The Role of State Public Health Agencies in Improving Assisted Reproductive Technology

Association of State and Territorial Health Officials (ASTHO)
June 28, 2016
2:00-3:00pm ET
Webinar Objectives

- Discuss ART and infertility, including the benefits of monitoring and studying maternal and infant health outcomes related to ART.

- Understand the public health department’s role in leading improvements in ART practices.

- Describe how state health agencies are using data to improve consumer and provider awareness of ART’s impact on twin births.

- Discuss the importance or partnerships in reducing preterm birth through ART.
Agenda

2:00pm: Welcome and Introductions

2:05-2:15pm: Leadership of State Health Agencies in ART - Susan Moran, MPH

2:15-2:30pm: SMART Collaborative - Mithi Sunderam, MA, PhD

2:30-2:45pm: Connecticut ART Presentation - Carol Stone, PhD, MPH, MA, MAS

2:45-3:00pm: Efforts to Reduce ART-Associated Twin Birth Rate by Dana Bernson, MPH

3:00-3:15pm: MiART Summit: Planning for Action by Cheryl Schott, MPH

3:15pm: Question and Answers

3:30pm: Adjourn
Susan Moran, MPH
Senior Deputy Director
Population Health & Community Services Administration
State of Michigan Department of Health & Human Services
Infertility and ART: State Leadership and Response

Susan Moran, MPH
Senior Deputy Director
Population Health and Community Services, Michigan Department of Health and Human Services

ASTHO Assisted Reproductive Technology Webinar, June 28, 2016
Infertility can affect anyone – not just a women’s health issue

Considered a disease of the reproductive system according to WHO

Can cause psychological stress, anxiety, and depression
Why Infertility is a Public Health Concern

Several known causes of infertility are public health issues

- Sexually transmitted infections/diseases
- Chronic diseases & conditions
- Environmental/occupational exposures
- Behavioral factors (e.g., obesity, smoking)
Why ART is a Public Health Concern

- Overall, lack of or limited insurance coverage for ART treatment
  - Leads to higher out-of-pocket expenses
  - Disparities in access to care & treatment
  - Use of less effective, less safe, but lower costs treatments
  - Desire for twins/multiples in order to decrease possibility of multiple procedures

- ART may result in twin/higher order births, increasing risks to mothers and infants, such as preterm birth and low birth weight
Why State Public Health Leadership Support is Important

- Increase Visibility
- Raise Awareness
- Serve as a Resource (e.g., data, surveillance, research, technical assistance)
- Convene stakeholders
- Facilitate cross-program collaboration
What State Health Agencies Can Do

- Implement public health strategies outlined in the National Public Health Infertility Action Plan
  - Promote healthy behaviors to preserve fertility
  - Promote prevention, early detection, and treatment of medical conditions that can threaten fertility
  - Reduce exposures to environmental, occupational, infectious, and iatrogenic agents that can threaten fertility

- Promote access to care and ART best practices

- Raise awareness of potential risks of multiple births, preterm birth and low birth weight associated with certain treatments/procedures

- Improve detection and response through surveillance
Thank you!
 STATES MONITORING ASSISTED REPRODUCTIVE TECHNOLOGY (SMART) SURVEILLANCE

Mithi Sunderam, M.A., PhD
ART SURVEILLANCE and RESEARCH TEAM
DIVISION of REPRODUCTIVE HEALTH
CENTERS for DISEASE CONTROL and PREVENTION
Background: CDC’s National ART Surveillance System (NASS)

- NASS is a web-based data collection system that monitors all ART procedures in the U.S. since 1995 (www.cdc.gov/art).
- Reporting of ART cycles to CDC is mandated by the Fertility Clinic Success Rates and Certification Act (FCSRCA) of 1992.
- Data include: patient demographics, obstetrical history, parental infertility diagnosis, parameters of ART procedure, information about birth outcome.
- NASS does not collect health information about ART-conceived children after delivery.
- The most efficient way to study long-term outcomes of ART is through data linkages with state-based surveillance systems and registries.
Overview of the SMART Collaborative

- Established in 2008.

