When Does Interconception Care Begin? Healthy Living Between Pregnancies

Arizona WIC Program Training
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Disclosure Statement

I have had no financial relationships with commercial interests related to this topic in the last twelve months.

There will be no off-label discussions of any drugs.
Objectives

1. Describe the rationale for the interconception movement;
2. Communicate opportunities for the WIC program to advance women’s wellness between and beyond pregnancy;
3. Discuss 4 topics of interconception significance that WIC can impact;
4. Define the interconception period.
Is “interconception” health a new concept?

Actually, yes!
Almost 30 years ago, the link between a woman’s health before pregnancy (and, thus, during the earliest days of pregnancy) and pregnancy outcomes was made.

More recently, epidemiological evidence has underscored that a key predictor of a poor pregnancy outcome is a previous poor outcome.

Even more recently, pregnancy complications have been identified as key predictors of a woman’s short and long-term health status.

These appreciations require that we approach the delivery of health care in a new, more integrated manner if we are to help our patients and population achieve higher levels of wellness for themselves and for their offspring.

Where Did Focus on Interconception Care Come From?
Some Examples of Missed Opportunities

To Make a Timely Difference
SW is 19 yo g2 p1 who had a 1500 gm infant 7 months ago. She was provided depo provera for contraception and was due for a re-dose visit last week. In following up on her missed appointment, you discover she is pregnant again. During her previous pregnancy she was noted to be

- Underweight (BMI 17.5)
- Smoker at 1 ppd
- Experiencing an unintended pregnancy
- Depressed
- Pregnancy complicated by severe pregnancy-induced hypertension

None of these issues were revisited after her last delivery—despite contact with the neonatal care unit for 6 weeks, a routine postpartum visit, home visiting care for infant follow-up, a visit to the Title X program and routine and high risk pediatric care.
Who dropped the ball: everyone?
(yes!)
An AZ “Snap Shot” of Need

- 8 postpartum women convened in AZ for a focus group about interconception care.
- Only sampling criteria was that they each had to have had two or more births.
- Purposive sampling included women who had participated in WIC.
- In course of observations and conversations, the following was assessed:
The Snap Shot

- 4-5 women obese (observational as did not compute BMIs)
- 1 markedly underweight (again observational)
- 3 demonstrated evidence of clinical depression
- 1 displayed evidence of unresolved grief (3 years)
- 1 had h/o LBW infant followed by a VLBW infant
- At least 2 had pregnancies complicated by PIH
- At least 1 had pregnancy complicated by GDM
- One had cardiomyopathy with ICU admission
- One had pp hemorrhage
Obvious Point for Addressing PP Issues:

The Postpartum Exam—

Unfortunately, far from universal:

Commercially insured women: 81% have a pp visit 3-8 weeks after giving birth.

Medicaid-insured women: 64% have a pp visit 3-8 weeks after giving birth.

Self pay: ???? (likely even lower).

USDHHS, Women’s Health, USA, 2013
Why Such Poor Attendance?

Possible Reasons:
- Inconvenient
- Competing priorities
- Not sure of purpose
- Previous poor experience
- Unresolved traumas about birth experience
- Fear of scolding
- No connection with provider they will be seeing
Why Such Poor Attendance--2?

- Afforded through global fees so no incentive for providers.
- Framed as the end of a health care event rather than the beginning of the “rest of her life.”
- Providers haven’t been educated about what should be included in the visit. New tools surfacing
  - California-ACOG Postpartum-Interconception Toolkit: at www.everywomancalifornia.org
  - Workgroup on defining content of care for low risk pp women
What Can We Do to Increase Utilization?

- Market postpartum visit like we market early and continuous prenatal care.
- Market well woman and family planning care with the same energy.
- How does WIC market—are there “lessons to be shared” on your successes?
- Those least likely to attend (low income, marginalized) are most likely to participate in WIC—how can WIC encourage postpartum visit attendance?
  - Is there a question on your postpartum assessment that specifically asks? What are the action steps if the woman answers in the negative?
Find out barriers to visits and address as much as possible (e.g. co-schedule with well child visit or with WIC; give vouchers or meaningful incentives to attend visit; provide privacy rooms for waiting mothers to breastfeed, etc.; use waiting room time for some useful purpose).
They Come to PP Visit and What Do They Get?

