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Megan: Hello, everyone, and welcome to this preconception care webinar. I'm Megan Hiltner. I'm with the Healthy Start EPIC Center. I'm located in Denver, Colorado along with Dr. Jan Shepherd, our presenter for today. And it's blizzard-like conditions here, so we are crossing our fingers that we do not have any technical difficulties due to this weather. We have approximately 60 minutes set aside for our webinar. It is being recorded, and the recording along with the transcript and slides will be posted to the Healthy Start EPIC Center's website following the webinar.

This webinar will focus on the basic elements of preconception care and why incorporating them into Healthy Start is essential to fulfilling the mission of decreasing infant mortality. This is the first in a four-part webinar series that will be covering the four phases of the pyramidal period. And before I do introduce our wonderful speaker for today, I do want to give a couple of more housekeeping announcements.

We do want your participation, and so we encourage you to chat in any questions or comments that you have. You can chat them in at the bottom left corner of your screen, and if we do not get to all of the questions that are posed during the webinar today, we will be including them into our frequently asked questions document that we will post along with the other webinar materials on the EPIC Center website.

So another housekeeping announcement I want to make is that we would really like your feedback. So after the webinar ends, there will be a survey. An evaluation survey will be shown on your screen, and we'll talk right up, so please complete that and give us your feedback.

Well, now, let me introduce your speaker for today. Dr. Jan Shepherd is the Maternal Health Technical Advisor for Healthy Start EPIC Center. She received her MD from Northwestern University and completed her residency in OB/GYN at the University of Cincinnati. Currently, her appointments include Associate Clinical Professor in Obstetrics and Gynecology at the University of

Colorado School of Medicine, Medical Advisor for the Women's Wellness Connection at the Colorado Department of Public Health and Environment, and consultant for two women's health clinics in the Denver area.

Dr. Shepherd also has a continuing appointment as an Adjunct Associate Professor at Florida State University College of Medicine, where she was the founding Education Director for Obstetrics and Gynecology. In that role, she participated regularly in the Panhandle Fetal and Infant Mortality Review sponsored by the Healthy Pregnancy Network at Capitol Area Healthy Start Coalition. So without further ado, I'm going to turn it over to you, Jan. You begin our webinar.

Dr. Shepherd: Thank you, Megan, and good afternoon, everybody, from snowy Colorado. Thanks for joining us today as we talk about preconception care. So these are my objectives for this program. I'm hoping that by the end of it, you'll all be able to define preconception care and explain why it's important, identify essential components of preconception care, and Megan, most importantly of all, describe ways in which preconception care is critical to and can be incorporated into the Healthy Start model.

So I said I'd start out with the definition, and here it is. When we talk about preconception care, what we mean is identifying and intervening on risk factors that impact pregnancy before pregnancy occurs. And we have strong evidence that intervening before pregnancy decreases maternal and infant mortality, reduces the risk of birth defects, and promotes the healthiest moms and babies.

So why is this so important? If we go back to our science classes, what we know is that the embryo begins to develop right at the time a woman expects her next period to start. So many women don't even know they are pregnant and the embryo is already developing. Think about it. Lots of women have irregular periods. One way or another, they barely notice. And even if somebody has regular periods, they may not think anything about it if they are there too late. But meanwhile, the day they expected their periods, the embryo had began to

develop. And should it be exposed to anything possibly toxic, major birth defects can occur. The first things that develop in the embryo are the brain and the heart, so you can see what I mean by major birth defects.

All major organs form in the first two months of pregnancy. Now, when you think about that, how many of your participants do you see before the first two months of pregnancy are up? Probably pretty rare. Even as an obstetrician, we rarely see people before the first two months are over. And by then, prenatal care is too late for a lot of things that we want to prevent.

This graph illustrates what I've just been talking about. Here we have, we remember that the egg and sperm get together, conception occurs right in the middle of a woman's menstrual cycle, and then two weeks later, she would have a period if she weren't pregnant, the day she expects her periods. And look, here's the embryo already developing at that time. In fact, the first thing that develops is the brain. And in those very early weeks is when neural tube defects can occur, such as spina bifida and anencephaly where part of the brain is actually missing.

