Reproductive Life Planning: From Concept to Practice

Merry-K. Moos
Faye Johnson

Speakers:

Merry-K. Moos. BSN (FNP), MPH, FAAN

mkmoos@med.unc.edu

Professor emeritus, UNC School of Medicine (adjunct UNC Schools of Public Health and Nursing)

Consultant, UNC Center for Maternal and Infant Care

Faye Johnson, BS

fjohnson@nefhsc.org

Project Director

Magnolia Project

Jacksonville, FL

Objectives:

- Explain the history and rationale for advancing reproductive life planning.
- Discuss strategies for encouraging reproductive life planning in community and clinical settings.
- Identify potential risks associated with advancing reproductive life planning and strategies to overcome.
- Reflect on the experiences of one Healthy Start site that adopted a reproductive life planning framework.

What is "Intendedness" and Why Do We Care?

Some Data

- The latest data indicates that **51%** of pregnancies are unintended (2010)
- 37% of the births in this country are from pregnancies self-identified as unintended at time of conception (2012)
- Unintended pregnancies are generally mistimed (wanted to become pregnant at sometime but not now) not unwanted (did not want to ever have a[nother] pregnancy).

We Care Because. . .Unintended Pregnancies Are Associated* with:

- Increased likelihood of abortion
- Exposures to potentially harmful substances in pregnancy
- Poor pre-pregnancy disease control
- Late entry to prenatal care
- Increased likelihood of low birth weight in offspring
- Maternal depression
- Reduced school completion and lower income attainment (if woman not married)

* note: association does not prove causality

Who Has Unintended Pregnancies?

- The short answer is: everyone who has sexual intercourse because there is NO perfect contraceptive (including sterilization and LARC)
  - Proportion of women who became pregnant while using contraception, (Data from 2002)
  - IUDs 1.0%
  - Injectables 6.7%
  - Pills 8.7%
  - Condoms 17.4%
  - Withdrawal 18.4%

Reports indicate that 48% of unintended pregnancies occur in a month in which the woman used contraception.

HOW CAN THIS BE?

Are Some People at Greater Risk?

- While teens ages 15-19 report 82% of their pregnancies as unintended, they contribute only 12% to the total number of unintended pregnancies in this country (ergo: they are **NOT** "the" problem!).
- The rate of unintended pregnancy in 2001 was substantially above average for:
  - Women ages 18-24 (26% of the total number of unintended pgs)
  - Unmarried, particularly co-habitating women
  - Low-income women
  - Women who had not completed high school
  - Minority women

What We Know about Altering the Unintendedness Rate is NOT Great

What We Know

- Two different analyses (of all available research) could find no studies that demonstrated strategies that work! (Moos, 2003; Grimes 2006). A third analysis is in manuscript stage and also finds little to guide clinicians.
- Possible reasons:
  - Poor studies
  - Ineffective strategies
  - Clinical interventions are inadequate to impact patient knowledge, attitudes and behaviors around contraception
  - Clinicians are often more comfortable “doing at” rather than “doing with”

Insights from Some Qualitative Studies

- Focus groups of pregnant women reflecting on planned/unplanned conceptions: n=29
- The concept “planned pregnancy” is not meaningful to many women
- Religious beliefs and frameworks help women accept and perhaps rationalize unintended pregnancy
- Planning for pregnancy is a stressful concept because it is associated with disappointment

Insights continued

- Previous unprotected intercourse without pregnancy gives false sense of safety or security
- The attitudes of males and others toward unprotected intercourse contribute to risk taking
- Unintended pregnancies have more social and psychological advantages than disadvantages for some women

Moos, MK, et. al. (1997) Pregnant women's perspectives on intendedness of pregnancy
Women's Health Issues, 7 (6),385–392

Reasons for *Not* Using Contraception

- Categories of Reasons Cited for Unprotected Intercourse in Adult Women

  N = 32 women > 20 yo:146 reasons given

  - Method-related (includes side effects, technical difficulties)
  - User-related (includes lack of thought/preparation; attitudes toward pregnancy)
  - Partner/relationship-related
  - Cost and Access

Nettleman, et al, AJNM, 2007

Reasons for Not Using Contraception

- Survey of 1392 women who had no h/o TAB attending family planning clinics across US.
- ~ 50% had unprotected intercourse in past 3 months
  - Barriers to accessing BC (49%)
  - Not planning to have sex (45%)
  - Belief could not get pregnant (42%)
  - Feels better (42%)
  - More natural (41%)

Biggs, et al. Womens Health Issues 22(3), 2012

Reasons for *Using* Contraception

- Survey of 2,094 women ages >20-<30 attending publically funded family planning clinics.
- Contraceptive use allowed subjects to:
  - Take better care of self/families (63%)
  - Support themselves financially (56%)
  - Complete their education (51%)
  - Keep or get a job (50%)
  - Young women, unmarried women and those without children had more reasons.
    - ". . .feeling that having a baby would interrupt their goals and wanting to maintain control in their lives were the most commonly reported 'very important reasons' for using BC"

Frost and Lindberg, Contraception 87(4), 2013

Summary of Quantitative and Qualitative Research

- Marked “disconnect” exists between the recreational and procreational functions of sex (among individuals and society, at large)
- Ambivalence about desire for a baby is common (intended vs unintended is probably not a useful construct)
- Life plans appear to be important motivators for avoiding unintended pregnancies
- “If it happens, it happens” is not an effective health promotion/disease prevention strategy.

Now a word about Short Interpregnancy Intervals

"IPIs"

Interpregnancy Intervals

- Women with IPIs of **less than 18 months** are 14-47 percent more likely to have premature infants.
- Prevalence varies by study:
  - In one study (NSFG, 2005) approximately 14% of all women in US reported to give birth within 24 months of a previous birth.
  - In another study (NSFG, 2013) 35% of pregnancies were conceived within 18 months of a previous birth.

Chandra A. et al. “Fertility, Family Planning and Reproductive Health of US Women: Data from the 2002 National Survey of Family Growth. National Center for Health Statistics. Vital Health Statistics. 23(25). 2005; Gemell & Lindberg. Short Interpregnancy intervals in the US Obstet Gynecol 122 (1) 64-71, 2013.

Short IPIs

- Short IPIs are higher among African-American, Latina, and poor women.

Chandra A. et al. “Fertility, Family Planning and Reproductive Health of US Women: Data from the 2002 National Survey of Family Growth. National Center for Health Statistics. Vital Health Statistics. 23(25). 2005

- In NSFG study (2013), women significantly more likely to have a short IPI if:
  - 15-19 years old
  - Married
  - Initiated childbearing after age 30
  - Reported pregnancy as unintended

Gemell & Lindberg. Short Interpregnancy intervals in the US Obstet Gynecol 122 (1) 64-71, 2013.

The Best IPIs are Neither Too Long or Too Short

- For each month that IPI was less than 18 months,
  - Preterm births increased 1.9%
  - Low birthweight increased 3.3%
  - Poor intrauterine growth increased 1.5%
- . . .BUT too long has problems as well: For each month that IPI more than 59 months,
  - Preterm birth increased 0.6%
  - Low birthweight increased 0.9%
  - Poor intrauterine growth increased 0.8%

Conde-Aqudelo JAMA 2006 296(15) 1809-23.

