

# Opportunities and Strategies for Improving Preconception Health through Health Reform

## *Advancing Collective Impact for Improved Health Outcomes*

### The AMCHP Role

**AMCHP supports state maternal and child health (MCH) programs and provides national leadership on issues affecting women and children.** We work with partners at the national, state and local levels to promote women's health; provide and promote family-centered, community-based, coordinated care for women and children; and facilitate the development of community-based systems of services for women, children and their families.

**The AMCHP National Center for Health Reform Implementation** provides state MCH leaders and their partners with the information, tools and resources to optimize the opportunities presented by the Patient Protection and Affordable Care Act (ACA) for improving services, systems and health outcomes for MCH populations.

### Background

The United States has made gains in reducing infant and maternal mortality rates over the past several decades. In spite of these gains, infant and maternal deaths remain high and disparities persist, particularly among the Native Indian/Alaskan Native and non-Hispanic Black populations.<sup>1,2</sup> In fact, the U.S. infant mortality and maternal mortality rates are higher than most other industrialized nations, despite significant health care system investments.<sup>3</sup>

Preconception health and health care can provide opportunities to promote the health of women before they become pregnant through improved access to health care. The Centers for Disease Control and Prevention (CDC) defines preconception health as “the health of women and men during their reproductive years, which are the years they can have a child. It focuses on taking steps now to protect the health of a baby they might have sometime in the future. Preconception **health care** is the medical care a woman or man receives from the doctor or other health professionals that focuses on the parts of health that have been shown to increase the chance of having a healthy baby.”<sup>4</sup>

With half of all U.S. pregnancies unplanned, preconception health and health care are important for all people of reproductive age.<sup>5</sup> The CDC identified several health domains to better understand and address preconception health including: general health status and life satisfaction, social determinants of health, health care, reproductive health and family planning, tobacco and alcohol use, nutrition and physical activity, mental health, emotional and social support, chronic conditions, and infections.<sup>6</sup> Preconception care is particularly critical to reducing persistent disparities in maternal and infant health between white and non-Hispanic Black women.<sup>7</sup>

Women's health insurance coverage plays an important role in a woman's ability to access health care. Insured women are more likely to obtain preventive care and other services such as prenatal care. Of women ages 19 to 64, 57 percent have employer-sponsored insurance. However, these women are less likely than men to be covered through their own job (35 percent vs. 44 percent respectively) and more likely to be covered as dependents (22 percent vs. 13 percent) making them vulnerable to losing insurance if they divorce, their partners lose their jobs, or they become widowed.<sup>8</sup>

A significant proportion of women receive their health insurance coverage through Medicaid. The public insurance program serves approximately 13 percent of

women of reproductive age.<sup>9</sup> Approximately two-thirds of Medicaid beneficiaries are women.<sup>10</sup> From 2008-2010, this public program financed about 48 percent of births in the United States.<sup>11</sup> Lack of health insurance remains a concern for women. In recent estimates, approximately one in six reproductive-aged women lack insurance.<sup>12</sup> Low-income women and minority women are at greater risk of being uninsured.<sup>13</sup> Uninsured women consistently report lower rates of screening tests than their insured counterparts for many conditions such as high blood pressure, high cholesterol and obesity. These are some of the key factors known to adversely affect maternal health and birth outcomes.<sup>14</sup>

Changes in public policy and health care financing, particularly health coverage and benefits, are needed in order to improve access to preconception health care.<sup>15</sup> Many states are investing resources in preconception health to improve maternal health and ensure healthy birth outcomes. The 2010 *Patient Protection and Affordable Care Act (ACA)* provides states and communities with new opportunities and resources to develop and expand preconception health efforts.

## About this Issue Brief

This issue brief is part of a national project, *Advancing Collective Impact for Improved Health Outcomes*, funded by the W.K. Kellogg Foundation to strengthen the capacity of state Title V maternal and child health (MCH) programs and their partners to improve birth outcomes through health reform. AMCHP is working with state Title V MCH programs and their partners in state Medicaid agencies, organizations such as the March of Dimes and community groups to: 1) examine and explore opportunities to improve birth outcomes, particularly improved access to preconception health care, through changes to the health care delivery system, 2) strengthen partnerships between state Title V MCH programs and other key stakeholders such as state Medicaid agencies, providers, community health centers, and local health departments, and 3) identify specific strategies for financing preconception health, particularly for Medicaid-supported births. This issue brief explores how states can capitalize on the opportunities presented by health reform to improve birth outcomes, particularly through preconception health. It highlights state Title V MCH programs, particularly programs in the three states (Michigan, Oklahoma and Oregon) that participated in an action learning collaborative and are working to strengthen partnerships to implement preconception health activities, enhance preventive care for women, explore financing options for preconception care services, and use data to inform policy and program development. Delaware and Colorado also are featured as states that are working toward improved access to preconception care.

