

One Key Question

An Innovation Station Best Practice

Purpose: This document is intended to support MCH professionals to implement a practice found in Innovation Station. This resource provides the information needed to replicate the practice and is divided into two sections: the first section provides a high-level overview of the practice while the second section describes how to implement the practice. For additional information on any of the content provided below, please reach out to the practice contact located at the bottom of this document.

Section I: Practice Overview

Location:	National	Title V/MCH Block Grant Measures Addressed NPM #1 Percent of women, ages 18 through 44, with a preventive medical visit in the past year
Category:	Best	
Date Submitted:	May, 2019	

Practice Description

One Key Question® is a transformative tool for health and social service providers that starts the conversation about if, when, and under what circumstances women want to get pregnant and have a child. The notion behind One Key Question® is simple: it provides a framework for health providers, social service providers, and champions who support women age 18-50 to routinely ask, “Would you like to become pregnant in the next year?” Though this is a seemingly simple question, the answers are more complex. One Key Question® meets women where they are, by offering four responses: yes, no, ok either way, and unsure. Follow up counseling is patient-centered and can be tailored appropriately based on a woman’s response.

Purpose

Maternal and Child Health (MCH) programs across the United States are faced with rising pregnancy-related death rates, high infant mortality rates and growing inequities among different groups by race, ethnicity and income. In addition, MCH programs continue to see high rates of unintended pregnancy.

Between 2008 and 2011, there was a 18% decline in the unintended pregnancy rate among women age 15-44 (Guttmacher, 2019). In 2011, the proportion of pregnancies that were unintended was 45%, the lowest rate since 1981 (Guttmacher, 2019). While the unintended pregnancy rate decreased across the board, disparities among women of color and low-income

women persist. Associations between unintended pregnancy and adverse pregnancy outcomes continue to be a concern for public health.

Pregnancy-related mortality has increased from 7.2 deaths per 100,000 live births in 1987 to 18 deaths per 100,000 live births in 2014 (CDC, 2018). Some studies indicate that these rising rates are related to more women entering pregnancy with chronic conditions like hypertension, diabetes, and chronic heart conditions, putting them at greater risk for pregnancy complications (CDC, 2018). System and structural barriers including oppression, racism, and lack of access to health care are contributing to racial disparities in pregnancy-related mortality with black women three to four times more likely to die than white women (California Newsreel, N.D.)

Infant mortality is often used as an indicator for overall population health. While infant mortality rates have declined 15% between 2005 and 2014, the decline appears to be plateauing (Peterson-Kasie Health Tracker, N.D.) However, the United States continue to have the highest infant mortality rate than other comparable countries and U.S. declines are slower than other comparable countries. As with unintended pregnancy and maternal mortality, disparities by race/ethnicity are seen in infant mortality. Rates among black and American-Indian/Alaskan Natives are higher than average (Peterson-Kasie Health Tracker, N.D.)

Often, we look to our health care system to address such health issues. However, we know that our system is not perfect. Women are expected to go to two different medical providers for their care – primary care and an obstetric/gynecologist or family planning provider. A study based on the data from the National Ambulatory Care survey found that among women of reproductive age receiving primary care in 2009-2010, only 14% reported receiving reproductive health care from their primary care provider (Bello, Rao & Stulberg, 2015). Thirty percent reported receiving reproductive health care from a separate reproductive health specialist (Bellow, 2015). This leaves 56% of women receiving primary care that year received no reproductive health care (Bello, 2015). In addition, our health care system has emphasized prenatal care as a starting point to be concerned about pregnancy outcomes as opposed to focusing on preventive reproductive health which includes both preconception and contraceptive care. Often prenatal care is started well into pregnancy after key developmental milestones have occurred, and there is not enough time to “fix” any major health complications within the nine-month period. While changes in our health care system are needed, MCH programs play a unique role to intervene to help improve outcomes related to pregnancy.

One Key Question® is a transformative tool for health and social service providers that starts the conversation about if, when, and under what circumstances women want to get pregnant and have a child. The notion behind One Key Question® is simple: it provides a framework for health providers, social service providers, and champions who support women age 18-50 to routinely ask, “Would you like to become pregnant in the next year?” Though this is a seemingly simple question, the answers are more complex. One Key Question® meets women where they are, by offering four responses: yes, no, ok either way, and unsure. Follow up counseling is patient-centered and can be tailored appropriately based on a woman’s response.

