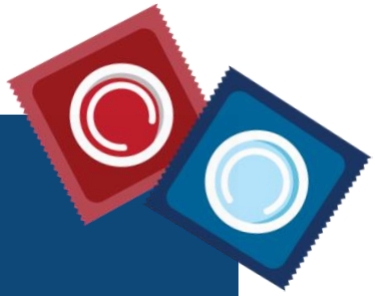
ENHANCING HIV CARE

WOMEN, INFANTS, CHILDREN, AND YOUTH (WICY)



Preconception Counseling, including Sexual Health Toolkit

2024

HRSA

Health Resources & Services Administration

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Table of Contents

Key Abbreviations and Definitions

U.S. Department of Health and Human Services (DHHS): Cabinet-level government department whose mission is to enhance the health and well-being of all Americans by providing effective health and human services and by fostering sound, sustained advances in the sciences underlying medicine, public health, and social services.

Health Resources and Services Administration (HRSA): Federal agency whose mission is to improve health outcomes and achieve health equity through access to quality services, a skilled health workforce, and innovative, high-value programs.

HRSA HIV/AIDS Bureau (HAB): Federal agency that administers the Ryan White HIV/AIDS Program.

Ryan White HIV/AIDS Program (RWHAP): A federal program that provides a comprehensive system of HIV primary medical care, essential support services, and medications for low-income people with HIV who are uninsured and underserved.

RWHAP Provider: An organization that receives RWHAP funding, either directly from HRSA HAB or from a RWHAP recipient, to provide direct care to people with HIV.

RWHAP Recipient: An organization funded directly by HRSA HAB through the RWHAP.

Driver Diagram: Visual planning tool that identifies and displays the relationship between your goal, the drivers (factors) and changes being tested.

Electronic Health Record (EHR): A digital version of a patient's paper chart.

Plan-Do-Study-Act (PDSA) Cycle: Iterative, four-stage problem solving model used for improving process or implementing a change.

Preconception Counseling, Including Sexual Health (PCC): Education, treatment, and care to ensure optimal pregnancy and fetal/newborn outcomes for people with reproductive potential who also have HIV.

SMART Goal: Goal that meets five criteria: Specific, Measurable, Achievable, Relevant, and Time-bound.

Whole Person Healthcare: A person-centered, integrated approach to health care that focuses on health creation and well-being by incorporating patients' goals into their health care (National Academies).

Introduction

Welcome to the Preconception Counseling, Including Sexual Health (PCC) Toolkit

This toolkit is designed for healthcare programs that work with people with reproductive potential with HIV. It provides a blueprint for identifying and implementing changes and improvements to how PCC is delivered to people with HIV. The toolkit is organized around the following components:

- **Assembling Your Quality Improvement Team and Completing a Needs Assessment**
- **Setting Improvement Goals and Identifying Benchmarks**
- **Improvement Goal Refinement and Implementation Planning**
- **Implementation, Evaluation, and Iteration**
- **Lessons Learned and Best Practices from the CoP**

In this toolkit, PCC refers to preconception counseling that fully integrates sexual health counseling.

Effective PCC helps people with reproductive potential with HIV make informed decisions about future pregnancies and ensures the health of the birthing parent and baby. Additionally, counseling focused on sexual health, such as taking and documenting a sexual health history, the use of barrier methods like consistent condom use, and routine testing for sexually transmitted infections, promotes healthier pregnancies among people with HIV.

Nearly half of people with HIV have a desire to start a family.[i,ii] Yet among people with HIV, there is a high prevalence of unplanned pregnancies and low contraceptive use.[iii] Despite the benefits of PCC for people with HIV and their children, it has not been widely integrated into HIV care. People with HIV may be unaware of the need for and relevance of PCC. Some do not realize their primary care provider can provide PCC and assume they need a referral to a specialist.[iv, v] Studies have found that people with HIV often avoid conversations with providers about their reproductive desires to avoid stigma, negative attitudes, disapproval, and conversations on contraception instead of conception.[vi, vii] Providers often face their own set of barriers. A combination of stigma, limited time, knowledge, and specialization prevent routine and consistent PCC.[viii, ix]

The process and strategies outlined in this toolkit were piloted during a 12-month Preconception Counseling including Sexual Health (PCC) Community of Practice (CoP) with 15 Ryan White HIV/AIDS Program (RWHAP) Part D recipients that was funded by the Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB) Division of Community HIV/AIDS Programs (DCHAP). The CoP focused on:

- Increasing the delivery of evidence-based interventions, evidence-informed interventions, and emerging interventions that enhance client outcomes.
- Increasing the skill level of the HIV workforce providing care and treatment to women, infants, children, and youth affected by HIV.
- Involving partner collaboration for dissemination of best practices.
- Implementing breakthrough improvements within each CoP domain.

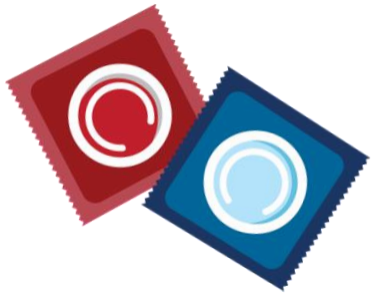
Key PCC Activities

- Discuss reproductive desires/plans with all people with HIV of childbearing potential on an ongoing basis throughout their care.
- Provide education/counseling on perinatal HIV transmission prevention interventions, including safer sex information.
- Take a sexual health history (if not already documented) and conduct STI screening.
- Provide information on effective, appropriate contraceptive methods.
- Offer all contraceptive methods or refer for contraceptive services.

Participants from across the nation came together to collaborate, learn, share ideas and experiences, and support each other in the process of improving their PCC protocols and practices. After piloting changes in practices and protocols, participants reconvened to share and review the success of their pilot strategies. This process was informed by the Institute for Healthcare Improvement (IHI) Breakthrough Series, an evidenced-based model for implementing improvements.

CoP Components

- 5 Learning Sessions
- 3 Action Periods
- 106 Leadership Calls
- Tailored Technical Assistance (TA) via Small and Large Group
- 3 Curated Emails
- Additional TA



- Provide Substance Use Disorder (SUD) focused education during pre-pregnancy counseling such as:
  - Ask about substance use (alcohol, nicotine, and other substances).
  - Provide/refer to evidenced-based SUD interventions (including medication-assisted treatment for opiate use disorder).
  - Counsel on managing health risks (such as access to syringe services) when indicated.
- For those considering pregnancy, provide patient-centered, evidence-based counseling on shared decision-making for infant feeding.
- When selecting/evaluating antiretroviral (ARV) regimens for persons of reproductive potential with HIV, consider the regimen's effectiveness, the person's hepatitis B status, and any potential adverse outcomes for the pregnant person and fetus.
  - Conduct pregnancy testing before initiation of antiretroviral therapy (ART) in all persons of childbearing potential.

Source: Based on Department of Health and Human Services, *Recommendations for the Use of Antiretroviral Drugs During Pregnancy and Interventions to Reduce Perinatal HIV Transmission in the United States: Prepregnancy Counseling and Care for People of Childbearing Age with HIV. Accessed February 5, 2024. Https://clinicalinfo.hiv.gov/en/guidelines/perinatal/prepregnancy-counseling-childbearing-age-overview*

Assembling Your Quality Improvement Team and Completing a Needs Assessment

Steps to Assembling Your Team and Completing a Needs Assessment

1. **Identify stakeholders** from within your organization and among your referral networks.

2. **Convene this team** to brainstorm, discuss, and identify strengths, needs, and gaps in your PCC.

3. **Examine the provision** of PCC within your organization including PCC and related data, relevant site visit findings, trainings, partnerships, and policies and procedures.

As you embark on this process, it is important to assess your organization's challenges and strengths in providing consistent PCC and your readiness to implement changes to improve your program. Engaging core staff in your needs assessment will provide more comprehensive findings. Providing routine and consistent PCC involves clinical and nonclinical staff within your organization and potentially from other providers in your community of care and referral network.

With your team in place, conduct a needs assessment that examines your current performance in providing PCC and identifies your organization's strengths and gaps. Your needs assessment findings will inform the development of goals and strategies to enhance delivery of PCC in your organization.

Potential Team Members

- Management
- Direct service staff
- Clinical staff
- People with lived experience
- Project director or manager
- Case managers
- Quality improvement staff
- Outreach/health education staff

Needs Assessment Focus Areas

- Findings and recommendations from HRSA site visits on PCC-related issues (e.g., cervical cancer screening).
- Steps taken to address findings or other PCC Quality Improvement projects.
- The number of clients seen in the past year and the number who received documented PCC (of all genders).
- Provision of PCC within your organization:
    - PCC models of care
    - PCC policies and procedures
    - PCC tools, protocols, and resources
    - Electronic health record prompts for PCC and related workflows
    - Care plans and PCC documentation
    - Coordination of care and referrals
- Unique partnerships related to PCC and established linkages and referral networks.
- Training for key staff (clinical and non-clinical) in PCC and cultural competence related to PCC.

While all the CoP participants had some policies, procedures, and workflows related to preconception counseling, the depth and breadth of these policies varied widely, from high-performing systems to those with minimal policies and procedures implemented on an irregular basis at best. The needs assessment identified the following findings and trends related to process improvements. Participants needed to:

- Enhance, develop, and implement **clinic-level support tools and resources** that are **provider-driven** (such as workflows, checklists, PCC scripts, and Electronic Health Record (EHR) prompts and templates).
- Establish a **continuous quality improvement** (**CQI**) **process to monitor and track** PCC and sexual health counseling.
- Develop a **comprehensive training program** on PCC for **all staff (clinical and non-clinical)** upon hire and at regular intervals.
- Develop and consistently offer training on **cultural competency in general and in relation to preconception counseling**/pregnancy/fertility/family planning/sexual health.

Setting Improvement Goals and Identifying Benchmarks

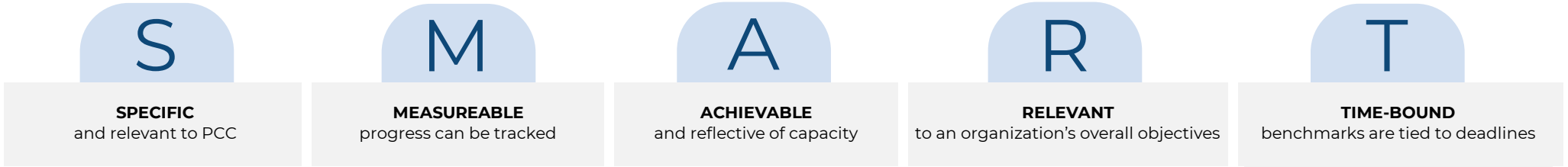
Intentional goal-setting practices position an organization for greater success by identifying specific strategies, benchmarks, and timelines. Effective goal setting allows for relevant data to be gathered and more fully informs the course of improvement.

