

Healthy Women: The Key to Healthy Families
Integrating Best Practices for Reproductive Health into Primary Care for Oregon Women

Purpose

The Oregon Foundation for Reproductive Health (OFRH) is seeking partnerships with direct health care providers, health care professional associations, researchers and other non-profit organizations to work with primary care settings on reproductive health. In particular, OFRH seeks to increase the attention paid in primary care to contraception and pre-conception care to maximize the chances that all pregnancies are wanted, planned and as healthy as possible. Ultimately, this will mean that infants will be healthier, families will be more likely to thrive and health care costs will be less.

We are proposing to incorporate into the routine primary care of women the standard, recurring question “Do you intend to conceive in the coming year?” If the woman answers “yes”, she can be referred for preconception care and advised to take folic acid. If she answers “no”, she can be assessed as to whether she is using contraception and is satisfied with her method, and referred for contraceptive services as needed. This question (and subsequent follow up) can be inserted as a prompt in Electronic Health Records and integrated into routine assessments done as part of the Patient-Centered Medical Home Model so that it becomes part of every woman’s health care.

Proposal

The Healthy Women: The Key to Healthy Families Project of the Oregon Foundation for Reproductive Health proposes to:

1. Enlist the support and endorsement of professional organizations such as the Oregon Medical Association, the Oregon Academy of Family Physicians, the Nurse Practitioners of Oregon, the Oregon Nurses Association and the Oregon Primary Care Association in advocating for best practices for reproductive health in primary care
2. Enlist the support and endorsement of key politicians and members of the Oregon Health Fund Board in advocating for best practices for reproductive health in primary care
3. Create an awareness campaign for primary care providers to encourage them to address contraception and pre-conception counseling with their patients at frequent intervals whenever it is appropriate
4. Develop a program to support and assist primary care providers in addressing contraception and preconception care through prompts, access to information and assistance with referrals. This may include prompts in the Electronic Medical Record, utilizing the Primary Care Home model to engage other members of the health care team or using social marketing methods to reach patients and health care providers.

There are multiple strategies that can be employed to fulfill these objectives, which are well-aligned with current health care reform goals both nationally and in Oregon. We need the support and endorsement of health care organizations, local politicians and the Oregon Health Fund Board as we strive for a more complete integration of reproductive health into primary care. Optimal women’s health and improved child outcomes are central to the health of all Oregon communities.

Endorsements

Each endorsing organization will be:

- Invited to be a member of the Healthy Women Coalition for one year—there will be no more than 3 meetings and participation may be by conference call.
- Kept up to date with our progress
- Asked to react to draft materials for providers and the public;
- Participate in problem solving, creating solutions, and responding to unanticipated barriers
- Asked to designate a liaison to the project

Healthy Women: The Key to Healthy Families
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into Primary Care for Oregon Women**

Vision

It is our vision that all Oregon women can rely on their primary care providers to provide access to the information and services they need for optimal reproductive health so that we can increase the rate of pregnancies that are planned, wanted and result in the healthiest infants possible. This includes access to contraception, emergency contraception, pre-conception care, prenatal care, postpartum care and all appropriate preventive screenings.

Introduction

The Oregon Foundation for Reproductive Health (OFRH) is proposing partnerships with direct health care providers, health care professional associations, researchers and other non-profit organizations to ensure that primary care providers have the resources they need to meet women's reproductive health care needs. In particular, OFRH seeks to increase the attention paid in primary care to contraception and pre-conception care to ensure that all pregnancies are wanted, planned and as healthy as possible. We are proposing to incorporate into routine primary care the standard, recurring question "Do you intend to conceive in the coming year?" If the woman answers "yes", she can be referred for preconception care and advised to take folic acid. If she answers "no", she can be assessed as to whether she is using contraception and is satisfied with her method, and referred for contraceptive services as needed. This question (and subsequent follow up) can be inserted as a prompt in Electronic Health Records and integrated into routine assessments done as part of the Patient-Centered Medical Home Model so that it becomes a basic part of every woman's health care.

