



Preconception Health+Health Care Initiative

A National Public-Private Partnership

Catalyzing Change Meeting MEETING REPORT

Vision: All women and men of reproductive age will achieve optimal health and wellness, fostering a healthy life course for them and any children they may have.

Meeting Goals:

- Synthesize current preconception efforts in consumer education, clinical integration, and population measures
- Develop plans for expanding preconception strategies across systems and population groups, including research
- Strategize about connecting with and amplifying Title V efforts around the well woman visit

Catalyzing Change across the Nation

On December 13-14, 2016 in Arlington, VA, PCHHC brought together over 100 people from 20+ states. Twelve out of the fourteen Show Your Love Diversification Grantees participated, as did the majority of the health systems in the learning collaborative. In addition, leaders from the national PCHHC team, representing key federal, national and state partners; including ACOG, AWOHNN, AAFP, AMCHP, City MatCH, March of Dimes, the Centers for Disease Control and Prevention, ZERO TO THREE, HRSA MCH Bureau, Federal Office on Minority Health, One Key Question, and more. Participants arrived the evening of the 12th. The meeting on the 13th was a full day with evening dinner circles organized to create opportunities for small group interaction. The meeting finished just before noon on the 14th. The meeting took place alongside the Federal Title V Directors summit, which fostered additional collaboration. All Title V summit participants received lanyards with their nametags with PCHHC websites and information. They also received postcards with information about preconception resources and branded lunch bags. PCHHC meeting participants received these items as well as branded water bottles.



Some of the Meeting Participants – More Photos Available on ShowYourLoveToday – Facebook

The first day began with separate groups for consumer-focused work and clinician-focused work. Lunch provided an opportunity for cross-pollination of ideas, including a presentation of the results of the WK Kellogg funded well woman

story research project and the release of new population health indicators by the CDC. The groups met separately in the afternoon briefly to finish up their separate deliverables for the WK Kellogg grant. The afternoon brought both groups together for joint discussion and strategic thinking. The second day combined both groups with opportunities for participants to engage in small, mixed groups to help problem solve and move forward several specific areas in preconception health. The meeting results were summarized and presented to the leadership team in January.

Consumer Workgroup

Consumer Meeting Charge:

1. HOW do we authentically – while being firm on science/accuracy – message and engage with all these different groups on preconception health?
2. WHO are the influencers in these communities? Who can help spark actual behavior change? How do we engage them?
3. WHAT do the grantees/our partners need to take their work to the next level (e.g. community campaigns)? What should Show Your Love Phase III look like?

This component of the meeting began with a brief overview of the work achieved to date with support from the WK Kellogg Foundation. Mini-grantees then each had an opportunity to present their work, including lessons learned. The group completed their time together by sharing ideas for next steps.

Show Your Love Background

The *Show Your Love* campaign first launched on Valentine's Day 2014. The campaign focuses on women during their childbearing years. As part of the campaign, the Initiative developed a series of educational materials including video and radio public service announcements, posters, a checklist of healthy habits, as well as online ads and a kit for organizations interested in supporting the campaign and helping to spread the word about the importance of preconception health. Original campaign products live at: www.cdc.gov/showyourlove Since the 2014 Show Your Love launch, PCHHC Consumer Workgroup, with support from the WK Kellogg Foundation has worked to expand and diversify their flagship program, [Show Your Love](http://www.showyourlovetoday.com). A Communication Director was brought on board for Phase II. In 2016, the PCHHC Consumer Workgroup began rolling out the new Show Your Love consumer-facing campaign, beginning with www.showyourlovetoday.com, the first and only national consumer-focused preconception health educational and community-building platform in the U.S.



The formal Show Your Love website and social media launch took place June 2016. All the launch week activity numbers added together: potentially reaching OVER 90 MILLION people. The Show Your Love launch week activities included: [Show Your Love launch press release](#), [PCHHC #PCHchat Tweet Chat](#), [Show Your Love Twitter](#) and [Show Your Love Facebook Page](#) launch, partner support: [March of Dimes' News Mom's Need](#) (2 blogs), [NICHQ Blog](#), [UNC OBGYN website](#) feature/newsletter, [Healthy Teen Network blog](#), [TheNC blog](#), OMH's [PPE Webinar](#) (Blog/Newsletter to follow), CDC NCBDD newsletter, CDC PCH Update, ASTHO newsletter/blog, *to name a few*.

Diversifying Show Your Love

In December 2015, the Consumer workgroup issued an RFA for the "[Show Your Love Diversification Grant Program](#)," aimed to diversify preconception wellness and reproductive life planning messages and improve our shared capacity to reach different consumer groups. The Workgroup funded 14 organizations across the U.S. to expand and diversify Show

Your Love preconception messages and educational materials. These organizations had a proven track record of successful engagement within their communities and tested preconception messages and Show Your Love materials with their audiences to improve upon and revise/reframe those messages. They produced Show Your Love campaign materials that are more relatable to their population, including videos, public service announcements, posters, digital ads, doctor dialogue toolkits, healthy habits checklists, and more. Each grantee received up to \$5,000 to fund their ideas. The morning was spent sharing highlights, materials and results of pilot testing. See below for a snapshot.

Grantees Highlights:

1. Latino Commission on AIDS

1. Target audience: Latina women/cisgender, English and Spanish speaking, ages 18-29
2. Location: U.S. and territories
3. Key Findings:
 - Need to recognize the issue of pregnancy ambivalence (large group of people not trying to become pregnant and not-not trying to prevent a pregnancy)
 - Need to address issues of sexual repro justice—it is one thing to know or be told about issues, but can consumer actually access the health services they need/want (can they safely run in their neighborhood, can they access birth control, etc.)

2. Family Tree Clinic

1. Target audience: LGBTQIA
2. Location: Twin Cities, MN
3. Key Findings:
 - Recognize that not all people with a uterus identify with the word woman; LGBTQ communities have the highest rates of unintended pregnancy
 - Ensure representation in clinic waiting rooms, magazines and outreach materials of diverse gender identities and sexual orientations/partner pairings
 - Offer opportunities for people to self-identify their sexual orientation, gender identity, names and pronouns in clinic settings: ensure you are asking people for their gender pronouns, and have options for people to use their preferred name which may not be their legal name
 - Improvements that are focused on LGBTQ communities in health have the potential for improving the care, health and wellbeing of all people. This is called targeted universalism: meeting the needs of marginalized or excluded groups (targeted) can meet the needs of the broader whole more effectively (universalism).

