A Strategic Plan for Improving Preconception Health and Health Care: Recommendations from the CDC Select Panel on Preconception Care

Presentation by
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<table>
<thead>
<tr>
<th>Adverse Pregnancy Outcomes Continue to be Higher Than Acceptable</th>
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<tbody>
<tr>
<td><strong>Major birth defects</strong></td>
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<tr>
<td><strong>Fetal Alcohol Syndrome</strong></td>
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<td><strong>Low Birth Weight</strong></td>
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<td><strong>Preterm Delivery</strong></td>
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<td><strong>Complications of pregnancy</strong></td>
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<td><strong>C-section</strong></td>
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<td><strong>Unintended pregnancies</strong></td>
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<td><strong>Unintended births</strong></td>
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The leading causes of infant death have changed over the years. In 1960, the infant mortality rate (IMR) was 26.0, with 110,873 infant deaths. The leading causes were:

- Congenital Anomalies: 20.1%
- Asphyxia/Atelactasis: 12.1%
- LBW/PTD: 11%
- RDS: 8%
- SIDS: 3.5%

In 1980, the IMR was 12.6, with 45,526 infant deaths. The leading causes were:

- Congenital Anomalies: 20.3%
- LBW/PTD: 12.1%
- SIDS: 11%
- RDS: 8%
- Unintentional Injury: 3.5%

In 2002, the IMR was 7.0, with 28,034 infant deaths. The leading causes were:

- LBW/PTD: 20.3%
- SIDS: 11%
- Unintentional Injury: 8%
- Congenital Anomalies: 3.5%

These trends show a decrease in the IMR and a shift in the leading causes of infant death.
## Prevalence of Risk Factors

<table>
<thead>
<tr>
<th>Pregnant or gave birth</th>
<th>Risk Factor</th>
<th>Prevalence</th>
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<tbody>
<tr>
<td></td>
<td>Smoked during pregnancy</td>
<td>11.0%</td>
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<td></td>
<td>Consumed alcohol in pregnancy (55% at risk of pregnancy)</td>
<td>10.1%</td>
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<td></td>
<td>Had preexisting medical conditions</td>
<td>4.1%</td>
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<td></td>
<td>Rubella seronegative</td>
<td>7.1%</td>
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<td></td>
<td>HIV/AIDS</td>
<td>0.2%</td>
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<td></td>
<td>Received inadequate prenatal Care</td>
<td>15.9%</td>
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<tr>
<td>At risk of getting pregnant</td>
<td>Cardiac Disease</td>
<td>3%</td>
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<td></td>
<td>Hypertension</td>
<td>3%</td>
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<td></td>
<td>Asthma</td>
<td>6%</td>
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<td></td>
<td>Dental caries or oral disease (women 20-39)</td>
<td>&gt;80%</td>
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<td></td>
<td>Diabetic</td>
<td>9%</td>
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<td></td>
<td>On teratogenic drugs</td>
<td>2.6%</td>
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<td></td>
<td>Overweight or Obese</td>
<td>50%</td>
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<td></td>
<td>Not taking Folic Acid</td>
<td>69.0%</td>
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</table>
What Have We Done?

- CDC Internal Workgroup (2004)
- 1st National Summit (June 2005)
- Select Panel Meeting (June 2005)
- Recommendations (April 2006)
- Supplement (September 2006)
- Workgroups to guide implementation
  - Clinical, Public Health, and Consumer Workgroups (June 2006)
  - Policy and Finance Workgroup (May 2007)
- 2nd National Summit (October 2007)
Themes / Areas for Action

- Social marketing and health promotion for consumers
- Clinical practice
- Public health and community action
- Public policy and finance
- Data and research
Focus of the Recommendations

1. Individual responsibility across the lifespan
2. Consumer awareness
3. Preventive visits
4. Interventions for identified risks
5. Interconception care
6. Prepregnancy checkup
7. Health insurance coverage for women with low incomes
8. Public health programs and strategies
9. Research, and
10. Monitoring improvements
Recommendations for Improving Preconception Health:

Individual Responsibility & Awareness

- **Recommendation 1. Individual responsibility across the life span.** Encourage each woman and every couple to have a reproductive life plan.