Unintendedness and Short IPIs Overlap but They Are Not the Same

Unintended Pregnancies and IPIs

- Some pregnancies with short IPIs could, in fact, be very intended. Here are some reasons:
  - Last pregnancy ended with a tragic or poor outcome such as fetal death, infant death, malformations, prematurity
  - Cultural/social familial expectations about how close in age children should be.
  - Partner pressure or reproductive coercion
  - Advancing maternal age
  - **Lack of awareness of the risks** (this is a preventable cause and one that Healthy Start can address).

So, What Are Our Goals around Unintended Pregnancies and Short IPIs?

Moving Women and Men Toward Deliberate Decision Making through Reproductive Life Planning (RLP)

A Strategy to Help People Recognize and Own Their Choices

Evolution of a Movement

“Reproductive Life Plan” circa 1980

- “. . .encourage young people to develop a RLP”
- “Young people” should ask themselves a series of questions. . .

Questions Continued

- Do you want children and, if so, how many and when do you want them?
- How would you feel if you could not have any children or were faced with an unwanted pregnancy?
- How do you feel about abortion?
- How much education do you want?
- Do you want to combine childrearing with a career and, if so, how do you plan to coordinate these activities?
- What do you most want to accomplish in life?
- How compatible are your educational, career, and other goals with your child rearing goals
- How compatible are your reproductive plans with your religious and moral beliefs?

- Harcher, R. Contracept Technol Update, 1980 1 (9):131-2

ACOG Weighs In:

ACOG Recommendation (2005):

> “Clinicians should encourage women to formulate a reproductive health plan and should discuss it in a nondirective way at each visit.” . . .

. . .such a plan would address the desire for a child (or lack of desire), the optimal number, spacing and timing of children in the family, and age related changes in fertility.

CDC's Select Panel on PCHHC, 2006

- Recommendation 1: Individual Responsibility across the Lifespan— Each woman, man, and couple should be encouraged to have a reproductive life plan.
- Related Action Step: Develop, evaluate and disseminate [culturally competent] reproductive life planning tools

. . .but where do we start?

Example of an PCC/ICC RLP

- Do you hope to have any more children?
  - If no, what are you planning to do to prevent becoming pregnant (again)
  - If yes, ask:
- How many more children do you hope to have?
- How long would you like to wait until you become pregnant again?
- What do you plan to do to prevent getting pregnant until then?
- Is your partner on board with your plan?
- What can I do to help you achieve your plan?

Adopted from Moos, MCN, 2003

Important Considerations Irrespective of Tool Used

- Reproductive life plans are NEVER right or wrong
- Reproductive life plans are fluid
  - They should never be considered set in stone because "life happens"
- Reproductive life planning should be offered to everyone, irrespective of assumptions or biases about the woman's (man's) circumstances

Examples of “Everyone”. . .

- SJ is a 15 y/o who states has never had sexual intercourse
- BW is a 26 y/o Lesbian
- TB is a 40 y/o with two living children
- NG is a 34 y/o with no children
- CK is a 24 y/o whose infant is in the NICU
- TK is a 29 y/o with two adopted children
- FW is 31 y/o with six children

Helping People Achieve Their Reproductive Life Plans Requires More Than a Series of Questions

- Must include high acceptance
- Women/men (and providers) should come to appreciate the choice to change—the plan and the contraceptive method
  - Discontinuation of a method is not a failure (for client, provider, etc.) as long as another approach is substituted in keeping with the current reproductive life plan
  - There is a choice of methods and all have distinctive risks and benefits (http://www.bedsider.org)
  - Choices are provisional (except for sterilization) and the decisions are reversible; acceptance of a method is thus a trial
  - Clients' needs and preferences often change over time

Helping People Achieve Their Reproductive Life Plans Requires More Than a Series of Questions

- The Transtheoretical Model for Behavioral Change helps frame the process (Prochaska and DiClemente, Transtheoretical Model of Behavioral Change, 1983. etc.).
  - The value of the **Stages of Change Model** is that it is driven by the client—not by the provider (whether clinician, home visitor, etc); in other words, it is client-centered.
  - The provider serves as a coach, an educator and a motivator but not a dictator.
  - It redefines "success" (and thus helps avoid burnout for clients and providers, alike)

Stages of Change Model as It Might Impact Reproductive Life Planning

1. Not ready to consider benefits or possibilities of thinking about if and when to have (more) children (Precontemplation)
2. Beginning to consider that there could be personal benefits (Contemplation)
3. Accepts that it is possible and beneficial to make deliberate decisions about if and when to have children (Preparation)
4. Creates a reproductive life plan that has personal meaning (i.e. not just answering yet more questions because they are asked) (Action)
5. Maintains belief that a reproductive life plan is personally valuable and chooses contraceptive behaviors in concordance with the plan (Maintenance)
6. Looses interest in planning and takes pregnancy risks (Relapse: [Invites reengagement])

Moving from Chance to Choice

- Awareness of possibilities
  - Outreach and educational efforts aimed at community attitudes and at individual's desires

- Clinical services that facilitate achievement of desires
  - Reinforce value of a plan
  - Access to services and array of methods
  - Client-centered

Reaching Women, Men and the Public

Many States/Agencies have created RLPs:

Delaware's Tool for Teens

Created by and for Teens--

Delaware's Adult Brochure

"If you don't have a plan to prevent pregnancy, you have a plan to get pregnant."

Preconception Health and Health Care
My Reproductive Life Plan

Thinking about your goals for having or not having children and how to achieve those goals is called a *reproductive life plan*. There are many kinds of reproductive life plans. Your plan will depend on your personal goals and dreams.

How to Make a Plan

First, think about your goals for school, for your job or career, and for other important things in your life. Then, think about how having children fits in with those goals.

If you do want to have children one day, think about when and under what conditions you want to become pregnant. This can help ensure that you and your partner are healthy and ready when you choose to have a baby. If you do not want to have children (now or ever), think about how you will prevent pregnancy and what steps you can take to be as healthy as possible.

Try to include as many details as possible in your plan. Some people find it helpful to write their plan down on a piece of paper or in a journal. Be sure to talk with your health care professionals. Doctors and counselors can help you make your plan and achieve your goals.

Questions to Get Started

When making a reproductive life plan, the following questions might be helpful. These are probably not all of the questions that you will want to ask yourself, but they will help you to get started.

If you **DO NOT** want to have children, you might ask yourself:

http://www.cdc.gov/preconception/documents/reproductivelifeplan-worksheet.pdf

Reaching Clinicians and Other Care Providers

Preconception Health and Health Care
Reproductive Life Plan
Tool For Health Professionals

Health care providers can encourage patients (women, men, and couples) to consider a ***reproductive life plan*** and educate patients about how their reproductive life plan impacts contraceptive and medical decision-making.