- **Who we are:** Partnership between Women’s Health and Fertility Branch (WHFB) in the Division of Reproductive Health (DRH), U.S. Centers for Disease Control and Prevention’s (CDC), State Departments of Health, Universities and Professional Societies.

- **Current Members:** CDC, MA, MI, CT (Health Departments), University of South Florida, Society of Assisted Reproductive Technology (SART).

- **Goals:**
  - Develop a surveillance system of assisted reproductive technology (ART) maternal and child health (MCH) outcomes
  - Strengthen the capacity for evaluating long-term ART maternal and perinatal outcomes
History of SMART Collaborative

- **2001**: MA ART Linkage Pilot (National Assisted Reproductive Surveillance System (NASS) and MA vital records)
- **2008**: SMART Collaborative (FL, MI, MA - NASS and state vital records and other registries)
- **2013**: CT joined SMART Collaborative
- **2014**: FL left SMART Collaborative
- **2016**: Proposed NASS-National Vital Statistics System (NVSS) linkage to create a National Surveillance System of ART maternal and infant health outcomes
WHAT we do?

- **Surveillance**: State-based surveillance of ART outcomes and programs to improve maternal, pregnancy and child health outcomes of ART
  - **Data linkages**: Link ART surveillance data with state birth records, other surveillance systems and registries to monitor and examine maternal and child health outcomes of ART

- **Research**: Population-based research of maternal and infant health outcomes of ART primarily using linked data

- **Public Health Practice**: Translating research into practice (using research findings to improve practice of ART and understand how ART impacts health outcomes)
Linkage Methodology

- Probabilistic linkage method using indirect link factors
  - Mother’s date of birth
  - Infant’s date of birth
  - Plurality
  - Gravidity
  - Zip code
- Link Plus (CDC’s Division of Cancer Prevention and Control)
- Linkage validation results:
  - Sensitivity: 99.0%
  - Specificity: 100%
  - Positive Predictive Value: 100%
  - Negative Predictive Value: 1%
What are some safety concerns of fertility treatments?
How do fertility treatments contribute to multiple births?
How effective are fertility treatments?
How can we prevent adverse outcomes of fertility treatments?
What do we know about infertility?
SMART RESEARCH

Embryo transfer practices and perinatal outcomes by insurance mandate status

Sheree L. Boulet, DPH, MPH,1 Sara Crawford, PhD,2 Yujia Zhang, PhD,3 Saswati Sunderam, PhD,4 Bruce Cohen, PhD,5 Dana Bemsen, MPH,6 Patricia McKane, DVM, MPH,7 Marvin A. Baling, M.A., M.S.W.8 Dylan J. Jamieson, M.D., M.P.H.9 and Dmitry M. Kissin, M.D., M.P.H.10 for the States Monitoring Assisted Reproductive Technology (SMART) Collaborative

ORIGINAL ARTICLE: REPRODUCTIVE ENDOCRINOLOGY

Maternal characteristics and pregnancy outcomes after assisted reproductive technology by infertility diagnosis: ovulatory dysfunction versus tubal obstruction

Yolanda Grigorescu, M.D., M.S.P.H.,1 Yujia Zhang, Ph.D.,2 Dmitry M. Kissin, M.D., M.P.H.1

Estimates of Lifetime Infertility from Three States: The Behavioral Risk Factor Surveillance System

Sara Crawford, PhD,1 Chris Fuisman, MS,2 Marie Bailey, MA, MSW,3 Dana Bemsen, MPH,4 Denise J. Jamieson, MD, MPH1, Melissa Murray-Jordan, MS,3 and Dmitry M. Kissin, MD, MPH1

Original Research

Antenatal Hospitalizations Among Pregnancies Conceived With and Without Assisted Reproductive Technology

Angela S. Mattei, MS, Yujia Zhang, MD, Sara Crawford, MD, Sheree L. Boulet, PhD, Patricia McKane, PhD, Dmitry M. Kissin, MD, MPH1, and Denise J. Jamieson, MD, MPH1, for the States Monitoring Assisted Reproductive Technology (SMART) Collaborative