- **Recommendation 2. Consumer awareness.** Increase public awareness of the importance of preconception health behaviors and increase individuals’ use of preconception care services using information and tools appropriate across varying age, literacy, health literacy, and cultural/linguistic contexts.
Recommendation 3. Preventive visits. As a part of primary care visits, provide risk assessment and counseling to all women of childbearing age to reduce risks related to the outcomes of pregnancy.

Recommendation 4. Interventions for identified risks. Increase the proportion of women who receive interventions as follow up to preconception risk screening, focusing on high priority interventions.
Percent Eligible Patients Receiving Preconception Care by Type of Provider (2002-2003)

- CNM: 17%
- OB/GYN: 20%
- F/GP: 21%
- Other non-MD: 26%
The Importance of Preconception Care in the Continuum of Women’s Health Care

ABSTRACT: The goal of preconception care is to reduce the risk of adverse health effects for the woman, fetus, or neonate by optimizing the woman’s health and knowledge before planning and conceiving a pregnancy. Because reproductive capacity spans almost four decades for most women, optimizing women’s health before and between pregnancies is an ongoing process that requires access to and the full participation of all segments of the health care system.
Core Components of PCC

1. Screening / assessment
2. Counseling / health education and promotion
3. Interventions / treatment
Screening, Counseling, & Brief Intervention

**Assessment & Screening**
- Medical & reproductive history;
- Genetic & family history;
- Environmental & occupational exposures; Family planning and pregnancy spacing;
- Nutrition, folic acid intake, and weight management;
- Medications; Substance use (alcohol, tobacco and illicit drugs); Infectious diseases;
- Psycho-social (e.g., depression, domestic violence, housing)

**Health Promotion & Counseling**
- Healthy weight; Nutrition;
- Preventing STD & HIV infection; Family planning methods, Abstaining from tobacco, alcohol, and illicit drug use before and during pregnancy;
- Consuming folic acid; Controlling pre-existing medical conditions (e.g., diabetes); Risks from prescription drugs; Genetic conditions

**Brief Interventions**
- e.g.
- Immunization
- Smoking cessation
- Alcohol misuse
- Weight management
- Family planning
- Folic acid
Counseling/Education Provided to Females During Office Visits, 2002

Source: CDC-NCHS, National Ambulatory Medical Care Survey; Women’s Health USA 2005

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Recommendation 5. Interconception care.
Use the interconception period to provide intensive interventions to women who have had a prior pregnancy ending in adverse outcome (e.g., infant death, low birthweight or preterm birth).
Medicaid Family Planning (1115) Waivers, By State, As of February 2007

Recommendation 6. Pre-pregnancy check ups. Offer, as a component of maternity care, one pre-pregnancy visit for couples planning pregnancy.
Recommendation 7. Health coverage for low-income women. Increase Medicaid coverage among low-income women to improve access to preventive women’s health, preconception, and interconception care.
Women 18-64 Who are at Greater Risk for Being Uninsured, US, 2005


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Recommendation 8. Public health programs and strategies. Infuse and integrate components of preconception health into existing local public health and related programs, including emphasis on those with prior adverse outcomes.
State Title V Priority Needs focused on Preconception Health and Health Care, 2005


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RESULTS from a Quality Improvement Initiative using HEDIS measures and mixed strategies
Postpartum Contraceptive Use, 19 States (PRAMS), 2000

*Postpartum contraceptive use is defined as using any of the following birth control methods at time of survey: tubal ligation, vasectomy, pill, condoms, foam, intrauterine device, Norplant®, Depo-Provera®, or rhythm.
†Data do not include New York City.
Opportunities for State Legislators

- Request information on your state’s public health / family health agencies priorities and consider additional funding for preconception health efforts (Florida)
- Introduce legislation that focuses on the highest risk women (California)
- Urge state Medicaid to apply for family planning waiver from Centers for Medicare and Medicaid Services (DHHS)
- Encourage coverage in state employee benefit plans and workplace health promotion (Washington State)
- Review postpartum visit rates for Medicaid managed care plans (Colorado)
- Examine your state’s PRAMS findings.