Identify Potential Goals to Test and Implement

CoP participants used several strategies to identify and develop goals for PCC, that they could test and implement within their organizations. These strategies may apply to your organization as you identify goals that will help you expand or enhance services for PCC.

- Consider any **existing organizational goals** that are relevant to PCC, which could be tested and implemented. One CoP participant had an existing organizational goal to develop a marketing plan for their services. The recipient adapted this goal to focus their marketing and social media outreach on the importance of PCC for people of reproductive potential with HIV.
- Use **relevant and related HRSA Site Visit findings** as a starting point for developing an organizational goal or goals. After receiving findings from site visits, two CoP organizations implemented changes to support more effective PCC (along with pregnancy testing and cervical cancer screening before ARV treatment) as part of their corrective action plans. Their goals included adding PCC prompts and templates to the EHR, along with policies and procedures on how often to conduct PCC.
- Examine any **challenges or gaps in implementing or providing PCC** that emerged from your internal Needs Assessment**.** A common theme among CoP participants was a lack of documentation about how they provided and delivered PCC. Several recipients developed goals to capture this information.

Once a goal has been identified, it should be **S**pecific, **M**easurable, **A**chievable, **R**elevant and **T**ime-bound (**SMART**) to be effective.



S M A R T

Goal Examples

- Use the Electronic Health Record to run reports to confirm that by September 30, 2023, all patients of reproductive potential with HIV are receiving preconception counseling at every visit from staff using the preconception counseling template.
- By June 30, 2023, increase the reach of {the organization} and its clinical partners by developing a marketing campaign, including social media and outreach to increase community members' and clinical providers' awareness of the importance of PCC for individuals of reproductive potential with HIV.
- All providers/staff who see patients of reproductive/childbearing will complete annual expanded preconception counseling education by December 31, 2023.
- Expand the electronic medical records (EMR) template for preconception counseling to include reportable fields such as sex assigned at birth and gender-inclusive identifiers, a provider checklist, and a PCC specific patient questionnaire by September 30, 2023.

Smart Goal Development Case Study

Bond Community Health Center (CHC) is a Federally Qualified Health Center in the Tallahassee, Florida Metropolitan area that serves Leon and surrounding counties. They have provided family-centered comprehensive primary health care services to underserved and vulnerable populations since 1984 and outpatient primary care services for people with HIV since 2001. They are committed to improving services for those with the greatest unmet need and the greatest gap in the HIV care continuum.

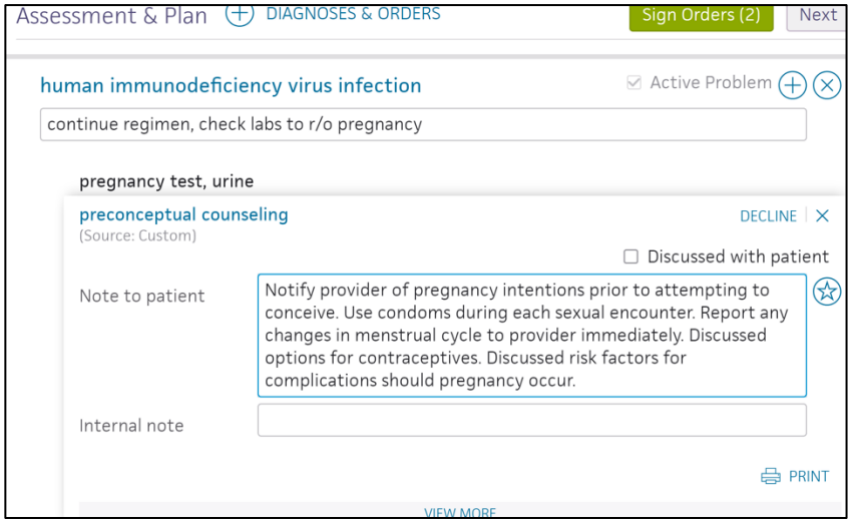
In 2012, Bond CHC received RWHAP Part D funding to provide medical and coordinated support services for the WICY patient population, including preconception counseling and sexual health education for women of childbearing age and youth.

Bond's SMART Goal: *Use Athena [Electronic Health Record system] to run reports to confirm that 100% of patients aged 13 to 48 are receiving preconception counseling at every visit from staff using the preconception counseling template by September 30, 2023.*

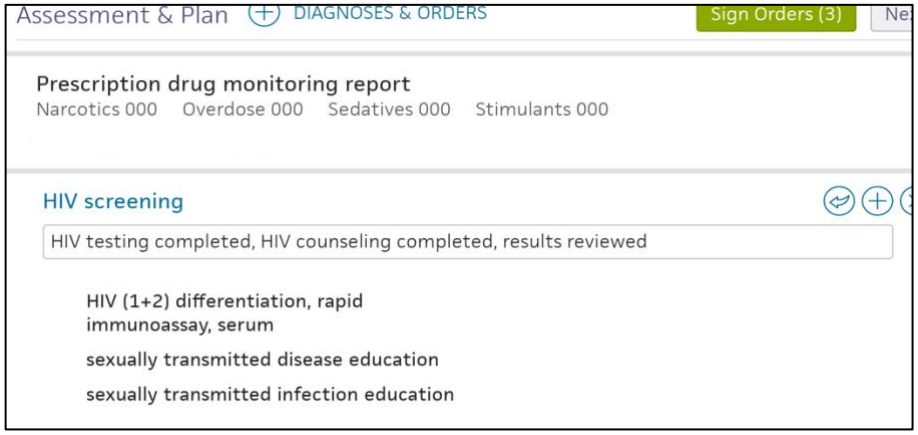
Bond CHC is committed to providing preconception counseling; however, they did not have a method for documenting that staff were providing preconception counseling to clients at every visit. They utilized Athena, an EHR system, and saw an opportunity to establish a process for documenting the provision of PCC within the EHR. This would also enable them to run regular reports to track the provision of preconception counseling to clients. Bond CHC developed a SMART goal to use Athena to run reports to confirm that by September 30, 2023, all clients, aged 13 to 48, were receiving PCC at every visit from staff using a PCC template. To meet this goal, Bond CHC established several steps they would implement during the CoP. These included:

- Creating an Athena-based preconception and sexual health template for clinical staff to use to track PCC at every visit.
- Identifying patients of childbearing age who would receive PCC.
- Training key staff on providing PCC at each visit.
- Running regular reports to assess their success in reaching 100 percent compliance with the goal.

Sample PCC Template Page from EHR



Sample Sexual Health Template Page from EHR



Improvement Goal Refinement and Implementation Planning

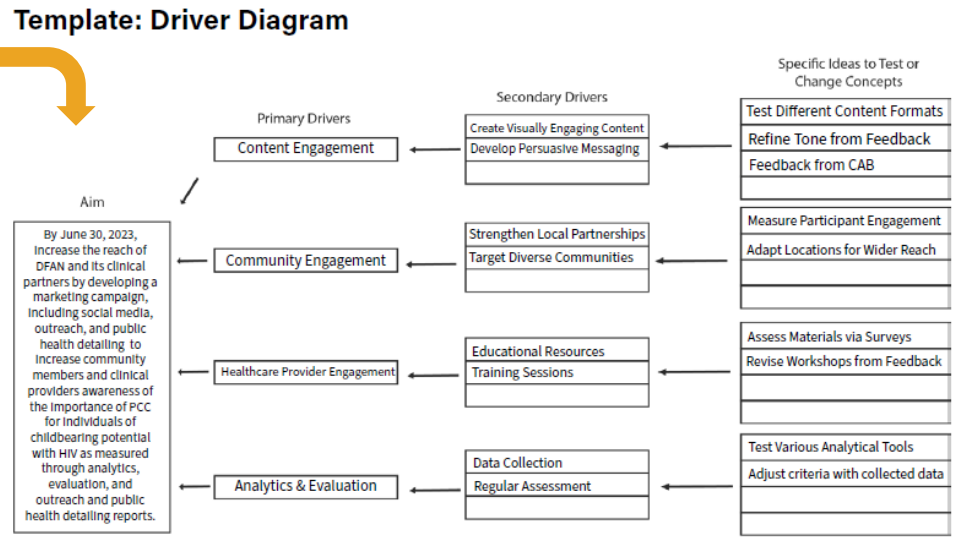
Once you have set your initial SMART goals, planning tools such as a Driver Diagram can help inform and refine the benchmarks and strategies for achieving your goal. You can use the Driver Diagram to identify the primary and secondary drivers (factors) and change ideas that impact the success of your goal. The Driver Diagram also visually displays the relationship between your goal, the drivers, and the changes that you are testing. This can help you communicate a shared goal across stakeholders and potentially help with coordinating initiatives that share drivers. You can review a CoP participant's completed Driver Diagram below and access a link to a blank template here.

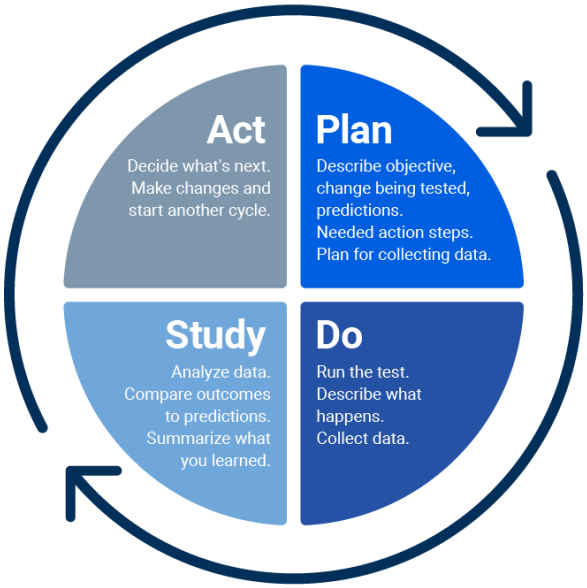
Steps to Goal Refinement and Implementation Planning

1. Use process improvement tools to focus the review and refinement of SMART goals and benchmarks (e.g., Driver Diagram).
2. Craft a process improvement implementation plan (e.g., PDSA model) that includes data collection for tracking improvement.
3. Create and/or provide necessary resources such as:
    - Forms and protocols to structure a change in workflow
    - Expanded staff training
    - Forms and protocols to collect, manage, and assess data
    - Informational or educational collateral
4. Consider relevant lessons learned and best practices that can inform the development and implementation of your PCC goals.

For further information and resources, please explore the Resource Section. There you can find links to a wide range of resources including the Learning Sessions held during this CoP, the IHI Breakthrough Series, and relevant articles, tools, guides, and trainings.