But she may not know she's pregnant. If you look, that week that a woman expects her period in the middle of the week, we start getting formation of the heart. A little heart on this embryo here. So those things are happening very early before a woman knows she's pregnant. And these are weeks up here. When you get to nine weeks, most of the major organs are totally formed. The rest of the pregnancy is about developing those organs. So by the time we see one of our participants, the basics of that baby are already formed, and it becomes so important that we start thinking about things ahead of time.

So what are the components of preconception care? Basically, what we're talking about is before pregnancy occurs, identifying risks, providing motivational education based on those risks, and initiating desired intervention. What kind of measures are we talking about? Well, nutrition would be important. In fact, that's a whole separate lecture, but nutrition, certainly

important from the get-go when the baby's forming, exercise as well. And then both of those things, of course, lead to a healthy weight. Weight is becoming a more important aspect all the time of pregnancy and pre-pregnancy health.

Another thing that we would like to see all of our participants do is take folic acid. Now, I know you all are accustomed to telling your prenatal participants to take folic acid 400 micrograms a day, encouraging them to continue doing that. It's part of their prenatal vitamin usually. That's important, because we know that folic acid can decrease neural tube defects, that I was just talking about, by 73%.

But if you think back to that graph we looked at, neural tube defects occur in those first couple of weeks when a woman is just missing her periods. So really by the time we start folic acid, it doesn't have quite the effect that we would wish. What we really would like is for this woman to be taking folic acid before pregnancy. That's when we are really going to see the significant effect on neural tube defects. In fact, ideally, three months before pregnancy. Now, folic acid is documented to decrease neural tube defects but also can decrease miscarriages and other birth defects as well. It's looking now like it can help decrease heart defects as well.

We all know that smoking is a significant risk factor in pregnancy, and you see right there the risk that smoking brings about. We know that if a woman's smoking in pregnancy, the earlier she stops, the better, the more she can decrease those risks. But if she stops ahead of pregnancy, she can eliminate those risks. So that has to be our goal, and what we know as far as quitting smoking is that motivated people are more likely to quit. Hopefully, if a woman is planning a pregnancy, she is motivated.

Alcohol, another big issue. The American Academy of Pediatrics just came out last month with the statement that no amount of alcohol should be considered safe in pregnancy. But again, early in a pregnancy, a woman may not know she's pregnant. She may drink and expose that developing embryo to the toxins

of alcohol, and you see the fetal alcohol effects there. In fact, alcohol is the most common preventable cause of mental retardation. And the brain's the first thing to form, so we ideally want all of our participants, all pregnant women to stop alcohol ahead of time. Of course, we know that women who continue to drink heavily during pregnancy, their babies are at risk of fetal alcohol syndrome, which you see depicted on this slide as well.

Then we've got the other mood altering substances. Opiates, I imagine most of you are aware that the use of heroine is increasing in our society, as well as the inappropriate use of painkillers. And look at this, these opiates increase neural tube defects. If a woman is taking these things very early on in the pregnancy, she's at risk of the neural tube defects. Of course, as pregnancy progresses, then there's a risk of neonatal abstinence syndrome as well on the new baby. Cocaine can cause birth defects, and marijuana has possible effects on intellectual development as well. So we would love for a woman to be off of all these things before the pregnancy.

So those are things that women may elect to engage in themselves, but there are some toxic substances that physicians prescribe, too. And of course, they're not toxic or narrowly, they're wonderful drugs, but if a forming embryo is exposed to these drugs, they can cause birth defects. So what we ideally would want is for anybody that's planning pregnancy to check in with her medical providers and make sure she's not on something that could cause birth defects.

Similarly, medical conditions can lead to problems in pregnancies, but not so much if they're under control, if the diabetes, the thyroid, whatever, is under control. But it needs to be under control from the get-go. Then there are additional factors that are important pre-pregnancy as well. Certainly, checking for infectious diseases like STIs, like TB, but especially HIV, because we know that if a woman's HIV positive, the earlier we begin to treat her, the lower the chance of her passing this on to her baby.

