

National Summit on Preconception Care

National summit on Preconception Care
June 21-22, 2005

at the
Atlanta Marriott Century Center
Atlanta, Georgia

Department of Health and
Human Services

Centers for Disease Control
and Prevention

June 21 - 22, 2005

The Atlanta Marriott Century Center
Atlanta, Georgia



Preconception Care

June 21-22, 2005



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Summit Partners

American Academy of Pediatrics

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national society of genetic counselors, inc.



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Planning Committee cont'd

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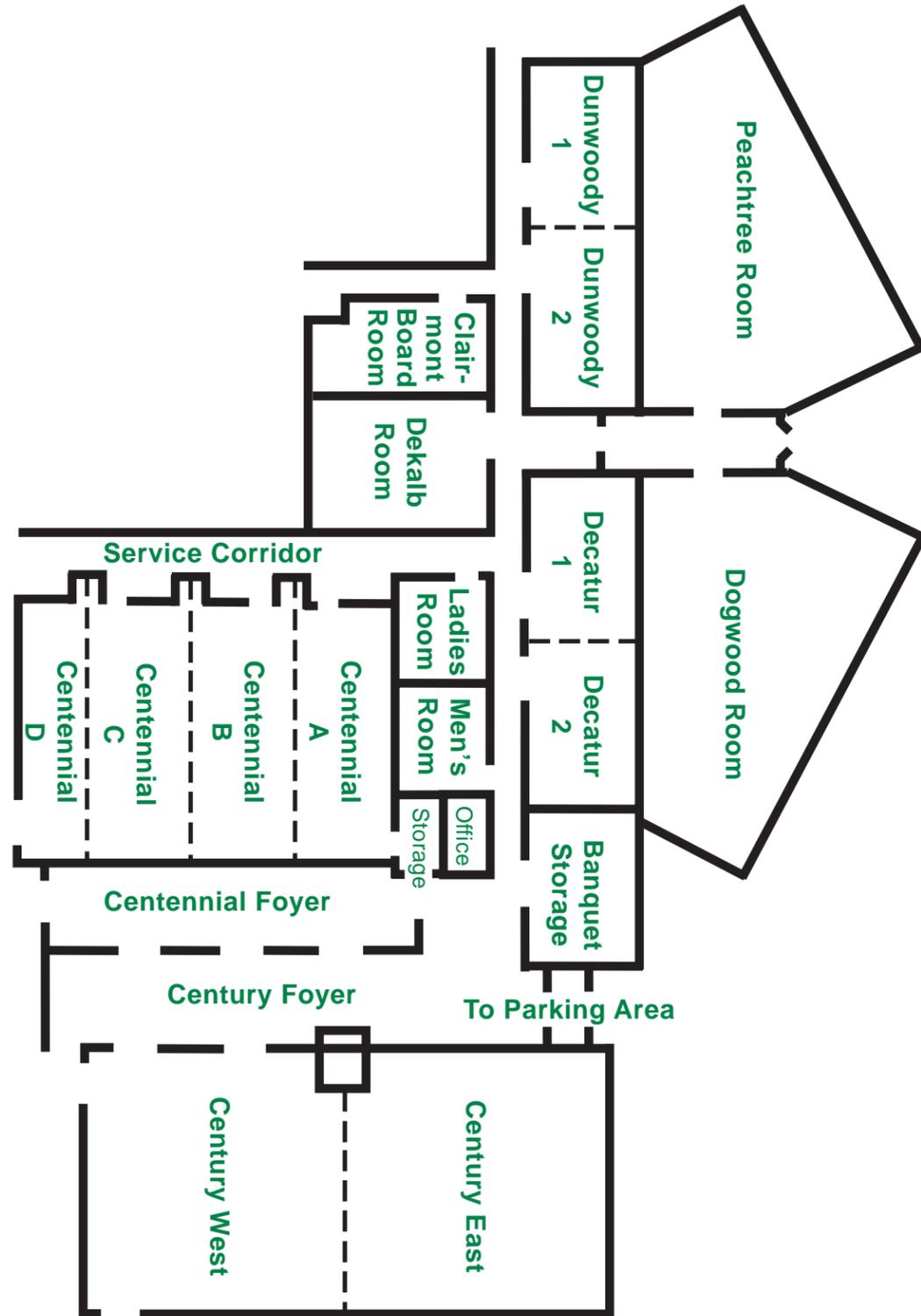
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National Center on Birth Defects and Developmental Disabilities

Paul I Eke, Ph.D.

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Centers for Disease Control and Prevention

Floor Plan



Agenda At-A-Glance

TUESDAY, JUNE 21, 2005

8:15 – 9:30 A M	Welcome and Opening Plenary Keynote Address: Preconception Care: Time to Act
9:30 – 10:45 A M	Plenary Session: What is it? The Evidence-base and Science Supporting Preconception Care
10:45 – 11:00 A M	Break
11:00 – 12:00 P M	Workshop breakout sessions A: Mini-plenary A1 – Genomics: The implications for preconception care A2 – Putting it All Together in Policy and Finance: The case of Illinois
12:00 – 2:00 P M	Luncheon
2:00 – 2:15 P M	Break
2:15 – 3:45 P M	Workshop breakout sessions B: Practice and Programs B.1 – Every Woman, Every Time. B.2 – Community-based approaches to Preconception Care. B.3 – Provider Education: What we know and what we need to do. B.4 – Tools You Can Use. B.5 – The Role of Infectious Disease Prevention in Preconception Care
3:45 – 4:00 P M	Break
4:00 – 5:30 P M	Workshop breakout session C: Data and Strategies C.1 – Key Strategies for High-risk Women. C.2 – Data for Change: Action, Policy, and Practice. C.3 – Using Surveys to Assess Knowledge, Attitudes, and Beliefs. C.4 – Reaching and Influencing Specific Populations.
5:30 – 7:00 P M	Reception with exhibits
7:30 – 9:30 P M	Special Session All Over the Map: Strategies from around the globe.

Expanded Summit Agenda and Abstracts

Tuesday, JUNE 21, 2005

Illinois

A.2 - Putting it all Together in Policy and Finance: The case of

Moderator: [Kay Johnson](#)

[Anne Marie Murphy, Ph.D.](#) - Illinois Medicaid Director &
[Stephen E. Saunders, M.D., M.P.H.](#) - Associate Director

12:00 - 2:00 PM

Luncheon

Moderator: [José Cordero, MD, MPH](#)

Assistant Surgeon General, Director, NCBDDDD

[Julie Gerberding, MD, MPH](#)

Director, CDC (invited)

Surgeon General Vice Admiral [Richard H. Carmona, MD, MPH, FACSOR](#) (invited)

[Joy Phumaphi](#)

Assistant Director-General, World Health Organization

2:00 - 2:15 PM

Break

2:15 - 3:45 PM

Workshop breakout sessions B: Practice and Programs

B.1 - Every Woman, Every Time.

• Moderator: [Lisa King](#)

Promoting Folic Acid Use through "Folic Acid Friendly" WIC and Family

• Planning Clinics ([Mary Beth Weber](#))

Every Woman, Every Time: The California Preconception Care

• Initiative ([Arlene Cullum](#))

Access to Women's Health Services through the Title X Family Planning

• Program ([Diana Cheng](#))

Enhancement and Integration of Preconception Care into MCAH/OFP

• Programs ([Emmett Gonzalez](#))

Oklahoma Birth Defects Registry in an Urban and a Rural Family Planning

Clinic ([Vicki Feuerborn](#))

B.2 - Community-based approaches to Preconception Care.

• Moderator: [Maureen Fitzgerald](#)

• Broward Healthy Start Coalition ([Robin Davenport](#))

Healthy Mothers Healthy Babies Coalition (HMHB) of Wake County,

• Raleigh, NC ([Laura Oberkircher](#))

• Toward Women Health: Cities Take Action ([Helene Kent](#))

• Preconception and Interconception Care Protocols ([Yvonne Beasley](#))

A Healthy Baby is Worth the Weight ([Stephanie M. Beaudette](#))

B.3 - Provider Education: What we know and what we need to do.

• Moderator: [Margaret Comerford Freda](#)

An Interdisciplinary Preconception Care Curriculum for four

• Medical Specialties ([Cynthia Chazotte](#))

Expanded Summit Agenda and Abstracts

Tuesday, JUNE 21, 2005

- What Every Health Care Provider should know about the "Preconception Visit" ([Margaret Malnory](#))
- Health Care Provider Knowledge and Practices Regarding Folic Acid, Us, 2002-2003 ([J.L. Williams](#))
- Improving Preconception Care ([Peter Bernstein](#))

B.4 - Tools You Can Use.

Moderator: [Cathy Melvin](#)

- Preconception Toolkit—Making it easy for providers ([Ann E. Conway](#))
- Folic Acid Education for Middle Schoolers and Girl Scouts ([Sue Samuels](#))
- Evaluating a Preconceptional eHealth Education Program and Message Delivery Tool ([Elizabeth Fassett](#))
- Preconception information for Hispanic women ([Beverly Robertson](#))
- Folic Acid Every Day: An educational toolkit for public health nurses, nurse practitioners, dietitians and nutritionists. ([Ron Lutz](#))

B.5 - The Role of Infectious Disease Prevention in Preconception

Care

- Moderator: [Marian McDonald](#)
- Infectious Diseases and Preconception Care ([Susan A. Wang](#))
- Planning for Pregnancy: What women need to know about STI prevention detection and treatment ([Madeline Sutton](#))
- Vaccine-preventable Infections and Preconception Care ([Susan Reef](#))
- Pre-Conception Prevention of Chronic Hepatitis B: Bridging the Gap to Break the Cycle of Infection ([Chari Cohen](#))

3:45 - 4:00 PM

Break

4:00 - 5:30 PM

Workshop breakout session C: Data and Strategies

C.1 - Key Strategies for High-risk Women.

• Moderator: [Al Brann](#)

• Interconceptional Education and Counseling of the Healthy Start High

• Risk Woman ([Laura Levine](#))

African-American women at Grady Memorial Hospital (GMH).

• ([Anne Dunlop](#))

• Interconceptional Care Counseling: A Curriculum for Health Care

• Educators & Providers ([Diana Sierra](#))

• A Novel Comprehensive Preconception Interconception Care (CPIC)

• Program. ([Ashlesha Dayal](#))

Magnolia Project ([Carol Brady](#))

C.2 - Data for Change: Action, Policy, and Practice.

• Moderator: [Jennifer Skala](#)

The Importance of Marketing Perinatal Health to Non-Contemplators: Th

Expanded Summit Agenda and Abstracts

Mini-Plenary

Wednesday, JUNE 22, 2005

- 10:00 – 11:00 A M** Plenary Session: How to pay for it? Financing Preconception Care
Moderator: [Charlie Mahan](#),
Professor, University of South Florida
- [Sara Rosenbaum, J.D.](#), Hirsh Professor and Chair, Department of Health Policy, George Washington University
 - [Mary Stranger](#), Director of Benefits – Synovus Financial Corporation
- 11:00 – 12:30 P M** Closing Plenary Session: Where do we go from here? Implications for Practice (“Nightline” style panel)
Moderator: Kay Johnson
- [Al Brann, Jr., MD](#)
Professor of Pediatrics
Emory University, School of Medicine
Director - World Health Organization Collaborating Center in Reproductive Health (in Atlanta)
 - [Magda Peck, ScD](#)
Senior Advisor, CityMatCH
Professor, University of Nebraska Medical Center
 - [Michele Curtis, MD](#)
American College of Obstetricians and Gynecologists
 - [Margaret Comerford Freda, EdD, RN, CHES, FAAN](#)
Professor, Obstetrics & Gynecology and Women’s Health
Albert Einstein College of Medicine, Montefiore Medical Center
Editor, MCN The American Journal of Maternal Child Nursing
 - [Ann Weathersby, CNM, MSN](#)
Kaiser Permanente
 - [Charlie Mahan, MD](#)
Professor, University of South Florida
 - [Maxine D. Hayes, MD, MPH](#)
State Health Officer
WA State Department of Health
 - [Carol Weisman, Ph.D](#)
Center of Excellence for Research on Pregnancy Outcomes, Penn State

A1 – Genomics: The Implications for Preconception Care

The 21st century has brought with it the completion of the sequencing of the human genome. As genetic discovery continues, with clear implications for understanding classic genetic diseases, genetic variation is increasingly appreciated to impart differential susceptibility to complex diseases. These complex conditions include many perinatal outcomes such as preterm birth, stillbirth, and infant health, which arise as the result of gene-environment interactions. Genomic research is allowing us to refine our understanding of many aspects of preconception care, including susceptibility to smoking, response to folic acid, and nutritional influences on growth and development. An accurate assessment of risk in the preconception period will allow personalization of clinical preventive measures as well as a strengthening of preventive public health measures.