States Monitoring Assisted Reproductive Technology (SMART) Collaborative: Data Collection, Linkage, Dissemination, and Use

Allison S. Mneimneh, MPH,1 Sheree L. Boulet, DPH,1 Saswati Sunderam, PhD,1 Yujia Zhang, PhD1 Denise J. Jamieson, MD,1 Sara Crawford, PhD,2 Patricia McKane, DVM,3 Glenn Copeland, MBA,2 Michael Merol-Barg, MD,2 Yolanda Grigorescu, MD,1 Bruce Cohen, PhD,1 JoAnn Steele, MPH,1

William Sappenfield, MD,1 Hafsaou Diop, MD,1 Russell S. Kirby, PhD,5

and Dmitry M. Kissin, MD,1 for the States Monitoring ART (SMART) Collaborative

Assisted reproductive technology and the risk of preterm birth among primiparas

Galit Donenui, M.A., M.P.H.,1 Claudia Holzman, Ph.D., D.V.M., Patricia McKane, M.P.H., D.V.M.,2 Chenshi Li, PhD,3 Sheree L. Boulet, DPH,3 David Treden, PhD,4 Dmitry M. Kissin, M.D., MPH,1 Glenn Copeland, M.B.A., Dana Bemsen, M.P.H., William Van Sappenfield, M.D., and Michael P. Diamond, M.D.,1
HAVING HEALTHY BABIES ONE AT A TIME
How many embryos should I transfer to have one baby?

During in vitro fertilization (IVF), you can transfer one embryo (single embryo transfer, or DET). If you are a good candidate for having a baby after two single embryo transfers is as good as your chance of having a baby after one embryo transfer. That’s important to know because twin pregnancies are rare.

The chart below compares the percentage of women who had single embryo transfers among good candidates for single embryo transfer for single embryo transfer because they were using IVF for the first time, transferring fresh embryos created from their own eggs, and frozen embryo transfers because they were using IVF for the second or more cycles, transferring fresh embryos created from donor eggs.

- 1 SET (fresh): transfer of one fresh embryo for the first cycle.
- 1 SET (fresh) + 1 SET (frozen): transfer of one fresh embryo by transfer of one frozen embryo, if the first fresh embryo transferred does not result in a pregnancy.
- 1 DET (fresh): transfer of two fresh embryos for the first cycle.

<table>
<thead>
<tr>
<th>Embryo Stage</th>
<th>1 SET (fresh)</th>
<th>1 SET (frozen)</th>
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</thead>
<tbody>
<tr>
<td>Cleavage (2-3 days)</td>
<td>All at least one baby</td>
<td>All at least one baby</td>
</tr>
<tr>
<td>Blastocyst (5-6 days)</td>
<td>All at least one baby</td>
<td>All at least one baby</td>
</tr>
</tbody>
</table>

Source: Centers for Disease Control and Prevention, National Assisted Reproductive Technology Program

For women who are good candidates for single embryo transfer, choosing DET over SET can have a variety of advantages. DET can:

- Almost 3 out of 5 women who have SET have pregnant twins, or at least 37 weeks of pregnancy.

- About 1 out of 4 women who have SET have twins that are admitted to the neonatal intensive care unit (NICU). Twin babies are more than 5 times as likely to be admitted to the NICU as single babies.

- About 7 out of 1,000 women who have SET have cerebral palsy. Twin babies are more than 4 times as likely to have cerebral palsy as single babies.

- Twin babies are more likely to be stillborn, experience neonatal death, have birth defects of the brain, heart, face, limbs, muscles, or digestive system, and have autism than single babies.

- Almost 1 out of 10 women who have SET are more likely to have high blood pressure. Twin babies are more than 10 times as likely to have high blood pressure as single babies.

- Almost 1 out of 20 women who have SET are more likely to have gestational diabetes. Women who have SET may be at higher risk for gestational diabetes than those who have SET.

HAVING HEALTHY BABIES ONE AT A TIME Why are we worried about twin pregnancies?