Immunizations are important. We can give flu vaccine and Tdap: tetanus, diphtheria, and pertussis. We can give those in pregnancy, and we do. A little better to give them beforehand, but we can give them during pregnancy. But some immunizations, we can't give during pregnancy. Anything that's a live virus, and one of those is MMR: measles, mumps, and rubella. We don't see a woman until she already is pregnant. We can't give her that to prevent those infections, and she is at risk. Best to get the immunizations all ahead of pregnancy.

It's good to evaluate pregnancy history prior to the current pregnancy, because if she has complications, she might be at risk for them again. And we could help her deal with that. Dental care, it's looking like dental care. We know it's important in pregnancy. It's looking like it might even be more important pre-pregnancy for preventing preterm birth. And I know that you all are very adept at performing depression screens and intimate partner violent screens, very, very important during pregnancy. But if you think about it, might even be more important to find out about this ahead of pregnancy.

So there are a lot of factors to take into account preconception, and you see that most of them are very important. So big issue, and it becomes an even bigger issue when you think about the fact that basically every woman from the time she has her first period to the time she has her last period is possibly preconception. She could become pregnant. So how we do get a handle on all of these? Well, one way and one of the best ways is to help all women access health insurance, and then find a medical home. If they do that, then they can schedule annual well-woman visits, which will cover a lot of the bases that we've just mentioned. And hopefully, in that annual well-woman visit, reproductive life planning will be brought up to encourage planned pregnancies.

It's easy to say that we should help all our patients get insurance, but that wasn't so easy to do until recently. Fortunately, now, we have the Affordable Care Act, and it's a game changer. Still, I see patients that don't qualify, can't get insurance, and I'm sure you do, too, but the majority of women can, and that includes Medicaid. So now, women do have access to insurance, and if they do,

the Affordable Care Act mandates that all of the things you see and read on this slide are covered for both men and women.

All the things on the slide are actually covered for both men and women, but the things in red are the things that we just talked about are important preconception. So blood pressure, testing for diabetes, screening for alcohol, tobacco, and depression, and counseling about those. Those are all important preconception. They're all guaranteed to be covered by the Affordable Care Act. Also, obesity screening and counseling, STI testing, and all recommended vaccines.

So a lot of our bases can be covered with an annual well-woman visit. And in fact, for men and women both, all these things are covered, but the Affordable Care Act adds that at least one well-woman preventive visit needs to be covered annually. So women can come in once a year to get all those things, and in addition, these things specific to women. And we mentioned the importance of HIV screening, the importance of screening and counseling for domestic violence, and finally, and very important, patient education, counseling, and availability of full range of contraceptive options. So more and more women now have coverage for insurance, just find a medical home, and to get this kind of follow-up every single year, which can help them prepare for future pregnancies.

Ideally, in that visit also, the reproductive life planning is discussed, so that the woman can actually plan her pregnancies. You've heard me talk about this before, I think, many of you, but we ask the woman, "Do you plan to have children? How many and when?" And then we help her work with that. We help her not get pregnant when she doesn't want to, and when she does, to achieve optimal health before pregnancy by obtaining preconception care, so that she can have the healthiest possible pregnancy.

So all of these measures that I've mentioned, getting insurance, finding a medical home, annual exam, reproductive life plan. All of these measures are

important for all women, including, of course, Healthy Start participants. But now, I want to focus on things specific to Healthy Start participants and how preconception care can be incorporated into Healthy Start program.

I'm going to do this with some cases. I guess I'd way rather talk about cases and people than give more didactic slides. So let's look at some cases, and here's the first one. And of course, obviously, these are not real people. These are made up, but let's pretend they're real. So this is Charisse, and she's a beautiful young teenager, and she comes in to the Healthy Start facility saying that she heard about preconception care and her health and life skills class at the Boys and Girls Club. Basically, Healthy Start either went to speak there or sponsored a speaker there and taught her about it. So she got the information from Healthy Start, so she comes to Healthy Start to find out more.

And she says, "I don't plan on getting pregnant anytime soon, but if it happened, I know it would be important to be as healthy as possible. That's what I learned. So what do I have to look out for?" So how are we going to counsel Charisse if she shows up on our doorstep? Well, I will say, if she was someone I saw, the first thing I'd bring up would be the reproductive life plan, because it sure sounds to me like she doesn't want to be pregnant right now, but she's not sure that she won't be. So we need to talk about this, "When do you want to be pregnant? And if it's not for a while, let's talk about contraception. Let's talk about your options, the effectiveness, and once we make some choices, I'll refer you to a healthcare provider for the method."