## Opportunities to Enhance Preconception Health through the ACA

Primary care for women encompasses screening and assessment, health promotion and counseling, and brief interventions or referrals for additional services when warranted. The ACA expands health insurance coverage and provides states with new tools and resources to improve access to health care for women, particularly those who are low income and uninsured. Under the ACA, several provisions have the potential to improve state efforts to implement preconception health activities and ultimately improve birth outcomes.

For qualified health plans sold in the marketplace and many other plans, they must cover preventive care. Within this category, there is a requirement to cover women's preventive services without charging co-payment or co-insurance.<sup>22</sup> The women's preventive service requirements were based on guidelines issued by the Health Resources and Services Administration that were developed from recommendations issued by the Institute of Medicine (IOM) in its report, *Clinical Preventive Services for Women: Closing the Gaps*. In the report, the IOM underscored the importance of women's health overall and makes several recommendations related to preconception and interconception care. In its report, the IOM recognized that several visits may be needed to obtain all necessary recommended preventive services depending on a woman's health status, health needs, and other risk factors.<sup>23</sup> Finally, the IOM recommended that the preconception component of the visit include an opportunity for a health care provider to conduct, "evidence-based tests, procedures, and screening for non-pregnant women to optimize reproductive outcomes and prevent or optimize treatment for chronic conditions, as well as topics for counseling and guidance for preconception health."<sup>24</sup>

Historically, Medicaid has been instrumental in providing coverage to women. Although coverage for women varies widely from state to state, the federal government establishes guidelines for benefits and cost sharing. In order to lower barriers to access, pregnant women and children are exempt from paying copayment or coinsurance for most health care services.<sup>25</sup> In addition, the federal government determines "mandatory" and "optional" Medicaid benefits and establishes state matching rates to fund these services.<sup>26</sup> Mandatory benefits include family planning, smoking cessation for pregnant women, and prenatal and postpartum care. Certain preventive services are covered, however many that are recommended for adults that are not pregnancy-related are "optional" benefits.<sup>27</sup> Starting in January 2013, the ACA provided incentives for states to cover preventive services rated "A" or "B" by the U.S. Preventive Services Task Force and vaccines recommended by the Advisory Committee on Immunization Practices, without cost sharing and provides a one percentage point increase in federal matching payments.

**Figure 1 – Overview of Select ACA Provisions**

<b>Medicaid expansion</b>	The ACA provides coverage for many uninsured adults through an expansion of Medicaid to 133 percent of the federal poverty level (FPL). Women, who were previously ineligible for Medicaid may now qualify for coverage if their state has chosen to expand its Medicaid program.
<b>Marketplace</b>	Women who earn incomes between 100 to 400 percent of the FPL may be eligible for tax credits to reduce the cost of insurance plans purchased in the health insurance Marketplace. <sup>16</sup> Individuals who earn between 100 and 133 percent of the FPL can qualify for premium tax credits in states that do not expand Medicaid, if states do not already cover those individuals.
<b>Coverage until 26</b>	If a health plan covers children (job-based plans and individual plans bought inside or outside the Marketplace), young adults up to age 26 may be added or kept on their parent’s health insurance policy. Coverage for adult children is available regardless of residency; student, marital or tax dependency status; or eligibility for employer coverage. <sup>17</sup>
<b>Consumer protections</b>	Prior to the ACA, insurance companies could deny women coverage based on a preexisting conditions such as pregnancy or charge them more based on gender. The ACA prohibits this type of discrimination. <sup>18</sup>
<b>Essential health benefits</b>	The ACA ensures qualified health plans sold inside and outside the marketplace offer a core set of 10 essential health benefits that include preventive services and maternity and newborn care. <sup>19</sup>
<b>Coverage of preventive services</b>	<p>Under the ACA, new health insurance plans must cover and eliminate cost sharing for preventive services recommended by the U.S. Preventive Services Task Force, the Advisory Committee on Immunization Practices, and the Bright Futures Guidelines recommended by the American Academy of Pediatrics.<sup>20</sup> Included are services for adults (15 services), women (22 services), including pregnant women and children (26 services). Some of the preventive benefits relating to preconception health include:</p> <ul style="list-style-type: none"> <li>• Immunization vaccines for adults</li> <li>• Obesity screening</li> <li>• Sexually transmitted infection prevention counseling for adults at higher risk</li> <li>• Tobacco use screening for all adults and cessation interventions for tobacco users</li> <li>• Comprehensive breastfeeding support and counseling, access to breastfeeding supplies</li> <li>• Folic acid supplements</li> <li>• Gestational diabetes screening for women 24-28 weeks pregnant</li> <li>• Contraception</li> <li>• Anemia screening for pregnant women</li> <li>• Annual well woman visits<sup>21</sup></li> </ul>