- Uneven services which are often incomplete
- Birth control (but unlikely in context of RLP or IPI)
- Post delivery recovery (usually focused on involution of uterus, anatomy and function of external genitalia)
- No evidence of good follow-up of problems that surfaced in prenatal/intrapartum period.
...and often a photo op of mom, baby and provider

Generally, the postpartum is framed as “the end” rather than the beginning of the rest of the woman’s life---

BUT there is one exception: the WIC clinic
Study of the content of the pp visit for 400 women

- Family planning counseling — 72%
- Weight recorded — 50%
- Weight discussed — 4%
- Return to sexual intimacy — 36%
- Breast exam — 28%
- Vitamin recommendation — 16%
- Inquired about substance use — 14%
- Inquired about maternal-infant bonding — 4%
- Inquired about family violence — 2%

Unpublished data from dissertation by S. Verbiest (SPH-UNC-CH, 2008)
Omission of Key Health Promotion and Disease Prevention Opportunities at PP Visit

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The Rationale for Engaging WIC in Interconception Care

The Opportunity
What Makes the WIC Setting So Unique?

- It is the one component of our current health care system that is already ideally positioned to provide interconception care!!
- Serves postpartum women with repeated encounters up to 6 months postpartum.
- Because WIC cares for a dyad—mother and child (children)–life course topics can be approached and discussed in the context of woman’s health/habits and impact on child’s health habits.
- A dyad approach allows exploration of important motivators for the mother to assume better self care (provided the exchanges aren’t all baby-focused).
Two WIC programs are known to have design initiatives to specifically reach the interconception population:

- **WOW (WIC Offers Wellness)** — Los Angeles program designed to provide comprehensive care coordination services, individual counseling and peer group support sessions to women who had a poor pregnancy outcome.

- **KEEP (Keep Energized and Empowered for Pregnancy)** — Texas program modeled after WOW. Both funded by local March of Dimes chapters. Sadly, do not know what became of these initiatives!!
One Published Study:

Acceptability and Potential Impact of Brief Preconception Health Risk Assessment and counseling in the WIC Setting

Dunlop, Dretler, Badal, Logue AJ Health Promotion, 2013; 27 (3)S58-65
Undertaken to determine feasibility of incorporating preconception {interconception} focus into WIC services.

Sample 150 AA women ages 18-44 recruited from attendees of WIC nutrition classes for pp, breastfeeding and/or mothers of children less than 5 yo.

Completed risk assessment questionnaire to determine topics for brief counseling.

Provided brief standardized counseling.
Findings:

Health and reproductive risks were prevalent:
- At risk for unintended pregnancy — 24%
- Current or recent problems with contraceptive method — 32%
- h/o STIs — 49%
- Inadequate folic acid supplementation — 66%
- Intimate partner violence — 47%
- Tobacco use — 21%
- Binge drinking — 10%
- Illicit drug use — 5%
Findings

- 66% of participants spontaneously commented that the assessment and brief counseling was a positive experience (when specifically asked about the experience, 92% conveyed a positive response).
- Many expressed benefits of face-to-face interactions rather than handouts—felt the face-to-face interactions made the information feel relevant to them.
- 98% felt the scope of the assessment and counseling appropriate to the WIC setting.
92.7% reported they would try to make the changes based on the counseling they received;

Main areas for engagement:
- Improving nutrition through better vitamin and nutrient intake (56%)
- Tobacco cessation (14.7%)
- Exploring birth control options (14.7%)
- Improving general nutrition (13%)
“...translating wait times into opportunities for reproductive and preconception health risk assessment and brief counseling would be an efficient use of the clients’ wait time and could improve clients’ experiences and satisfaction with WIC and overall public health.”
Important Considerations:

- This was a study
- Study personnel did the assessments and the targeted counseling

That said, are there some important “take-aways” that could/should play forward?
CAUTION!!

WIC staff do NOT need more things to do... so the challenge is to frame topics and opportunities to work...

As SMART as Possible
NOT
as HARD as Possible!!!
Which of these topics could be integrated into routine WIC care without overly burdening the program?

Choice 1: Continued use of folic acid (a habit for a lifetime)
Choice 2: Query about whether had postpartum visit?
Choice 3: Satisfaction with birth control method?
Choice 4: Education about interpregnancy intervals?
Discussion Poll #1
Which of these topics could be integrated into routine WIC care without overly burdening the program?

- Weight management recommendations
- Tobacco cessation recommendation and referral
- Referral for guidance for previous poor pregnancy outcome (e.g. SGA, PTB, congenital anomalies)
- Referral for guidance for h/o GDM and PIH
Discussion Poll #2
Honestly, I don’t know the “right” answer or if there is one for every WIC Program.