Most American women desire only 2 children; to reach that goal, they must spend nearly 30 years trying to avoid an unintended pregnancy [Sonfield 2003]. In this sense, the ongoing need for reproductive health has many of the characteristics of a chronic health condition requiring frequent monitoring and oversight by primary care. As most women go through the "full circle" of puberty to pregnancy prevention, then desired pregnancy and back to pregnancy prevention into menopause, they need reliable information, services and referrals in order to have optimal health and optimal birth outcomes. Reproductive health is essential to women's ability to sustain good health from childhood through senior years, as well as to enable women to play a full and vital role in the social and economic fabric of our communities. Reproductive health of women is also critical to ensuring that pregnancies are planned and result in the healthiest outcomes for infants. The climate of health care reform and the renewed focus on prevention provide key opportunities for this reintegration of reproductive health into primary care. While prenatal care, postpartum care and preventive screenings are key components of reproductive health, contraception and pre-conception counseling will be the first focus of the Healthy Women: The Key to Healthy Families Project.

Since the focus of this paper is on pregnancy prevention and healthy conception, we will be addressing the needs of sexually active, heterosexual women who are at risk for pregnancy because neither they nor their partners are sterile. We acknowledge that many women need

gynecological services unrelated to pregnancy and contraception because they are not at risk for pregnancy, and these services are part of our broader vision of comprehensive reproductive health.

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Background

The Oregon Foundation for Reproductive Health was formed as a 501 (c)3 organization in 1983 and in 2005, we launched our Prevention First Initiative and successfully advanced policy solutions to prevent unintended pregnancies and therefore reduce the need for abortion. These policies included:

- Insurance coverage for birth control
- Increased access to family-planning services
- Stopping pharmacists from refusing to fill birth control prescriptions
- Improving access to the "morning-after" pill (also called emergency contraception)
- Comprehensive, medically accurate and age-appropriate sex education

The work of OFRH complements the work of NARAL Pro-Choice Oregon and fulfills the goals of *Prevention First* by focusing on access to contraception, especially emergency contraception. OFRH also emphasizes the importance of healthy pregnancies in order to deliver healthy infants, and as such also advocates for preconception health assessments and folic acid supplementation for women intending to conceive.

Through foundation grants and individual donations (in particular, a 2008 Meyer Memorial Trust grant), OFRH successfully developed and implemented a statewide Emergency Birth Control

Access Project to improve awareness of and access to emergency contraception throughout Oregon, especially in rural areas. The project involved pharmacist education (with a project pharmacist to do one-on-one peer outreach and education); provider education (based on our experience with pharmacist training); and consumer education. While we have been successful in implementing pharmacist and consumer education, provider education has been more challenging. We learned that many primary care practices do not routinely provide basic reproductive health care such as contraception counseling. We also learned that many primary care practices are unlikely to integrate reproductive health without an established Best Practice guideline that is supported and encouraged by their respective professional organizations. OFRH is in a unique position to facilitate conversations about a Best Practice in reproductive health, and to encourage professional organizations to endorse that practice.

In 2007 and 2008, OFRH conducted online surveys of our membership and grassroots activists about gaps in reproductive services and what priorities they recommended for our organization. The foremost issue identified was that women found it difficult to access private health care providers in rural areas due to cost, yet those areas are too remote to have good access to public health care services. The second issue was that women often found that their primary care provider expected or assumed they went elsewhere for their reproductive health needs.

In 2009, Oregon Health Care Quality Corporation (QCorp) analyzed visit claims data relative to health indicators at private-pay primary care visits (9 private plans, serving two-thirds of Oregon adults). They found that only 29% of women received screenings for sexually transmitted infections, when ideally all sexually active women would be offered that screening. In their summary report, QHC asserts that primary care in Oregon needs to more effectively integrate reproductive health into women's health care [QCORP 2009].

