HRSA
Health Resources & Services Administration

# *Enhancing HIV Care*
# *Preconception Counseling, Including Sexual Health, Community of Practice (CoP)*
## *Learning Session 2:*
## *What is preconception counseling and why does it matter?*

***June 21, 2023***

**Division of Community HIV/AIDS Programs**
**HIV/AIDS Bureau (HAB)**

**Vision: Healthy Communities, Healthy People**

# HIV/AIDS Bureau Vision & Mission

ENHANCING HIV CARE
WOMEN, INFANTS, CHILDREN, AND YOUTH (WICY)

## Vision

Optimal HIV/AIDS care and treatment for all to end the HIV epidemic in the U.S.

## Mission

Provide leadership and resources to advance HIV care and treatment to improve health outcomes and reduce health disparities for people with HIV and affected communities.

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

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# Welcome

## Welcome & Team Introductions

- RWHAP Part D CoP Team
- Bizzell CoP Team

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WOMEN, INFANTS, CHILDREN, AND YOUTH (WICY)

# Ice Breaker

- Bizzell CoP Leads


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# Agenda

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- Reflections on Learning Session #1: IHI Breakthrough Model
- Overview of women and persons with reproductive potential served by RWHAP
- Overview of preconception counseling (PCC) requirements in the RWHAP Part D program
- PCC clinical performance measures
- Featured faculty speaker – William R. Short, MD, MPH, FIDSA
- PCC resources and references
- Interactive breakout sessions (CoP Participants Only)
- Post-training announcements (CoP Participants Only)

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# Learning Session #1 – Reflections

- IHI Breakthrough Series
  - SMART Goals
  - PDSA Cycle
  - PDSA Worksheet
  - Cause and Effect Diagram
  - Driver Diagram
  - Project Planning Form

- How have Learning Session 1, the IHI Breakthrough series tools, and your monthly learning sessions helped you prepare for the upcoming action period?

# Learning Objectives

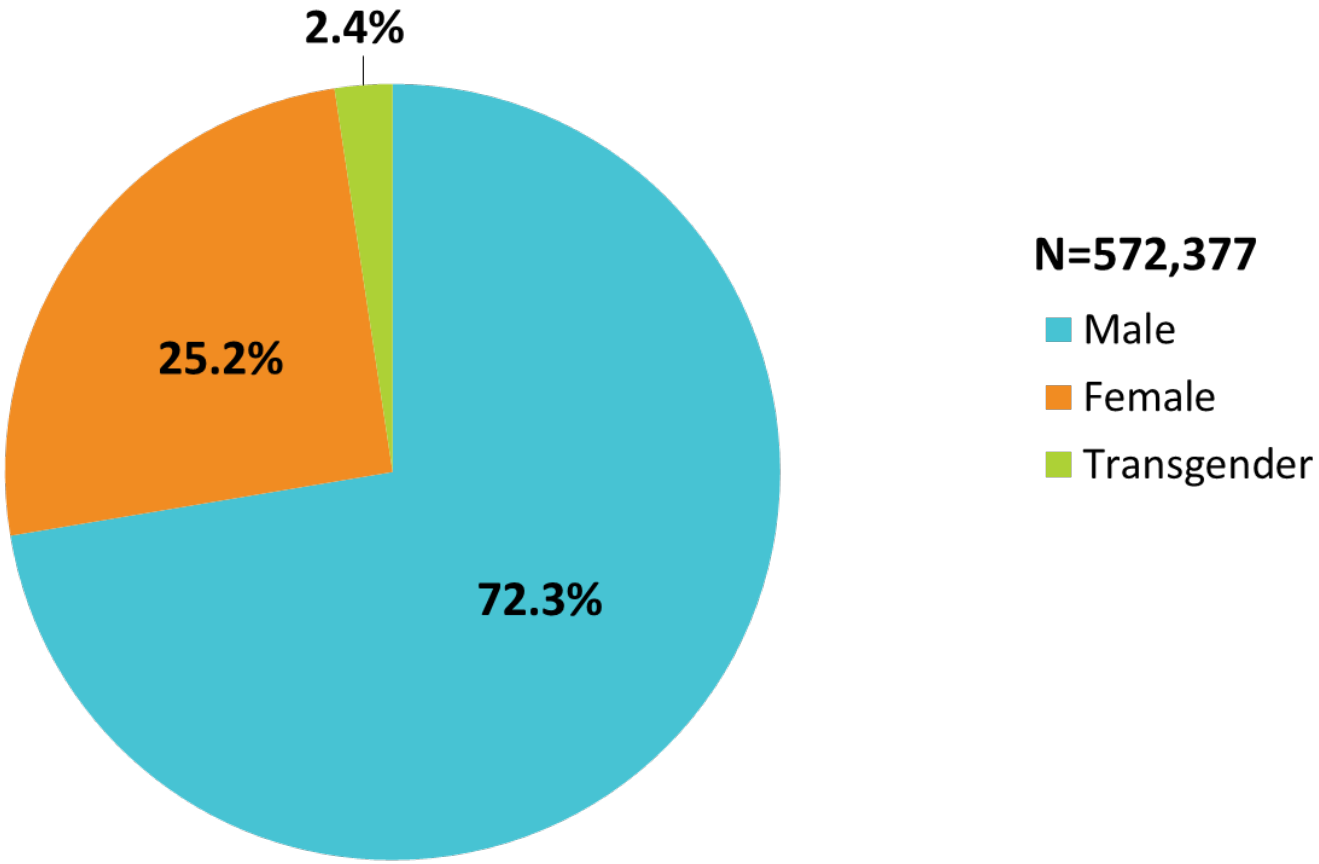
By the end of this learning session participants will be able to:

- Gain knowledge of strategies and approaches for integrating preconception counseling (PCC) and sexual health into HIV care.
- Understand the HIV guidelines for preconception counseling and care for persons of childbearing potential.
- Explain the Ryan White HIV/AIDS Program (RWHAP) Part D program requirements related to PCC and women's health.
- Describe the HAB clinical performance measures related to PCC and reproductive health.
- Summarize the comprehensive guidelines for PCC.


# HRSA DCHAP Program Requirements

# Overview of Women and Persons with Reproductive Potential Served by the RWHAP

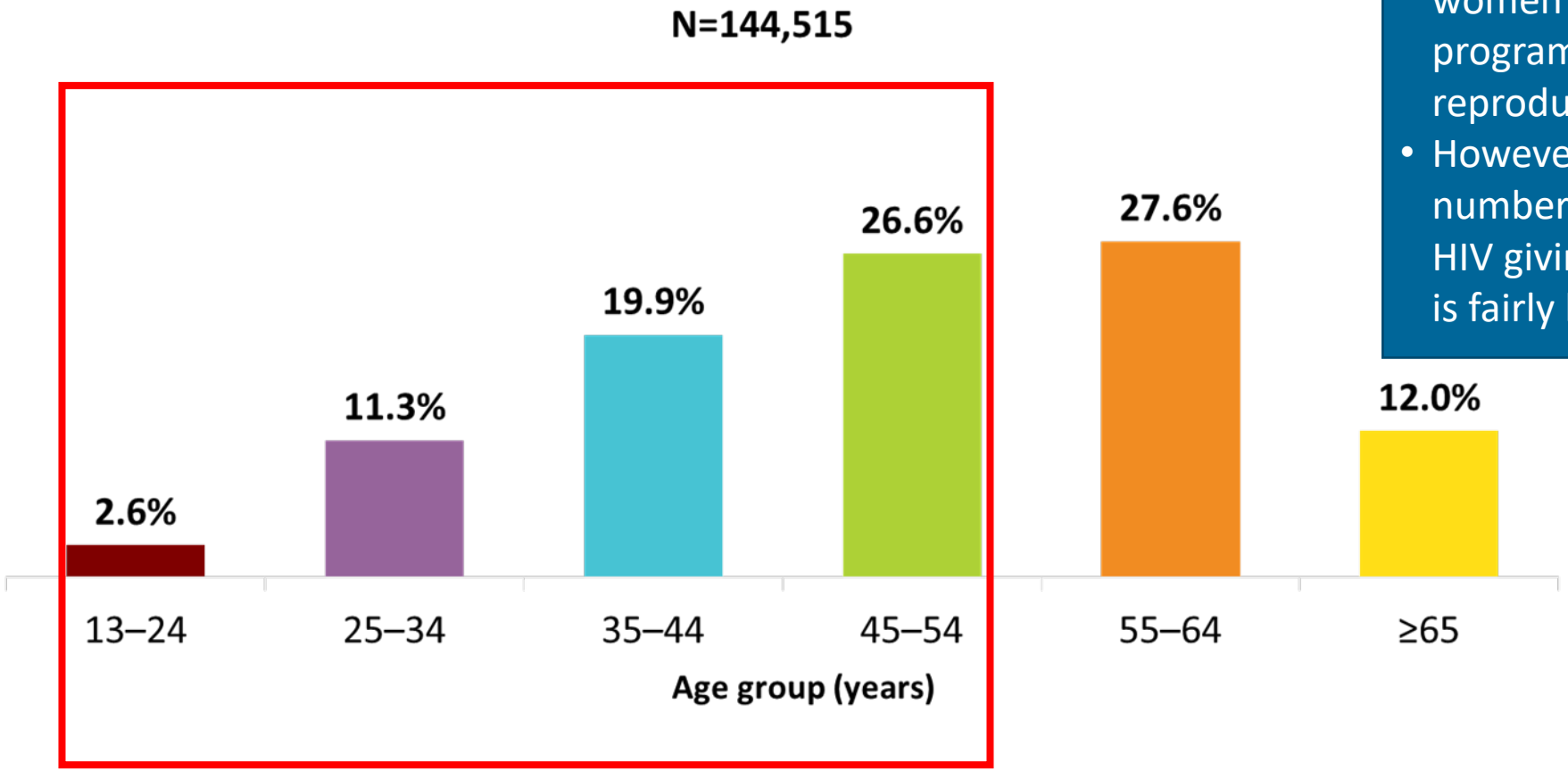
# Clients Aged 13 Years and Older Served by the Ryan White HIV/AIDS Program, by Gender, 2021—United States and 3 Territories[a]




