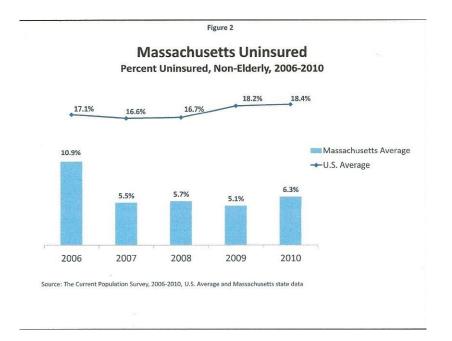
THE IMPACT OF UNIVERSAL HEALTHCARE ON PRECINANCY OUTCOMES IN MASSACHUSETTS

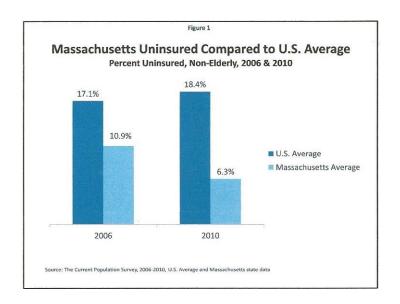
## **SITUATION**

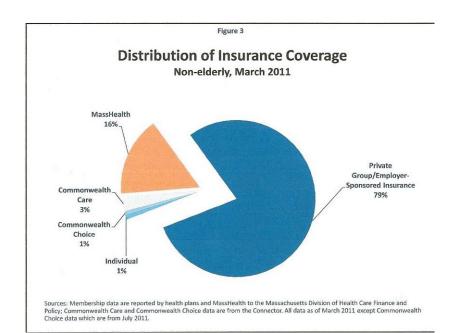
Do we know if Universal Healthcare Coverage has improved pregnancy outcomes in Massachusetts?

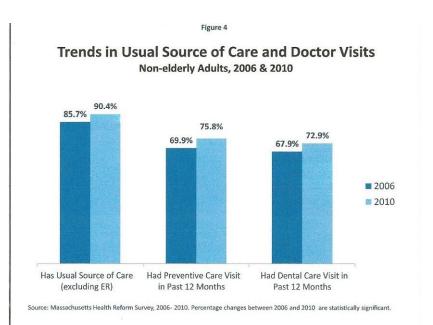
### **BACKGROUND**

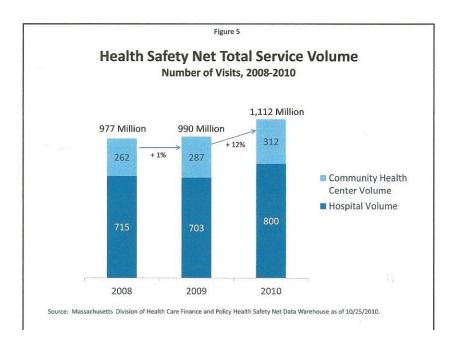
- 2006 Legislation requiring all citizens of the state of Massachusetts to have health insurance was enacted and signed by Governor Mitt Romney.
- 1963 Title V of the Social Security Act amended to include comprehensive maternity and infant care for women who were low income and high risk.
- 1972 WIC food program started.
- 1992 Office of Research on Women's Health authorized by US Congress.
- 1993 Family Medical Leave Act.
- 2010 The Patient Protection and Affordable Care Act











## **SUMMARY**

"After six years of implementing an ambitious health reform initiative, Massachusetts has clearly demonstrated the potential for reducing the number of uninsured through a model of shared responsibility. With the lowest rate of uninsured in the country, major challenges lie ahead for a state struggling to contain the growth of health care costs."

from: "Massachusetts Health Care Reform: Six Years Later", <u>Focus on Health Reform.</u> The Kaiser Family Foundation, May 2012.

## **ASSESSMENT**

What evidence do we have that pregnancy outcomes have improved?

### MA DEPARTMENT OF PUBLIC HEALTH

#### Data from 2010 Birth Report

- Total number of births decreased slightly (3%) from 2009.
- Teen birth rate in MA lowest ever recorded: 17.1/1000 women ages 15-19, decrease from 19.5 in 2009.
- Mothers smoking decreased from 7% to 6.8%.
- Mothers receiving adequate prenatal care increased 0.7% to 84.9%.
- Breastfeeding at time of discharge was 83%, a record high, 1% more than 2009.
- Infant mortality rate 4.4/1000, 4.9 in 2009. Black infant mortality rate was 2.5x higher than white: 8.2 vs 3.4/1000 live births. 319 deaths in 2010. 75% occur in neonatal period.
- Percentage of mothers with prenatal care paid for by public programs was 35.8%, similar to 2009 rate of 36%.
- No change in primary C/S rate of 23%.