3. Florida Department of Health- Duval County

1. Target audience: African American women and males ages 19-29, significant others of "planning/non-planning" women, Fathers
2. Location: Northeast FL (Duval County / Jacksonville)
3. Key Findings:
 - Formative research for men and cultural barriers (language translation)
 - Must link to repro and social justice issues!
 - Add humor to social – memes, thunderclaps, snapchat, etc.
 - Reaching men where they are – sports, barber shops
 - Interest and knowledge varied: Some women gave feedback that folic acid messages didn't resonate others said folic acid messages were already well understood

4. Women Watch Afrika

1. Target audience: Refugees from African countries
2. Location: Atlanta, Georgia (and surrounding counties)
3. Key Findings:
 - Discussing the benefits of child spacing and small family size, leading to healthy family and good quality education for the children, and healthy family as a whole helps to improve the knowledge, attitudes and behaviors of low income underserved refugee and immigrant women related to preconception health.
 - In a refugee friendly culture and language we encouraged women to take proper care of their bodies, and allow it to heal in the same manner of time it took before delivery.
 - Program address cultural and religious barriers that negatively affect the health of women, youth and children

- Topics require a higher literacy level and experience from program participants in engaging in community health promotion activities
- How can we include prayer in messages that is a cornerstone part of culture?

5. **Healthy Start Coalition of Jefferson, Madison and Taylor Counties**

1. Target audience: Young Black women and partners, low-income
2. Location: North Florida (Jefferson, Madison and Taylor Counties)
3. Key Findings:
 - After the workshops, 82% of the participants felt their understanding of unplanned pregnancy prevention was 'Excellent.' Over 80% also marked their understanding the harm of drugs/alcohol and smoking topics as 'Excellent.'
 - After the workshop, 73% of participants agreed that how a woman feels is a good measure of her health.
 - The Coalition created an informational kit specific to their target audience and community. This pamphlet incorporates information from the Show Your Love guide and CDC website, "Taking Care of Me"

6. **Black Women Wellness**

1. Target audience: African American young women ages 18-29
2. Location: National organization based out of Los Angeles, CA
3. Key Findings:
 - The participants suggested using models that represent the range of Black women of darker skin tones as well as body types to make the campaign more relatable. Simple style changes were key to identifying with the characters in the campaigns (hair style, outfit color, earrings)
 - Using vibrant Pan-African colors was also suggested to demonstrate that this campaign is for an African American audience. Showing the different women in different class backgrounds. (Baldwin Hills to the Hood)
 - There is a such thing as too much information. The focus group felt that although it was good information it was a lot of information and wouldn't hold the reader's attention for long. They would have liked to see more local health resources on it & more information on STD screening and condom use in the campaign.
 - Images with people driving in cars—did not match their SES reality
 - Messages were well received but often stated they wouldn't "share" on social media
 - More info wanted about STDs and condoms)

7. **Healthy Teen Network (App)**

1. Target audience: African American and Latina teenage girls
2. Location: National Membership Organization based out of Baltimore, MD
3. Used Show Your Love information in section of their Pulse App. Key Findings:
 - Idea to link SYL info in an app where you can put in your zip code and more tailored health services could be provided
 - SYL checklist is more for health educators, not consumers

8. **Brigham & Women's Hospital**

1. Target audience: Latinas ages 14-45/their senior support systems ages 45+, 85% Spanish is primary language
2. Location: Boston, MA
3. Key Findings:
 - Campaign needs accompanying information - Healthy Eating Example: Suggestions on sample meals, info on most important nutrients, cultural considerations like salt substitutions, community resources like local food pantries.
 - Should include a texting service, app, link to local website with resources by zip code, etc.
 - Pair taking care of your health with the other ways women practice self care—example: Visit your doctor after your mani/pedi
 - Needs to be paired with on-the-ground health education/information that incorporates social opportunity
 - Acknowledge women through positive messaging and grounding campaign in reality
 - Acknowledge prioritization of needs—people often have to choose between food and medication (short term versus long term needs).

- Missing Messages: Learn about your body so you can notice changes; Align your physical health, mental health and your personal goals; Build your social support system; Always continue to educate yourself and seek out information from trusted sources
- Images: Want more images featuring women supporting each other, younger women, and women practicing good health behaviors with their teens;
- Marketing Materials: More diverse, fewer tips (only top 6), more information about what Show Your Love is, more youth-friendly, bilingual
- Spanish speaking groups really liked the idea of SYL was connected to “preparing for your future”

9. LA County Dept. of Public Health (LA FAMILIA digital campaign)

1. Target audience: Nearly 100K Hispanic men and women ages 18-29 in California (FAMILIA text campaign)
2. Location: National campaign based out of Los Angeles, CA
3. Key Findings:
 - Meet women where they are.
 - Transcreation is critical component. Not as easy as a Google Translate.
 - Sharing real actions that women can take in any community or walk of life.
 - Don't assume Hispanic women don't want info on birth control and diversify messaging, skin tones, social status, clothing, colors, literacy levels, language

10. Health Advancement for Pacific Islanders (HAPI)

1. Target audience: Pacific Islander men and women ages 18-29
2. Location: Alameda County, CA
3. Key Findings:
 - “Preconception”—focus on different terms that might resonate better “taking charge of your health”
 - Too much information—narrow it down. Too many URLs on the site; Some materials too wordy
 - Important to have different literacy levels!

11. Ohlone Community College District

1. Target: Reach over 3K Asian Pacific Islander and Latina female students at Ohlone Community College
2. Location: Alameda County, CA
3. Key Findings:
 - Pamphlet is a great conversation starter. Could be more consumer-friendly. Liked that you can select top overall goals.
 - Need more awareness about contraception, folic acid, info about how mental health impacts reproductive health.
 - Really want to help people move from knowledge to action
 - Some mentioned that health is more than just things like BMI—it is the idea of getting ahead
 - Multiple messages about consumers not wanting to take print material with them (i.e., not wanting parents, roommates to see pamphlet).