In this session, participants will:

- 1) Consider the role of genetics, genomics, and epigenetics in improving birth outcomes
- 2) Review risk assessment and the role of genetic counseling in preconception care
- 3) Employ a life cycle approach to health promotion and disease prevention and consider prenatal determinants of adult health

Moderator: [Muin Khoury](#)

- The Role of Genetic Counseling in Preconception Care ([Jennifer Hoskovec](#))
- Preventing Prematurity: Genomics and Preconception Care ([Siobhan Dolan](#))
- Maternal Nutrition, Epigenetics and Offspring Health ([C S Yajnik](#))

The Genetic Counselor’s Role in Preconception Care – ([Jennifer Hoskovec](#))

Current literature and practices encourage the implementation of multidisciplinary preconception care programs. Genetic counselors are allied healthcare specialists with unique training and expertise, who can enhance preconception care by identifying women and their partners who may have an increased risk to have a child with a birth defect or genetic condition. This is accomplished through the comprehensive assessment of a client’s family and medical history, as well as the discussion of appropriate screening options and diagnostic tests. Genetic counselors employ skills such as contracting, active listening, and empathy to elicit clinically-relevant information as well as address the client’s questions and concerns about their possible reproductive risks. Through the process of genetic counseling, the counselor assesses the client’s understanding and facilitates decision-making regarding options for screening, testing, and related medical management.

Family history assessment is an invaluable tool used to evaluate the risks for specific birth defects and genetic conditions in a family. Genetic counselors encourage women to collect their medical family history information and thereby take an active role in this process. If the family history is addressed prior to pregnancy, couples have more time to obtain additional information from family members and/or pursue additional evaluation (if necessary) that may aid in a more accurate risk assessment. For example, a woman with a family history of mental retardation would benefit from a complete family history assessment that may include recommendations for further evaluation of affected family members in order to clarify the etiology of the condition and refine genetic risks.

In regard to a client’s personal medical history, genetic counselors educate women with conditions such as diabetes and epilepsy about their increased risk for birth defects. Women with pre-gestational diabetes are at an increased risk to have offspring with specific birth defects and proper compliance with diet and

Moderator: [Kay Johnson, MPH](#)

- Using Medicaid Waiver's to Promote Women's Health and Pre/Interconception Care – ([Anne Marie Murphy, PhD](#) - Administrator, Division of Medical Programs, Illinois Department of Public Aid)
- Using Title V and Other MCH Resources to Improve Pre/Interconception Care – ([Stephen E. Saunders, MD, MPH](#), - Associate Director for Family Health, Division of Community Health and Prevention, Illinois Department of Human Services)

1. Using Medicaid Waiver's to Promote Women's Health and Pre/Interconception Care - [Anne Marie Murphy, PhD](#), Administrator, Division of Medical Programs, Illinois Department of Public Aid

The Illinois Department of Public Aid (IDPA) is committed to improving the health of women and children. The department has recently created a new bureau for "Maternal and Child Health Promotion" dedicated to this goal. Using Medicaid, the IDPA has extended pre- and inter-conception care for low-income women.

The IDPA's long-standing request for a waiver to extend Medicaid coverage of family planning services was approved and has been implemented as the Illinois Healthy Women initiative. Illinois Healthy Women provides preconception and interconception to women who have recently lost their medical assistance benefits. Implemented on April 19, 2004, this five-year demonstration project is designed to improve the health outcomes of women and their future children by expanding access to women's health care services.

Illinois Healthy Women is a voluntary program, and women can re-enroll every 12 months as long as they are eligible. Eligibility is extended to women who would otherwise lose maternity-related coverage after 60 days postpartum, along with all women ages 19-44 who were enrolled in and lost full Medicaid benefits. Coverage will enable low-income women who are leaving IDPA's medical assistance programs to have continued access to essential preventive and reproductive health care services, as well as contraceptives, thereby allowing them to reduce unintended pregnancy, choose the number and spacing of their pregnancies and, when desired, to plan a healthy birth. Such coverage is key to improving access for preconception and interconception care to this group of women at high-risk.

Since there is no application process, outreach efforts have been targeted to those providers who have frequent contact with the eligible population. Mailings to local health and social service agencies, notices to all family planning providers, trainings for local health departments, and press releases have been used to increase awareness and knowledge of the Illinois Health Women program.

The implementation of Illinois Healthy Women is expected to increase the capacity of Illinois' Family Planning Program. Those individuals not eligible for IHW are referred to Title X, for assistance in locating low cost family planning services in their area.

Illinois also obtained a waiver under Title XXI (State Children's Health Insurance Program – SCHIP) to operate Family Care, which provides health insurance coverage to parents with income equal to or less than 90 percent of the FPL. Governor Blagojevich requested budget funds for SFY'05 to increase the eligibility threshold for Family Care from 90 to 133 percent of the federal poverty standard. Such extensions of family coverage provide access to interconception care for women additional low-income families.

2. Using Title V and Other MCH Resources to Improve Pre/Interconception Care - [Stephen E. Saunders, MD, MPH](#), Associate Director for Family Health, Division of Community Health and Prevention, Illinois Department of Human Services

In Illinois, the Department of Human Services (IDHS) as the state health agency responsible for the administration of the MCH Services Block Grant; however, services are coordinated through several units. The IDHS allocates its resources by "Giving highest priority to those areas in Illinois having high concentrations of low-income families, medically underserved areas, and those areas with high infant mortality and teenage pregnancies . . ." Illinois' Title V program focuses on three main areas: the reduction of infant mortality; the improvement of child health, and the prevention of teen pregnancy.

Preconception care is one priority area, and four strategies are designed to improve preconceptional health. The Family Planning program is the state's primary strategy for improving preconceptional health. This program – primarily supported with Title X funding – provides comprehensive family planning services related to the avoidance, achievement, timing, and spacing of pregnancy. The second preconception care strategy is the IDPH-supported statewide genetic counseling program through grants to public health and private specialty providers.

The third preconception care program – a statewide campaign promoting the consumption of folic acid – jointly conducted by the state Title V program and the Illinois Chapter of the March of Dimes.

A fourth strategy focuses on women with perinatal depression, which can have major impact of interconception care and health. The Title V program, working with the Department of Psychiatry in the University of Illinois at Chicago to applied for and received a "State Grant for Perinatal Depression and Related Mental Health Problems in Mothers and Their Families." Further, as of December 1, 2004, the Illinois Department of Public Aid (IDPA) began reimbursing providers for screening mothers for perinatal depression when their child is on the state's Medicaid program. The Title V agency is working with the Illinois Academy of Pediatrics to encourage use of this new resource.

In addition, Title V supports programs that provide interconception care and education for teen parents. The Teen Parent Services (TPS) program is mandated for parents under age 21 who are receiving TANF and offered to young parents who receive Medicaid, WIC, FCM or Food Stamps. The Parents Too Soon (PTS) program helps teen parents to delay subsequent pregnancies, improve their own health, and promote the healthy development of their children. The Responsible Parenting program assists mothers ages 13 and 14 years to delay subsequent pregnancies, effectively practice birth control, graduate from high school, develop parenting skills and cope with problems related to pregnancy and parenting.

3. Preconception and Interconception Care in the Healthy Start Program of Southern Illinois - [Paula Brodie, MSHPE](#)

The communities of Greater East St. Louis, Belleville, and Alton, Illinois, collectively comprise the project service area for Southern Illinois Healthcare Foundation's (SIHF) Healthy Start program. As well as being the most culturally diverse area in Southern Illinois, this area also has the distinction of being four of the nation's poorest communities. Women of childbearing age represent over one-quarter of the population. Once the economic backbone of the region, East St. Louis continues to experience a decaying infrastructure that has resulted in socioeconomic devastation and intractable poverty not only for East St. Louis, but its neighboring communities as well.

PROMOTING FOLIC ACID USE THROUGH "FOLIC ACID FRIENDLY" WIC and FAMILY PLANNING CLINICS. [Mary Beth Weber, MPH](#), [Anne L. Lifflander, MD, MPH](#), [Godfrey P. Oakley, Jr, MD, MSPM](#), [Karen N. Bell, MPH](#) Emory University, Rollins School of Public Health, Dept. of Epidemiology

Program description including target population: The Georgia Folic Acid Campaign (GFAC) sought to increase the number of reproductive age women consuming at least 400 µg of synthetic folic acid and the proportion of health care providers who promote folic acid to their patients.

Services offered or intervention approach and providers: The GFAC is a WIC and Family Planning Clinic-based initiative to increase folic acid consumption through directed provider outreach and in-office education. The program, based on pharmaceutical office detailing, sought to create "folic acid friendly" offices, where folic acid consumption would be promoted actively and folic acid materials would be prominently displayed and available to clients.

Evaluation and/or evidence of success: There was a significant increase in consumption of cold breakfast cereals (52%-59%, p=0.0187) and folic acid knowledge (29%-34%, p=0.0293) among non-pregnant women and in the proportion of women who reported learning about folic acid from a health professional (52%-57%, p=0.0219). The proportion of women who had never heard of folic acid decreased from 18% to 11% (p<0.0001). Approximately 75% of the women read nutrition labels, but fewer than 10% looked for folic acid content on labels.

Conclusion: Promoting fully fortified breakfast cereals may be an effective way to increase folic acid use. Improving label reading skills to include checking for folic acid can be taught to encourage folic acid consumption. Intensive and ongoing folic acid promotion is still needed. In spite of improvements in cereal consumption, less than one-third of all non-pregnant women are consuming a multivitamin or a fully-fortified cold cereal, and three quarters of pregnant women were not taking a multivitamin at the time they became pregnant. This program could be easily replicated and modified for use in other health care provider offices.

EVERY WOMAN, EVERY TIME: THE CALIFORNIA PRECONCEPTION CARE INITIATIVE. [Arlene S. Cullum, MPH](#), Sutter Medical Center, Sacramento

Program description: The California Preconception Care Initiative was a grant partnership between Sutter Medical Center, Sacramento and the March of Dimes, which began in 1998. Increasing access to preconception care was accomplished through two major activities: (1) conducting a meta-analysis of preconceptional care literature, serving as rationale for content, and (2) developing and distributing a marketing packet to promote adoption of preconceptional services/interventions by medical providers in California.