[a] Guam, Puerto Rico, and the U.S. Virgin Islands.

# Women Aged 13 Years and Older Served by the Ryan White HIV/AIDS Program, by Age Group, 2021—United States and 3 Territories[a]

ENHANCING HIV CARE
WOMEN, INFANTS, CHILDREN, AND YOUTH (WICY)




- More than half of the women served by our program are of reproductive age.
- However, the estimated number of women with HIV giving birth in the US is fairly low.

[a] Guam, Puerto Rico, and the U.S. Virgin Islands.

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# Pregnant Women with HIV Served by RWHAP, 2021

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WOMEN, INFANTS, CHILDREN, AND YOUTH (WICY)

| Table 1: Number of Pregnant Women* with HIV** Served by the RWHAP 2017-2021 | | | | |
|---|---|---|---|---|
| Year | | | | |
| 2017 | 2018 | 2019 | 2020 | 2021 |
| 2685 | 2259 | 3042 | 2002 | 1979 |

*Include FTM
** HIV Positive includes: HIV positive-not AIDS; HIV positive-AIDS unknown; HIV positive-AIDS and HIV positive-presumed
Source: RSR 2017-2021, HRSA HAB

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# Overview of Preconception Counseling Requirements in the RWHAP Part D Program

# RWHAP Part D Program

- As of 2021, the RWHAP (all Parts combined) serves nearly **144,515** women, infants, children, and youth with HIV.
- **RWHAP Part D: Women, Infant, Children and Youth**
  - Of WICY clients served by Part D, most are women, followed by youth aged 13-24.
  - Funds outpatient, ambulatory, family-centered primary and specialty medical care for women, infants, children, and youth with HIV.
  - 70,971 clients served by RWHAP Part D in 2020.

# RWHAP Part D Requirements and Expectations

- Develop **comprehensive** and **coordinated** system of **family-centered** care and support services for low-income **women, infants, children, and youth (WICY)** with HIV in **entire** service area.

# What is a Comprehensive Coordinated System of Care?

- Provides patient/family-centered services
- Maintains continuity of medical and support services
- Coordinates referrals for any clinical care needs
- Identifies problems and interventions early
- Transitions patients to new providers as necessary
- Facilitates communication between providers
- Utilizes culturally and linguistically competent staff
- Improves health outcomes

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# RWHAP Part D Preconception Counseling including Sexual Health Expectations

## Women's Health

- Address the health care needs for women and people of childbearing potential, including **family planning**, **pre-conception counseling**, chronic disease self-management, and domestic violence awareness.
- Provision of **pre- and postnatal care**, including the **transition back into HIV primary medical care after delivery** for women and people of childbearing potential with HIV

**Source:** HRSA-22-037 RWHAP Part D Coordinated HIV Services and Access to Research for WICY Existing Service Areas

HRSA Ryan White HIV/AIDS Program

# RWHAP Part D Preconception Counseling including Sexual Health Expectations

## Adolescent Health

- Educate youth about basic HIV information, including therapy treatment adherence, viral suppression and its prevention and health benefits, transmission, prevention methods, as well as sexuality, **family planning**, and chronic disease self-management.

**Source:** HRSA-22-037 RWHAP Part D Coordinated HIV Services and Access to Research for WICY Existing Service Areas

# Common Challenges

- **Population-specific care or services, such as:**
  - pre-conception counseling,
  - cervical cancer screening, or
  - pregnancy testing

- **Collaboration with Title V**
  - Lack of coordination of activities with other providers under Title V of the Social Security Act
  - Lack of documentation to support coordination of activities with other providers of health care services under the RWHAP

# HAB Clinical Performance Measures

Priority Measures for the RWHAP Part D Program

# HAB Performance Measures

- **Reproductive Health/Family Planning and Sexual Health Measures**
  - Pregnancy testing before initiation of or change in anti-retroviral therapy
  - Pre-conception counseling in person with reproductive potential at every visit
  - Syphilis testing once per measurement year
- **Perinatal Exposure Clinical Performance Measures**
  - Exposed infants received appropriate ART for 4-6 weeks after birth
  - Exposed infants receive PCP/PJP prophylaxis
  - Exposed infant record with mother's ARV history
- **System Coordination**
  - Coordination of activities with other providers under Title V Maternal and Child Health (MCH) Block Grant Program *(Legal)*

# Key Findings From Site Visits
# Family Planning & Reproductive Health

Of the 22 eligible site visits, 45% (n=10) had a finding in pre-conception counseling.

Of the 22 eligible site visits, 50% (n=11) had a finding in cervical cancer screening.


Of the 22 eligible site visits, 45% (n=10) had a finding in pregnancy testing prior to initiation or modification of ART.

**Data as of June 1, 2023**
Total Site Visits: n=25 (includes comprehensive and diagnostic)
Site Visits excluded: n=3 (includes two diagnostic and one Part F dental)
Remaining Eligible Site Visits: n=22

# Key Findings From Site Visits
# Title V Collaboration

- **As of June 1, 2023,** DCHAP has completed 25 site visits.
- Of that number, eight (8) were dually funded Part C/D and three (3) were Part D only. That equals 11 eligible Part D clinics.
- Of the 11 eligible site visits, 27% (n=3) had a finding in this category.
- 14 site visits were not included in this measure because they were a Part C only (n=13) or Part F Dental (n=1) program.

# Questions?

Penn Medicine

FEATURED FACULTY PRESENTER

## William R. Short, MD, MPH, FIDSA

University of Pennsylvania
Perelman School of Medicine

# Risk of Perinatal HIV Transmission in the U.S.

- Once upon a time, prior to the availability of antiretroviral therapy (ART), the risk of perinatal transmission was **~25%.** *Perinatal transmission refers to mother to child transmission during pregnancy, labor, and delivery.*
- With zidovudine (AZT) during pregnancy (after 14 weeks gestation) and during labor (given intravenously) and for the infant after delivery for 6 weeks: **8%**
- With 3-drug ART regimens: **<1%**

**BUT…**

- With ART and undetectable VL at conception, throughout pregnancy, and at delivery (5482 mother-baby pairs reported)

Kind C et al. AIDS 1998;12:205-210, Mandelbrot L et al.. JAMA 1998;280:55-60, The European Mode of Delivery Collaboration. Lancet 1999;353:1035-1039, Sibiude J et al. CID 2022

# Preconception Counseling

> The purpose of prepregnancy care is to improve the health of each person before conception by identifying risk factors for adverse outcomes for the pregnant person and their fetus, tailoring education and counseling to individual needs, and treating or stabilizing medical conditions to optimize outcomes for the pregnancy and the fetus/newborn.

