



Reproductive Health Action Plan

Indiana Perinatal Quality Improvement Collaborative
Approved by the Governing Council March 219 |

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Indiana Perinatal Quality Improvement Collaborative (IPQIC) Reproductive Health Planning Task Force Action Plan 2019

Introduction:

Indiana has the highest infant mortality rate in the Midwest ¹. Unfortunately, we have been unable to move the dial towards improved health care outcomes for Hoosier infants. In 2016, 634 infants died before their first birthday in Indiana. We continue to have a rate higher than the US average which is also above the Healthy People 2010 goal². A large part of the high infant mortality rate is due to racial disparity in that black non-Hispanic infants die at a 2-3 times higher rate than white non-Hispanic infants³.

Data shows that roughly half of the infant deaths in Indiana are associated with perinatal risk factors ⁴. These risk factors include low birth weight, spontaneous preterm birth, unplanned pregnancy, maternal smoking and substance use, poorly controlled chronic maternal health conditions such as obesity, diabetes and hypertension and lack of initiation of prenatal care in the first trimester. These risk factors are identifiable and therefore potentially amenable to change.

Goal:

The goal of the Reproductive Health Planning Task Force is to create a 3 to 5-year strategic plan to reduce the high infant mortality rate in Indiana by creating healthier families. The overarching goal is to help the families and communities in Indiana work together to create healthier lifestyles. Earlier work done by the IPQIC Interconception and Preconception task force has shown that healthier moms have healthier pregnancies, deliver healthier infants and create healthy families⁵.

¹ <https://www.statista.com/statistics/252064/us-infant-mortality-rate-by-ethnicity-2011/>

² <https://www.cdc.gov/nchs/pressroom/states/indiana/indiana.htm>

³ <https://www.in.gov/isdh/26292.htm>

⁴ <https://www.in.gov/isdh/26292.htm>

⁵ <https://www.in.gov/laboroflove/762.htm>

We have created a strategic plan that identifies goals, areas of focus and specific action items for each stage of a person's life regarding reproductive health decisions. This document outlines the task force strategic plans based on the reproductive cycle: pre-childbearing or adolescent phase, childbearing phase and post-childbearing phase. We realize that no one committee will be able to complete all these action items but the goal is that this document serves as a blueprint for several committees to work together in a statewide effort to improve the health of the families in Indiana.

Overarching reproductive cycle goals:

The IPQIC Reproductive Health Planning (RHP) task force identified specific phases to focus to efficiently address issues that contribute to the high infant mortality rate. The goals during each phase of reproductive health planning are as follows.

1. **Pre-childbearing and Adolescent phase:** this phase begins during the adolescent years and continues until young women and men make a choice to begin a family.
 - a. To develop life-long healthy lifestyle habits and mindsets.
 - b. To develop healthy communities that encourage positive youth and family development.
 - c. To introduce the importance of reproductive health planning.

2. **Childbearing phase:** this phase begins when women and men begin actively reproducing and creating families.
 - a. To identify all women and men that desire to start a family and encouraging them to be physically and emotionally ready to begin childbearing.
 - b. To identify perinatal risk factors for adverse pregnancy outcome early for potential evidence-based interventions to be effective.
 - c. To develop healthy communities that support healthy lifestyle habits and address modifiable social determinants of maternal and infant mortality.
 - d. To develop adequate resources for birth spacing for all women to promote healthier mothers prior to attempting to conceive a subsequent pregnancy.

3. **Post-childbearing phase:** this phase begins after the completion of active childbearing (actively reproducing years) and continues during the child-rearing and family support building phase.
 - a. To develop and promote healthy life long behaviors.
 - b. To promote a healthy family identity and social support of families.
 - c. To prevent unplanned pregnancy after active perceived child-bearing is completed.

In the remainder of the document we will detail and outline areas of focus and specific action items in each of these three life cycle phases.

