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# Integrating Preconception Care into the Patient-Centered Medical Home

**Janice Magno, MPA, PCMH-CCE**

Executive Director, NYC REACH

NYC Department of Health and Mental Hygiene





# AGENDA

- About NYC REACH
- Maternal health inequities in NYC
- Preconception care model overview
- Lessons learned from pilots and provider feedback

# Learning objectives

At the conclusion of this session, learners will be able to:

1. Describe the importance of addressing preconception health
2. Engage primary care providers on preconception care
3. Identify opportunities to incorporate preconception care into existing PCMH workflows

# NYC REACH

- Primary care arm of the NYC Health Department at the Bureau of Equitable Health Systems
- Founded as a Regional Extension Center via HITECH Act to provide on-the-ground health IT technical assistance to NYC providers
- **Mission:** Strengthen primary care through innovation, tailored support, and data-driven resources to advance health equity and the health of communities.

[www.nycreach.org](http://www.nycreach.org)

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*"NYC REACH always lets us know what's new, what's coming along, what's the next program."*

*"Doctors know they must change their approach in order to see results. NYC REACH gave us the tools we needed to make that change."*

*"NYC REACH provided assistance every step of the way. Without them, I'd be blind."*

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# Maternal Health Inequities in NYC

- Pregnancy-associated deaths in New York City increased 13.7 percent, from 58 deaths in 2021 to 66 deaths in 2022, highest number since 2016.
- Black non-Hispanic women and people who gave birth accounted for 42.4 percent of pregnancy-associated deaths
- The leading cause of pregnancy-associated deaths are mental health and cardiovascular conditions

<https://www.nyc.gov/assets/doh/downloads/pdf/data/maternal-mortality-annual-report-2023.pdf>,

# NYC Strategy

- 1 Community Voice: Stakeholder Working Group**  
 Convene a group of diverse stakeholders to identify a collective impact birth equity goal, achievable within 4 years, starting in Brooklyn
- 2 Sustainability: Advancing a Payment Policy**  
 To establish a payer and provider agnostic Maternal Home Collaborative, including Stress Free Zones & Family Wellness Suites
- 3 Alignment: Primary Care Integration**  
 Support integration with Birth Equity to identify a specific scope of primary care services and establish connections with other safety net programming



The city aims to reduce pregnancy-associated deaths in Black non-Hispanic women by 10% by 2030

# Why primary care?



Most common causes of preventable maternal mortality in NYC are related to CVD & behavioral health, which can be addressed upstream



About 50% of pregnancies are unplanned; there is opportunity to incorporate preconception into standard preventive care



Primary care is first-contact, continuous, comprehensive care throughout a patient's life cycle

*Only 1 in 6 PCPs reports delivering preconception care to the majority of their eligible patients. Nearly 60% of patients report never receiving preconception care.*

[pregnancy-associated-mortality-report-2018-2022.pdf](https://www.aafp.org/pubs/afp/issues/2006/1201/p1967.html), <https://www.aafp.org/pubs/afp/issues/2006/1201/p1967.html>

# Preconception Care

- Focus population is patients assigned female at birth, ages 18-44
- Preconception Care defined as
  - *"A set of interventions aimed at identifying and modifying biomedical, behavioral, and social risks to a woman's health or pregnancy outcome through prevention and management."*
  - *"The goal is to ensure that the woman is as healthy as possible before conception to promote her health and the health of her future children. Preconception care is integral to primary care for women in their reproductive years."*
- Reproductive justice framework

<https://www.aafp.org/pubs/afp/issues/2013/1015/p499.html>

# PCMH Model



*NYS PCMHs receive enhanced reimbursement from Medicaid.*

# Preconception Care in a PCMH

**In a PCMH practice:**

*All patients receive an annual Comprehensive Health Assessment...*

*Practice reviews and reconciles medications at all relevant visits*

*Patients receive care coordination and navigation support to ensure access to other care needs...*

**Integrating preconception care:**

...including **Pregnancy Intention Screening:** "Would you like to get pregnant in the next year?"

...including discussing any current medications that could impact reproduction and pregnancy

...including women's health (contraception, fertility, prenatal), behavioral, and social care

# PCMH workflow alignment

Preconception Care Components	PCMH Standards
Pregnancy Intention Screening	KM 02 Comprehensive Health Assessment
Screenings: Family/genetic history, occupational & environmental exposures, nutrition & physical activity, HRSNs, infertility risk	KM 02: Comprehensive Health Assessment
Medication review and counseling	KM 14/15: Medication Lists & Reconciliation
Physical & Mental Health Management	KM 01/06: Problem lists; KM 03/04: BH Screenings
Referral to women’s health, fertility, behavioral health, etc.; eventually transition care back from OB	CC 04: Referral management
Support with HRSNs	KM 21/26: Community resources
Care management support to address management of chronic conditions, behavioral health needs, etc.	CM 04-10: Care plans for care management patients

# Provider Feedback

- Consensus on importance of preconception care, though not consistently addressed. Integrating into PCMH is a good pathway.
- Key challenges: provider time, training, reimbursement, implementation lift, patient education/awareness
- Recommendations included:
  - Ensure the Preconception Care model allows for customization & cultural responsiveness
  - Find opportunities for care team efficiency (e.g., team-based approach, leverage health IT)
  - Develop language to articulate, "what makes this different from *care as usual*?"
  - Find additional ways for reimbursement opportunities

# Current Pilots

- Pilot Site #1:
  - FQHC primary care site in Brooklyn
  - Starting implementation OKQ pregnancy Intention screening & counseling workflow
- Pilot Site #2:
  - Hospital- affiliated FQHC primary care site in Brooklyn
  - Testing preconception counseling workflows using short videos for education

# Lessons learned, so far

- PCPs are very open to discussing preconception health and would like more training
- Consider separate visit for preconception counseling; including it in the annual visit may be too rushed (e.g. Telehealth visit)
- Plan team-based workflow (including MA, CHW, LPN, etc.)
- Identify high-impact patient materials & community resources corresponding to preconception counseling points
- Leverage EHR for efficiencies (e.g. patient education)
- Ensure contraception workflows are also in place

# Add'l NYC REACH Services

- **Preconception Care in the PCMH Webinar:** Live and recorded sessions for PCMH practices
- **Contraceptive Care in FQHCs:** Workflow support and contraceptive care education for primary care providers through our partner [Upstream](#)
- **Billing:** Training and technical assistance on Medicaid billing for CHW and Doula services
- **Unite Us:** Licenses at no cost to use for community care referrals
- **Resources:** Tools in [nycreach.org](#) Resource Library; Linkage to Health Dept Services (Abortion Hub, Nurse Family Home Visiting, Diabetes Self-Management)

# Next Steps

- Pilots are currently still in progress
- Refine and iterate on tools and trainings based on results of pilots
- Seek funding and partnerships to expand the model to more FQHCs and primary care practices
- Continue messaging that preconception care is an integral component to the continuum of reproductive healthcare

# Thank you!

Janice Magno, MPA, PCMH-CCE

[jmagno@health.nyc.gov](mailto:jmagno@health.nyc.gov)

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