**American College of Obstetricians and Gynecologists (ACOG) uses the term Prepregnancy counseling**

From the NIH guidelines: https://clinicalinfo.hiv.gov/en/guidelines/perinatal/prepregnancy-counseling-childbearing-age-overview

# Why PCC is Important for People with HIV

- High rates of unintended pregnancy
- High rates of serodifferences
- High rates of comorbidities potentially affecting maternal and fetal health
- Advances in HIV care and prevention of perinatal transmission
- Pregnancy desires and intentions of individuals with HIV similar to those without HIV
- By the time a pregnancy is realized, it may be too late

*ACOG Practice Bulletin No 117*; December, 2010

# Definition: Preconception Counseling and Care

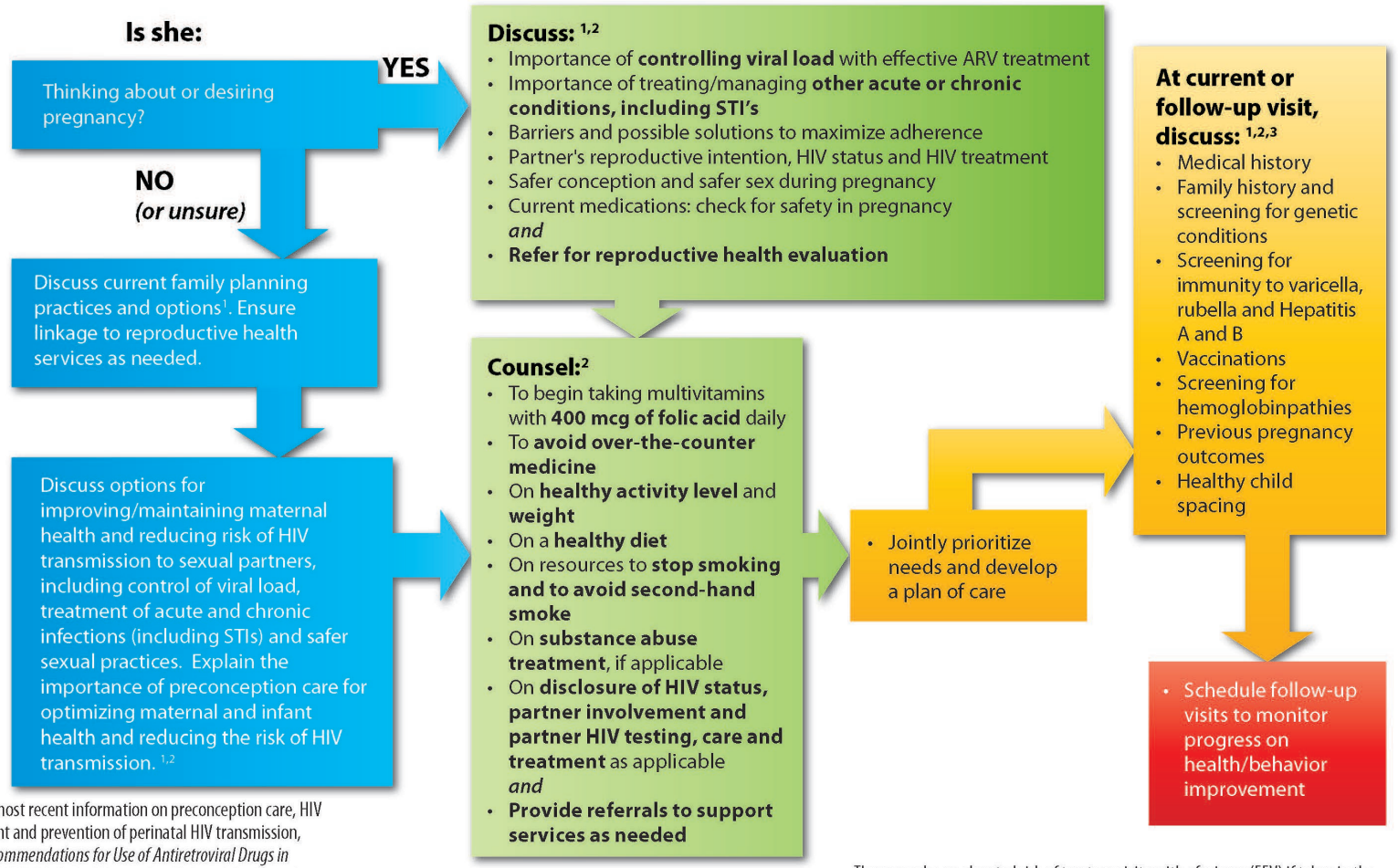
Ongoing education, care, and treatment to improve the health of a person with childbearing potential* before pregnancy. Preconception counseling and care involves identifying and managing conditions and behaviors that could put the person or their child at risk.

For people with HIV, this includes counseling on the risks and benefits of antiretroviral (ARV) drugs to prevent perinatal HIV transmission and to protect the pregnant person's health.

Preconception counseling may include advising a partner with HIV on how to prevent HIV transmission to a partner with childbearing potential before and during pregnancy.

*https://clinicalinfo.hiv.gov/en/glossary/preconception-counseling-and-care Note that original definition used the term "woman" and feminine pronouns, which have been altered on this slide to conform with the most up-to-date inclusive language guidelines.

# Preconception Care Algorithm for Women Living with HIV




1 For the most recent information on preconception care, HIV treatment and prevention of perinatal HIV transmission, see *"Recommendations for Use of Antiretroviral Drugs in Pregnant HIV-1-Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV Transmission in the United States"* available at: www.aidsinfo.nih.gov

2 For general information on evidence-based practices for preconception care for all women, see the Centers for Disease Control and Prevention (CDC) recommendations: *"Preconception Care"* available at: http://www.cdc.gov/ncbddd/preconception

3 When prescribing ART to women of childbearing age consider the regimen's effectiveness for treatment of HIV, an individual's hepatitis B disease status, the drugs' potential for teratogenicity should pregnancy occur and possible adverse outcomes for mother and fetus.

- There may be an elevated risk of teratogenicity with efavirenz (EFV) if taken in the first trimester of pregnancy. Review the most recent guidelines on use of EFV in women of childbearing potential and pregnant women: www.aidsinfo.nih.gov
- There is an elevated risk of hepatic toxicity in pregnant women taking nevirapine (NVP) with CD4 count >250.
- There is an elevated risk of side effects, including pancreatitis and hepatic toxicity in women taking a combination that includes stavudine (d4T) and didanosine (ddI).

Revised 8/15/12

EMCT_Algorithm_Providers.pdf (fxbcenter.org)

# Key Activities of PCC*

1. Discuss reproductive desires and plans with all persons with HIV of childbearing potential on an ongoing basis throughout the course of their care.
2. Provide information about effective and appropriate contraceptive methods to people who do not currently desire pregnancy.
3. Offer all contraceptive methods or refer for contraceptive services.
    - Individuals with HIV can use all available contraceptive methods (e.g., pill, patch ring, injection, implant); however, the presence of other medical co-morbidities and drug interactions between hormonal contraceptives, antiretroviral (ARV) drugs, and other medications should be considered.

*As noted in Prepregnancy Counseling and Care for Persons of Childbearing Age with HIV. (Note some formatting changes to accommodate the use of these guidelines to fit slides). https://clinicalinfo.hiv.gov/en/guidelines/perinatal/prepregnancy-counseling-childbearing-age-overview?view=full

# Key Activities of PCC (continued)

4. During pre-pregnancy counseling
    - provide information on safer sex;
    - screen for sexually transmitted infections
    - ask about the use of alcohol, nicotine products, and other substances;
    - provide or refer to evidence-based interventions for substance use disorder, including medication-assisted treatment for opiate use disorder (e.g., methadone, buprenorphine);
    - and counsel patients on how to manage health risks (e.g., access to a syringe services program) when indicated

# Key Activities of PCC (continued)

5. Provide education and counseling about interventions to prevent perinatal **HIV** transmission, including antiretroviral therapy (ART).