### MA DEPARTMENT OF PUBLIC HEALTH CONT'

- Mothers with a high school education or less were
  - 1) less likely to receive adequate prenatal care.
  - 2) more likely to report smoking.
  - 3) more likely to have publicly financed prenatal care.
  - 4) more likely to deliver low birth weight babies.
- There is a decreasing trend in births to women over the age of 30 since 2003.
- Total percent of multiple births has been stable since 2003, 4.6% in 2010.
- The percentage of LBW infants is 7.8%, relatively stable since 2004. Rate for black infants is higher at 10.9%.
- Preterm deliveries ( < 37 wks) 8.6% in 2010, 8.7% in 2009.</li>

# MA DEPARTMENT OF PUBLIC HEALTH CONT'

- The percentage of VLBW infants was 1.3% in 2010, 1.4% in 2009.
- Adequacy of prenatal care utilization (APNCU) had been declining for 2001-2008 at 0.5%/year. Since 2009 APNCU has increased by 1.6%/year.
- Proportion of mothers receiving adequate prenatal care range by community is 70.5%
   92.9%.
- In 2010 Black and Hispanic mothers have the lowest proportion of ACPNU, 76.8-79% respectively.
- There is a disparity delta of 20% among cities in MA whose pregnant residents receive adequate prenatal care.
- 35.8% of prenatal care was financed by public programs, similar to 2009.
- Overall C/S delivery rate is 33.6%. Variation of 26.1 42.9 by ethnicity and 20.9 43.1 by hospital.
- Prevalence of GDM has not increased from 4.7%.

## REPORTS FROM THE LITERATURE

Massachusetts women have the highest rates of health insurance coverage in the nation and women's access to care has improved across all demographic groups.

A review of the literature and data analysis comparing healthcare services access, utilization, cost and health care outcomes from Massachusetts pre and post 2006 health care reform identified two key challenges in women's continuity of coverage and affordability.

- Approximately 60,000 women were underinsured in 2009.
- Women continue to be vulnerable to gaps in coverage related to churn, dependent status and income fluctuations.
- Affordability: between 2006-2009 there was no significant change in the percentage of women spending 5% or more of family income on out-of-pocket medical expenses.

## Implications for Practice and Policy

- Reduce coverage volatility for women.
- Improve insurance affordability for women.
- Make healthcare reform data available by gender, race, ethnicity and socio economic status.

"Failure to assess the impact of health care reform on women is a missed opportunity to improve population health."

from Fitzgerald T, Cohen L, HyamsT, Sullivan KM, Johnson PA, "Women and Health Reform: How National Health Care Can Enhance Coverage, Affordability and Access for Women (Examples from Massachusetts)", Women's Health Issues, 24-1, Elsevier, 2014.

- Following state health care reform in Massachusetts, young women reported confusion over coverage of contraception and other reproductive health services under newly available health insurance products.
- Web site information found to have high literacy demands and problems with ease of navigation.
- To avail themselves of sexual and reproductive health services newly available under expanded health insurance coverage, women require customized educational resources that are rigorously evaluated to ensure accessibility.
  - from "Translating access into utilization: lessons learned from the design and evaluation of a health insurance Website to promote reproductive health for young women in Massachusetts", Janiak E, Rhodes E, Foster AM, Contraception, 88, 2013, pp 684-690.

An investigation of the impact of Massachusetts health care reform on low income women's experiences accessing insurance and health services.

Between 2006-2010 the number on non-elderly adults with insurance rose from 86.6% to 94.2%.

Access to and use of health services also rose.

Gains in health appear to be the result with the number of non-elderly adults reporting that their health status was very good or excellent rose to 53.2% from 46.7% four years after health care reform.

Access to health care has not improved or has gotten worse for some populations of women: immigrants, young women, minors, those with erratic health insurance coverage and those living in rural areas.

Undocumented immigrants are afraid to seek insurance coverage.

Women under he age of 18 are not eligible for Commonwealth Care plans and may not be covered by their parents insurance.

7% of the MA population live in areas that are medically underserved.

Women in this study had difficulty finding providers who accepted plans developed under Massachusetts reform.

Safety net providers will continue to deliver care to those who remain uninsured or underinsured, usually with the support of public funds.

from The Policy and Politics of Reproductive Health, "What Happens to the Women Who Fall Through the Cracks", <u>Journal of Health</u>, <u>Politics, Policy and Law,</u> Vol 38, No.2, April 2013, Duke University Press by A Dennis, K Blanchard, D Cordova, B Wahlin from Ibis Reproductive Health and J Clark, K Edlund, J McIntosh, L Tsikitas from Masschusetts Department of Public Health.

## REPORTS FROM THE LITERATURE

## **Infant Mortality**

"Worcester's high infant mortality rate is not a medical issue, but rather a reflection of socioeconomic stress and living conditions in our community. In reflecting for over a decade on effective ways to improve conditions, we believe promoting educational attainment is the key. As a community interested in healthier babies, we need to continue working to improve high school graduation rates and access to a college education."

from "Infant Mortality Realities", As I See It by B. Dale Magee and Sara Shields, Worcester Telegram and Gazette, 12/20/13.

There are many factors, other than insurance, that influence perinatal outcomes.