12. Heritage University

1. Target: Young women and children enrolled tribal members of Yakama Nation & other families in Yakima Valley
2. Location: Washington State (Ttawaxt, indigenous Native American community)
3. Key Findings:
 - Idea of Self Love-really resonated across various groups (Latina teen moms, Native American women, etc.)
 - Need to include Elders and men in healthy conversations
 - Community-level support to create real behavior change

13. Native American Community Health Center

1. Target: American Indian women and men ages 18-44
2. Location: Maricopa County and surrounding areas, Arizona
3. Key Findings:
 - Multigenerational support and education is critical: Elders need to be engaged with and educated to support young women
 - Many young women in this community lead their families, households, communities – need to feel empowered to take time for themselves

- Positive messages were well-received; they also liked seeing themselves doing healthy things in photos and messaging-seeing their community in a positive way.
- Need to address toxic stress and historic trauma
- SDOH must be addressed
- Focus on short terms goals vs. long term goals when prioritizing messages
- Limit messages to SIX tops – nine is too many

14. UNC Pembroke – Healthy Start CORPS

1. Target: Native American and Hispanic women ages 18-29 from UNC Pembroke and Community College
2. Location: Robeson County, NC
3. *Key Finding: ongoing focus groups; analysis forthcoming.*

Outstanding Questions:

WHO are the influencers?

- Many of the grantees – GET IN the communities - Need FTE to get in these communities
- Peers, Churches, salons, fraternities, mentorship for middle, high school and college students
 - How do they operationalize the advice?
 - Communities funding is too low – need help getting funding for themselves!
- Grandparents – INTERGENERATIONAL messaging needed

HOW do we engage with these influencers? WHAT do we need to work on?

- Work on a hook for non-planners/ambivalent
- Not demonizing what people do – woman felt guilty when she saw an apple but didn't have access to healthier foods
- Group engagement strategies – finding women where they are, building relationships,
- Address medical mistrust!
- Template for materials that can be widely distributed and individualized images can be inserted for communities
- Synthesizing information/data (bring data to life) – how can we gather data
- Focus on solutions
- Frame preconception health to be health
- Need personalized, customizable tools, apps
- Cultural sensitivities for HCPs

HOW can we begin to work on this?

- Funding for sustaining materials and a FTE to devote to disseminating pilot projects, messaging and building partnerships in the communities (on the ground)
 - Staff capacity: building relationships in communities – PPEs that are supported on a higher, national level
 - National PCHHC- general messaging and let LOCAL groups customize messages and images (template checklists, resources)
- Work on addressing various language and cultural barriers
- Multi-generational focus
- Do not reinvent the wheel—partner with folks who are doing the work!
- Transcreation for work (example- templates with material and upload your own images)

Funding/Collaboration

The consumer partners then discussed next step strategies. First, expanding upon the ever-growing PCHHC Consumer Workgroup and new Show Your Love Grantee partners, the communications director and workgroup members are regularly connecting with influencers in the field. This connection needs to continue. The group identified a variety of organizations that have a shared mission and model, and recommended ongoing conversations about partnering long-term. The group suggested the importance of involving different funders for different segmented asks:

- Digital media – funders in silicon valley
- Transcreation – Robert Wood Johnson, Word Trail
- Reproductive justice - community-based, grass roots, progressive foundations and donors
- Bigger partnership for major media buys and influence – pharmaceutical companies that are unbranded, for-profit unbranded companies
- Other potential funders include the federal Office on Adolescent Health, Insurance Providers, grassroots non profits, college networks, local women's health circles

- Expand work with [The National Campaign to Prevent Teen & Unplanned Pregnancy \(TheNC\)](#). They are working to improve the lives and future prospects of children and families and, in particular, to help ensure that children are born into stable, two-parent families who are committed to and ready for the demanding task of raising the next generation. This is a natural partnership – they have both clinical and consumer-facing properties and are regularly releasing research and tools to support their mission.
- Expand partnership with [Healthy Teen Network](#).
- The group also expressed a strong hope that the WK Kellogg Foundation might consider providing additional funding to allow them to continue and deepen their work. While \$5,000 is not a lot of money, the participants agreed it was a good catalyst.

Clinical Workgroup

Health Systems & Clinicians Meeting Charge:

Develop a universal framework that health care systems can use to integrate preconception care across the services they provide to women of reproductive age.

- What are the core categories that make up the framework?
- For each category, what are the key components?
- For each of the components, what are the granular elements?

Health Systems Collaborative

With WK Kellogg Foundation resources in partnership with the Mountain Area Health Education Center (MAHEC) a Health Systems Collaborative was established. Aims for this work included sharing ideas, developing and disseminating best practices and strategies, defining barriers and challenges, and developing solutions with the ultimate goals of developing a series of recommendations for system level integration of preconception health. There were five webinars over a period of seven months. Each system presented their success and challenges in their system integration of preconception health. More information about the collaborative along with detailed information about the projects is available on [beforeandbeyond.org](#). The following partners participated in the in-person meeting either by sending a representative or dialing in for the morning session, which was made available by live-stream webinar.

- Mission Health Systems
- Cook County Care and Hospitals System
- New York State Department of Health
- Health Share of Oregon
- The Veterans Affairs
- Indian Health Services: Shiprock Service Unit
- Washington State Hospital Association
- Ohio State Hospital Association
- Alabama State Department of Health
- The Providence Community Health Centers
- Samaritan Health Services

The session began with an overview of the work of the collaborative, brief discussion of the lessons learned and review of the goals of preconception health, wellness and opportunistic care. Participants were to have reviewed the clinical workgroup's published paper on clinical measures of preconception wellness. The work then moved to smaller table discussions where each group was tasked in elevating the key categories, elements, and components required to assure that women of reproductive age received appropriate preconception care at all health care system encounters. Groups then reported back in and the morning session closed with a full group discussion.

There was considerable conversation about the importance of promoting reproductive justice, recognizing implicit and explicit bias in clinical care, concerns about the impact of the Trump Administration on access to health care and the reality that most clinicians do not understand what preconception care is, why it is important and that it is not difficult to integrate into practice. Likewise, given the energy and enthusiasm among the different health systems that engaged in the collaborative, it is clear that there is an interest in improving women's preconception health care and that there are

many different ways to approach this work. The challenge for the group is to develop a model that might be universally applied.

