**Who’s Caring for Half of America?**

*Ob-Gyns are Women’s Primary Care Physicians.*

**Thursday, October 9, 2014**

12:00 PM - 1:00 PM  
Capitol Visitors Center SVC 202

**SLIDE 1  INTRODUCTION**

It is a pleasure to be here today representing the Board of Directors of the Association of Maternal & Child Health Programs, known as AMCHP.

**SLIDE 2**

We like to refer to AMCHP as a “national resource, partner and advocate for state public health leaders and others working to improve the health of women, children, youth and families, including those with special health care needs.” Our members come from the highest levels of state government and include directors of maternal and child health programs, directors of programs for children with special health care needs, and other public health leaders who work with and support state MCH programs.

I want to especially thank our colleagues at the American Congress of Obstetricians and Gynecologists for the invitation to join this panel today to talk about how state MCH programs are working with OB/GYNs and others to expand services and improve the lives and health of women and their families.

**Slide 3OVERVIEW**

Today, I would like to focus today on three areas:

1) First, I want to highlight how the Title V Maternal and Child Health Services Block Grant helps provide a foundation in every state to assess and expand services and systems to improve the health of women and families.

2) Second, I’ll share a few brief examples of how state MCH programs are collaborating with OB/GYNs and others to expand and link public health and primary care, integrate services, and promote population-wide health improvements by implementing policy solutions.

3) Finally, I’ll close some ideas on how you and the members of Congress you work for can help raise the awareness of challenges and potential solutions in this area.
Slide 4
I want to start with a few observations AMCHP has made about where the field of MCH has been and where we see it going. Twenty or thirty years ago, I think it’s fair to say the primary focus of our field was on increasing access to early, quality prenatal care. And we’ve seen great improvement here, but the lack of substantial progress on sentinel measures such as infant and maternal mortality in relation to other industrialized nations has led us to look deeper.

What we are learning is that while prenatal care remains essential and fundamental, we are seeing that seven or eight months of the world’s best prenatal care cannot reverse a lifetime of unhealthy exposures and behaviors. This is leading to a movement called preconception and interconception health, which is based on the premise that our best opportunities to improve the health of babies is to focus on the health of women before they become pregnant.

In even simpler terms, we’re saying that healthy babies begin with healthy women in healthy communities. We know that neither primary care systems nor public health efforts can bear the full responsibility here, but rather the combined power of clinical care supported by community and state public health efforts offers our best path to improvement. That is why this briefing today is such a wonderful opportunity to talk about how these efforts connect, and the role of Title V in making those linkages.

Slide 5
How Title V Provides a Foundation in All States

First, a brief background on the Title V MCH Block Grant. I’m curious – how many of you in the audience know about Title V? [If there are many you can say this is encouraging and you will just provide a brief overview for those who are new; if more likely you get blank stares, you can pivot to say “This is a great opportunity then to learn more about a program that’s actually been around for nearly 80 years, but like many efforts in public health and prevention is too often hidden behind the scenes.”]

Very briefly, the roots of the Title V MCH Block Grant go back to the Great Depression, when the federal government clearly recognized that poor economic conditions contributed to the declining health of women and children. As the Maternal and Child Health Bureau explains, “With the passing of the Social Security Act in 1935, the Federal Government - through Title V of that law - pledged its support of state efforts to extend health and welfare services for mothers and children. This landmark legislation actually resulted in the establishment of state departments of health or public welfare in some states, and facilitated the efforts of existing agencies in others.

Over the years, the achievements of Title V-supported projects have been integrated into the ongoing care system for children and families. Landmark projects have produced guidelines for child health from infancy through adolescence known as Bright Futures; influenced the nature of nutrition care during pregnancy and lactation; recommended standards for prenatal care; and identified successful strategies for the prevention of childhood injuries.
At the state level, there are three key components about how the Title V MCH Block Grant works that you should know. **First**, the statute requires that every five years each grantee conduct a statewide assessment to determine the preventive and primary care needs of women and children. This assessment serves as the foundation for us to know what is going well, where the most critical opportunities for improvement are, and where there are gaps in services that can either be addressed directly with Title V funds or in partnership with other resources.

**Second**, states use these assessments and other inputs to create an annual plan describing what services they will provide and how they will partner with all of the key stakeholders in their state, including, of course, OB/GYN clinicians as well as the families we seek to serve. In contrast to many categorical funding streams that focus on specific body parts or diseases, the Title V MCH Block Grant is unique in its focus on how we support systems and services, with the obligation to have a statewide focus.

**Third** – and a key component of the MCH Block Grant, is annual reporting on a set of performance and outcome measures. Because the nature of a block grant provides flexible funds to states, we recognize the high level of accountability needed to ensure there is data to demonstrate results as well as emerging needs. Under the leadership of Dr. Michael Lu at the Maternal and Child Health Bureau, we are currently in the process now of updating the set of performance measures to do an even better job of demonstrating value and how a broad range of Title V-supported services are both evidence based and focused on current needs.

