PICCK

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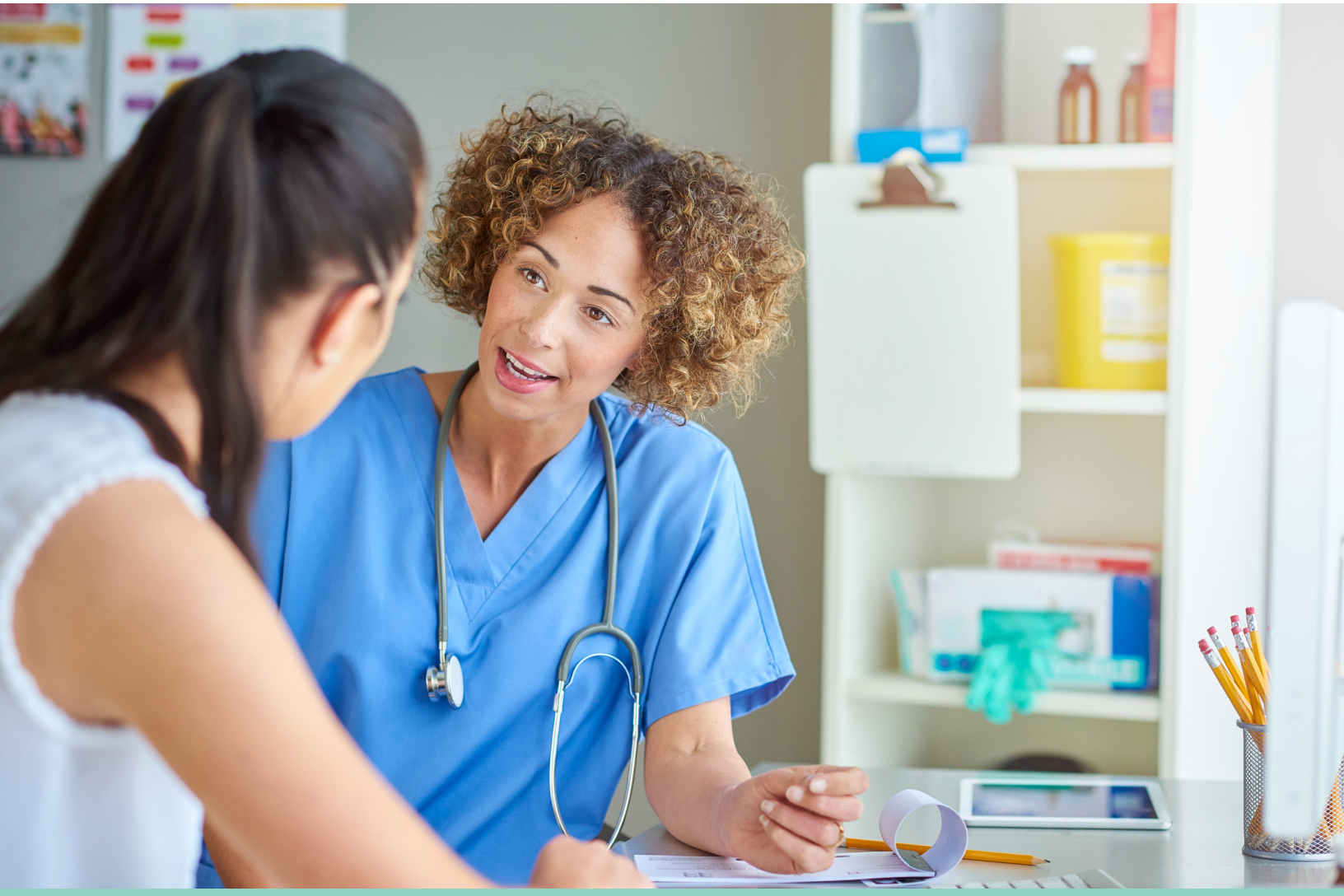

PREGNANCY INTENTION AND CONTRACEPTIVE NEEDS INTERVENTIONS FOR CLINICS (PICNIC) TOOLKIT

A resource for clinicians and administrative staff providing contraceptive services to patients in ambulatory and postpartum settings.

PICCK is an innovative clinical and public health program designed to promote contraceptive choice and quality contraceptive counseling across the Commonwealth of Massachusetts.

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INTRODUCTION TO PICNIC

A note on the name PICNIC: Universal screening of family planning interests is termed one of two things: a Pregnancy Intention Assessment or a Contraceptive Needs Assessment. We use the comprehensive name PICNIC—Pregnancy Intention and Contraceptive Needs Intervention for Clinics—to allow each practice to choose the question and workflow that works best for them.

Patients may have a need to discuss both their current contraceptive needs and future pregnancy intentions. Asking about both opens conversation paths to optimally help patients achieve their reproductive desires.