   - Explain that persons with HIV should attain maximum viral suppression before attempting conception, for their own health, to prevent sexual HIV transmission to partners without HIV**,** and to minimize the risk of *in utero* HIV transmission to the infant**.**

   - When fully suppressive ART is started before pregnancy and undetectable viral load is maintained throughout pregnancy and at delivery, there is no risk of HIV transmission to the infant.

# Key Activities of PCC (continued)

6. For people with HIV who are considering or planning a pregnancy, begin to provide patient-centered, evidence-based counseling to support shared decision making about infant feeding.

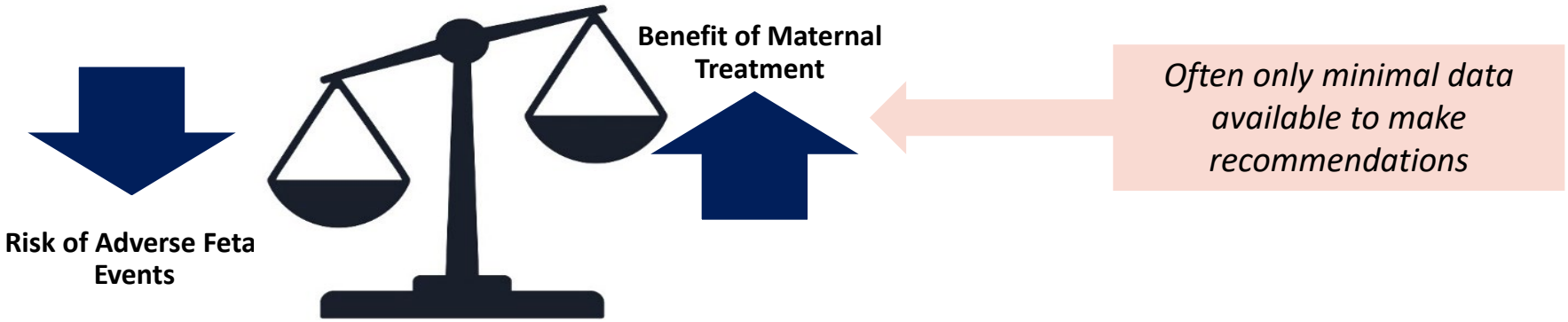
   - Information and plans for infant feeding should be reviewed throughout pregnancy and again after delivery.

7. When selecting or evaluating an ARV regimen for persons of childbearing potential with HIV, consider a regimen's effectiveness, a person's hepatitis B status, and the possible adverse outcomes for the pregnant person and their fetus.

   - The Panel on Treatment of HIV During Pregnancy and Prevention of Perinatal Transmission emphasizes the importance of counseling and shared decision-making regarding all ARV regimens for persons with HIV.

See Infant Feeding for Individuals with HIV in the United States And see Teratogenicity and Recommendations for Use of Antiretroviral Drugs During Pregnancy: Overview.

# ARV Medication Considerations During Pregnancy: A Balancing Act




**Efficacy data:** generally established from trials in nonpregnant individuals[1,2]

**Pharmacokinetic data:** monitoring drug levels especially during the second and third trimesters of pregnancy[3]

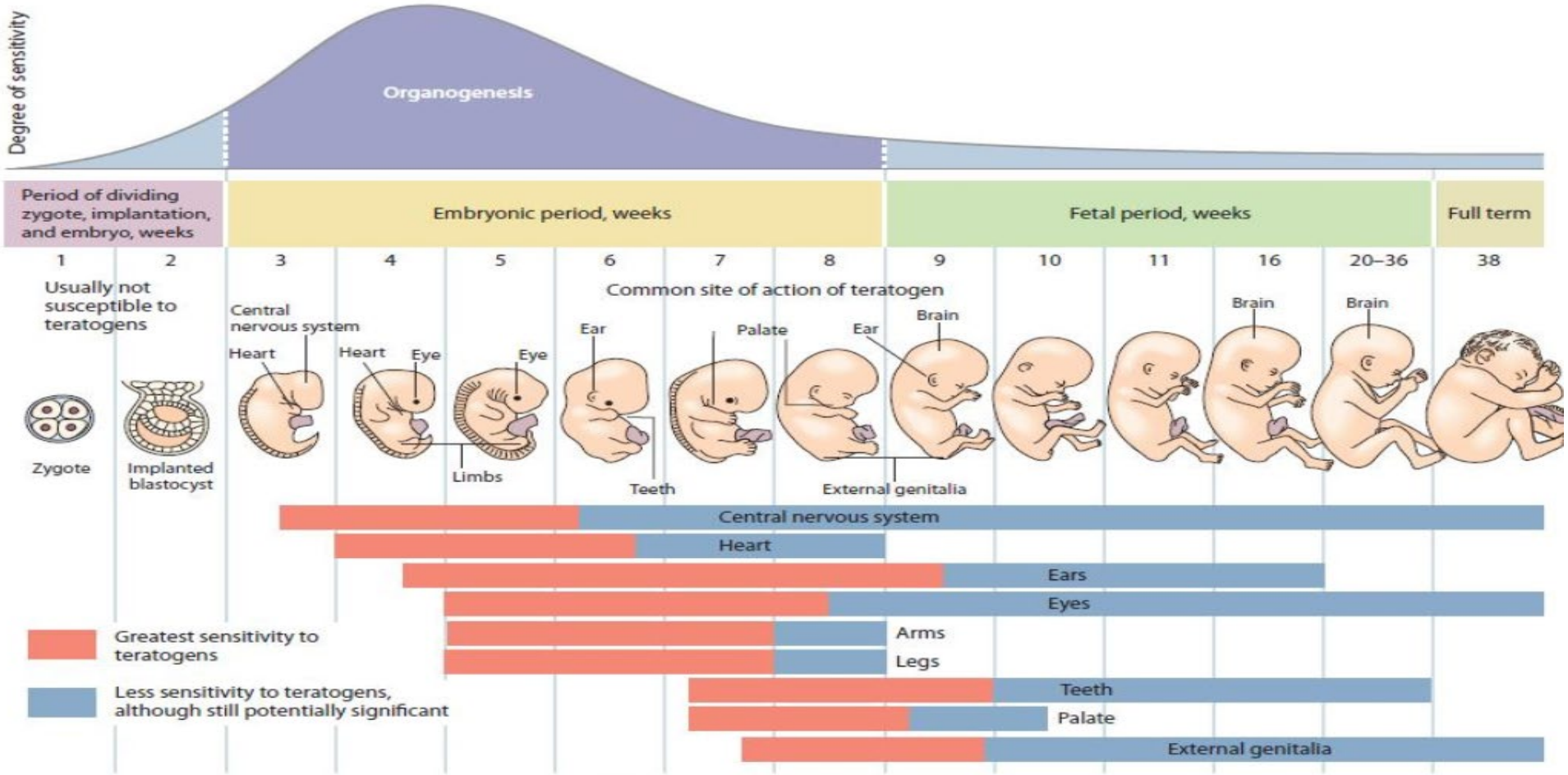
**Safety data:** evaluating birth defects and adverse maternal or pregnancy outcomes[2,3]

1. Pepperrell. J Virus Erad. 2020;6:70. 2. Mofenson. J Int AIDS Soc. 2019;22:e25352. 3. Colbers. Clin Infect Dis. 2019;69:1254.

