

AMCHP 2007 ANNUAL CONFERENCE

HEALTHY COMMUNITIES

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Preconception Care:

Achieving Healthy Communities

DISCUSSION

NAN STREETER: I'd like to thank the panel for some wonderful information about what's going on in California. What we want to do with the rest of the time that we have is to hear from states. But before I hear from states, what I'd like to do is hear from the National Healthy Start. Is Belinda here?

BELINDA: I think that (inaudible) had mentioned it earlier, all of the Healthy Start sites in the country are required to (inaudible) inter-conceptual care, work with (inaudible) six months (inaudible), of you already know that. They're already required to work with mothers and their children two weeks after the babies are born. One of the things that the National Healthy Start Association itself is doing is that we are working with CDC and some with Kay Johnson and others, and we're in the process of working with (inaudible) University of Chapel Hill to (inaudible) information specifically from consumers. 'Cause we really wanted (inaudible) people to be included in the whole process. And one other process that we're working with is working through UNC Chapel Hill, we're (inaudible), and we're doing some (inaudible) studies, specifically with African American

women, to create a panel on, is there a reason, or what is the reason women tend to participate in preventive health services or not. Some of this has worked, it's still (inaudible) the work that we actually did in North Carolina. In North Carolina as part of our State Infant Mortality Collaborative, we started off with doing some focus groups. In our focus groups, what we wanted to find out from women were, is there a reason? For most women, women tend to participate in preventative health services. And we were able to do over 20 focus groups with those women, and it was a mixed group. I mean, we worked with African-American women, Hispanic women that spoke English, Caucasian women and American-Indian women. We also had some fathers in the group. And what we found out from those women, it was not a knowledge issue, as many of you have stated already. Women are already aware that they need to look at their health and women's wellness in general. The issues that they kept telling us about were issues of trying to find time in their daily life. I mean, women wear multiple hats. And they were looking at wearing the hat of being a mother, a partner of a husband or another man. They were also volunteering in their community, they were volunteering in their churches. So by the time they did all that, even though they knew it was important, you know, they were too tired at the end of the day. So (inaudible) women kept telling us that they were just too tired.

The other issue they kept dealing with or telling us was issues around having accessible provider that they could get to. Some of it was issues of did they have medical coverage that would cover it, but the other issue that we kept dealing

with was feeling that they could provide (inaudible) being culturally competent, so that many of the women that we talked to in our public schools, that might have dealt with that whole issue of cultural competency, and feeling that especially if Medicaid was their (inaudible) of choice, that providers wouldn't treat them as they treated everyone else. So they were feeling that they were missing something. And it may not have always been the provider per se. But it could have been the office assistant at the front desk. But whoever made them feel uncomfortable when they got to the provider was the problem. So I see many of you shaking your heads, so I think many of you have seen that as well. We're trying to build on a very similar approach to the National Healthy Start Association, and work with some of the Healthy Start sites around the country and get a feel for, what are those women telling us? Is it any different than what we found out in our state in North Carolina? We are also, trying to do some (inaudible) and interviews at some point down the road with providers. Because we also want to see if our providers are giving us similar information as the (inaudible). So I think that's kind of what you wanted me to share.

PHILLIPS: Hi, I'm (inaudible) Phillips from Florida, and we sort of had a convergence of opportunity, I think, in our state. We were using the Perinatal (inaudible), variety of other tools to look at where we might be able to make a difference in our outcomes. And things kept pointing to the (inaudible) for the better. And so we began to look at what we had in terms of resources that we could utilize. We were fortunate to get a (inaudible) grant project, which was

called the (inaudible) focus project, and we were in the (inaudible) March of Dimes, a staff person who sits in her office at the state home office, and has worked across the state at (inaudible) project. Then the Healthy Start Coalition that, well, you know, the state (inaudible) system, Healthy Start Coalitions, but we also had a buyer (inaudible) Healthy Start projects. And one of those decided to apply for a preconception focus grant (inaudible) project. We learned a lot from that project. (inaudible) conducted in that (inaudible).

And then what that led us to was to think about sort of changing the tire on cars. We were rolling down the road, but our policies were (inaudible) money. And of course the money was going into the prenatal period, and the preconception was sort of an afterthought, if that. And part of that had to do with our policies. So we needed, the challenge we had was to allow for the use of some funds that we had that said they were about screening pregnant women and infants, and expanding that opportunity to be able to offer preconception health. So we worked with those statewide Healthy Start coalitions to come up with some standards and guidelines, with some training, and to provide (inaudible) training, to break from California, to share solutions, (inaudible), and (inaudible) two years in a row. We focused on the preconception period, trying to get providers across the state (inaudible). This past year, we were able to have a \$3 million project with the (inaudible) that we were going to put the money out, 2.7 million of it, directly to the communities who were doing a variety of things from providing direct care, such as a preconception health visit to dental care, to a variety of

other concepts, direct service kinds of things, all the way to that social marketing career campaign. And then a (inaudible) of that money, 'cause it was non-recurring, and that was a real challenge for us to, how do you make non-recurring dollars last you longer at getting a more sustainable project. And what we're looking at is working with the California March of Dimes project they had (inaudible) time to educate the writers more about what they need to be doing in the preconception period to work with the March of Dimes to change that curriculum a little bit, and to really have a ongoing project with our providers across the state.