Want to spend some of the next time discussing a few of these topics and what we know—

Need to manage expectations: cannot cover them all!! (Am focusing on those that AZ WIC Leaders thought most important)
Addressing Specific Risks in the Context of Your Visits and Your Patient’s Empowerment

- Chronic disease risks
- Weight retention
- Interpregnancy intervals
- Depression
- Interpersonal violence
- Multivitamins for life
Pregnancy Is a Stress Test for Life

A previous pregnancy is useful in predicting:

- **Woman’s future health risks:**
  - Most Common and Perhaps Most Researched:
    - PIH (1.4-3.98 increased risk to develop chronic hypertension)
    - Gestational diabetes (50% risk of Type 2 diabetes within 5 years—7x women w/o GDM; metabolic syndrome 2-5x risk; cardiovascular disease 1.7x risk).

Appropriate follow-up of known risks is often absent, leaving women in peril for their own health (first) and the health of any pregnancies and children in their futures.
Follow-Up after GDM

ACOG, WHO and others recommend postpartum testing at 6-12 weeks for women diagnosed with GDM in pregnancy:

- Only about 50% of women who attend their postpartum visit actually are tested.
- The women who have abnormal results (pre-diabetic or T2DM) need follow-up:
  - What can be done to increase access to appropriate follow-up?
- The women who have normal results need continued surveillance:
  - What can be done to assure appropriate care?

Is There A Role for WIC?
ACOG Innovation to Remind Providers... 

Gestational Diabetes Follow-Up Instructions

Dear Ms. ________________________________.
You had gestational diabetes while you were pregnant and need to be retested for diabetes after your baby is born. Please have the test 6 weeks after your baby’s birth date or ______________________.
(6 weeks postpartum)
Instructions:
  o Call my office ____________________________ to schedule the test or
  o Go to this laboratory ________________________

This is the test you need to have:
  o Fasting plasma glucose
  OR
  o 75 GM, 2 hours, Oral glucose tolerance test
    (appointment will take 2 ½ hours)
Note:
Please do not eat anything after midnight of the night before your scheduled test. You may drink plain water only.
I want to see you in my office _________________ after your diabetes test to talk about the test results and for your postpartum visit.
Call my office _____________________________to make an appointment.
_________________________________________
Physician name print
_________________________________________
Is there a role for WIC to stimulate women to get the tests they need?
The handout that accompanies the GDM postpartum follow-up guidance includes this information:

**What can I do now?**
You can help to prevent or put off getting type 2 diabetes by breastfeeding your baby, by making smart food choices and by keeping active at least 30 minutes 5 days a week.

How might WIC know what messages to echo?
How might WIC impact quality of care in the community?
Interpregnancy Intervals and the RLP

A True Interconception Opportunity to Make a Difference
My Recommendations for Assessing an Individual’s RLP

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

Adopted from Moos, MCN, 2003 and subsequently adopted by CDC
What We Know About Interpregnancy Intervals

Among low-income women, the length of the interval between a delivery and the conception of the next child has a significant impact on preterm birth.

- 2.4% of women had intervals less than 13 weeks.
- 7.5% of women had intervals between 13 and 25 weeks.
- 17.4% of women had intervals between 26-51 weeks.

Interpregnancy Intervals

Women with interpregnancy intervals of less than 18 months are 14-47% more likely to have premature infants.

The most recent data suggests that approximately 14% of women aged 15-44 gave birth within 24 months of a previous birth.

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

How and Why Interpregnancy Intervals Matter, cont.

For each month that IPI was shortened below 18 months,
- PTB increased 1.9%
- LBW increased 3.3%
- SGA increased 1.5%

For each month that IPI extended beyond 59 months,
- PTB increased 0.6%
- LBW increased 0.9%
- SGA increased 0.8%


Note: I believe in AZ, short IPI is defined as 16 months.
Why and How Interpregnancy Intervals Matter

Controlling for socioeconomic status, use of health care services, tobacco, alcohol and other exposures does not alter the finding that interpregnancy intervals exercise an independent influence on poor pregnancy outcomes. (Conde-Aguidelo et al., JAMA, 2006)

Some hypothesize that increased risks for women with short interconceptional lengths relate to maternal nutrition depletion and/or inadequate maternal folate levels.
What Is Value of RLP Being Integrated into WIC Visit?