Unintended pregnancy

Nearly half of pregnancies in the United States are unintended [Finer 2006]. Twenty-nine per cent occur earlier than desired, and 20% occur after women have reached their desired family size [Guttmacher 2001]. In 2001, such pregnancies resulted in 1.4 million unplanned births and 1.3 million induced abortions (plus an estimated 400,000 miscarriages) [Finer 2006].

In 2007, almost 48% of all Oregon births were unintended [PRAMS 2007]. Thirty-two percent of women who delivered an infant that year stated that the pregnancy was mistimed, and 8% said it was unwanted [PRAMS 2007]. While unintended pregnancy occurs in all groups of women (49% unintended among women overall in 2008 nationally), incidence is particularly high among those under age 20 (82%), with low income (62% for those below poverty level), and African American (69%) [Guttmacher 2009].

Forty-one per cent of Oregon women delivering an infant in 2007 had no insurance when they conceived [PRAMS 2007]. Being uninsured prior to pregnancy means they likely had less access to contraception if they were trying to avoid pregnancy, and little or no pre-conception care if they were intending to become pregnant. In 2007, 45% of all deliveries in Oregon were to women on the Oregon Health Plan (OHP)/Medicaid, however, only 9.7% of women were on OHP/Medicaid when they conceived [PRAMS 2007]. It is likely that most of the remaining 35%

of women were uninsured at the time they conceived and became eligible for OHP once they were pregnant.

Healthy People 2010 underscores the importance of preventing the social, economic and medical costs of unintended pregnancy. “Medically, unintended pregnancies are serious in terms of the lost opportunity to prepare for an optimal pregnancy, the increased likelihood of infant and maternal illness, and the likelihood of abortion.... The mother is less likely to seek prenatal care in the first trimester and more likely not to obtain prenatal care at all. She is less likely to breastfeed and more likely to expose the fetus to harmful substances, such as tobacco or alcohol. The child of such a pregnancy is at greater risk of low birth weight, dying in its first year, being abused, and not receiving sufficient resources for healthy development.” [HP2010] Unintended pregnancy also contributes to important social determinants of health for women such as limited lifelong income, limited educational achievement, stress (increased anxiety, early life challenges, reduced job opportunities, childcare burden) and addiction (alcohol/smoking during pregnancy and child’s early years).

Disparities in rates of unintended pregnancy

In 2002, the National Survey of Family Growth found that approximately 69% of pregnancies among black women and 54% among Hispanics were unintended, compared with 40% among white women [Finer 2006]. Low socio-economic status, as measured by education level and income, was also associated with increased risk for unintended pregnancies. Sixty-two percent of pregnancies were unintended among those earning <100% of the Federal Poverty Level (FPL), compared to 38% of pregnancies in those earning >200% of the FPL [Mosher 2010]. Race and ethnicity were also predictive of unintended pregnancies even within each income group [Finer 2006].

Adverse child outcomes

In addition, children of unintended pregnancies have an increased risk of adverse birth outcomes. In one study, an unintended pregnancy was almost twice as likely to result in a preterm birth, even after controlling for clinical and behavioral risk factors for preterm delivery [Orr 2000]. Another study showed that the proportion of infants who are premature, low-birth-weight or small for gestational age is substantially higher if the birth was unwanted (26%) or mistimed (20%) than if it was intended (16%) [Kost 1998]. Unintended pregnancies also increase the risks for infant mortality, mother-infant transmission of HIV and maternal morbidity and mortality [Gipson 2008].

Effective reproductive health care can enable women to avoid many unintended pregnancies, have healthier children and protect their overall health. An investment in reproductive health care is returned manifold in improved health outcomes and a decreased reliance on limited public services.

The CDC has labeled family planning as one of the top 10 public health achievements of the 20th century [HP2010]. And, indeed, there is clear evidence that the provision of family planning services is effective preventive care. For example, publicly funded contraceptive services and supplies alone help women in the United States avoid nearly two million unintended pregnancies each year [Gutmacher 2010]. In the absence of such services (from family planning centers and

from doctors serving Medicaid patients), estimated U.S. levels of unintended pregnancy, abortion and unintended birth would be nearly two-thirds higher among women overall and nearly twice as high among poor women [Guttmacher 2010].