Some patients are clear about their reproductive desires, some are uncertain, and others do not wish to plan their pregnancies. PICNIC accommodates patients across this spectrum of desires. To remain patient-centered, incorporate PICNIC to meet patients where they are and follow up with appropriate counseling.

WHY IMPLEMENT UNIVERSAL SCREENING?

Implementation of a routine family planning screening question creates an opportunity for sharing information and is an important step toward empowering patients to take control of their health. When people plan pregnancies, they can achieve better pre-pregnancy health, engage in healthy behaviors like taking prenatal vitamins, and they are more likely to initiate prenatal care early in pregnancy. Pregnancy planning helps optimize birth spacing, which leads to healthier babies and parents. However, not all patients value pregnancy planning, and no patient should be pushed to embrace planning as a goal. Whatever PICNIC tool you choose to use, patients will have the opportunity to decline to answer.

Addressing a patient's pregnancy intention and contraceptive needs ***at each visit*** opens the door to this conversation, even when contraception is not the presenting reason for their visit. A key component to universal screening is to have a standardized question.

By reaching all patients, and not just those presenting for contraception, clinicians have an opportunity to **optimize maternal and child health outcomes** by helping patients plan for and space pregnancies. In addition, universal screening can:

- **Decrease lapses in use of short-term methods.** For example, a patient may present for a yeast infection when their current prescription for oral contraceptive pills is about to expire. By conducting PICNIC, you can assess contraceptive needs and offer a prompt refill prescription, preventing a gap in method use.
- **Eliminate the need for a rapid return visit.** In the example above, asking PICNIC during the current gynecological appointment eliminates the need for a future call or appointment to get a refill. During public health crises, like the COVID-19 pandemic, patients may have challenges seeking care, may not feel comfortable coming into facilities, or face obstacles like limited clinic schedules and lack of child care.[1]
- **Help prevent unprotected intercourse for those who have a new need for contraception.** Patients' contraceptive needs change over time, particularly for adolescents and those beginning new relationships.
- **Reduce future complications of chronic medical conditions.** Diabetes, hypertension, psychiatric illness, thyroid disease, and other such conditions should be well managed before pregnancy.[2]
- **Offer preconception counseling and planning to those considering pregnancy in the next year.** Health outcomes can be improved with planning before pregnancy, such as taking prenatal vitamins, managing weight, stopping medication that is unsafe for pregnancy, and screening tests.

WHY IMPLEMENT UNIVERSAL SCREENING?

To understand whether patients desire help with contraception, preconception care, or infertility services, clinicians must ask about fertility preferences, intentions, and needs. But *which question should be asked? And when? How should it be implemented? What are the factors to consider when implementing PICNIC?* There is no one-size-fits-all PICNIC. This toolkit explains options for PICNIC and guides practices looking to implement PICNIC through the steps to choose an assessment tool that fits their needs and constraints.

Patients of all genders and sexual orientations can benefit from PICNIC

PICNIC should be asked of all nonpregnant patients who can become pregnant (not post-hysterectomy or post-sterilization).[2] This includes heterosexual, lesbian, gay, bisexual, transgender, queer, intersex, asexual, and gender nonconforming patients. A patient should recieve PICNIC regardless of their gender; historically, transmen have been excluded from PICNIC interventions. LGBTQ-identifying adolescents are 12% more likely to have an unplanned pregnancy than hereosexual adolescents.[3] A patient's pregnancy intention and contraceptive needs can be more complicated than their identity may imply.

We encourage using an inclusive question that does not assess for pregnancy intention alone; assuming someone needs contraception because they don't want to become pregnant is heteronormative.

Furthermore, a patient may be seeking contraception for reasons beyond preventing pregnancy, such as to regulate their menstrual cycle, reduce acne, or reduce pain due to endometriosis. It is important to address contraceptive needs of all patients, whether or not they are having penile-vaginal intercourse.

WHERE CAN UNIVERSAL SCREENING HAPPEN?

PICNIC can be conducted in a number of different health care settings. Pregnancy and contraception are part of comprehensive care and screening in OB/GYN, family medicine, primary care, pediatric and adolescent medicine, and inpatient during postpartum care. PICNIC may also be able to be incorporated into other settings, such as inpatient medicine services and emergency departments and urgent care, to allow timely referrals for contraceptive care or preconception counseling.

OB/GYN offices

- While it may be assumed that pregnancy intention and contraceptive needs are assessed at all OB/GYN visits, patients presenting for symptom-based concerns or management of chronic conditions may not be screened for PICNIC. Implementing PICNIC begins a reproductive health review of systems in this setting.
- In practices that find it difficult to establish a same-day protocol for LARC (long-acting reversible contraception), conducting PICNIC early in the appointment may be a supportive task that makes same-day LARC provision more feasible.
- Prenatal care in OB/GYN offices should include a discussion of postpartum contraception and reproductive life planning. All methods that a patient is medically eligible for should be explored. For LARC, see our resource on counseling and consent for postpartum LARC during the prenatal period **here**.
- Postpartum visits in the office should include PICNIC. Many patients do not know that fertility can return as soon as 25 days after delivery. Contraceptive needs can change throughout the postpartum period.

