

ARHP Commentary – Thinking (Re)Productively

ONE KEY QUESTION®: Preventive reproductive health is part of high quality primary care[☆]

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Contraception and other reproductive health services have recently gained national attention as part of the core preventive services that should be available to all women as part of health care reform. In Oregon, we have a unique model of health care reform with an emphasis on measuring quality, and sexual and reproductive health advocates in our state have achieved a major milestone: inclusion of contraception provision as a marker of quality care. This was possible because of the widespread support of an initiative called ONE KEY QUESTION.

ONE KEY QUESTION was created and developed by the Oregon Foundation for Reproductive Health (OFRH) to address the issue of diminishing access to contraceptive services in primary care. Typically, women access contraception only by requesting it from their clinician. However, if contraception truly is a primary prevention service, then women should be screened for their pregnancy intentions on a routine basis and offered contraception if they do not want to become pregnant. ONE KEY QUESTION proposes that

primary care providers ask women: “Would you like to become pregnant in the next year?” For women who answer “yes,” the clinician offers preconception counseling and screenings to ensure that they are in optimal health for a pregnancy. For women who answer “no,” the clinician counsels on the full range of contraception options to ensure that the method they use is optimal for their circumstances. Women who are ambivalent or unsure of their pregnancy intentions comprise a substantial portion of the population, and clinicians offer these women a combination of both services.

While this initiative would only reach women who have access to primary care (a substantial shortcoming), we believe that it is a promising approach in beginning a conversation about a woman’s reproductive health needs. The approach of ONE KEY QUESTION equally supports women who want to conceive and those who do not want to conceive, and it aims to help women meet their own goals for the number and spacing of their children. ONE KEY QUESTION also establishes a new category of preventive services — preventive reproductive health — comprised of preconception care and contraception services. Using the frame of contraception as a prevention strategy fits it squarely in the national conversation of high-quality primary care.

To date, there have been no publishable studies on ONE KEY QUESTION to determine its effectiveness, and that

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remains a high priority in Oregon and elsewhere. However, ONE KEY QUESTION has gained support and recognition throughout the state of Oregon and has been endorsed by all professional organizations serving adult women, including the Oregon Medical Association, the Oregon Chapter of the American Congress of Obstetricians and Gynecologists, the Oregon Academy of Family Physicians, the Oregon Nurses Association, the Oregon Public Health Association and seventeen other professional and public health organizations. This support was crucial to our effectiveness in advocating for a contraceptive metric in the design of Oregon’s health care reform structure.

1. Background

Unintended pregnancies account for half of all births and about 1.2 million abortions each year [1]. According to the 2002 cycle of the National Survey of Family Growth, 83% of women age 15–44 years have had at least one male sexual partner in the past year [2] yet only 41% state that they received any contraceptive services from a health provider in the past year, and only 19% of them received contraceptive counseling [3].

In July 2011, the Institute of Medicine recommended that insurers fully cover the costs for all contraceptive methods approved by the Food and Drug Administration, as well as for education and counseling [4]. In the *New England Journal of Medicine*, Pace et al. called for a meaningful response to the Institute of Medicine recommendations, stating that “primary care practices and patient centered medical homes must prioritize contraceptive care [5].”

In 2010, Schwarz et al. found that routine collection of information about women’s pregnancy intentions and contraceptive use in primary care practices is feasible, acceptable to women, and has the potential to reduce both unsafe prescribing to women and primary care physician liability [6]. In 2011, Lee et al. published a study demonstrating that contraception counseling by a primary care clinician can increase the likelihood that women use contraception [7].

Preconception services such as counseling on folic acid, limiting alcohol and tobacco use, managing chronic diseases and avoiding teratogenic medications can significantly improve pregnancy outcomes [8]. Maternal behaviors, health conditions and risk factors that most significantly impact pregnancy outcomes are best modified and, often, only modifiable prior to pregnancy. By the time a woman makes it to her first prenatal visit, even if that visit is in the first trimester, most fetal organs have been formed and interventions to prevent birth defects or other adverse outcomes will have little to no effect. Prenatal care is a program of surveillance; true prevention happens before the pregnancy.

Preconception care gained national attention in 2006 when the Centers for Disease Control and Prevention (CDC) published its proceedings of the *Preconception*

Health and Health Care Clinical, Public Health, and Consumer Workgroup. One of their four goals is to “Assure that all women of childbearing age in the United States receive preconception care services that will enable them to enter pregnancy in optimal health [9].” The fifth edition of the American Academy of Pediatrics/American Congress of Obstetricians and Gynecologists *Guidelines for Perinatal Care* reflects an emphasis on integration of preconception health promotion into all health encounters during a woman’s reproductive years [10], and the CDC makes a similar recommendation [11].

2. Health policy context in Oregon

Oregon is among a handful of states leading the nation in innovative health care reform efforts, and is the only state utilizing the model of Coordinated Care Organizations (CCOs). CCOs are new legal entities serving the Medicaid population that are locally organized and provider driven. They are comprised of the major hospitals and clinics, public health departments, health plans and community organizations working together to coordinate services in order to reach the triple aim: better health, better care and lower costs. Health care providers in our state will be required to track quality metrics that are linked to a global budget for payment of services.

Quality metrics are variables that clinics and hospitals measure to determine some aspect of the care that is delivered — access to services (e.g., average wait time for an appointment), processes clearly linked to better outcomes (e.g., time to initiation of antibiotics in hospitalized patients with pneumonia) or outcomes themselves (e.g., Cesarean section rates). Health care providers use these measures to assess the quality of health care services they deliver by finding their institutional baseline, and then setting targets for improvement.