We know that you are ready to start or add to your family. You may be concerned about your chances of having a baby using in vitro fertilization (IVF) or how much cycles of IVF cost. These concerns are common and may lead you to think about transferring more than one embryo during your IVF procedure. However, transferring more than one embryo increases your chances of having twins or more. Twin pregnancy is risky for baby and mother, whether or not IVF is used. Some of these risks include:

- Almost 3 out of 5 women who have SET have pregnant twins, or at least 37 weeks of pregnancy. Twin babies are nearly 6 times as likely to be born preterm as single babies.

- About 1 out of 4 women who have SET have twins that are admitted to the neonatal intensive care unit (NICU). Twin babies are more than 5 times as likely to be admitted to the NICU as single babies.

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Trends in ART from 1996-2013

Number of ART cycles, embryo transfers, resultant pregnancies, live-birth deliveries, and live-born infants, United States, 1996-2013

- Number of cycles*
- Number of transfers**
- Number of intrauterine pregnancies
- Number of live births
- Number of live born infants

[Graph showing trends from 1996 to 2013]
Percentage of Single Embryo Transfers among All Embryo Transfers

All-time largest increase in the proportion of single embryo transfers (23.8% increase) was observed between 2012 and 2013.
Other noteworthy changes between 1996 and 2013

- The average number of embryos transferred decreased from 3.9 to 1.9.
- The percentage of singleton live births among all ART births increased from 62.6% to 75.4%.
- The percentage of normal birth weight infants among ART-conceived infants increased from 58.0% to 71.5%.
- The average gestational age of ART births increased from 37.6 weeks to 37.8 weeks.
- The percentage of term births increased from 68.0% to 73.8%.

All trends were significant (P<0.0001).
What’s next for the SMART Collaborative?

- Expansion to more states and linkage with state vital records and registries
- Additionally, explore linking NASS to NVSS
- Strengthen research infrastructure:
  - Standardized linked data
  - Robust research review process
  - Single IRB for all states
  - Efficient data analysis through RDC or on site at DRH
  - Studying other MCH outcomes using available data
  - Sustainable funding
THANK YOU!

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www.cdc.gov/ART

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Telephone, 1-800-CDC-INFO (232-4636)/TTY: 1-888-232-6348
E-mail: cdcinfo@cdc.gov Web: www.cdc.gov

The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.
Carol L. Stone, PhD, MPH, MA, MAS
Supervising Epidemiologist
Connecticut Department of Public Health
The Role of State Public Health Agencies in Improving Assisted Reproductive Technology (ART): Connecticut Presentation

Presented to members of the Association of State and Territorial Health Officials (ASTHO)
June 28, 2016

By
Carol Stone, PhD, MPH, MA, MAS
Supervising Epidemiologist
Health Statistics and Surveillance Section
Connecticut ART Insurance Mandate


• Mandated coverage: Women less than 40 years old, two cycles of *in vitro* fertilization, no more than two embryos per cycle.

• Exclusions: Religious organizations, employers who self-insure, public insurance recipients.

• Law revised in August, 2015 to include women 40 years old and older, explained in Bulletin HC-104, State of Connecticut Insurance Department.
ART Surveillance by CDC

• Released Annually, most recent in August 2015: MMWR Vol 64 (No 6);

• Presented at CityMatCH/MCH Epi meeting in December, 2012.

Efforts to reduce low birth weight (LBW) in the state must include ART
Connecticut ART Statistics, 2012

- Ranked sixth in country for ART usage (4,584.5 ART procedures per million) among women aged 15-44 years old;
- 895 deliveries due to ART, 452 twins or higher;
- Risk of LBW: 8% among singleton babies, 55% among twin babies;
- 10% of all LBW attributed to ART;
- 16% eSET* use among women less than 35 years old (Range among all states: 2% - 60%).