When I talk to women like this about contraception, I love to use the World Health Organization chart. I like it, partly because every method's on there, so every method comes to mind, and also because it shows how effective the methods are. The top tier are at the top. They are the most effective. If somebody is absolutely sure she doesn't want to get pregnant, look there. But the hormonal methods on the next tier, they're pretty good.

I suspect and I imagine many of you who've talked to young women like this suspect that maybe what she and her partner are using is withdrawal. And she knows maybe somebody that got pregnant using that, and that's why she's not sure she won't get pregnant although she doesn't want to. And this is the perfect chart to use to show withdrawal, not as effective as a lot of other things. If you really don't want to get pregnant, let's talk about these other things. And of course, if that's what's working for you, it's obviously your choice.

But Charisse came in to talk about preconception, and especially, if she elects to continue using withdrawal, she could get pregnant. So we need to talk about preconception risk factors as well then ask about some other things that we mentioned before. Is she on any medication? Does she have any medical conditions, any red flags here? And then discuss additional health measures, exercise, diet. If she continues to use withdrawal or even condoms, I would suggest that she'd be on folic acid all the time, so that she will be on it should she conceive inadvertently.

Also, of course, I would also urge her not to be smoking or drinking or using drugs, to get that annual well-woman check, to get the immunizations they recommend. And while she's there, how about doing an intimate partner violence and depression screen. Just to be sure and just in case she gets pregnant in the future but just in general for her health.

All right. Here's another client that shows up at your doorstep. She also heard about preconception care at a Healthy Start sponsored lecture at her community college. So she comes to you, and she says that she's worried, because she thinks she's overweight. And in that lecture, they said that being overweight could cause problems for her pregnancy, like high blood pressure, diabetes, and even an increased risk of stillbirth or baby with birth defects. She says, "My partner and I have been planning to have a baby when we finish school next year, but now I'm worried."

So let's talk first of all about the risk of obesity in pregnancy and how important it is these days - either calculate it at the place where you work or have it calculated at the associate clinic - that we know everybody's BMI or body mass index. And to check obesity, a BMI of 30 or greater, we are now ready to work with those women. What we know is that obesity in pregnancy does increase the risk of hypertension, diabetes, blood clots. And this is maybe the scariest thing we're finding out is more and more women are obese during pregnancy, that it increases the risk of birth defects, growth abnormalities, including small and large pregestational age, and stillbirth. So it's a big deal.

The other thing we know is that women who are overweight tend to become diabetic, type 2 diabetes. So when we see someone overweight, we like to do a glucose tolerance test to be sure if she is diabetic, because that would involve a whole other level of management. And then, of course, if we see somebody preconception, we've got the opportunity to help her lose some weight before she gets pregnant.

So what about Tanya? She showed up at your facility, and she is overweight. So she has a high-risk preconception issue. And she could be enrolled in your program and assigned a case manager, and that would really help her get her situation under control preconception. Case manager would help arrange for that glucose tolerance test and make a plan for weight loss, and not just say, as so many people do for people with weight problems, "Well, you ought to lose weight," but really make a plan or get a referral or both to help Tanya lose some weight before pregnancy.

Now, of course, it's all going to have to do with her reproductive life plan, and she wants to get pregnant in a year, so you've got little time to work with. And maybe ask if she thinks she could defer pregnancy until she really does get her weight under control. If so, then help her with contraception. And of course, we'd want to look at other preconception risk factors as well.

Now at first, Tanya's concern, turned out her BMI was 34, so she is in the obese range, and she was sent for that glucose tolerance test, and it showed that she did have type 2 diabetes. So then she needed some counseling about the risks of diabetes on top of the risks of obesity, and the fact that if she does get pregnant, she will need to think about maybe needing to be hospitalized, maybe needing insulin. I'm sure many of you have seen this with your diabetic patients or with your diabetic participants.