Do you plan to have any (more) children at any time in your future? *(Open ended and allows branching.)*

IF YES:

- **How many children would you like to have?** *(Encourages the person to consider that there is a choice about the number of children one has.)*

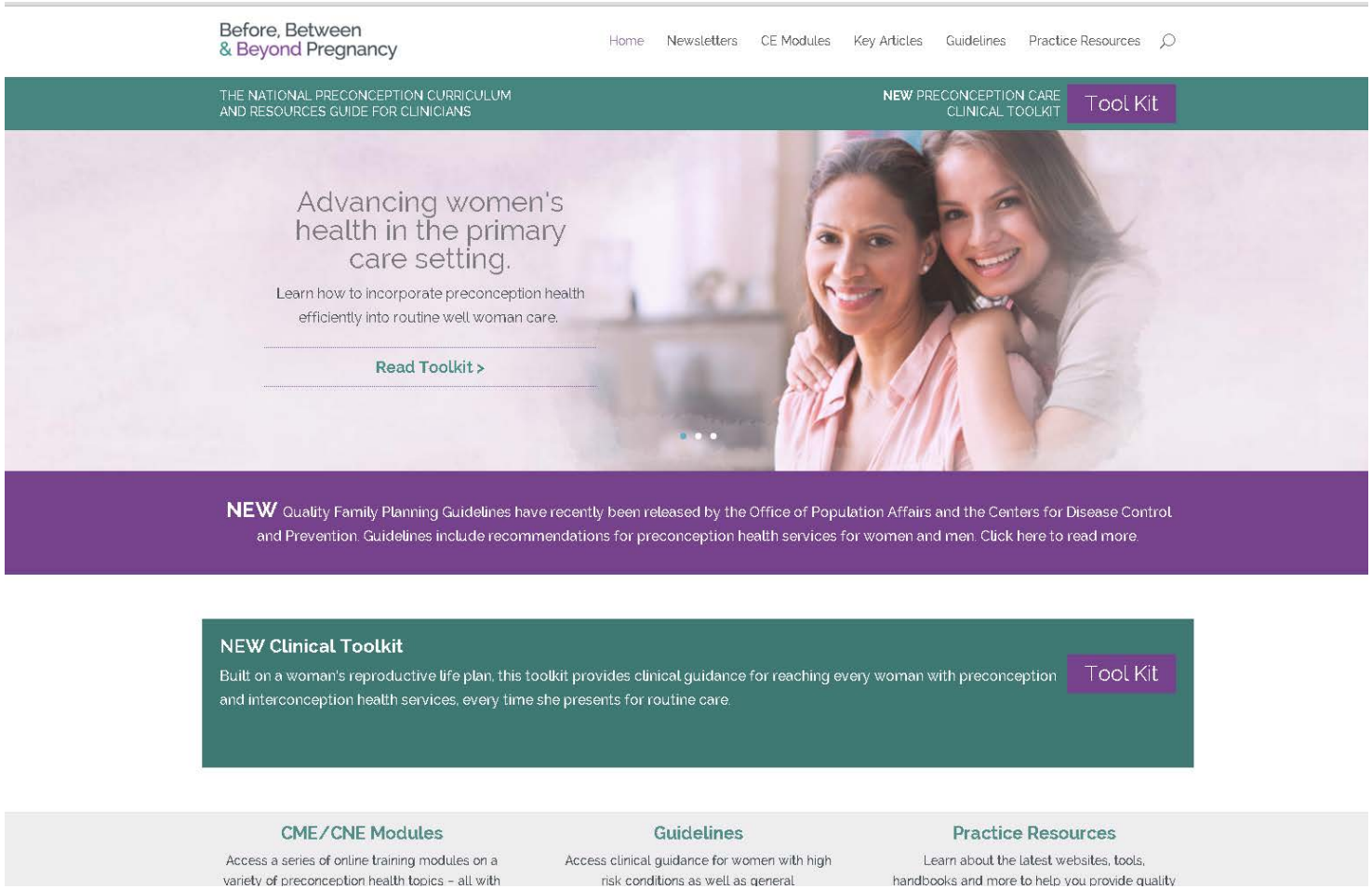
- **How long would you like to wait until you or your partner becomes pregnant?** *(Encourages the person to vision their own future.)*

  Studies have shown an association between shorter birth intervals (less than 6 months between giving birth and conception), and several adverse fetal outcomes, including low birth weight, preterm birth, and small for gestational age. Intervals of 60 months or longer had higher risks for preterm birth and very small for gestational age.[II]

  Many women are waiting until their 30s and 40s to have children. About one-third of couples in which the woman is older than 35 years have fertility problems.[III]

http://www.cdc.gov/preconception/rlptool.html

Preconception Care Clinical Toolkit



National Healthy Start Interconception Care Toolkit Goal:

Create a resource that helps staff provide evidence-based interconception care to women (and families).

The Scope

- 4 modules (8 units):
  1. **The Birds, the Bees and The Plan** (includes 4 sub-modules)
  2. **Weighty Matters**
  3. **Chronic Diseases**: Decreasing Risks In and Beyond the Interconception Period (includes 2 submodules):
  4. **Poor Pregnancy Outcomes**: From Loss to Grief and Beyond

Engaging the Learners:

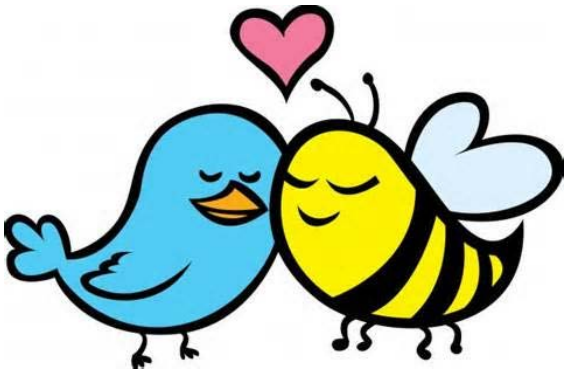
Some of the educational strategies included in the Healthy Start Interconception Toolkit/Curriculum

Some of the Educational Strategies

- When possible, interaction with content
- Case Studies
- Participants called upon to imagine own responses to specific scenarios
- Utilization of evidence-informed counseling frameworks
- Links to resources
- End of module/unit quizzes with referral back to relevant content

NHSA Interconception Care Toolkit
Module 1

- **The Birds, the Bees, the Plan** has four parts:
  - Part 1: Challenging Common Myths that Place our Patients at Reproductive Risk
  - Part 2: The Basics of Reproduction and STI Protection.
  - **Part 3: Considering if and when to become pregnant again.**
  - Part 4: From Plan to Action—Finding and Using the "right" Method of Contraception.



Part 3: Deciding If and When to Become Pregnant Again

- Learning objectives: After completing Part 3 you should be able to:
  - Discuss the risks of unintended pregnancies and pregnancies with short interpregnancy intervals (IPI)
  - Help your clients consider a reproductive life plan
  - Avoid unintended consequences of advancing RLPs
  - Discuss reproductive coercion and how it impacts reproductive decision making.

What Is a Reproductive Life Plan?

- It is a strategy to help women, men and couples make deliberate decisions about becoming pregnant in their futures—in other words to move from “chance” to “choice”.
- It is designed to help women and men actively think about how many children they want to have (or father) and to find their voices to express their thoughts.
- It provides a framework for clinicians and health workers to “LISTEN” first to understand the clients desires.

