

## POLICY AND FINANCE FOR PRECONCEPTION CARE Opportunities for Today and the Future

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**This special supplement of *Women's Health Issues* offers 2 types of articles related to the policy and finance context for improving preconception health and health care. These articles discuss the impact of finance and policy on preconception health and health care, as well as the strategies that are being used to overcome the challenge of implementing preconception care with limited resources and inadequate health coverage for women. Invited papers from authors with expertise in health policy and finance issues describe how women's health and preconception care fit into the larger debates on health reform and how the paradigm for women's health must change. Other invited papers discuss opportunities and challenges for using programs such as Medicaid, Title X Family Planning, Title V Maternal and Child Health Services Block Grant, Healthy Start, and Community Health Centers in improving preconception health and health care. Contributed articles on health services research in this supplement characterize the types of change occurring across the country. This paper also presents a framework for understanding the role of policy and finance in the larger Centers for Disease Control and Prevention Preconception Health and Health Care Initiative.**

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**T**his special supplement of *Women's Health Issues* offers 2 types of articles related to the policy and finance context for improving preconception health and health care, including a discussion of the impact of finance and policy on preconception health and health care and the strategies being used to overcome the challenge of implementing preconception care with limited resources and inadequate health coverage. First, we invited papers from a group of authors with expertise in health policy and finance issues for women, children, and families, many with particular expertise in programs such as Medicaid, Title X Family Planning, Title V Maternal and Child Health Services Block Grant, Healthy Start, and Community Health

Centers. Their papers highlight the potential role of these programs in improving preconception health and health care at the state and local levels, as well as opportunities and challenges. Second, health services and policy researchers submitted articles which characterize the types of change occurring across the country. These articles, for example, highlight how 1 state is changing policy, augmenting funds, developing new partnerships, using epidemiologic data, and conducting evaluation related to preconception health. Other submitted health services research articles offer approaches to understanding the impact of policies, programs, and services on preconception health and health care.

As defined by the Centers for Disease Control and Prevention (CDC) Select Panel on Preconception Care, preconception health and health care efforts include an array of services and supports before and between pregnancies. Preconception care aims to promote the health of women before conception and thereby improve pregnancy-related outcomes. Thus, the goal is to improve a woman's health before she conceives a baby, whether it is before a first or a subsequent

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pregnancy. Some efforts aim to encourage women and men to plan for childbearing. Others are designed to provide screening and health promotion as a part of well woman visits from menarche to menopause. Still other efforts are contained in the subset of services known as interconception care, typically delivered in the 18–24 months after a pregnancy.

Improving preconception health among the >62 million women of childbearing age (15–44 years) will require a multistrategic, action-oriented initiative. Changes in public policy and health care financing, particularly health coverage and benefits, are essential for improving preconception health and health care. The 10 recommendations of the CDC/ATSDR Select Panel on Preconception Care (CDC, 2006) recognized the importance of policy and finance changes to improving preconception health and health care. Specifically, the strategies defined under recommendations 3, 4, 5, 7, 8, and 10 call for changes in the structure of public health programs or health care financing (Table 1). The articles in this supplement touch on all of these strategies and describe additional policy and finance changes that will be required to implement the recommendations.

It is clear that policy and finance changes are critical to implementation of these recommendations and achievement of the associated goals. Notably, recommendations for improving preconception health issued between 1989 and 1995 never advanced, in part owing to policy and finance constraints (Jack & Culpepper, 1990; Moos, 2004).

Between 2006 and 2007, the CDC Preconception Health and Health Care Initiative convened the Clinical, Consumer, Public Health, and Policy and Finance Work Groups to accelerate implementation of the recommendations. These work groups have engaged experts and practitioners in projects, studies, and action. For example, the Clinical Work Group has assembled and published the evidence that supports and defines the content of preconception care (Jack, Atrash, Bickmore, & Johnson, 2008). The Public Health Work Group recently completed a pilot public health practice collaborative involving 3 cities (Thompson, Peck, & Brandert, 2008). The interactive and cross-cutting nature of this work is illustrated in Figure 1. If policy and finance changes do not occur, the capacity for change in clinical care, in public health, and in consumer behavior will be seriously constrained.