Although it varies by state, states must cover pregnant women with incomes at or below 133 percent of the FPL, with three states covering up to 300 percent of FPL and all other states falling somewhere in between these limits.<sup>28</sup> The woman can remain on that coverage through the month in which the 60-day postpartum period ends, even if she has a change in income otherwise making her ineligible. In states where Medicaid eligibility is expanded, if a woman is pregnant at the time of enrollment, she will not be eligible for coverage through the Medicaid expansion but may qualify for pregnancy-related coverage under Medicaid. This may leave gaps in coverage in the preconception period.<sup>29</sup>

## **State Strategies to Advance Preconception Health**

As part of this W.K. Kellogg Foundation funded project, AMCHP convened state Title V leaders and their partners to explore and discuss issues, challenges and opportunities for advancing preconception health and health care through an action learning collaborative (ALC). The work builds on other related national initiatives including the CDC/ Agency for Toxic Substances and Disease Registry (ATSDR) Preconception Care Work Group and the Select Panel on Preconception Care, and the peer-to-peer learning project:

Helping States Address Women's Health through Medicaid, funded by the CDC and The Commonwealth Fund, as well as opportunities presented through the ACA and health reform.

States participating in the AMCHP-supported ALC identified several challenges to advancing comprehensive preconception health and health care initiatives, particularly for state Title V MCH programs. These challenges include:

- Weak partnerships between state Title V MCH programs and Medicaid agencies in many states
- Lack of a protocol for the design, development, and dissemination of a preconception health assessment tool that could be used widely and seamlessly by providers
- Ineffective strategies to fully address health disparities and health inequities in maternal and infant health outcomes
- Lack of provider reimbursement for certain components of preconception health care
- Lack of health insurance coverage for low-income women following childbirth – a challenge that could be remedied for many women with full implementation of the ACA in the coming years
- Inadequate reimbursement of mental health services within the context of preconception health and health care (mental health services are optional benefits under Medicaid<sup>30</sup>)
- Inadequate data to enable states to make a fiscal case for preconception health and health care

Four issues emerged as areas where state Title V MCH programs and their partners can play a core role in strengthening access to preconception health. These four areas are the need for:

- Building and strengthening state and community partnerships to develop comprehensive systems of care for women
- Improving access to and quality of primary care (e.g., preconception health care screening and follow-up) for women, particularly those who are low income
- Improving financing of preconception health care services
- Using data to inform program development and policy change

The remainder of this issue brief discusses each of these four areas in further detail and identifies areas where project states and other states are beginning to make progress.

## Building and Strengthening State and Community Partnerships

Partnerships between state Title V MCH programs and other state and community agencies such as Medicaid agencies, providers, home visiting programs including the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program, local health departments, and community health centers are critical to developing and advancing comprehensive preconception health efforts at the state and local level. In other similar projects and state work, public/private partnerships between key state and

local level stakeholders combined with strong state leadership and some type of ongoing structure (e.g., state task force or advisory committee) have shown to be core elements of sustained success and the ability to make improvements to policies, programs and services for low-income women and their families.<sup>31</sup>

### Oklahoma

The work of Oklahoma illustrates the benefits of these partnerships. As part of a broader birth outcomes initiative in Oklahoma, *Preparing for a Lifetime*, a [Preconception and Interconception Care and Education Workgroup](#) was convened and charged with understanding women's perceptions of health before, during, and after pregnancy. Focus groups were conducted in the fall of 2009 through the summer of 2010 to assess what women know and how they learn about pregnancy-related health during their reproductive years. The information gathered in these focus groups has helped Oklahoma State Department of Health programs and partner agencies understand how to provide services and interventions in effective, culturally appropriate ways.