Costs of unintended pregnancy

The adverse consequences of unintended pregnancies affect not only the children and families of these pregnancies, but also the society as a whole through the increasing costs of health, education and social services. Prevention of unintended pregnancies can have profound economic impacts nationally, and has the potential to decrease the disparities in health among those of different socio-economic status [Singh 2007].

One example of the potential for cost savings from prevention of unintended pregnancy is evident in California's family planning program, Family PACT (Planning, Access, Care and Treatment). Family PACT provides contraception and reproductive health services to women and men of reproductive age whose incomes do not exceed 200% of the federal poverty guidelines and who have no other reproductive health care coverage [Biggs 2010]. The following statistics are taken from the executive summary of a 2010 report on the project [Biggs 2010]:

- More than 2,000 private and nonprofit enrolled clinician providers across the state delivered family planning services and receive reimbursements from the Family PACT Program on a fee-for-service basis.
- In 2007, nearly one million women (998,084) and 99,218 men of reproductive age (ages 15-44) were provided with contraceptives in Family PACT. This resulted in the aversion of an estimated 296,200 unintended pregnancies in California. These 296,200 pregnancies would have led to approximately 133,000 live births, 122,200 abortions, 3,000 ectopic pregnancies, and 38,000 miscarriages.
- Each pregnancy averted to a female Family PACT client saved the public sector approximately \$6,557 in medical, welfare, and other social service costs for a woman and child from conception to age two and saved \$14,111 from conception to age 5.
- The total public sector cost-savings of the pregnancies averted attributable to Family PACT female clients in 2007 was \$1.88 billion from conception to age two, and over \$4 billion from conception to age five.
- The Family PACT Program's total service expenditures were \$437.3 million in 2007. By reducing public health and welfare expenditures resulting from unintended pregnancies, every dollar spent on Family PACT saved the public sector \$4.30 from conception to age two and \$9.25 from conception to age five.

It is clear that preventing unintended pregnancy is cost-effective, and would go a long way toward reducing health care costs as well as social costs across all economic strata in this country. The impact on low-income Americans, however, would likely be the most beneficial.

Inconsistent use of contraception by women not intending to conceive

Family planning services are frequently used by American women of reproductive age. According to the 2002 National Survey of Family Growth, 42% of women aged 15-44 have sought a family planning service from a medical provider in the last 12 months [Mosher 2010]. The numbers are even higher for young women, as 63% of women 20-24 years old and 55% of

women aged 25–29 have sought a birth control service in the last year [Mosher 2010]. Yet many women are dissatisfied with their method and use it sporadically or inconsistently, which contributes to high rates of unintended pregnancy [Guttmacher 2008].

Nearly one in four women in the US each year (more than six million women) are at high risk for becoming unintentionally pregnant because they experience a gap in contraceptive use: Eight percent use no contraceptive all year, and 15% have a gap in use of one month or longer [Guttmacher 2008]. An additional 27% are at elevated risk for unintended pregnancy because they use their contraceptive method inconsistently or incorrectly [Guttmacher 2008]. Among women who experienced an unintended pregnancy, slightly more than half were not using any method of contraception in the month they conceived, and more than 40% of the remainder occur among women who used their method inconsistently or incorrectly. Only 5% are attributable to method failure [Kost 2008].

Women living in poverty and some women of certain racial or ethnic groups face additional barriers to using contraception consistently. The 2002 National Survey of Family Growth found that, of women at risk for unintended pregnancy, 9% of whites, 12% of Hispanics, and 15% of blacks did not use contraception [Mosher 2010]. Income differences also affected rates of contraception use, with 12% of women earning <150% of the FPL not using contraception, compared to 9% of those earning >300% of the FPL [Mosher 2010]. Stressful life events also disrupt use: more than half of women who have a gap in use of at least one month report that the period of nonuse coincided with a stressful event, such as the beginning or ending of a relationship, a move to a new home, a job change or a personal crisis [Guttmacher 2008].