# Timing of In Utero Drug Exposure and Fetal Risk of Birth Defects

Periods of Fetal Development

Periods of Teratogenic Risk



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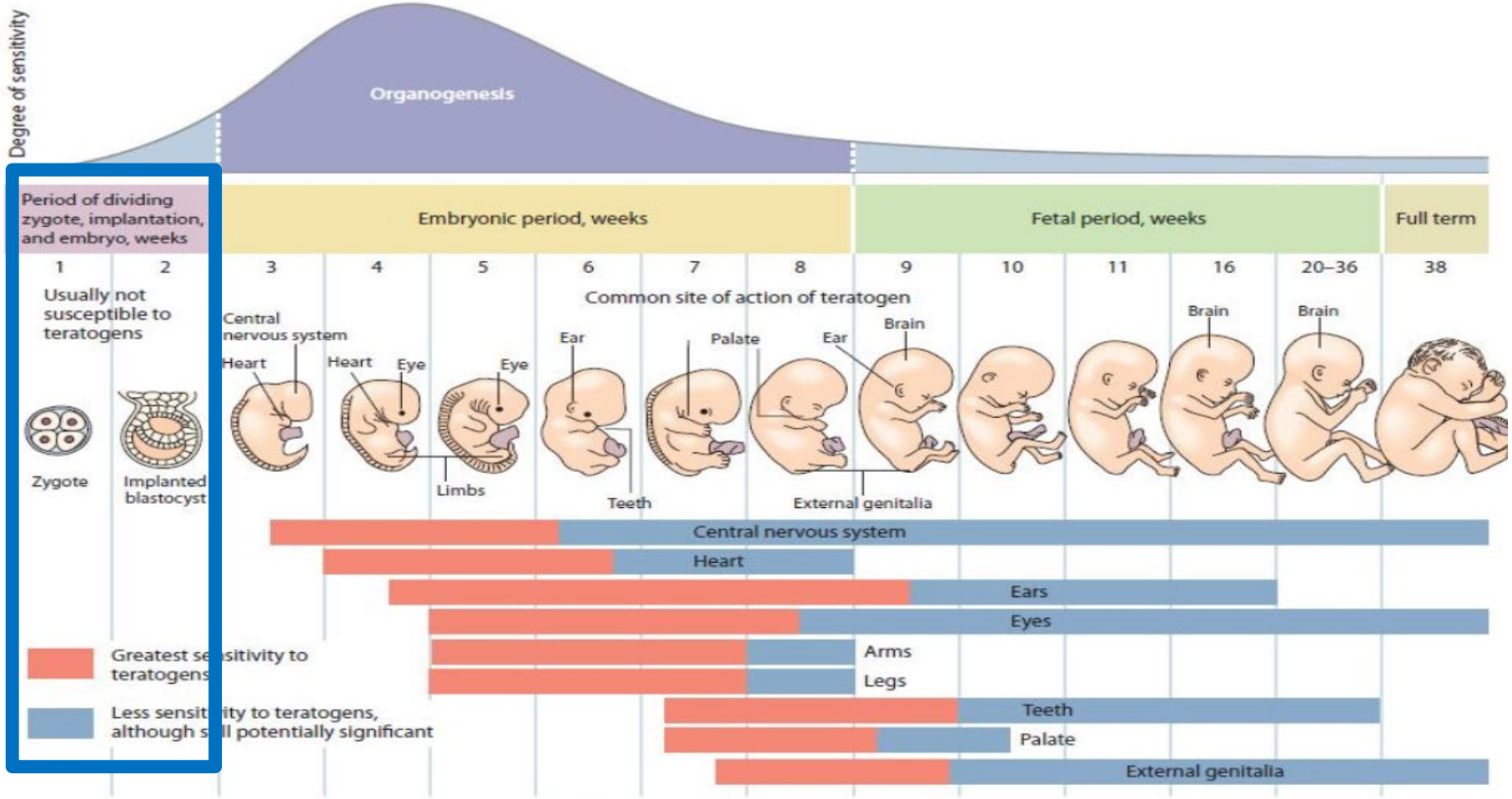
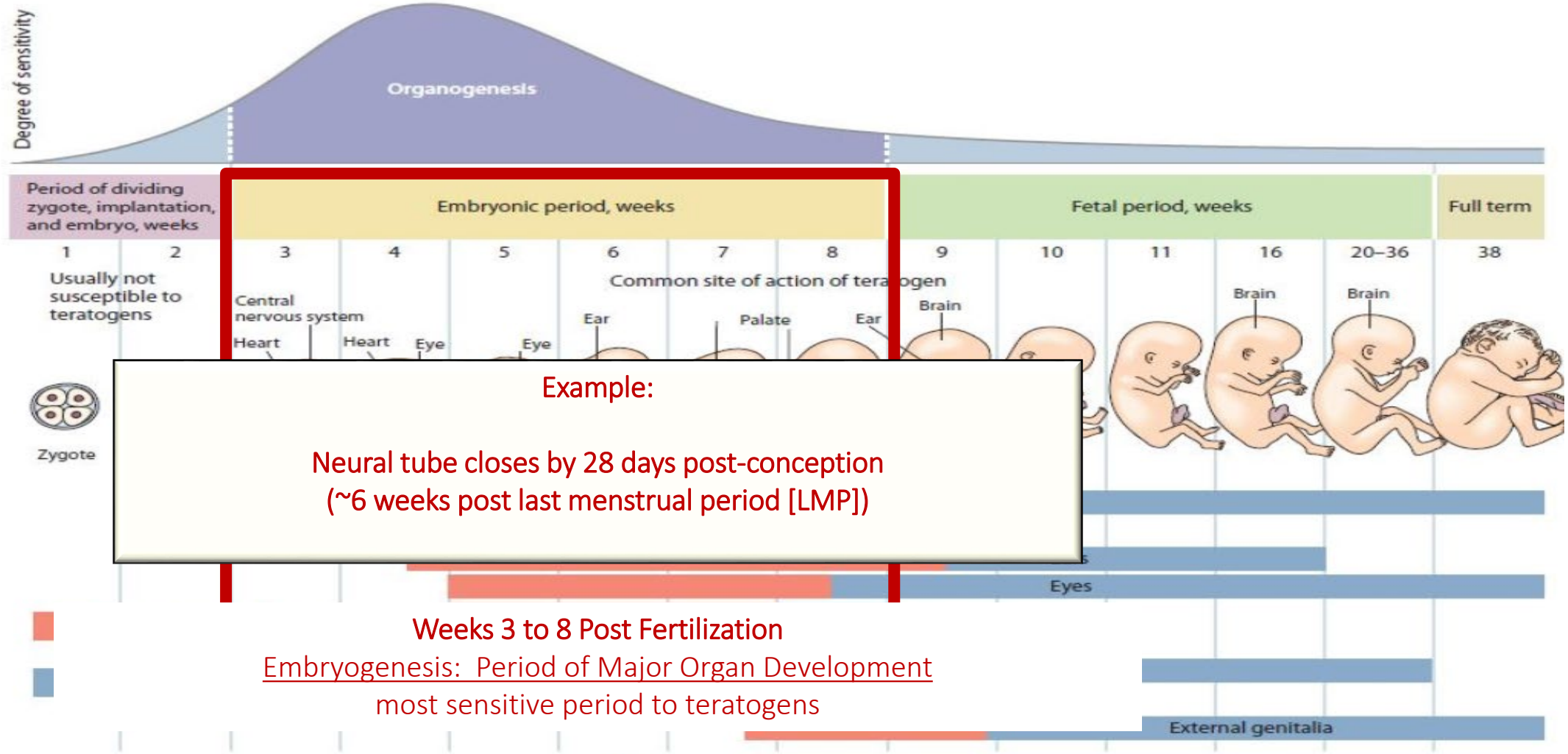



First 2.5 Weeks Post-Fertilization:

Pre-Organogenic Period

Unknown sensitivity to teratogens

# Timing of In Utero Drug Exposure and Fetal Risk of Birth Defects




Periods of Fetal Development

Periods of Teratogenic Risk

Example:

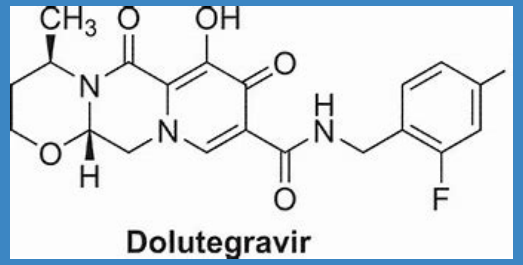
Neural tube closes by 28 days post-conception
(~6 weeks post last menstrual period [LMP])