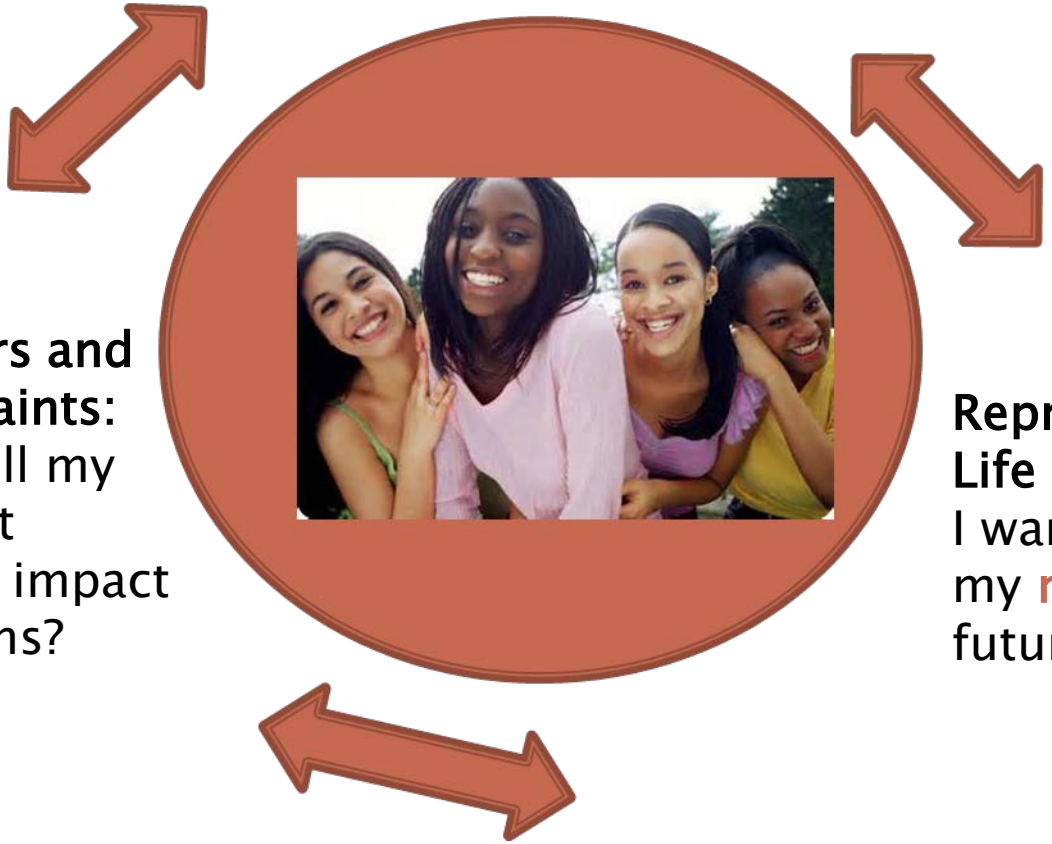
What Is a Reproductive Life Plan (continued)?

- It builds on what the individual/couple want to accomplish in their futures (their “life plan”) and encourages them to think about how a pregnancy could affect that plan.

- It is **NEVER** right or wrong.

RLP FRAMEWORK for NHS Engagement

Life Plan: What do I want to do with my future?



Enablers and Constraints: How will my support system impact my plans?

Reproductive Life Plan: what do I want to do with my reproductive future?

Healthy Start Interactions

- Encourage clients to think about their futures and to create life goals and a reproductive life plan
- If reluctant, reinforce value of having a plan
- Provide **relevant** education about risks of unintended pregnancies and short interpregnancy intervals.
- Help identify contraceptive options that will assist woman/couple achieving plan (Part 4 of this training will help you do this).
- Refer for clinical care when indicated.

What Are the Benefits of Encouraging Your Clients to Have a RLP?

- Though not yet proven, RLPs are likely to help women/couples
  - Deliberately choose contraceptive methods that best fit with their plan
  - Decrease their risk for an unintended pregnancies
  - Decrease their risk for a short interpregnancy intervals
  - Increase the likelihood of achieving some of their life goals such as finishing school or getting a different job, etc.

Important Considerations about RLPS

- Reproductive life plans are NEVER right or wrong.
- Reproductive life plans are fluid--they should never be considered set in stone because “life happens”.
- Reproductive life planning should be offered to everyone, irrespective of assumptions or biases about the woman’s (man’s) circumstances.

*From deliberations of Ad Hoc Committee of PCCHC Select Panel on Reproductive Life Planning, Washington, DC, November 23, 2009

Are There Potential Problems in Using RLPs?

Yes! RLP tools are only as good as the skills of the people using them!

Some Potential Problems

- Used in a way that offends your clients:
  - Clients think you are suggesting who should and who should not have children.
  - Clients think you are judging their plan negatively (remember: the plan belongs to the woman/couple—your job is to be sure they have the knowledge to make a plan based on the evidence and that they have access to follow-up).
  - Clients feel their desires are being disrespected.
  - The plan or the process for developing one is never revisited

Some Potential Problems (continued)

- Blames the woman (man) for not achieving previously articulated plan when there are many possible explanations:
  - No perfect contraceptive
  - Few individuals able to use user-dependent methods flawlessly
  - No guaranteed access to desired methods
  - Made deliberate decision to place herself at risk for conception
  - Coerced or forced to put herself at risk of unintended conception
  - Etc.

Applying What You Have Learned

- **Carmen's baby, Josue, is 4 months old. She tells you she wants to get pregnant again as soon as possible.**

- What are important questions for Carmen before you give her any information?
- Find your own words before you go to the next slide.

Application

- You want to understand what is important to Carmen before you provide her with information.
- By collecting information first, your education can be patient-centered.
- You might say:
  - Carmen, I have had other women tell me they wanted to get pregnant soon after giving birth (you are communicating that you heard her desire).
  - What are some of your reasons for wanting another pregnancy in the next few months? (you are indicating to Carmen that you are interested in HER reasons, without judgment).

Some Possible Reasons for Short Interpregnancy Intervals

- I want my children close together--like my siblings and me.
- I want to finish having children quickly so I can go back to school (or work).
- It's the way my people—e.g. religious or other cultural group—do things.
- It's what my partner wants.
- Can you think of some others you have heard?

Now You Can Move Forward with Some Educational Content

- **Validate the woman:** I hear you saying that you want to become pregnant soon because. . . .

- **Give limited information:** Pregnancies this close together can work out OK for the woman **and** her children. BUT women can increase their chances of having healthy children if they don't become pregnant again until at least 18 months after they give birth. Let's think together. For you that would mean not getting pregnant again until _____.

Continued

- More limited information: We also know that every extra month between “0” and 18 months increases the chances of a healthy pregnancy and healthy baby. So, if you wait 12 months instead of 9 it is better—and 14 months instead of 12 is better AND if you wait at least18 months it is best!!

- Check on receptivity to education: How long do you think you and (partner’s name) would be willing to wait if it meant a better chance of having a healthy baby?

continued

- What if she says, “I am not willing to wait at all?
  - Remember: RLPs are never “right” or “wrong” because decisions about reproduction are very personal.
  - If the woman has enough information to make an informed decision you have done your job.
  - “Enough information” is more than reading a script or handing the woman a pamphlet. It means:
    - she has the information,
    - she understands the information
    - she knows what to do with the information (e.g. access a method of contraception).

To Finish Part 3 of The Birds, The Bees, The Plan, Answer these 10 Questions:

- 1. Unintended pregnancies are associated with all of the following except which one?
  A. Late entry into prenatal care
  B. Depression
  C. Exposure to harmful substances
  D. All of the above

- 2. The majority of unintended pregnancies in the U.S. occur to women ages 15-19.
  A. True
  B. False

Good Work!!