### Changing the Paradigm

The CDC Select Panel set out goals and strategic directions for improving preconception health and health care. In an editorial, Howse discusses areas where progress has and has not been made. Lack of access to care, particularly for women without health coverage or in medically underserved areas, is a significant bar-

rier. In 2007, 20% of women of childbearing age (ages 18–44) were uninsured (US Census Bureau, 2008). Likewise, too little progress has been made in reducing risks indicated by a previous adverse pregnancy outcome or reducing disparities (goals 3 and 4). Although we have made headway in improving the health of women during pregnancy, we must continue to accelerate and translate our understanding of evidence-based practices to improve the health of women of childbearing age overall. She emphasizes that improvements in maternal health, preterm birth, birth defects, and developmental disabilities will require policy initiatives that promote and financially provide for preconception care, both in public and private coverage.

Wise discusses the need to transform concerns about birth outcomes into a commitment to women's health. He stresses that the construct of preconception care, although helpful in underscoring the continuity of risk that can ultimately find expression in adverse birth outcomes, has the potential to undermine rather than strengthen a comprehensive system of women's health care. As documented here and elsewhere, the science of poor birth outcomes has been characterized by studies designed to identify singular risk associations, or "risk factors," such as teenage pregnancy, maternal illicit drug use, or the lack of prenatal care. Yet the vast majority of neonatal deaths occur among women in their 20s and early 30s, who do not use illicit drugs, and who receive some prenatal care.

The portrayal of adverse birth outcomes as the product of a series of relatively rare, largely behavioral, risk factors has created a deeply fragmented epidemiology and a failure to attend to health and related factors that affect much larger groups of women throughout the lifespan. This paper and others published in this supplement show how narrow perspectives have generated a fragmented array of policies, programs, and constituencies all joined in the common goal of improving birth outcomes but all insulated from one another. Wise concludes that "preconception, prenatal, and interconception care must be extended even further and ultimately transformed into components, albeit important components, of women's health care over a lifetime."

Projecting the future of preconception care through a clinical practice lens, Jack et al discuss the need for a fundamental shift toward well woman care and preventive visits that include health promotion, risk assessment, and counseling within primary care. Building on the work of the Clinical Workgroup of the CDC initiative, the clinical content of preconception care and barriers to providing such care are described. The authors call for a new model of care that emphasizes a primary care medical home that accepts responsibility for delivering more prevention services, including more consistent screening and use of new information technology tools such as electronic medical

**Table 1.** Health Policy- and Finance-Related Recommendations for Improving Preconception Health and Health Care

Recommendation	Implementation
<i>Preventive visits.</i> As a part of primary care visits, provide risk assessment and educational and health promotion counseling to all women of childbearing age to reduce reproductive risks and improve pregnancy outcomes.	Use the federally funded collaboratives for community health centers and other Federally Qualified Health Centers (FQHC) to improve the quality of preconception risk assessment, health promotion, and interventions provided through primary care. Develop fiscal incentives for screening and health promotion.
<i>Interventions for identified risks.</i> Increase the proportion of women who receive interventions as follow-up to preconception risk screening, focusing on high-priority interventions (i.e., those with evidence of effectiveness and greatest potential impact).	Develop fiscal incentives (e.g., pay for performance) for risk management, particularly in managed care settings.
<i>Interconception care.</i> Use the interconception period to provide additional intensive interventions to women who have had a previous pregnancy that ended in an adverse outcome (i.e., infant death, fetal loss, birth defects, low birthweight, or preterm birth).	Use existing public health programs serving women in the postpartum period to provide or link to interventions (e.g., family planning, home visiting, and the Special Supplemental Nutrition Program for Women, Infants, and Children). Encourage additional states to develop preconception health improvement projects with funds from the Title V Maternal Child Health Block Grant, Prevention Block Grant, and similar public health programs.
<i>Prepregnancy checkup.</i> Offer, as a component of maternity care, 1 prepregnancy visit for couples and persons planning pregnancy	Modify third-party payer rules to permit payment for 1 prepregnancy visit per pregnancy, including development of billing and payment mechanisms.
<i>Health insurance coverage for women with low incomes.</i> Increase public and private health insurance coverage for women with low incomes to improve access to preventive women's health and preconception and interconception care.	Improve the design of family planning waivers by permitting states (by federal waiver or by creating a new state option) to offer interconception risk assessment, counseling, and interventions along with family planning services. Such policy developments would create new opportunities to finance interconception care. Increase health coverage among women who have low incomes and are of childbearing age by using federal options and waivers under public and private health insurance systems and the State Children's Health Insurance Program. Increase access to health care services through policies and reimbursement levels for public and private health insurance systems to include a full range of clinicians who care for women.
<i>Public health programs and strategies.</i> Integrate components of preconception health into existing local public health and related programs, including emphasis on interconception interventions for women with previous adverse outcomes.	Use federal and state agency support to encourage more integrated preconception health practices in clinics and programs. Provide support for CDC programs to develop, evaluate, and disseminate integrated approaches to promote preconception health. Analyze and evaluate the preconception care activities used under the federal Healthy Start program, and support replication projects.
<i>Monitoring improvements.</i> Maximize public health surveillance and related research mechanisms to monitor preconception health.	Expand data systems and surveys (e.g., the Pregnancy Risk Assessment and Monitoring System and the National Survey of Family Growth) to monitor individual experiences related to preconception care. Include preconception, interconception, and health status measures in population-based performance monitoring systems (e.g., in national and state Title V programs). Develop and implement indicator quality improvement measures for all aspects of preconception care. For example, use the Health Employer Data and Information Set (HEDIS) measures to monitor the percentage of women who complete preconception care and postpartum visits or pay for performance measures.