# SOME FACTORS THAT INFLUENCED PERINATAL OUTCOMES 2006-2010

- Average age of 1<sup>st</sup> time mother was 3.6 years older in 2007 than 1970.
  - Increased incidence of comorbidities
  - More multiples
  - More preeclampsia and diabetes
- Obesity (BMI >30) in women of childbearing age 24.4 % in 2007.
- 22% of women in reproductive years smoke, 10% use alcohol during pregnancy
- Cesarean birth rate 31% in 2007
  - Incremental increase r/t to repeat C/S
  - Since 1996 C/S rates have increased 54%
  - Increase in incidence of maternal hemorrhage r/t C/S delivery

Troiano, Harvey, Flood-Chez, <u>High Risk and Critical Care Obstetrics</u>, 3<sup>rd</sup> ed, Lippincott, Williams and Wilkins, 2013, pp. 3-7.

# STANDARDS AND OUTCOMES

How are standards for perinatal outcomes established?

Who collects the data and analyzes?

# **RESULTS**

Structure

**Process** 

Outcome

# ORGANIZATIONS THAT SET STANDARDS TO GUIDE PRACTICE AND IMPROVE CARE

- The Joint Commission (TJC)
- ACOG, AWHONN, AAP, ACNM, NANN, ASA, SOAP
- DPH
- CRICO
- US Department of Health and Human Services, Healthy People 2020
- Centers for Disease Control (CDC)
- Institute of Medicine (IOM)
- National Institute of Child Health and Human Development (NICHD)
- Federal Drug Administration (FDA)
- American Heart Association (AHA)

# ORGANIZATIONS THAT SET STANDARDS TO GUIDE PRACTICE AND IMPROVE CARE CONT'

- State Quality Collaboratives ie Massachusetts, California, Ohio, etc.
- Institute for HealthCare Improvement (IHI)
- National Quality Forum (NQF)
- Agency for Healthcare Research and Quality (AHRQ)
- World Health Organization (WHO)

### **BOX 1-2** HEALTHY PEOPLE 2020 PERINATAL PROPOSED OBJECTIVES

#### **OBJECTIVES RETAINED FROM HEALTHY PEOPLE 2010**

- Reduce maternal deaths.
- Reduce maternal illness and complications due to pregnancy (complications during hospitalized labor and delivery).
- Increase the proportion of pregnant women who receive early and adequate prenatal care.
- Reduce cesarean births among low risk (full-term, singleton, vertex presentation) women.
- Reduce low-birth-weight (LBW) and very low-birth-weight (VLBW).
- · Reduce preterm births.
- Increase the percentage of healthy full-term infants who are put down to sleep on their backs.
- Increase abstinence from alcohol, cigarettes, and illicit drugs among pregnant women.
- Reduce the occurrence of fetal alcohol syndrome (FAS).
- Increase the proportion of mothers who breastfeed their babies.

## OBJECTIVES RETAINED BUT MODIFIED FROM HEALTHY PEOPLE 2010

- Reduce fetal and infant deaths.
- Increase the proportion of pregnant women who attend a series of prepared childbirth classes.
- Increase the proportion of mothers who achieve a recommended weight gain during their pregnancies.
- Reduce the proportion of children diagnosed with a metabolic disorder through newborn screening who experience developmental delay requiring special education services.

- Decrease the proportion of children with cerebral palsy born as LBW infants (<2500 grams).</li>
- Reduce the occurrence of neural tube defects.
- Increase the proportion of pregnancies begun with the recommended folic acid level.
- Ensure appropriate newborn blood-spot screening and followup.

#### **OBJECTIVES NEW TO HEALTHY PEOPLE 2020**

- Decrease postpartum relapse of smoking among women who quit smoking during pregnancy.
- Increase the percentage of women giving birth who attend a postpartum care visit with a health care worker.
- Among women delivering a live birth, increase the percentage that receive preconception care services and practice key recommended preconception health behaviors.
- Increase the percentage of employers who have worksite lactation programs.
- Decrease the percentage of breast-fed newborns who receive formula supplementation within the first 2 days of life.
- Increase the percentage of live births that occur in facilities that provide recommended care for lactating mothers and their babies.
- Increase the 1-year survival rates for infants with Down syndrome.
- Reduce the proportion of persons ages 18 to 44 years who have impaired fecundity (i.e., a physical barrier preventing pregnancy or carrying a pregnancy to term).

# DATA SOURCES

- Massachusetts Department of Public Health
- Centers for Disease Control
- National Perinatal Information Center (NPIC)
- Leapfrog
- MPQC
- CRICO
- Outcome and Assessment Information Set (OASIS), CMS
- Cochrane Pregnancy and Childbirth Database
- IHI
- US Census Bureau
- Joanna Briggs Institute

# RECOMMENDATION

What data should we be monitoring to track pregnancy outcomes?

Who should collect and analyze data?

What are data sources?

Who should be held accountable for the results?

# RESPONSE

How shall the challenge be met to:

Provide care for all.

Ensure efficient use of resources.

Monitor outcomes.

Report transparently.

Share accountability.

Move adeptly.

The success of any society is measured by the health and well-being of its women and children.

- Marian Wright Edelman