In Oregon in 2007, 46% of women who were recently postpartum stated that they and their partners were not doing anything to prevent pregnancy when they became pregnant. The majority of those women (70%) gave reasons indicating that they lacked comprehensive contraceptive advice from a clinician: they thought they couldn't get pregnant at that time, they had side effects from the birth control they were using (and presumably discontinued use), they couldn't access contraceptive services or they were in disagreement with their partner about birth control [PRAMS 2007].

The availability of services and counseling for reproductive health is often related to whether the provider's focus is contraceptive or primary care. Primary care providers are relatively unlikely to offer a wide range of contraceptive services if fewer than one-quarter of their patients see them for contraceptive care [Guttmacher 2008]. Private family practice doctors, community health centers and hospital clinics are especially likely to have a primary care focus, and they offer a narrower range of contraceptive services than obstetrician-gynecologists, health department clinics and Planned Parenthood clinics, which generally provide contraceptive services to at least one-quarter of their clients [Guttmacher 2008].

Consistency of use and satisfaction with contraceptive methods can be improved if primary care providers review patients' experiences and satisfaction with their method at each visit, and promptly address problems, dissatisfaction or concerns about side effects. Providers can also implement practices that make it easy for clients to switch methods until they find the one best suited to them, which will likely change over time. Contraceptive counseling needs to be an

ongoing discussion in primary care in order to meet women's reproductive health needs most effectively.

Emergency Contraception

Emergency Contraception (EC) is an important part of a comprehensive approach to prevention of unintended pregnancies. EC involves taking a high dose of contraceptive hormones within 72-120 hours of unprotected intercourse in order to prevent pregnancy. It does not disrupt an established pregnancy. A 1992 study estimated that if emergency contraception were used after all contraceptive failures, 50% of unintended pregnancies and 60–70% of abortions would be prevented [Trussell 1992].

The American College of Obstetricians and Gynecologists, the Society for Adolescent Medicine, the American Academy of Pediatrics and the International Planned Parenthood Association have all recommended that information about EC be included in all routine health care provider visits [ACOG 2002, Gold 2004, AAP 2005, IPPF 2004], but there is evidence that this is far from the case. A study based on the 2002 National Survey of Family Growth showed that only 3% of women reported that a clinician had discussed emergency contraception with them in the past year [Kavanaugh 2008]. Even among those who had seen a gynecologist for a pelvic exam, only 4% reported receiving EC counseling [Kavanaugh 2008]. The likelihood that the woman received EC counseling was reduced if they were 30 or older (odds ratio, 0.2), and was elevated if they were Hispanic (odds ratio, 4.1), black (odds ratio, 2.6) or ever-married (odds ratio, 2.4). Receiving EC counseling in the last 12 months was the strongest predictor of whether a woman used EC or not (odds ratio, 11.7) [Kavanaugh 2008].

Among the women who had received EC pills or a prescription for EC in the past 12 months and had visited a health care provider during this time, most reported being seen at a family planning or Planned Parenthood clinic (42%) [Kavanaugh 2008]. Less frequently used sources were private doctors' offices (20%), community clinics or schools (20%), HMOs (6%), hospital outpatient centers (6%), urgent care or walk-in facilities (2%) and other locations (5%) [Kavanaugh 2008].

Preconception care

Preconception care is recognized as a critical component of health care for women of reproductive age [Frey 2002, Moos 2002]. The main goal of preconception care is to provide health promotion, screening, and interventions for women of reproductive age to reduce risk factors that might affect future pregnancies.