You are now ready to move on to Part 4 of the Interconception module,
The Birds, The Bees, The Plan.

To Access the NHSA ICC Toolkit

- Available to Healthy Start and any other agency involved in the care of interconception women.
- Visit http://www.nationalhealthystart.org
- In the upper right hand corner, next to the Donate button, click Member Login
- On the Member Login page, create an account for a First Time User
- Within a couple of days, you will receive a new account notification which will grant you access to the toolkit.

Impacting intendedness and IPIs will require coordination between the woman/couple's desires and their clinical care

How Can They Work Together

Framework for Creating a RLP

Life Plan: Focus is on: What do I want to do with my future?

Reproductive Life Plan: Focus is on: Do I want to have any (more) children at any time in my future?

Routine ("Every Woman, Every Time") Triage (Based on OKQ ®)

Focus is on: Assessment of desires and provision of relevant care to help woman (man) achieve RLP at each primary care/well woman visit.

OKQ™ = "One Key Question": Would you like to become pregnant in the next year?

Yes: (visit includes special emphasis on preconception wellness)

Unsure or OK either way: (visit includes emphasis on preconception wellness, counseling on advantages of deliberate decisions re: childbearing and provision of acceptable contraception)

No: (visit includes extra emphasis on contraceptive choices to achieve goal and acknowledgement that goals change)

Questions/Comments/ Stretch and then. . .

Reproductive Life Planning In Action

The Magnolia Project

Reproductive Life Planning in Action

Initiative of the Northeast Florida Healthy Start Coalition, Inc.

Presenter: Faye Johnson, BS November 16, 2015

Mission

To Improve the health and well-being of woman during their childbearing years by empowering communities to address medical, behavioral, cultural, and social services needs.

Snap Shot of Jacksonville

- Infant mortality rate (2014): 8.8 deaths per 1,000 live births (2005 rate 11.6)
  - The Magnolia Project located in Jacksonville/Duval County Health Zone 1
- IM driven by disparities
  - 44% of births were to Blacks & other nonwhites
  - Blacks historically have poorer outcomes in Jacksonville than in other urban areas of the state
  - IM rate is slightly 2x higher than the White rate

Services

- Women's Health Services
- Clinical Care
- Home Visitation
- Case Management
- Reproductive Life Planning
- Outreach
- Health Education
- Mental Wellness
- Fatherhood
- Group Education

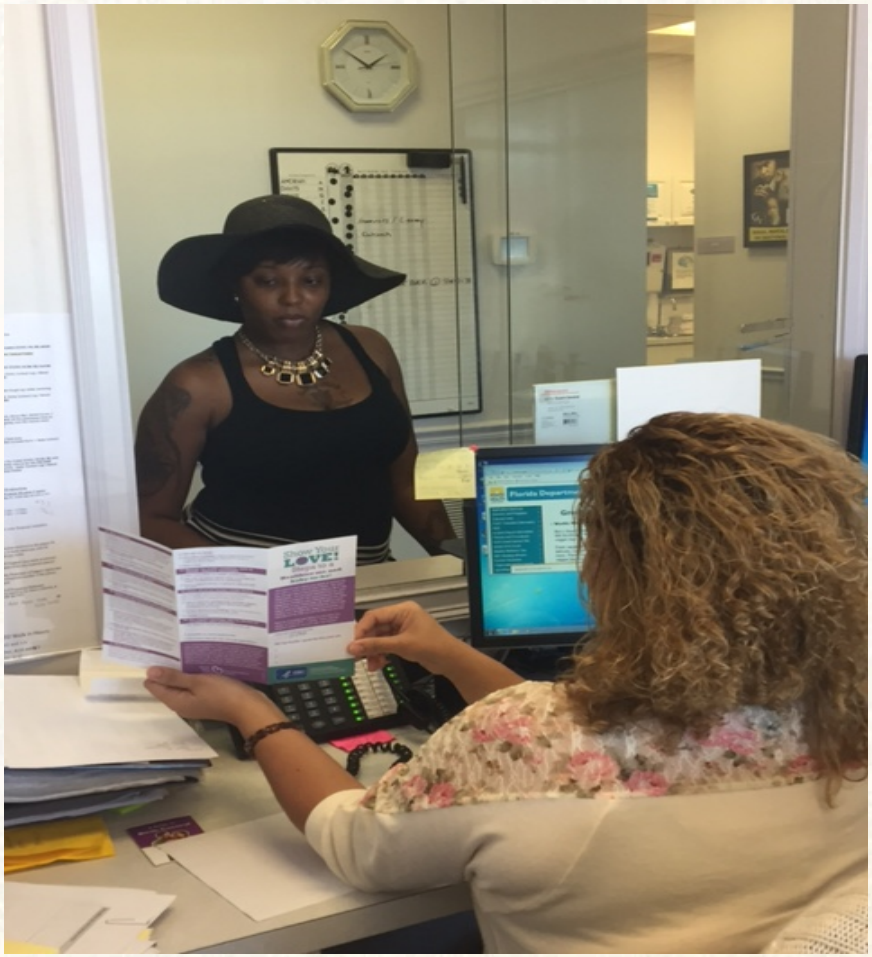
Health Zone 1

- The population is 78.1 percent African- American
- There are 21,632 women of childbearing age; nearly one-fourth of families live below the federal poverty level.
- There was an average of 1,938 births annually in the project area during 2007-2009, accounting for about 13 percent of the births in the city.

Show Your Love Campaign

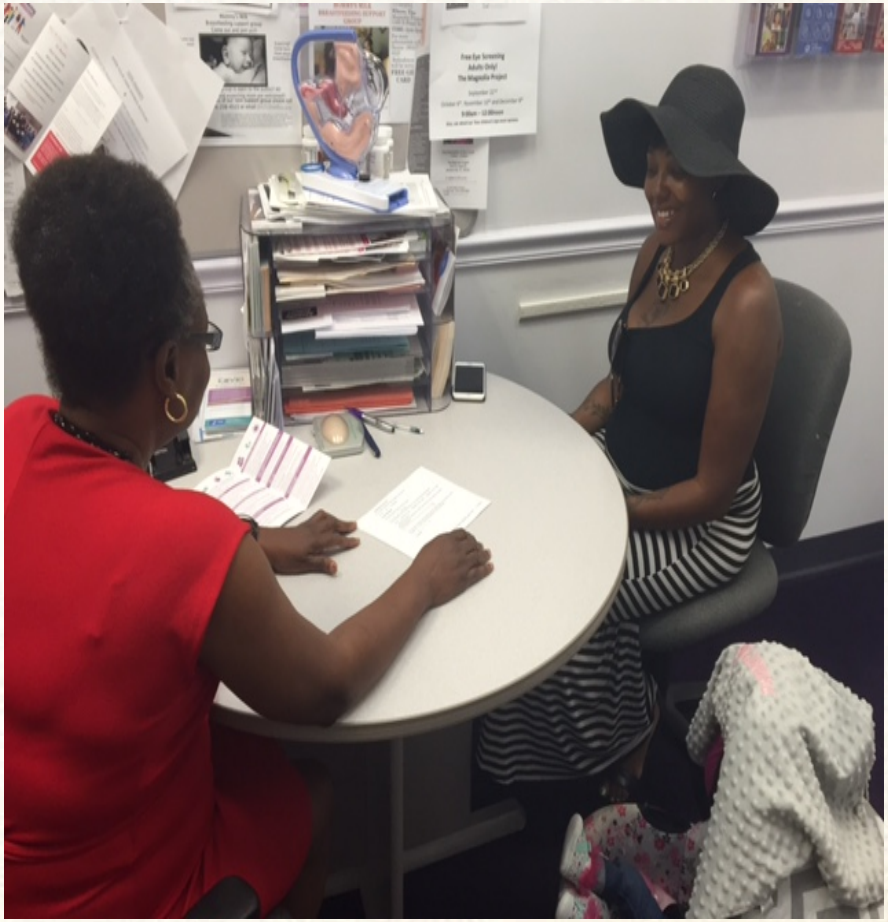
- The pamphlet “Show Your Love! Steps to a Healthier Me!” is distributed to all participants that came to Magnolia for a clinic visit.