records and virtual patient advocates. Such a new model of care also would assist with coordination of specialty and social support services. Application of the patient-centered medical home model—a partnership approach between patients and providers to

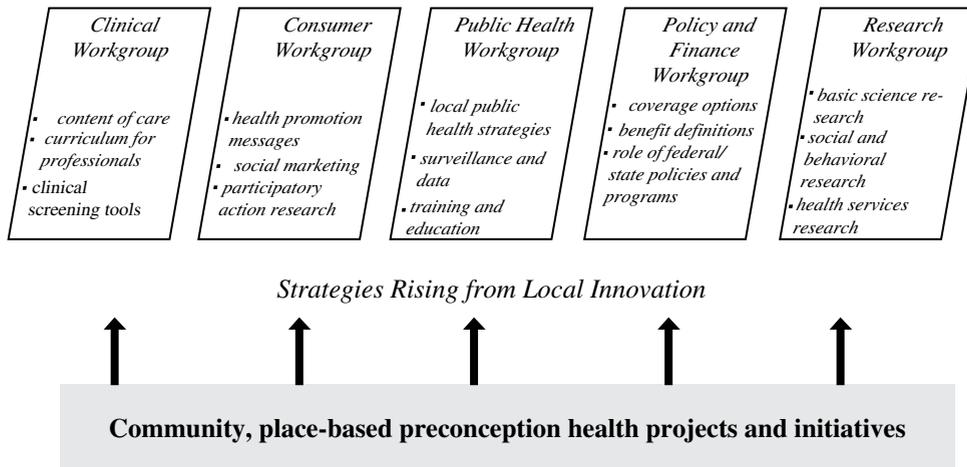
provide primary health care that is accessible, patient-centered, coordinated, comprehensive, continuous, and culturally appropriate—could be the means to fundamental change in the way primary care is structured, delivered, and financed, leading to

## National Initiative to Improve Preconception Health and Health Care CDC Preconception Health Program

### Leadership

CDC Internal Working Group, Select Panel, Steering Committee,  
National Organization Partners

### Workgroup Concepts and Products



**Figure 1.** National Initiative to Improve Preconception Health and Health Care: CDC Preconception Health Program leadership, CDC Internal Working Group, Select Panel, Steering Committee, and National Organization Partners.

a more efficient and cost-effective health care system. For women's health, such a paradigm shift is called for.

### Improving Health Coverage for Women of Childbearing Age

In her article on "Women and Health Insurance: Implications for Financing Preconception Health," Rosebaum provides a framework for thinking about health coverage to improve preconception care and how the concept fits into larger health reform debates. She examines health insurance coverage among women of reproductive age and considers how national health insurance reform may affect access to high-quality, timely, and affordable preconception and interconception care. The underlying assumption of this article is that preconception and interconception care can serve as bellwethers of the extent to which health reform achieves preventive results, that is, coverage reforms that not only put acute treatments within financial reach, but that also help to finance interventions that can help to achieve population-wide preventive results, in this case, long-term improvement in the health of both women and children. The author concludes that whether or not the preconception health of women becomes a specific goal of reform depends in great measure on the extent to which thought leaders and reform stakeholders perceive women's health as a central aim of reform.

