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**PCHHC Kellogg Grant Collaborative: Engaged Health Systems and Clinics**

1. **New York State Department of Health**
   1. Lower Hudson Valley Perinatal Network, LHVPN – Rockland County, LHVPN – Westchester County
      * 1. Collaboration with Hudson River Healthcare
        2. FQHC that spans MICHC Areas of Westchester, Rockland, Dutchess & Sullivan
        3. Interconception Care Workgroup - Led by Dr. Sophia McIntyre, Chief of Clinical Quality and Physician Leadership Development
        4. Before , Between, and Beyond Toolkit Presentation to leaders and site managers on General Communications/ Best Practices Conference Call
   2. Maternal and Infant Health Community Collaborative
      * 1. Coordinate activities with local Maternal Infant Community Health Collaborative (MICHC) lead agencies and foster Interconception follow-up of HRHCare patients who have had an adverse birth outcome.
           1. Pre/Interconception health promotion provides pathway to the primary prevention of poor pregnancy outcomes beyond traditional prenatal care.
           2. After sharing the Preconception/Interconception Care Clinical Toolkit, providers intend to incorporate
           3. “One Key Question” in their practice and utilize website and access the Toolkit resources
           4. MICHC Team provided HRHCare county specific database of support services, including CHW services, to share with patients in need of services beyond medical care.

MICHC Partners recommended 4 HRHCare pilot sites – which could be supported by a MICHC Partner

Goal for Pilot Sites – Implement 1 Key Questions: “Would you like to become pregnant in the next year?” and follow up.

Finalize Resource List for MICHC Subspecialty Tab

Follow up meeting scheduled for this quarter to discuss implementation plan.

* 1. NCPPC – CoIIN
     + 1. Development of two PowerPoint Presentations
       2. Meeting with PCMH for the Tug Hill PPS
       3. Promotion at RPC Educational Outreach Events
       4. Preliminary outreach to both Primary Care and OB/GYN at Carthage Area Hospital
       5. Preliminary discussion with Massena Memorial Hospital
       6. Presentation to Carthage Family Health Center and OB/GYN staff and providers
  2. **Successes**
     + 1. Raised awareness of need for integration of reproductive health care into primary care
       2. Implementation of One Key Question into Carthage EHR with launch date of July 11th
       3. Working with Head Start/Early Hard Start
       4. Educating the provider
  3. **Barriers**
     + 1. Massive health care reform
       2. Complexity of implementing BBB toolkit
       3. Placement into HER
       4. Were making progress with FQHC
          1. Barriers- No time- so they had to back out of the project
          2. Taken projects in a different direction

1. **CCO- Health Share of Oregon** 
   1. **Actual projects**
      * 1. One Key Question
        2. Contraception Quality Checklist
           1. Based on CDC guidance documents
           2. Clinic self-assessment of contraception care
           3. Domains
           4. Competencies
           5. 0-1-2 point scoring system
           6. Total scoring qualifies clinic as “quality family planning provider” or “expert family planning provider”
           7. Certification process will likely be managed through our state PCPCH system
        3. Contraception Domains
           1. Access

Timeliness of care

Affordability

Special populations/diversity

Language, health literacy, communication

* + - * 1. Service provision

Assess for pregnancy intentions

Counseling and Education

Services for males, youth, postpartum and breastfeeding women

Contraception supplies

Contraception procedures

Contraception management

* + - * 1. Community collaborations

Referrals and linkages

* + - 1. Preconception domains- working on Preconception Checklist
         1. Access
         2. Service Provision

Chronic disease

Nutrition, exercise, weight

Immunizations

Genetic counseling

Preparation for parenting

Behavioral health

* + - * 1. Community collaborations

Referrals and linkages

* + 1. **Barriers to success**
       1. 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