I. Pre-childbearing and Adolescent phase

The areas of focus identified by the task force for this phase include providing education in healthy lifestyle habits, weight, diet, physical activity, immunization and sexual education to prevent sexually transmitted diseases and unplanned pregnancy. Focus areas also include educating young men and women to avoid unhealthy lifestyle habits including smoking, vaping and chewing tobacco, use of illegal or non-prescribed substances.

Realizing that young men and women mature and physically develop at different ages the task force has identified an evidence-based simple assessment for all providers (physicians, advanced practice providers, mental health providers, school nurses, youth case managers, technical school and college advisors, social workers and faith leaders) to ask young men and women. The One Key Question (1KQ) has been identified as a nonjudgmental, nondiscriminatory way to begin a conversation to help young men and women identify their life goals and priorities. This question involves asking young men and women: “Do you or your partner see yourself ready to start a family within 1 year?” This question in different formats provides a starting block for a discussion around reproductive and family planning regardless if the discussant is a medical provider or a youth leader. It also enables a discussion around identifying life goals and helps young men and women create priorities based on their identified goals.

The final area involves a creating a statewide priority to improve HPV vaccination rates in Indiana. The Indiana immunization rates for HPV vaccination are low compared to other states . The reasons for low vaccination rates are cost, accessibility for lower socioeconomic families, changed indications for young men and women and misunderstanding the benefits of the vaccination (as a cancer prevention vaccination).

Specific action items for Pre-childbearing and Adolescent phase identified by the IPQIC RHP task force.

1. Educate all providers (physicians, advanced practice providers, mental health providers, school nurses, youth case managers, technical school and college advisors, social workers and faith leaders) on the use and benefits of universal pregnancy intention screening in starting the discussion around life planning including

reproduction goals.^{6,7} Young men and women who desire to become pregnant or desire their partner to become pregnant are directed to preconceptional health and planning for a healthy pregnancy. Those do not desire to become pregnant or for their partner to become pregnant are directed how to identify their life priorities and prevent unplanned or mistimed pregnancies. The goal is to include young adult males in the discussion regarding family planning early and often.

2. Educate women’s health providers on the recently released ACOG infographic “*21 Reasons to see a Gynecologist Before Age 21 Years*”⁸. This document helps medical providers begin a conversation regarding life goals and priorities and sexual health during the adolescent years.
3. Focus areas of education and health promotion statewide on the counties with the highest teen pregnancy rates.
4. Increase access and education regarding the benefits of HPV vaccination as a **cancer prevention drug** to decrease the stigmata associated with sexual transmission. The benefits of HPV vaccination are to decrease the burden of-HPV related cancers in adulthood including cervical, oropharyngeal, anal, vulvar and vaginal cancers that usually present in the adult phase after inoculation several years earlier. This includes working with college campus student health offices to utilize existing successful campaigns such as the IUPUI HPV bathroom stall campaign. This campaign could be utilized and spread to other college campuses in Indiana.
5. Develop a primary prevention strategy to promote positive youth development and prevent unintended pregnancy. This strategy would recommend a grant program that promotes goal setting among adolescents in their communities and encourages parents to talk about healthy behaviors in the home. This has been a successful venue in the past. Sexual Risk Avoidance Education funds and Personal Responsibility Education Program grants support funding for health education programs across the state. Seeking additional funding and promoting the implementation of curricula such as Making a Difference, the Teen Outreach Program and other evidence-based

⁶Johnson K, Posner SF, Biermann J, Cordero JF, Atrash HK, Parker CS, Boulet S, Curtis MG; CDC/ATSDR Preconception Care Work Group; Select Panel on Preconception Care. 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. MMWR Recomm Rep. 2006 Apr 21;55(RR-6):1-23.

⁷ Prepregnancy counseling. ACOG Committee Opinion No. 762. American College of Obstetricians and Gynecologists. Obstet Gynecol 2019;133:e78–89.

⁸ <https://www.acog.org/Patients/FAQs/21-Reasons-to-see-a-Gynecologist-Before-Age-21-Infographic>

curricula will equip adolescents with skills and knowledge necessary to make choices that will enable them to achieve their personal goals.