WHERE CAN UNIVERSAL SCREENING HAPPEN?

Family Medicine offices

- Many patients see a family medicine clinician as their main source of health care. PICNIC can be integrated into this setting to improve care and counseling.
- Family medicine clinicians are devoted to comprehensive health care for the individual and family across all ages, genders, diseases, and parts of the body. These physicians are familiar with providing screening and diagnostic testing in the prenatal period. There is opportunity to screen for preconception care.
- Reproductive plans should be assessed at each visit because plans change over time. These discussions should include considerations of age, medical conditions, and obstetric or family history. This discussion is especially important for patients with chronic medical problems where pregnancy may exacerbate existing medical conditions or be potentially harmful.[4]
- The CDC recognizes the need to improve men's reproductive health. The American Academy of Family Physicians recommends that men should be counseled on contraception.[4]
- If your practice is not equipped to provide a full range of contraceptive methods, such as LARC, counsel on the full range of methods and then refer patients who desire LARC to a clinician who can offer insertions and removals. Standardize a referral system to family planning services as part of workflow development.

Primary Care offices

- Family planning is an essential part of primary care. Primary care clinicians should consider patients' reproductive goals and screen for pregnancy intention and contraceptive needs. This is especially important for those with chronic medical problems for whom pregnancy may exacerbate existing conditions or be potentially harmful. Adolescent and perimenopausal patients, in particular, do not consistently receive screening, yet are at the highest risk of unintended pregnancy.
- If your practice is not equipped to provide a full range of contraceptive methods, such as LARC, counsel on the full range of methods and then refer patients who desire LARC to a clinician who can offer insertions and removals. Standardize a referral system to family planning services as part of workflow development.

Pediatric offices

- Sexual and reproductive health can be difficult to discuss with adolescents. Clinician discomfort may lead some clinicians to skip this conversation altogether. Adolescents need regular comprehensive reproductive health counseling because their behaviors and needs change. Clinicians should discuss contraceptive options with patients in order to help them decide which method is right for them.[5] Ideally, clinicians should counsel patients *before* they become sexually active. The American Academy of Pediatricians has compiled resources for counseling adolescents on contraception and pregnancy **here**.
- Confidentiality is critical when determining how to conduct PICNIC. Procedures should be established that protect the privacy of adolescent patients.[6] Adolescents should be asked about their pregnancy intention and contraceptive needs in a way that allows them to answer not in the presence of support people or caregivers. This may be done on a paper or electronic screener, or it may be done verbally, during a portion of the visit where support people are asked to exit the exam room.
- If your pediatric office integrates screening of new parents into newborn care visits for things like postpartum depression, you can consider integrating PICNIC into any screening tool.

WHERE CAN UNIVERSAL SCREENING HAPPEN?

- If your practice is not equipped to provide a full range of contraceptive methods, such as LARC, counsel on the full range of methods and then refer patients who desire LARC to a clinician who can offer insertions and removals. Standardize a referral system to family planning services as part of workflow development.

Inpatient Postpartum

- With focus on a patient's physical recovery, contraceptive planning may be overlooked during the inpatient postpartum stay. Though the idea of a future pregnancy may seem distant, PICNIC can ensure patients receive crucial information before they need it. PICNIC begins a discussion about recommended pregnancy interval spacing, return of fertility during breastfeeding and postpartum, and effects of contraception on lactation. These conversations should be conducted during prenatal care. However, it is important that prior to discharge, patients have a contraceptive plan and their questions are answered.
- See our **postpartum contraception resources** for more information.

Emergency Departments (ED) or Urgent Care settings

- EDs and Urgent Care often screen for contraceptive use and require pregnancy tests because both affect care delivered. This is an opportunity for PICNIC and referral to family planning or pediatrics.
- These facilities are the main source of health care for many patients, making PICNIC essential.
- If a patient presents needing emergency contraception, it is an opportunity for PICNIC and referral to family planning or pediatrics for long-term care.
- PICNIC results can inform which patient education materials may be shared at discharge. For example, information about birth control, preconception planning, or caring for pregnancy.
- A referral system to family planning services can be standardized as part of workflow development.

DEVELOPING YOUR PICNIC

This section outlines considerations in designing and implementing routine screening for pregnancy intention and contraceptive needs.