The thing we know about diabetes is that probably it's this high blood sugars very early in pregnancy, like we were talking about before. Right around the time a woman misses her period or shortly thereafter, those high blood sugars can cause birth defects, and they can also lead to stillbirth or miscarriage later in the pregnancy. But if a diabetic patient ahead of pregnancy gets her diabetes in really good control, she decreases the risk of birth defects by three times and the chance of stillbirth or a miscarriage. So preconception, extremely important for diabetics.

Here's another case, another lovely young woman named Vanessa. And Vanessa comes to you, because her mother sent her in, and her mother actually participated in Healthy Start during her pregnancies 15 to 25 years ago. We all know Healthy Start has been around just about 25 years right now. So we do see this, and I'm sure many of you do at your facilities, the daughters of women that you've worked with.

So this mom send her daughter in, because Vanessa wants to have a baby, but she's been treated for epileptic seizures since childhood. So Mom's worried, and she wants her to touch base with you before she tries to get pregnant. So Vanessa shows up at your facility, and clearly, she does have a risk factor. She enrolls as a preconception participant and is assigned a case manager to work with her as far as her risk for the future pregnancy.

So what do we know about epilepsy? Well, unfortunately, what we know about epilepsy is that it does increase the risk of birth defects two to three times, and

some of that's probably from the disease itself, but a lot of it is probably from the medications that we use to treat it. So this is someone that will need to be referred to a medical home, and the case manager and the medical home will have to be coordinating a lot of care for Vanessa. What is often done for these women is that they're tried off the medication to see if they really still need it. And then if they do, they try to put them on the single most safest drug that they possibly can.

The other thing, though, for patients in this situation is that they need 10 times the folic acid of our other patients, 4 milligrams. And hopefully, that medical home practitioner is going to recommend that to Vanessa, but the case manager is going to to want to follow up on that and to ensure she understands the importance of that, because that is evidence-based to decrease her risk of having a baby with birth defects. Of course, the other thing that case manager may want to mention is that contraception's going to be important until this is done and also to assess other preconception risk factors.

Last participant here we're going to take a look at, and this is Cristina. Now, Cristina is already in Healthy Start. She was a participant since halfway through her pregnancy, and she needs a C-section, because her baby weighed nine and a half pounds at birth. Her doctors told her this is probably because she had type 2 diabetes, and she didn't know about that until she was pregnant. So you're talking to Cristina, and you say what a cute baby she has, because she does, and she mentions that her sister thinks her baby is really cute, too, and her sister's in love with her baby, and her sister is thinking about having a baby very soon, too. So how can we counsel Cristina?

Well, first of all, Cristina is what we call interconception, but really it's the same as preconception. At this point for her, what we want is, because she is planning another pregnancy, before her next pregnancy, we want to help her get to her medical practitioners and get her diabetes under control before pregnancy. If we do that, as we have said, we can decrease her risk of having a baby with birth defects, having a stillbirth. Luckily, this one turned out okay, so it turned out really well, but it was nine and a half pounds. And if we got her

blood sugar under control prior to pregnancy, chances of having a baby of a more normal weight as well. Of course, she is interconception, so we want to talk to her about spacing pregnancies if that works with her reproductive life plan.

And then finally, and this is a real important clue we want to get used to picking up on, her sister's talking about getting pregnant soon. And her sister, of course, is also at risk for diabetes, because we know that runs in families. So suggest she sends her sister in to become a preconception care participant and get all the things we can offer for preconception care and particularly tested for diabetes.

So those are some examples, and of course, they are all women. That's what we're constantly dealing with, but what we're also becoming accustomed to thinking of is the importance of the partner. And it's very important to realize that preconception care is for men, too. If a man can be involved in this preconception visit, that is wonderful, because after all, men should have a reproductive life plan, too. They should have some say and when and how many babies the couple is going to have. And it's important for men to be in good health when pregnancy is attempted to prevent and treat STIs, to stop tobacco, alcohol, and drugs, to have a healthy weight.

In fact, I've read a study recently that showed that men who are significantly overweight have an increased risk of having babies that are overweight. They actually see changes in their sperm, and then their babies tend to be overweight. So it depends on a man's behavior, too, how that baby is going to turn out. As far as preconception care for men, we want to think about their family history, any help they may need for violence, staying mentally healthy, and maybe most important of all, supporting their partner.