6. Focus education and media on teens and adolescents regarding the dangers of cigarette smoking, vaping and chewing tobacco. These unhealthy behaviors can contribute to lifelong health issues and are risk factors for adverse pregnancy outcomes leading to infant and maternal mortality.

II. Childbearing phase

Ideally this area begins when a young man or woman answers “Yes” to the one key question regarding their desire to start a family within the next year. This should identify an important transition to all providers of young adults including physicians, advanced practice providers, school nurses, therapists, mental health workers, youth case managers, college and technical school advisors, faith leaders, etc.

One of the primary areas of focus identified by the task force during the childbearing years include stressing the importance of the preconceptual visit to include discussion and education regarding optimal maternal health, smoking, substance use disorder, mental and physical health readiness and assessment of possible genetic issues. There was consideration in the task force that any primary care visit should be viewed as a preconceptual visit if the patient had answered the one key question affirmatively.

A second area of focus identified by the task force is to work to eliminate barriers to prenatal care for women in Indiana. These barriers to adequate prenatal care may include a lack of providers as there are 32 of the 92 Indiana counties without OB providers per the most recent state data⁹. There are an equal number of Indiana counties that do not have delivering or birthing centers. Both require women and families to travel great distances for not only delivery but for prenatal care.

The task force recognizes that racial disparity plays a key role in women’s health during the childbearing years. Black women share a higher burden of medical conditions including hypertension, diabetes and obesity. Preexisting medical conditions, socioeconomic factors, and educational level are contributing factors to the disparity seen in black women’s healthcare. Although statistical data from studies validate the increased risk factors that contribute to both infant and maternal mortality in black women, not all patients have these known components. There are recent reports in the lay media of near misses and maternal deaths in black women with known and unknown medical conditions and complications

⁹ Unpublished data. See attachment 1

including Serena Williams, Kira Johnson and Shalon Irving.¹⁰ These situations have been felt to be largely due to implicit or unconscious bias among health care providers in caring for black women. The task force felt that implicit bias on the part of health care providers may contribute to racial and ethnic disparities in health. The task force felt that healthcare providers must become knowledgeable about their own implicit biases and ways to eliminate their own biases in the care of minority women.

The task force felt that optimal birth spacing would improve the chances of a successful healthy pregnancy. The ideal pregnancy length is 39 to 40 weeks. There is an optimal birth spacing length that decreases the chance of fetal and infant mortality. The length of time between giving birth to one baby and getting pregnant with the next should be 18 months or more¹¹ [8]. Women who get pregnant sooner than that are more likely to have a premature baby.

“Significant public health disparities exist surrounding teen and unplanned pregnancy in the United States. Women of color and those with lower education and socioeconomic status are at much greater risk of unplanned pregnancy and the resulting adverse outcomes. Unplanned pregnancies reduce educational and career opportunities and may contribute to socioeconomic deprivation and widening income disparities. Black and Latina teenagers are more than twice as likely as white teenagers to experience a pregnancy, with half of black and Latina teens becoming pregnant before age 20. Half of teen mothers do not receive a high school diploma by age 22, perpetuating a cycle of lower educational attainment and poverty.”¹² Methods of contraception that have been shown to be the most effective with the lowest failure rates are those forms known as long acting reversible contraception (LARC). LARC methods including intrauterine devices (IUDs) and implants work by preventing fertilization. The task force was aware that more education was needed in both providers and patients regarding the benefits of LARC as an evidenced-based method of birth spacing. In addition, lack of access to an insurance coverage for these most effective methods was identified as a need to be addressed at the state-wide, local and institutional levels.

The task force members also felt that we needed to address the level of maternal smoking during pregnancy. Nearly 14% of women report that they smoke during pregnancy¹³. Thus,

¹⁰ <https://hub.jhu.edu/2019/02/26/shalon-irving-maternal-mortality-symposium/>

¹¹ Interpregnancy Interval and Adverse Pregnancy Outcomes: An Analysis of Successive Pregnancies. Hanley, Gillian E. PhD; Hutcheon, Jennifer A. PhD; Kinniburgh, Brooke A. MPH; Lee, Lily MPH. *Obstetrics & Gynecology*: March 2017 - Volume 129 - Issue 3 - p 408–415.