One Key Question® is effective because it focuses on understanding a woman’s goals and providing follow-up care based on her response, whether that is for birth control, preconception health, prenatal care, or referral to other services. One Key Question® proactively addresses the root causes of mistimed pregnancies, poor birth outcomes, and disparities in maternal and

infant health. It is non-judgmental and equally supports women who want to become pregnant, those who do not, and those who are ambivalent.

This strategy focuses on what women desire rather than intent or how they plan, as research indicates pregnancy planning is not a practice that resonates with all ages, cultures, and backgrounds (Schwarz, Lohr, & Gold, 2007; Yoo, Guzzo, & Hayford, 2014). This shift away from 'planning' is significant. It can avoid off-putting dissonance for those women whose religious or cultural beliefs are antithetical to any version of reproductive self-determination: those who see pregnancy as the result of God's will or fate, rather than a woman's choice. It also obviates the need for a woman to admit to actively "planning" a pregnancy that may incur social disapprobation. Current cultural norms in the United States have eased considerably in relation to what used to be termed "unwed pregnancy." Taboos against "planning pregnancy while poor," however, are still going strong. Framing the discussion in terms of wanting, rather than planning, may ease women's concerns about risking provider disapproval.

It is recommended that sites implement One Key Question® at every visit with eligible clients – people who can become pregnant age 18-50. Additional populations to consider include people who cannot become pregnant/do not have a uterus and adolescents. It can be implemented through a written questionnaire or verbally. One Key Question® providers are asked to implement with fidelity – meaning they use the correct question, provider the four response options, and provider services directly or through referral based on the person's response. If a client responds "yes" to One Key Question®, follow-up should include assessment and treatment based on the core preconception care factors recommended by the American Congress on Obstetrics and Gynecology (ACOG), the National Preconception Health and Preconception Health Care Initiative and other national and international guidelines. Key preconception services include medication review, immunization history, screen/treat for chronic conditions, folic acid supplementation (and other nutritional considerations), genetic risk, review of health behaviors like tobacco and substance use, social supports, mental health, previous pregnancy outcomes, and optimal birth spacing.

If a client responds "no" to One Key Question®, the provider provides contraception counseling and services. This includes assessing for current/prior use of birth control, satisfaction with methods, and assessing what is most important to them in a birth control method. Discussions and provision of emergency contraception and the importance of condoms for sexually transmitted infection prevention should be included.

If a client response "unsure" or "ok either way", providers should offer education and services on preconception and contraception care. When a client expresses ambivalence or neutrality about pregnancy, the conversation is a bit more complex and should be sensitive to family and cultural background. This response may reflect their conflicted feelings about having another child given their financial or relationship situation. It may reflect their religious or cultural beliefs. The complexity of pregnancy ambivalence, and the lack of any research in this area that could guide provider behavior, may make these responses to One Key Question® the most challenging to navigate for providers in any setting. However, this complexity cannot stand in the way of follow-up. Clients who are uncertain about their pregnancy intention are more likely not to be using any form of contraception, or to discontinue contraceptive use for an extended period of time, putting them at a higher risk for unplanned pregnancy.

Whatever the cause of ambivalence, providers should make time available to work with the client to determine what preconception and/or contraceptive care is most appropriate. Given the complexity of responses in this domain, it is likely, however, that follow up may require a

further visit whether in house or via referral. Some of the issues that drive ambivalence are particularly sensitive, so there is special value to follow up with a known provider or via a warm hand-off in these cases.

Successful implementation of One Key Question® requires a plan for systematic incorporation of screening into standard practices and a set of site-specific protocols guiding the course of care for each person based on their response to screening, minimizing barriers. One Key Question® has been adopted by large health systems, state and local public health departments, and others to address a myriad of health equity efforts, including perinatal equity and maternal child health. One Key Question® can be implemented in a variety of clinical and non-clinical settings including home visiting programs, behavioral health, and WIC. One Key Question® providers include clinicians, home visitors, community health workers, dietitians, and many more.

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Practice Foundation

One Key Question's® goal is to transform health care by optimizing access to reproductive health care through standardized screening of pregnancy intention by health and social service providers. It is designed to improve the quality of reproductive care by increasing the probability of a forthright conversation between patient and provider starting with acknowledgement and support for the patient's true aspirations.