Weeks 3 to 8 Post Fertilization

Embryogenesis: Period of Major Organ Development

most sensitive period to teratogens

# The Preconception Dolutegravir Story




CDC promotional logo; all others Microsoft stock images

# Botswana Tsepamo Study – Birth Defect Surveillance

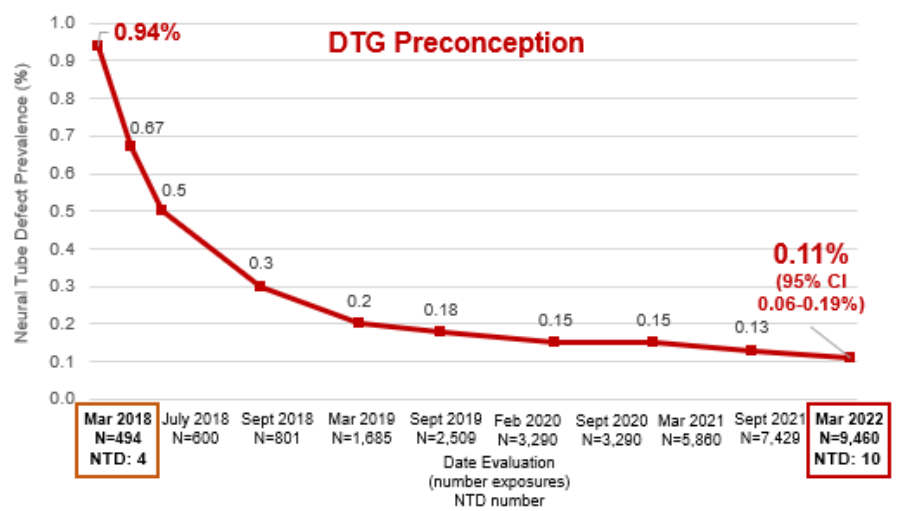
*Zash R et al. N Engl J Med 2018;379:979-81*

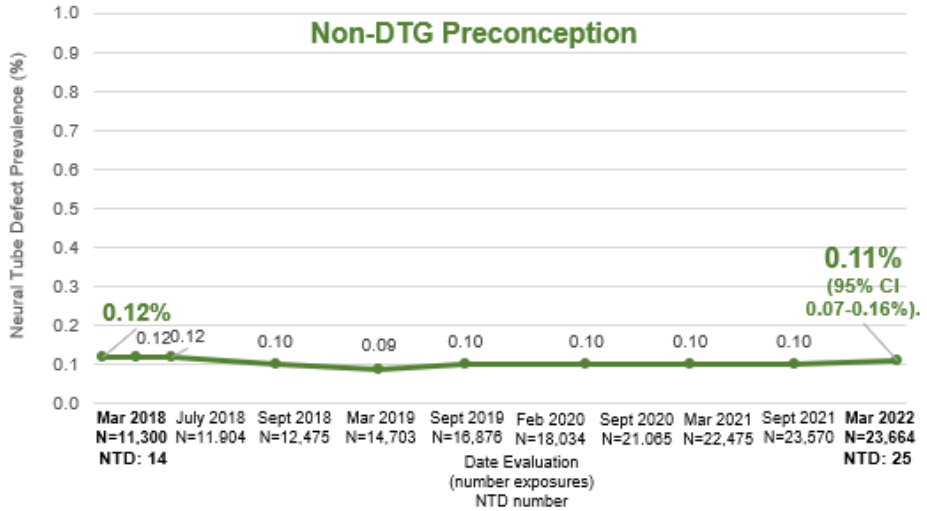
- Designed to evaluate the *risk of neural tube defects (NTD) with preconception **EFV** exposure*
- Prospective birth outcomes surveillance for major surface birth defects, 8 large maternity wards, population-based (45% of Botswana births) (increased sites, now cover 70% births)
  - Trained hospital-based midwifes surface exam
  - Research assistant consent mother for photo
  - Medical geneticist reviews blinded to exposure

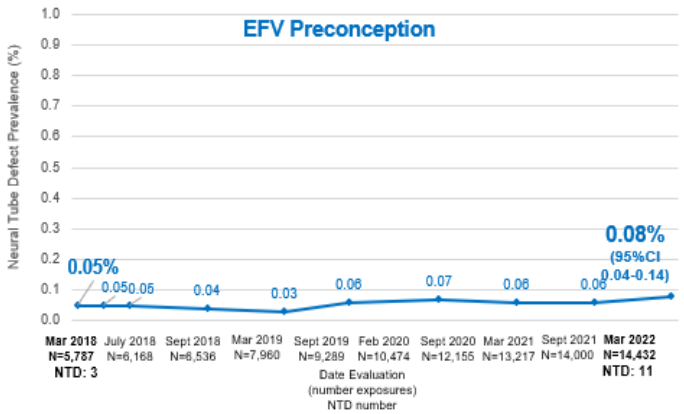
- 2016 national guidelines changed to dolutegravir for 1st line ART, allowing comparison
- Good denominator with control groups and ability to distinguish between ARV regimens
  - Pregnant without HIV
  - Pregnant with HIV on ART preconception or started in pregnancy

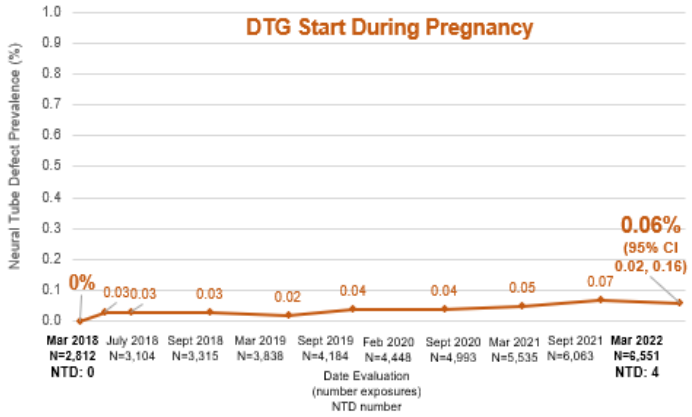
# Tsepamo: Evolution of NTD Prevalence Over Time

