of the Steering Committee are in the room. Sam Posner, Nan Streeter, Allison Johnson, Kay Johnson, Marybeth Bedura. Mike Depeck was supposed to be here. Janice Dielman Magdas cannot make it. She was in a car accident. But she's doing very

well today. The Select Panel represents about 35 national organizations, public, private, federal government state organizations, clinical public practice and so on. These are the group who met in 2005 for two days and developed the recommendations that you saw in that were published. And they continue to be our advisory group, and we consult with them, meet with them on the phone every few months. In fact, we have an in-person meeting in May. They would review all the products that come out of the preconception care initiative.

CDC (inaudible) workgroup represents 22 programs around CDC, ranging from HIV to injury, to violence, obesity, diabetes. Every program dealing with women of reproductive age. About 84 members, and when we have a meeting, I always say we range from 10 to 84 people showing up for the meeting. And then there were groups that met in June of 2006 to basically take the recommendations from theory to practice. Eighty-nine people met in three umbrellas of clinical public health and consumer workgroups to develop strategies for implementing the recommendations. Most of the members of those workgroups were actual practitioners, physicians, obstetricians, pediatricians, primary physicians, nurses, and so on. Public health workers, state and local health departments and community workers. We basically wanted to be concrete and make sure that whatever is developed is realistic and makes sense, and not just theoretical. So thanks to all those people, and there's more to come, as you just heard. The fifth workgroup, or the fourth workgroup on policy and finance will happen this Friday in DC and Kate will tell you about it.

This is what I call my bottom-line slide. Why preconception care? There are five main reasons. First, full pregnancy outcomes continue to be at an unacceptable level in our country. We know that low birth weight continues to be high. Preterm delivery, 12.3% low birth weight, 7.9%, 3.3% of babies are born with a major birth defect. The estimate is about five to 7% having any birth defect. Complications of pregnancy for women, about 30% of women have complications in pregnancy. More than 29% now have C-sections. I think it's okay to have a C-section, but I'm sure some of those women have C-sections because there was some trouble with their pregnancy. The worst news is that as you know, in many of those conditions, we're actually getting worse. There has been, since 1980, an increase of pre-term births by 26%, 14.7% increase in low birth weight, and 3.2% increase in maternal mortality. And when we look at our ranking among the 35 developed countries in the world, we were 11th in 1960, we were 23rd in 1980, and now we are 28th. That's really not progress. What this means is that other countries have made faster progress than we have. However (inaudible) did decrease by about 45%, but apparently not as fast as other countries have. We also know that a good proportion of women enter pregnancy with risks for adverse pregnancy outcome. And we know that pregnant women also have a high proportion of those who have high risk for at risk of pregnancy outcomes. Over 10% smoke or drink alcohol, about 4% have chronic conditions, and so on and so in many of them, 70% do not take folic acid to reduce the risk of (inaudible) defects. We currently intervened too late. We have really done an

outstanding job between the mid-'80s and now of getting women into early prenatal care. We have now up to 85% of women getting early prenatal care. However, the average decision age of entering prenatal care is 11 weeks. We know that by 11 weeks, all of the fetal organs have been formed, and therefore, any preventive measure you want to take to reduce the risk of the defects, it's too late to do that. So early prenatal care is good, it's important, but it is too late to intervene. And we know that most, or many, or practically all professional organizations have recommended intervening before pregnancy to improve pregnancy outcome. And there is consensus around the country that preconception care is needed and will be helpful to improve pregnancy outcomes.

I have seen this saying, I think about a month ago, somebody showed this, that if you continue to do what you always did, you will continue to get what you always got. I went back to Google, and there were thousands of references to this saying, but nobody knew who started it, (inaudible) and none of us all the time. But this is reality. I mean, we've been doing the same thing for over 30 years. We did some new things, like there were some discoveries that were introduced, but practically, I think with early prenatal care, analyzing data on low birth weight and pre-term delivery, to try to find a new magic answer why we have pre-term delivery, low birth weight, and so on and so forth, and, you know, it's, actually where not even getting what we always got, we are getting worse. We're getting more pre-term deliveries, more low birth weights. And so we need to do

something different. I think, and we think as a group, that it's time for us to go beyond anticipation and management. I train in obstetrics. I know prenatal care is good. And you know that prenatal care is about monitoring, observing closely a woman during her pregnancy, and at the first sign of anything happening, you intervene and control, manage the conditions. I think we need to go beyond that into health promotion and prevention. We need to start before pregnancy, and control those conditions before they become worse, and introduce preventive measures, like a folic acid and controlling weight and diabetes and chronic conditions and so on before the pregnancy happens. So it's about health promotion and prevention. It's about women's health and affect. So healthy women, healthy mothers, healthy babies. Healthy mothers and healthy babies has worked for a very long time and we really love it. We like it, it's a great model, it's a great concept. But better yet is extending that beyond healthy mothers and healthy babies to say healthy women, healthy mothers, healthy babies. Healthy mothers don't really just appear. They start somewhere. They start as a healthy mother, a healthy woman, and then you become a healthy mother.