Step 1: Understanding current practices: *Is there any regular screening currently being done?*

The first step in PICNIC development is to assess current practices around screening for pregnancy intention and contraceptive needs. Reflect on the following questions to understand current practices:

- *Are you currently screening for pregnancy intention and contraceptive needs at all?*
    - *Is there **universal** screening for **new patients? Returning patients? Certain visit types?***
    - *Are there **individual clinicians** who regularly ask?*
- If yes to any of the above:
    - *What tool, question, or protocol is used to conduct screening? Is it standardized?*
    - *When is screening conducted? Who conducts screening? If the staff screening is not a clinician, how are results handed off to clinicians so that they know to conduct contraceptive counseling?*
    - *How, if at all, is this screening documented in the chart/EMR?*

Step 2: Assessing interest and need for universal screening: *Is PICNIC right for you?*

The second step is to assess interest and need for PICNIC.

- *If your practice already conducts screening in any capacity, how is it perceived by clinicians, staff, and patients?* Understanding attitudes toward current practices (or lack of) can influence decisions about which strategies to employ to improve screening quality.
- *Is there interest in establishing a universal PICNIC?* Assessing the practice's appetite for PICNIC can help determine next steps. Clinician buy-in prior to implementing PICNIC is necessary. PICNIC works best when it is truly universal. If there is not consensus that adopting PICNIC is a good idea, it may not make sense to pursue implementation. Instead, focus on education for individual clinicians about options for screening their own patients.

Step 3: Determining workflow: *What works for your practice and staff? Who should conduct PICNIC, when should it be done, and how?*

Before selecting a PICNIC question, determine what workflow makes sense for your practice as some question options lend themselves better to being asked at certain times, by certain staff members, or in certain formats.

Who should conduct PICNIC?

Anyone *can* conduct PICNIC. Studies have shown that both nurses and medical assistants feel comfortable screening and that it can be done without disrupting workflow.[7] Depending on the practice setting, any staff or clinician may be best to conduct PICNIC. **Whomever does it, PICNIC should be consistent and systematized.**

It is risky to ask patients PICNIC multiple times in one visit because it may frustrate them, or be perceived as targeted screening based on their demographics. If a patient perceives bias, this may prevent an honest response and damage the patient's trust. Additionally, it is important to determine whose role this is, as ownership increases the likelihood of universal screening.

Is there a role for non-clinical staff in your practice to begin or conduct PICNIC? Often, practices have an intuitive feeling about what workflow is best for them. For example, PICNIC might make sense on an intake form, asked by an MA (Medical Assistant) during rooming, or led by the clinician. The fact is, there is no right person or way to conduct PICNIC, but the core ideal of PICNIC is that it must be done consistently.

Options for who conducts PICNIC

If a non-clinician conducts PICNIC, workflow will need to include hand off of the results to the clinician. A workflow for documenting results in the chart/EMR will need to be developed.

- **Scheduler:** Verbally — When patient calls to make their appointment
- **Intake forms or pre-appointment screeners:** Written
- **Medical assistant:** Verbally — While rooming patient or obtaining vital signs
- **Family planning counselor:** Verbally — While providing initial education

- **Nurse:** Verbally — Only if they visit each patient. Due to the importance of standardization, nurses may not be ideal screeners if they are only in contact with some patients.
- **Clinician (NP, PA, CNM, MD, DO):** Verbally — This is the simplest workflow and transition into education and counseling. However, postponing PICNIC until the clinician encounter delays adjusting schedules to accommodate counseling, and, if needed, setting up for a same-day LARC insertion. Some questions (for example, PATH) may be better suited for clinicians.

Considerations for selecting PICNIC staff — *you know your practice!*

Here are three considerations when determining who will conduct screening:

- **Comfort of clinicians or staff conducting PICNIC.** It is pertinent to consider who is comfortable discussing family planning with patients. This is especially true in non-OB/GYN settings, where staff may not be used to discussing reproductive health issues with patients. If staff do not routinely ask questions about possible pregnancy or birth control needs, screening may be better performed by the clinicians. Alternatively, if there is a desire to take on this role, staff can be trained to conduct PICNIC and can gain confidence in their abilities to do so. Do not assume that staff would feel comfortable conducting PICNIC screening just because leadership wants to implement it. In order for PICNIC to be successful, there needs to be staff support of the initiative and fulfillment of education and coaching needs. If staff are to begin contraceptive education after screening, it is vital that they are prepared to counsel on a full range of methods; if not, they should only conduct the PICNIC assessment and defer education and counseling to the clinicians.
- **Language translation needs and service.** *Does your practice or clinic serve many patients who speak/read languages other than English?* If yes, this may affect how complex and nuanced your PICNIC is to ensure adequate translation into multiple languages. It is important to determine how patients who do not speak or read English will be screened. *Who at your practice can request an in-person or telephone interpreter? Is it common practice for the MA rooming the patient or the scheduler conducting the phone triage to use an interpreter?* If not, and interpreter services are usually only available to clinician encounters, then PICNIC should be conducted at the point in the patient experience when interpreter services are available.
- **PICNIC with adolescents.** If your practice serves adolescents, be thoughtful about who asks highly sensitive questions to them. It is critical to ensure confidentiality and trust with this population. An adolescent patient may have chosen a particular clinician (similar to their own race/ethnicity or gender) with whom they feel more comfortable having conversations about sexual and reproductive health. Ensure patients are able to complete PICNIC screeners alone without support people present. Consider using paper or computer-based screeners.