NAN STREETER: Great, thanks, (inaudible). Can we hear from another state? What's (inaudible)?

LORETTA JAMES: My name is Loretta James and I'm from Delaware. And although Delaware has a very small population, we're approximately (inaudible), period. (inaudible). (laughter) A few years ago, we were titled with the dubious distinction of being number one as far as infant mortality, in terms of 100,000. Okay. So, as a result, two years ago, we (inaudible) in our government, (inaudible) a task force. And at the year (inaudible) of that task force, they gave recommendations to the governor. And it resulted last year in a million dollars from the General assembly. And with the million dollars, they were supposed to execute the center of excellence, which we have. We also were in partnership with, there's the (inaudible) that we have on loan for the Center of Disease

Control, and she's playing an instrumental role in leadership in the Center of Excellence. As a result, there were two contracts last year, and they have services for at risk mothers in targeted areas and (inaudible) Delaware qualified centers to Delaware qualified centers. And either they had experienced (inaudible) outcomes, or they were at risk of experiencing poor (inaudible) outcomes. So they entered into the program, this contract between public health and those two federally qualified health centers, and they had services for those target eight women. They're also wraparound services, and additional increased outreach and additional screens.

This year, the budget went from one million, and we have asked the (inaudible) budget, for to double that amount. They also have contracts with three more contractors. And the emphasis is on the preconception care. They've also started collecting data for PRAMS, which is the Pregnancy Risk Assessment Management System, and they were having a little bit of a delay because they needed to get, the human subject reviewed more. There were various agencies and stuff that they had to get that cleared first, but they were supposed to be collecting (inaudible) data, they started it, and then they'll (inaudible) of the analysis from that. So, we were also aware of this start as far as targeting infant mortalities, but during a small state, it's a shame (inaudible) distinction, but I think as a result of it, we've, the governor has provided leadership in our state, as far as addressing infant mortality, one, which is additional preconception care through our contractors.

NAN STREETER: Sometimes, there is a benefit to being dubious status. Before, we have time for one more comment, but one thing I want to mention, and Connie had mentioned about frequent (inaudible) care and being misperceived as a message that women are reproductive vessels. And, you know, we've talked about it with the Steering Committee, and, I think the way to look at it is that it has generated conversations. And those conversations have generated ideas. And so, this is good. If we label it women's health, it would (inaudible). So, it's a (inaudible) in volume weigh-in. Okay, one more statement. Or, we have (inaudible). And then we'll (inaudible).

UNKNOWN SPEAKER: If I can just comment, one of the things we're doing in Los Angeles is incorporating other stakeholders that as (inaudible) table, and that is the employer, we've now, actually for the Los Angeles Chamber's Health Committee and (inaudible), they have agreed to endorse our recommendations for (inaudible), but (inaudible) the state (inaudible) network has put together a brief, and I can share them with you. We brought copies, it's on our website, employer of pregnancy and family policies in the workplace. They will place that on their Website and work with us in partnership to help promote wellness as well as (inaudible).

LISA: Hi, I'm Lisa (inaudible), with the Maternal and Child Health Bureau, and I'm a women's health specialist. And I just wanted to briefly tell you about online

program that I have received. It addresses the risk of over, reducing the risk of overweight and obesity in women, (inaudible) approaches for short. Many of you already know about the grant program. There are 12 grantees right now, that are funded under this grant. Two of them, spoke at a session on Sunday. And that is so far some preliminary and some very good information. Some of them are coming out with maybe 100% or looks to, like, 97% positive results in reducing weight, BMI, blood (inaudible), that sort of thing. They have, some of the important things that are going on are the importance of social support, partnerships, community, mental health associations. Many of them are screened, we had some questions about depression in women programs. And many of them are finding that they are (inaudible) positively, for risk of depression, which makes sense. It's a (inaudible) morbidity factor in terms of depression and eating disorders. Sometimes binge eating. So, we're very appreciative in (inaudible) the future. So I would say, just look out for that one.

NAN STREETER: Thanks, Lisa. Join me in giving a round of applause to our panel. (applause) I have to say that given the—what do I want to say? The numbers of states that are working on preconception care, that unfortunately, we didn't have time to hear from, it speaks to the need for us as AMCHP to maybe sponsor another session next conference, and, you know, promote it, and have a little more time to share state to state. So, we'll go ahead and adjourn, and at your next activity is your regional meetings, so if you will all go to those, thank you.

