Choice, not chance: Reproductive life plan assessment as a clinical management framework

By Jacki S. Witt, JD, MSN, WHNP-BC, SANE-A and Patricia J. Kelly, PhD, MPH, FNP

The use of certain strategies and tools by nurse practitioners caring for reproductive-aged women can help decrease adverse health outcomes such as unintended/mistimed pregnancy and pregnancy complications. The authors discuss two important strategies: consistent integration of a reproductive life plan assessment into regular office visits and implementation of risk-based health-promotion interventions. Widespread use of these strategies will increase the odds that women get pregnant by choice, not by chance, and that if women are ready to have a baby, preconception problems will have been resolved and the likelihood of achieving the best possible outcomes for mother and newborn will have been enhanced.

Sexual and reproductive health statistics in the United States show troubling outcomes for many women. Forty-nine percent of all pregnancies in this country are unintended, and, although the rate of adolescent pregnancy has declined in the past two decades, the U.S. still has the highest rate in the developed world—750,000 adolescent pregnancies annually, virtually all of which are unintended.[1,2] About 12% of pregnancies end in preterm birth; infant mortality rates in the U.S. are high compared with those of other developed countries, and low birth weight continues to be a public health problem, with about 8% of all infants born here weighing <2,500 grams.[2] These adverse outcomes disproportionately affect members of racial and ethnic minorities.[1-3]

Prenatal care has been one of the most widely used preventive health services in the United States. However, several decades of research have demonstrated that prenatal care has minimal impact on some adverse pregnancy outcomes, especially among minority women and women living in poverty.[4] For many of these women, prenatal care starts too late and offers too little to substantially mitigate risks associated with a lifetime of social, behavioral, and economic hardships.[5] Even healthcare interventions over a 6- to 8-month span in a disadvantaged woman's life are unlikely to ameliorate years of unaddressed risk behaviors or counter omnipresent negative social determinants.[5]

Between menarche and menopause, most women spend the better part of 3-4 decades trying to avoid an unintended pregnancy. This reality forms the basis of a new national campaign championed by the Cen-

Online resources

Patients

- Reproductive life plan worksheet (see page 48 in this issue)

Health professionals

- Reproductive life plan tool for health professionals
- Motivational interviewing for health professionals

ters for Disease Control and Prevention.[6] This campaign is based on an approach to providing health services to women of childbearing age that first emerged in the mid-1990s.[5] Elicitation of a reproductive life plan (RLP) has been proposed as an assessment and intervention strategy for clinicians to assist reproductive-aged patients in tailoring family planning methods and lifestyle choices to their unique life circumstances.[6] RLPs change with a patient's age, financial status, relationship status, and other factors, so they need to be assessed on a regular basis.[7]

More than just pre-conception care, the RLP process is particularly helpful for women/couples with complex health- and/or reproduction-related risks. However, targeting only women with high-risk health conditions or those planning a pregnancy would miss many who become pregnant by chance rather than by deliberate choice.[8] The largest impact would be achieved by elicitation of RLPs for *all* women of childbearing age seen in primary care and reproductive health settings. Nurse practitioners are in an excellent professional position to lead this movement.

Case reports

The authors present two cases to illustrate that eliciting their patients' RLPs will enable NPs to provide more comprehensive and safer care for them.

Case 1: *Paula is a 28-year-old presenting for a well-woman visit, specifically asking to talk to someone about the best birth control method for her. Paula's history includes an unplanned pregnancy at age 16, lack of use of birth control at present, and normal physical examination findings, with cervical cytology done a year ago. Paula has no contraindications to the use of any contraceptive. Her body mass index (BMI) is 26 kg/m^2, she does not smoke, and she is in a monogamous relationship with a 32-year-old man. She and her partner have been sexually active for 3 months and have tired of using condoms. Both Paula and her partner work, but plan to move into Paula's sister's residence soon in order to save money.*

Case 2: *Carina is a 21-year-old college student who has scheduled her visit for a Pap test and a prescription for a birth-control product. Carina is healthy, has a BMI of 29 kg/m^2, and has no contraindications to the use of any contraceptive. Carina has used oral contraceptives (OCs) periodically over the past 4 years, with no adverse consequences.*

Assessment

Nurse practitioners have extensive experience in developing individualized patient plans based on family planning/contraception, physical, behavioral, and psychosocial assessments—all of which are considered core components of the patient-centered process.[3] NPs can pose two or three questions to initiate a conversation about reproductive intentions: "Are you planning to have a child [or another child] in the future?" and/or "Would you [or When would you] like to become pregnant?"[8]

In response to these questions, Paula indicates that she is thinking about becoming pregnant. She adds that her partner, who has no children, agrees with the idea.