Driver Diagram: University of Texas Southwestern Medical Center's Dallas Family Access Network's (DFAN) example
(Click image to enlarge)





Similarly, a model such as the Institute for Healthcare Improvement's (IHI) Plan, Do, Study, Act Cycle (PDSA) Worksheet provides a structure to your planning, implementation, analysis, and adjustments (click image to enlarge).

Complete a PDSA worksheet for any SMART goal that you established to expand PCC in your organization. Using this tool will help you track your outcomes, adjust your strategies, and make other related improvements. See below for a PDSA Worksheet completed by a CoP participant whose goal was to deliver two skills-based trainings on PCC-related guidelines. You can access a blank PDSA Worksheet template here.

Template: PDSA Worksheet

Objective:

Deliver two PCC skills trainings based on the ARVT Guidelines By July 31, 2023. Identify existing training, modify, and deliver two online trainings to enhance DFAN and its clinical providers ' skills to provide PCC based on the ARVT Guidelines for individuals with childbearing potential with HIV as measured by pre- and post-evaluations.

1. Plan: Plan the test, including a plan for collecting data.

Questions and predictions:

- How can existing PCC training materials be modified to align with the ARVT Guidelines effectively?
  Will the modified online trainings significantly enhance the skills of DFAN and clinical providers in delivering PCC for individuals with childbearing potential and HIV?
-

Who, what, where, when:

Who: DFAN staff,
What: Modify and deliver two online PCC skills trainings based on the ARVT Guidelines.
When: Training sessions to be conducted by Feb 2024, delays due to staff changes and creation of content
Where: Online training sessions using a chosen platform (Zoom, Microsoft Teams, etc.)

Plan for collecting data:

Pre and Post Training evaluations

2. Do: Run the test on a small scale.

Describe what happened. What data did you collect? What observations did you make?

Revising existing trainings to deliver to our clinical providers. Trainings are expected to be attended by all contracted staff. All three of our subrecipients that provide medical services had representation on PCC Learning Session 2. Share training through social media channels to reach a broader audience.

3. Study: Analyze the results and compare them to your predictions.

Summarize and reflect on what you learned:

Plan to compare pre- and post-training evaluation results to measure the improvement in participants' skills and knowledge.

4. Act: Based on what you learned from the test, make a plan for your next step.

Determine what modifications you should make — adapt, adopt, or abandon:

We plan to adjust based on feed back and recognize participant improvement

Identifying and collecting relevant data is an essential component of monitoring your success in achieving a change of practice. Data collection quantifies the measure of success and potentially informs adjustments, goal modification, and the scope of future staff training (click image to enlarge).

As they refined and implemented their PCC goals through the PDSA cycles, CoP participants received relevant information and links to resources through curated emails and factsheets. Check out these helpful resources:

- Got Data? Why Collecting Preconception Counseling (PCC), including Sexual Health Data Matters
- Partnerships in Preconception Counseling
- Developing Workflows to Support Preconception Counseling and Care

Your goals for process improvement reflect your organization's circumstances and capacity and thus inform the scope and direction of strategies to best affect change.

Within this CoP, strategies focused on improving PCC practices in three main areas:

1 **Improve documentation, data collection, and outcome monitoring.**

- Create and modify EHR templates to capture PCC data.
- Integrate Smart Text/Smart Phrases related to PCC.
- Develop PCC reports from improved EHR data collection.
- Improve clinical EHR workflows.

2 **Build organizational and staff capacity.**

- Assess and/or modify PCC practices, protocols, and workflows.
- Educate and train all staff on PCC.
- Improve referral practices and protocols.
- Train toward cultural competency.

3 **Increase outreach to and education of clients.**

- Create outreach, marketing, and educational materials.
- Engage service populations to inform the scope of materials.

Implementation, Evaluation, and Iteration

While a clear SMART goal coupled with a Driver Diagram provides a strong focus and structure for piloting a change, the short-term and iterative nature of the PDSA model allows for the process to be both flexible and responsive to real time factors. Each "action period" in this iterative process calls for data, relies on assessment, and encourages flexibility and adaptation. The PDSA worksheet allows you to track outcomes and captures the data you will use to evaluate the success of your piloted changes in PCC. Below are three case studies, one for each of the three main areas of focus for improvement.

Improve documentation, data collection, and outcome monitoring.

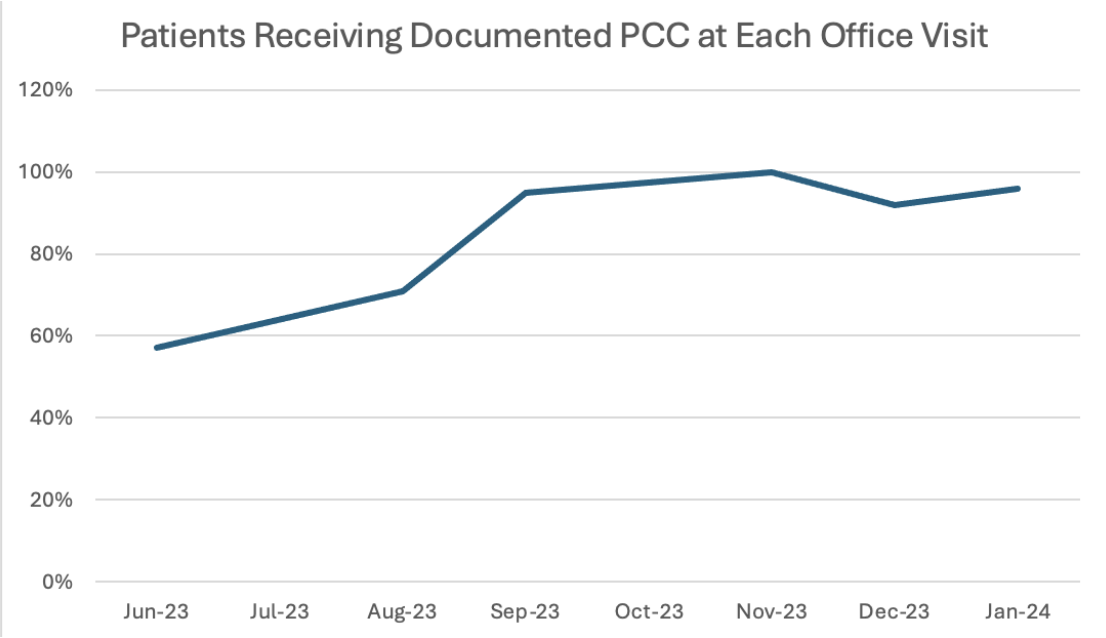
- Create and modify EHR templates to capture PCC data.
- Integrate Smart Text/Smart Phrases related to PCC.
- Develop PCC reports from improved EHR data collection.
- Improve clinical EHR workflows.

Case Study: Bond Community Health Center

In operation since 1972, Bond Clinic became the Bond Community Health Center (Bond CHC) in September 1994 after receiving funding from HRSA. Designated to operate as a Federally Qualified Health Center (FQHC), Bond CHC provides preconception counseling and sexual health education for individuals with reproductive potential and youth. They have an EHR-based preconception and sexual health template for clinical staff use to ensure patient education at every visit.

For their first two action periods, Bond CHC focused on an interrelated set of goals: Use the EHR to run reports to confirm 100 percent of women aged 13 to 48 are receiving PCC at every visit from staff using the PCC template by September 30, 2023, and then also run reports to confirm that the same women are receiving sexual health education at every visit from clinical staff by February 1, 2024.

During the first PDSA cycle, Bond CHC identified women in the specified age range and staff who needed training, provided more consistent education on PCC to clients and providers, and tracked the data. As anticipated, change in practice takes time, so during the second PDSA cycle, while still focused on the same goals, Bond CHC made adjustments. They extended the age range to 50 to reflect the expanded reproductive potential within their clients, revisited and expanded staff training, continued to track data, and campaigned internally to champion the importance of their expanded PCC. Bond CHC presented an overview of their process to the CoP participants as part of the TA Session: Electronic Health Record (EHR) Templates in Preconception Counseling, Including Sexual Health: Lessons from the Field.



Over a nine-month period, this concerted effort produced a significant increase so that by January 2024 Bond CHC went from a 57 percent success rate with delivering PCC to achieve a result of 96 percent of the priority population (see above graphic).

Build Organizational and Staff Capacity

2

- Assess and/or modify PCC practices, protocols, and workflows.
- Educate and train all staff on PCC.
- Improve referral practices and protocols.
- Train toward cultural competency.

Case Study: University of Toledo Medical Center

Since 1984, The University of Toledo Medical Center has been the regional referral center for people with HIV and, through the RWHAP Parts C and D, has developed a multidisciplinary clinic to meet the needs of this growing priority population.

For this CoP, one of University of Toledo's SMART Goals read: 100 percent of all providers/staff affiliated with the Ryan White Part D will complete annual expanded preconception counseling education by December 31, 2023.

During the first PDSA cycle, they completed four tasks in preparation for expanding their PCC educational offerings:

- Identified 12 potential training or educational opportunities.
- Identified five learner audiences: client learners, all staff, clinical staff, non-clinical staff, and providers.
- Reviewed and assessed the 12 opportunities.
- Selected five final choices and assigned them to the appropriate audience.

Informed by this initial work, the second PDSA Cycle focused on formalizing content, delivering the training, and tracking data. University of Toledo developed three competencies associated with whole person healthcare and added these to the training modules for all staff, clinical and non-clinical. The new content was delivered to 100 percent of their program staff.

Increase Outreach to and Education of Clients

3

- Create outreach, marketing, and educational materials.
- Engage service populations to inform scope of materials.

Case Study: University of Texas Southwestern Medical Center's Dallas Family Access Network (DFAN)

UT Southwestern Medical Center's DFAN, within the Community Prevention and Intervention Unit (CPIU), has operated for over 30 years. DFAN serves WICY clients (both cis and transgender) across Dallas and eight surrounding rural counties. In addition to providing medical and support services directly, DFAN subcontracts with other providers: three clinical, one dental, and one supporting transportation needs.

Based on their initial SMART goal, in their PDSA cycle, DFAN proposed to "use social media to cultivate a supportive environment where shared knowledge, open dialogue, and the exchange of best practices will empower community members and clinical providers to recognize the importance of PCC, enabling them to advocate and actively promote its benefits within their respective spheres of influence." In response to immediate challenges posed by staff turnover and the rehiring process, DFAN modified their timeline and strategies to ensure their social media initiative remained on course.