Education

Most women do not know the significance of IPIs
Focus groups suggest most physicians don’t either
(She should get pregnant again “whenever she feels like it” is not evidence-based!!)
There is little more personal than decisions about reproduction:

- Our job is to provide enough information for women (and their partners) to make informed decisions—it is not to fall into the trap of trying to rescue them from decisions we think wrong.

- IPI data (and other data we are discussing) is population-based—it may not predict the next outcome of the specific woman you are working with.

- If a woman makes a risky decision and did not know the potential consequences: we have failed!! . . . BUT

- If she made an educated decision, it belongs to her (and her partner).
Postpartum Weight Retention

Too Often Neglected
Weight Retention: What We Know

- Women tend to gain in excess of the IOM guidelines for weight gain in pregnancy (recommendations individualized to pregravid weight)
- In one study, 73% of more than 8200 women gained in excess of guidelines (Johnson, et al, Obstet-Gynecol 121 (5); 969-75).
- Socioeconomically disadvantaged women are at greater risk for excessive weight gain in pregnancy, postpartum weight retention and transitioning to a higher weight category over 5 years following childbirth (e.g. from normal to overweight or over weight to obese). (Hernandez, J Women’s Hlth, 2012, 21:10;1082)
Weight Retention: What We Know

- SER found women who took part in a diet or diet plus exercise program lost significantly more weight than women entered in no weight loss program.
  - A combination of diet and exercise may be preferable because of cardiorespiratory and body fat benefits. (Amorin & Linne, Cochrane Database Syst Rev 2013.)

- SER and meta-analysis:
Weight Reduction Strategies

Five key points which have been associated with greater success:
- Self-monitoring
- Counselor feedback and communication
- Social support
- Structured programs
- Individually tailored program

Use of pedometers or heart rate monitors as important tools as provide objective measures.

How Do We Start the Conversation?

I strongly recommend AGAINST focusing on the BMI for those who have a lot of weight to lose before they are in the normal range—we are caring for women

...not numbers!!
Ways to start:

“Many women carry excess weight after giving birth and some of the women I see are pretty discouraged when they think about weight loss. What are you thinking about your current weight?”

“One of the things we talk about with every woman we see is weight--Have you thought about a weight you think is a good goal for you?”

“Many women I see are unhappy about their weight. Do you have a weight goal you want to reach?”
Use the Evidence: Combine Diet and Exercise

Help women choose specific, individualized, realistic strategies (don’t prescribe—help her come up with a workable plan).

Start with small steps (losing 60 pounds is overwhelming for anyone—how about guiding her toward something with a relatively quick success—like lose 15 pounds?).

Monitor strategies (which means don’t come up with a plan and act as if your work is done—if you are in the home for any reason, check on the woman’s progress and on need for course directions).

Celebrate achievements—even small achievements.
Make it fun—zumba dancing, stroller walking groups, group calisthenics. . .community center weigh-ins, contests, etc.

Partner with the local health department or other agencies engaged in activities to promote the health of the community to:

- Get community centers, churches, housing projects, parks and recreation programs to offer free activities (women respond to connectedness—so use group activities to facilitate exercise and social support).
Some Needed Supports

- www.myplate.gov does not have a specific focus on postpartum weight loss—why not? The current “site map” includes pregnancy and breastfeeding.
  - Let’s urge a focus on the needs of exhausted, overwhelmed new mothers who are unlikely to embrace “pregnancy” as the place to turn for guidance.
- Let’s find a way to afford pedometers for all postpartum women—a clear focus on a woman’s importance and health. Pedometers are CHEAP!!!(and obesity is expensive!)
Postpartum Mood Disorders

Silent Suffering with Serious Ramifications
Note Title: Not “Just” PP Depression

Perinatal Mood Disorders:
- Depression during pregnancy
- Postpartum depression
- Postpartum anxiety disorders
- Postpartum psychosis
Depression that occurs during pregnancy or within a year after delivery is called “perinatal depression.”

Risk factors:
- History of depression
- History of substance abuse
- Family history mental illness
- Inadequate social/family support
- Problems with previous outcome (past or present) or with birth experience
Postpartum blues or “baby blues” occur in 50-85% of women in the first 1-3 weeks after delivery; they usually last a few days or up to a week.

Postpartum depression occurs in ~ 10% of births usually surfacing in first 2-3 months following childbirth (but can occur much sooner).