One Key Question is an innovative, applied Reproductive Life Planning (RLP) strategy and patient-centered approach to counseling. One Key Question seeks to empower all women in a non-judgmental way, even those who may not hold clear intentions regarding pregnancy (e.g.,

ambivalence) or have complex feelings about achieving or avoiding pregnancy. Using this tool in practice ensures that efforts are being made to engage women in meaningful conversations about their reproductive health goals.

RLP is a process in which both the provider engages in conversation with a patient/client about if and when they might want to become a parent (Tyden et al., 2016; Moos et al., 2008) and then collaboratively make appropriate health care plans to safely and realistically meet those goals (Edmonds & Ayres, 2017). Key components of RLPs include asking patients about their desire for children, the number of children desired, the spacing of children, the timing of children, and include both contraceptive counseling and preconception care when pregnancy is desired (Edmond & Ayres, 2017; Moos, 2006).

In addition, One Key Question® exemplifies patient-centered care (Epstein & Street, 2011), in that the patient or client's specific health needs (e.g., desire for pregnancy, desire for contraception) are the impetus for all health care decisions, including a comprehensive counseling/care plan. Follow-up care and support are based on an individual's response to One Key Question®, whether that is for contraception, preconception health, prenatal care, or a referral to other services. One Key Question® equally supports women who want to become pregnant, those who do not, and those who are ambivalent. (The counseling pathway based on patient/client response has been described previously in this application). One Key Question promotes a more equal provider-patient partnership to achieve the client's reproductive aspirations and increase patient empowerment in decision making about their health. It supports a patient's decisions to have a pregnancy or prevent a pregnancy. It also shifts the conversation of a healthy pregnancy prior to pregnancy as opposed to once it has occurred.

Ultimately, One Key Question® strives to reduce poor pregnancy outcomes, such as infant and maternal mortality, and unplanned pregnancy by increasing evidenced-based contraception and/or preconception care based on the patient's pregnancy desires. Short-term outcomes of using One Key Question® include:

- Improved interpregnancy intervals
- Increase in preconception counseling
- Increase use of folic acid
- Early entry into prenatal care
- Increase in contraception counseling
- Increase in contraception use

One Key Question® is designed to reduce disparities by asking all patients, who can become pregnant, the same question without applying a subjective filter to who needs to be asked. It addresses equity by providing care based on what the patient wants related to pregnancy desires and not based on what the provider thinks they need. This is emphasized through discussions and activities focused on exploring implicit bias and the importance of health equity during the required One Key Question® certification training.

One Key Question® is a way to accomplish the American College of Obstetrics and Gynecology (ACOG) and the American Academy of Family Physicians (AAFP) recommendations to incorporate contraception and/or preconception care tailored to a woman's pregnancy desires into primary care visits. Additionally, One Key Question® is aligned with the Quality Family Planning Guidelines jointly released from the Center for Disease Control and Prevention and Office of Population Affairs which suggest there is no "wrong door" for family planning care and that regardless of how a patient enters the health system, they should receive the benefits of

being screened for reproductive health needs and be linked to appropriate care (Gavin, Moskosky, Carter, et al, 2014).

Although One Key Question® is not based on one particular theoretical framework, it is most closely aligned with Life Course Theory (Elder, 1998) which is an interdisciplinary theory that seeks to understand the complex factors that influence an individual across the lifespan (Hutchinson, 2014; Fine & Kotelchuck, 2010). One Key Question® gives women in clinical and non-clinical settings the opportunity to think about individual pregnancy desire in the next year rather than intention or the ability to plan for pregnancy. Similarly, patients/clients are able to personally reflect on environmental, biological, and social influences in their lives that may contribute to this desire. While this may not be a verbal reflection with the provider, it is often an internal reflection that happens before the response is given. Because One Key Question is intended to be asked a number of times over a woman's life, this approach recognizes that influences and experiences that contribute to pregnancy desire may change over time. Thus, One Key Question® can be seen as a life-course informed approach of thinking about pregnancy desire.

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Core Components

Successful implementation of One Key Question® requires a plan for systematic incorporation of screening into standard practices and a set of site-specific protocols guiding the course of care for each person based on their response to screening, minimizing barriers. In addition, this would include conducting a Pre-Implementation Assessment, building staff buy-in and support, conducting Certification Training and/or Training of Trainers, and developing an evaluation/quality improvement plan. Activities associated with integrating One Key Question into a system or program may differ depending on the setting (i.e. clinical vs. non-clinical).