So that is the basics of preconception care, and why is preconception care so important to Healthy Start? The biggest reason is that, what is the mission of Healthy Start? It's decreasing perinatal mortality, and we now have strong evidence that if we want to decrease perinatal mortality, we need to start

thinking preconception. The other reason why it's so important, many of you are familiar with the concept of life course theory, and life course theory means continuum of care across the entire life course. So not just when a woman becomes pregnant, and postpartum, and interconception, and next pregnancy, but even before the pregnancy. Continuum of care across the entire life course.

And I know many of you heard Dr. Lu talk about this at the recent convention. This is quotations from an article by Dr. Lu where he talks about life course theory and the importance of preemptive intervention, intervening when it counts the most, which in many cases is earlier than has been done in the past, and preventing adverse birth outcomes by improving women's preconception health. So Dr. Lou, I know, is very, very committed to increasing preconception care and incorporating it into the Healthy Start model.

So another way that preconception care relates to Healthy Start's mission is...I imagine most of you are familiar now with the five approaches and the benchmarks that we are aiming for. If you look at those approaches and benchmarks, you see that many of them fit with exactly what we've been talking about; increasing the proportionate patients with health insurance, those with the documented life plan, medical home, well-woman visits, all the things we've covered here. And in addition to the postpartum visit, because, of course, the postpartum visit is our chance to begin preconception care for the next pregnancy.

As far as the second approach, we've got smoking, decreasing smoking, spacing pregnancies 18 months apart. And the third approach, depression, intimate partner violence screening, and increasing partner involvement. So all of these things fit so well with the concept of preconception care, and it's a way that we can meet those benchmarks. So we know that some Healthy Start programs are already providing preconception care. I know that many have not yet integrated it into their programs, and it's a challenge, and I appreciate that's a challenge.

So these are just some ideas about how to begin to do that. I would state first of all that you use your CAN [SP] to promote and recruit preconception patients, preconception participants. A lot of people don't know about preconception care. It's kind of a new idea, and maybe the members of your CAN don't know. But if you talk about it to them, then they will likely become interested and maybe help you promote it with lectures and other materials that we've mentioned, and they might also help you recruit preconception participants from whatever organizations they're involved with.

You certainly want to think about outreaching to recruit yourself and maybe with the help of the CAN. I've listed a bunch of suggestions here as far as groups to outreach, too, but basically, we were thinking about groups where there are women who are in the age where they might get pregnant. It's maybe on their mind. They've got a partner. These are the women that we want to tell about preconception care. Plan your pregnancies, and let's help you become as healthy as possible prior to your pregnancy.

Another thing that some organizations have tried is starting preconception discussion or support groups. I've read about this in the literature, and they seem to be quite successful. Young women who are thinking about getting pregnant to talk about health measures they might take, but also just to plan for pregnancy in general, as far as their life plan for having the babies, the fun parts, too, but work together to plan pregnancies and be as healthy as possible when they do become pregnant.

Once you start thinking about preconception care, I think it comes to your mind many times a day with people that you encounter, so that if you're with one of your participants, and she does mention, as Cristina did, that her sister wants to get pregnant soon or that one of her friends is trying to get pregnant, something like that, perfect time to recommend preconception care. Invite that person in to become a preconception participant in your program. Really all women of reproductive age that you encounter, somebody who is a participant, talk about preconception care, and certainly, we already do that, and you all already do a wonderful job with your interconception participants.

So what do we do when somebody seeks preconception care? Where do we start? I think the very best place to start is with that one key question that I imagine most of you have heard of. Would you like to become pregnant in the next year? Now, if you ask Charisse, our first participant, if you ask her that question, she will probably say no. And so you don't have to go in detail on preparing her for pregnancy, but we do need to discuss and refer for contraception. And it's good we ask the question.

Many patients though, many clients, will come in, and they're there because they're planning to get pregnant in the next year hopefully, and so they say yes. Now, if you're just mentioning this casually, and you don't have time to go into all of this today, you can schedule a preconception visit. And if she's there for a preconception visit, then you can proceed to assess preconception risk factors. And of course, there's a whole list of them in the early part of this presentation that you can look through, but there are a couple of things on the horizon that I think are really going to help us assess each risk factor as well.