Many women have chronic conditions which require treatment and/or stabilization before conception in order to maximize the chances for a healthy pregnancy. For example, in 2002, approximately 6% of adult women aged 18–44 years had asthma, 50% were overweight or obese, 3% had cardiac disease, 3% were hypertensive, 9% had diabetes, and 1% had thyroid disorder [USDHHS 2005]. Dental caries and other oral diseases also are common (>80% of women aged 20–39 years) and associated with complications for women and infants. These diseases can result in preterm delivery, birth defects, fetal death or significant obstetric complications.

Another reason for the importance of preconception care is the large proportion of women who are at risk of becoming pregnant who engage in high-risk behaviors that can contribute to adverse pregnancy outcomes. In 2003, a total of 11% of pregnant women smoked during pregnancy, a risk factor for low birth weight [Martin 2003], and 10% of pregnant women and 55% of women at risk for getting pregnant (i.e., those not using contraception or using ineffective contraceptive methods or using effective contraceptive methods inconsistently) consumed alcohol, a risk for fetal alcohol syndrome [CDC 2002]. Some women also engaged in high-risk sexual behavior, potentially exposing themselves to sexually transmitted diseases (STDs), including HIV [CDC 2001]. A smaller proportion of women used illicit drugs, and several of these behaviors often occur together in the same woman, compounding the risk for adverse birth outcomes.

Approximately one-third to one-half of women have more than one primary care provider (i.e., a family physician, nurse practitioner, midwife, physician assistant, internal medicine physician and an obstetrician/ gynecologist) [Weisman 1996]. This fragmentation in women's health means that all providers who routinely treat women for well-woman examinations or other routine visits play an important role in improving preconception health. However, only approximately one of six obstetrician/gynecologists or family physicians had provided preconception care to the majority of the women for whom they provided prenatal care [Henderson 2002]. Systems changes that facilitate preconception care will likely lead to better outcomes for patients and their pregnancies.

Guidelines for Perinatal Care, jointly issued by the American Academy of Pediatrics (AAP) and the American College of Obstetricians and Gynecologists (ACOG), has recommended that all health encounters during a woman's reproductive years, particularly those that are a part of preconception care, should include counseling on appropriate medical care and behavior to optimize pregnancy outcomes [Brundage 2002]. Eight areas of risk screening outlined in these recommendations are 1) reproductive awareness; 2) environmental toxins and teratogens; 3) nutrition and folic acid; 4) genetics; 5) substance use, including tobacco and alcohol; 6) medical conditions and medications; 7) infectious diseases and vaccination; and 8) psychosocial concerns (e.g., depression or violence) [Frey 2002, Moos 2002].

According to the Oregon MothersCare program, many women do not receive early prenatal care because they do not have health coverage or cannot afford care, do not know what services are available, or find 'the system' confusing or overwhelming [OMC]. In Oregon in 2007, 23% of women failed to get prenatal care in the first trimester [PRAMS 2007]. Among Oregon women who delivered in 2007, 9% stated that their infant required treatment in the ICU after he or she was born [PRAMS 2007].

Folic acid supplementation for those intending to conceive

Prior to conception and during the first weeks (before 52 days' gestation) of pregnancy, lack of essential vitamins (e.g., folic acid) can adversely affect fetal development and results in pregnancy complications such as neural tube defects [Botto 2005]. Daily use of vitamin supplements containing folic acid has been demonstrated to reduce the occurrence of neural tube defects by two-thirds [Lumley 2001].

Women in the US are not fully aware of the benefits of taking multivitamins with folic acid prior to conception and during pregnancy. A 2002 survey showed that only 20% of women knew that folic acid could prevent certain birth defects. Even fewer women knew they have to take folic acid prior to conception (7% in the survey) [March of Dimes]. Women who said they did not consume folic acid daily were asked whether they would take the vitamin if their physician or other health care provider recommended it. More than half (53 percent) said they would be very likely to do so, with another 37 percent saying they would be somewhat likely to take recommended vitamin supplementation. Oregon PRAMS data from 2007 shows that 53% of Oregon women did not take a prenatal or multivitamin in the month prior to conceiving, and only 31% took one every day [PRAMS 2007].