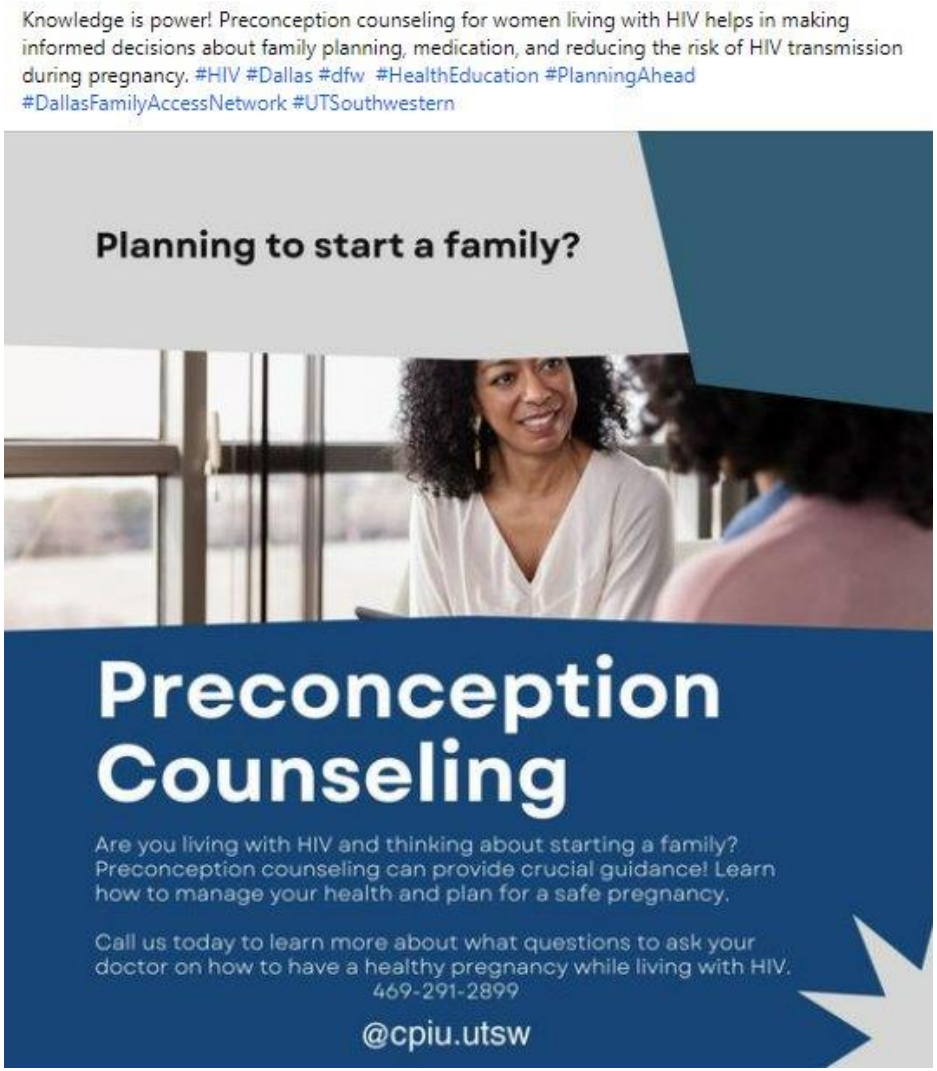
Flexibility and adaptability are recurring themes when implementing any initiative. These characteristics allow a team to better navigate challenges, maximize available resources, and continue making strides toward a relevant goal.

The second installment of Target HIVs Social Media Influencers Series highlighted DFAN's challenges and perseverance (see call out box below).

Target HIV's Social Media Influencers Series provided the following targeted TA and social media tips:

- How to Implement a Social Media Plan
- Challenges of Building a Social Media Presence and Lessons Learned
- Benefits of Social Media

In tandem with each social media post, DFAN notified clinic partners and asked them to amplify the message by sharing on their social media accounts (see right graphic). Per their intent and design, DFAN continues to analyze identified metrics and refine their outreach collateral and strategies based on feedback. Moreover, they are also researching how best to reach providers outside of their clinic partners to inform them about HIV testing and PCC among their patients.



Lessons Learned and Best Practices from the CoP

The process of change depends on effective communication. Transparency and an effective assessment and feedback loop will better ensure success. The toolkit has emphasized flexibility and adaptability as essential to delivering effective and responsive improvements with providing PCC. Below are the lessons learned and best practices as identified by the CoP participants. They are organized by each phase of the implementation process.

Steps to Identifying Lessons Learned and Best Practices

Convene your team to brainstorm, discuss, and identify:

1. Lessons learned during the implementation process.
2. Modifications that would further improve a change in practice.
3. Practice changes that worked well and that should become standardized.
4. Supports or inputs that are needed to sustain a change in practice.

Assembling Your Quality Improvement Team and Completing a Needs Assessment

- Organizations need an in-house champion, along with full buy-in from leadership and clinical providers to support, initiate, and sustain change.
- Resources supporting change management would benefit the process.

Setting Improvement Goals and Identifying Benchmarks

- Process change requires strong planning, acknowledging the complexities, input from across staffing levels, and adaptability.
- Collaboration with clients and partners is essential to improve awareness of PCC and of programmatic supports offered around the community. These collaborations improve quality and continuity of care for all patients in the community (see right graphic). Some strategies include establishing advisory boards and incorporating tech-friendly components like QR codes.
- A useful strategy is to break down a larger goal into smaller goals or steps.

Flyer created by Johns Hopkins University's HIV Women's' Health Program in collaboration with a youth advisory board.

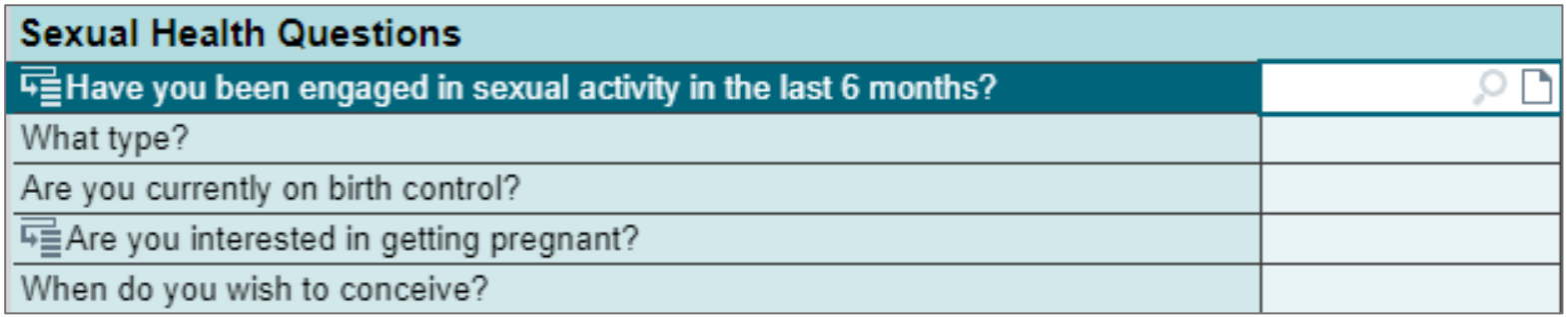
Improvement Goal Refinement and Implementation Planning

Social media post sponsored by DFAN.

- Using a tool such as the Driver Diagram is essential for identifying the drivers or factors throughout the PDSA cycle and action periods.
- Outreach and educational materials benefit from input from service populations and professional designers (see left graphic).
- Staffing turnovers need to be anticipated and inform planning.

Implementation, Evaluation, and Iteration

- As the process of improving PCC is ongoing, the review of forms, templates, and practices should be ongoing as well.
- Staff education and training needs to be coordinated and consistent across all audiences (clinical, non-clinical, providers).
- Staff education and training improved confidence in discussing PCC among staff and with patients.
- Patient-centered and provider-driven tools related to PCC, like EHR prompts, templates, and scripts, are key in capturing individual and aggregate process and outcome data (see graphic below).



Sexual Health Questions	
Have you been engaged in sexual activity in the last 6 months?	
What type?	
Are you currently on birth control?	
Are you interested in getting pregnant?	
When do you wish to conceive?	

Detail of Sexual Health Flowsheet developed by Southeast Mississippi Rural Health.

- Consistent and uniform documentation of PCC is essential for tracking outcomes and assessing benchmarks (see call out box below).

AIDS Care Group is a community-based organization in southeast Pennsylvania that provides testing and treatment for HIV, hepatitis C, sexually transmitted infections, and opioid use disorders. They created an expanded template to include partner history, lab testing plan for PCC, and documentation. They provided training that included use of the new template and data collection plans. They added a template in their EMR with multiple elements including counseling date, sex, age, and diagnostic criteria.

- No-show appointments need to be factored into assessing data and benchmarks. Sometimes there is a need to develop new ways to capture PCC data in existing structures. For example, you might assess data collected via current workflows and consider creating new workflows.

A final step is to review lessons learned and identify what has become an effective practice in providing PCC in your organization. Effective practices may vary across organizations. You are looking for those strategies with the most traction and that work well within your existing capacity. These are the practices you should document, train toward, and use to establish a sustainable standard of care.

Resources

Community of Practice Learning and TA Sessions

- Learning Session 1: *IHI Breakthrough Series* (Video), (Slides): Overview of the IHI Breakthrough Model for Achieving Breakthrough Improvement including the purpose and benefits of various tools.
- Learning Session 2: *What is Preconception Counseling and Why Does it Matter?* (Video), (Slides): Overview of RWHAP Part D program PCC requirements, and key activities, strategies approaches, and resources for integrating PCC into HIV care.
- Learning Session 3 Presentation: *Moving from Theory to Practice: Implementing Pre-Conception Counseling in YourB Program (Video-Recording Unavailable)*, (Slides): Review of the steps to implement effective PCC, including the construction of an action plan and a real-world example.
- Learning Session 4: *CoP Participant Report Out, December 2023* (Video), (Slides): Seven CoP participant presentations on their PCC SMART goal progress, lessons learned, and key takeaways following completion of the CoP.
- Learning Session 5: CoP Participant Report Out, February 2024 (Video), (Slides): Eight CoP participant presentations on their PCC SMART goal progress, lessons learned, and key takeaways following completion of the CoP.
- Technical Assistance Session: Cultural Competency in Preconception Counseling, Including Sexual Health (Video – Passcode: Mj!$3v1r), (Slides)
- Technical Assistance Session: Electronic Health Record (EHR) Templates in Preconception Counseling, Including Sexual Health: Lessons from the Field (Video), (Slides)
- Technical Assistance Session: Social Media Influencer Series: Three-part series providing tips on using social media to engage with people with HIV, specific to the Ryan White HIV/AIDS Program Part D.

Preconception Counseling, Including Sexual Health

Recommendations and Guidelines

- National Preconception Health and Health Care's Preconception CoIIN: HRSA Maternal and Child Health Bureau (MCHB) initiative to develop, implement, and disseminate a woman-centered, clinician-engaged, community-supported approach for a well-woman visit.