Services offered/intervention/providers: These two initiatives were chosen to provide clear information about the value of preconceptional interventions and to provide user-friendly materials to change practices in patient education and billing. Other key partners in the project included the American College of Obstetricians and Gynecologists, the California Academy of Family Physicians, and a university-based health policy institute. A statewide medical advisory committee was formed with representation from public, private, university-based, and governmental physicians. This committee developed the framework for a quantitative and cost-effectiveness analysis of the literature using the systematic approach of the Cochrane

A technical advisory committee was then formed to develop a promotional packet for primary care providers entitled California Preconception Care Initiative: Every Woman, Every Time. Key components of the packet included the rationale for providing preconceptional care, a description of the essential elements of care, patient education handouts in multiple languages at low reading level, and methods for billing. 9,000 educational packets were distributed at statewide professional conferences and meetings and distributed to professional organization mailing lists. Currently, plans are underway to update the packet.

Evaluation and/or evidence of success: An evaluation of product effectiveness was conducted by a university-based center for health policy studies. Responses from 187 providers showed that 75% indicated the material in the packet would change advice in the practice setting somewhat or very much, 62% indicated the patient education information was very useful, 80% of providers stated they would distribute the handouts, and 72% would use the billing codes provided. Evaluation of the change in volume of preconception services on a statewide basis is being considered for further evaluation of effectiveness.

Conclusions: Every Woman, Every Time can serve as a model to other states for promoting preconception care to primary care providers for women. It continues to be a challenge to comprehensively fund preconception care services, have routine provision of preconception care services to reproductive age women, and to assure complete access to care across the age and health care continuum.

ACCESS TO WOMEN'S HEALTH SERVICES THROUGH THE TITLE X FAMILY PLANNING PROGRAM. [Diana Cheng, M.D.](#), Maryland Department of Health and Mental Hygiene, Center for Maternal and Child Health

Program: The Women Enjoying Life Longer (WELL) Project was initiated by the Maryland Department of Health and Mental Hygiene following a community needs assessment. Comprehensive preventive women's health services were added to three Title X family planning centers in Eastern Baltimore County. Funding from the Maternal and Child Health Bureau supplemented the already existent budget from Title X. Most of the 1,600 annual clients have difficult access to health care – 33% are teens, 42% are of a racial or ethnic minority, 75% are at or below the federal poverty level and 86% are uninsured.

Services: Services introduced include nutrition and physical activity counseling, adult immunizations, smoking cessation management, preconception counseling, as well as screening and referrals for substance abuse, depression, domestic violence, and chronic disease. These WELL services were integrated with HIV counseling and testing, STD testing, Pap smears and colposcopy - which were already part of the family planning program. All services are provided by health educators and counselors, nurse practitioners and ob/gyn physicians. Staff was trained about women's health topics during monthly meetings. Educational client materials created specifically for WELL include brochures, screening cards, patient history cards, health resource book, promotional items, health "risk" wheel, and posters designed in collaboration with the Maryland Science Center.

Evaluation: Program activities were evaluated, focusing on the implementation and early impact of services and patient and staff perceptions. Surveyed patients and staff responded positively to new services offered and felt they should be continued. Clients identified many services as ones they would not have otherwise received without WELL. Knowledge of women's health, evaluated by a patient questionnaire, improved after the introduction of WELL. Patient volume has increased 37% from 2001 to 2003.

Learning Objectives:

- Provide an overview of a variety of pre- and/or interconception care initiatives;
- Describe a discrete set of evidence-based approaches to address this critical aspect of women's health;
- Offer resources, opportunities, and linkages in/with local programs and practices in this area;
- Provide tools in the form of promising practices to improve pre-conception care;
- Challenge participants to consider new partnerships, coalitions and unique collaborations to positively impact women's health and birth outcomes.

Moderator: [Maureen Fitzgerald](#)

- Broward Healthy Start Coalition (Robin Davenport)
- Healthy Mothers Healthy Babies Coalition (HMHB) of Wake County, Raleigh, NC (Laura Oberkircher)
- Toward Women Health: Cities Take Action (Helene Kent)
- Preconception and Interconception Care Protocols (Yvonne Beasley)
- A Healthy Baby is Worth the Weight (Stephanie M. Beaudette)

INTERCONCEPTIONAL COUNSELING. [Robin M Davenport, RN, BSN, CCCE, CPPI](#), [Barbara A Lesh, MPA](#) Broward Healthy Start Coalition, Inc.

Program Description and Target Population: The program identifies reducible or reversible risks prior to pregnancy, maximizes maternal health, and intervenes to achieve optimal birth outcomes through individual and group sessions. The target population is all Healthy Start Postpartum women.

Services Offered or Intervention Approach and Providers: The approach involves assessment and reassessment of the woman's health using the Woman's Health Questionnaire and provides education and counseling to address the factors that may contribute to poor birth outcomes and to maximize maternal health. Focus areas include primary care, smoking cessation, substance abuse treatment, counseling to reduce stress, nutrition counseling, family planning, dental care, physical activity, baby spacing, maternal infection and environmental risk factors. All Healthy Start Case Managers are trained in the Interconceptional Counseling curriculum.

Evaluation and Evidence of Success: Evaluation is provided through site visit reports and peer record reviews. The greatest success is that over 30% of records reviewed reveal that women have been provided Interconceptional Counseling.

Conclusion: All women of childbearing potential should be educated to increase the awareness of the optimal health status needed to improve the birth outcome of a potential pregnancy. All components of the curriculum can be replicated. Challenges include: willingness of clients to accept the services and teaching the staff to market the program.

HEALTHY MOTHERS HEALTHY BABIES COALITION (HMHB) OF WAKE COUNTY, RALIEGH, NORTH CAROLINA. Contact: [Laura Oberkircher](#), Executive Director

Target Population: Women in Wake County, North Carolina

Services offered or intervention approach: A coalition of community professionals and citizens developed a community-wide women's health improvement plan. The health improvement plan led to the development of a Lay Health Worker program directed at improving the health of community women. The Advisors work in seven low resource communities throughout the county, and provide information, resources, and needed referrals to women at any time they need assistance, not just when they are pregnant.

Providers: Community women, Healthy Mothers, Healthy Babies Coalition, the Wake County Human Services (the departments of health, social services, and mental health), March of Dimes, a local college, and sixteen other community partners participated in the development of the women's health plan. Each of the Lay Health Advisors associated with the Woman 2 Woman program is a community leader who receives regular training on health issues.

Financing: The Healthy Mothers, Healthy Babies Coalition, Wake County Human Services, March of Dimes, Wake AHEC, Wake County Child Fatality Team, St. Augustine's College, and other community partners provided financial and in-kind support to the Health Forum. Grant funding originally supported the Women 2 Women project, which is now funded through Wake County Human Services. The project has a half time paid coordinator, and each Lay Health Advisor receives a stipend.

Evaluation and/or evidence of success: Project evaluation is underway. The Women 2 Women project reaches about 313 women and their families and provides 82 needed referrals each month. Lay health advisors participate in neighborhood outreach going door-to-door or reaching women by phone. They also arrange house meetings, engage in street outreach, do presentations, and participate in health fairs and other community events.

Implications for advancing preconception care: Wake County Perinatal Periods of Risk data indicated that the poor birth outcomes associated with African-American women, who often begin their pregnancies in poor health, was driving the infant mortality rate in Wake County. Thus by working to improve the health of community women prior to pregnancy, it is expected that poor birth outcomes will be reduced.

Potential for application and/or replication of strategies and tools: The activities described are replicable and have application to other communities. HMHB has developed reporting tools to track lay health advisor outcomes, and have training materials.

Lessons learned, both successes and challenges: The success of the women's health planning process is because community members and agency personnel have been involved in all stages of the plan's development. Community engagement can be challenging, but the positive results justify the time, creativity, and effort it takes.

B3 -Provider Education: What we know and what we need to do.

Educational programs for interdisciplinary health care providers will be described. Participants will hear how to recognize and care for chronic conditions. Screening for risk factors such as smoking will also be addressed.

Learning Objective: Describe strategies to educate a variety of health care providers in preconception care.

Moderator: Margaret Comerford Freda

- An Interdisciplinary Preconception Care Curriculum for four Medical Specialties (Cynthia Chazotte) Helping Internists to Help Women with Medical Illness Have the Best Pregnancy Outcomes
- (Margaret Miller)
- What Every Health Care Provider should know about the “Preconception Visit (Margaret Malnory) Health Care Provider Knowledge and Practices Regarding Folic Acid, Us, 2002–2003 (J.L. Williams) Improving Preconception Care (Peter Bernstein)

AN INTERDISCIPLINARY PRECONCEPTION CARE CURRICULUM FOR FOUR MEDICAL SPECIALTIES. Cynthia Chazotte MD, Peter Bernstein MD, Ellen Harrison MD, Sophie Balk, MD, Robert Koppel, MD, Leena Shah MD, Nancy DeVore CNM, MS, Karla Damus Ph.D., Margaret Comerford Freda Ed.D., RN. Departments of Obstetrics & Gynecology and Women’s Health, Internal Medicine, & Pediatrics, Albert Einstein College of Medicine, Montefiore Medical Center, Bronx, NY. & Long Island Jewish Medical Center, NY

Program Description: A curriculum on preconception health care was developed specifically aimed at residents in ob/gyn, internal medicine, pediatrics, and family medicine.

Intervention Approach: The curriculum consists of a series of 5 power point slide sets: a general module for all a specialty module for: ob/gyn, internal medicine, family practice and pediatrics. The general module was designed to provide core knowledge important to all providing care to women. The specialty module describes relevance and importance of preconception care in the context of the specialty, barriers to preconception care and strategies for integration into practice. The format is both didactic and case-based and may be used as a standard lecture or as a small group discussion session. It can also be used for independent study.

Evaluation: Each pair of modules was piloted in all specialties in 2 sites. A total of 189 physicians completed the pre and posttests for the curriculum. Knowledge gain demonstrated on all content questions. National leaders in ob/gyn, internal medicine and family medicine and pediatrics reviewed the curriculum. The material was revised based on evaluation data.

Conclusions: This curriculum is a useful education tool that can be used for physicians at all levels of training as well as nurses and primary care practitioners. It is available as a free download from the March of Dimes website: http://www.marchofdimes.com/professionals/14429_1483.asp

HELPING INTERNISTS TO HELP WOMEN WITH MEDICAL ILLNESS HAVE THE BEST PREGNANCY OUTCOMES. Raymond Powrie¹, Lucia Larson¹, Margaret Miller¹, Niharika Mehta¹, Erin Keely², Robyn A. North³, Karen Rosene-Montella.¹ ¹Women and Infants’ Hospital of Rhode Island, Brown University, USA. ²University of Ottawa, ³University of Auckland, New Zealand

Background: Many of the most important interventions and decisions that will help ensure the best outcome for a pregnancy in a women with medical illness occur before a woman comes to see her obstetrician. At the same time the growing complexity of medical illness means that there is an increasing need for the expertise of internists to be the care of medical illness in pregnancy. Despite this need, training in medical illness in pregnancy is sorely lacking in the majority of medical residencies and fellowship programs.

Program descriptions: We describe a series of unique and related programs developed in collaboration with Women and Infants’ Hospital of Rhode Island and Brown University that aim to assist internal medicine providers in pursuing further progress in research, education and clinical expertise related to the care of medical illness in pregnancy.

Services offered and evaluation of success:

1. A mandatory internal medicine resident rotation: All residents in the Brown University Internal Medicine and Medicine/Pediatrics program spend 4 weeks on the obstetric and consultative medicine rotation during their third year of residency. In addition to an extensive clinical experience at one of the nation’s busiest obstetrics centers, the medicine residents all receive a 13 part curriculum (that includes a pre and post curriculum examination) on management of medical illness in pregnancy that equips them to help prepare women with medical illness for pregnancy. The residents demonstrate dramatic improvement in their knowledge about medical illness in pregnancy over the course of this rotation. The curriculum is available on the web at www.obmed.org and received an award for excellence in medical innovations from the Society of General Internal Medicine in 2000.