The implications and lessons learned from the focus groups highlights the importance of engaging women of reproductive age in discussions surrounding their health, access to care, and barriers. The report from the focus groups includes recommendations for various groups.

### Oregon

As part of the AMCHP-supported ALC, Oregon assembled a team consisting of representatives from Oregon Public Health Division offices (Women's Health and Adolescent Health); Oregon Health & Science University, Office of Women's Health; Women with Disabilities Health Equity Coalition (WowDHEC); National Youth Leadership Network; GimpGirl Community; and youth with disabilities, with the goal of developing and implementing action plans, sharing strategies and problem solving across communities with a focus on preconception health. The Oregon team set the goal of creating a set of [Preconception Health Recommendations for Young Adults with Disabilities](#), to build on its Preconception Health Action Plan that was created in 2008. The action plan focuses on four main recommendations:

1. Increase public awareness of the importance of preconception health behaviors and preconception care services by using information and tools appropriate across various ages; literacy, including health literacy; and cultural/linguistic contexts
2. As a part of primary care visits, provide risk assessment and educational and health promotion counseling to all women of childbearing age to reduce reproductive risks and improve pregnancy outcomes
3. Integrate components of preconception health into existing local public health and related programs,

including emphasis on interconception interventions for women with previous adverse outcomes

4. Maximize public health surveillance and related research mechanisms to monitor preconception health.

The team working on the Preconception Health Recommendations for Young Adults with disabilities performed a literature review, data analysis, and online survey of youth with disabilities to inform the recommendations. The recommendations were developed as a starting point for a national discussion to further expand on the work by continuing the dialogue and test their viability. Using the Socio-Ecological Model of Health (SeMH) as a framework, the ALC made recommendations organized by four levels: individual, relationship, community, and societal. Within each level, a variety of recommendations were made. These included:

1. Individual-level: Preconception health care for young adults with disabilities (YAWD) should be supported by encouraging access, information, health equality, and physical safety
2. Relationship-level: Family members, caseworkers, and teachers should work to support and encourage environments that allow for access of reproductive and preconception health information and services
3. Community-level: Community-based programs, social service providers, and health systems play an important role in creating a community that is supportive, ensuring that YAWD are included in program and services design and implementation and recognized for their strengths and contributions to the community
4. Societal-level: Preconception health policies, marketing and health messages, data collection, and research should reflect the inclusion and support of young adults with disabilities

Suggestions for further work regarding preconception health and disability include developing recommendations and suggestions for alcohol, tobacco and other drug use, obesity and physical activity, folic acid, diabetes, and special challenges that YAWD may face, such as physical barriers to receiving clinical care, such as mammograms or PAP smears. The ALC team recommends that YAWD, stakeholders, public health entities, and the medical community continue this work, and contribute to the dialogue to improve upon these recommendations and test their viability. Oregon is continuing its preconception health care work by focusing on well-women visits and health equity issues.

## Improving Access to and Quality of Primary Care for Women

With the understanding that gaps in access and coverage continue to exist, the opportunities for enhancing preventive and primary care services for women are numerous and partnerships between Title V and Medicaid, providers and other groups will be even more critical than before. State Title V MCH programs and their partners can play a core role in helping to ensure that state implementation of preventive services and essential

health benefits for women is fully achieved and that coverage of preconception care services is maximized through qualified health plans. Many state Title V programs have played an important role in helping women access care by helping to fund direct clinical services for women who lack health insurance coverage, finding other sources of care such as clinics, and referring women to other available community-based health services. The need for Title V involvement in education and enrollment activities in support of new health coverage options, and assistance with accessing providers will remain important as ACA implementation continues. Until all states adopt the Medicaid expansion, many non-pregnant and post-partum women will fall into the Medicaid coverage gap, whereby they are over-income for existing Medicaid coverage and under-income for subsidized coverage in the health insurance Marketplace.