¹² [https://www.ajog.org/article/S0002-9378\(16\)00301-X/fulltext](https://www.ajog.org/article/S0002-9378(16)00301-X/fulltext)

¹³ Indiana State Department of Health. Indiana Natality Report, State and County Data 2015. Published December 2016. www.in.gov/isdh/19095.

Indiana ranks as the 11th highest state in maternal smoking. Smoking is a well-known risk factor for prematurity, low birth weight, preterm birth, miscarriage and SUIDS (sudden unexpected infant death syndrome).

The task force felt that in pregnancies that do not end in a live birth such as miscarriage, stillbirth, ectopic and pregnancy termination, there is an important but often missed opportunity to effect a change and optimize and women's chance of successfully completing a subsequent healthy pregnancy if she chooses or preventing a subsequent unplanned pregnancy. The task force felt that urgent care and hospital emergency room facilities could better assist in arranging continuing care and insurance coverage until follow up care was established.

The rising substance use disorder (SUD) rate during pregnancies was felt to contribute to the high infant mortality rate in Indiana. Thus, the task force identified that providing women and families with better access for medication-assisted therapy for women with SUD during and, importantly, continuing after pregnancy would improve the high infant mortality rate in Indiana. Women with SUD must have effective forms of contraception (LARC methods) accessible and readily available to ensure they meet treatment and family goals before attempting another pregnancy, if desired.

Specific action items for Childbearing phase identified by the IPQIC RHP task force.

1. Define and educate providers regarding the key components of a preconceptual visit. Disseminate this information to providers around the state to improve patient care and patient education to optimize maternal health prior to pregnancy.
2. Provide implicit bias training for healthcare providers in Indiana using existing educational programs and the planned March of Dimes training. Indiana is now a state partner with Alliance for Innovation on Maternal Health (AIM), a program sponsored by ACOG. AIM has a practice bundle on health equity. These training opportunities support an awareness for providers on unconscious bias that can affect the health care they deliver to minority patients.
3. Work with Indiana Family Social Services Administration (FSSA) to increase access to care and eliminate potential barriers by extending postpartum coverage to allow women with chronic medical conditions including substance use disorder more time and access to optimize their health. This has long term dividends regarding the improving the overall health of families in Indiana. A recent legislative initiative in Missouri resulted in the extension of postpartum coverage for one year for women with substance use disorder. Other suggestions to consider are to decrease the

number of cases requiring prior authorization including treating women with substance use disorder and incentivizing earlier entry into prenatal care financially using MK reimbursement policies. In addition, the task force felt that patient enrollment into Medicaid funded programs during pregnancy may need to be evaluated regarding potential barriers.

4. Determine the current accessibility and needs of women in the state regarding access to affordable long acting reversible contraception (LARC) in both outpatient and inpatient settings (immediate postpartum placement of IUDs and implants). This will assess the supply of trained LARC insertion providers using multiple contacts:
 - A. Delivering facility nursing and pharmacy leaders
 - B. County health commissioners
 - C. Healthcare providers (state Nurse Practitioner Association, CNM, Indiana provider professional associations including ACOG, AAP, AAFM)
 - D. College, university, secondary and trade school campus health care representatives
 - E. Special groups such as incarcerated women or juveniles, high schools, homeless shelters, domestic violence shelters and food pantries.
5. Provide multiple venues to increase LARC insertion training among current women's health care providers (OBGYN, Pediatrics, Family Medicine, Certified Nurse Midwives, Nurse Practitioners, Physician Assistants). These training venues can include local and large statewide meetings.
 - A. Labor of Love Conference
 - B. ISDH Breastfeeding Conference
 - C. Indiana statewide professional meetings such as Indiana sections of chapters of the American College of Obstetricians and Gynecologists (ACOG), American Academy of Pediatrics (AAP), and the American Academy of Family Medicine (AAFM) meetings.
 - D. We will also assemble a training team to travel to local sites in areas outside of metropolitan Indianapolis for immediate postpartum IUD placement, IUD insertion and Nexplanon insertion training.
6. Initiate and perform same day LARC insertion quality improvement projects at select sites around the state to improve the access to care for women in rural areas. This will involve mobile sites and training to increase provider training.
7. Identify LARC insertion trained care provider champions in each perinatal region, hospital systems and specialty to provide ongoing navigation and troubleshooting to set up LARC contraceptive insertion sites.