Hospitals, federally qualified health centers and others have been tracking various quality metrics for many years to comply with Joint Commission standards, Medicare rules or federal grant obligations. However, decades of work in the public and private sectors, leading up to and including the Patient Protection and Affordable Care Act (Obama’s federal health care reform law), are quickly moving metrics from the periphery of health care delivery to the center. It will not be long before most health care delivery is paid based on performance assessed using quality metrics. Oregon is transforming payment models now, in 2013. Starting with Medicaid beneficiaries, Oregon providers will no longer be paid for volume of visits, but for the quality of care they deliver to their population.

Most of Oregon’s CCO metrics for women’s health are based on national metrics (such as Healthcare Effectiveness Data and Information Set and National Quality Forum) and include measures such as “entry to prenatal care in the first trimester” and “elective inductions before 39 weeks.” There

are currently no national metrics regarding unintended pregnancy or the delivery of contraceptive services or preconception care. This is a critical omission because, as we move toward a future where most health care is evaluated (and paid for) based on performance on quality metrics, the lack of a reproductive health metric means that reproductive health will fall further off the radar of most primary care providers. Because of the widespread support for ONE KEY QUESTION among professional organizations in Oregon and the advocacy of OFRH, the quality metrics for CCOs in Oregon now also include “Effective contraceptive use among women who do not desire pregnancy.” It is one of the only Oregon metrics that is not based on a national metric and is an important milestone.

This metric matters because if clinicians are required to report the proportion of women in their practices who are using effective contraception (among those who do not want to become pregnant), then they will have to screen women for their pregnancy intentions and document this in the medical record. The proportion of who do *not* wish to become pregnant but are *not* using effective contraception will be a quality deficiency of the clinic. After screening, clinicians will need to ensure that women have access to all forms of contraception services, whether or not they provide contraception themselves. This will hold primary care providers accountable for whether their patients have access to contraception in the same way we are holding them accountable for blood sugar control in diabetics. Doing so prioritizes contraception as a necessary preventive service that is part of high-quality primary care.

OFRH is a statewide nonprofit advocacy and policy organization whose mission is to improve access to comprehensive reproductive health care, including preventing unintended pregnancies and planning healthy families. OFRH’s success in advocating for this metric was partly attributable to the recognized prevalence of this challenge — women comprise more than half the population and they are fertile for about 35 years of their lives. Most spend about 30 years trying to prevent unintended pregnancy and a few years trying to have healthy pregnancies. In this context, reproductive health mimics chronic disease management; there is an ongoing need for attention to a woman’s changing reproductive health needs over long periods of time. Reproductive health would benefit from the proactive, prevention-focused model we have so eagerly adopted for chronic diseases.

In addition, there is immediacy to the cost savings in prevention of unintended pregnancy that is difficult to match in prevention of chronic diseases. In Oregon, more than half of all deliveries are paid for by our Medicaid plans. If we need to bend the cost curve, especially in publicly funded health care delivery, we must not overlook the importance of ensuring that women are using contraceptive methods that meet their needs and that all women have access to long-acting methods of contraception.

OFRH hopes that many clinicians in Oregon will use ONE KEY QUESTION as the tool to screen women for their pregnancy intentions and report their performance on the metric “Effective contraception use among women who don’t desire pregnancy.” If we are successful in using this metric and this tool to promote preventive reproductive health, then we will have laid the groundwork for a national metric in reproductive health. A national metric based on an evidence-based tool would serve two very important functions: first, it would ensure that reproductive health is a core component of primary care, and second, it would offer a new approach to preventing unintended pregnancies and ensuring that wanted pregnancies are healthier.

3. Opportunities for action

Screening women for their pregnancy intentions could prove to be the intervention we need to make more significant reductions in rates of unintended pregnancy and develop metrics in the field of reproductive health. Methods of measuring pregnancy intention, including ONE KEY QUESTION, need to be studied in various settings to determine whether they are effective in improving uptake of contraception and preconception care.

Here are three things you can do if you believe this is a promising direction for family planning: (1) Try asking women in your clinic “Would you like to become pregnant in the next year?”, notice the effect it has on preconception care and contraception services and share your experience with the OFRH. Go to www.onekeyquestion.org to learn more. (2) Design a clinical study of pregnancy intention screening at your clinic and share your results. (3) Learn about the importance of metrics by reviewing two reports from the Institute of Medicine:

- <http://www.iom.edu/Global/News%20Announcements/Crossing-the-Quality-Chasm-The-IOM-Health-Care-Quality-Initiative.aspx>
- <http://www.iom.edu/Reports/2010/For-the-Publics-Health-The-Role-of-Measurement-in-Action-and-Accountability.aspx>

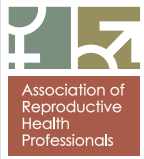
Then, when your clinic or hospital is looking for quality indicators to measure, get involved! Providers need to play a stronger role in creating new standards of quality. Suggest measuring pregnancy intendedness, contraception access, preconception care delivery or other reproductive health measures. Advance the discussion about the need for a national metric regarding prevention of unintended pregnancies and provision of contraception services. This is critical to ensure that reproductive health is included in our evolving definitions of high-quality clinical care.

Ultimately, reducing the number of unintended pregnancies and improving the health of wanted pregnancies will require us to take a more proactive approach. ONE KEY

QUESTION is a practical way to screen women for their need for reproductive health services while staying in the neutral ground of helping our patients and their families meet their *own* reproductive goals and achieve better health.

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