Rosenbaum also proposes a taxonomy for thinking about health insurance reform in the context of health

and health care generally, and preconception and interconception health care in particular. Applied to a health insurance discussion, the Recommendations to Improve Preconception Health and Health Care (CDC, 2006) essentially call for 3 major reforms in the design of coverage to create a comprehensive women's benefit for women of reproductive age. First, a "well woman" benefit consisting of coverage of routine preventive visits to assess risks, identify, for treatment, previously undiagnosed chronic illnesses and conditions, and provide health promotion counseling is essential. Second, comprehensive preconception treatment consisting of a broad array of otherwise covered benefits, as well as a provision that would override otherwise applicable benefit limitations and exclusions in the case of diagnosed conditions in women of childbearing age that pose the potential to adversely affect maternal health and birth outcome. Third, and parallel to the second recommendation, the coverage should include comprehensive interconception treatment for women whose previous pregnancies have ended in adverse outcome.

Short of full health reform, Medicaid coverage for low-income women has been identified as an avenue to improve preconception health, particularly given that employer-sponsored coverage and individually purchased insurance policies are beyond the reach of many low-income women. Where available, Medicaid provides coverage for a broad range of reproductive health services that can improve maternal and infant health. In their paper in this supplement, Salganicoff and An (2008) examine the evolution and current role

of Medicaid in improving access to preconception care for low-income women. They review Medicaid policy and benefits of relevance to women of reproductive age and discuss various approaches to promote preconception care in Medicaid. These authors emphasize that implementation of a large-scale initiative to promote use of preconception care to low-income women requires that policy makers give the issue the same level of attention and effort that they provided to improving access to prenatal care. Although Medicaid has had considerable success in improving access to prenatal care, federal and state governments could do more to integrate preconception care into the mainstream of medical care for women. Opportunities for states to make policy changes under current federal law to promote access to preconception care include simplifying the eligibility process, broadening eligibility requirements, extending the scope of benefits, and building on family planning programs.

Medicaid's family planning waivers could become the basis for expanding services to include basic preconception care including screening, education, and/or interventions (Gold & Alrich, 2008; CDC, 2006). Gold and Alrich describe how Medicaid eligibility expansions and the family planning clinic network present opportunity to improve reproductive and preconception health. The low-income women (and men) eligible for Medicaid family planning waiver programs are a population that could benefit from recommended preconception services. The authors describe how the family planning waivers and other Medicaid eligibility expansions, combined with adequate reimbursement, make coverage of preconception care under Medicaid possible in a meaningful way.

Welfare policy decisions also have direct impact on health coverage patterns for low-income women and children in the United States. Kosali and Handler (2008) document how welfare reform has affected health insurance status for unmarried women and their children. Looking at the effects of welfare policies over the time period 1990–1999, as well as over the time period 1990–2003, they explore both long- and short-term impacts. Comparing married and unmarried mothers with high school completion or less, they found that state and federal welfare reforms combined have decreased access to Medicaid health insurance, increased access to employer health insurance, and led to a decrease in overall insurance. The strongest effect of welfare reform for women with Medicaid coverage was in the months after a pregnancy (15.1% decline by 10 months postpartum). The authors conclude that:

For policy makers who are increasingly focusing on the health care of nonpregnant women as a strategy to improve the health outcomes of mothers and infants, it is essential to not only consider the period before a first birth (strictest definition of "preconception" care) but the period after a pregnancy,

which for many women may become an interconception period.

As important as Medicaid may be for low-income women, a majority of women who have health insurance receive coverage from private, employer-based plans. In recent years, employers have struggled to find effective ways to prevent poor birth outcomes among their beneficiaries. Phillips-Campbell and Flood (2008) describe how, as purchasers of health care and as providers of wellness services, employers have an important role to play in the promotion of preconception care. The authors provide an overview of the business case for preconception care and concrete steps employers can take to support preconception health among their employees. The Maternal and Family Health Plan Benefit Model of the National Business Group on Health is described, including the model's preconception care benefit, which is based on the CDC national recommendations. They note, however, that before preconception care benefits can be widely adopted and promoted by employers and other purchasers, certain billing and claims coding issues must be resolved.