Alignment with Health Care Reform

The Healthy Women: The Key to Healthy Families Project is well-aligned with current efforts for health care reform nationally and in Oregon, and with the concept of a Patient-Centered Medical Home.

National Health Reform

In March of 2010, Congress passed the Patient Protection and Affordable Care Act, as the health care reform law is officially titled. In addition to eventually providing health insurance for millions of uninsured Americans, the law also provides coverage for many preventive health services without any cost-sharing. Four groups of services are required for coverage:

1. Items or services currently recommended by the U.S. Preventive Services Task Force (USPSTF);
2. Immunizations currently recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC);
3. Preventive care and screenings for infants, children and adolescents, as recommended by guidelines supported by the Health Resources and Services Administration (HRSA); and
4. Preventive care and screenings for women, also as recommended by HRSA-supported guidelines.

The third category of guidelines include a wide array of preventive services for minors that go well beyond the limited screenings, vaccines and counseling recommended by the USPSTF and ACIP. They include contraceptive management, routine gynecologic examination, and promoting healthy sexual development and sexuality. The guidelines further state that “information about contraception, including emergency contraception and STIs, should be offered to all sexually active adolescents and those who plan to become sexually active.” [Guttmacher 2010]

The fourth category of guidelines was introduced as an amendment by Senator Barbara Mikulski, and adds women’s preventive care and screenings as a fourth category of mandated preventive services. Although the impetus for the amendment was the current debate about mammography screening, the provision was clearly designed to guarantee coverage of a far broader group of preventive services, notably including family planning. It was recognized that several crucial women’s health services are omitted from the USPSTF recommendations, and this amendment

closes the gap by including services such as the well woman visit, prenatal care, and family planning.

Providing family planning and prenatal care, including pre-conception care is now an explicit part of our national health reform agenda.

Oregon Health Reform

In 2009, the Oregon Legislature passed HB 2009, which created an Oregon Health Authority (OHA) responsible for maximizing efficiency in health care, organizing state health policy and health services, and implementing the health reform policies and programs also created in HB 2009.

OHA has as its priorities a focus on preventive care, providing health care for everyone and reducing waste in the health care system. To that end, HB 2009 also established a Patient Centered Primary Care Home (PCPCH) Program within the Office for Oregon Health Policy and Research (OHPR). The goals of the PCPCH program are to develop strategies to identify and measure patient centered primary care homes, promote their development, and encourage populations covered by the Oregon Health Authority to receive care in this new model [OOHPR].

To assist in achieving these goals, the OHA director appointed a committee to develop primary care standards and specific measures by which to evaluate their work. Included as a Standard is *Comprehensive Whole Person Care*, defined as providing or helping patients access the health care and services they need. The Measure associated with this Standard is “providing most of the care patients need for common problems at the primary care clinic”. This measure is further elaborated (in part) as follows [OOHPR]:

The PCH routinely assesses common health risk behaviors in its population and offers interventions to support behavior change. Examples of common health risk behaviors include, but are not limited to: alcohol or drug use, tobacco use, obesity, physical inactivity, injury or violence, nutrition and sexual risk behaviors.

Given the facts that most women use some form of contraception at some point in their lives, almost half of all pregnancies are unintended, and birth defects and obstetric complications resulting from uncontrolled pre-pregnancy factors are too common, contraception and preconception care seem to fit squarely in this category. Integrating reproductive health into primary care assessments to ensure that pregnancies are planned and that women receive preconception care should be a key strategy to increase health, improve quality and reduce costs.

Patient Centered Primary Care Home Model

The Patient Centered Primary Care Home (PCPCH) is a new model of primary care that has received attention in Oregon and across the country for its potential to advance the “triple aim” goals of health reform: a healthy population, high quality patient care and cost control. Patient Centered Primary Care Homes achieve these goals through a focus on wellness and prevention,

coordination and integration of care, proactive management and support of individuals with chronic diseases and a patient centered approach to all aspects of care.