Depression after childbirth is a serious illness with the potential for significant and long-lasting consequences for the woman, the infant (s) and other family members.

Symptoms last more than 2 weeks.

Postpartum psychosis is relatively rare: 0.1-0.2%--usually occurs in first month following childbirth.
Symptoms of Postpartum Depression:

- Feeling sad, depressed and/or crying a lot
- Intense anxiety, obsessions
- Loss of interest in usual activities
- Feelings of guilt, worthlessness or incompetence
- Fatigue, irritability, sleep disturbances (what new mother doesn’t have this?? – but that’s the problem: normalizing that which may not be normal)
- Change in appetite
- Excessive worry about baby’s health
- Feeling inadequate to cope with new infant
- Suicidal thoughts
Symptoms of Postpartum Anxiety Disorders

- Panic attacks
- Hyperventilation
- Extreme worry
- Repeated thoughts or images of frightening things happening to the baby
What Can You Do?

- Make it safe for woman to report her feelings and then assess situation (for every woman—not just the one who looks blue!).

- Might start with something like, “Many of the women I see are feeling worried, anxious or depressed—sometimes this shows up as not eating, not being able to find any pleasure in anything, and not being able to sleep. Have you had any of these feelings?” “Sometimes women worry so much about the safety of their baby they are unable to do anything else all day long—have you been worrying a lot about (baby’s name) lately?”
Provide education and refer:

- If is important to help the woman seek care if the symptoms have lasted longer than 2 weeks or they are severe or worrisome.
- Explain that, “Mood changes and postpartum depression can happen to anyone—it doesn’t say anything about you as a woman or a mother or a partner—it is not a weakness and there are treatments that will help you get back to the person you know!”
- It may be necessary for you to walk her to someone in your setting who can help her get connected with the resources she needs and to actually place the call if the woman is too anxious or immobilized to take that initiative.
Important “Do Not Miss”

- Ask **every** woman whom you assess to be depressed, “Have you ever thought about hurting yourself?” “Have you thought about hurting anyone else?”
- You cannot infer the depths of the woman’s hopelessness without exploring difficult questions.
- If you use a matter-of-fact and calm manner, the query will most likely be received as it was intended—as clinical query without judgment but with caring.
This is a medical emergency—you must not leave a woman whom you think may be having a psychotic break!!

These women can do harm to themselves and/or to others in their environment like their baby, older children, partner, etc.

Symptoms:
- Delusions (thoughts that are not based in reality)
- Hallucinations (hearing or seeing things that aren’t there)
Interpersonal Violence

Added this topic because of study I cited: “intimate partner violence — 47%”
More than one-third of the women in this country have experienced physical violence, stalking and/or rape by a partner.

Interpersonal violence can take many forms:
- Physical abuse
- Sexual assault
- Isolation
- Intimidation
- Stalking
- Reproductive coercion
Have a High Index of Suspicion

- If woman is at the visit without a partner or relative and you have concerns based on physical features, mannerisms, emotional status, etc., you might say:
  - “Do you ever feel afraid for your safety at home or other places?”
  - “Do you have any concerns about the safety of your baby?”

- If the woman does reveal a problem, you need to ask permission to refer her to her primary care provider (arrange for her to be seen asap); have her explain to her partner that you want her seen because her iron is so low (or some other invisible problem).
If the woman does not reveal any problems but you have a strong gut reaction, I often say something like, “I want you to know it is never ok for someone to hurt another person—If you are ever in an unsafe situation, it can feel helpless but there are programs and people that can help you and have successfully helped thousands of women with those same kinds of problems.”

Be very careful about giving information that can be traced (e.g. “Area Shelters” or Abuse Hotline #).

Put posters into women’s bathroom with numbers that do not have identifiers.
To help address IPV in a setting with limited services, talk with the staff at a local domestic violence agency.

Multivitamins for Life

An Opportunity for Two Life Times
Opportunity to Build on a Prenatal Habit

- **All** women of childbearing years should have an intake of at least 400 mcg of synthetic folic acid daily (through supplementation and fortification) as well as consume a balanced, healthy diet of folate-rich foods (1998).

- The USPSTF recommends that **all** women planning or **capable** of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid. Grade: A (2009)
Motivator to Take: Recommendation of Health Care Professionals

- 58% of women ages 18-45 have not been advised by any health care provider to take a multivitamin when not pregnant.
  
  March of Dimes: Improving Preconception Health, 2008

- Remember the Dunlop study: 66% of interconception women attending a WIC clinic were NOT taking exogenous folic acid.