One of them Dr. Brian Jack has talked about, and I know some of you are piloting right now, and that is Gabby, the computer program that women interact with to help figure out their own risk factor, and then we can help them follow up on that. The other one is a tool being developed by the COIN right now. The COIN is developing a preconception screening tool, as well as screening tools for all the other three Ps. But the screening tool hopefully will be helpful.

It's still in the developmental stage. I assisted in the development, so I know pretty much about it, and I think it's exciting. Probably, most of you will be seeing it in the next few months, because we're going to send it out for feedback. Hopefully, that will eventually, though, be another tool that will help you assess preconception risk factors, and after that, counseling the participants and assigning a case manager if the participant is high-risk.

Now, some people, you might ask that question, "Would you like to become pregnant in the next year?" And the answer is, "I don't know. Whatever happens." Because some people don't believe in planning pregnancies, of course. And others, they're not sure of their relationship yet, whatever, but if somebody is at risk of being pregnant in the next year, if they say that they probably are, then it's time to assess their preconception risk factors, reinforce healthy lifestyle, preconception habits, etc., and it's really good that you had that encounter, too.

So there are a lot of preconception risk factors as we've seen, and actually, believe it or not, it's only a partial list that I've given you. So it can get pretty complex, pretty long, and sometimes you say, "Oh, I don't know if I have time to deal with all of that." So I put this list in here, because these are the preconception measures that have the strongest evidence base. These are the ones, if you are limited in how much you can cover, these are the ones that can make a huge difference. Getting that participant on folic acid before pregnancy, being sure she's not smoking or drinking before pregnancy.

Many women planning a pregnancy, they're healthy. They are not on any teratogenic medications, but if she is, getting that evaluated. Certainly, control of diabetes is hugely important. Getting an HIV test in dealing with the issue of obesity, which as we all know, can be challenging. But those are the most important things to go after if your time is limited.

Again, I know that for many of you, this is something new to incorporate in your program, and I wanted to give you some additional resources since this is really just an introduction. So first of all, I have to remind everyone that at healthystartepic.org, we have the evidence-based inventory, and the evidence-based inventory has a lot of tools, ideas, and resources for preconception care. My favorite sites are probably the CDC, and beforeandbeyond.org, an excellent site as well.

So hopefully, this has been a helpful introduction. I was going to make a summary slide with the whole list of the points that I've tried to make, but then I realized that it's really very simple. If a man and a woman both optimize their health prior to pregnancy, they're likely to have a healthy family, like the families that you see here. So thank you very much for listening, and I will go back to Megan.

Megan: Thank you so much, Dr. Shepherd for the informative presentation. I do appreciate it. We do have a couple of questions, and I just want to remind everybody if you do have a comment or questions that you'd like to ask Dr. Shepherd, just chat them into the chat box, it's at the lower left-hand corner of your screen, and we'll do our best to get to them. So the first question for you, Dr. Shepherd is this participant is asking, they heard that if you're overweight, that it would be harder for someone to become pregnant. Is that true?

Dr. Shepherd: Yes, it is true that overweight women do have a little harder time getting pregnant. Being overweight changes the hormone balance enough that it can become hard. And you've talked to a lot of women who are overweight. You'll find that their periods are irregular, and their periods are heavy, other problems that come along with this.

Nevertheless, we do see, and I'm sure you all see, that pregnancy happens to women who are quite obese in fact. So it's a little less predictable for them, but it certainly can happen, and it, I think, makes it more important than ever that they're optimizing all their other preconception risk factors, because it's going to be hard for them to know whether they're at risk of pregnancy, when they might get pregnancy. And hopefully, though, they can if they want to, but we would rather they lost a little weight first, if at all possible.

Megan: Great. Another question for clarification. Someone asked, you referred to STIs in your presentation at all times, and I just wanted to let everybody know that that acronym stands for sexually transmitted infections.

Dr. Shepherd: And that's correct. That's correct. But it's called both STI and STD. People are moving more in the direction of STI. It just sounds a little less intimidating, and most of the time it is an infection rather than a disease per se. So that's why we're moving to STI, but they're the same.