Top Level Findings:

Core Categories: Health Equity, Leadership, Information Technology, Consumer Engagement/Education, Provider Engagement/Education, Incentives for Systems/Providers, Measurement

Key Components: Clinic culture change, Increased discourse and dialogue about preconception health and wellness, Communication across silos within health care and between clinics and community / public health programs, Collaboration to improve patient care via Integrated Clinical Teams/Medical Home models

Granular Elements: Finances – Reimbursement, Cost, Return on Investment, Provider Needs Assessment, Community Needs Assessment, Technology – Electronic Health Record (EHR) documentation, Data input/extraction, Reporting, Templates/guides, Alerts, Decision supports, Universal templates

Small Group Discussion Notes:

The discussions among the different groups were rich. Below are more detailed notes from those conversations. These will be used to develop a white paper in 2017.

Screening

- Online intake form, with introduction / preamble – it is really important to contextualize the questions for patients so they know why you are asking
- Gabby / Show Your Love pamphlet
- Waiting room screening tools to focus visit
- Integrate large system EMR to identify PCC risks
- Pop ups in EHR to remind providers to ask or do specific things
- Adding One Key Question (OKQ) to existing pre visit screening forms – patient answers on her own
- EMR templates incorporates chronic disease management into a well woman visit, check list guided, data guided, ease in documentation
- OKQ – patient survey hand out, medical assistant asks, clinicians ask, health questionnaire before visit
- Ask men and women about their desire for pregnancy
- Patient wellness survey in advance of visit, which address the elements of PC wellness (all but 1st trimester care). Applies to men too
- Screening form needs to be simple – no more than one page to identify PCC areas of need

Documentation

- Demographic data collection so all documentation can be analyzed across subpopulations
- Pilot test and document results to build evidence base for expanded use
- Preconception score build into HER as tool or prompt to guide provider's counseling
- Documentation need an addition to HER and then data collection systems so the fact that the question was asked AND the answer can be recorded

Measurement/Outcomes

- Epic (HER) – health maintenance measures – include contraceptive surveillance
- Build metrics into national data systems such as PRAMS and Healthy Start
- Feedback to all team members working in any size system – how well are you/we doing based on collection of coding data or other data sources
- Integration of hard stop and soft stop measures in EMR – see California PHCC
- Preconception health scores as metric for value based care
- Demographic data collection so all measures can be analyzed across subpopulations
- Utilize PRAMS data to create PCC programming and services by assessing need
- Patient reporting – of experience especially regarding bias and reproductive justice

- Lobby NCQA, HEDIS etc. to develop a PCH measure
- Use ICD10 data collected to bundle PCH
- Determining backbone organization to own data and be responsible for providing TA and analysis to ensure improvement at a national or site level
- Pregnancy intention screening metric
- Build in to state ACO metrics
- Revising hospital clinic protocol to include PCC assessment tool use

Billing and Finance

- Billing limitations - some systems only allow you to be paid to see patient for one thing
- Collate ICD10 codes to facilitate billing
- Outcomes are hard because preconception health outcomes are distant and difficult to link to
- There isn't a HEDIS measure for preconception health however this is also a challenge given that there are 9 potential indicators
- There's an unstable relationship between a person and her insurance - average duration in a Medicaid health plan is 10 months - people shift among income categories, move and have other life events -> little incentive for payers to look at other than very-short-term outcomes
- What's going to make a hospital administrator do this? Needs to save money - payers need to know they will save money - and should pay for us to do the right thing

Health Equity Components

- Community needs assessment
- Data collected and reviewed by race/ethnicity
- Involvement from people being served (community health worker from community being served)
- Training for clinicians and staff

Reproductive Justice

- There is an urgent need for shared decision-making tools about risks, etc.
- There is an implicit cultural bias around intendedness – there are many elements of privilege. Need to be careful of giving a “demerit” at a first prenatal visit for an intention – it needs to be socially ok for women to say they wanted to be pregnant. Shouldn't give a teen a demerit etc.
- There are tough unavoidable issues out there – abortion, LARC coercion, provider bias
- Catalyzing a Reproductive Health and Social Justice Movement paper was published by leaders in the PCHHC
- LARC - it should be a woman's choice, NOT a mandate. We need to be very careful in our rush to LARCs. At the Magnolia project they ask OKQ and work w/ their providers to ask the question correctly – they don't want women penalized if they are pregnant at 16 (or want to be pregnant when providers think they “shouldn't”).
- We need to attend to the social determinants of health – could we do more clinic-based referrals to social work, housing, etc.?

Leadership/ Buy-In Components and Champions

- Provider champions, admin/staff/community leaders, Senior Administration (e.g. Vice President of Women's and Children's Services or Chief Medical Officer), Program director/Clinic managers, RN/Medical Assistant champions
- Formal and informal champions / opinion leaders are needed – clinic administrators and community or state groups should also be considered as resources for champions
- Policy makers, Medical Society, Surgeon General, Primary Care Associations could be possible champions
- Need a champion from each “team” – multi-disciplinary - providers, front desk, etc. as well as units, social worker, nurses, home visitors, rep of public health services etc.
- Make the problem more visible. Question: Why are 30 gun deaths in Boston an issue while 30 infant deaths – disproportionately black – are not?
- Engaging state health officials and governor agencies to bring together key players – hospital associations, housing, transportation, etc. to make this a priority and support clinical movement – CMS etc.
- Recognize publically providers / practices that are participating in implementing preconception health
- Champions might be in bariatric clinics and other specialty clinics where women of childbearing age are prevalent (chronic disease and ED champions).