- Perinatal HIV Clinical Guidelines - What's New in the Guidelines | Clinicalinfo.HIV.gov: Guidance for HIV care practitioners on the optimal use of antiretroviral agents for treating HIV infection in pregnant people and prevent perinatal transmission.
- Preconception Care for People Living with HIV: Recommendations for Advancing Implementation: Recommendations and key considerations for advancing PCC implementation efforts in both high-resource and low-resource settings.
- Pre-pregnancy Counseling/American College of Obstetricians and Gynecologists: Pre-pregnancy counseling recommendations including considerations for individuals with HIV.
- Prepregnancy Counseling and Care for Persons of Childbearing Age with HIV: Panel on Treatment of HIV in Pregnancy and Prevention of Perinatal Transmission's guidelines on prepregnancy counseling and care that address the specific needs of persons with HIV.
- Recommendations to Improve Preconception Health and Health Care—United States: A Report of the CDC/ATSDR Preconception Care Work Group and the Select Panel on Preconception Care: Ten recommendations to improve both preconception health and care, including specific action steps that can yield results within 2-5 years.

PCC Tools, Checklists, Guides, Training, and Consultation Resources

- A Clinical Practice Guide: What HIV Care Providers Need to Know about HIV Pregnancy Planning to Optimize Preconception Care for their Patients: Guide for primary and specialty care providers working with individuals and/or couples affected by HIV.
- Antiretroviral Pregnancy Registry: Voluntary registry/observational study that collects and evaluates data on outcomes of pregnancy exposures to antiretroviral products. Patients are registered by their health care provider.
- MCH Navigator: Hosts competency-based learning opportunities for professionals and students focused on improving maternal and child health.
- National MCH Workforce Development Center: Trainings, collaborative learning sessions, coaching, and consultations for MCH Title V agencies and organizations.
- PCC Algorithm for Women Living with HIV: Decision tree outlining steps and best practices for patients with HIV who are considering pregnancy and for those who are undecided.

- Perinatal HIV/AIDS | National Clinician Consultation Center: Consultation on all levels of perinatal HIV management from national experts in perinatal HIV care.
- Pocket Guide to Open-Ended Sexual Health Questions | AIDS Education and Training Centers National Coordinating Resource Center: Printable guide on asking open-ended sexual health questions.
- Preconception Counseling Checklist: Checklist for providers to use during preconception counseling and care for educating clients and addressing any modifiable risk factors.
- Preconception Counseling for Women Living with HIV Infection: Downloadable PCC guide with sample scripts, patient questionnaire, provider checklist, PCC algorithm for providers, and a patient leaflet.
- Reproductive Health National Training Center: Go-to source for family planning and adolescent health training and technical assistance.
- Towards Parenthood: Working with You: Canadian HIV Pregnancy Planning website with up-to-date, expert-approved pre-parenting information for people with HIV and care providers.
- University of Liverpool's HIV Drug Interactions Checker: Online tool for checking drug interactions between HIV drugs and co-medications.

Goal Setting and Implementation

- 7.3 SMART and SMARTER goals | CDC: Information on developing SMART goals and examples.

IHI Breakthrough Series Tools and Resources (*Username, email address, and organization information are required to download IHI tools and resources.*)

- Driver Diagram Template: Template for displaying drivers that contribute to the achievement of a project aim. Includes an example of a completed template.
- Institute for Healthcare Improvement (IHI) Resources and Tools: IHI webpage with wide range of tools to help organizations accelerate improvements.
- PDSA Worksheet Template: IHI PDSA test of change template including instructions and completed worksheet example.

- The IHI Breakthrough Series Overview: Highlights the key elements of the IHI Breakthrough series.

Additional Tools, Templates, Guides, and Trainings

- A Guide to Taking a Sexual History | CDC.gov: Framework for discussions about sexual health issues with patients, including discussion questions.
- About CIE | TargetHIV: Center for Innovation and Engagement's catalogue of evidence-informed approaches and interventions to engage people with HIV who are not receiving care, or who are at risk of not continuing to receive care.
- HIV in Pregnancy: Principles of Management and Care in 2022 | AIDS Education and Training Centers National Coordinating Resource Center: Presentation on the safety and efficacy of ART during pregnancy and breastfeeding, HBV/HCV coinfection during pregnancy, current data on intrapartum management, and review of HIV PrEP regimens. *User registration is required to access the recording*.
- Online Learning Curriculum | AIDS Education & Training Center: Free, self-paced training developed by HIV experts to increase healthcare providers' capacity to counsel, diagnose, treat, and medically manage people with HIV. *Enrollment or registration is required to access courses and tools*.
- Resources for Women Living with HIV: Comprehensive guide of programs across New Jersey offering HIV, mental health, substance use disorder, and maternal and child health services.
- Resource Library for Trainers | François-Xavier Bagnoud Center: Toolkit with resources to assist primary care providers with addressing reproductive health and healthcare needs of people with HIV.
- TargetHIV Clinical Quality Management Library: Various tools, resources, trainings, webinars, and conference presentations on quality management.
- The 7 Basic Quality Tools for Process Improvement | American Society for Quality: Templates and resources for the 7 basic tools of quality including the cause-and-effect diagram, check sheet, control chart, and stratification template.
- Using a Fishbone Diagram to Assess and Remedy Barriers to Cervical Cancer Screening in Your Healthcare Setting: Aids Education Training Center's presentation on using a fishbone diagram.

Best Practices Compilation

- Best Practices Compilation Search | TargetHIV: Central repository of RWHAP best practice intervention strategies for engaging people with HIV in care.

Relevant Articles and Studies

- A Nurse-Led Initiative to Improve Implementation of HIV Preconception Care Services: Nurse-led initiative incorporating collaborative strategic planning with staff education and continuous quality improvement to strengthen PCC implementation in a small urban HIV care clinic.
- A Systematic Review of Women's and Health Professional's Attitudes and Experience of Preconception Care: Systematic literature review (2003–2015) examining women and healthcare professionals' perceptions and experiences with preconception care.
- Fertility Desires among Women Living with HIV | PLOS ONE: 2016 study exploring knowledge, attitudes, and practices regarding fertility planning, reproductive desires, and safer conception practices of women with HIV.
- JBI Manual for Evidence Implementation: Overview of the JBI-endorsed approaches to implement evidence into practice.
- Models of HIV Preconception Care and Key Elements Influencing These Services: Findings from Healthcare Providers in Seven US Cities | AIDS Patient Care and STDs: 2018 study examining provider's current PCC models and factors that influenced services.
- Providers' Perspectives on Preconception Counseling and Safer Conception for HIV-Infected Women: 2015 study examining health care providers knowledge, attitudes, and practices in PCC, and safer conception and pregnancy among women with HIV.
- Transforming health care to create whole health: Strategies to assess, scale and spread the whole person approach to health: Study sponsored by the Department of Veteran Affairs, the Samueli Institute, and the Whole Health Institute that is examining the use of a whole healthcare model to improve health outcomes. The study will identify best practices for health systems and strategies for scaling and disseminating whole person care.

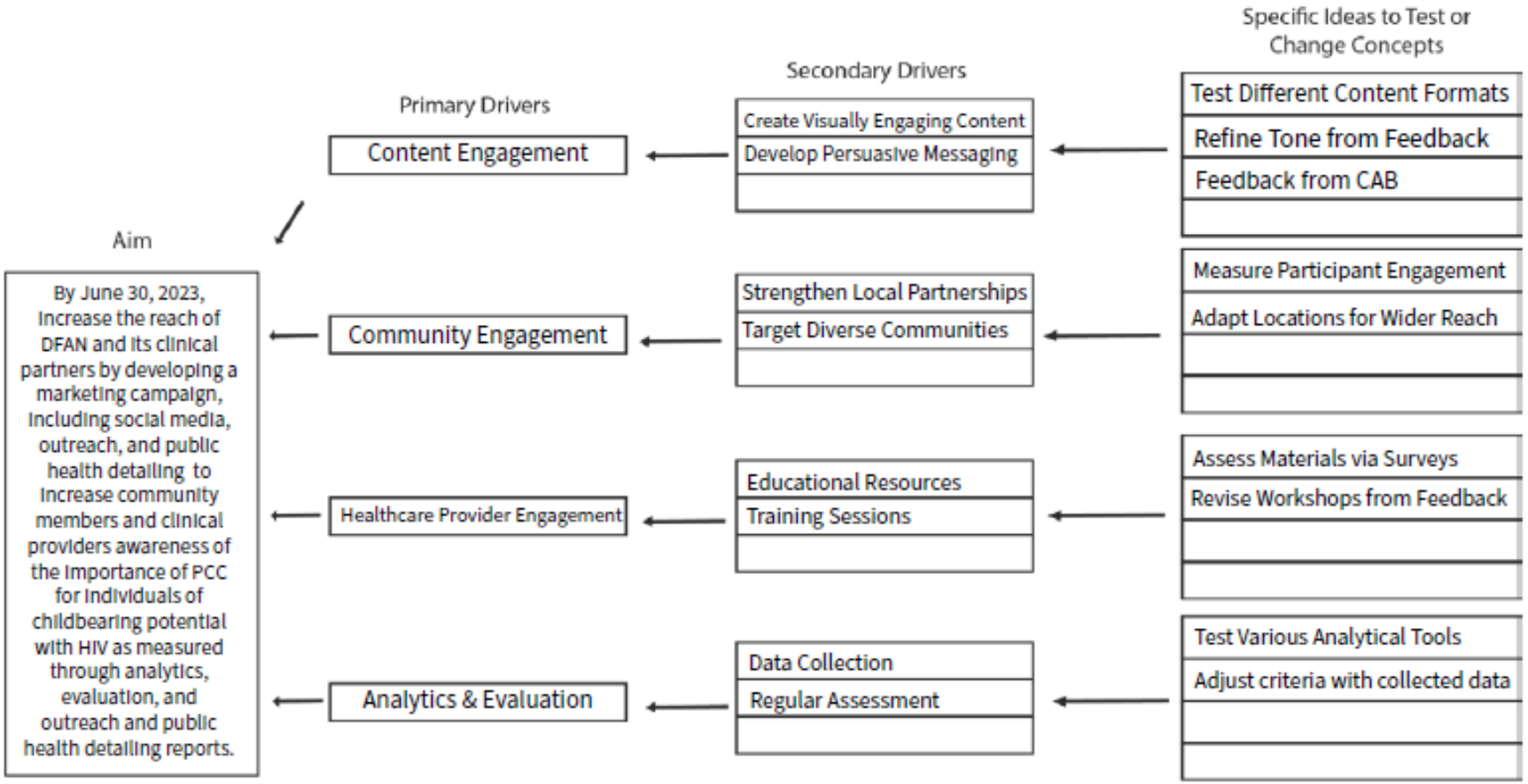
- Using the Knowledge to Action Framework in Practice: A Citation Analysis and Systematic Review: Review article examining use of the Knowledge to Action (KTA) Framework in practice.