- 181 Magnolia Participants were introduced to the campaign during the pilot phase 2014.



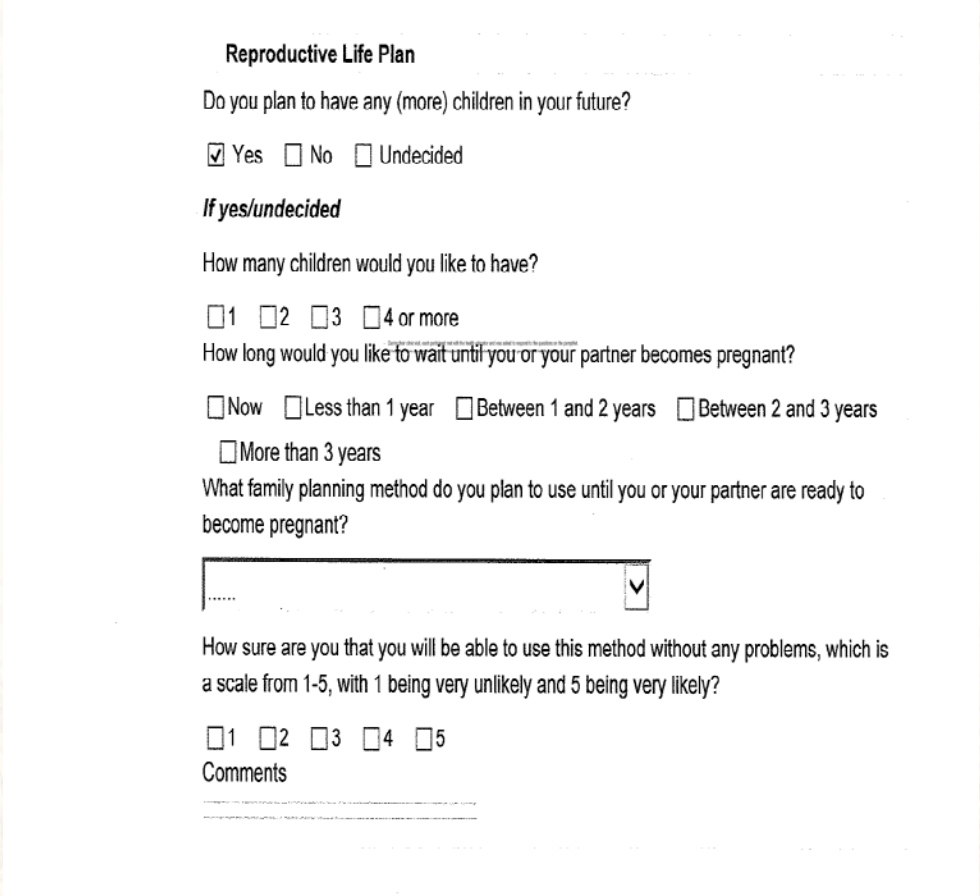
Show Your Love Campaign (continued)

- During their clinic visit, each participant meets with the health educator and reviews the completed questionnaire on the pamphlet.
- At her next clinic appointment, each participant reviews or adjusts her previously set goals with the health educator.



Clinical RLP

- Electronic Health Record
- Health Educator
- Reproductive Life Plan Developed



Reproductive Life Plan

Do you plan to have any (more) children in your future?

☑ Yes ☐ No ☐ Undecided

If yes/undecided

How many children would you like to have?

☐1 ☐2 ☐3 ☐4 or more

How long would you like to wait until you or your partner becomes pregnant?

☐Now ☐Less than 1 year ☐Between 1 and 2 years ☐Between 2 and 3 years ☐More than 3 years

What family planning method do you plan to use until you or your partner are ready to become pregnant?

.....

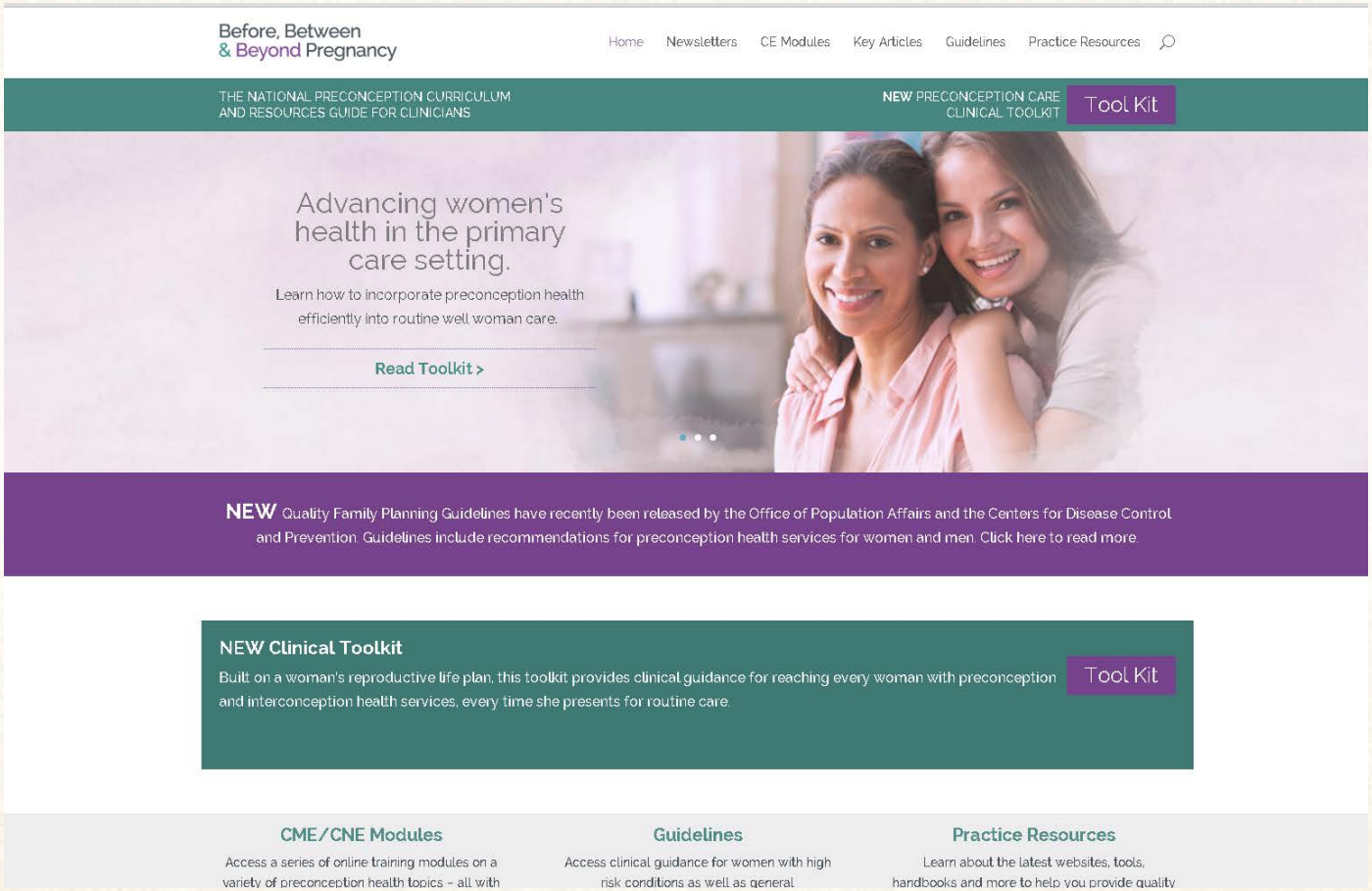
How sure are you that you will be able to use this method without any problems, which is a scale from 1-5, with 1 being very unlikely and 5 being very likely?