- Avoid the lazy saboteurs (identify them)
- Individual buy in (and belief that it is the right thing to do) is important
- Leaders need to be decision makers, accountable to finances, and have the ability to negotiate the priorities
- Need for data and voices to drive initial engagement
- Leaders need a view on the long game, interest in leading the effort/and shaming if not coming along
- National clinical organizations are important – their opinions add weight
- Collaborative projects or concrete activities to engage champions inside and outside the health system, generate buzz and buy-in as they work together – small wins

Provider Engagement/Education

- Didactics – e.g. a standard talk to teach and engage via grand rounds, podcasts etc.
- Assessment of baseline interest and knowledge resource tools
- Workflows and algorithms that put evidence into practice
- Awareness of the time challenges, where to document - make it easy to integrate into routine care
- Make it simple/drilled down (like OKQ) – clinical teams need to know what do, how to talk about preconception – need education on patient centered discussions, awareness of individual desires preferences and needs, not a one size fits all
- Modeling correct behavior for practitioners

Training / Motivation (for providers and patients)

- In order to increase knowledge we need to do better at communicating about the well woman frame. To do so we need to put together good trainings that are hands on and address issues around bias, engagement and language
- In person, role playing, online modules, articles w/ CME questions
- Residency – lecture for interns, training, get preconception care into the curriculum
- First achieve buy in by asking all team members about their objections / resistance to using the word preconception / providing PCC then tailor the message and work
- Clear brief description to prove the “aha” of PCC – need a compelling script
- Shared platform for work – virtual and engaging opportunities to connect, share best practices / worst practices
- In anticipation of rolling out OKQ in 2017 we provided an in service on contraception for primary care teams (contraception facts and fiction). The teams included providers, RNs, medical assistants, etc. Included written materials
- Train ALL staff to change clinic culture, not just providers but clinical staff because providers are “too busy”
- Motivational interviewing training as well as training on implicit bias and shared decision making
- Education to uncouple (decrease anxiety) well woman exam from pap smear visit. All visits do not require pelvic exams.
- Training formats – easily accessible (e.g. smart phones), concise, action-oriented answers with what to do
- Develop a standard PCC module / You tube video for providers and mid-levels to learn more about what PCC is
- Make a game to educate providers
- Grand rounds – pay external agencies to demonstrate the role of social determinants of health and life course

Patient-Provider Relationship

- What happens when we put this out into the medical industrial complex that we call health care - power dynamic between patient and doctor is really tricky - need to meet the patient where they are.
- Key: we have to change the providers first - if the patient seeks care, and the provider doesn't meet her where she is - it's a disaster.
- Competing priorities for the patient and the provider - patient may come in with a specific chief complaint, may not want to address a broad preconception health agenda
- Shared decision making is essential – could this be a niche for us?
- Need to increase diversity of providers – recruit more from impacted communities

Consumer Engagement/Education

- Self-assessments (see break out group discussion)

- Provide resources to women/men to raise awareness of risks and needs, available clinical resources
- Employ community organization partnerships as conduits to consumers awareness with PCC info
- Make preconception health legitimate and a routine part of care empowerment
- Provide women with starter questions to ask her doctor (Show Your Love Campaign)
- Recognize the barriers to care and women's ability to act on advice – e.g. SDOH, education gaps, provider judgment and possible coercion

Patient Engagement

- Outreach via community groups
- Have consumer materials available in clinical settings like the waiting room as well as take home materials
- Important not to send message to woman that she is only worthy of help and intervention if she bears a child
- Use the same approach that was used when domestic violence screening was introduced, e.g. 'I am asking all my female patients about...'
- Interconception as an opportunity: women prioritize their children – acknowledge and build around that vs competing against it
- Video for waiting room on what PCC is and why it is important
- Social media promotion of PCC
- Text messages on PCC for patients
- Ask patients reflective questions about their reproductive life in every medium and getting with a path back to health care
- Never underestimate the power of great customer service in any setting and initiative to engage on any topic – why not PCC too?
- Maybe use language that acknowledges women's roles not just as birth mothers but as caregivers across generations
- Patient advisory council – patient on planning committee (or more than one)
- Normalize the conversation with integration across multiple settings
- Develop a program to give/create a preconception health score

Well Woman Care

- Checklist in the EMR for what needs to be done for preconception health
- Create a preconception care bundle
- Team based care - not just the provider who is doing all of the counseling - starting from the person doing the intake, all the way to the person discharging the patient
- Well woman care does not happen in a single visit
- Who (e.g. which agency) is responsible for resourcing and supporting HRSA MCHB NPM 1 on well woman visit?

Incentives

- Don't have to be financial, but finances are powerful driving forces
- Competition works comparing one to another
- Quality clinic designation (contraception, preconception)
- Forced decision making – can't close note without doing it
- CMS quality metrics, (contraception?) paired with concerns about the negative consequences of incentivizing contraception measures that are practical and drive care
- Important to providers and consumers system wide incentives vs individual ones – elements may be different

Intervention (conversation / services / referral)

- Care teams – e.g. medical assistants ask OKQ during blood pressure and weight screening. Teams can maximize the woman's time in the office and provide follow up information after providers start the conversation.
- Create models of well woman care incorporating community health workers to build trust and support behavior change
- Improve counseling between pregnancies
- Interventions that involve communities
- Start small – pilot project at one small site before rolling it out to entire organization

- Educational tools for women that use shared decision making strategies
- Family planning case management – using your team to provide care
- Evidence based SBIRT like counseling strategies that can be taught and implemented
- Educational tools for clinicians based on best practice guidelines
- Provide services based on her response to OKQ including infertility services and infertility prevention
- Can you clearly identify in your system WHO does the prework aligned with each PCC measure?
- Reproductive life planning / OKQ
- Each PCC measure should have a “what can you do” strategy with perhaps multiple options to pick from based on interest

New Partnerships

- Referral resources – if women screen positive for substance use or violence there must be an easy way to support a warm handoff
- Need more connection between community-based providers / non-clinical settings and clinicians - close the gap
- We need to ensure we have the right people around the table to change policy.
- Increased collaboration between family medicine / OB / GYN / internal medicine / pharmacies / emergency medicine in regards to well woman health
- Gaining input from consumer as to who should be included as partners i.e. education system, transportation system, recreation system
- EHR companies
- Appropriate engagement of external partners (e.g. housing, support services) to facilitate referral at point of care
- Partner with state Department Title X, prematurity prevention efforts and with CDC LARC efforts
- Partner with ACOG, AMA to get better buy in from providers
- The patients are always the most important partners – workforce partnering with them in their lives
- Health insurance plans - BC/BS bundled payment for MCH based on quality measures
- Community housing and jobs programs, mental health agencies, FQCHCs, Federal Healthy Start, WIC, programs for undocumented women in the community, child/elder care, employer barriers, organizations providing service for women experiencing IPV / shelters
- Form action learning collaborations with hospital associations and systems doing similar work
- State Medicaid offices, Title V agencies (re: well woman visit)
- Identify hotspots that overlap (e.g. unintended pregnancy, incarceration, high school drop outs) and concentrate efforts to create multi-system buy in and braid funding
- Example: New York City DOHMH established a sexual and reproductive justice community engagement group that meets regularly, co-creates campaigns with the department and provides feedback on activities, projects, systems, etc. This model of community engagement could be adapted to other health systems to ensure that PCC activities are relevant to community and consistent with reproductive justice.