Practice Activities

Core Component	Activities	Operational Details
<i>Incorporate Screening into Standard Practice</i>	<p>Conducting a pre-implementation assessment</p> <p>Ensure staff buy-in and support for implementation</p> <p>Conduct training (see below)</p> <p>Integration into electronic health record (EHR) or other electronic data system</p>	<p>Assess existing program services and policies to determine what additional action items need to be considered before implementation.</p> <p>Conduct internal outreach to gain staff buy-in.</p> <p>See below</p> <p>Meet with IT staff/EHR system to discuss needed changes to current system.</p>

<i>One Key Question Certification Training and/or Training of Trainers</i>	Training Pre and Post Training Survey Technical Assistance	One-day in-person training for staff implementing One Key Question.
<i>Established protocols for each response option</i>	Assess and establish ability to provide onsite services Establish referrals and linkages to external community resources	Determine how the program will either provide onsite services based on patients' responses to One Key Question. For services not available onsite, programs will establish partnerships and referrals with outside agencies.
<i>Establish a quality improvement or evaluation plan to assess effectiveness of implementation and client outcomes</i>	Develop an evaluation plan Track and analyze Data	Develop an evaluation plan to track and analyze data related to implementation and outcomes.

Evidence of Effectiveness (e.g. Evaluation Data)

See the table below for a list of key findings from One Key Question® pilot sites across the US.

Evaluation Findings from Select One Key Question® Pilot Sites

Milwaukee Lifecourse Initiative for Health Families; Milwaukee, WI (Pilot Results, 2017). This implementation was spearheaded by the Milwaukee Lifecourse Initiative for Health Families (LIHF), convened by United Way of Greater Milwaukee & Waukesha County with funding from the UW School of Medicine and Public Health from the Wisconsin Partnership Program. A 1-year pilot was conducted in four diverse health care settings. Each site selected a champion to serve on the One Key Question® Implementation Team During the pilot (One Key Question® Pilot Results, 2017), 24,042 eligible women were seen at participating sites. Of those women, 9,857 (41%) women were asked One Key Question®. The percent of women answering “No” to One Key Question® was 83% and 13% answered “Yes.” Sixty-two percent of the women asked One Key Question® received contraceptive services or related referrals. Of those asked, 5% initiated a Long Acting Reversible Contraceptive and 4% received preconception counseling. Facilitators to implementation included One Key Question® seen as an opportunity to offer patient-centered care, the success of clear prompts and place in the clinic flow, and existing infrastructure to support follow-up service provision. Barriers included competing priorities, lack of time/comfort with providing needed services, and issues of documentation and data extraction from EHRs. Based on the findings of the pilot, there is an opportunity for expanding One Key Question® to more and varied providers, to track intermediate and long-term outcomes related to One Key Question®, and to raise public awareness of One Key Question®. All of these recommendations support the goal of creating a Milwaukee community that supports healthy pregnancies and strong babies.

Hawaii Department of Health Home Visiting Service Unit (HVSU); Honolulu, HI (Hipp et al., 2017). One Key Question® was selected in 2016 by the Hawaii Maternal and Infant Health Collaborative (HMIHC) as the RLP strategy that would be piloted in three targeted community agencies that deliver both clinical and nonclinical services statewide. In 2017, One Key Question® was implemented in all six home visiting agencies across 10 home visiting sites. As of 2018, 302 providers have received One Key Question® training including WIC providers, home visiting staff, Title X providers, MedQUEST care

coordinators, and military family support staff. As a result, the HMIHC is using data to inform implementation and program monitoring to reduce infant mortality, improve birth outcomes, and build the evidence base for One Key Question®. Response to the implementation of One Key Question® in home visiting has been positive, with many home visitors and others reporting feelings of empowerment and increased knowledge of reproductive health. Of critical importance is the cultural acceptability of One Key Question® to the Pacific Island and Native Hawaiian Community.

OHSU Family Medicine Richmond Clinic; Portland, OR (Yonke, 2011). This 6-week pilot conducted in 2011 sought to test the feasibility and acceptability of screening for pregnancy intention in primary care (N=154). Findings indicated that One Key Question® met patient needs, was acceptable to providers, and was feasible in a 15-minute primary care visit. None of the providers thought the clinic slowed or patient flow was significantly disrupted. Women screened using One Key Question® were 3.5 times more likely to receive a prenatal vitamin prescription ($p=.011$), 4.8 times more likely to receive an emergency contraception prescription ($p=.003$), and 2.07 times more likely to receive any reproductive health prescription ($p=.003$) compared to those that were not screened. The majority (77%) of providers thought communication with their patients improved because of this initiative, and 95% of providers reported they would recommend One Key Question® to another clinic. This pilot showed great promise for improving women's health care in a primary care setting.