DEVELOPING YOUR PICNIC

When should PICNIC be done?

When considering the timing of PICNIC it is important to consider what is feasible for clinic workflow in order to add contraception provision to a visit. The earlier PICNIC is conducted, the more time there is to allow for scheduling adjustment, equipment preparation, and insurance verification if aiming to offer same-day access to LARC methods. Offering same-day access to all contraceptive methods is a best practice; see our **Same-Day LARC Toolkit** for more information on how this patient-centered service is feasible even in busy clinics.

Here are some options of when to conduct PICNIC:

- **Call center:** When a patient calls to make an appointment for ANY reason, have phone staff ask *"Would you like to talk about birth control or pregnancy planning as part of your visit?"* Your practice will need to standardized a way to document that this question was asked and what the patient's response was so there can be appropriate follow-up during the visit. Phone staff will need to be instructed to ask this question and trained on how to respond and appropriately document the patient's response.
- **Pre-visit screener**: Consider adding a PICNIC question onto an existing pre-visit electronic screener.
- **Waiting room:** Include a question on an intake form or another waiting room screener. **Intake forms only work if it becomes standard for forms to be reviewed prior to seeing a patient.** If this review does not become routine, PICNIC on the intake form might actually decrease the likelihood that a patient brings up contraception on their own because they believe they have already made their request on the form and are waiting for the clinician to address it.
- **In the consultation or exam room:** Prior to the clinician encounter, a staff member (MA, RN, family planning counselor) can meet with the patient to conduct PICNIC (often at this time medical history and vitals are recorded).
- **During the clinician encounter:** The clinician can conduct PICNIC during a patient encounter in the office, or virtually through a telemedicine visit.
- **Inpatient postpartum:** PICNIC may be conducted by a clinician during rounding. Postpartum nurses can include PICNIC in pre-discharge counseling.

As we said earler in Step 3, it is risky to ask patients PICNIC multiple times in one visit because it may frustrate them, or be perceived as targeted screening based on their demographics. If a patient perceives bias, this may prevent an honest response and damage the patient's trust. Additionally, it is important to determine whose role this is, as ownership increases the likelihood of universal screening.

DEVELOPING YOUR PICNIC

How should PICNIC be done?

When deciding who will conduct PICNIC and when, you are also deciding if it will be verbal or written. Consider your patient population, how will this workflow be perceived, and what will be the most successful.

Verbally	
Pros	**Cons**
Patients may not have a clear answer to whether or not they have a need for pregnancy prevention or conception planning. Sometimes patients aren't sure and sometimes they definitely want both. A verbal screener allows for nuance and values clarification.	Could be an additional ask of MAs or RNs during rooming, which is already a busy time.
May be more confidential than written if asked after excusing a patient's support people from the room. This is particularly a concern for adolescents, victims of violence, and those who want to keep their reproductive life planning secret.	May lack privacy if a patient has support people in the room.
May be more comfortable for patients who are concerned about confidentiality of paper or creating a "record."	Opportunity for a verbal PICNIC is later in the appointment than a written PICNIC, which may decrease flexibility for same-day LARC.
May be preferred by patients who feel uncomfortable "checking a box" on a form.	
Better for patients who do not read English.	

Written	
Pros	**Cons**
Ensures standardization of PICNIC in implementation.	Forms are not always completed.
Allows for clear questions about both pregnancy prevention and contraception planning.	Close-ended questions on forms do not allow for nuance or indecision.
May be more confidential than a verbal question if the patient completes the form and they have support people in the room during their appointment.	Forms may not be completed by the patient (could be completed by a support person).
Allows for earliest possible screening prior to the patient seeing the clinician (except for scheduling).	Forms are in limited languages and require literacy in those languages.
May be preferred by patients who feel uncomfortable verbalizing a desire for either contraception or pregnancy.	Patients may be concerned information completed on a form will not be kept private.
May be more comfortable for a patient who does not want to discuss contraception with a male staff member (they may have specifically made an appointment with a female clinician).	

Step 4: Assessing documentation and hand off: *How can PICNIC be documented and communicated (if needed) at your practice?*

If using a scheduler or intake form, there needs to be a standardized way the result is documented in the EMR so the clinicians know where to look. If a clinician is to conduct PICNIC from start to finish, there is no hand off but documentation is still needed. If you will have a staff person ask PICNIC, there needs to be a way to give the result to a clinician. MAs and RNs can hand off the results of PICNIC to a clinician in one of three ways:

Verbally:

- If the normal workflow at a practice is to have a verbal hand off between staff and clinician before the clinician sees the patient, this would be a natural point to add the result of PICNIC. However, if a verbal hand off is not part of routine workflow, we caution that such a timed hand off for PICNIC alone can be complicated, especially for large practices. We suggest that if the MA is documenting other information during the initial patient encounter, they can also document PICNIC, so it can be referred to in future visits.