Strategic Ideas:

The notes below highlight many key points from discussions with the larger clinical group during the afternoon session.

- Preconception measures MUST be reported by race/ethnicity.
- We must be sure to prioritize populations who need this information and resources the most – we must focus on what needs to happen to narrow gaps
- There is a chronic lack of knowledge about what preconception is – need a clinician education campaign along with a large national consumer education campaign.
- What is the ultimate return on investment for preconception? This is key and must be considered.
- If the system’s mission is crafted properly, you can get anything you want if you connect to the mission – find a way for each health system to connect.
- Ban the box – we are about women and need to hold them front and center.
- Be opportunistic - link preconception to the dish of the day – e.g. tie opioids into preconception, diabetes or ride the Zika wave – train and reframe.

- We still need to do the study showing that comprehensive preconception care actually improves outcomes. Can we get the big comparative effectiveness trial funded? We need to show the PAYERS that low birth weight does DECREASE they will then be mandated to figure out how to implement it.
- Preconception needs to become a priority on the system level as a value-based initiative for population health.
- Preconception care bundle – could we build on the bundle concept that is being used widely by ACOG and AIM now and create a bundle for preconception care? Would just be about repackaging what we’ve already got.
- Overall, we need a mix and match approach for the framework, toolkit and resources we share. For each category of the framework we need a variety of tools and resources that a system can choose based on where they are beginning. It may be that the best a system can do is look at their data or offer an in service – we should have ready tools for that. Others may be able to do more. What is the vital behavior the system wants to influence? What fits the outcome measure you are looking for? Every population may be different. Let each system choose, and then we give them the tools/ core elements. System flows, patient flows, templates, protocols and patient tools are all important.
- Much of the discussion we started having is already something done via implementation science. There is the [National Implementation Research Network](#) (located at UNC Chapel Hill), which specializes in the methodology around implementing evidence-based practices.
- The book *Influencer: The New Science of Leading Change* by Grenny, Patterson, Maxfield, McMillan and Switzler is another good read that provides a model for implementing change. Model includes focusing on motivation and ability across the personal, social and structural. The book highlights that incentives, without motivation, will not be effective. This book looks at the personal, social, system and community.

The hook: Addressing women's wellness

The intervention: Identify health needs and address them

The approach: Shared decision-making, enabling women to make informed choices

The follow-up: Ascertain whether it worked, and what to do next

BIG Questions for Further Discussion

- What is our aim? What exactly is it that we are trying to accomplish? We have been going at this for some time without result.
 - Is our goal informed control of fertility by women - the deepest sense of choice? Enabling every woman to achieve wellness and make informed decisions about whether / when to have children
 - Go upstream - care about women before they are pregnant - preconception health makes sense.... majority of PTB due to obesity, diabetes, chronic disease
- Do we have what we need around interventions? E.g. high BMI – what is evidence based to do? We need to educate on that. If we have topics that need interventions they should be developed OR perhaps that topic should not be prioritized right now. Going back in time we can highlight other things that we don’t have evidence to do before pregnancy or during pregnancy and do anyway. This also can present a risk.
- Focus to prioritize only a few preconception health messages – to make it more doable. Could we start with the 9 PCC wellness measures? The CDC population measures? It is ok if a clinic or system only takes on a few preconception health messages at a time – need to have space for that to be recognized and accepted as reasonable.
 - What if we said the vital behavior we wanted to see happen was One Key Question? What can we do to promote organizations, providers and patients to ask/answer about reproductive intention - that becomes the vital behavior that we want to see changed. Make reproductive health risk assessment a key part of the care we provide?
 - Can we use weight as the starting point - what's the best question to ask at that point? Obesity - could be something that we could build out from - working from existing infrastructure.
 - Our ability to help women change their weight w/o bariatric surgery is really small
 - Based on the experience of the California interconception care project - adding a new module is very difficult; but adding to another existing screening practice is more feasible – e.g. when BMI screening is done, follow w/ a question re whether patient plans to become pregnant
 - We want our recommendations to be evidence based - USPTF does that
- How do we respond to the double comment (often from the same person) that we are “Already doing it” AND “It’s Impossible”?

- How do we change a culture for a whole system?

Final Comments

- The team added a payer discussion group to the breakout group the next day
- There is a lot of value in sharing a working space with consumer facing groups – let’s do it more often
- We need to look at exploring many different options/tools for systems so they can mix and match based on their stage of change and need
 - Are we caring for everyone?
 - What is the banner?
 - Is there a voice among us to bring up the voices that aren’t there?
 - Is there anyone looking for a big study?
 - Look for evidence based treatment options to deploy
 - We unpackaged our work around frameworks, instead of packaging it! Unpackaging is very important.
 - Shared decision-making and health equity emerged as critical areas.

Lunch and Learn Sessions

On second day of the meeting participants had the opportunity to join in two of the breakout group discussions below. These discussions were selected as areas where work needed to advance but input was needed. The highlights of the groups are described below.