Megan: Great. So another question. Someone asked if they would like to get a copy of that great WHO chart that you showed with regard to contraception and counseling, could they just go to the WHO website, the World Health Organization website?

Dr. Shepherd: I believe that's true, and I believe it might be available in the CDC website as well. I'm not certain about that.

Megan: So another question. "Thank you so much for this presentation. Your summary statement was great. Would you mind extending on a father's involvement during preconception?"

Dr. Shepherd: Well, I think that ideally if someone has an appointment as to enroll as a preconception participant, if their partner can be with them, that is perfect. That is perfect, because, again, the reproductive life plan isn't just hers. It should be theirs. And I think that men need to be as motivated as women to optimize their health before pregnancy, partly, like I said, because we see changes in sperm based on men's health status, but also partly because once they have that baby, then for both of them to be at their optimal, physical, mental, emotional health is just so important.

So the more we can get men involved in preconception as well, the better. On the CDC website, there's a section of preconception, health recommendations for men, and it's a good place they can tell men to turn. If they're even shy to

come in maybe to the Healthy Start facility, there's a good place for them on that website.

Megan: Great. Here's another question for you, Dr. Shepherd. Due to the storage of toxins in adipose tissues, how do you address this in overweight women that are encouraged to minimize weight gain during and immediately prior to pregnancy.

Dr. Shepherd: This person brings up a really good point, and as I said, I didn't even go through all of the preconception guidelines, because trying to make it simple for this presentation, but one of them is exposure to toxins, and that is worth mentioning right now, especially since she brought it up. But it is an important point to mention, toxins that may be in people's water or environment, toxins that they may work with in their job, or the partner may work with in his job. So those things are important, and then another component of preconception care is looking at those and seeing what changes can be made.

Now, that's true that some of those toxins also are stored in adipose tissue. I think it won't be affected so much by whether the person gains or loses weight. It's one of the risks of being overweight, but I think that really that's an issue for everybody as far as planning a pregnancy and staying away from toxins as much as possible.

Megan: Great. We got a question about how soon will the PowerPoint slides be made available on the EPIC Center's website for those that weren't able to attend? And we will aim to get the slides up within the next couple of days. So just you can look for those on the website, and we will also include the transcription as well as the frequently asked questions in a summary.

There was a question also, Dr. Shepherd, that I don't expect for you to answer this, but I wanted to let folks know that we will include it on the FAQ

document, because I think it's more of a question for the [inaudible 00:50:33] division, but it's about counseling or tracking those women that enroll in your program for preconception. The question is, will providing preconception care be based upon target area only, meaning where you only will be able to counsel those women who reside within your target area? We will include that in our FAQ document after this webinar. So I just want to let you know that I acknowledged that you will get a response to your questions after the webinar.

So folks, are there any other question? Well, actually, I gave you a moment or two to think about any salient question that you have. I want to give you a few reminders to mark your calendar for some upcoming webinars we have. In January of 2016...so I'm crazy as to think that 2016 is right around the corner. So on January the 11th, from 3:00 to 4:30 p.m., there'll be a screening tool roll-out webinar. This will be presented by the Healthy Start COIN members. So mark your calendar for that.

Also in January, on the 19th, there will be a webinar, the second webinar and Dr. Shepherd with the series of four webinars. And she's going to be leading a webinar prenatal care from 3:00 to 4:00. And then on January 28, there will be a webinar on a centralized intake. And on that webinar, there will be presenters both from the EPIC Center and also from the Bureau of [inaudible 00:52:13] Prevention. So mark your calendars for those, and you can always go to the Healthy Start EPIC Center website to look at the calendar and view what events are coming up. And you can also go back to other previous events and download the webinar slides, recordings, and transcripts.

I do see that someone has raised her hand, and just, folks, if you do have a question, please type it into the chat box in the lower left-hand corner of your screen. I'm just going to give another person a moment to chat her question in. Well, I just want to thank everybody on the webinar for participating, and also, Dr. Shepherd, thank you so much for a very informative presentation, and the cases were a great way for the information to be shared. Thank you so much for providing that presentation. And if you do have any follow-up questions, you can always email the Healthy Start EPIC Center email address. That email

address is info@healthystartepic.org. Thanks again. This concludes our webinar for today.