8. Create mass public educational campaign to EDUCATE patients regarding the benefits of birth spacing and prevention of teen and unplanned pregnancy using LARC in multiple venues (social media, print, blogs, audiovisual, buses, billboards, multimedia, public service announcements, radio talk shows) using prepared vetted culturally sensitive messages.
9. Provide focused education to increase awareness among influential stakeholders and decision makers regarding the benefits of optimal birth spacing to reduce Indiana's high infant and maternal mortality. We plan to discuss the safety, method of action (prevent fertilization and not abortifacient), and failure rates of LARC methods.
10. Increase collaboration with statewide stakeholders ¹⁴including:
 - A. Indiana University School of Medicine and Indiana University Clinical and Translational Sciences Institute to provide data analytics for statewide deployment of improved contraception access. This will include creating a mobile LARC training, counseling and insertion vehicle to reach places with very limited access or access limited by religious affiliation.
 - B. Perinatal Level 3 and 4 hospitals: Assist level 3 and 4 hospitals in the requirement to provide ongoing educational sessions and quality improvement projects in all the delivering hospitals in Indiana for providers, lactation consultants and obstetric nurses regarding updates on therapies during pregnancy to reduce infant mortality including:
 - a. training on topics such as breastfeeding with LARC, the benefits of immediate postpartum placement of LARC and breastfeeding difficulties.
 - b. the benefits and recommendations of aspirin therapy to reduce the risk of preeclampsia in women with hypertension and prior preeclampsia.
 - c. the use of hydroxyprogesterone therapy to prevent preterm birth in women with a prior history of preterm birth.
 - d. the use of late preterm corticosteroids to reduce respiratory distress syndrome (RDS).
 - e. evidence-based smoking cessation methodology that is readily and currently available.
 - f. promotion of parental and family education regarding safe sleep and postpartum family support therapy including the use of postpartum doulas.

¹⁴ See Attachment 2

- g. using medication-assisted therapy for the treatment for women with opiate use disorders in pregnancy and postpartum.
 - h. education regarding the early recognition and treatment of perinatal mood disorders.
- C. Indiana Family Health Council has expertise to help create an inventory stockpile of affordable, low cost contraceptive devices for women that cannot afford or have access to contraception. This expertise can help with ordering, managing supply and shipping of LARC methods to sites around the state in need of low-cost contraceptive devices.
 - D. Indiana State Department of Health “LIV” app, Mom’s Helpline and 211: Our plan is to utilize already existing state informational platforms that have a toll-free phone number for women to call in and determine where pregnancy, women’s health care and contraceptive services are available in their area.
 - E. WIRSHARP (Workgroup on Implementation for Reproductive and Sexual Health Advocacy, Research, and Programs) is an existing statewide Pediatric and Women’s Health collaborative formed between IUSM, Indiana Section of the American Academy of Pediatrics (AAP), Indiana Section of American College of Obstetrics and Gynecology (ACOG), and key community stakeholders to focus efforts of improving adolescent access to contraception.
 - F. Indiana professional societies including Indiana Section of ACOG, Indiana Section AAP and Indiana Section AAFM can provide advocacy statewide to providers, patients and policy stakeholders.
 - G. Develop a strategy to focus on specialists taking care of nonpregnant women of childbearing age with chronic disease to include a discussion and provision for contraception until they are healthy enough for childbearing or eliminating unplanned pregnancy.
11. Convene a working group of providers, lactation consultants and nurses to discuss, create and disseminate a document regarding the recommendations for LARC usage and concurrent breastfeeding that is consistent with breastfeeding recommendations and provides safe access for women in Indiana.
 12. Expand and extend tobacco smoking cessation programs to all counties that currently do not have this service.
 13. Emphasize the dangers of cigarette smoking and vaping during pregnancy and postpartum to all providers including nursing, medical and advanced practice provider students such that dissemination is widespread. The task force also felt that current medical providers needed to be better educated on the hazards of smoking and vaping during pregnancy including an association with SUIDs, preterm birth,