1. **Ohio Hospital Association**
   1. **Actual Projects**
      1. Ohio Collaborative to Prevent Infant Mortality
         1. Subcommittee with people focus on Preconception Health
   2. **Barriers to success**
      1. Ohio is still deciding where the focus should be
      2. Competing demands
      3. Staff turnover
2. **Washington State Hospital Association**
   1. **Actual projects**
      1. Identifying best practices among primary care throughout the state
      2. Currently, they are developing measures (in pregnancy): 7 outcome measures, 15 process measures.
      3. Developing a patient assessment tool (again, during pregnancy, I believe) and guides for reimbursement.
         1. Currently focusing on healthy weight during preconception/ICC.
      4. There are other projects that are going on simultaneously on the DOH side:
         1. CMMI - healthier Washington. They are interested in discussing barriers to advancing the PCC and ICC components of the roadmap
         2. Discussion of a catalog the "levers and barriers" of the process work. They are interested in discussing more about reimbursement issues related to PCC.
   2. **Barriers to success**
      1. Having it in a format the can be disseminated
      2. Implementation hasn’t moved forward- the hospital is making a lot of changes
      3. Staff turnover
      4. Competing system priorities
3. **MCO- CountyCare/Cook County Health System**
   1. **Actual projects**
      1. Serve a majority low income population, primarily
      2. African American and Latina. This includes many women of reproductive capacity who have one or several chronic medical, behavioral or psychiatric problems.
      3. Working on a project that would change the way members access prenatal vitamins and condoms,
         1. Over the counter medications can be paid for by Medicaid
         2. Exploring a way to administer payment for vitamins and condoms without prescription -how to get in the hands of consumers?
      4. Starting an implementation oriented project
      5. **Barriers:** 
         1. The prescription is a barrier- people have to go or request from the provider
4. **Veterans Affairs Health System**
   1. **Actual projects**
      1. Preconception Care template in EHR for designated women’s health providers (have a women’s health fellowship to standardized care in the VA system)
      2. PCC is a priority area for Women’s Health dept – key leadership buy-in (Laurie Zephyrin)
      3. Plan for a retrospective data analysis of existing data – utilize pregnancy registry and outcomes and match with PCW measure areas
      4. Plan for prospective data collection through maternity care coordinator intake – most of pregnant VA beneficiaries will have a VA assessment and then referred to community maternity care providers – initial assessment could obtain the 9 PCW measures.
   2. **Barriers to success**
      1. They have data, but not reporting reproductive health data; need time and resources dedicated to the effort
      2. Concern was raised about how the data might be interpreted – care to obtain demographic data (race, age, insurance status), who is accountable for the results of PCW?
5. **IHS- Northern Navjao Medical Center, Shiprock Service Unit**
   1. **Actual projects**
      1. The need for preconception counseling is recognized, but Navajo rates are still <5%. With increasing numbers of young patients with Type 2 Diabetes (sometimes undiagnosed), we’re seeing more uncontrolled DM in prenatal clinic…and then related to poor outcomes.
      2. 50% of all their pregnancies are unplanned
      3. 98% obesity rates coming into pregnancy
      4. High A1C in pregnancy
   2. **Barriers to success**
      1. Looking to get baseline data, but having issues with the E H R
         1. Working to fix this issue
         2. Wanting to be able to measure
6. **CCO- Samaritan Health Services**
   1. **Actual projects**
      1. Implemented OKQ in 2015 and used surveys to assess patient acceptance of being asked One Key Question at every visit (where appropriate)
         1. The initial response was unfavorable, with fewer than 30% of women wanting to be asked at every visit.
            1. This was a surprise to us so we added a preamble to the survey explaining the public health consequences of unintentional pregnancy and that our organization was attempting to ensure that every pregnancy was healthy and wanted.
            2. After adding the preamble the acceptance rate leapt to greater than 80% regardless of socio-economic status or education level.
            3. Feel it is valuable to explain to the public that we screen everyone so that they can help some
   2. **Barriers to success**
      1. Trying to get leverage in OBGYN world
      2. Integrating into 3rd trimester- make LARC available at delivery
      3. ACOG- Opinion- pregnancy intention should be at every visit
      4. Next Steps
         1. Go to the people- Quality
7. **Title V- Alabama State Department of Health** 
   1. **Actual projects**
      1. Currently working on a LARC initiative and smoking cessation. Looking at ways to reinvent the way they do public health, large portion of patients are women with comorbid conditions (obesity especially), interested in learning more about billing, interested in the preconception health measures.
   2. **Barriers to success**
      1. Time and resources
      2. Data collection
      3. Moving outside of contraception
8. **FQHC- Providence Community Health Centers**
   1. **Actual projects**
      1. RI Title X Program has endorsed the OKQ initiative. As a major Title X provider in the state (in 2015 PCHC performed 75% of the total Title X visits in RI)
      2. Plan to become a pilot site for the adoption of the OKQ.
   2. **Barriers to success**
      1. No report out yet
9. **FQHC and FM Residency Clinic- Codman Square**
   1. **Actual projects**
      1. Multidisciplinary clinic (Peds, IM, FM, Psych)
         1. Peds implementing SWYC (Survey of Well-being of Young Children)
            1. Includes IPV screen and Caregiver depression screening