* eSET – elective single embryo transfer

Source: MMWR Vol 64 (6), Aug 14, 2015
ASTHO Funding, January – June, 2015

• Add questions on infertility to the Connecticut Behavioral Risk Factor Surveillance System (CT BRFSS);
• Develop a factsheet on ART in Connecticut;
• Field test the factsheet on ART;
• Facilitate vital records linkages.
Infertility Questions in the CT BRFSS

• Set of three questions to estimate
  – Infertility in the population;
  – Fertility treatments, if any; and
  – Result of the most recent treatment;

• Includes fertility drugs as an option – not collected by CDC and may be more heavily used by families of low income;

• Originally offered in Connecticut among women 18-50 years old in 2013, sample size was small (n=1,038):
  – Prevalence of infertility: 11.0% (95% CI: 8.2% - 13.8%);

• Repeated the questions in the 2015 CT BRFSS survey.
Factsheet on ART in Connecticut

- Extracts data from ART Surveillance Report by CDC;
- High twin rate;
- High ART rate;
- Link between ART and LBW;
- eSET as an option to reduce LBW.

http://www.ct.gov/dph/ART
Field Test among Connecticut Residents

- Tested among patients at the University of Connecticut Center for Advanced Reproductive Services (n=10);
- Tested among general public (n=10);
- Results:
  - Factsheet is most useful in the clinical setting;
  - Patients found it beneficial;
  - (Staff liked having an aid for their discussions);
    - Neutral source of information?

http://www.ct.gov/dph/ART
Funded Partner in 2015

• Grateful for the opportunity;

• Linking birth, death, fetal death, hospitalization, birth defects records;

• Data are involved in five research projects
Current ART Activities in Connecticut

- Funded partner since 2015, linking records, sharing linked data with CDC, and participating in research studies;
- Explore more fully the potential benefits of incorporating a DPH factsheet into clinical practice;
- Analyze data on infertility from 2015 CT BRFSS.
Thank you!

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Diane Aye, Section Chief, Health Statistics and Surveillance  
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Karyn Backus, Epidemiologist, Health Statistics and Surveillance  
Amy Smart, Public Health Associate, CDC
Dana Bernson, MPH
Epidemiologist III
PI for MA in the States Monitoring ART Collaborative
Massachusetts Department of Public Health
Dana Bernson, MPH
Epidemiologist III/MA SMART PI
Massachusetts Department of Public Health

ASTHO ART Webinar
June 28, 2016

Efforts to Reduce the ART-Associated Twin Birth Rate in Massachusetts: The MA Patient Education Project (PEP)
• High contribution of ART to multiples, despite “comprehensive” insurance mandate to cover infertility services

• Significant reduction in rates of triplets and HOMs over time, but not twins

• Research suggests that patients are not fully aware of (or underestimate) the various risks associated with multiple births, especially twin pregnancies.
In 2014, eSET rates for women < 35 were relatively high in MA.

Source: Preliminary 2014 data from CDC's National ART Surveillance System
Despite relatively high rates of eSET and low rates of multiples among ART births, high utilization of ART means that contribution of ART to all multiples in MA is highest in the U.S.

**Source:** CDC, Assisted Reproductive Technology Surveillance—United States, 2013
Project Objectives

- Engage MA fertility clinics in SMART activities: we’re on the same page – how can we help?

- Increase patient knowledge about risks associated with multiple gestation pregnancy/birth (with an emphasis on twin risks)

- Reduce the rate of ART-conceived multiples, especially twins, in MA
Project Overview

- Kick off meeting with clinic directors
- Survey on current clinical practices
- Development of materials
- Clinic Visits
- Materials rollout
Key Insights

- The clinicians already got it!
- Education needs to begin as upstream as possible
- Redefining success: “good perinatal outcome”
- Financial landscape/reforms
Having Healthy Babies
One at a Time

How many embryos should I transfer to have one baby?

During in vitro fertilization (IVF), you can transfer one embryo (single embryo transfer, or SET) or two embryos (double embryo transfer, or DET). If you are a good candidate for single embryo transfer, your chance of having a baby after a single embryo transfer is as good as your chance of having a baby after a double embryo transfer. That’s important to know because twin pregnancies are risky for baby and mother.