☐1 ☐2 ☐3 ☐4 ☐5

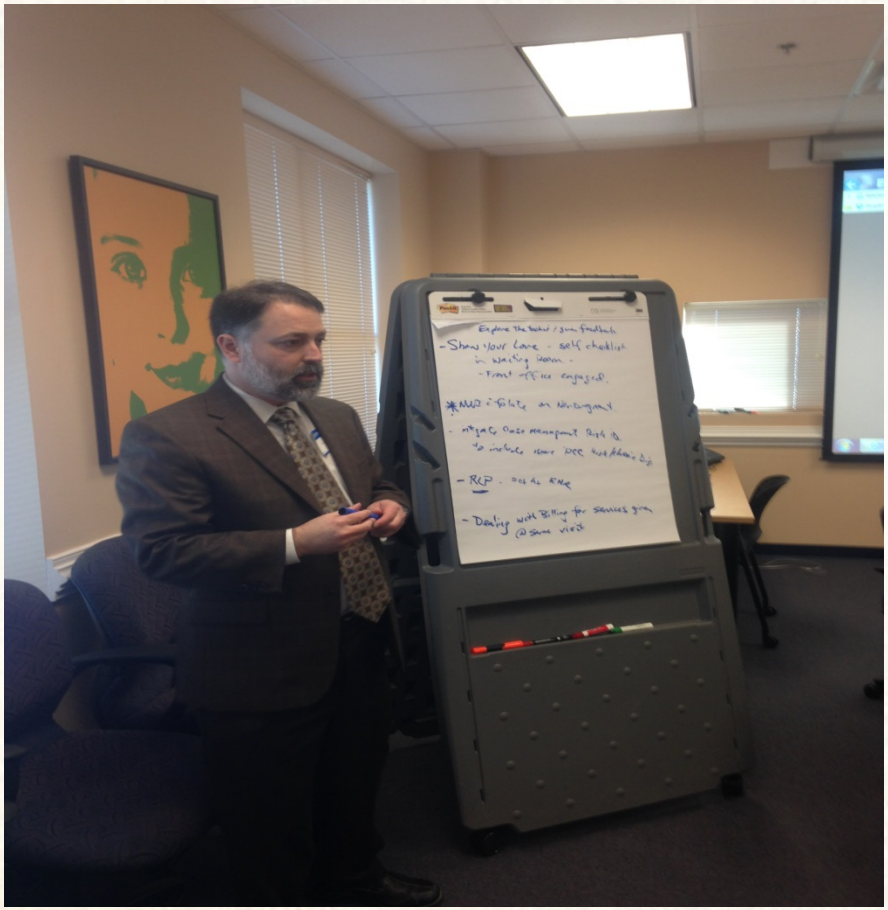
Comments

The Magnolia Project

Preconception Care Clinical Toolkit



Preconception Toolkit Training



The Preconception Toolkit
RESOURCE TRAINING

The National Preconception Health Health Care Initiative was designed to help primary care providers, their colleagues and their practices incorporate preconception health into the routine care of women of childbearing age.

Before, Between & Beyond Pregnancy

Before, Between and Beyond Pregnancy is designed to be a "one stop" resource for clinicians and others who want to learn more about preconception health, its history, the evidence supporting it and strategies for incorporating relevant content into daily clinical practice.

Show Your Love Preconception Health

WHAT:
The National Preconception Health Health Care Initiative: *Improving Preconception Health, Every Woman, Every Time*

WHO:
Primary Care Providers, Nurses, Health Support Tech/Medical Assistant & Clerical Staff

WHEN:
December 17, 2014
1:00 - 3:00 pm

WHERE:
Jacksonville Children's Commission
1095 A Philip Randolph Blvd
Jacksonville, FL 32206

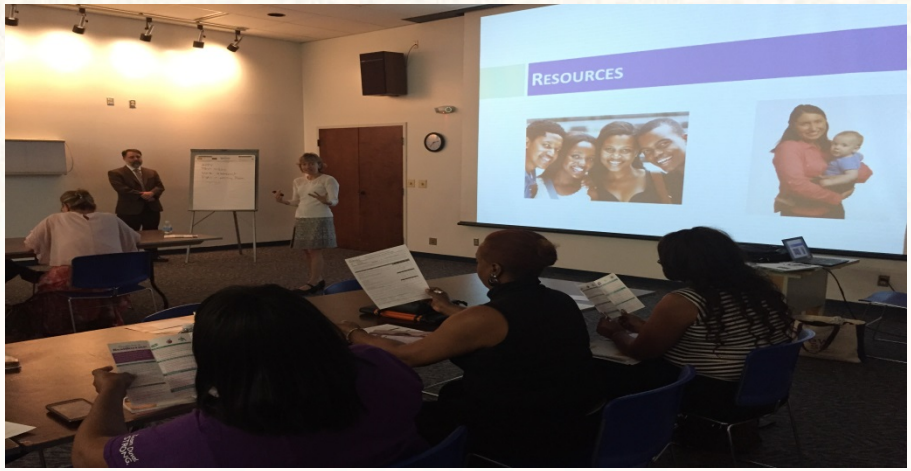
REGISTER BY:
December 10, 2014
Contact Marsha Davis at 904.353.2130 ext. 1002 or register at nefhealthystart.org/preconceptiontoolkit

PRESENTER:
Daniel J. Frayne, MD
Co-Chair, Clinical Working Group Preconception Health Health Care Initiative
Assistant Residency Director, MAHEC Family Medicine Residency
Medical Director, MAHEC Division of Regional Education
Medical Director, Simulation Lab, Mission Health Systems
Assistant Professor, UNC Chapel Hill School of Medicine

Funded by HRSA (H49MC00051) and Florida Department of Health

The Magnolia Project · Northeast Florida Healthy Start · JAX Kids Jacksonville Children's Commission