2. A fellowship for internal medicine physicians: Women and Infants’ Hospital of Rhode Island and Brown University began a 2 year fellowship in Obstetric Medicine in 1993 to train internists to become leading educators and researchers in the care of medical illness in pregnancy. To date, 15 Obstetric Internists have graduated from this program and 13 of these graduates now practice obstetric medicine in academic medical departments. The program is unique in North America and is an important step towards creating a critical mass of internal medicine providers who are expert in the care of medical illness in pregnancy who can then train the next generation of internists in this often neglected area.

3. A website resource for members of the International and North American Society of Obstetric Medicine (ISOM and NASOM): The North American Society of Obstetric Medicine and International Society of Obstetric Medicine were established in 1987 and 2002 respectively. These societies provide a multidisciplinary forum for the propagation and dissemination of knowledge about medical illness in pregnancy. In December 2004, the ISOM launched a new website at www.isom.net that was developed and by Women and Infants’ Hospital of Rhode Island with additional support from a grant from the State of Rhode Island. This website provides the following aids to the clinical practice of obstetric medicine:

1) educational resources (shared PowerPoint slide presentations), 2) notification of collaborative research opportunities 3) regularly updated access to the latest clinical guidelines 4) access to excellent patient information resources 5) access to an obstetric medicine ‘journal watch’ that informs members of important new articles in a wide range of journals that are relevant to the care of medical illness in pregnancy 6) a ‘clinical forum’ that offers the opportunity for members to discuss difficult cases on line with experts around the globe and 7) ‘structured reviews in obstetric medicine’ - a systematic review of the world literature on key topics that will help us to guide our patients better about their expected outcomes.

Results: Following the two-pronged intervention, there was evidence of improved documentation of the delivery of preconception care. Documentation of screening in almost all categories was found to be significantly improved ($p < 0.05$). The greatest improvements were noted in complete screening for medical risk factors (from 15% to 44%), for over-the-counter and prescription medication use (from 10% to 70%, and 30% to 77%, respectively), domestic violence (from 10% to 57%), and nutrition (from 9% to 50%). However, provider knowledge and attitudes about preconception care was not significantly changed.

Conclusion: The combination of education about preconception care and the insertion of a standardized form into a patient's chart led to a clear improvement in the documentation of preconception care. Given the significance of preconception care, insertion of a standardized form should be considered to help providers deliver complete and appropriate care to their patients.

B.4 - Tools You Can Use.

Presenters will share various tools and technology strategies for preconception care. The practice settings for use of the tools include clinical, schools and community.

Learning Objectives:

- 1) Learn about practical tools for practicing preconception care.
- 2) Learn how to use technology to promote preconception care.

Moderator: [Cathy Melvin](#)

- Preconception Toolkit—Making it easy for providers ([Ann E. Conway](#))
- Folic Acid Education for Middle Schoolers and Girl Scouts ([Sue Samuels](#))
- Evaluating a Preconceptional eHealth Education Program and Message Delivery Tool ([Elizabeth Fassett](#))
- Preconception information for Hispanic women ([Beverly Robertson](#))
- Folic Acid Every Day: An educational toolkit for public health nurses, nurse practitioners, dietitians and nutritionists. ([Ron Lutz](#))

PRECONCEPTION TOOLKIT--MAKING IT EASY FOR PROVIDERS TO EDUCATE WOMEN AND FAMILIES. [Ann E. Conway, RN, MS, MPA](#) and [Jennifer M. Wilen, MPH](#)
Wisconsin Association for Perinatal Care, Preconception & Prenatal Care Committee

Program Description Including Target Population: The "Becoming a Parent" toolkit, developed by WAPC, provides materials for both providers and consumers about preparing for parenthood.

Services Offered or Intervention Approach and Providers: The "Becoming a Parent" toolkit provides five resources for both consumers and providers, including any primary care provider, specialist and community health provider who sees women of childbearing age. It includes:

- Preconception Checklist--A self-assessment for a woman and her partner, to be reviewed with a health care provider.
- Health Care Provider's Reference--Accompanies the Preconception Checklist and provides detailed instructions for use, information, references and resources for the provider.

- Information to Consider if you're Thinking of Becoming Pregnant--A detailed booklet and a shortened pamphlet version for women and families to use to think about the implications of a pregnancy and family.
- "Becoming a Parent" video--A 20-minute video of first-person testimonials that encourages people of childbearing age to think about two things: the decision to become a parent and healthy lifestyle.
- WAPC Preconceptional Care Position Statement--A document primarily for providers that describes what preconception care is, who should provide this care and its benefits.

Evaluation and/or Evidence of Success: Measures of success include order information and "hit" the WAPC Web site for free materials. Over 7,000 copies of "Becoming a Parent" materials have been ordered since 2002 by hospitals, family planning providers, WIC clinics, public health departments and other organizations who provide preconception care.

Conclusions: By educating women and their partners about preconception care, women are empowered to take control of their own health prior to conception. In addition, these materials are extremely holistic, touching on not only medical issues women should consider, but also emotional, reproductive, environmental, social and financial issues.

THE ADVENTURES OF FOLIC ACID WOMAN. [Sue Samuels, BSN RN](#)
Christiana Care Health System, Wilmington DE

Program Description: The Adventures of Folic Acid Man/Woman program is designed for elementary and middle school children. The 30 minute program includes class discussion of healthy lifestyles and the importance of folic acid. The class then presents a short play about folic acid. Each student receives a folic acid activity book and folic acid drink cup, and is asked to share the message with family and friends. The second piece of this program is a Folic Acid Woman patch developed with the Chesapeake Bay Girl Scout Council, involving the scouts in various activities to learn about folic acid.

Intervention Approach & Provider: The school program is facilitated by a nurse educator or registered dietitian as Folic Acid Woman. The scout program is facilitated by troop leaders. The approach is interactive activities with the youth as described above.

Evaluation: Students complete a certificate including a picture or sentence reflecting what they learned. Teachers are surveyed about program satisfaction. Statistics are kept by age, sex, race and zip code to evaluate numbers reached.

Conclusion: The Folic Acid program has the potential to provide an important preconception health message in a way that appeals to children, who then share with the adults in their lives. The biggest success is its positive reception by students and teachers. Requests for the program by teachers who have heard of others are reflective of its value. The program can be replicated easily through the Delaware chapter of the March of Dimes, which holds the Folic Acid Man copyright, and through the Chesapeake Bay Girl Scout Council.

Conclusions: This program provided a comprehensive, flexible tool for educating health care providers and their patients about the importance of folic acid. Future activities include updating toolkit information to reflect current knowledge, training of healthcare professionals to increase awareness and use of the toolkit, and more extensive evaluation of the use and effectiveness of toolkit components. Funding for this program was provided by the CDC, Florida Dept. of Health, March of Dimes East Central Florida Division, March of Dimes North Central Florida Division, and Healthy Start of North Central Florida.

B.5: The Role of Infectious Disease Prevention in Preconception Care

Description of the session: Proactive and prospective education and health care targeted at infectious diseases can improve preconception care, address health disparities, and generally promote healthy living and well-woman care. This session will discuss concepts underlying the prevention and control of infectious diseases that impact fertility, conception, prematurity, fetal and infant mortality, congenital syndromes, and maternal-to-child transmission of infection. The session will provide an overview of the scope and diversity of potentially preventable infections, modes of transmission for the various agents, and related measures for infection prevention. Effective primary prevention strategies, including screening, education leading to behavior modification, and treatment will be discussed for two specific groups of infectious diseases, sexually transmitted infections and vaccine-preventable infections. Best practices and successes in programs, policies, and clinical practice, and barriers to overcome to address these infections will be reviewed to inform possible integrated preconception care strategies for other health issues and to promote healthy living for women during their reproductive years and beyond.

Learning objectives:

- 1) Describe successful prevention strategies for infections that affect conception and pregnancy.
- 2) Establish infection prevention education as a key element of healthy living and preconception care to maintain fertility and facilitate healthy pregnancies.
- 3) Identify those lessons learned and those barriers that have been overcome with regards to preventing infections that affect conception and pregnancy in order to inform integrated preconception care strategies.

Moderator: [Marian McDonald, DrPH, MPH, MA](#), Director, Office of Minority and Women's Health, NCID, CDC

Presenters: [Susan A. Wang, MD, MPH, FAAP](#), NCID, CDC
[Madeline Sutton, MD, MPH](#), NCHSTP, CDC (invited)
[Susan Reef, MD, MPH, NIP](#), CDC (invited)
Pre-Conception Prevention of Chronic Hepatitis B: Bridging the Gap to Break the Cycle of Infection ([Chari Cohen](#))

Pre-Conception Prevention of Chronic Hepatitis B: Bridging the Gap to Break the Cycle of Infection. [Molli Conti](#), [Chari Cohen, MPH](#), [Joan Block, RN](#), [Fonta Reilly](#), [Peggy Farley](#)
Hepatitis B Foundation, www.hepb.org

Program description including target population: Chronic hepatitis B, caused by the hepatitis B virus (HBV), is the world's most common serious liver infection. With over 400 million chronically infected individuals, HBV is associated with 80% of primary liver cancer globally. HBV continues to infect Americans in epidemic proportion, with over 1.25 million chronically infected Americans and 80-100,000 new infections each year. Adults between the ages of 19-39, which includes women of childbearing age, have the highest incidence rate. Primary prevention efforts, including vaccination of all infants and children in the U.S. have been successful in reducing the number of chronic hepatitis B infections. However, prevention efforts geared towards adolescents and adults, especially high-risk adults, have not yet shown such positive results. There is a significant hepatitis B prevention gap in women of childbearing age, particularly in those women who missed vaccination mandates as children, and were not given the catch-up vaccine as adolescents or young adults. With the silent nature of chronic hepatitis B, and the high rate of vertical transmission (over 90% of newborns infected at birth will develop lifelong chronic HBV infections, and an increased risk of progressing to cirrhosis or liver cancer), it is critical that young women be targeted for specific education and vaccination efforts.

Services offered or intervention approach and providers: Prevention of hepatitis B in women needs to have a multi-faceted approach. This includes vaccination campaigns geared at adolescent and young adult women, particularly those at higher risk: having more than one sexual partner, a history of drug use (intravenous), having been diagnosed with another STD, or having Asian/Pacific Islander, Native American, Latino, or African American descent. "Missed opportunities" need to be addressed as well. Almost 50% of new hepatitis B infections could be prevented. HIV/STD clinics, family planning clinics, and drug/alcohol treatment centers are among the existing services into which hepatitis B education, screening, and vaccination programs can be integrated.

Evaluation: Existing model programs around the U.S. will be discussed, with evaluations, recommendations, and ideas for future education and screening programs. Physicians and other health care providers who treat women of child-bearing age, and social service providers, need targeted education for hepatitis B prevention and diagnosis, with information for the proper follow-up for those women who test positive. Innovative "Train the Trainer" programs geared at educating health care and social service providers will be discussed. An overview of existing perinatal screening programs, and a model program for the integrative prevention of vertical transmission of hepatitis B will be described. Discussion will include current barriers, ideas for reaching high-risk women, and the use of innovative technology as an educational tool.

Conclusions: There are many barriers to preconception hepatitis B prevention at the national, state and local community levels. This presentation will outline the necessary components of a comprehensive education and awareness campaign for preconception prevention of hepatitis B, which should be integrated into a national hepatitis B prevention strategy.

Evaluation: (1) A comparison of the health status of women before and after IPC in terms of the prevalence of conditions linked to LBW delivery; (2) A comparison of the proportion of women enrolled in IPC to those enrolled in a historical control group who achieve desirable interpregnancy intervals (of at least 9 months and preferably 18 months); (3) A comparison of the birth weight distributions and morbidity and mortality experience (prior to hospital discharge) of subsequent births to women enrolled in IPC and those in a historical control group; (4) A determination of the feasibility, acceptability, and cost-benefit of delivering IPC to women at risk of repeat VLBW delivery in the setting of a county-supported, public hospital.