Appendices

Appendix A: Driver Diagram Example

Return to Toolkit

University of Texas Southwestern Medical Center's Dallas Family Access Network (DFAN)



Appendix B: Institute for Healthcare Improvement's (IHI) Plan, Do, Study, Act Cycle (PDSA)

Return to Toolkit

Appendix C: Data Collection Curated Email

Return to Toolkit

Got Data? Why Collecting Preconception Counseling (PCC), Including Sexual Health Data Matters

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

Community of Practice 1, Issue 1: August 15, 2023

Preconception Counseling Including Sexual Health

GOT DATA?

Why collecting Preconception Counseling (PCC), including sexual health data matters.

The first calls with Community of Practice (CoP) #1 recipient core teams focused on identifying needs and developing SMART goals related to preconception counseling (PCC). Many teams reported having PCC related conversations but were unsure what PCC-related data was being collected, and did not have clearly delineated policies, procedures, workflows, and training to to demonstrate that PCC took place on a regular basis. Documentation is important! If it isn't documented, it isn't happening. **So how can recipients change this trend?**

Make sure you understand key elements in the data flow process:

These key elements include collection, management, reporting, and usage. Their relationships to each other, provide a way for you to assess the quality of your data collection process. Essential Steps in Data Flow: Collect it, Manage it, Report it, and Use it.

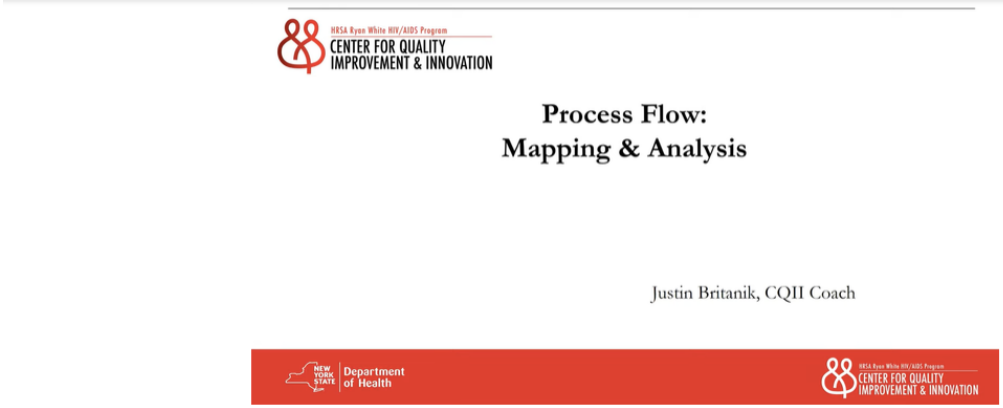
Start with assessing your current data.

What data are you collecting now? Where in your current process is this documented?

- **Do you have client-level data documentation to show that the following key elements of PCC have been provided?**
- **Do you have provider-level/clinic-level data about the provision of PCC and training on it?**

Review your workflows.

Many CoP participants noted that as part of their process improvement project they would have to assess data collected via current workflows and create new workflows. You may find it helpful to develop a workflow map that describes your current workflow to show the various data collection points, and then determine what new data you need to collect, and where in the process you need to collect it.



Data collection and new workflows impact **workforce needs**. Some programs may find that developing **new** data collection strategies for PCC and accompanying workflows mean changes in their staffing patterns. Look at the new workflow to determine possible staffing needs.

Oh, and all that data you're collecting…?

You will need to use a variety of measures to test whether a positive change has taken place. Familiarize yourself with how relevant data is reported out of the system. Confirm that it aligns with your benchmarks and goals.

Keep your eyes on the prize.

All these efforts to determine what data you need to collect and document PCC will pay off when you report to HRSA that more than 80% of your patients with childbearing potential have received high-quality PCC at every visit using best practices learned through your process improvement project.

Appendix D: Preconception Counseling (PCC) Curated Email

Return to Toolkit

Partnerships in Preconception Counseling

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

Community of Practice 1, Issue 2: November 15, 2023

Partnerships in Pre-Conception Counseling

During this Community of Practice, you have been working on implementing and/or improving preconception counseling (PCC), including sexual health, in your organization. The Clinical Leaders Checklist for Implementing PCC (see below) outlines four steps to complete so that your organization is optimally prepared to implement PCC. The Clinical Leaders must ensure that you've completed these four steps, outlined in the "Clinical Leaders Checklist for Implement PCC" in order to optimally prepare internally.

Clincal Leaders Checklist

for Implementing PCC

Please ensure that:

- INFRASTRUCTURE IS IN PLACE TO SUPPORT PCC.
- STAFF RECOGNIZES THE VALUE OF PCC AND SEXUAL HEALTH.
- ISSUES THAT IMPACTED PCC DELIVERY IN THE PAST HAVE BEEN ADDRESSED AND NEW WORKFLOWS ARE IN PLACE.
- TRAINING IS IMPLEMENTED FOR ALL STAFF, EVEN NON-CLINICAL STAFF.

Does Teamwork *STILL* Make the Dream Work?

We agree! That's why in addition to internal preparations, we suggest that clinical leaders consider partnerships that can enhance your program's delivery of PCC. Partnerships with organizations that share a common focus and combine resources to implement joint activities and avoid duplication of efforts benefit everyone. The Community Asset Mapping Guide can assist you in identifying potential partners.

Steps to Build Effective Partnerships

Identify champions and connect with leaders at partner organizations to promote engagement.

For an effective partnership, leaders from both organizations must allocate the time and staff needed to develop and manage the relationship. Consider the 5 steps for building and growing an effective partnership: Review, Host, Begin, Explore, and Develop.

Title V Funded Organizations

Be sure to establish partnerships with Title V funded organizations. They target the same populations, and it is a requirement for Part D programs. Also consider partnerships with local Maternal, Infant, and Early Childhood Home Visiting(MIECHV) program recipients and/or local implementing agencies.

Once the MOU is developed, it's important to maintain a healthy partnership. Here are two resources with tips on how to strengthen your collaboration.

1

Hogue's Levels of Collaboration

Hogue's Levels of Collaboration describes five levels of collaboration to discuss and determine with your partners:

1. Networking (Awareness of organization and communication beginning)
2. Cooperation (Providing information to one another formally)
3. Coordination (Sharing information and resources frequently)
4. Coalition (All members have a vote in decision-making)
5. Collaboration (Consensus is reached on all decisions)

2

ASPHN Collaborative Process Checklist

Once you have determined the level of collaboration, discuss the purpose, structure, and process for your collaboration with your partners. You can review the ASPHN's Collaborative Process checklist to see if your partnership checks off the factors associated with an effective collaborative process.

You can find the checklist and do a deeper dive into successful collaborations in the ASPHN's Collaboration Primer.

Suggestions to Strengthen Your Long Term Relationships:

Remember that the overall goal of collaborating with alike-minded organization is to improve the delivery of pre-conception care by combining forces and resources.

To sustain partner relationships:

- Revisit your MOU annually to ensure it is serving you both well.
- Thank your collaborative partners!!
- Throw an ice cream social or host a holiday meet and greet for staff from your agency and those from your partner agency who work collaboratively.
- Provide notepads or other useful swag with your organization's information on it to make referrals and contact easy for your partners.
- Feature your partners in your newsletter or on your website.

Appendix E: PCC Workflow Fact Sheet

Return to Toolkit

Developing Workflows to Support Preconception Counseling and Care

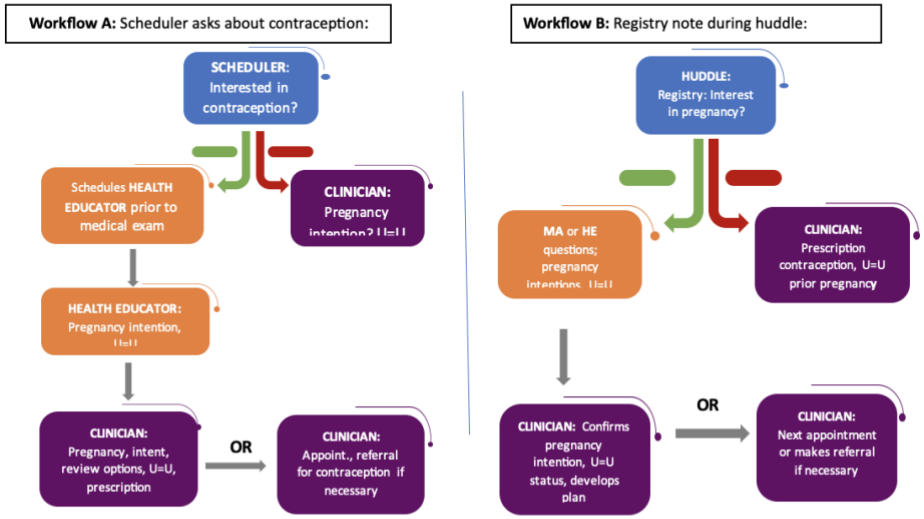
Developing Workflows to Support Preconception Counseling and Care (PCC)

Why focus on workflows for preconception counseling and care (PCC)? Workflows are one of the most important strategies to ensure that PCC takes place in the most efficient and effective way possible. HRSA wants to see at least 80% (*more is better!*) of all patients to receive PCC. With that goal in mind, workflows act as a map to reach that "destination."

Workflows can save you time and effort. Think about a new set of patient flow activities, tasks and **staffing that will allow clinicians to** have more time for meaningful conversation with patients. Workflows can be used to:

- **Prompt** medical staff (providers, nurses, medical assistants) to ask and educate about PCC.
- **Delegate** tasks to non-medical staff (health educators, case managers, care coordinators/navigators) to ask and educate about PCC.
- **Prompt** schedulers to ask about PCC-related concerns (e.g., contraception) to plan for visit.

Consider strategies to anticipate patient needs and improve workflows. A **patient registry** that is used during **weekly** or **daily huddles,** or **automated systems that trigger staff actions** can improve workflows and document key actions.



HELPFUL TOOLS

Quality improvement materials to support workflows:

- How to Map Workflows in Health Care Settings
- **Institute for Healthcare Improvement (IHI) materials:**
  - Improve Workflows and Remove Waste
  - Huddles

Appendix F: IHI Breakthrough Series Overview

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

HHS/HRSA/RWHAP

Enhancing HIV of Women, Infants, Children and Youth Building Capacity through Communities of Practice

The IHI Breakthrough Series[1]

The Institute for Healthcare Improvement developed the Breakthrough Series to help health care organizations make "breakthrough" improvements in quality while reducing costs. The driving vision behind the Breakthrough Series is this: sound science exists on the basis of which the costs and outcomes of current health care practices can be greatly improved, but much of this science lies fallow and unused in daily work. There is a gap between what we know and what we do.