prematurity, fetal and infant death. This may include incentivizing smoking cessation using Medicaid reimbursement policies.

14. Develop community education programs about the dangers of cigarette smoking, tobacco chewing and vaping during pregnancy and postpartum. The areas of focus should initially include those counties or regions with the highest smoking rates and those with the highest infant mortality rates.
15. Work with Indiana Hospital Association and hospital emergency rooms around the state to improve follow up care for patients without a live birth (miscarriage, stillbirth, ectopic pregnancy and pregnancy termination) and without established care. This may include getting patients signed up for medical insurance care during the primary visit.
16. Establish an ongoing direct working relationship with the newly formed Maternal Mortality Review Committee (MMRC) to determine and direct attention to preventable causes of maternal death. This connection will allow the task force to respond and quickly direct attention to those recurring preventable causes of maternal death as maternal and infant mortality are directly related.

III. Post-Childbearing phase

This phase begins after the completion of active childbearing (actively reproducing years) and continues during the child-rearing and family support building phase. During this phase the task force identified healthy weight management as a critical area of focus as many women are unable to maintain a healthy body weight. The task force felt this was phase was associated with a lack of education regarding ongoing unhealthy lifestyle habits including smoking, substance use disorder, physical activity and an unhealthy diet.

The task force also felt during this post-childbearing phase access to adequate contraception and sterilization methods was important including vasectomy, tubal ligation and LARC methods. This would help to prevent unplanned pregnancy during this period.

The task force felt that communities would play an influential role in improving the health of families by providing places where families can meet, play and feel safe. These places include libraries, parks, playgrounds, recreation areas, bike trails, and after school care areas.

Specific action items for post-childbearing phase identified by the IPQIC RHP task force.

1. Increase the number of providers capable of performing vasectomy services throughout the state. Racial disparity has been noted in the uptake of vasectomy in black and Hispanic men as they do not generally use vasectomy as a form of contraception.¹⁵ This should include access for low income and minority males possibly through providing training and access at FQHCs (federally qualified health care centers) throughout the state. Consider partnering with urology provider groups to provide vasectomy procedural training.
2. Continue to provide easy affordable access to all forms of contraception including LARC and sterilization methods for women throughout Indiana such that unplanned and mistimed pregnancies are decreased.
3. Increase community involvement and access to recreation areas including parks and walking and biking trails. Other areas of importance to the development of healthy families include access to libraries, safe preschool child care, and before and after school child care.

Summary

The IPQIC Reproductive Health Planning Task Force has set forth a strategic plan to improve the lives of families in Indiana and reduce the high infant and maternal mortality rate. This plan as outlined above addresses many of the burdens that infants and their mothers carry despite ongoing work during the past 20 years. Social determinants of health associated with infant and maternal mortality include incomplete or inadequate maternal education, poverty, lack of safe and affordable childcare, lack of transportation, lack of accessible healthcare providers and affordable health care for early initiation of prenatal care. Perinatal risk factors and social determinants of health contribute to half of the fetal and infant deaths annually in Indiana. Implicit bias of healthcare providers plays a role in the health care disparity seen in Indiana.

Unfortunately, maternal mortality shares many of the same risk factors as infant mortality in Indiana. Maternal mortality is seen more frequently in women living in poverty, those living in rural areas, non-Hispanic black women, older mothers and those with chronic conditions such as cardiovascular disease, hypertension, obesity and diabetes. The fact that maternal mortality and infant mortality are linked is understandable. This task force created a

¹⁵ Eisenberg, M.L., Henderson, J.T., Amory, J.K., Smith, J.F., and Walsh, T.J. *Urology* 74: 1020–1024, 2009.

strategic plan to use as a guide over the next 3-5 years to improve the lives of infants, mothers, fathers and thereby families in Indiana.