Implications for advancing preconception care: Potential findings will contribute to the field of primary care of reproductive age women in several important ways: (1) the concept of IPC will be tested as a means of decreasing recurrence of VLBW delivery among high-risk women; (2) the content of a successful IPC package for improving the health of high-risk women will be explored; (3) the potential cost effectiveness of IPC for high-risk women will be studied.

Lessons learned: We are currently in the 'pilot phase' and have enrolled 30 participants since November, 2003. To date, we have retained 22 women in the program.

- For about 1/4 of participants, unrecognized or poorly-managed chronic diseases can be identified in the IPC period;
- For about 1/3 of participants, substance abuse is likely a major contributor to repetitive VLBW delivery;
- Reproductive tract infections are common in the IPC period;
- None of the women desired to conceive another child in the next 2 years; yet many barriers to effective contraception exist (misinformation about methods, perceptions of partners' desires, concerns about side effects). With extensive case management and patient education, we have achieved 21/22 women contracepting in accordance with their stated reproductive plan (1/22 became pregnant with an interpregnancy interval of 11 months; 21/22 with 12-15 month interpregnancy interval and counting..);
- For participants', concerns about finances, employment, and needs of the child are important stressors;
- Average annual outpatient charges for are \$1,801 (average 4.6 visits, average \$389 per visit).

Interconceptional Care Counseling: A Curriculum for Health Care Educators & Providers.
[Natalia Coletti, LCSW](#); [Manuel Fernin, MPA](#); and [Diana Sierra, MPH](#)
Healthy Start Coalition of Miami-Dade

Program description including target population: Women of childbearing age at high-risk for poor pregnancy outcomes, including pre-term delivery, low birth weight, and infant mortality. The Interconceptional Care Curriculum will be available in English, Spanish and Haitian Creole, includes topics that are applicable to all women of childbearing age and is of a 6th grade literacy level. It can be easily applied and replicated, with minimal if any adaptation, to any target population of women of childbearing age, including minority women and teenagers. The target population is tri-lingual, has low levels of literacy, and under-utilizes interconceptional care services available in the community. Not only are there limited services available in the community, high-risk women generally are unaware of the services, or don't know how to access them.

Services offered or intervention approach and providers: Four (4) module interconceptional curriculum with the following major topics: 1) Baby Spacing; 2) Health and Nutrition; 3) Mental Health and Substance Abuse; 4) Infant Growth and Development. The curriculum is designed for individual education or group settings. The curriculum will be available in English, Spanish and Haitian Creole at a 6th grade literacy level. The Modules are based on interactive learning experiences; include the distribution and review of educational materials, and information, linkages and referrals to community resources. Health educators and community based organizations that provide educational and/or psycho-social services, among others, in a variety of settings.

Evaluation and/or evidence of success: The curriculum is being developed and will be completed by June 30th 2005. At least three (3) modules will be available for presentation at the Summit. The curriculum is being developed in collaboration with the Miami-Dade Family Learning Partnership, a community-based organization that specializes in health literacy. Upon completion of each module, these will be reviewed, revised and approved by a group of external experts in the fields of interconceptional care, preconception care, fertility, obstetrics and gynecology, and overall maternal and child health. Upon implementation of the curriculum, participants will complete a pre- and post-test after each module to assess increase in knowledge. Effectiveness of the module in increasing baby-spacing in Miami-Dade County will not be evident for approximately 3-4 years.

Conclusions: The implementation of the Interconceptional Care Curriculum will contribute significantly to the health, psycho-social and educational components of pre-conception care among women who have already had a child, prior pregnancy termination, prior fetal loss or spontaneous abortion. This curriculum will equip health care providers and educators to provide structured interconceptional care education that will significantly contribute to the advancing of preconceptional care to the target population in Miami-Dade County.

A NOVEL COMPREHENSIVE PRECONCEPTION INTERCONCEPTION CARE (CPIC) PROGRAM. [Ashlesha Dayal MD](#), [Nancy DeVore CNM, MA](#), [Lynne Moore CNM](#), [Cynthia Chazotte MD](#) Albert Einstein College of Medicine/Montefiore Medical Center, Bronx, NY

Program description including target population: We describe an innovative model of delivery of preconception and interconception care to a high risk population. The Comprehensive Preconception Interconception Care (CPIC) Program was developed with the support of the Greater NY March of Dimes. The CPIC is specifically designed to target women at risk for preterm delivery. The program is staffed by a Maternal Fetal Medicine Specialist and a Perinatal Nurse. The components of the program are:

Services offered or intervention approach and providers: 1. Outreach Patients who would benefit from the program are identified from numerous sources including: NICU, postpartum units, pediatric early intervention programs, internal medicine practices and subspecialty areas such as the sickle cell center and the community lupus society. The Perinatal RN and physician provide patient and physician education about preconception care at various sites through brief informational talks and brochures introducing the CPIC program.

C.2 - Data for Change: Action, Policy, and Practice.

Description: Many preconception interventions have proven capable of addressing adverse maternal and perinatal outcomes. However in order to be general accepted and supported the data substantiating their efficacy is needed.

Learning objectives:

- 1) Identify how data might be used to develop evidence-based interventions to create “integrated” models of preconception care
- 2) Identify how data can be used to market preconception care and direct related activities.

Moderator: Jennifer Skala

- The Importance of Marketing Perinatal Health to Non-Contemplators: The Cases of Folic Acid and Alcohol (Kenneth Rosenberg)
- Preconception Care: An Opportunity to Prevent Maternal Mortality (Cynthia Chazotte)
- Using the PPOR Approach to Implement Preconception Health Policies and Programs (Amy Johnson)
- Utilizing PPOR Results to Develop Strategic Interventions and Implement Healthy Start Interconceptional Education and Counseling Initiative (Jennifer Opalek, Jane Bambace)
- 51 The Fountain Project: Toward an Integrated Model for Evidence-Based Preconceptual Care (Betty Cook)

THE IMPORTANCE OF MARKETING PERINATAL HEALTH TO NON-CONTEMPLATORS :
THE CASES OF FOLIC ACID AND ALCOHOL

[Kenneth D. Rosenberg, MD, MPH^{1,2}](#), [Scott Spencer¹](#), [Jill M. Gelow, MD, MPH¹](#), [Alfredo P. Sandoval, MBA, MS²](#), [Jodi A. Lapidus, PhD¹](#) ¹ Oregon Health & Sciences University, Department of Public Health and Preventive Medicine, Portland, Oregon, ²Oregon Office of Family Health, Portland, Oregon

Background: Perinatal use of folic acid (FA) and alcohol can prevent birth defects.

Methods: Oregon PRAMS surveys a stratified random sample of postpartum women who delivered in Oregon. Folic acid data is from births in 1998-99; binge drinking data is from births in 2000.

Results: FOLIC ACID: Women whose pregnancies were unintended were more likely to have not taken FA than women whose pregnancies were intended: adjusted odds ratio=3.70 (95% confidence interval [CI] 2.38, 5.56). BINGE DRINKING: Women whose pregnancies were unintended were more likely to have had at least one episode of binge drinking in the three months before they became pregnant: adjusted odds ratio=2.56 (95% CI 1.49, 4.40).

Discussion: Women whose pregnancies were unintended were more likely to have not taken periconceptional folic acid and more likely to have had at least one episode of binge drinking in the three months before they became pregnant. Attempts to educate fertile women about the need to take folic acid and stop using alcohol have focused on educating women who were contemplating becoming pregnant (“contemplators”). But only about half of U.S. pregnancies are intended. In order to reach women who are not intending to get pregnant (“non-contemplators”), public health messages must find ways to convince fertile non-contemplators

Preconception Care: An Opportunity to Prevent Maternal Mortality. [Cynthia Chazotte, Jeffery King, MD, Adiel Fleischer, MD, Donna Williams, MPP](#). Albert Einstein College of Medicine/Montefiore Medical Center, Bronx, NY, New York Medical College/St. Vincent’s Medical Center, NY, NY, Albert Einstein College of Medicine/Long Island Jewish Medical Center, NY, American College of Obstetricians & Gynecologists, District II, Albany, NY.

Program Description: Although the maternal mortality ratio (MMR) has significantly decreased from 582 maternal deaths per 100,000 live births in 1935 to a current level of approximately 8.9, it is far from the Healthy People 2010 goal of 3.3. To achieve this goal it is important to understand the factors that contribute to the risk of maternal death. The Safe Motherhood Initiative, a collaborative project between New York State Department of Health and the American College of Obstetricians & Gynecologists, District II, has undertaken a statewide review of maternal deaths in New York.

Evaluation: Preliminary data reveal that underlying medical conditions were the immediate cause of death in 9.1% of cases and an associated cause of death in 36.4% of cases.

Conclusion: Maternal risks of pregnancy in women with chronic diseases are best addressed in the preconception period. Care prior to pregnancy allows women with medical disorders to attempt a pregnancy in optimal condition or decide to defer or avoid pregnancy when risks are high. Preconception care provides an opportunity to prevent maternal mortality.

Using the PPOR Approach to Implement Preconception Health Policies and Programs. [Amy Johnson, BS, PPOR](#) Project Coordinator, CityMatCH, University of Nebraska Medical Center

Program Description: CityMatCH has worked with CDC, March of Dimes and community partners since 1997 to define, test and disseminate the Perinatal Periods of Risk (PPOR) Approach in U.S. urban communities to improve women’s and infants’ health. CityMatCH utilized its Practice Collaborative (PC) model to facilitate translation of knowledge into prevention of fetoinfant mortality. The Practice Collaborative provided selected community action teams with strategic leadership, scientific support, effective cross communication, structured peer exchange, continuous assessment and promotion of data driven policy and program decisions. The 2000-2002 PPOR-PC enabled 14 U.S. urban communities to translate knowledge into action through the six-step PPOR approach. The teams worked together over two years to build community and analytic “readiness,” map and further investigate fetoinfant mortality, translate findings into targeted community-driven actions, and evaluate impact.

Intervention Approach: Cities’ specific focus on <1500g deaths yielded targeted prevention strategies notably preconception health. All PPOR-PC cities found the widest gaps and greatest excess of fetoinfant deaths in the “Maternal Health/Prematurity” (VLBW <1500g >24 weeks) Period of Risk cell. The overall excess (compared to the rates of a national reference group) ranged from 3.9 to 14.9. VLBW deaths alone contributed from 22.9% to 73.7% of the overall excess of mortality. According the national 1998-2000 PI analysis, investigating fetoinfant deaths to women 20 + age and 13+ years of education, the rate for black non-hispanic women (6.4) is almost triple for the rate for white non-hispanic women (2.2) in the maternal health/prematurity cell. In fact, the maternal health/prematurity rate for black non-hispanic women (6.4) more than the overall fetoinfant mortality rate for white non-hispanic women (5.8). As a result of the analysis, many of the PC cities focused their interventions on the health of African American women prior to pregnancy.

C.3 - Using Surveys to Assess Knowledge, Attitudes, and Beliefs.

Description: Knowledge, attitudes and beliefs serve as either enhancers or deterrents to behaviors relating to the provision of preconception care. Research has shown that they have the potential to influence provider and patient behaviors in this regard.

Learning objectives:

- 1) Describe current status of knowledge, attitudes and behavior about folic acid use among reproductive-age women in the U.S.
- 2) Understand how enhanced services can improve women's involvement in their own health care and improve chances for healthy birth outcomes.
- 3) Discuss knowledge and attitudes of reproductive-age women who engage in health behaviors that affect pregnancy and birth outcomes.
- 4) Describe predictors that affect women's behavior in obtaining preconception care.