### Maximizing Federal and State Programs

#### *A need to increase service capacity in existing federal health programs*

The articles in this supplement highlight 3 existing federal programs that provide grants directly to community-based health service providers. The federally funded Community Health Centers, Healthy Start, and Family Planning programs each provide important service capacity in communities with high concentrations of women at risk for adverse pregnancy outcomes. The authors describe opportunities and barriers to using these safety net providers to improve preconception health and health care. Notably, a major limitation is the gap between federal appropriations to fund these programs and the level of funding needed to provide these services in all qualified communities.

#### *Community health centers*

The national network of Community Health Centers are vital source of care for low-income women and health centers can provide preconception care services to women who might otherwise not have access to care. Health centers provide prenatal care for >17% of US births to low-income women. Proser and Wilensky also describe how the comprehensive, prevention- and community-oriented approach of health centers is an ideal setting for the delivery of preconception care to traditionally at-risk women. As medical homes, health centers offer a comprehensive array of primary and preventive health care services, and many also provide dental, behavioral health, and pharmacy services. The authors also describe barriers, such as

shortfalls in federal funding or provider shortages, that limit the capacity of health centers to provide preconception services in the context of a medical home for women in medically underserved communities.

#### *Healthy Start*

Badura et al. (2008) describe the role of the federal Healthy Start program, launched in 1991, in addressing the factors that contribute to the Nation's high infant mortality rate. Its goals are to reduce disparities in access to and utilization of health services by using a lifespan approach, improving the local health care system, and increasing consumer and community input into health care decisions. Since 2005, all Healthy Start grantees (of which there were 99 in 2007) have been required to include an interconception care component. Healthy Start has demonstrated the need for and potential impact of effective interconception services for high-risk populations such as women living in poverty, in medically underserved communities, and those without health coverage. Three essential approaches include case management and care coordination, multidisciplinary and multilevel staff teams, and a focus on detecting and treating underlying disease and health conditions. The authors conclude that, for community-based projects serving the highest risk women in medically underserved communities, there are important lessons to be learned from the experience of Healthy Start in providing interconception care and support.

#### *Title X family planning clinics*

For a significant proportion of young women seeking sexual and reproductive health services, family planning clinics serve as that critical network of providers. The >7,600 publicly funded family planning clinics provided contraceptive services to 6.7 million women in the United States, a majority of whom were teens and young adult women <25 years old. Family planning programs hold great promise in improving preconception care, but would need to be broadened to include a wider range of services than what they currently offer. Gold and Alrich discuss how the successful integration of preconception care into family planning clinics depends on both the availability of adequate funding and shifts in service delivery strategies.

#### **State Leadership in Promoting Healthy Behaviors and a Continuum of Services Across the Lifespan**

State Title V programs funded through the Maternal and Child Health Services Block Grant are in a position to encourage development of a continuum of women's health services. Kent and Streeter (2008) describe how Title V programs are maximizing opportunities to promote women's health, including preconception health. The public health and population focus of Title

V programs makes their contribution unique. One approach is the development of state-level information systems that can monitor the status of children and women. Under federal requirements, each state Title V program conducts a needs assessment to identify state priority areas that they will address over a 5-year planning cycle. National and state-specific Performance Measures are defined to track progress. Another approach uses state Title V authority to either add or expand programs to include preconception services. Some such expansions involve direct services in local health departments, whereas other work is focused on health promotion outside of clinical care. In other instances, Title V leaders are leveraging change through partnerships with Medicaid, Title X, physicians, and consumers. The authors assert that Title V leaders also can "bring this issue to the attention of policy makers and participate in discussions related to financing and designing of state and national health care reform systems."

Although many state Title V programs are planning and setting priorities, only a few have adopted new policies and programs to improve preconception health. The state legislature of Delaware enacted policy and allocated funding to translate preconception knowledge into practice through a statewide program. The Delaware Division of Public Health was given responsibility for defining and implementing the preconception care program, targeted to higher risk women. Public Health/Title V partnered with Medicaid, private practitioners, local hospitals, state service centers, and Federally Qualified Health Centers to develop a scope of services that supplement routine clinical care through annual preventive visits for women of childbearing age. Notably, the state's Division of Public Health followed up after implementation, using provider feedback to modify the policy. Kroelinger and Ehrental (2008) discuss how this feedback loop was valuable in streamlining both the set of preconception care services and the cost of the program.