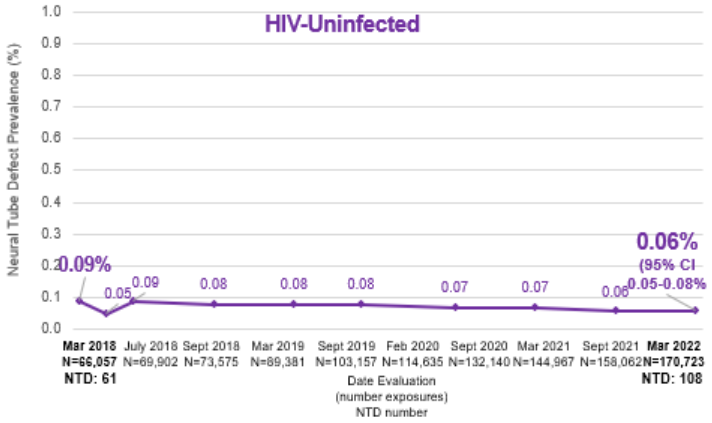
## July 2022



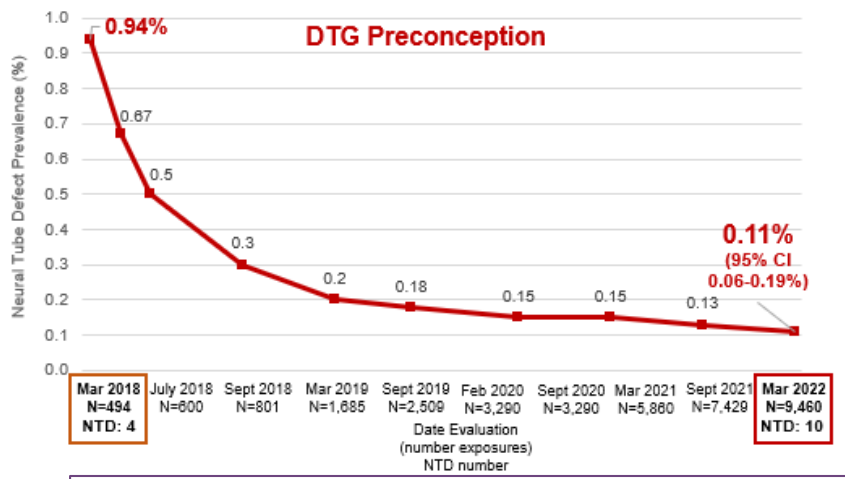



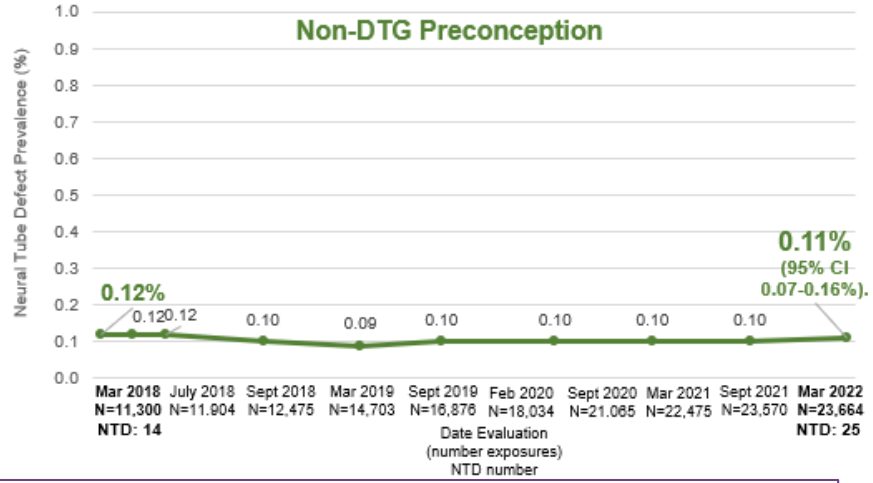




*Zash R et al. AIDS 2022, Montreal, Canada, Abs. PELBB02*

# Tsepamo: Evolution of NTD Prevalence Over Time

## July 2022





→The prevalence of NTD in infants born to women on DTG at conception has **declined to 0.11% and does not substantially differ from other exposure groups**.

*Zash R et al. AIDS 2022, Montreal, Canada, Abs. PELBB02*

# Addressing PCC Challenges

## Strategies and Approaches to Address Challenges:

- Lack of standardized policies, procedures and workflows re: PCC
- Lack of regular PCC (e.g., only at initial visit)
- Not all staff see PCC as something they should be concerned about (e.g., only some medical providers provide PCC; non-medical staff not included or trained on PCC; not all staff feel comfortable discussing PCC
- Referrals to external collaborators for contraceptive and/or pregnancy care lack feedback

# Integrating PCC into HIV Care

## Strategies and Approaches

- Provide comprehensive medical care to person of childbearing potential
- Provide education at any patient encounter with nonpregnant person with reproductive potential
- Can occur several times during the reproductive lifespan
- Provide family planning services/integrate into HIV clinics or provide appropriate referrals
- Can be done in conjunction with referral to reproductive endocrinology for infertility evaluation/treatment

Penn Medicine

# Questions?

# PCC Resources and References

- Preconception counseling for women living with HIV infection
- Preconception care for people living with HIV recommendations for advancing implementation
- Models of HIV Preconception Care and Key Elements Influencing These Services: Findings from Healthcare Providers in Seven US Cities
- Preconception counseling checklist
- Pre-pregnancy Counseling | ACOG
- Pre-pregnancy Counseling and Care for Persons of Childbearing Age With HIV
- Overview | NIH (hiv.gov)
- Reproductive Health National Training Center
- National MCH Workforce Development Center
- Antiretroviral Pregnancy Registry
- MCH
- National Preconception Health and Health Care's Preconception CoIIN
- Providers' perspectives on preconception counseling and safer contraception for HIV infected women
- A systematic review of women's and health professional's attitudes and experience of preconception care
- Preconception Care Algorithm for Women Living with HIV
- University of Liverpool's HIV Drug Interactions Checker

*FY 2023 DCHAP Chart Review guidelines will be available to Preconception Counseling CoP participants via a HRSA WICY MS Teams Channel site.*

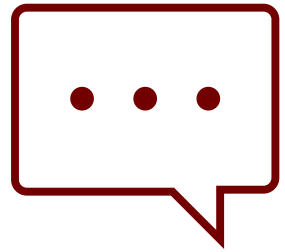
# Learning Session 2 - Satisfaction Poll

How satisfied were you with the information presented in this Learning Session?

- Very Satisfied
- Satisfied
- Somewhat Satisfied
- Dissatisfied
- Very Dissatisfied

I expect to use the information presented during this Learning Session to enhance the care provided to women, infants, children, and youth served by our organization.

- Strongly Agree
- Agree
- Somewhat Agree
- Disagree
- Strongly Disagree




ATTENTION

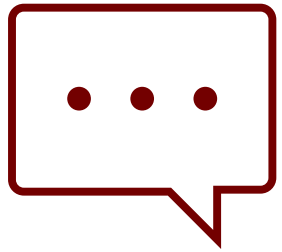
# Interactive Breakout Sessions – 20 minutes

- Key players in the provision of PCC
- Cultural competency and PCC
- PCC in a collaborative setting
- Barriers to providing PCC
- Electronic health records and PCC

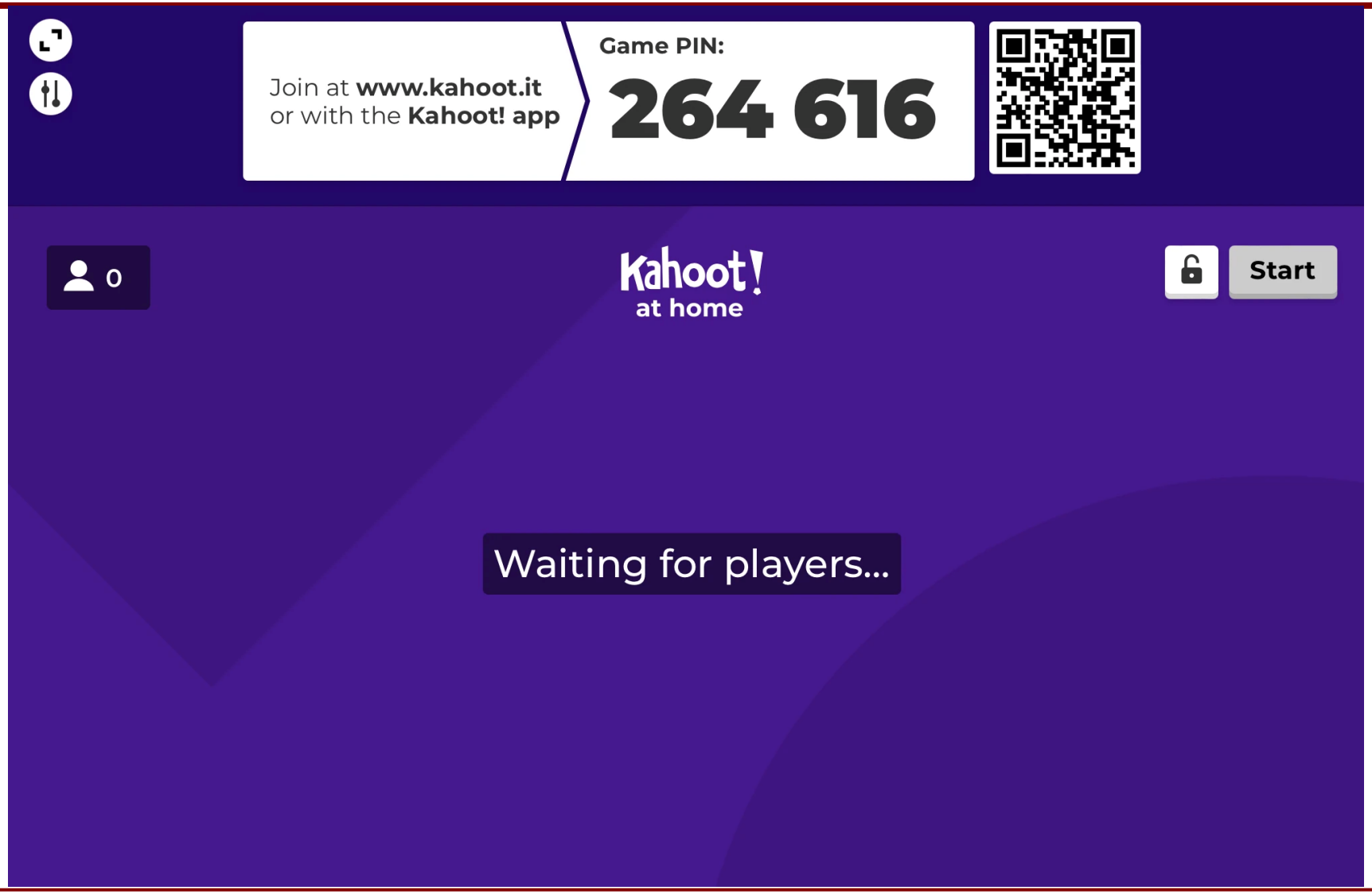
# Chat Check-in

When reviewing the 5 client charts during your Learning Session 2 pre-work, how many charts documented that PCC was addressed during the most recent visit?

