Advancing Preconception Wellness in Health Systems
Learning Collaborative Webinar Notes
In Accompaniment to Webinar PowerPoint Presentations
June 2016 - January 2017

Webinar 1- June 30, 2016

Participating person(s) and organizations:

1. **Janice Smiley- Alabama State Department of Health**
    a. Developing preconception health state plan
2. **Jennifer Hosmer-Providence Community Health Centers**
    a. Multi specialty group- 40 – 50,00 patients- Chair of Dept of OBGYN- Implement real
    b. State of RI- mandating title X to implement OKQ
3. **Ryan Everett- Ohio State Hospital Association**
    a. Work with all hospitals – Infant Mortality- focusing on Preconception Care- how to connect hospitals and collaborative into group
4. **Lisa Callegari- Washington State Hospital Association**
    a. OBGYN- University of Washington- Need to clarify point person for Washington State Hospital Association- setting up a set of recommendations and
5. **Lisa Callegari- Veterans Affairs**
    a. Laurie Zephryn- Collaborating on provider training- app, template for use in clinical care around preconception visit, working on patient centered care, hoping to look at internal VA Data, trying to track measures
6. **Andrea McGlynn and Ellen Mason- Cook County**
    a. large population of women with chronic conditions- interested in data analysis and fine tuning approach
7. **Cindi Dubner- New York State Department of Health-**
    a. MICH- Maternal and Infant Community Health Collaborative- Pre and Interconception care through training and technical assistance to primary care providers- have been giving presentations via the Before and Beyond Toolkit. Incorporating OKQ into daily work.
    b. Cheryl Hunter Grant
        i. Preconception on intake form
8. **Hellen Bellanca- Health Share Oregon**
    a. Samaritan Health Services- Not o
9. **Dan Frayne - Mission Health, Western North Carolina**
    a. - Diabetes Care Process Models
10. **Eleanor Bimla Schwartz- UC Davis**

Webinar 2- July 28, 2016

New York State Department of Health

1. Currently focusing on birth intention and PP LARC use
    a. How are you measuring this and how are you reporting?
        i. There is information in vital records
        ii. PRAMS

NOTE: CDC has moved to 10 preconception measures- hopefully by the end of this year- Cheryl Robbins

2. birth certificate data - patient reported - at the State level, they have gotten permission to data
    a. not easily accessible
    b. not easy in Washington
    c. some Health Care systems asking at prenatal visits

NOTE: NYSDOH is measuring provider education and training

QUESTION: How are you collecting pregnancy intention and where is it being extracted?

    d. developed specific data collection tools- for Quality Improvement
    e. paper based, pre and post collection, hoping to collect intention a few months later
    f. FQHC- paper based form, ask about PI- imputed into system - makes it difficult

NOTE: Many using contraceptive as main measure for preconception wellness - - need to think about how we can do more

    a. Use the other measures in tandem with contraception
    b. Are you asking about pregnancy intention, contraception?
    c. Next step- asking the other questions at the prenatal visit
    d. Preconception can also be all women, not just prenatal

3. **QUESTION**: When is the best time to catch/collect the PW data?
4. **QUESTION**: How do you get to patient level
    a. –Cook County- Strategizing to find databases- pharmacy, claims, lab, crosscheck of pregnancy/prenatal visit-- which women are pregnant an which women are not
    b. – Rhode Island- Cross collaboration of claims/integral data that can be shared across public/private
        i. Smaller size makes it more feasible

NOTE: Ohio- State wide collaborative- currently surveying providers in Ohio

    a. Have access to claims data/ limited to who can share with/ LARC insertion

Washington - sharing data through multiple different platforms- value of Hospital Association

Webinar 3 – September 15, 2016

NOTE: The assessment (presented by Helen Bellanca) of what providers are able to provider with 0,1,2 is something that she can see them using

- hard to measure content
- specific interventions
- Can it extract what providers are doing?

QUESTION: What are your thoughts on using it in Health Plan setting?

- It can work in the Health Plans
- Health Plan can create incentives
    - self-assessment tool
    - using support/bonuses/ to train others- move toward a better model of care
    - preferential assignment depending on use

QUESTION: Can is be used as a tool? (with the goal to have every clinic up to a 2 or at least to a 1)

- encourage everyone to be at a "good" level (1)
    - create a solid base of 1's
    - create the networks of providers-
    - Stop paying the networks that are not scoring at least a 1
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QUESTION: Is there an outcome Measure with Pregnancy Intention with contraceptive use?

- As part of the National Movement- meeting to talk about what PI would look like?
- What we can measure?
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NOTE: Contraceptives can't exclude/include women that do and do not want to be pregnant- in Claims data

NOTE: Bundled measure- pregnancy intention screening with her response and the services offered

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Webinar 4 – November 10, 2016

QUESTION: Pregnancy Intention is starting to grow in the Family Planning clinics, how to break down unwanted/mistimed

- There is no specific way to obtain it, but we want to figure out something to start with

NOTE: NYSDOH- making progress with FQHC

- Barriers-
    - No time- so they had to back out of the project
    - Taken projects in a different direction
- Working with Head Start/Early Hard Start
- Educating the provider

NOTE: Health Share of Oregon

- Contraception is the checklist that they are using now and they are starting the work on the preconception checklist
    - Providers can do one or both modules-
- People don't understand what preconception care is- this is what distinguishes when providers are really doing it- unique to preconception health- not always a part of primary care visits

NOTE: Ohio isn't sure where the focus needs to be between OHA and

- Ohio Collaborative to Prevent Infant Mortality
    - Subcommittee with people focus on Preconception Health

NOTE: Washington State Hospital – Identifying best practices among primary care throughout the state

- Having it in a format the can be disseminated
- Implementation hasn't moved forward- the hospital is making a lot of changes

- It will progress, but it is on a small

NOTE: Cook County- felt compelled to get a little more proactive

- Project that would change the way members access prenatal vitamins and condoms,
- Over the counter medications can be paid for by Medicaid
    - The prescription is a barrier- people have to go or request from the provider
- Exploring a way to administer payment for vitamins and condoms without prescription
    - How to get in the hands of consumers?
    - They are going to do an implementation oriented project
- To do: they want to add the contraceptive quality and possibly preconception health

NOTE: The VA

- They have great data, but not great reproductive health data
- Need a system to get data from pregnant women
- Have maternity care coordinators
- More immediate- they have a small working group that is progressing in the area
- Looking at women's experience around preconception care
- Priority for Laurie Zephryn

NOTE: Shiprock Service Unit

- 50% of all their pregnancies are unplanned
- 98% obesity rates coming into pregnancy
- High A1C
- Looking to get baseline data, but having issues with the HER
    - Working to fix this issue
- Wanting to be able to measure

QUESTION: Would the urgency also be related to the massive changes in primary care via DSRIP and other similar initiatives must look at women's reproductive health to reduce avoidable hospitalizations in general?

NOTE: Head Start has new regulations to look at how to address health/social determinants of health

QUESTION: Is infant mortality the way to talk about sense of urgency?

NOTE: Maternal mortality review- focus on PCC and ICC- focus on chronic conditions-

- Key drivers for maternal mortality- chronic conditions
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QUESTION: Infant mortality- preterm birth- how strong is the data to support this?

- Risk factors that are modifiable all effect preterm birth

NOTE: Chronic conditions is the real- every day/ sense of urgency

FOR NOTES RELATED TO WEBINAR 5- JANUARY 12, 2017 – PLEASE REFER TO POWERPOINT SLIDES