The chart below compares the percentage of women who had single babies or twins after single and double embryo transfers among good candidates for single embryo transfers. These women were good candidates for single embryo transfer because they were using IVF for the first time and were (1) younger than 36, (2) transferring fresh embryos created from their own eggs, and (3) receiving at least one embryo or (2) any age and transferring fresh embryos created from donor eggs.

- 1 SET (fresh): transfer of one fresh embryo for the first IVF cycle.
- 1 SET (fresh) + 1 SET (frozen): transfer of one fresh embryo for the first IVF cycle, followed by transfer of one frozen embryo, if the first fresh embryo transfer does not lead to having a baby.
- 1 DET (fresh): transfer of two fresh embryos for the first IVF cycle.

<table>
<thead>
<tr>
<th>Embryo Stage (Day of Transfer)</th>
<th>EMBRYO TRANSFER OPTION</th>
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<tbody>
<tr>
<td></td>
<td>1 SET (fresh)</td>
</tr>
<tr>
<td>Cleavage (2-6 days)</td>
<td>At least one baby, 50%</td>
</tr>
<tr>
<td></td>
<td>Twins: less than 1%</td>
</tr>
<tr>
<td>Embryo (8-10 days)</td>
<td>At least one baby, 53%</td>
</tr>
<tr>
<td></td>
<td>Twins: less than 1%</td>
</tr>
</tbody>
</table>


For women who are good candidates for single embryo transfer, transferring one fresh embryo followed by one frozen embryo, if a second transfer is needed, offers the best chance of having a baby without increasing the chance for twins.
Current Insurance Environment in MA

- **Coverage Gaps**
  - Exemption for employers who self-insure
    - > than 50% of private-sector enrollees are in self-insured plans
    - Larger employers are more likely to self-insure
  - Exemption for employers who are based out of state
  - Exemption for public insurers (Medicaid)
  - Rise in high deductible plans
  - No coverage for “experimental” procedures, such as PGD, which can improve pregnancy rates and lead couples to choose SET

1 Source: Employee Benefit Research Institute
The Reality

- Clinicians told us that between 25 and 50% of patients seeking IVF are paying out-of-pocket for at least some portion of their treatment.

- Continued high rates of twins in MA as financial incentives for eSET are limited.

- In clinician survey, “financial consideration” was listed as a top reason why couples request that more than one embryo be implanted.
Patient Education Will Only Go So Far

- For a segment of the population seeking IVF in MA, financial pressure may be high enough that no amount of education will outweigh desire to conceive pregnancy in as few cycles as possible.

- Financial risk disproportionally falls on couples who have to pay for IVF, but likely do not feel the full financial impact of subsequent medical problems.

- Need to work with insurance companies to incentivize eSET; they pick up the bill when multiples face health problems.
Next Steps

- Feedback on materials now that they are being used
- Quantifying the magnitude of coverage gaps
  - Adding payments details to NASS?
- Insurance Reform
  - BCBS updated SET policy in 2014 and clinics saw impact on eSET rates.
Cheryl Schott, MPH
Consultant/MiART Summit Coordinator
State of Michigan Department of Health & Human Services
Michigan Assisted Reproductive Technology (MiART) Summit: Planning for Action

Cheryl Schott, MPH
ASTHO Webinar:
The Role of State Public Health Agencies in Improving Assisted Reproductive Technology (ART)
June 28, 2016
Background

Infertility and Treatment in Michigan (MI BRFS 2012-2014):

- 7.3% of Michigan adults reported ever experiencing infertility (men and women), among those who tried to get pregnant

- Of those with infertility, 61.2% reported that they received infertility treatment

- Of those receiving treatment, 16.9% used ART

- ART-conceived infants accounted for 1.2% of all births in Michigan in 2013*

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Background

Percentage of Multiple-Birth Deliveries, Preterm Births and Low Birth Weight Infants in MI by Type of Conception, 2013*