Paper-based options:

- If you use paper patient records in your practice, or a "tickler" chart with a paper billing form, the MA could indicate patients who want to discuss contraception with a blue sticky note on the outside of the chart, and patients who want to discuss conception planning with a yellow sticky note. The clinician will then know what to discuss (and document) with the patient.
- The MA or RN could offer the patient a contraceptive decision aid or other patient education material to review while they wait for the clinician to arrive. Alternatively, the decision aid could be placed in the door of the patient's room with other paperwork for the clinician. When the clinician sees the decision aid, they know that the patient may want to discuss contraception.
- The number of alternative hand offs that are neither in the EMR or verbal are endless. PICCK is happy to support you in thinking through some options if this might be the best way for your practice to communicate PICNIC results between staff and clinician.

Electronic Medical Record (EMR):

- Routine screening is most effective when consistent and systematized. Essential to integrating screening into care is documentation in the EMR. Involve an expert in EMR systems early in the process to help design a feasible prompt.
- Documenting PICNIC in the EMR allows other clinicians to see that the question was asked (and can refer to the results when asking the question in the future).
- **Even if not used for a hand off, clinicians should still document PICNIC results and any counseling or method provision that follow in the EMR.**

Once PICNIC is established, the documentation, handoff, and counseling **must** happen with every patient. It is harmful to screen a patient for a need and then not address it. Additionally, if a patient answers PICNIC with staff, they may not raise contraception with the clinician because they expect the clinician to know they want to discuss it and to start the discussion.

- There are several options for how to document PICNIC in the EMR:
    - "Pop-up" question with a hard stop
    - "Pop-up" question without a hard stop
    - Question in the flowsheet
    - Place in a pre-completed note

- While best practices have not been established, certain technological features can ensure routine uptake. Here are some things to consider while building EMR integration of the selected screening question:
    - *Where are the patient's answers recorded?*
    - *How visible is this response in the EMR?*
    - *How is it ensured that the responsible clinician has seen the patient's answers? (ie: Once it is recorded, what happens to this information?)*
    - *Is it pulled into a note template?*
    - *Does it appear in highlighted color?* Make it easy for clinicians to see the results like a vital sign.
    - *Is drop down response recording possible?* This can minimize the need for free-texting, and can easily auto populate into a flow sheet or note.

Step 5: Choosing a PICNIC question: *What PICNIC question makes sense for your workflow (as designed in Steps 3 and 4)?*

There are several different questions that your practice can adopt for PICNIC, both written and verbal. None of the following approaches are definitively better than another. Some have been evaluated more than others, but there is no consensus on a universal question. When selecting a PICNIC question, choose one that makes the most sense for your patients and your staff, and be consistent with using it across the practice.

Verbal question for scheduler

We suggest keeping scheduler questions as simple as possible, with a yes/no answer and one that does not require more discussion or values clarification. Scheduler screening is not appropriate for adolescents.

- Our preferred question during scheduling adult office visits:

Would you like to talk about birth control or pregnancy planning as part of your visit?

This question should be asked after the scheduler has received the necessary information about the primary purpose of the visit to avoid the perception that contraception is being unduly encouraged, or that a patient's primary concern is not being taken seriously. The scheduler will need a way to document the response so that the clinician can see it during the visit.

- Our preferred question during scheduling postpartum visits:

Would you like to talk about birth control as part of your visit?

This question can be asked at the time of scheduling routine postpartum visits. A variant of this question could also be asked by pediatrician's offices that use well-baby visits as an opportunity to screen parents for various needs, including depression and social determinants of health.

Written questions for intake forms and pre-visit screeners

PICNIC can be written in a number of different ways, as one question or a series of questions. Questions can have multiple choice checkboxes or fill in the blank. Typically, to decrease confusion, we suggest one, simple question with checkboxes. If you believe your patient population is highly literate and can work through a series of questions, then there are alternative options. See below for adolescent appropriate options.

- Our preferred written question for adult office visits:

> ***Would you like to talk about: [ ] Not getting pregnant/birth control***
> ***[ ] Interest in getting pregnant in the future?***

We suggest locating this question either in the "Current GYN History" section of the intake form or in a section of the form that asks about their last menstrual period, current contraception use, or sexual behaviors. An alternative placement is near a question asking about reasons for visit.

- Our preferred written question for postpartum visits:

> ***Would you like to talk about birth control during your visit today?***

This question reflects that 75% of rapid repeat pregnancies—those that occur within 18 months of giving birth—are unplanned, and many are undesired. This question should be asked at the time of routine postpartum visits, whether they are virtual or in-person, if a contraception plan is not documented in the chart. A variant of this question could also be asked by pediatrician's offices that use well-baby visits as an opportunity to screen parents for various needs, including depression and social determinants of health.