### Colorado

The work of Colorado provides a good example of one state's effort to improve preconception health. In 2009, the Colorado Department of Public Health and Environment Maternal Wellness team, and two nonprofit organizations, HealthTeamWorks and Healthy Women, Healthy Babies, collaborated to develop the [Colorado Guidelines for Preconception and Interconception Care](#) to improve women's health and promote healthy births. Development of the guidelines was supported by state Title V program funds and guided by an advisory committee comprised of a multidisciplinary team of physicians, nurses, researchers, academicians and others. Critical to the guideline development was the use of the recommendations from the CDC Select Panel on Preconception Care to ensure the guidelines were evidence based. The front page of the two-page guideline covers 12 clinical components that apply to all women of reproductive age, including tobacco and alcohol consumption, body weight, immunization history and mental health history. The back of the guideline covers preconception health and contraceptive recommendations related to specific health conditions such as diabetes, HIV and obesity. The guideline was initially mailed to more than 7,000 providers in Colorado and presented at statewide conferences and webinars. In spite of the overall support for this guideline, Colorado experienced several challenges implementing the guideline in clinical practice settings. These challenges are consistent with those identified in the literature in the implementation of similar screening and assessment tools such as developmental screening for young children. They include the following:

- Provider time constraints to fully implement the guideline
- Provider difficulty in addressing certain topics included in the guideline (e.g., weight management, mental health)
- Limited or unknown referral resources (e.g., weight management program, mental health providers) for issues identified by the guideline
- Lack of provider reimbursement for preconception care services, particularly screening and assessment

To assist with provider use of the guideline, HealthTeamWorks introduced the guideline to providers in clinical settings through a process known as a “Rapid Improvement Activity,” which involved

- Setting clinical goals for guideline implementation
- Designing clinic workflow around the guideline
- Identifying roles and responsibilities of clinic staff
- Implementing the guideline into clinic protocols

Additionally, Maternal Wellness staff worked with Title X Family Planning staff to incorporate the preconception care clinical guideline into practice through local family planning clinics.

## Improving Financing of Preconception Care Services

As ACA implementation unfolds, the promise of expanded access to preconception care has not been fully realized for many women. Financing of preconception care services remains a challenge for many states, even those that expand Medicaid.

There is no one ‘bundle’ of preconception services covered by Medicaid or private insurance in most states. Furthermore, few states specifically reimburse for services such as preconception care screening. As with other multifaceted initiatives, states must use a combination of federal, state, and local public and private funding sources to fund preconception health initiatives. These funding sources include the federal Title V MCH Services Block Grant, Medicaid including Medicaid Family Planning waivers, the federal Title X Family Planning program, state general revenue funds, and funds from private foundations. The work of Colorado and Delaware highlight how two states are working to overcome financing barriers.

### Delaware

In Delaware, the Healthy Women, Healthy Babies (HWHB) program reimburses seven provider groups at 21 sites statewide for four bundles of services not routinely covered by health insurance. These four service bundles are: 1) preconception care including preconception care screening, 2) mental health, 3) interconception and prenatal care and 4) nutrition. Without this reimbursement, Delaware providers have little incentive to provide these services. The HWHB program is supported by a \$5 million state appropriation, the Title V MCH program, and Medicaid reimbursements for key services.

The Delaware provider groups offer these services to women most likely to have poor health and birth outcomes and who are located in geographic areas with the highest risk populations, as determined by public health data. Larger payments are provided for uninsured women. The program supplements funding provided by the Title X Family Planning program, Medicaid, cancer screening, and other programs.

## Using Data to Inform Program Development and Policy Change

The need for improving health outcomes while reducing health care costs has become a significant driver of federal and state health care investments and decision making. The ACA underscored this priority with its focus on quality improvement and cost savings. State Title V programs have a long history of collecting and using data to inform program development and policy decisions. Public health surveillance systems, such as the Pregnancy Risk Assessment Monitoring System (PRAMS), public health data such as birth certificate data, and Medicaid claims data provide important sources of information for measuring the impact of program investments. While readily available in most states, the use, integration, and application of this data particularly across agencies and systems can be challenging in many states and communities.