**Slide 6 Examples of How State MCH Programs are Collaborating with OB/GYNs**

Next, I’d like to share a few brief examples of how state MCH programs are collaborating with OB/GYNs and others to expand and integrate services and promote policy-level solutions.

For example, in New Mexico, Title V and the state ACOG chapter are working closely together around perinatal regionalization. Perinatal regionalization is a system of designating where infants are born or are transferred based on the amount of care that they need at birth, and many states are working today to expand their approach to extend not just to the level of care needed of newborns, but of mothers as well. New Mexico also is working with the state ACOG chapter on initiatives such as reducing early elective deliveries, which are deliveries performed early without a medical reason, and expose the mother and newborn to increased risk. They also worked with ACOG neonatal abstinence syndrome and promoting the use of and reimbursement for long acting reversible contraceptives (LARC’s).

The Colorado Title V program – like many states – includes OBs on their state maternal mortality committee and are working together to address perinatal depression as a top priority.

In Georgia, the public health department noticed a low uptake of the TDAP vaccine to protect against pertussis. The Title V program worked with the Georgia OB/GYN Society to identify the reasons for low uptake and then developed materials and messages to OB/GYNs and other women’s health providers in the state to improve vaccination rates for pregnant women.
Finally, Wisconsin’s Title V program is working with OBS and many statewide perinatal partners to create a Wisconsin Perinatal Quality Collaborative. They have also partnered with Medicaid on a Medical Home OB Pilot to improve and reduce disparities in birth outcomes. They are also engaged with the University of Wisconsin School of Medicine OB GYN leadership on the issue of Long Acting Reversible Contraceptive services, especially post-partum usage.

**Slide 7 What Can Members of Congress Do – A Suggested Call to Action**

Finally, I know many of us attend briefings like these on a regular basis and sometimes walk away thinking that was great information, but what can I do about this today? Well, here are a few suggested action steps to help raise awareness of current challenges and potential solutions:

- **First, get your local data and help raise awareness** – Many people are shocked to learn that the United States ranked 12th in the industrialized world for infant mortality in 1960, but has fallen to 27th in recent years. Even more shocking is the persistent two-to-three fold higher rates among African American babies. Additionally, in recent years, we’ve seen a troubling increase in the rates of maternal mortality and severe maternal morbidity in the United States, with recent estimates indicating that each year, approximately 650 women die as a result of pregnancy or delivery complications, and more than 50,000 women are affected by a severe pregnancy complication. Congress can strengthen support for public health data systems, research and epidemiologists – known informally as ‘disease detectives’ – that can help find answers about why we are falling behind and develop plans of action to address these troubling trends.

  Members of Congress or their staff can request data that highlights opportunities for improvement. The cosponsors of this briefing can link you with your state health department to get the most recent data on infant and maternal mortality in your states and districts; how many babies are being born prematurely with expensive and often avoidable complications; racial and ethnic disparities; and, most importantly, how you can lead local forums to identify and highlight the primary opportunities for prevention, including the role of OB/GYNs and other women’s health providers as primary care providers.

- **Second, you can highlight investments in programs that work** – The Secretary’s Advisory Committee on Infant Mortality (known as SACIM) recently made a series of recommendations for a national strategy to address infant mortality, with improving women’s health as a key part of the foundation. Members of Congress can ask HHS for a briefing on this emerging national strategy, and look carefully at the many important ideas in the SACIM report. One area of particular concern they highlight is protecting key federal investments that make up the “maternal and child health safety net.” This includes programs such as the Medicaid, the Title V MCH Services Block Grant; Community Health Centers; Healthy Start; Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program; and WIC Supplemental Nutrition Program. Additionally, Congress has the opportunity right now to consider extending the MIECHV home visiting program before it expires on March 30 of 2015.
Specifically on breastfeeding which has proven health benefits for moms and babies, Congress can consider if the current level of investments in programs like WIC, the Title V MCH Block Grant, and Healthy Start are adequate to reach enough women with the message about why breastfeeding is the best choice for both mom and baby. Additionally, members of Congress can seek out the Baby Friendly Hospitals and businesses in your states that are promoting breastfeeding. You can visit these places to help bring attention to the health and economic benefits of breastfeeding friendly policies.

Finally, you can make addressing disparities a national priority. Tackling the racial and economic inequity, unequal treatment, and social determinants that drive disparities in women’s health, infant and maternal mortality, as well as birth outcomes overall, must be a priority in any national plan to reduce infant mortality. What Congress does to address issues such as income inequality, education, safe communities and affordable housing are fundamental to ensuring that every woman and baby has the best opportunity to reach their full potential, regardless of where they are born.

Slide 8- conclusion

The MCH challenges I have highlighted today can only be addressed through continued collaboration between public health and primary care, including women’s health professionals who provide much, if not most, of the primary care services a woman will receive especially during her reproductive years. I appreciate the opportunity to be with you today to highlight the role of Title V in these collaborations and look forward to a discussion after the presentations.

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1 This history is taken from MCHB’s “Understanding Title V” booklet.