How Might WIC Narrow the Gap Between Best Practice and Patient Use?
What We Don’t Know

What percent of women receive direction about continuing a multivitamin in the postpartum period and beyond (no evidence that it is majority—or more than a handful).

What percent of women stop multivitamins after pregnancy because “no longer important.”

What percent of women are directed to an affordable option to obtain and take a multivitamin (in combination with a diet that includes folate-rich foods).

Too often women are told to continue their prenatal vitamins until they are gone—thus unlikely to be on them when they next become pregnant or to continue prenatal vitamins indefinitely. If using the prescription option, this is an incredibly expensive option for a relatively inexpensive cheap intervention—especially in AZ.
Current Dominant Perinatal Prevention Paradigm
Current Dominant Perinatal Prevention Paradigm

- Relies on patient-medical service interface
- Community services, if available/accessed, often disconnected from medical services
- Features categorical focus with little integration with woman’s preexisting care or with her future health needs
- Initiated at first prenatal visit with
  - Risk assessment
  - Health promotion and disease prevention education
  - Prescription for prenatal vitamins
- Ends with the postpartum visit (if there is one)
Features of Current Categorical Approach

- Episodic
- Disjointed
- Inefficient
- Too often ineffective . . . especially for those at disproportionate risk
An integrated, life course approach
Usual Approach to Addressing Weight Status in Women of Reproductive Age

Orange lines = some but inconsistent guidance; purple lines = little, if any, guidance
A Life Course Clinical Model Relative to Obesity Prevention
An Important Tool For Making A Difference

. . .and avoiding burnout!!
The Transtheoretical “Stages of Change” Model Is Yours and Your Patient’s Best Friend!!

- Not ready to consider benefits or possibilities of thinking about your information/education/follow-up actions. *(Precontemplation)*

- Beginning to consider that there could be personal benefits. *(Contemplation)*

- Accepts that it is possible and beneficial to make deliberate decisions about one or more of the opportunities you and she discussed. *(Preparation)*
Creates a plan that has personal meaning (i.e. not just answering yet more questions because they are asked). *(Action)*

Maintains belief that enacting the plan is personally valuable and continues to work toward achieving the personal goal. *(Maintenance)*

Loses interest or comes across an obstacle too big to hurdle on her own. *(Relapse: invites reengagement)*

Prochaska and DiClemente, Transtheoretical Model of Behavioral Change, 1983.
Why Is This Model So Critical?

- Reminds us that behavior changes are about choice not commands
- Frames change as a process
- Celebrates small changes (yours and theirs) which allows to move from a deficiency model (you haven’t done “that thing” YET!!!???) to an achievement model. . .“I am so happy you are thinking about exercise now—last month it seemed like it was not something you wanted to explore. Can you share some of the things you are thinking about?”
- Recognizes that behavior changes include backslides (the average smoker “stops” many times before the final cigarette). Frame backslides as opportunities to learn not as failures.
- Antidote to burnout (yours and theirs)
The Conundrum: Which of These Women Will Become Pregnant or Pregnant Again?
Leave them with direction for a healthier tomorrow by encouraging them to:

- Make decisions about when and if to become pregnant again
- Taking care of their health as a way to care for their child (and family)
- Choose a health goal for the next 6 months
- Articulate a (reasonable) plan “to make it so”
- Have a medical care visit at least once a year
- Take a multivitamin!!
Create a Strategy to Make It Easy

Necessity IS the Mother of Invention!!
WOMEN'S WELLNESS Rx
(because not all habits are bad!)

Name ___________________________ Date _______________
BP ______________ Next Pap smear due _______________________
Next mammography due _______________________
☐ Self breast exam monthly
☐ 30 minutes of exercise most days of the week
☐ Sunscreen daily
☐ 1200 mg calcium daily, or other ______________
☐ 5-9 servings fruits and vegetables daily
☑ Take a Multivitamin DAILY with 400 mcg FOLIC ACID

signature ___________________________

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March of Dimes  Defeating March of Dimes  March of Dimes
Innovations Matter (but it can take time to appreciate the impact)
Competing priorities result in unusual choices—we cannot judge until we’ve walked their walk. . .

There is always something to celebrate—they kept an appointment, they followed through on an agreement, they walked twice since we last saw them.

People don’t want to fail—they may not know how to succeed.

High expectations and high acceptance are a recipe for positive impact.