Moderator: [Joe Mulinare](#)

- Consumer knowledge ([Janis Biermann](#))
- Low income women of diverse ethnic groups who receive enhanced services ([Carol Korenbrot](#))
- Pregnancy planning and lifestyle behaviors among nonpregnant women of childbearing age, Southern California, 1998-2000 ([Kathleen Raleigh](#))
- Predictors of Preconception Care and Birth Defects Prevention ([Amy Case](#))

A National Survey of Pre-pregnancy Awareness and Behavior Among Women of Childbearing Age. [Janis Biermann, MS](#) March of Dimes, White Plains, New York

Program description including target population: In 1992, the US Public Health Service (PHS) recommended that all women who are capable of becoming pregnant consume 400 micrograms of the B vitamin folic acid per day to reduce their risk of having a pregnancy affected by neural tube defects. In 1995, the March of Dimes received funding from the Centers of Disease Control and Prevention to conduct a benchmark survey of women of childbearing age to assess their knowledge and behaviors relative to daily consumption of folic acid.

Services offered or intervention approach and providers: Since the 1995 survey, the March of Dimes has commissioned The Gallup Organization to conduct seven follow-up surveys to measure any changes that may have occurred since 1995 in women's awareness and behavior relative to folic acid and other pre-pregnancy health issues, such as a preconception visit to discuss pregnancy with a health care provider and advice given by the provider about ways to have a healthy baby.

Evaluation and/or evidence of success: In 2004, 77% of respondents were aware of folic acid. This is an increase from 52% in 1995, but has remained constant since 2001. Vitamin consumption has been fairly constant from 1995-2004, with approximately 30% of nonpregnant women saying they take a multivitamin containing folic acid daily.

Conclusions: As such, these surveys serve as rough measures of effectiveness of the educational campaigns designated to increase awareness of folic acid and behavior among women of childbearing age. The finding suggests the need for continuous educational strategies to promote behavior change as part of preconception care.

LOW INCOME WOMEN OF DIVERSE ETHNIC GROUPS WHO RECEIVE ENHANCED SERVICES REPORT BETTER COMMUNICATION, DECISION-MAKING, INTERPERSONAL PROCESSES AND SATISFACTION WITH CARE. [Carol Korenbrot](#)

For decades federal and state Maternal and Child Health programs have developed health promotion and psychosocial services to enhance care of child-bearing age women of low income and diverse race and ethnic groups. In California the Maternal and Child Health Branch sets standards for health promotion and psychosocial services of pregnant women in Medicaid managed care plans. The health promotion services include individualized assessments of what preventive health measures women need most to improve chances of healthy birth outcomes, and also culturally adapted information on how women can improve their own preventive health care. The psychosocial assessments include asking women about problems that they are having with food, housing, their partner, child care, and the like, and provide the women access to resources for obtaining help with the problems. We have evaluated the content, delivery and birth outcomes of these services for years. In recent evaluations of these enhanced services we have linked the services to improved communication to reach and serve low income women of diverse ethnic groups, and to improved satisfaction with care that encourages managed care plans to implement the services. Women report that the enhanced services do what providers have said for years: they improve women's involvement and satisfaction with their own health care. Satisfaction with care has in turn been linked with adherence to treatment, continuity of care and continued managed care plan enrollment.

Interpersonal processes of care according to conceptual theory include provider-patient communication, mutual decision-making, and provider respect and courteousness. Using confirmatory factor analysis we developed a multidimensional measure of interpersonal processes of care from a conceptual-based theory of quality interpersonal care for low income patients. We tested the reliability and validity of the measure in ethnically diverse pregnant women. We conducted a telephone survey of 363 African American, Latino (U.S. and foreign born) and Caucasian women in Medicaid managed care plans in California in 2001. We performed a psychometric evaluation of the quality measure, including reliability, variability, and construct validity. We identified the factors that define the dimensions of the measure for these women. The multidimensional measure was then used for assessing what women report happens between themselves and their providers during their prenatal care.

We tested whether health promotion advice and psychosocial assessment were associated with better interpersonal care and satisfaction using data from the same telephone survey and multivariate regression analysis. We found that women who received more health promotion and psychosocial services reported higher quality interpersonal care and higher satisfaction with care. What is more, for both types of service, the effects of the services on the quality of interpersonal care explained the effect of the services on satisfaction with care. In other words, providing health promotion and psychosocial services improves interpersonal care which in turn improves the women's satisfaction with their clinical care.

We conclude that the enhanced health promotion and psychosocial services as developed by Maternal and Child Health programs, particularly those of the California Maternal and Child Health Branch, constitute a best practice in developing communication and health promotional tools and methods that overcome important barriers to care of low income women of diverse ethnic groups. These enhanced services should be applied to preconception care as standards are developed and managed care plans are urged to include preconception care services.

PREGNANCY PLANNING AND LIFESTYLE BEHAVIORS AMONG NONPREGNANT WOMEN OF CHILDBEARING AGE - SOUTHERN CALIFORNIA, 1998-2000.

[Kathleen Green Raleigh, PhD](#), [Jean M. Lawrence, ScD](#), [Huichao Chen, MS](#), [Owen Devine, PhD](#), [Christine Prue, PhD](#), National Center on Birth Defects and Developmental Disabilities, Division

FOLIC ACID AWARENESS AND USE BY WOMEN IN CALIFORNIA (1997-2002)
[Suzanne C Haydu MPH, RD](#), [Gretchen L. Caspary PhD](#), [Shabbir Ahmad, DVM, MS, PhD](#),
[Joyce Weston, BSN, MSHA](#). Maternal Child, and Adolescent Health (MCAH)/ Office of Family Planning
(OFP) Branch, California Department of Health Services (CDHS)

Program Description including target population: A folic acid education campaign targeting low-income and Hispanic women of childbearing age in California.

Services offered or intervention approach and providers: The CDHS MCAH Branch disseminated English and Spanish folic acid pamphlets developed by the Texas Department of Health from 1993-1999, in order to reduce the incidence of neural tube defects. A new set of English and Spanish folic acid pamphlets and posters were developed by the MCAH Branch in 1999 and were further revised in 2002; these continue to be distributed via MCAH programs. Supportive program-specific folic acid education materials and guidelines have been developed and distributed in MCAH programs. These interventions were in addition to the National Folic Acid campaign, which began in 1999 and reduced its intensity in 2002.

Evaluation: Annually since 1997, California Women's Health Survey (CWHS) respondents (n = 4,000) were interviewed by telephone (in English and Spanish) and asked questions regarding folic acid knowledge, attitude and consumption. Responses to these questions were analyzed for women of childbearing age (18 through 44 years). The preliminary analyses cited here are the result of population-weighted frequencies and logistic regressions.

There was a trend from 1997-2000 of increasing folic acid awareness (increased from 55.4% to 65.5%) for women of childbearing age in California. The trend was most dramatic for Latina (from 26.2% to 39.6%) and Black respondents (from 45.4% to 60.2%).

However, Latinas consistently have lower knowledge and use of folic acid compared to other ethnic/racial groups. Latinas who are aware of folic acid cite physicians as their primary source of information. From 1999-2001, consumption of folic acid by women of childbearing age in California remained steady at 55%, but for yet undetermined reasons, fell to 50% in 2002. This decline in 2002 was statistically significant, and suggests an overall lowered awareness of the importance of folic acid.

In 2002, the strongest predictor for not taking folic acid was youth: logistic regression analyses indicated that women less than 24 years of age were 83% more likely to not be taking folic acid supplements than women aged 24 to 45. Other significant predictors for not taking folic acid included having less than a high school education, being a member of a non-white racial/ethnic group, having a household income of less than \$35,000 per year, and not having health insurance.

Conclusions: The CWHS suggests that Latina women were consistently less likely than non-Latina women to consume multivitamins, prenatal vitamins or supplements containing folic acid/folate. Young women under the age of 24 are also at risk of not ingesting sufficient folic acid. A decline in folic acid intake in 2002 was substantively large and statistically significant, and suggests an overall lowered awareness of the importance of folic acid.

Encouraging physicians to recommend use of folic acid for all women, especially for Latina women, younger women, and women with low education levels may increase folic acid awareness and preconceptional folic acid use.

THE DOUGLAS PRECONCEPTION PLAN. [Patty Baker](#)

The DOUGLAS Plan, a woman's guide to a healthy lifestyle, was developed in memory of Carole A. Douglas, a dedicated Public Health Nurse, whose career focused on making our community healthy. The DOUGLAS

Preconception Program provides education for women of child bearing years on Diet, Omitting drugs, alcohol and smoking, Underlying health conditions, Gynecological visits annually, Lactation for a lifetime of good health, Abstinence and birth control to avoid unplanned pregnancy and Screening and immunizations. As Public Health Nurses we partnered with multiple resources, which lead to the development of an educational program, including a pamphlet and power point presentation which have been utilized throughout our community. A "Pre and Post Pregnancy I.Q. Tool" from March of Dimes has recently been added to our presentations as an evaluation tool.

Our pilot project, Madres Saludables, is a Spanish speaking women's project focused on preconception health in Lincoln, Nebraska. The Hispanic population in our community has seen a 143% increase in the decade. The decision to focus on Madres Saludables was based on language barriers as well as lack of knowledge, interpersonal support and transportation that can compound women's health issues in this population. The DOUGLAS Preconception Program has allowed staff to provide education to empower women and resulted in an increase in self sufficiencies in women attending this group. Meetings have been expanded to three times per month at convenient public locations and discussions at these sessions focus on the various topics of the DOUGLAS Plan. Health screenings are offered twice per year and referrals are made to primary care physicians, dentists and other resources.

Plans are currently underway to duplicate this program for women who speak Arabic and could be adapted for presentations to any group of women between the ages of 14 and 45. Partnerships are being formed with other health departments to share preconception health resources and ideas on how to expand opportunities to reach all women in their child bearing years.

Funding for the Madres Saludables program has been obtained from a "Building Strong Families Grant". This grant has also facilitated a monthly calendar and newsletter, which allows for greater dissemination of the DOUGLAS Plan and community resources.

In this past year we have learned that all women want to do well by their future babies. They want to be as healthy as possible prior to conception but many lack the knowledge. We have also learned to listen to each woman's story about her life's journey and to tailor information for individual needs. As we have incorporated women of different cultures into the DOUGLAS Plan, the plan itself has been strengthened by the effort. We have all become more sensitive as we guide women toward optimal health.

SAVE OUR BABIES - ORANGE COUNTY, FL. [Lesli Ahonkhai](#)

Target Population: The primary target population is African American Women who live in Orange County zip codes with the poorest birth outcomes.

Services offered or intervention approach: Disseminating information to the community, hosting training workshops and informational sessions in non-traditional environments such as beauty salons and churches, and engaging the community for action.

Providers: Orange County Health Start Coalition contracted staff and Orange County Health Department

Financing: Orange County Healthy Start Coalition, March of Dimes (last year of three-year funding cycle), Pfizer and Aetna (one-time funding)

Evaluation and/or evidence of success: Results: 2004 Annual Report and Evaluation indicated a increased awareness of racial disparities in birth outcomes in the community, increased awareness of maternal and child health issues, willingness of citizens and businesses to form an advisory committee for the program in order to take ownership of the problem, and increased understanding of how to access the current health resources.

Application of preconceptional care in Korea.