Verbal questions for MA/RN or clinician

While individual clinicians may have their own way of assessing patients' needs around contraception and pregnancy, there are several questions that are in wider use with varying degrees of supportive research, and expert opinion. The four questions outlined below can be adapted to be written or verbal questions with varied people screening. Answer options are offered, if you want to use a multiple choice question on an intake form or in the EMR for documentation; all questions can also be open-ended. Questions A and B are true PICNIC questions, assessing both pregnancy intention and contraceptive needs. Question C is a pregnancy intention screener, so follow up will be needed to see if contraception is desired. Question D is a contraceptive needs screener, which may be most appropriate for settings where preconception counseling is not in the expertise of the clinician or may not be generally relevant to the patient population. Questions E and F explore adaptations to PICNIC that are more appropriate for adolescents and pregnant/postpartum patients.

A. The Institute for Family Health: Seven federally qualified health centers throughout New York City and the Mid-Hudson Valley Region implemented the question *"would you like your provider to help you with birth control or pregnancy planning today?"* as a family planning services screening question. The pilot site had an overall 96% screening rate for the 13-month intervention period for 1,500 patients, ranging from 93% to 100% by month. Most (80%) medical assistants and nurses were comfortable asking this question.[7]

B. PATH question framework: The HER Salt Lake City Initiative asked the PATH questions of over 3000 women who did not plan to become pregnant in the following year. Women who planned to become pregnant in the following 2-5 years felt that pregnancy prevention was less important when compared to women who wanted to wait 5 or more years before becoming pregnant. Surprisingly, the importance of

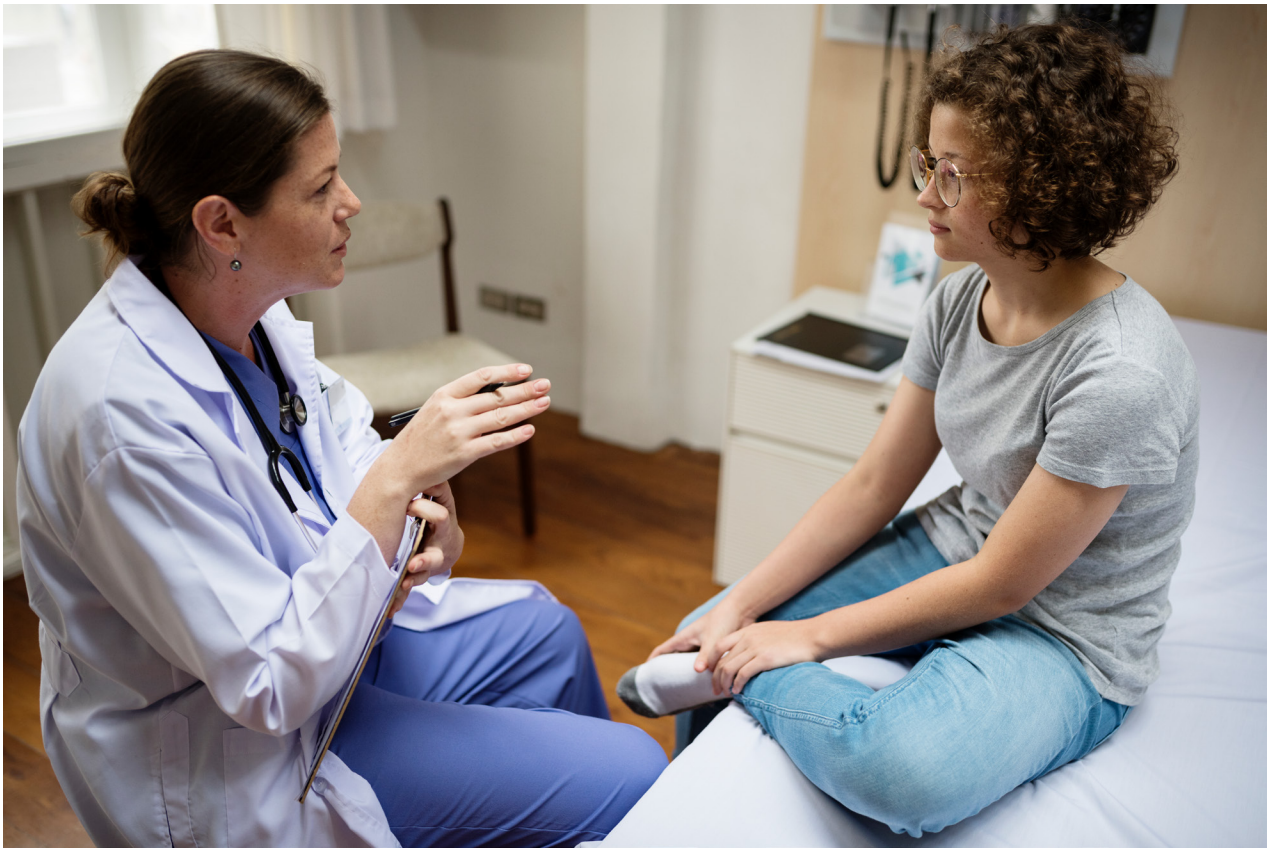
pregnancy prevention was lowest among those who never intended to get pregnant in the future, showing how nuanced this conversation needs to be. Shared decision-making is important in addressing the nuances of how pregnancy attitudes, plans, and emotions affect contraception choices.[8]