<table>
<thead>
<tr>
<th>Type of Event</th>
<th>ART-Conceived Infants in Michigan</th>
<th>All Infants Born in Michigan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multiple-birth deliveries</td>
<td>44.2%</td>
<td>3.7%</td>
</tr>
<tr>
<td>Preterm Births</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• &lt;37 weeks</td>
<td>37.4%</td>
<td>11.6%</td>
</tr>
<tr>
<td>• &lt;32 weeks</td>
<td>7.6%</td>
<td>2.2%</td>
</tr>
<tr>
<td>Low Birth Weight</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• &lt;2,500 g</td>
<td>30.1%</td>
<td>8.2%</td>
</tr>
<tr>
<td>• &lt;1,500 g</td>
<td>6.5%</td>
<td>1.6%</td>
</tr>
</tbody>
</table>

Michigan Efforts

- Member of the SMART Collaborative since 2008
- Comprehensive surveillance plan
- Michigan Infertility Advisory Committee (MIADCO)
- BRFSS Infertility Module conducted 2011-2014
- Various research initiatives and publications
Challenge

Translating surveillance and research findings into actionable items
MiART Summit

Goals and Objectives:

- Raise awareness of infertility and contribution of ART to preterm births
- Develop recommendations to improve ART access, practices, and birth outcomes in Michigan
  - Provider Practice
  - Policy/Insurance Coverage
  - Patient Education
  - Contributing Risks from Non-ART Treatments
- Enlist stakeholders and organizations to take action
MiART Summit

Stakeholders:

- State Health Officials
- Policy Makers
- Practitioners
- Public Health Professionals
- Insurers/Health Plans
- Researchers
- Consumers
- Pharmaceutical Reps.
- Legal and Ethical Experts
- National Partners (ASTHO, CDC)
Agenda:

- **Morning – Large group plenary with state and national speakers**
  - Sue Moran, MDHHS
  - Dmitry Kissin – CDC
  - Eli Adashi – Brown University
  - Barbara Collura - RESOLVE

- **Lunch - Consumer Panel**

- **Afternoon – Breakout Work Groups**

- **Large Group Report Out and Wrap Up**
Draft Recommendations

Provider Practice:

• Increase education and training
• Greater commitment to and practice of SET
• Increase care coordination and psychosocial support for patients
• Encourage rigorous research
MiART Summit

Draft Recommendations

- Policy/Insurance Coverage:
  - Engage additional stakeholders
  - Work to develop consistent, succinct, unified messages
  - Foster relationships with insurers, employers, and policy makers
  - Convene another summit
Draft Recommendations

Patient Education:

- Conduct a comprehensive public awareness and patient education campaign
- Better understand the patient experience
- Ensure providers have training and resources to educate patients
- Disseminate existing patient education materials more widely
Contributing Risks from Non-ART:

- Increase provider and patient education about non-ART treatments
- Develop/implement clearer guidelines for use of non-ART treatments
- Increase ultrasound monitoring during non-ART treatments
- Conduct surveillance of non-ART use and outcomes
- Use non-ART less by increasing access to ART
MiART Summit

Draft Recommendations

➢ Cross-Cutting:

• Promote greater awareness of reproductive health
• Define and officially recognize infertility as a disease
• Educate legislators/policy makers about infertility
• Promote insurance coverage for ART
• Better understand the male-factor side of infertility
• Expand and diversify research on infertility issues and outcomes
Next Steps

- Finalize plan and recommendations based on review and input from stakeholders
- Disseminate plan throughout the state
- Continue dialogue and engage stakeholders in integrating recommendations into their work
Questions and Answers

- We will begin by asking our speakers questions from the chat box that came up throughout the presentations.

- **Reminder** – please type any questions you have in to the Chat Box located on your screen or please use the notification box so the operator can take you off mute to ask your question.
Thank You!

- Please remember to fill out the meeting evaluation form after the webinar ends.

- Today’s slides and presentation will be made available here: http://www.astho.org/Programs/Maternal-and-Child-Health/

- Contact Ellen Pliska for any follow up questions or to sign up for ASTHO’s Primary Care and Prevention Newsletter at epliska@astho.org,