There is scientific evidence that preconception care works. We did an extensive review of the literature and identified 14 interventions that individually are effective in improving pregnancy outcome. They are all listed in the recommendations, such as folic acid and alcohol cessation and tobacco cessation, and hepatitis immunization and obesity management and (inaudible) disease and so on and so forth. I'm not going to talk about them except to say

that there were three criteria that were required to meet that, to qualify for those conditions. One is those interventions have solid scientific evidence for being effective and improving pregnancy outcome. Two, those interventions had to be implemented before pregnancy or on early pregnancy to qualify. And three, those interventions must have existing clinical practice guidelines that people could know how to implement them. In addition to those 12 or 14 individual interventions, their analysis at the population level indicates that at the population level there is also evidence that preconception care of a woman's health before pregnancy does contribute, or is essential to improve pregnancy outcomes.

There were three articles published from New York City, Tulsa, and Kansas City, based on the perinatal periods of risk, and ever since then, many of you are familiar with, sponsored by CityMatCH, that indicated that interventions to reviews, frequent infant mortality should include preconception care and improvements in women's health. Lately, or recently, CityMatCH also did a national analysis from national data and concluded that preventive action must address maternal health prior to conception and early in pregnancy, to mostly reduce the black/white gap in fetal infant mortality, but also to improve pregnancy outcome, or reduce fetal death and infant death. As I mentioned, there is consensus. Margaret Freeda, I think, analyze reports and data from, reports from meetings in the United States, publications from organizations and so on. And we know that organizations, including March of Dimes, ACOG, (inaudible), Public Health Service, Healthy People 2000 endorse and recommend preconception care. In fact, Healthy People 2000 included an objective to increase the

proportion of women delivering babies in the United States who received preconception care to 70% by the year 2000. Unfortunately, that objective does not exist in 2010. And when we asked about why, they said nobody was counting, nobody was monitoring. And to me, if you think it's a really important, if nobody is counting, then start counting. Don't just remove that objective.

Anyway, it's not a new concept. This is something we found in the literature that goes back as far as 350 B.C., when Aristotle in his *Problemata* warned that foolish, drunken, or hair-brained women often, most often bring four children, like unto themselves. He's talking about 2000 years ago, people knew that if you're a healthy woman, you get a healthy baby. If you're not a healthy woman, the likelihood of having an unhealthy baby is reality. So, so, and also, things are happening. Even though it may not be really that formal, that standard of care, lots of us, many of you are doing it. You may not call it preconception inter-conception care, but you're doing it anyway. In fact, despite the fact that there are no uniform guidelines for preconception care, no billing codes, and no reimbursement, many states and many providers are interested and are performing it. Sherri Bolay in our center recently analyzed data from the Web based Title V information system for the 2005/2010 Needs Assessment Cycle. She identified 23 states who reported priority needs focusing on preconception health and preconception care. They literally said preconception health is a priority for us. If you look at performance measures associated with preconception health, such as, we want to promote folic acid, or we want to work

on (inaudible) cessation pregnancy, the number went up to 42. So there are at least 42 states who are currently interested and focusing on improving preconception health in order to improve the pregnancy outcome.

There is a very high level of awareness among providers, among health departments, among communities. A recent survey by Keith Frye of a 500 women who are presenting the primary care practice found that 98.6% of those women were aware of the need to optimize their health before pregnancy in order to improve their pregnancy outcome. 94% of them said we prefer to get that service from our provider, from clinical care providers. We know that that is not happening, unfortunately. Almost 40% of them said that they do not recall their physicians talking about that subject at all. Nobody told them that if you're planning to get pregnant, you better worry about making sure you're healthy and take some measures.