### Delaware

In Delaware, the state links payment of provider invoices to provision of data on services provided as part of the Healthy Women, Healthy Babies program. This linkage allows the state to measure the extent to which women are receiving the full complement of 16 program services and to measure the impact of the program. Program data is integrated with birth records for all women served by the program so that the state can link provision of preconception, prenatal, and postpartum care to improvements in birth outcomes. Data are used not only to measure impact of the program but also to make the fiscal case for the infant mortality investment – state general revenue funds of \$5 million. Legislators were provided district specific data on infant mortality to educate them about the program and to make the fiscal case for continued state investment in the effort. Since implementation of the Healthy Women/Healthy Babies program, the state has seen a reduction in infant mortality for five consecutive years. The Delaware prematurity rate fell from 14.2 percent to 12.7 percent for the reporting periods of 2006 to 2010 and the infant mortality rate has fallen from 9.3 to 8 deaths per 1000 live births.

### Michigan

In Michigan, infant mortality is one of the health indicators selected for the dashboard implemented by Governor Rick Snyder to provide a quick assessment of state performance in key areas including: economic strength, health and education, value for government money, quality of life, and public safety.

Through inclusion in the dashboard, the expectation among the MCH community was that the Michigan infant mortality rate would improve. A steering committee of MCH experts, stakeholders, and advocates convened to examine the causes of infant death in Michigan and developed the [Michigan Infant Mortality Reduction Plan](#).<sup>34</sup> The state plan released in August 2012 can be viewed on the recently [launched state infant mortality website](#).<sup>35</sup>

Improving the health status of women and girls is one of eight strategies to improve birth outcomes and infant survival rates. Data collection is essential in this effort to obtain baseline knowledge, trends, and in-depth analyses, and to inform programs, policymakers and other stakeholders. Data collected thus far demonstrate associations between preconception chronic conditions such as asthma, anemia and depression and poor birth outcomes, such as low birth weight, preterm birth, and admission to the NICU. This Michigan specific data was recently published in a [PRAMS factsheet](#), part of an ongoing series highlighting preconception health indicators. The chronic conditions examined were found to correlate with higher prevalence of at least one of the birth outcomes that were monitored. In addition, a [second preconception health factsheet](#) was developed to inform stakeholders and policymakers about the importance of nutrition and physical activity for women's health. This data will be used to estimate the costs of labor and delivery in the state. Michigan PRAMS also came up with an [issue brief](#) highlighting the status and importance of oral health during pregnancy. Further analysis on the social determinants of health will be used to promote state preconception health efforts. The Practices to Reducing Infant Mortality through Equity (PRIME) project recently released the [inaugural health equity status report](#), examining the impact of the social determinants on health and infant mortality.

In addition to strengthening data to inform preconception program development, Michigan is moving to expand Medicaid and insurance coverage under the ACA. MCH programs such as Title X Family Planning and Maternal Infant Health Program (MIHP) are moving to support enrollment activities to ensure access to primary care for women, especially low-income women. It is anticipated that Michigan can demonstrate increased access to health insurance as well as use of routine health care services among women of reproductive age using Michigan's behavioral risk factor survey (MBRFSS). The most recent annual report can be viewed [here](#).

## Conclusion

The benefits of preconception health and health care are well documented for improving maternal and infant health outcomes. Many states and communities readily acknowledge the importance of preconception health and health care and are leading efforts to develop new ways of improving access to preconception care, financing of preconception care services, and using data to inform policy and program development. The ACA provides states and communities with new opportunities to develop and improve preconception health and ultimately improve birth outcomes.

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## Selected Resources for Further Information

- Centers for Disease Control and Prevention: Preconception Health and Health Care
- Council of State and Territorial Epidemiologist: Core State Preconception Health Care Indicators
- HealthTeamWorks (CO): Guidelines for Preconception and Interconception Care
- U.S. Department of Health and Human Services Office of Women's Health: Preconception Health Quiz
- U.S. Health Resources and Services Administration: Maternal, Infant, and Early Childhood Home Visiting Program
- Michigan Department of Community Health: Michigan Infant Mortality Reduction Plan
- Michigan Dashboard
- Oklahoma: Healthy Women, Healthy Futures
- Oklahoma: Preconception and Pregnancy Health Focus Groups Summary Report and Recommendations
- Oregon Health Authority, Public Health Division, Center for Prevention and Health Promotion, Maternal and Child Health: Preconception Health Recommendations for Young Adults with Disabilities

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