Washington County Family Planning; OR. This 2013 study of One Key Question® involved 2,500 women between the ages of 18 and 50 years old seeking family planning services, including approximately 800 Spanish speakers. Six in ten (60%) women who received One Key Question® reported satisfaction with their current method of contraception and 23% received new contraception services (14% began using contraception, 9% changed to a preferred method). In addition, 12% of women were given preconception care. A critical discovery reported was the significant uptake in the identification of women most at risk for unintended pregnancy: the women who were ambivalent about their pregnancy intentions. 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; Portland, OR. This pilot study, conducted between 2013-2014, showed that even among a small sampling of women (N=100) seen by a single provider, One Key Question® can impact women's health. About 20% of the women were seeking family planning services. Approximately 14% of participating women wanted to become pregnant (9%) or responded they would be okay either way (5%), yet most 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; Hood River and The Dalles, OR. This pilot study aimed at enhancing the pregnancy intention screening rate was implemented in 2015. The study (N=500) 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 for pregnancy desires compared to 12% at the non-intervention site, suggesting that staff were able to incorporate the change into their workflow. 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 Public Health Center; Liberty, MO. A pilot was conducted through the STD and Women's Health Programs (N=203) between 2014-2015. Nearly four in ten (38%) clients did not want to become pregnant and 42% reported they only wanted to become pregnant in the future. Only 3% of clients desired pregnancy and 2% reported pregnancy ambivalence (didn't care). The Center reported that staff struggled at first, asking One Key Question® only to 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. One Key Question® has been implemented into the Center's Electronic Medical Record and now also asked within the WIC/Prenatal Case Management Program.

Brigham and Women's Hospital; Boston, MA. This 2018 pilot was comprised of 517 women seeking treatment for a systemic rheumatic disease. 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 post-intervention.

Patient Experiences with Family Planning in Community Health Centers; National Survey. In an attempt to provide comprehensive findings on the patient experience with family planning care in community health centers, researchers from the George Washington University Milken Institute School of Public Health conducted a national survey of women of childbearing age (N=1,868) in 19 non-Title X community health centers across the United States as well as focus groups with women (N=82) in 6 additional health centers. The national survey implemented in 2014 included One Key Question® as the metric for pregnancy intention and ambivalence. Only 10% of women surveyed affirmatively desired to get pregnant in the coming year, and yet among women who were not actively seeking pregnancy, nearly one in three were not using contraceptives. Findings from this work support that greater efforts should be made to ensure that women of childbearing age who receive care at health centers are routinely screened for their pregnancy intentions and are assured access to immediate follow-up counseling, contraceptive care, or referral for family planning services.

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Replication

One Key Question® has been replicated in multiple settings across the United States. It is being implemented in approximately 30 states in clinical and non-clinical settings. Clinical settings include Federally Qualified Health Centers (FQHCs), Title X/Family Planning clinics, Sexually Transmitted Disease clinics, Indian Health Services, Primary Care clinics, Obstetrics and Gynecology clinics and specialty clinics like Rheumatology. Non-clinical settings include home visiting, WIC, behavioral health/substance use disorder treatment programs, dental office, and 2-1-1 call centers. The target population for One Key Question continues to be women and people who can become pregnant ages 18-50, however, different settings have expanded their target population to include adolescents and men.

In addition to the evaluation data described above another pilot site, the most recent we are aware of and first study of its kind was conducted by Stulberg et al. (2019) to assess if implementing One Key Question® in the Electronic Medical Record (EMR) of an urban community health center, coupled with a light touch clinician training (different from current Power to Decide training), would increase rates of contraceptive and preconception counseling and patient satisfaction. Patients that received usual care plus One Key Question® reported significantly higher rates of contraception counseling and recommendations for a long-acting reversible contraceptive (LARC) vs. patients receiving usual care. Preconception counseling did not significantly differ pre- vs. post-intervention.