A recent survey of our March of Dimes of 1200 obstetricians, physicians, nurse practitioners, and so on, people caring for pregnant women found that only 25% of providers who provide prenatal care, provided preconception care and counseling to the same women to whom they provide prenatal care. So, people know it, but not much is happening in terms of implementation. So why did we start the CDC Preconception Health and Healthcare Initiative? We realize, as you just heard, that there are opportunities that are missed. In fact to me, not providing preconception care and counseling and ensuring preconception health

before pregnancy is a missed opportunity, and we need to do something about it. They also realize since everybody has been talking about it for 30 years and it's not happened, that we need to do something differently. We needed new strategies. We need to do something different than just say obstetricians should provide the service. A woman should know better to take folic acid or whatever. We needed to develop standard recommendations that everybody agrees with and supports. We also needed to identify and address obstacles and opportunities in many areas, not just clinical or public health, or consumer, but also policy and finance and research and surveillance and monitoring, and cover all bases. Make sure that if you tell, recommend to clinicians to provide preconception services, that somebody will pay for it, that there is a billing code, that there are standards, there are guidelines to deliver those services, and that there are assessment tools to identify needs for women getting those services.

As I said in the morning, we are working with a wide range of partners and providers. We started three years ago within CDC. We then met with the non MCH community, AMCHP, CityMatCH, HRSA, and others. We started getting calls from around the country from other organizations saying, "We want to work with you." We're very fortunate actually. We don't have any opposition yet. I confess when we publish recommendations, we got 24 emails from some group, some women actually saying, this is pronatalist, we don't like it. There was a report in the Washington Post that said forever pregnant people don't like to think of themselves as vessels, and that was not the idea, actually. If you read the

recommendations, you know it was not the idea. And the answer to that is, you know, there are 82 million women in this country of reproductive age. Or, 62 to 82 million women. So we get 24 emails. There may have been 50, but that's still less than one in a million. And, you know, that's still okay. (laughter) I think it's still something that's popular, people like to support it, it is about women's health. It is about also improving pregnancy outcomes in the process. Why not?

And, you know, we listed all those partners down there anyway. What have we done so far? We had a summit in 2005, June. Actually, that was recommended by our partners. They said, "Let's convene and see what's happening." We planned for a summit of 70 people, 425 people showed up. We had to use over four hotels. Within, you know, following the summit, we had a select panel meeting, developed the recommendations, and then we had a supplement of the MCH journal, that was published a couple months ago, actually four months ago. The supplement includes 33 articles on all aspects of preconception care. There are subject articles on diabetes and ART and family planning and everything else. And there are articles that deal with genetic issues of policy finance, guidelines, and so on, so forth. All those articles, actually, we are thankful to the journal. They made those articles available for free downloading online. If you go to the CDC Website, and search for preconception, you should be able to get all of those. Or let me know, I'll give you the Website.

We also established a speakers bureau, we have 35 experts from around the country who enlisted and are willing to come and speak at your meetings or provide counsel and advice and March of Dimes had offered to support their travel to come and help you. You don't have to worry about getting them to your place. We are sponsoring evaluation and trying to earn five best practices with the working with Grady Memorial Hospital Inter-conception Care Program and (inaudible) Project in Jacksonville. And we have those three workgroups I mentioned it to you. We do continue to provide technical assistance to programs around the country.

I'm trying to rush through this. The recommendations were developed a long a framework that's like a pyramid. We started with developing guidelines, guiding principles, and these are all spelled out in the recommendation. I'd be glad to talk to them about them, if we need to. We had the vision, they had four goals, including a goal about eliminating how disparities in pregnancy outcomes, recommendations, and action steps that were published and recently, strategies for implementation. The strategies for implementation, the meeting, from proceedings from the meeting in June, actually, the report is ready, about to go out for a final review, will be placed online hopefully within three or four weeks. Helene Kent, who is also in the audience, helped with synthesizing those. It's not easy to have discussions of 90 people for two days, put in 20 pages, believe me. But, thanks to Helene and Kay, we got lots of help getting those things together. So look for those strategies soon. Recommendations, Dr. Collins mentioned

those in the morning. And I'm going to just go through them very quickly.

Recommendations range from individual responsibility across the lifespan. We wanted to make sure that consumers take responsibility for their own health and take action and be informed and be aware. Consumer awareness. A second recommendation, we want to make sure that we can, we sponsor and support preventive visits for women and couples, and during those preventive visits, if intervention is needed, those interventions are supported. You don't just provide preventive services, identify risks, and don't act on them.