But not family planning or MVI

* + - 1. Has already implemented depression screening for caregiver at peds
      2. Measures: OKQ and LARC placement rate, hope to include pregnancy intention
      3. Opportunity to work with Boston ACO?
      4. Family planning registry
  1. **Barriers to success**
     1. Time
     2. Resources to build reports

1. **ACO- Mission Health Partners**
   1. **Actual projects**
      1. Diabetes Care Process Model
         1. Introduced concept of OKQ, routine MVI, and MFM referral for those with desire for pregnancy
         2. EHR template built, in hospital and outpatient settings
         3. Beginning to collect data
      2. Preconception Wellness Care Process Model
         1. 10 PCW measures (included IPV)
         2. Will start with OKQ as primary care metric
         3. Will start collecting the PCW measures at first prenatal visit
         4. Incentives as part of ACO metrics in women’s health
      3. MAHEC OBGYN
         1. Working on collecting and reporting Preconception Wellness Measures
         2. Will utilize the NC Pregnancy Medical Home intake screening questions along with EHR and hospital data
      4. MAHEC Family Medicine
         1. Employee wellness programs
            1. MVI and Smoking Cessation incentivized
            2. RLP incentivized
         2. Interconception Care implemented at all WCC birth to 2 years of age
            1. New Medicaid payment for maternal depression screen under child’s Medicaid
         3. Multivitamin distribution project
         4. Family planning registry created
            1. Single location to document in EHR
            2. Pharmacy team collaboration to match chronic disease and teratogens to the family planning documentation, intervention on those with high risk or lack of documentation for contraception
      5. Buncombe County HHS
         1. Systems support for promotion and integration of PCC
   2. **Barriers to success**
      1. Data collection
      2. Proposed to measure the 9 PCW measures, difficulty with three
         1. Tetragon drugs, MVI BEFORE pregnancy is hard to capture
      3. Willing to work on pregnancy intention
      4. Time and resources- Data/
2. **Magnolia Clinic**
   1. **Actual projects**
      1. Family Planning Clinic
         1. Fatherhood initiatives
         2. Post-partum follow-up staff
         3. Community engagement staff
         4. Implemented routine RLP in each visit, reviewed routinely
            1. Also added routine MVI distribution
      2. New partnership with AGAPE ( FQHC) and Magnolia clinic
         1. Working together to provide optimal PCC
         2. Healthy eating/cooking classes
         3. Yoga and wellness classes
         4. Looking to implement MVI and OKQ into visits
   2. **Barriers to success**
      1. Measurement
      2. Data
      3. RLP is documented in EHR but not visible on facesheet, only attached to a visit
      4. Routine PCC becomes very overwhelming for an FQHC due to time limitations (specifically financial)
      5. New partnerships are challenging– different ways of doing things
      6. It’s hard for the FQHC staff to offer certain services to people at one clinic but can’t be provided at another clinic
3. **Grant Family Medicine**
   1. **Actual projects**
      1. Resident driven CQI project around preconception or interconception care
      2. Received foundational didactics on concepts and options for moving forward
   2. **Barriers to success**
      1. Time, resident driven effort
      2. Competing demands