In order to reduce the influence of external factors in this pilot, input was solicited from local clinicians and experts to help develop the EMR form, cognitive interviews were conducted with patients to inform survey instrumentation, and post-hoc analysis was performed to examine potential differences in demographics between comparison groups. Patients with no risk potential for unintended pregnancy were excluded from analysis. Despite limitations that may have restricted the generalizability of findings, One Key Question® showed great promise for increasing the rates of contraceptive counseling in a setting with disproportionate rates of unintended pregnancy and poor birth outcomes. Published results with complete methodology are forthcoming. It is expected that findings from this study will lay the groundwork for future effectiveness research.

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Section II: Practice Implementation

Internal Capacity

Personnel needed and staff time to support integration of One Key Question® depends on the setting, size of staff, and number of clients. We recommend that sites use a team approach that

includes staff at all levels of the program. This would include administration and/or leadership staff who are decision makers, on-the-ground staff most likely charged with implementation, evaluation or quality improvement staff, and IT staff.

Besides One Key Question® training, other supports needed for implementation may include training on topics such as contraception methods, preconception care, shared decision making, referrals, and tracking/data collection. Teams should meet regularly to discuss implementation, track and monitor data, and challenges/successes. After completing a pilot of One Key Question®, the Team should consider how they plan to build buy-in from other staff/programs as well as how they will roll out implementation.

Collaboration/Partners

Stakeholders have been and continue to be involved in all aspects of One Key Question® from development to implementation. Stakeholders include health and human service providers, consumers, and the general community.

Health and Human Service Providers: Clinicians were involved initially through interviews to identify what reproductive health care services they provided, identify barriers to integrating reproductive health assessment into their existing practice, and identify what support would be needed to achieve this practice change. This included 104 clinicians - 70 Family Medicine physicians, five Obstetricians/Gynecologists, five Women's Health Specialists and 24 Nurse Practitioners - working in Community Health Centers, Federally Qualified Health Centers, and Public Health Clinics. In addition, Oregon leaders in reproductive health were interviewed.

From this group, a Medical Advisory Committee was formed to consider the gaps identified in interviews and develop a strategy for changing practice patterns. The Medical Advisory Committee and OFRH staff collaborated with the National Preconception Healthcare and Preconception Health Initiative to develop a clinical algorithm that begins with the One Key Question® and offers a road map of information and services to be offered when the patient gives different answers. Over the course of three years, the Medical Advisory Committee met quarterly, reviewed pilot project findings, and advised on how best to make One Key Question® feasible and sustainable for providers.

Consumers: As the Oregon Foundation for Reproductive Health began developing One Key Question®, they convened focus groups with reproductive-age women and surveyed patients from family planning clinics, family medicine clinics, WIC programs, and/or Healthy Start programs. It was the women engaged in this process who developed and guided the 'How'. The women said, "Ask us what we want and then offer us the services we need!" From this critical feedback, the question and 4 optional answers were developed.

Community Advisory Committee: Following the development of One Key Question®, OFRH recruited 65 members from the greater community to be involved. Individuals with experience in other fields (i.e. education, behavioral health) not represented in the initial stakeholder interviews or the Medical Advisory Committee were recruited to provide guidance and technical assistance to the program. This group met four times a year over the course of seven years. The committee provided input on challenges and enhance program development. The Community Advisory Committee helped develop areas of emphasis for a white paper and adapted the clinical version into community education, flyers, and brochures.

Eventually the Medical Advisory members joined the Community Advisory Committee to stay involved and maintain the clinical stakeholder input as the implementation process was fine-tuned and began to be more widely disseminated. The Community Advisory Group was the joint stakeholder group which continued to convene until 2017. In July 2017, One Key Question® moved from the Oregon Foundation for Reproductive Health to Power to Decide. Now, Power to Decide’s Health Care Advisory Group members provide support and guidance to Power to Decide programs such as One Key Question®. Membership has expanded beyond contraception experts to include experts in preconception care and pregnancy intention screening.

Power to Decide also uses feedback from health and human service providers engaged in training and implementation of One Key Question®. This feedback is gathered formally through post-training and six-month follow-up surveys as well as informally through technical assistance calls. Power to Decide will also use our Provider Portal to communicate with providers and seek input on One Key Question®.

Practice Cost

One Key Question® implementation costs are dependent on program infrastructure, implementation, size of program, and capacity. Costs to consider include training and licensure, technology (i.e. EHR changes), patient/client materials, evaluation, and staff time. Training and licensure are provided by Power to Decide and depends on the number of people being trained and reach of EHR. The biggest cost and most difficult to estimate is staff time. Programs should consider what their internal capacity is to do items such as evaluation and technology change. These may require external contracts to accomplish.