The Primary Care Home is the perfect setting for contraception education and preconception care. The focus on wellness and prevention is particularly important in terms of unintended pregnancy. Contraception and preconception care are proactive means of ensuring that pregnancies are wanted and as healthy as possible. Primary care providers can oversee the provision of access to information and services for reproductive health, but they do not need to deliver them personally as part of the visit. Contraceptive and preconception care can be incorporated into a team approach to care, and addressed through Electronic Medical Records prompts, and education and advice from nurses and other health educators. Women of reproductive age can be screened by a medical assistant regarding whether they intend to conceive in the coming year. If so, they can be given a standardized, pre-printed prescription for folic acid and urged to seek pre-conception care, either by a provider in that setting or through a referral. If they are not intending to conceive, they can be referred to a nurse or other health educator to review their current contraceptive method and level of satisfaction, and be educated about emergency contraception.

OFRH and Primary Care involvement

The Oregon Foundation for Reproductive Health (OFRH) can assist primary care settings in more effectively adopting best practices in all areas of reproductive health. However, our priority areas are increasing contraceptive access (including Emergency Contraception) and increasing rates of pre-conception care and folic acid supplementation. OFRH can assist primary care settings who see high numbers of reproductive age women age 18-45 in numerous ways:

- If a primary care setting does not provide contraceptive services, or only provides them on a limited basis, OFRH can provide that setting with a list of local referral resources as well as a full range of reproductive health patient education materials.
- If a primary care setting offers the full range of contraceptive services, OFRH could provide trainings and updates to the providers regarding new developments in contraception and Emergency Contraception
- OFRH can update primary care settings on the status of Emergency Contraception and Oregon Law, including regulations which apply to pharmacists.
- OFRH can provide support and consultation in creating prompts in the Electronic Health Record which could be asked by a medical assistant, nurse, provider or other member of the care team as part of a routine visit. These questions would identify the need for intervention in either preconception care or contraceptive management. A sample of a possible short algorithm of questions would be:

Are you intending to become pregnant in the next year? (Yes/No/unsure)

If yes: **Are you currently taking folic acid supplements?** (Yes/No)

If yes: Flag for provider to discuss other preconception needs as indicated.

If no: Provide prescription for folic acid, and flag for provider to discuss other preconception needs as indicated.

If no or unsure: **Are you currently using some type of contraceptive method?**

(Yes/No/Not needed)

If yes: **Are you satisfied with that method?** (Yes/No)

If yes: Ask about awareness of/access to emergency contraception.

If no: Refer to provider, other member of care team, or outside resource to discuss contraceptive options. Ask about awareness of/access to emergency contraception. Provide condoms.

If Not needed: Done

- The algorithm of questions above could also be used as part of a patient education campaign in the waiting room or exam room, as a self-guided tour through the questions, which lead to information and resources.
- Nurses, medical assistants, health educators and other staff can be trained as a clinic resource in the primary care setting, and become an expert for “internal referrals”.

In the future, similar models and strategies could be used to address prenatal care, postpartum care, sexually transmitted infection prevention and treatment, and reproductive health preventive screenings such as Pap smears and mammograms.

Conclusion

OFRH seeks to partner with health care providers, health care professional associations, researchers and other non-profit organizations to ensure that primary care providers have the resources they need to provide effective reproductive health care based on evidence and accepted best practices. Our first priorities are access to contraception and preconception care, with particular attention to emergency contraception and folic acid supplementation. The Healthy Women: The Key to Healthy Families Project proposes a variety of strategies that can be employed to fulfill that objective, which are well-aligned with current health care reform goals both nationally and here in Oregon. We need the support and endorsement of health care organizations, local politicians and the Oregon Health Fund Board as we strive for a more complete integration of reproductive health into primary care. Optimal women’s health and improved child outcomes are central to the health of all Oregon communities.

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