Carina relates that she had a pregnancy scare about 6 months ago, when she had sex with an old boyfriend after skipping a few OC pills. She wants to finish college and go to graduate school and is not ready to become a mother at this time.

Management

After eliciting a patient's RLP, NPs can use patient-centered motivational interviewing[9] techniques to guide her toward the most acceptable method of contraception for her, as well as assisting her in further exploration of behavioral, financial, and health-related factors that may influence her reproductive outcomes.

Paula and her partner are receptive to the idea of a pregnancy, but they have some financial challenges. Focused follow-up comments/questions that might be useful are: "I understand that a pregnancy would be acceptable to you and your partner, but you are concerned about finances and want to decrease your living expenses to save money. Am I correct so far? Will you be able to continue this living arrangement with your sister if you get pregnant? If you have a child? Do you have any backup plans?"

Carina is focused on continuing her education and has not been a consistent or persistent OC user in the past. A question about how an unplanned pregnancy might alter her educational goal would help the NP and Carina explore contraceptive methods that would enable her to reach her goal. The NP might say: "It sounds as though completing your degree is really important to you right now, Carina. Have you thought about when, or even if, you may want to have a baby?" Such a discussion allows verbalization of goals and practices, as well as possible inconsistencies between the two. It also provides an opportunity for the NP and Carina to address contraception within the context of the patient's overall life plan.

Conclusion

Although not a panacea, use of the RLP format to consistently assess reproductive intentions and contraceptive use allows NPs to decrease unintended and mistimed pregnancies. The goal is to optimize maternal and newborn outcomes and quality of life.

Jacki S. Witt is Clinical Associate Professor at the University of Missouri-Kansas City School of Nursing and Health Studies and Project Director at the National Clinical Training Center for Family Planning in Kansas City, Missouri. Patricia J. Kelly is Professor and Associate Dean for Research at the University of Missouri-Kansas City School of Nursing and Health Studies in Kansas City, Missouri.

References

1. Finer LB, Kost K. Unintended pregnancy rates at the state level. *Perspect Sex Reprod Health.* 2011;43(2):78-87.
2. Hamilton BE, Martin JA, Ventura SJ. Births: preliminary data for 2011. *Natl Vital Stat Rep.* 2012;61(5).
3. Lu M, Kotelchuck M, Hogan V, et al. Closing the black-white gap in birth outcomes: a life-course approach. *Ethn Dis.* 2010 Winter;20(1 suppl 2):S2-62-76.
4. Alexander GR, Kotelchuk M. Assessing the role and effectiveness of prenatal care: history, challenges, and directions for future research. *Public Health Rep.* 2001;16(4):306-316.
5. Dillard RG, Improving pre-pregnancy health is key to reducing infant mortality. *NC Med J.* 2004;65(3):147-148.
6. Centers for Disease Control and Prevention. Preconception Health and Health Care. Last updated May 13, 2013. http://www.cdc.gov/preconception/index.html
7. Foster DG, Biggs MA, Ralph LJ, et al. Reproductive intentions among individuals seeking reproductive health care. *Womens Health Issues.* 2008;18(5):351-359.
8. Moos MK, Dunlop AL, Jack BW, et al. Healthier women, healthier reproductive outcomes: recommendations for the routine care of all women of reproductive age. *Am J Obstet Gynecol.* 2008;199(6 suppl 2):S280-S289.
9. Petersen R, Payne P, Albright J. et al. Applying motivational interviewing to contraceptive counseling: ESP for clinicians. *Contraception.* 2004;69(3):213-217.