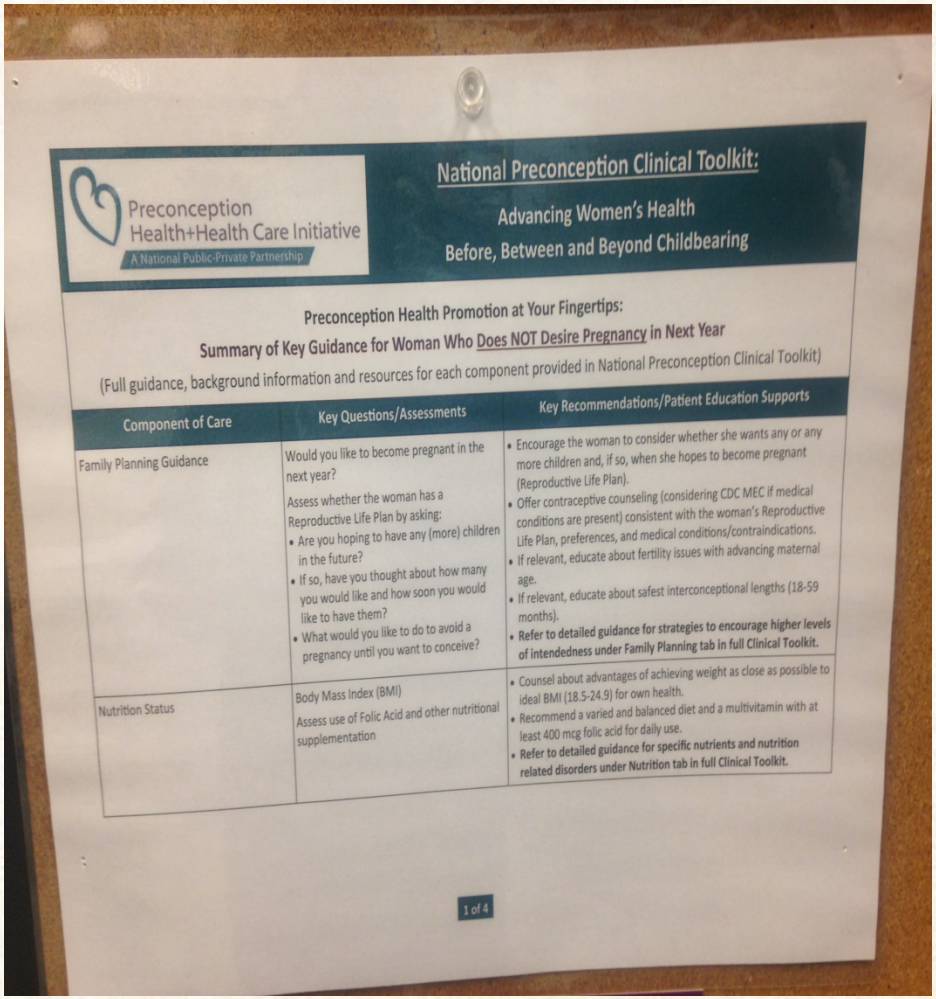
Preconception Clinical Toolkit Training



- Dr. Daniel Frayne, MD, Co-Chair Clinical Working Group Preconception Health - Health Care Initiative and Sarah Verbiest, PH.D, MSW, MPH Show Your Love Campaign
- During the pilot phase 31 project and partner primary care provider staff completed Preconception Care Toolkit Training

Preconception Care Integrated into Primary Care Visit

- During the pilot phase Primary Care was offered one day per week
- The medical provider help participants, who were there for a primary care appointment, formulate a Reproductive Life Plan.
- During this phase 85 Magnolia participants completed the Toolkit.



Preconception Health+Health Care Initiative
A National Public-Private Partnership

National Preconception Clinical Toolkit:
Advancing Women's Health Before, Between and Beyond Childbearing

Preconception Health Promotion at Your Fingertips:
Summary of Key Guidance for Woman Who Does NOT Desire Pregnancy in Next Year
(Full guidance, background information and resources for each component provided in National Preconception Clinical Toolkit)

Component of Care	Key Questions/Assessments	Key Recommendations/Patient Education Supports
Family Planning Guidance	Would you like to become pregnant in the next year? Assess whether the woman has a Reproductive Life Plan by asking: • Are you hoping to have any (more) children in the future? • If so, have you thought about how many you would like and how soon you would like to have them? • What would you like to do to avoid a pregnancy until you want to conceive?	• Encourage the woman to consider whether she wants any or any more children and, if so, when she hopes to become pregnant (Reproductive Life Plan). • Offer contraceptive counseling (considering CDC MEC if medical conditions are present) consistent with the woman's Reproductive Life Plan, preferences, and medical conditions/contraindications. • If relevant, educate about fertility issues with advancing maternal age. • If relevant, educate about safest interconceptional lengths (18-59 months). • **Refer to detailed guidance for strategies to encourage higher levels of intendedness under Family Planning tab in full Clinical Toolkit.**
Nutrition Status	Body Mass Index (BMI) Assess use of Folic Acid and other nutritional supplementation	• Counsel about advantages of achieving weight as close as possible to ideal BMI (18.5-24.9) for own health. • Recommend a varied and balanced diet and a multivitamin with at least 400 mcg folic acid for daily use. • **Refer to detailed guidance for specific nutrients and nutrition related disorders under Nutrition tab in full Clinical Toolkit.**

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Case Management

- Project participants may be enrolled in both clinical services and case management or case management only

- Case management and care coordination services is provided to at-risk pregnant and preconception women residing in the catchment area.

Case Management

- Women enrolled in case management services completed a Reproductive Life Plan with the Women's Intervention Specialist

Reproductive Life Planning

- Reproductive planning is priority focus of the Magnolia Project.

- All program participants complete a group on Reproductive Life Planning, facilitated by Magnolia project clinic staff, or the women's intervention specialist which stresses the importance of waiting longer than 18 months to get pregnant again and the impact of baby spacing on reducing the risk of preterm birth, low birth weight and other complications of pregnancy.

Reproductive Life Plan Group

- During the reproductive life planning group project participants review their reproductive life plans to determine if or when they plan to have children in the future, as well as identify family planning methods to help them fulfill their plans.

- Promote the inter- and independence of Magnolia Project participants while building reproductive capital in the community

Participants' Thoughts!

I really never thought about a plan

Before I get pregnant again I want to work hard and become something great

I want to be strong and stable before I have a baby

I want to go to school and take care of my baby before I get pregnant again

Remember The Data

- The latest data indicates that 51% of pregnancies are unintended (2010)
- 37% of the births in this country are from pregnancies self-identified as unintended at time of conception (2012)
- Unintended pregnancies are generally mistimed (wanted to become pregnant at sometime but not now) not unwanted (did not want to ever have another pregnancy).

Slide source: Merry-K. Moos. BSN (FNP), MPH, FAAN

We Care Because. . .Unintended Pregnancies Are Associated* with:

- Increased likelihood of abortion
- Exposures to potentially harmful substances in pregnancy
- Poor pre-pregnancy disease control
- Late entry to prenatal care
- Increased likelihood of low birth weight in offspring
- Maternal depression
- Reduced school completion and lower income attainment (if woman not married)

note: association does not prove causality

Slide source: Merry-K. Moos. BSN (FNP), MPH, FAAN

HRSA Benchmark

Percentage of participants who have a documented reproductive life plan!

The Magnolia Project

Thank You!

Initiative of the Northeast Florida Healthy Start Coalition, Inc.

fjohnson@nefhsc.org

http://nefhealthystart.org/for-women/magnolia-project/

@nefhealthystart