Jung-Yeol Han^{1,2}, Alejandro A. Nava-Ocampo³, June-Seek Choi^{1,2}, Hyeon-Kyeong Ahn^{1,2}, Jae-Hyug Yang²,
Mee-Kyeong Koong², Inn-Soo Kang², Jae-Uk Shim²

Preconceptional care represents an important challenge for women's health in order to improve medical attention related to pregnancy and to reduce morbid-mortality related to obstetric complications. We have been trying different activities for improving preconceptional care in Korea. Such activities are being performed through the recently-founded The Korean Motherisk program at Samsung Cheil Hospital in Seoul, a hospital where approximately 8,000 babies are delivered every year.

The activities can be grouped in 2 parts: One is related to the clinical risk counseling and follow-up of women who are willing to have a baby. The second part is related to lectures and researches. We have developed a protocol that intends to identify the risk factors for adverse fetal and pregnancy outcomes by means of a questionnaire and laboratory tests. We have preconceptionally counseled and followed-up women who have chronic diseases such as epilepsy, hypertension, as well as those women with previous history of malformations, spontaneous abortion, chromosomal abnormalities. The lectures on preconceptional care are addressed to obstetricians and gynecologists as well as for women of child-bearing age at a Maternity School, in which we are getting data on folic acid intake. According to the data, rate of folic acid intake at periconceptional period is 9.6% (n= 764). Finally, we are writing a Korean book on preconceptional care which is intended to be used for public information.

As a conclusion, preconceptional care has to be more rapidly and broadly extended to all Korean women who are willing to be pregnant.

PRE-PREGNANCY PREPARATION SERVICE OF THE FAMILY PLANNING ASSOCIATION OF HONG KONG. Dr. Sue Lo, MBBS, MRCOG, Senior Doctor

The Family Planning Association of Hong Kong specializes in providing sexual and reproductive health services for men and women. It was established in 1950 and is one of the founding members of the International Planned Parenthood Federation in 1952. Its Pre-Pregnancy Preparation Service (PPPS) was launched in 1998. It is a new innovation in Hong Kong and remains the sole service that integrates medical, counseling and education services for couples who are preparing for conception. The attendance fluctuates between 3700 to 4700 each year depending on the desire of couples to conceive. The program is self sustainable. Each person pay US\$75 which includes a doctor consultation and counseling with physical check-up and blood tests for blood group and type, complete blood picture, VDRL, hepatitis B antigen and antibody, rubella antibody (female only) and semen analysis (male only). HIV testing is offered with additional charge, on an opt-in basis after pre-test counseling. A VCD is used to deliver education on pregnancy preparation and contraception.

The service is targeted at both healthy couples and couples with pre-existing diseases that may affect conception and pregnancy. The aims of the service are:

- 1) To facilitate conception by detecting risk factors for female subfertility through history taking and physical examination and performing semen analysis for men;
- 2) To help couples understand their own health conditions and to adjust lifestyle behaviour if risk factors are identified;

- 3) To assess for hereditary diseases that may affect the offspring;
- 4) To prepare the couple to be responsible parents.

For those couples with pre-existing medical diseases, especially when the female is affected, the pre-pregnancy counseling will focus on:

- 1) Helping couples understand how the disease will affect the pregnancy and their offsprings and vice versa
- 2) Optimizing the chance of conception and minimizing risk during pregnancy by advising the woman to change current medications that are teratogenic, to stabilize her medical condition before getting pregnant and to have close follow up and monitoring by the obstetricians and physicians when she is pregnant.

The basic counseling and assessment is provided by non-Specialist and those with complicated problems will be seen by Specialist in Obstetrics and Gynaecology. Regular case conferencing is conducted to enhance the knowledge of the non-Specialist and improve their counseling skill. The continuous support of clients reflects the popularity and success of the service.

PRECONCEPTIONAL HIV SCREENING, GUANGXI, CHINA.

J Zhuo¹, W Liao², Peilan Qin², Yihai Chen², ¹Guangxi Provincial Centers for Disease Control, Nanning, Guangxi, ²Hezhou City Centers for Disease Control, Hezhou City, Guangxi

Babu County (population 0.93 million) of Hezhou City, Guangxi Province (population 48.9 million) experienced the fastest increase in reported HIV/AIDS cases in the Province between 2000 (18) and 2004 (629). Though the epidemic predominantly affected drug users initially, with a narrowing male to female ratio of HIV/AIDS cases (2004; 4:1), affecting mainly the younger age group (90%, age 20-49 years) and predominantly rural farmers (70%), superimposed on a low condom usage rate (STD clients 5%, drug users 5%, sex workers 40%), the potential for mother to child transmission was evident (38 HIV-exposed pregnancies during 9/2003 through 12/2004). To reduce the impact of HIV on women, children and families, the county health department embarked on a three-pronged approach in 9/2003 embedded in the premarital medical examination system. The activities included family and community awareness to reduce transmission among couples and young people, preconceptional voluntary HIV counseling and testing for couples (PVCT), an antiretroviral treatment component, 40 antenatal and maternal/child care clinicians were trained. To facilitate the broad based interventions, 942 medical and public health professionals and barefoot doctors were trained on VCT and other prevention approaches. To facilitate the community engagement process, training seminars using a combination of entertaining and educational films were conducted in middle schools and high schools for both students and adults in the catchment's area with a one-time post and pre-test evaluation in selected locations. The students were required to take educational materials to their homes to educate parents and neighbors as part of their homework requirements. Information on HIV and VCT opportunities were displayed on the community information blackboard, which is the usual tool for disseminating information on public health, legislative, and social policies to villagers and updated frequently by community volunteers. In the first quarter after launching the program (October to December 2003) an average of 1099 (73%) of the 1500 eligible couples each month sought PVCT consultation, and 52% of them (or 38% of eligible couples) accepted HIV testing. By the end of 2004, the PVCT consultation rate among eligible couples increased to 77% and HIV testing rate reached 80% (or 62% of all eligible couples).

The O.N.E (“Office de la Naissance et de l’Enfance” = “Organization for Birth and Childhood”), the governmental organization of the French Speaking Community of Belgium for promotion and organisation of MCH, has proposed, in its latest strategic plan, the promotion of preconceptional care. The O.N.E already has in charge the child health protection and promotion and also that of women during pregnancy. In particular, it organizes free prenatal and child health clinics until 6 years all over the French speaking part of Belgium. The French Speaking Community of Belgium represents approximately 5 millions people and 50 thousands births per year.

Choice of a strategy: An ad-hoc committee has been instituted to propose strategies, activities, financial issues and options, and evaluation modalities. This had first to make the choice of a strategy: either the O.N.E itself would organize preconceptional care in its own network, or it organizes a campaign addressed both to people and to professionals. This second strategy was selected, for the time being, by the committee campaign.

Purposes of the campaign: The O.N.E does sustain the project of a campaign to inform and to sensitise the population about the benefits of preconceptional visits. It hopes that such a campaign will incite women who have a child project to consult a medical practitioner before pregnancy.

Target Population: The campaign will target, in one side, all people between 15 and 35; and, on another side, health professionals involved in women and children health protection and promotion: not only general practitioners, gynaecologists, paediatricians, midwives and all medico-social workers of the ONE, but also the Family Planning Centres, and PSE Centres (“Promotion de la Santé à l’Ecole” = Health Promotion at School), school affiliated organisms, which have in charge health education, in particular of adolescents.

Methodology:

The first step was the creation of the tools:

- 1) Folders, posters, letters to professionals and guidelines has been realized.
- 2) They are actually evaluated by experts of the ad-hoc committee and tested by a selected group of ONE-health visitors, some social workers and other midwives or nurse- practitioners.

The second step will be the initialisation of the campaign itself by dissemination of the different messages:

- 1) People in procreative age will be informed by different ways: posters, folders, radio and TV spots, but also by medical practitioners, and by ONE-health visitors, care-takers of the Family Planning centres and of the PES centres which would relay the information’s.
- 2) Medical and social workers will receive folders and posters to distribute to the target population. They will also receive a letter to inform them about the purposes and the methodology of the campaign.

Finally, medical practitioners will receive the guidelines to help them in the choice of information’s to give and exams to ask.

Evaluation: Evaluation procedures will consist in interviews and sample surveys both in the target population and in the medico-social workers to estimate the behavioural changes in that field.

D.1 - Medicaid Waivers for Family Planning, Preconception, and Interconception Care.

Moderator: [Kay Johnson](#)

[William H. Hollinshead, MD, MPH](#), Medical Director - Division of Family Health Rhode Island Department of Health

Preconceptional care includes an array of interventions to address medical, psychosocial, and environmental risks. Many of these occur in the context of office or clinic practice. Policy and finance barriers limit the ability of preconception care and, reportedly, limit professional practice changes. Millions of women of childbearing age lack adequate health coverage, and others live in underserved areas. Service delivery fragmentation contributes further to this problem. This session will review barriers and opportunities for financing the ongoing process of preconception care using Medicaid, particularly waivers and expansion programs. More than a dozen states have implemented so-called “family planning waivers” under Medicaid. Many of these efforts were designed to provide coverage during the pre- and inter-conception period for low-income women who would otherwise be uninsured. States’ experience with these efforts will be discussed from the point of view of preconception risks and service needs. Opportunities and implications for other states’ replication will be discussed.

D.2 - Disparities in Preconception Health Care.

Moderator: [Rosaly Correa-de-Araujo](#)

- Disparities in Preconception Health Care ([Rosaly Correa-de-Araujo](#))
- Socioeconomic and racial disparities among infertility patients seeking care ([Tarun Jain](#))
- Preconception prevention and treatment of infectious diseases among minority women ([Lara Weinstein](#))
- Disparities in Perinatal Outcomes using PPOR: Results for the Bay Area Data Collaborative ([Ellen Stein](#))

DISPARITIES IN PRECONCEPTION HEALTH CARE: OVERVIEW.

[Rosaly Correa-de-Araujo, MD, MSc, PhD](#)

Preconception health care is complex and involves genetic screening and counseling; screening, immunization, counseling, and treatment of infectious diseases; investigating exposure and effects, and managing environmental toxins; assessing and treating chronic conditions; and, addressing lifestyle behaviors. Although not all causes of low birth weight, infant mortality, and obstetric complications can be prevented, the risk of certain birth defects can be significantly decreased through preconception counseling as well as prenatal care. The risk of having a medical condition during pregnancy varies by both age and race/ethnicity. For instance, the incidence of anemia among teenage mothers (36 women per 1,000 live births) is greater than among women of child-bearing age (20 women per 1,000 live births). Also, diabetes incidence among teenage mothers is far lower than among other women of childbearing age. Racial/ethnic differences in risk factors also exist and include: a greater incidence of anemia among American Indian/Alaska Native compared to nonHispanic white women (56 vs. 22 per 1,000 live births); a greater incidence of pregnancy related hypertension among American Indian/Alaska Native compared to Asian/Pacific Islander women (46.5 vs. 20.5 per 1,000 live births); an increasing number of HIV/AIDS cases among women, with Hispanic and

Intervention: Analysis of 1999-2001 county and regional fetal-infant mortality (FIM) rates using the PPOR model and the variance of county rates from the regional mean using ANOVA; analysis of racial disparities in FIM rates using the PPOR model for three years of regionally pooled data. The PPOR model excludes fetal-infant deaths weighing <500 grams and fetal deaths with <24 weeks gestation. The model analyzes fetal and infant mortality by birthweight and by age at death into four categories with differentially attributable risk factors; then uses comparison groups to calculate excess/preventable fetal and infant deaths. The model classifies fetal deaths 24+ weeks and infant deaths until one year with birthweights between 500 and 1499 grams as attributable to risk factors of Prematurity and Maternal Health.

Resources also include the California Department of Health Services Birth Master File (285,960 births), the Birth Cohort File (2,210 fetal and infant deaths linked to births for SF Bay Region, 1999-2001) and the BADC county-level Title V Core Indicators, 2001.