The Breakthrough Series is designed to help organizations close that gap by creating a structure in which interested organizations can easily learn from each other and from recognized experts in topic areas where they want to make improvements. A Breakthrough Series Collaborative is a short-term (6- to 15-month) learning system that brings together a large number of teams from hospitals or clinics to seek improvement in a focused topic area. Since 1995, IHI has sponsored over 50 such Collaborative projects on several dozen topics involving over 2,000 teams from 1,000 health care organizations. Collaboratives range in size from 12 to 160 teams. Teams in such Collaboratives have achieved dramatic results, including reducing waiting times by 50 percent, reducing worker absenteeism by 25 percent, reducing ICU costs by 25 percent, and reducing hospitalizations for patients with congestive heart failure by 50 percent. In addition, IHI has trained over 650 people in the Breakthrough Series methodology, thus spawning hundreds of Collaborative initiatives throughout the health care world, sponsored by organizations other than IHI.

[1]This document is based on the Executive Summary, The Breakthrough Series: IHI's Collaborative Model for Achieving Breakthrough Improvement, 2003: https://www.ihi.org/resources/Pages/IHIWhitePapers/TheBreakthroughSeriesIHIsCollaborativeModelforAchievingBreakthroughIm

Key Elements of the Breakthrough Series paired with Plan, Do, Study, Act (PDSA) Cycles[2]

- Topic Selection
- Recruit Participants (leadership, staff, faculty)
- Engage with Partner Organizations
- Learning Sessions

PLAN

- Action Periods

DO

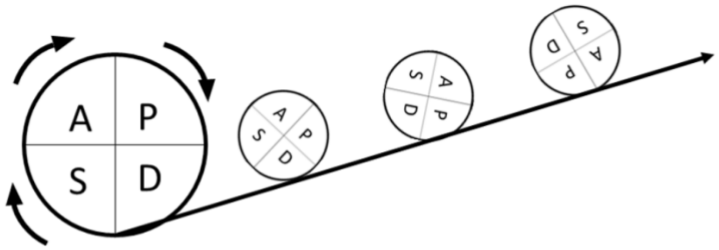
- Assess Pilot(s)

STUDY

- Revise/Iterate Improvement Plan

ACT

Iterative PDSA Process



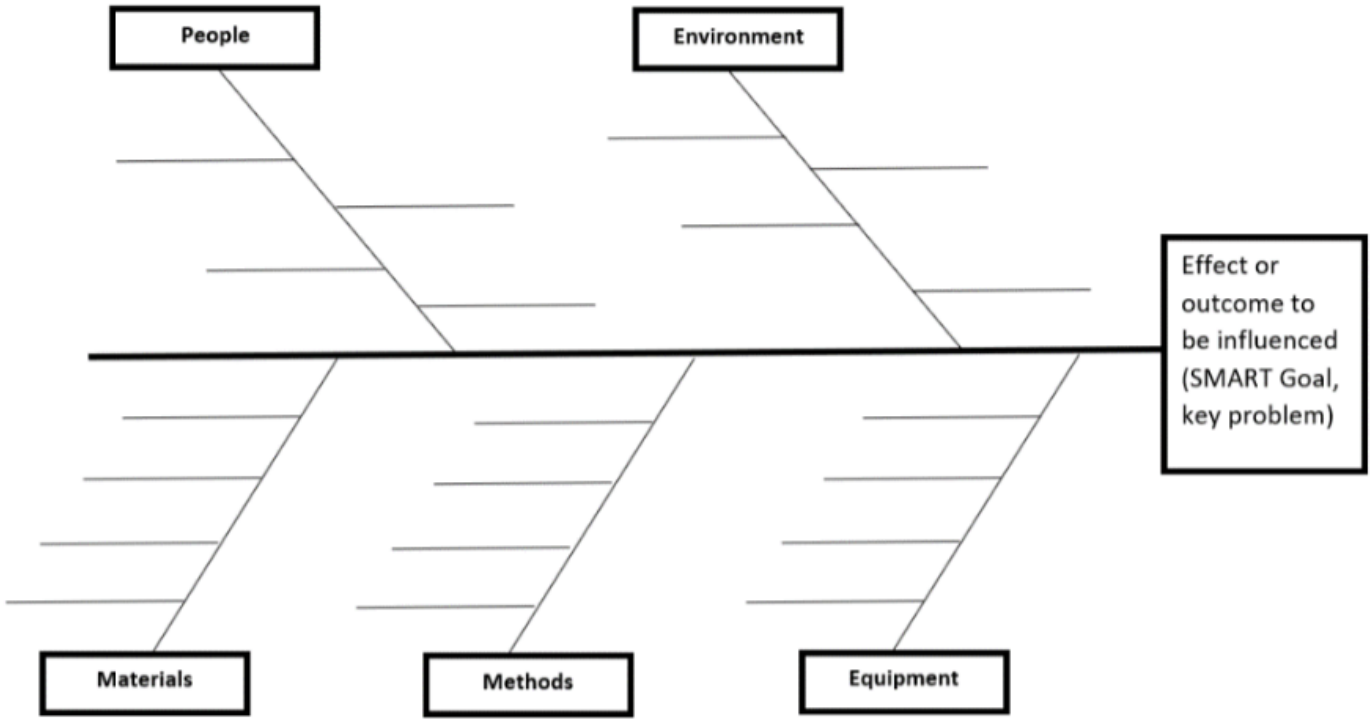
Guiding Questions in preparation for Learning Session 1: Core Components of the IHI Breakthrough Model: Using the Cause and Effect (Fishbone) Diagram and PDSA Cycles to Identify and Reach PCC Goals

- Can we prioritize one SMART Goal?
- Have we identified and engaged/oriented all the stakeholders?
- Who are our "change champions"?
- What will it take to coordinate and complete a minimum of three PDSA cycles in nine months?

Cause and Effect Diagram: Fishbone Diagram

A common challenge for improvement teams is determining what changes they can test to improve a process. A cause and effect diagram is an organizational tool that helps teams explore and display the many causes contributing to a certain effect or outcome. It graphically displays the relationship of the causes to the effect and to each other, helping teams identify areas for improvement.

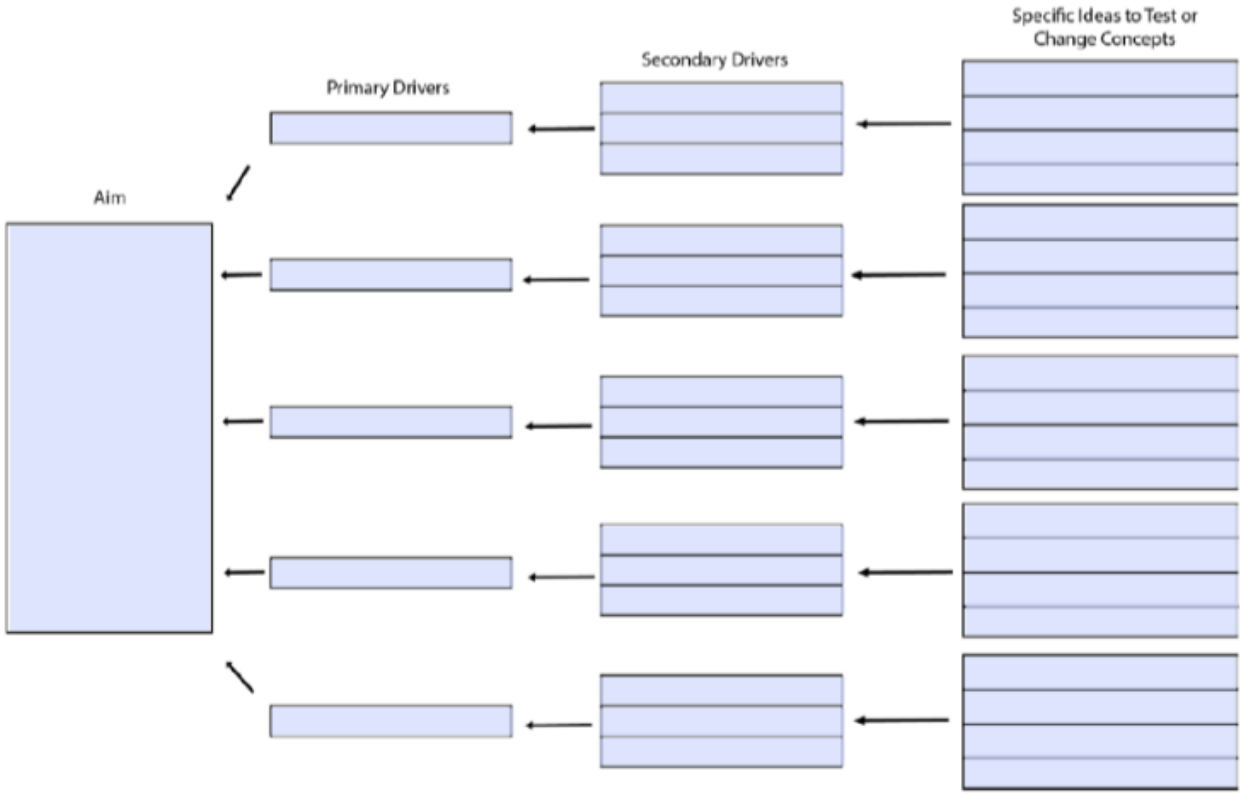
Example Fishbone Diagram



Driver Diagram

A driver diagram is a visual display of a team's theory of what "drives," or contributes to, the achievement of a project aim. This clear picture of a team's shared view is a useful tool for communicating to a range of stakeholders where a team is testing and working.

Example Driver Diagram



PSDA Worksheet

The Plan-Do-Study-Act (PDSA) cycle is a useful tool for documenting a test of change. Running a PDSA cycle is another way of saying testing a change – you develop a plan to test the change (Plan), carry out the test (Do), observe, analyze, and learn from the test (Study), and determine what modifications, if any, to make the next cycle (Act).

PDSA Worksheet Excerpt (Username, email, and organization information are required to download.)

Link to Entire PDSA Worksheet Template

Objective: Deliver two PCC skill trainings based on the ARVT Guidelines by July 31, 2023. Identify existing training, modify, and deliver two online trainings to enhance DFAN and its clinical providers' skills to provide PCC based on the ARVT Guidelines for individuals with childbearing potential with HIV as measured by pre- and post-evaluations.

Return to Toolkit

1. Plan: Plan the test, including a plan for collecting data.

Questions and predictions:

How can existing PCC training materials be modified to align with the ARVT Guidelines effectively?
Will the modified online trainings significantly enhance the skills of DFAN and clinical providers in delivering PCC for individuals with childbearing and HIV?