Practice Timeline

An implementation timeline varies based on the size of the program, staff infrastructure and capacity, and funding. For some programs, they may be able to fully implement in a shorter timeframe and vice versa.

Practice Timeline				
Phase	Description of Activity	Date/Timeframe	# of hours needed to complete/oversee activity	Person(s) Responsible
Planning/ Pre-implementation	Pre-Implementation Assessment	1 -2 months prior to training	2-3 hours	Team
	Certification Training		6.5 hours for in-person training	Program Lead
	Action Planning – determine additional items needed in place prior to implementation	Immediately following training	5-10 hours	Team

	Implement Action Plan	6 – 12 months following training	Varies	Team
Implementation	Pilot of OKQ – either based on a certain # of clients or a timeframe (i.e. 3 months)	6-12 months following training (dependent on Action Items)	Varies	Team
	Evaluation/Quality Improvement – monitoring of data and adjusting implementation as needed	Ongoing	Ongoing	Evaluation/Quality Improvement Staff lead
Sustainability	Training of Trainers – develop an internal team of trainers to train new staff or provide support to implementers	Varies	2 days	Team
	Integration into EHR or other electronic record	6-12 months	6-12 months	IT Staff

Resources Provided

Website/Print Materials

One Key Question® at Power to Decide: <https://powertodecide.org/one-key-question>

One Key Question® Patient Brochure: <https://shop.powertodecide.org/educational-materials/one-key-question.html>

Peer Reviewed Articles/References

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Lessons Learned

Challenges with One Key Question® implementation have been varied across different systems and settings. Challenges may include building buy-in across a system or program, ensuring consistent use across a program, EHR integration, and capacity to do evaluation and monitor data. The two most common challenges are related to consistent and correct use and EHR integration.

Ensuring consistent and correct use of One Key Question® across a system is one challenge that can be overcome by staff training, program protocols or policies, data monitoring and sharing results, and consistent messages from program leadership about implementation. Programs who develop a One Key Question® team to address and build program buy-in, monitor implementation, and regularly discuss One Key Question® (i.e. during each staff meeting) may be more successful in overcoming this challenge.

Integration of One Key Question® into an EHR or other electronic data system is one of the most common challenges. This is an important component to help support routine and consistent use of One Key Question® across a program or system. The challenge is not the technology but competing with other top EHR priorities and requests from across a system. To help overcome this challenge, once programs have selected to implement One Key Question®, conversations and plans for EHR integration should be started.

For examples of specific lessons learned from one pilot study, see below.

Pilot Study: Milwaukee, WI (One Key Question® Pilot Results, 2017)

Methods:

Lessons learned were identified through key informant interviews conducted at each evaluation site with site administrators and clinicians. The guiding questions for the key informant interviews were:

- What were the barriers to successful implementation?
- What site-level factors facilitated implementation?

Emergent themes from these interviews can be used to make modifications for continued implementation of One Key Question® in practice.

Results:

A series of seven key informant interviews with site administrators and clinicians were conducted in order to identify lessons learned and areas for continuous quality improvement (One Key Question® Pilot Results, 2017). A number of themes emerged during these interviews including how the question was asked, following-up on the question, and considerations for future evaluation. All pilot sites from this evaluation have indicated that they are continuing to ask One Key Question® beyond the completion of the pilot.

Lessons learned from this pilot include:

1. Expand implementation of One Key Question® to more providers throughout Milwaukee
 - Primary and emergency care providers are a possible gateway to reproductive health services. There are many women who may be seeing providers in primary or emergency room settings who are not receiving care elsewhere. Starting a reproductive health care conversation by asking One Key Question® may

provide an important introduction. With more providers in the community asking One Key Question®, there is an opportunity to create the expectation that providers will discuss reproductive health with all female patients and it will become more normalized.