Population Indicators for Preconception Health

Presented by: Cheryl Robbins, Centers for Disease Control and Prevention

- Goal: Develop a small set of key indicators to help states & territories report on PCC progress
- Cheryl Robbins reviewed the evaluation and prioritization process used by the CDC’s ad hoc committee for the Research and Surveillance workgroup to identify 10 preconception health indicators for state and national surveillance.
- A manuscript on the process and results has been submitted for publication and is under review.
- There is considerable overlap between the population indicators and the clinical measures, which is great, particularly as the groups used different criteria. That said, it is always challenging to narrow the list of preconception health factors!
- *See breakout sessions for Indicators next steps.*

Women's Experiences of Well Woman Care – the Well Woman Story Study

Presented by: Arden Handler and Regan Johnson, UIC School of Public Health & CityMatCH

- Goal: Elevate women's voices about what makes them healthy and able to receive well-woman care in the context of their lives, neighborhoods & cities
- Method: Listening sessions, secure blog and secure phone line where women could leave their stories / Listening sessions - guided conversation, English & Spanish, 10 women per session
- Targeted women of reproductive age \ Women received a stipend, a community health resource guide and a navigating insurance guide for participation.
- Results:
 - The healthcare delivery system is not woman-friendly: adopt and promote a charter which delineates the components of a women and family-Friendly healthcare system
 - 24-7, internet-based, hotline access
 - Women's competing demands and priorities make accessing healthcare difficult
 - develop policy & educational materials focused on city-specific sick and personal leave policies
 - create city-wide task force to include key stakeholders to consider adoption of paid sick leave for public & private employers
 - Women weigh costs vs. benefit when deciding to access care
 - insurance navigators - hotline to find out what care will cost
 - funding for uninsured women or to pay high deductibles
 - sponsor periodic "free care" / Medicaid days
 - Relationships with providers are key to women’s decisions about accessing care

- Yelp for rating women-friendly providers
- offer training to increase cultural competencies / humility of the clinical workforce
- explore approaches that enable women to have their health histories available on personal "apps" so that there is access to info when moving among providers
- Health and insurance literacy empower women to advocate for the self and others
- appointments outside traditional hours
- women's health peer advocates who could be present at women's appointments & advertise availability through mobile technology
- Positive mental health is integral to being a health woman
 - "seeking psychological counseling is not acceptable in the black community"
 - work w/ community partners to ensure availability of community-based resources for self-care & respite - yoga, mindfulness, stress reduction, exercise, drop-in centers, etc
 - psychiatric consult line for PCPs
- Healthy food, safe environments and opportunities for physical activity were vital
 - apply for SNAP at health care provider
- Social support systems facilitate a woman's willingness and ability to seek care
 - separated by long distances from friends and family
 - group approaches to care
- Lack of transportation and childcare are major impediments to accessing healthcare
 - Medicaid van doesn't take kids
 - partner w/ Uber and Lyft, childcare during appointment
- Fear - worried that going to the doctor means that you are sick - or you will find out you are sick
- Integrating into the pediatric visit:
 - piloting this in Illinois - add questions about future goals to the PPD screen
 - NP at pediatric visit - can we set up a same-day women's wellness visit at the time of the well-child visit?
- What prompted women to get care
 - family member / friend encouraged them to go
 - recent diagnosis in a friend / family member
- Training on trauma informed care - which translates into treating people nicely...
- Bedsider.org - has reviews from Yelp integrated into ratings... trying to get people to review their health care providers and tell us what they think.

Breakout Sessions

On the second day of the meeting participants had the opportunity to participate in two different breakout sessions to apply their ideas and thinking to several key areas of action for the PCHHC and partners. Below please find the key points / learning from those sessions.

Before and Beyond Clinical Preconception Health Tool Kit – Review & Improve

Led by: Sarah Verbiest & Maggie Adams, Senior Advisor National PCCHC and Mission Area Health Education Centee

This group reviewed the beforeandbeyond.org website and offered some suggestions for edits and improvements. They agreed that it would be helpful to do some reorganization and expand the content to also be applicable to public health practitioners and other professionals interested in preconception health.

- They also suggested that an additional presentation with notes be added to the site that could be used by speakers in grand rounds and meetings with clinicians about WHY preconception health is important. Basically, they would like to see Dan Frayne's key presentation available for download and use.
- A website redesign should also provide an opportunity to feature partners and clinicians who are modeling interesting approaches to integrating preconception health into practice.
- It would be helpful to have some kind of collaborative platform to allow for more shared work, google meet ups and other ways to share tools, resources and ideas.
- There are lots of opportunities to expand messages and information to health care providers in the same way that there are major communications initiatives for consumers. It would be great to be able to hire a communications coordinator to focus providers as a key audience.

The group then focused discussion on the Preconception Health Toolkit for Clinicians.

- The group found that the toolkit was more of a resource guide than actual source of tools to support practice. There is a significant amount of information listed, which was updated in 2016 by Dan Frayne. Keeping the information current is an ongoing challenge.
- The group suggested that before major changes were made to the resource guide it would be wise to get input from users first. Residents seem to be one key target audience. This effort would require additional resources to be done well.
- It was suggested that we review the tools / apps that providers ARE using (e.g. contraceptive technology) and integrate preconception health messages into those tools, instead of making something separate. This idea was met with widespread approval and interest. With funds to support a clinician's time this would be a feasible approach as long as the different tools/apps would be willing to add the information.
- There is a need to develop mix and match tools for clinicians and healthcare systems to use in practice (as described previously). As these are developed again where they are housed on the website/toolkit should be done with end user input.
- Overall there is a lot of work that could be done with digital and social media to engage providers. This, however, would also require resources – a communication person with a budget dedicated to getting preconception health and resources in front of clinicians AND to feature the work of clinicians who are doing this well.

Next Steps for Preconception Health Indicators

Led by: Cheryl Robbins & Shanna Cox, CDC

This group reviewed the status of planned milestones/actions of the Data and Surveillance workgroup and the new short list of recommended preconception health indicators. The group suggested the following next steps:

- Need to find funding to seek stakeholder input on prioritization of preconception care indicators
- Discussed dissemination of short lists of indicators
 - Clarified the aim of wide dissemination is to make the case for this set of indicators and the evidence that makes them value-based care (e.g., USPSTF or community guide references) and alert professional groups that CDC will be monitoring these by states.
 - Develop commentaries for peer review journals
 - Develop briefs for advocates/professional organizations
 - Brainstormed a list of agencies/groups to extend the reach and web of support
- Develop state report cards
 - Acknowledged possible (but unlikely) unintended consequence of state rankings
 - Suggest giving a grade for each and could base this on progress to HP 2020 target
 - Began exploring the feasibility of coming up with a single, overarching score for preconception health based on the short list of indicators

Public Health Workgroup and Catalyzing Paper – What's Next?!