A. All of them
B. 3 - 4
C. 1 - 2
D. None of them


# Key Players in the Provision of PCC - Kahoot



# Key Players in the Provision of PCC

ENHANCING HIV CARE
WOMEN, INFANTS, CHILDREN, AND YOUTH (WICY)

This chart and the questions below will be presented in a kahoot format.

- Who currently administers PCC at your facility?
- Can you identify additional staff members who can assist in the administration of PCC?

| PCC components | Type of provider: OB/GYN | HIV or primary care provider (including mid-level provider[a]) | Nurse | Midwife | Lay counselor |
|---|---|---|---|---|---|
| Assess childbearing plans/desires | X | X | X | X | X |
| Assess partner HIV status, including HIV testing | X | X | X | X | X (rapid tests) |
| Screen for and counsel re: drug, alcohol, smoking, and effect on pregnancy | X | X | X | X | X |
| Screen for depression/abuse | X | X | X | X | X |
| Counsel re: importance of planned childbearing | X | X | X | X | X |
| Counsel re: HIV and pregnancy | X | X | X | X | X |
| Counsel re: contraceptive options | X | X | X | X | X |
| Counsel re: ART/PrEP as prevention | X | X | X | X | X |
| Counsel re: other safer conception strategies, e.g., timed intercourse, home insemination | X | X | X | X | X |
| Counsel re: medical/surgical and obstetrical/gyn history re: effect on pregnancy/pregnancy outcome | X | | | | |
| Counsel re: medications in pregnancy and possible adverse effects on fetus | X | X[b] | | | |
| Comprehensive HIV, medical and reproductive history | X | X | | | |
| Provide contraception | All (including implant, IUD, tubal sterilization, Essure) | Condoms, combined oral, patch, ring; DMPA | Condoms[c] | Condoms[c] | Condoms[c] |
| Implement ART | | X[d] | X[e] | X[e] | |
| STI screening/semen analysis | X | X | | | |
| Optimize medical conditions prior to conception | X | X | | | |
| Implement PrEP[f] | X | X | | | |
| Discuss/manage infertility | X | | | | |

Take a moment to consider a team-based approach to PCC. In your facility, how might that change the way PCC is administered? Define some benefits to this type of approach.

Preconception Counseling is often most effective when there is a staff member who identifies as the office champion. Is there a person(s) on staff who can become that champion?

PCC, preconception care; OB/GYN, obstetrician and gynecologist; ART, antiretroviral therapy; PEP, post-exposure prophylaxis; STI, sexually transmitted infections; IUD, intrauterine device; DMPA, Depo medroxyprogesterone acetate

[a]Includes clinical/medical officers, advanced practice nurses, physician assistants.
[b]With appropriate training, HIV providers could address impact of ART during pregnancy.
[c]In some low-resource settings, nurses and midwives have been trained in IUD insertion and lay workers may be involved with community distribution of contraceptives, especially pills.
[d]The HIV provider may also be the patient's primary care provider (PCP), but as HIV treatment has increased in complexity, many PCPs do not feel comfortable prescribing and monitoring ART.
[e]In many low-resource settings, generally with limited first-line treatment options, nurse-prescribed ART is allowed. Midwives would generally only prescribe ART during pregnancy.
[f]These strategies are not yet widely available in low-resource settings.

# Cultural Competency and PCC

- Which population within your community has the most difficulty accessing PCC and/or sexual health services? What barriers to help-seeking exist within this population? Consider barriers that fall under the following:
  - Behavioral
  - Cultural
  - Political
  - Socioeconomic
- In what ways are you creating low barrier access to populations that lack connection to PCC and/or sexual health services within your community?
- How are you engaging with populations that may feel ambivalent or uncertain about receiving PCC/SH care due to negative experiences with health care/providers (i.e., medical racism)? How are you making your organization a safe space for these populations?
- Refer to the table:
  - Can you identify any provider bias/attitudes that may influence lack of competency, humility and responsiveness to providing PCC? What about issues relating to gender diversity? How do you/will you address provider bias?
  - Considering all the "identities" listed in the table, how does your identity influence your interactions with clients receiving PCC?
  - What is one example where an element of your identity had a positive impact on your interaction with a client? Negative impact? Share your experience.

| | | |
|---|---|---|
| Race | Religion/ Spiritual Belief | Sexual Orientation |
| Ethnicity | National Origin | Language |
| Gender | Ability (Disability) | Appearance (Body Size/Type) |
| Sex | Socio-Economic Class | Age Group |
| Military | Recovery | Other |

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# PCC in a Collaborative Setting

Using Jamboard, please provide short responses to the following question:

1. What key elements makes collaboration between partners more effective? (i.e., MOUs, team meetings)

2. What are the barriers you face in implementing some of these key elements for effective collaboration?
   - Are there different barriers for external or internal collaborators?

3. What are some strategies you have developed to implement effective collaboration with external collaborators, particularly sub-recipients?

| KEY ELEMENTS FOR EFFECTIVE PCC COLLABORATION | | |
|---|---|---|
| Creating a shared vision for PCC | Identifying champions among collaborators | Developing shared expectations and MOUs |
| Establishing data exchange / EHR (referrals, etc.) | Convening collaborators with a regular cadence | Training and TA for collaborator staff re: PCC |
| Including collaborators in process improvement | Sharing materials (protocols, templates, checklists, prompts, collateral material) | Developing financial agreements if necessary |
| Developing communication strategies | Developing shared outreach and referral strategies | **Your ideas?** |

# Barriers to Providing PCC

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Mentimeter will be used to generate a word cloud based on answers to the following questions:

1. What do you think is the greatest barrier for Providers in the delivery of comprehensive PCC?
2. What do you think is the greatest barrier for patients receiving PCC?


- Facilitator will address each word in the cloud and ask recipients to elaborate on their answers.
- Following the discussion, the facilitator will share the findings from Models of HIV Preconception Care and Key Elements Influencing These Services: Seven US Cities

# Electronic Health Records and PCC

Using Mentimeter please answer these poll questions:

1. Do EHR barriers show up in your fishbone diagram?
   - Yes, in procedures
   - Yes, under people
   - Yes, under both people and procedures
   - No, our EHR is not a barrier
   - What's a fishbone diagram?

2. Are you able to share any information from EHRs among/between collaborators?
   - Yes, we can share data among internal collaborators
   - Yes, we have figured out some workarounds to share limited data with external collaborators
   - No, that would probably take an act of God
   - No, but we're working on it

3. Which EHR system does your program use? (name of program)
4. Which features in your EHR system best support providing PCC to patients?

# Group Report Backs

Please provide a 90 second summary of the key points discussed in your group:

- Key players in the provision of PCC
- Cultural competency and PCC
- PCC in a collaborative setting
- Barriers to providing PCC
- Electronic health records and PCC

# Continue the Conversation on MS Teams

- Have you joined the DCHAP CoP MS Teams Channel?
- Look for the 5 discussion threads
  - Key players in the provision of PCC
  - Cultural competency and PCC
  - PCC in a collaborative setting
  - Barriers to providing PCC
  - Electronic health records and PCC
- Share resources, continue the conversation, ask questions!!

# Participant Evaluation & Upcoming Events



- Summer TA Series – July and August 2023

- Learning Session #3 – September 20, 2023

# Upcoming Events

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## CoP Learning Sessions and Action Periods (tentative dates)

- **July through August 2023** – Action Period #1 (PDSA specific activities, data collection and analysis)
- **September 20, 2023** – **Learning Session #3**
- **October through November 2023** – Action Period #2 (PDSA specific activities, data collection and analysis)
- **December 20, 2023** – **Learning Session #4** – Peer-to-Peer report out/combined summary session
- **January 2024** – Action Period #3 (PDSA specific activities, data collection and analysis)
- **February 21, 2024** – **Learning Session #5** - Final Presentations from each CoP Core Team

Leadership Check-in Calls with the Bizzell Team will be scheduled and occur monthly.

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# See you in the next session!