- Importance of pregnancy to chronic disease outcomes should be emphasized. One Key Question® presents an opportunity to start conversations about chronic conditions with women before they become pregnant. Pregnancy can be a challenging time to ask women to make changes to manage chronic conditions, so this early intervention provides an opportunity to improve the health of women and the health of their potential future children.
- Empower non-medical staff to conduct screenings and provide health education. One Key Question® can be asked by a variety of providers in health care and social services, not just physicians or nurses. The success of having medical assistants asking One Key Question® during the pilot indicates a good opportunity for expansion. Additionally, there may be an opportunity for other service providers (e.g. social workers, care coordinators, home visitors) to provide educational information, reinforcing messaging, and check-ins on compliance with recommended services.
- Need for multilevel buy-in from systems for the greatest success. Providers and administrative level staff all need to be invested in wanting to ask One Key Question® to ensure that there are needed resources and services available to support providers in asking.
- Need for culturally responsive reproductive health care for all patients. It is crucial that providers recognize that patients come with a variety of personal and cultural viewpoints regarding reproductive health. One Key Question® provides an opportunity to start a conversation on reproductive health from a culturally neutral position and to work with patients to ensure that they are receiving care that best fits their needs and values. One Key Question® 14 embraces the right of women to not have children or to have children under the conditions of their choosing.

2. Make it easier for providers to implement

- Put One Key Question® in a prominent place in the EHR to ensure that it gets asked of all eligible women. Clear, easy prompts are needed and definitions for documentation should be clearly outlined. Buy-in from IT and staff managing EHR systems would assist to adapt the data gathering in the EHR and retrieve data for process improvement and outcomes measurement.
- All providers at the pilot sites received training at the inception of the pilot, but there was turnover at all sites throughout the pilot. There is an opportunity to provide ongoing trainings to ensure that new staff receive information on One Key Question® and that previously trained staff are given reminders regarding asking the question. At one site, the site champion sent regular email reminders to staff, but did not feel that those made an impact on their asking of the question. They identified that they felt they had better success with in person outreach to staff members.
- Emphasize to providers that while the addition of the question is new to an appointment, One Key Question® can be an opportunity to steer the

patient/provider conversation to the most important priorities for the patient's health.

3. Collect additional data

- Need to collect and track patient outcomes and the correlation with the asking of One Key Question®. Short term outcomes might include early entry into prenatal care, chronic condition management, and vitamin or birth control compliance. There is a need for outcomes data to determine whether One Key Question® can achieve the outcomes of improving women's preconception health and eventual birth outcomes, and improving access and use of effective contraception to prevent pregnancies.
 - There may also be an opportunity to link with billing and/or prescription mechanisms to measure these intermediate indicators.
 - Analysis of services stratified by each answer to One Key Question® may provide additional insight into the process.
- There may be value in examining responses to One Key Question®, services provided, and intermediate outcomes by various demographics (e.g. age, race/ethnicity, income level).
- The best practice is to ask One Key Question® of all women of reproductive age at every appointment. However, individual providers or clinics may opt to ask less frequently if women are being seen regularly. There is an opportunity to consider how responses change over time or compliance with recommended services by tracking how often each woman was asked and what her responses are over time.

4. Increase public awareness

- One Key Question® is still relatively new in Milwaukee, and many women and providers are not familiar with the question. Public awareness could work to normalize One Key Question®, but also normalize conversations more generally around reproductive health for all women. With additional community awareness, more patients might start prompting providers to discuss their reproductive health needs.
- Increased community awareness could work to support programs and services beyond health care to support women's preconception and contraceptive health needs.

5. Ask One Key Question® of men

- There is an opportunity to engage men in conversations regarding pregnancy intentionality, preconception health, and contraception. The question would need to be adapted to be relevant for men and resources would need to be identified to ensure that men are getting connected with the needed services.

Reference:

One Key Question® Pilot Results September 2016-August 2017. (2017). Milwaukee, WI: United Way, Lifecourse Initiative for Healthy Families, University of Wisconsin School of Medicine and Public Health.

Next Steps

Although there have not yet been published efficacy studies of One Key Question® related to improved health outcomes, we are fully committed to continuing to measure its impact. Several evaluations of One Key Question® implementation sites in Hawaii are currently underway. It is anticipated that future publications will describe the effectiveness of these efforts. Also, Dr. Debra Stulberg of the University of Chicago is currently leading a multi-site, clinic-based study with cluster randomization to examine up to 4 university-affiliated Primary Care and Ob/Gyn practices in order to compare changes in counseling, preconception health, contraceptive use, and patient satisfaction between patients receiving usual care vs. patients receiving usual care plus One Key Question®. Published results of this study are forthcoming.

Practice Contact Information

For more information about this practice, please contact:

- *Becky Griesse, Director of Programs at Power to Decide*
- *703.581.4795*
- *bgriesse@powertodecide.org*