#### **Health Services Research and Data to Support Best Practices**

##### *Randomized, controlled trials to demonstrate the effectiveness of interventions*

Reporting results from a randomized trial of a unique, multidimensional, small group format intervention, Strong Healthy Women, Hillemeier et al. (2008) from the Central Pennsylvania Women's Health Study describe success in improving health attitudes and behaviors. Women in the intervention group were significantly more likely than control group women to have improved self-efficacy and behavioral intentions, as well as actual behavior change, related to risk factors for adverse pregnancy outcomes. Significant dose effects were found: Each additional intervention session

attended was associated with higher perceived internal control of birth outcomes, reading food labels, engaging in relaxation exercise or meditation for stress management, and daily use of a multivitamin with folic acid. This test of the Strong Healthy Women intervention offers initial evidence of the effectiveness of a preconception program for reducing risks of adverse pregnancy outcomes among women in high-risk communities.

Elsinga et al. (2008) from a study group in The Netherlands assessed the extent to which Dutch women who participated in “Parents to Be” (a randomized, controlled trial) to receive preconception counseling increased their knowledge on pregnancy-related risk factors, change their behavior, and have improved adverse pregnancy outcomes. Women who received preconception counseling had significantly more knowledge of risks and prevention strategies such as folic acid. Notably, the knowledge of women who attended preconception counseling but who had never been pregnant was significantly higher than that of matched control women who had never been pregnant. Here again, health services research is pointing to effective preconception care strategies. This study also found, however, that it was difficult to recruit women into this study—reflecting low knowledge and demand for these services among women in general. Health policy leaders in The Netherlands are exploring ways to improve preconception health for their population.

Promoting health and healthy behaviors is fundamental to improving preconception health. At the same time, millions of women have chronic health conditions that need medical management to avoid complications for women and their pregnancies. In an analysis using Medical Expenditure Panel Survey data, Chatterjee et al. (2008) found that chronic illnesses are relatively common in pregnancy and in women of childbearing age in general. This finding runs counter to the widely held assumption that pregnant women are relatively young, healthy, and have pregnancy-limited problems that can be resolved during the prenatal time period only. Among those with chronic illnesses, nonpregnant women were not significantly different from pregnant women in terms of total, emergency room, and other health expenditures. Finding few significant cost differences between pregnant women with and without chronic illness, the authors speculate that extension of regular insurance coverage to women postpartum could be a potentially reasonable and cost-effective solution to preventing complications in future pregnancies.

### Data and Information Systems to Guide Quality and Improvement

With an eye toward ensuring quality and value-based purchasing, there is increasing pressure from both the public and private sectors to have evidence that

documents the effectiveness and efficacy of health services. Posner et al. (2008) describe national and state-level data sources relevant to preconception health and health care, as well as steps that can be taken to improve the quantity and quality of preconception health data. Much individual-level data collection to date has focused on the burden of specific chronic disease and risk factors such as diabetes and tobacco use; few efforts provide information on the impact of these conditions or intervention on health outcomes. Public health surveillance systems such as the Pregnancy Risk Assessment and Management System and the Behavioral Risk Factor Surveillance System measure the broader sociocultural context with items including social stressors and perceived racism. Each of these has value for understanding the context for and impact of preconception care. These authors also provide perspectives on how evaluative clinical sciences and health services research can add to the evidence base.

### Conclusion

This special supplement presents a framework for understanding the role of policy and finance in improving preconception health and health care. Since 2004, this initiative has involved 22 CDC programs working in partnership with 5 sister federal agencies, 35 national organizations, and hundreds of subject matter experts. What has evolved is a growing movement to promote preconception health and health care as a new approach to improve pregnancy outcomes for mothers and infants. The innovations taking place in clinical practice and communities across the country need policy and finance support, or they are doomed to be unsustainable as have been other pilot projects and new directions in health care. Most of the policy and finance changes described in this supplement are aimed at reducing barriers in access to care for women of childbearing age to improve their health and pregnancy outcomes. This is essential given the number of poor and uninsured women and the fact such women have higher fertility rates. Other changes underway are focused on improving the public health infrastructure, through which health promotion and education may support consumer engagement. In the end, improving preconception health requires changes in the knowledge, attitudes, and behaviors of individual women, health professionals, and policy makers.

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