While the recommendations identified in this action plan are ambitious, they are achievable with a united effort across stakeholders. Emerging evidence and research will require that the action plan be periodically reviewed and modified to reflect evidence-based practices and evolving information.

Attachment 1: Obstetric Provider Capacity

Attachment 2: One Key Question

What is One Key Question®?

One Key Question® supports women’s power to decide by helping to transform their health care experience. The notion behind One Key Question® is simple: it asks all health providers and champions who support women to routinely ask, “Would you like to become pregnant in the next year?” By dividing patients’ answers into four categories (yes, no, ok either way, and unsure), the provider or champion takes the conversation in the direction the woman herself indicates is the right one, whether that is birth control, preconception health, prenatal care, or other needs.

This approach works because it focuses on understanding a woman’s intentions and providing follow-up care based on her response. By proactively approaching women, One Key Question® addresses the root causes of unintended pregnancies, poor birth outcomes, and disparities in maternal and infant health. It is non-judgmental and equally supports women who want to become pregnant and those who do not.

***Milken Institute:** “Health centers should move rapidly toward assessing women’s pregnancy intention by adopting a screening protocol such as the One Key Question®. Women readily answered the question in our survey, and use of the question helps ensure identification of all women of reproductive age who do not affirmatively intend to become pregnant, so that such women can receive immediate follow-up counseling, contraceptive care, or referral for family planning services.”*

Does it work?

Multiple positive pilot studies of One Key Question® have taken place across the country and a randomized control evaluation is currently underway.

OHSU Family Medicine Richmond Clinic

This pilot found that clinicians and their support staff easily navigated the One Key Question® questionnaire, found the screening was feasible in a busy clinic setting, and did not add significant time to patient visits. This pilot also found that the patients thought the screening met their needs.

Washington County Family Planning

This study of One Key Question® involved 2,500 women, including around 800 Spanish speakers. Six in ten (60%) of women who received One Key Question® reported satisfaction with their current method of contraception, and 23% of women received new contraception services (14% began using contraception, 9% changed to a preferred method). In addition, 12% of women were given preconception care. Participating providers reported they were better able to identify women who were ambivalent about pregnancy due to other conditions such as IPV, mental health disorders, and substance abuse, which prompted additional services and referrals.

Multnomah County Southeast Primary Care Clinic

This pilot showed that even among a small sampling of women seen by a single provider, One Key Question® can impact women's health. More than 14% of participating women wanted to become pregnant, and yet most of them were not taking steps toward a healthy pregnancy. Half of the women in this pilot who did not want to become pregnant were at risk of unintended pregnancy. Among them, One Key Question® decreased the proportion using no method of contraception from 26% to 4%, and increased the proportion using the most effective methods from 32% to 46%.

One Community Health

This study compared two clinics, one that implemented One Key Question® and one that did not. The analysis using electronic health records found 64% of patients in the intervention site had received appropriate screening compared to 12% at the non-intervention site. The 52% improvement rate was attributed to adopting One Key Question® as a simple clinical procedure for staff to incorporate into their normal workflow of patient care.

Clay County (MO) Public Health Center

Nearly four in ten (38%) clients did not want to get pregnant and 42% reported they only wanted to become pregnant in the future in this pilot study. The Center reported that staff struggled at first, asking only clients they thought would need preventive reproductive health care. After further training to discuss bias and opportunities missed when predetermining who needs what care, staff began using One Key Question® with all clients.

Brigham and Women's Hospital

Comprised of 517 women seeking treatment for a systemic rheumatic disease during the course of the pilot, this study demonstrated the feasibility of implementing a reproductive health intention screening tool in a high-volume academic practice. In addition, One Key Question® reduced barriers to OB/GYN referrals for contraceptive and preconception counseling, 71% of providers felt One Key Question® was a helpful guide, and OB/GYN appointments rose from 5% to 15% six months after the intervention.