Evaluation: Using PPOR criteria, the regional FIM rate is 7.7 per 1,000 births + fetal deaths; county rates ranged from 5.6 to 9.1 with generally little statistical variance from the mean. The disparity between Black and White FIM rates is 16.2 vs. 6.2. Prematurity/Maternal Health (<1500 grams) accounted for 42% of all deaths and 50% of Black deaths. Using a national “best outcomes” comparison group, 56% of excess deaths (n=658) could be prevented by focusing on Prematurity/Maternal Health, which may include preconceptional and interconceptional risk factors. The 2001 County Reports indicate regional rates for: low birth weight (<2500 grams) 7%, pre-term birth 9%, first trimester entry to prenatal care 86%, and adequate care 63%.

Conclusion: PPOR analysis reveals that 56% of excess deaths may be avoided by focusing on preconceptional/interconceptional risk factors that may include tobacco/alcohol/drug use, infection, stress, access to health care, injuries/abuse, family planning, nutrition, and prior pregnancy outcomes. The highly discrepant regional Black/White FIM rates differ by a factor of 2.5. Excess Black deaths may be reduced regionally by focusing on preconceptional and interconceptional health. The BADC recommends identifying county-specific periods of risk as well as geocoding the data in order to identify regional “hot spots” for fetal-infant mortality. Successful strategies for program and outcome improvement can be shared with other regions. Regional collaborations, such as the BADC, provide the power to develop evidence-based preconceptional and interconceptional health interventions.

D.3 - Where are the Men in Women's Health? Relevance to preconception care.

Men's health is often overlooked during the formulation of preconception care health policies and guidelines. Yet an increasing body of evidence demonstrates the centrality that both men and women's health play in influencing pregnancy outcomes.

Learning objectives:

- 1) Discuss the role(s) of lifestyle, environmental, and occupational exposures in men and women and their impact in preconception care.
- 2) Discuss how to translate this increasing body of information into effective policy measures.

Moderator: [Melissa McDiarmid](#)

- Healthy Dads ([Steven Schrader](#))
- Improving Preconception Care for men and women exposed to reproductive hazards in the workplace ([Linda Frazier](#))
- The Occupational and Environmental History: A Key Element of the Pre-Conception Visit ([Melissa A. McDiarmid](#))
- Missouri Bootheel Healthy Start – “Educating a Community through Its Own Ingenuity” ([Cynthia Dean](#))

HEALTHY DADS . [Steven M Schrader, Ph.D.](#) National Institute for Occupational Safety and Health, Centers for Disease Control and Prevention, Cincinnati, OH

Program Description: A pregnancy is a couple event and the health of each parent determines the pregnancy outcome and the health of the baby. Because the woman carries the pregnancy the preconception health of the father is often overlooked. Life style factors such as nutrition, smoking, alcohol consumption, hot tub use, and clothing can affect his fecundity. Medical therapies can affect fecundity and pregnancy outcome. The mechanism of action of drugs can reduce sperm production, alter sperm genetics or be transported to partner. Therapeutic radiation and many cancer drugs are mutagenic and men should not father children while under such treatment. Cyclophosphamide (a potent mutagenic cancer drug) is excreted in the semen and could be absorbed transvaginally by the partner. Recreational drugs have a negative effect on both fecundity and pregnancy outcome. Cocaine readily attaches to the sperm membrane and can be transported to the site of fertilization. Many environmental and workplace chemicals can have a profound effect on the man's fecundity and the on pregnancy outcomes. There is strong scientific evidence that exposure to some heavy metals (e.g. lead, cadmium), pesticides (e.g. ethylene dibromide, 2,4 D) and solvents (e.g. glycol ethers) will have negative effect on male fecundity. It has been reported that preconception workplace exposure to men results in adverse pregnancy outcomes. Reports show an association with the father's exposure to organic solvents, aromatic hydrocarbons, and petroleum refinery chemicals resulting in spontaneous abortions. Men's exposures to some paints and inks have possible association to specific birth defects (paints – cleft palate, damage to CNS; printing industry – cleft lip)

Intervention Approach: Preconception health of the potential father should be stressed to men and women in preconception clinic visits as well as in health communication tools and information.

Conclusions: It must be stressed that healthy dads are important for healthy babies. His medical history, his lifestyle, and his exposure to chemicals may affect the pregnancy.

IMPROVING PRECONCEPTION CARE FOR MEN AND WOMEN EXPOSED TO REPRODUCTIVE HAZARDS IN THE WORKPLACE: PUBLIC HEALTH COMMUNICATION AND RESEARCH NEEDS. [Linda M. Frazier, MD, MPH](#), [Margaret A. K. Ryan, MD, MPH](#), [Melissa McDiarmid, MD, MPH](#), University of Kansas School of Medicine, Wichita, Naval Health Research Center, San Diego, University of Maryland School of Medicine, Baltimore

The content of preconception health counseling needs to include hazardous exposures in the workplace among both women and men. In toxicologic studies among male laboratory animals, exposure in the preconception period to certain chemicals causes congenital anomalies even when the female animals are not exposed. When men have substantial workplace exposure to certain pesticides, solvents or metals

D.4 – Promising Clinical Practice Strategies.

The latest clinical guidelines for preconception care from ACOG will be highlighted. The presenters will share practice strategies that have been implemented in a variety of settings.

Learning Objectives:

- 1) Understand the implication for practice based on the new ACOG guidelines
- 2) Understand the group care concept for the continuum of preconception care through interconception.

Moderator: [Abby Rosenthal](#)

- An Innovative Model for Preconception/Interconception Counseling during [\(Bernstein, Peter\)](#)
- First Page: Screening for Birth Defects and Genetic Disorders [\(Kloza, Edward\)](#)
- Current clinical practice and guidelines [\(Michele Curtis\)](#)
- Evidence-Based Interventions to Achieve Smoking Cessation in Pregnant Women [\(Susan Albrecht\)](#)
- Improving Perinatal Outcomes by Providing Preconception Care for Women with a History of Depression [\(Jennifer Wilen\)](#)

AN INNOVATIVE MODEL FOR PRECONCEPTION/INTERCONCEPTION COUNSELING DURING PRENATAL CARE. [Peter S. Bernstein, MD, MPH](#), [Sharon S. Rising, CNM](#), [Siobhan Dolan, MD, MPH](#), [Setul Pardanani, MD](#), [Irwin R. Merkatz, MD](#). Albert Einstein College of Medicine/Montefiore Medical Center, Department of Obstetrics & Gynecology and Women's Health.

Introduction: Pregnant women are an ideal target population for counseling about preconception care. By definition, they are fertile and sexually active. Unfortunately, pregnancy is often viewed as an isolated period in the reproductive life of a woman. As a result little or no time is spent addressing interconception/preconception care during traditional prenatal visits. In order to meet this challenge we describe our adoption of the group model of prenatal care promoted by the Centering Pregnancy and Parenting Association (CPPA), Inc. This model, which has been implemented at more than 50 sites around the country, views pregnancy as one phase in a continuum in the reproductive life of a woman and affords healthcare providers the resources to address all the phases, including preconception care.

Methods: In February 2002, we began to offer to our pregnant patients at the Comprehensive Family Care Center at Montefiore Medical Center the group model of prenatal care developed by CPPA. This model replaces traditional prenatal care revisits with group appointments for 10-12 women and their partners that each last 2 hours. All the elements of traditional care are offered in the group setting, but additional time is available for providers to facilitate discussions among the participants on topics that are set forth in a curriculum provided by CPPA and that are relevant to pregnant couples and new parents. Women begin their group visits between 12-16 weeks of gestation and continue with a total of 10 sessions until the end of their pregnancies. Many of the topics covered during the group sessions are especially relevant to interconception/preconception care, including discussions of nutrition, substance use/abuse, contraception, sexuality, safe sex, and family planning.

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Results: Since February 2002, 14 groups for prenatal patients have been conducted according to the CPPA model at our office. The model has since been made available at three other offices operated by Montefiore Medical Center. Groups are conducted by midwives, attending physicians, and residents in obstetrics and gynecology under the supervision of attending physicians.

Patient and provider satisfaction with the program is high because of the additional time offered for prenatal care. Providers, in particular, report satisfaction with being able to adequately educate their patients about all elements of prenatal care, including preconception care.

Conclusion: The Centering Pregnancy? group model of care is a superior to the traditional model of individual visits for teaching pregnant women about the importance of interconception/preconception care. The model offers the opportunity to address issues that impact women's health broadly and is being extended to include first year of life groups (known as Centering Parenting?), as well the prenatal groups that have been successfully implemented at Montefiore Medical Center.

First PAGE: A STRATEGY FOR SCREENING FOR BIRTH DEFECTS AND GENETIC DISORDERS APPLICABLE TO PRECONCEPTION CARE. [Edward M. Kloza, MS](#), [Sara Ellingwood MS](#), [Judith Johnson, PhD](#). Foundation for Blood Research, Scarborough ME and the University of Southern Maine, Portland ME

Program description including target population: Prenatal care providers (PCPs) are recognized as essential to the identification of women at risk of delivering children with birth defects or genetic conditions. Efforts to engage PCPs in genetic risk identification however, have had mixed success. Since 1996 we have used a strategy suitable for preconception care to identify and manage women at risk while educating PCPs about genetic issues relevant to their practice.

Smoking cessation interventions need to begin during preconception care to have the maximum influence on infant mortality and morbidity. The smoking status of women needs to be assessed at every healthcare encounter. By effectively training the healthcare team to intervene with women of childbearing age, positive healthcare outcomes will increase and costs will be reduced.

IMPROVING PERINATAL OUTCOMES BY PROVIDING PRECONCEPTIONAL CARE FOR WOMEN WITH A HISTORY OF DEPRESSION. [Jennifer M. Wilen, MPH](#) and [Ann E. Conway, RN, MS, MPA](#) Wisconsin Association for Perinatal Care, Preconception and Prenatal Care Committee

Program Description and Target Population: Responding to the need for basic information about depression and pregnancy in 1999, the WAPC Preconception & Prenatal Care Committee developed a brief, low literacy information sheet entitled “Women with Depression.” This sheet is designed for women whose pregnancy outcomes may be adversely affected by depression and is available free of charge.

Services Offered or Intervention Approach and Providers: “Women with Depression” helps women understand the importance of talking with their health care provider about depression, so that the necessary precautions can be taken to reduce the risks associated with this serious condition. It answers four basic questions: How does depression affect pregnancy? How does pregnancy affect depression? How could medications for depression affect the pregnancy? What can you do before pregnancy? Health care providers who have contact with women during the preconception period, including, but not limited to, primary care physicians, nurse practitioners, mental health experts, social workers, certified nurse midwives and pediatricians, can utilize this information sheet with their patients.

Evaluation and/or Evidence of Success: The availability of “Women with Depression” has been publicized widely through print and electronic means, including the WAPC Web site. In March 2004, the Bronx Health Link, Inc., a group of approximately 35 inpatient and outpatient providers in New York, requested to print “Women with Depression” in a special edition of their newsletter entitled “Chronic Illness during Pregnancy: Planning for a Healthy Outcome.” This is one measure of the success of electronic distribution.

Conclusions: Preexisting depression in women is the strongest predictor of depression occurring during pregnancy or postpartum, something that 10-15% of women and up to 28% of women living in poverty experience. By treating depression as a chronic condition and by actively managing depression prior to conception, a woman’s chances of being prepared for a depressive episode during the perinatal period greatly increases.

Plenary Session: How to pay for it? Financing Preconception Care

Moderator: [Charlie Mahan](#), Professor, University of South Florida
[Sara Rosenbaum, J.D.](#), Hirsh Professor and Chair, Department of Health Policy, George Washington University
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Closing Plenary Session: Where do we go from here? Implications for Practice (“Nightline” style panel)

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