And we wanted special attention given to inter-conception care for women who have adverse pregnancy outcomes. Recommendation number six deals with pre-pregnancy checkups. We want to allow for couples and women who planned their pregnancy to be able to go and see their provider for a pre-pregnancy counseling session. Health coverage for a low-income women, public health programs and strategies, we're talking about integrating preconception care into existing public health programs. I'd just like to remark here that we are not trying to promote a new vertical program. What we're talking about is integrating preconception messages, counseling services, into existing programs, so if a woman comes to see you for a family planning visit, you also talk to her about alcohol and smoking and healthy weight and those messages that are important to improving her health and the health of her baby if she were to get pregnant. Of course, if a couple is planning pregnancy and they would like to have a special visit for preconception counseling, I think that's also important. But it's all about

integrating services and comprehensive women's healthcare. The research of course, to further identify the most effective approaches, and basically show and prove that there is a link between better health before pregnancy and better pregnancy outcomes. And of course, monitoring improvements, and to try to show, you know, what works best, and monitor how practices are changing and how outcomes are changing. I did mention the workgroups. The purpose of the workgroups or the goals are to change consumer clinician and public health professionals, knowledge, attitudes, and practices of preconception care. It's not enough to just educate providers and consumers. We want to make sure that attitudes tell us those issues as well as their practices have changed. And there is a model that we have been following over developing those activities.

So, out of the workgroup meetings, we got strategies that were developed and synthesized into eight different groups of strategies, falling under information sharing guidelines, professional education, monitoring and surveillance, health practice, health, services research, demonstration projects, learning collaboratives, and stakeholders' correlations. I'm not going to go through all of those. So, just to mention a few, under information sharing, I mentioned the supplement and many articles that have been published, we've been giving presentations all over the country at state and local meetings and so on. The Websites of CDC and March of Dimes were revised to be much more friendly, consumer friendly so you could visit either March of Dimes or CDC and get as much information as you want about preconception care. Our clinical public

health and consumer workgroups in June continued to work on their own. Actually, this is mostly volunteer work. They meet on the phone, they communicate by e-mail. We are currently developing clinical care practice guidelines for preconception care. Brian, Jack, (inaudible), and several, Michelle (inaudible) from Eckerd, are developing a new uniform set of clinical practice guidelines. They will have a draft ready for the meeting in May. They also, along with the consumer workgroup, developing an assessment tool for consumers, it will be self delivered and for providers, it's, you know, it's a clinical assessment as well as consumer assessment tool. I'm going to skip, but you could ask me about those if you want. We realize that what we can do at the federal level is not necessarily what we expect the states to do at the state level. So we have implementation strategies for the state level. For example, at information sharing, we would recommend that states convene statewide meetings, disseminate information, educate providers, consumers, and the media, and the public. The guidelines will include disseminating guidelines, and reviewing existing screening tools and maybe developing ones that are developed at the national level. Stakeholders and coalitions, creating advisory committees, or groups, and building working groups across the agencies. At the local level, similar activities as that at the state level, but maybe a little, you know, modified differently. Don't expect the same thing to happen.

This is my last slide. We think that immediate, what we refer to as low hanging fruit opportunities for federal and state governments include things like increasing

health coverage for low-income women of childbearing age through Medicaid policy changes and waivers. In fact, that's one of the main things we're focusing on. We think it shouldn't be really impossible to extend or expand coverage for a woman from six weeks after delivery to one year after delivery. And that will target the highest risk population. As a first step, we're actually working with Medicaid. They will be attending our policy meeting on Friday. Continuing to increase support for community health centers and other federally qualified health centers and medically underserved communities and giving greater attention to financing for health promotion and prevention programs, particularly programs such as Title X, Title V, which focus on services to women of childbearing age.

And finally, I just want to give some reference to the flyer that you see in front of you. We're working with the California Council on Preconception care on planning the Second Summit on Preconception Care. The reason you don't have a date there is we're still having difficulty finding a hotel to accommodate the expected 500 participants. The summit is generously supported as well by MCHB. In fact, MCHB is very actively involved with this. Marybeth Bedura and the Healthy Start group are involved with this activity and are supporting the Summit, and the California Department of Health is also a very active partner in this activity. So, watch out for further announcements, start working on your abstracts, preparing them, because the call for abstracts hopefully will come up

within the coming couple of weeks. I will hope to see you in San Francisco,
maybe somewhere else. Thank you.