Led by: Kiko Malin, Alameda County Health Department

- Identify and reframe what is Preconception health – which includes social justice.
- Uplift community based work that is effective - even if not yet recognized as “evidence based”
- Make partnerships to reach other groups
- Next steps: The group considered the following questions. They ultimately felt that it would be good to link up to any existing work in reproductive justice as partners (e.g. City MatCH and Black Mamas Matter) at the same time that they hold the compass and focus for the national work on social, reproductive and economic justice.
 - Do we continue to meet as a public health workgroup under PCHHC?
 - Decide our purpose as a workgroup
 - Bridge to other groups?
 - Develop partnerships to impact policy
 - Develop and facilitate learning community within workgroup
- Better connection with grass roots – black mamas matter; health coaching; repro social justice movements; learn from community, past campaigns – good and bad,
- Toolkit with templates to help community message PCH
- Include economic justice
- Work on creating RIGHTS of preconception health!

Engaging National Preconception Peer Educators

Led by: Teddy Owusu, Office on Minority Health PPE Network

- Cultural Competency: The PPE program has been having issues during certain trainings where instructors weren't familiar with the audience and, consequently, messages got lost in translation.
 - The group suggested that there has to be a baseline of understanding between presenters and the audience (that is unique to each audience). The group suggested the development of tools and opportunities for presenters/lecturer and the audience to learn about/from each other prior to disseminating the training content. This will build trust and ensure effective communication. It's not about right or wrong, who or what, it's about understanding.
- Feminism and male privilege: This is a rapidly emerging issue of concern amongst PPEs
 - The group had a robust discussion about what it is to not have privilege and being able to communicate empathy. The things that women think about in everyday activity are different for men who don't stress or think twice about them. It is important for men to acknowledge that gender inequity exists and respect (or even in most cases, defer to) the voices of those who are affected.

Assessment Tools – for Patients and Clinicians

Led by: Diana Ramos & Erin McClain, LA County Health Department and Center for Maternal and Infant Health

- A PCHHC Tools Taskforce should be created to assess tools & provide recommendations. This group should include both consumers and clinicians.
- An inventory is needed to assess what tools are out there; where there are gaps/opportunities.
- We know we need something to streamline Well Visit dialogues, but what about women that don't plan before a doctor's appointment?
- Need a waiting room assessment tool that will provide more valid results – what are the TOP 10-15 questions we really want patient's to focus on?
- Utah and Texas are doing focus groups in 2017 to gauge women's preconception health knowledge - update from Nickee Palacios and Ashley Weaver
- Target tools for 1) HCPs, 2) Public Health, 3) Consumers
- Tools needed:
 1. Counselling Tools – clinical TEAM approach (algorithm for nurse, health educators to adapt to different roles); algorithm for providing care (high-risk)
 2. Consumer assessment/info (SYL app, Pulse app, The NC birth control) – for planners, non-planners, ambivalent
 3. Billing and Coding System Tool
 4. Valid Screening Tools
- Show Your Love Checklist is NOT consumer-friendly; more for a health navigator
 - Need tools to get the conversations started for 1) Health navigators/public health, 2) Consumers (teen through older women), 3) Clinicians
 - Delivery of tools: need to offer at a pediatrician visits, telephonic/managed care
- “Maternity Bundle” Payment Plan for HCPs billing from prenatal through postpartum

Synthesizing & Setting the Direction

One of the most unique and important components of the two day meeting was the opportunity to bring consumer / community representatives together with clinicians and public health professionals to have very honest conversations about how to advance the health and well-being of young adults in the U.S. at this moment in time. The political climate was an underlying current across the meeting, given the November 2016 US elections and looming change in administration and leadership. This last section highlights some conversation themes from the two-day meeting – ideas shared across clinical, consumer and public health partners.

Equity

- It is important to recognize the impact of racism - know our history, learn from it, address implicit and explicit bias, and dismantle systems of oppression.
- We can NOT forget our refugees and immigrants. Now hate speech layers on to their pain.
- Deep authentic listening to communities is critical to learn about their needs.
- Create connection to facilitate transcreation of materials and programs
- Elevate the deep wisdom in communities who have fought against oppression for decades. Shift. Learn from them.

- Fusion/Alliance with other groups is starting to happen at last.
- Harness fear and turn outrage into a collective health care vision.
- Our messages are elitist – although the work with the new community partners is allowing us to shift. Why aren't we emotionally connecting with people who need this work –urban black, urban white, young adults?
- Reproductive and sexual justice – do we incorporate together or apart?
- What about intimate partner violence? Human rights frame is something we should also consider in our work.
- We need to add to the well women vision conversation – culture/human rights/repro justice/sexual justice
- Remember our own co-workers / staff may be more similar to “underserved” than we think.
- We need to develop (or share existing) tools and resource for supporting deep and authentic engagement.

Transform the Way the Healthcare is Delivered

- Make sure patients centered care is part of testing for clinicians
- Well Woman CARE doesn't only happen in a visit. Our role is to push beyond that one clinical visit.
- Elevate other professions and groups to see their role in preconception / reproductive health
- Patient Centered Care is CRITICAL – this is not just clinicians, but also schedulers, receptionists, financial dept. “Provider” really is all workers in health care who must be engaged
- The states that desperately need expansion aren't marching for it - we need to make connection. And if things change we need to underscore the necessity of health care coverage for all.
- Consider safety and security of the people we serve in clinics at all times.
- New models of care = promote and share and create. Pay attention to our public health/social work community outreach staff.
- Close the provider v. community gap by more interaction – this is something we can model
- Board of Exams / Med Education should test on patient centered care
- Step back and use something (proximity) to connect on an emotional level with real people/between people.

Sex

- In order to address preconception health and justice completely we have to be willing to talk about sex, sexuality, relationships and intimacy
- Add Kinsey Institute to ACOG Group
- Talk about sex – worried? Get over it. Is sex part of the guideline discussion?
- Sexual health should be broadly defined – mental / emotional / trauma (non-medical) components matter along with the “mechanical”
- Be the voice of courage and hope: that women deserve to be more than uteruses.

The group as a whole will continue to think about what is the most important gap we should fill at this time.

Intergeneration health is a concept that we must explore – it matters to communities and families and is a new way to frame preconception health. The opportunity this meeting offered to bridge consumer, clinician and public health partners was considered invaluable. As our work moves forward there is a strong desire to pair consumer advocates with clinicians to co-create tools, materials and resources. Participants also appreciated the creation of a space for both sharing and acknowledging fears and sharing ideas for positive action.

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