A pilot study using cluster randomization is currently underway. Six health care sites are participating in research to determine the effect of One Key Question® on rates of:

- contraceptive counseling and use
- preconception counseling and folic acid use
- patient satisfaction

How do I get certified in One Key Question®?

Power to Decide provides a 1-day, in-person certification training and consultation package for clinics, community-based organizations, public health departments, and other organizations. Each training can accommodate up to 50 people and costs are determined based on the number of individuals. The package also includes: provider and patient materials, five hours of consulting (prior

Attachment 3: POTENTIAL PARTNERS FOR REPRODUCTIVE HEALTH PLANNING

The following are suggested for partnering with the RHP Task Force:

- Native American Indian Affairs Commission
 - Melissa J. Williams, Director
- Nurse Family Partnership
 - Gloria Rivera, RN; Nurse Home Visitor
 - Lisa Crane, MSN, RN, Senior Director for Goodwill of Central and Southern Indiana
- Office of Judicial Administration
 - Lun Pieper, staff attorney; connection with the Burmese community
- Black Nurses Association of Indianapolis
 - Sallye Morris, President
- Northwest IN Black Nurses Association
 - Mona Steele, President
- Lake County IN Black Nurses Association
 - Michelle Moore, President
- Phillipino Nurses Association – IN Chapter
 - Matilde S. Upano, MSN, President
 - Karlene McGill, President –elect
- Pakogo Band of Potowatomi
 - Matt Wesaw, Tribal Council Chairman
- The Aesculapian Society, Indianapolis Chapter of the National medical Association
 - Millicent Moye, President
- Muslim Alliance of Indiana University
 - Aliya Amin, Executive Director
- Indiana Black Expo, Inc.
 - Tanya Bell, CEO
- Jan Clark
 - Senior VP, Leadership Development and HR
YMCA of Greater Indianapolis
- ✓ International Marketplace
 - Mary Clark, Executive Director
- ✓ Indiana Latino Institute
 - Marlene Dotson, President and CEO
- ✓ Indiana Commission on the Social Status of Black Males
 - James E. Garrett, Jr, Executive Director
- ✓ Indiana Commission for Women
 - Kristin Svyantek Garvey, Executive Director

- ✓ Abdul Hakim-Shabazz
 - Political Analyst and Commentator
- ✓ Indianapolis Public Library, Center for African-American Literature and Culture
 - Nichelle Hayes, Specialist/Director
- ✓ Quinton Holland
 - Mental Health therapist
- ✓ Herd Strategies, integrated marketing and communications
 - Denise Herd, President
- ✓ McMiracle Foundaton
 - Reginald and Tracey Jones, founders
- ✓ Flanner House
 - Brandon Cosby, Executive Director
- ✓ Indianapolis Recorder
 - Jose Lucende, Vice President of Strategy and External Relations
- ✓ Indiana Institute for Working Families
 - Jessica Fraser, Director
 - Erin Macey, Policy Analyst
- ✓ Indianapolis Urban League
 - Tony Mason, CEO
- ✓ Black on Black Network
 - Gregory Merriweather, President
- ✓ Jewish Community Relations Council
 - Stephen Klapper, MD, Board President
 - Lindsey Mintz, Executive Director
- ✓ Patricia Payne
 - Retired IPS educator
 -
- ✓ NAACP – Indianapolis
 - Crystal Radcliffe, President
- ✓ Central Indiana Community Foundation
 - Brian Payne, President and CEO
 - Pamela Ross, VP of Opportunity, Inclusion and Equity
- ✓ Women for Change Indiana
 - Rima Shahid, Executive Director
- ✓ Pay It4ward
 - Sabrina Stennette, Executive Director
- ✓ Maurice Young
 - Homeless Advocate
- ✓ National Coalition of 100 Black Women – Indianapolis chapter
 - Rita Venable, Board member