Who, what, where, when:

Who: DFAN staff
What: Modify and deliver two online PCC skills trainings based on the ARVT Guidelines.
When: Training sessions to be conducted by Feb 2024, delays due to staff changes and creation of content
Where: Online trainng sessions using a chosen platform (Zoom, Microsoft Teams, etc.)

Plan for collecting data:

Pre and Post Training evaluations

2. **Do:** Run the test on a small scale.

Return to Toolkit

Describe what happened. What data did you collect? What observations did you make?

Revising exisiting trainings to deliver to our clinical providers. Trainings are expected to be attended by all contracted staff. All three of our subrecipients that provide medical services had representation on PCC Learning Session 2. Share training through social media channels to reach a broader audience.

3. **Study:** Analyze the results and compare them to your predictions.

Summarize and reflect on what you learned:

Plan to compare pre- and post-training evaluation results to measure the improvement to participants' skills and knowledge.

4. **Act:** Based on what you learned from the test, make a plan for your next step.

Determine what modifications you should make – adapt, adopt, or abandon:

We plan to adjust based on feedback and recognize participant improvement.

Project Planning Form

The Project Planning Form is a useful tool to help teams think systematically about their improvement project. By tracking a list of the changes that the team is testing — including all of the Plan-Do-Study-Act (PDSA) cycles, the person responsible for different aspects of each test, and the timeframe for each phase of the work — the form allows a team to see at a glance the full picture of a project.

Project Planning Form Excerpt (Username, email, and organization information are required to download.)

Link to Entire Project Planning Form

Team:	**Project:**

Driver – list the drivers you'll be working on	**Process Measure**	**Goal**
1.		
2.		
3.		

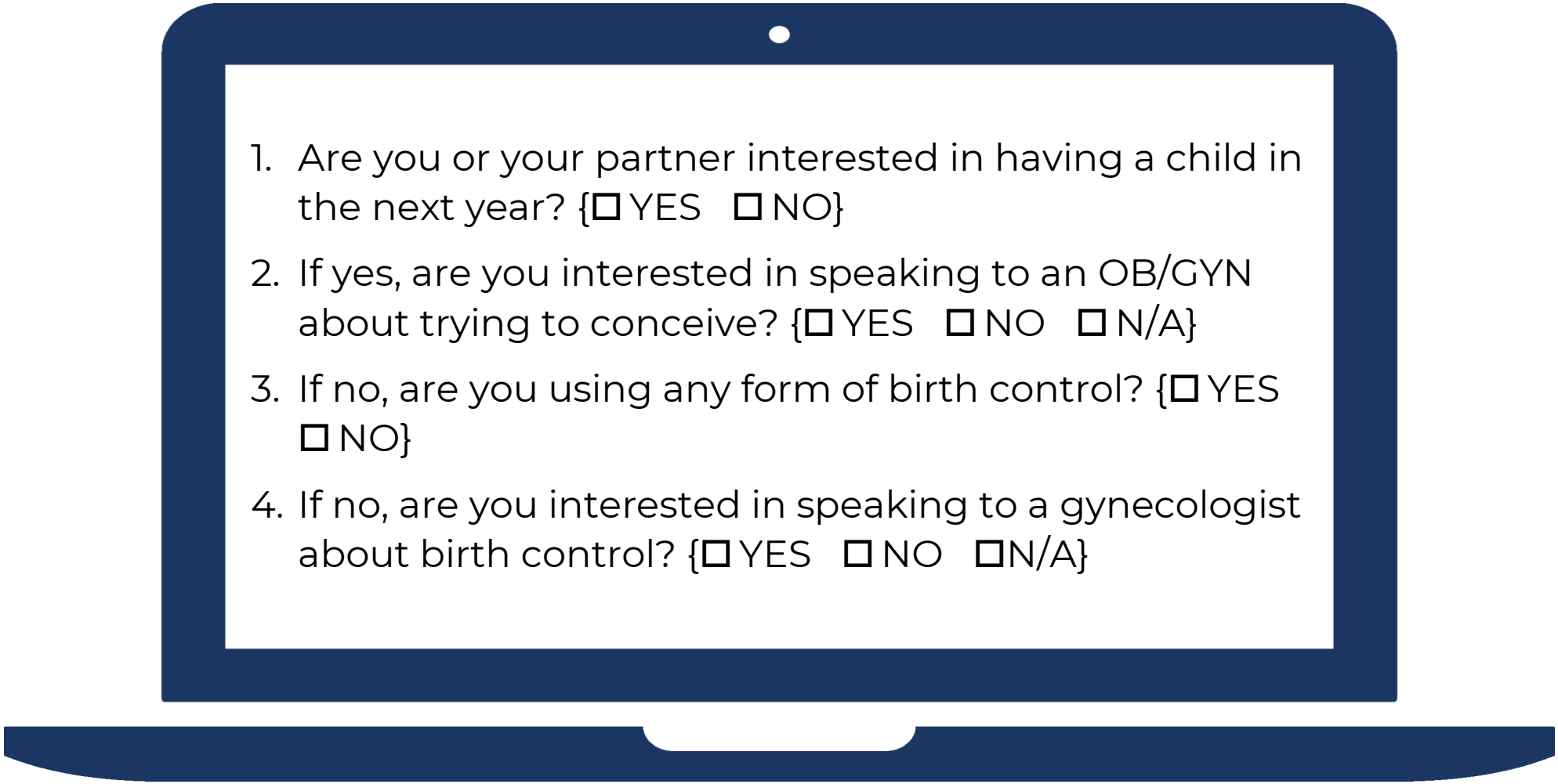
Driver Number (from above)	**Change Idea**	**Tasks to Prepare for Tests**	**PDSA**	**Person Responsible**	**Timeline (T = Test; I = Implement; S = Spread)**												
					Week												
					1	2	3	4	5	6	7	8	9	10	11	12	13	14

Appendix G: Johns Hopkins University Educational Flyer

Flyer created by Johns Hopkins University's HIV Women's' Health Program in Collaboration with a Youth Advisory Board

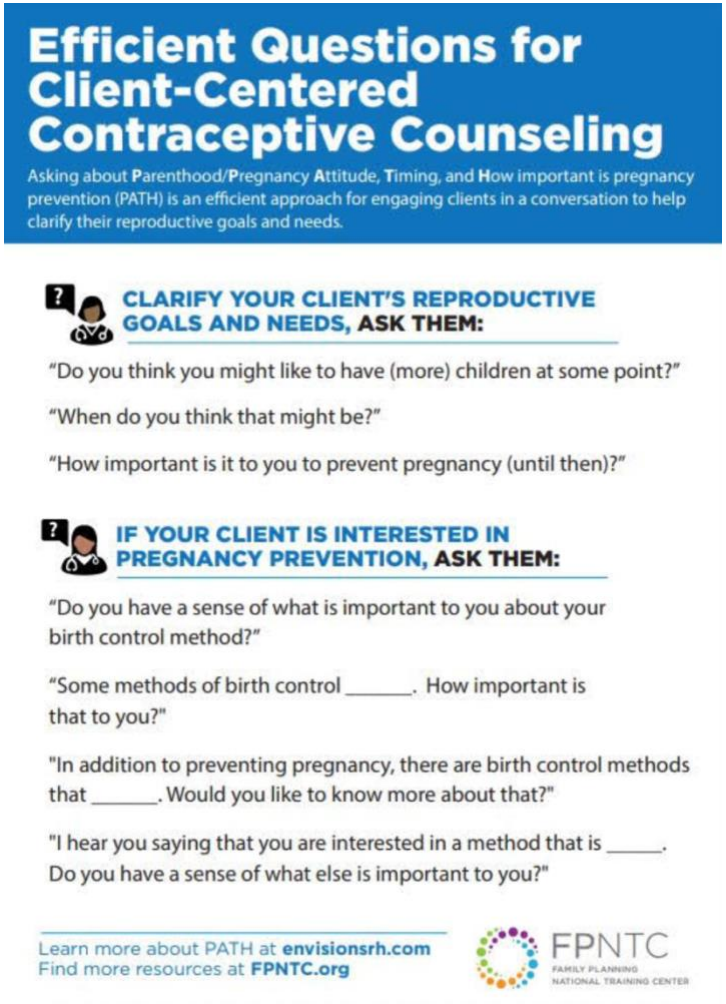
Appendix H: Electronic Health Record Screening Tool for PCC

Harris Health Epic (EHR) PCC Smart Phase Screening Tool



Appendix I: Family Planning National Training Center (FPNTC) Script: Efficient Questions for Client-Centered Contraceptive Counseling.

FPNTC Script utilized by a CoP participant to engage clients in conversation about reproductive goals and needs.



Efficient Questions for Client-Centered Contraceptive Counseling

Asking about **P**arenthood/**P**regnancy **A**ttitude, **T**iming, and **H**ow important is pregnancy prevention (PATH) is an efficient approach for engaging clients in a conversation to help clarify their reproductive goals and needs.

CLARIFY YOUR CLIENT'S REPRODUCTIVE GOALS AND NEEDS, ASK THEM:

"Do you think you might like to have (more) children at some point?"

"When do you think that might be?"

"How important is it to you to prevent pregnancy (until then)?"

IF YOUR CLIENT IS INTERESTED IN PREGNANCY PREVENTION, ASK THEM:

"Do you have a sense of what is important to you about your birth control method?"

"Some methods of birth control _____. How important is that to you?"

"In addition to preventing pregnancy, there are birth control methods that _____. Would you like to know more about that?"

"I hear you saying that you are interested in a method that is _____. Do you have a sense of what else is important to you?"

Learn more about PATH at **envisionsrh.com**
Find more resources at **FPNTC.org**

FPNTC
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Efficient Questions for Client-Centered Contraceptive Counseling *(cont.)*

QUESTIONS TO ASK ALL YOUR CLIENTS...

"Since you've said _____, would you like to talk about ways to be prepared for a healthy pregnancy?"

"What questions do you have about _____?"

"We covered a lot of information. What do we need to go over again?"

TRY THESE FACILITATION SKILLS...

Start with "YES" (agreement, empathy, or validation) before offering clarifying information:
"YES, you're absolutely right, AND…"

"Wow! I think most people would find that hard to deal with AND..."

"YES, I can absolutely see how you would think that, AND…"

Uncover misconceptions with:
"Many of my clients say _____. Is that something you think about?"

Offer follow-up questions after giving a piece of relevant information:
"How would that be for you?"

"Has that ever happened to you before?"

"How do you see yourself managing this?"

Learn more about PATH at **envisionsrh.com**
Find more resources at **FPNTC.org**

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End Notes

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