C. **One Key Question®:** The question *"would you like to get pregnant in the next year?"* was added to the EMR of a Chicago community health center to evaluate if it would increase contraceptive counseling by family medicine physicians, nurse practitioners, and nurse midwives. A post-implementation patient survey (n=63) found that contraceptive counseling during visits increased from 52% to 76%, with a noticeable increase for visits that were scheduled for general health reasons. While there was no difference in dissatisfaction between patients before and after the intervention, fewer patients reported they were very or extremely satisfied with their overall medical care after the intervention (97% vs. 56%, p=0.001).[9]

D. **PICCK contraceptive needs screener:** This question has not yet been evaluated. PICCK offers it as an option if you are looking to implement only a contraceptive needs screener, and not a question that asks about pregnancy intentions or planning.

E. **Adolescents:** These questions have not been evaluated.

F. **Postpartum patients:** This question has not been evaluated.



A. The Institute for Family Health[7]

This question was developed by researchers at The Institute for Family Health, one of the largest federally qualified health center networks in New York State. The researchers implemented a family planning services screening prompt for support staff to ask women 13–44 years at nonobstetric visits at specified time intervals.

Would you like your provider to help you with birth control or pregnancy planning today?

Answer choices:

- Yes, help with birth control
- Yes, help plan pregnancy
- No, happy with method
- No, not sexually active
- No, not sexually active with men
- Unsure
- Not asked/defer to next visit

Timing/staff:

Originally designed to be an automatically displaying EMR multiple choice question for an MA/RN to complete. The response would then be displayed as an alert for staff in the EMR and link to possible contraception order sets, preconception, and other reproductive health services. Depending on the response selected, the screening question automatically refires when the patient next comes into the center, in 3 days (for response: "Not asked"), 3 months (for responses: "Yes, help with birth control or pregnancy", "Unsure", or "No, not sexually active"), 6 months (for response: "No, happy with method") or 12 months (for response: "No, not sexually active with men"). The question can be adapted to be used verbally by a clinician or scheduler, or written on an intake form or pre-visit screener.

Pros	Cons
Is both a pregnancy intention and contraceptive needs screener (PICNIC)	Answers as developed by researchers are not mutually exclusive
Specific to the current visit	Answers as developed by researchers do not allow a patient to choose both contraception and pregnancy planning
Focuses on service provision and not on what patients plan to do	In the answer choice, the term "men" is used to refer to cisgender men, which may feel exclusionary or confusing to patients who have partners who are transgender men
Intended to facilitate a broader conversation between patient and clinician	
Each visit builds on the response from the last visit, indicating to the patient that their response is being heard and important to their clinician	

B. PATH question framework[10]

The purpose of the PATH framework is to help patients gain clarity about their reproductive desires so they can make choices that are aligned with their goals. It seeks to re-frame patients' thinking to focus on their future rather than their current partner or sexual experiences, as well as inform the clinician about the direction of the visit (offering to discuss preconception care, fertility support, and contraception).

P*regnancy *A*ttitudes:** ***Do you think you might like to have [more] children at some point?
T*iming:** ***When do you think that might be?
H*ow Important:** ***How important to you is it to prevent pregnancy [until then]?

Answer choices:

P*regnancy *A*ttitudes:** ***How important to you is it to prevent pregnancy [until then]?

- Yes → Proceed to "***T***"
- Unsure → Proceed to "***T***". Examples include:
  - "I'm not really sure."
  - "Somedays yes, somedays no."
- No → Skip "***T***" and proceed to "***H***". You do not need to ask about timing if the patient has told you that they do not desire children in the future. Examples of responses include:
  - "No, I really don't think so, I've really got my hands full with the three I've got!"
  - "I seriously doubt it, I mean I love kids and all, but I think it would be too much to deal with."
- Patients may give an expanded answer that answers the question "***T***" or even questions "***T***" and "***H***". If this is the case, do not repeat a question that they have already answered. Examples of when you would skip "***T***":
  - "I'm not really sure, but I can tell you that it's no time soon if I do."
  - "Yes! I definitely want to be a parent some day. I am pretty traditional, and family is one of the most important things in my life, but I definitely want to be married first, which I don't see happening for at least four to five years."

T*iming:** ***When do you think that might be?

Open-ended

H*ow Important:** ***How important to you is it to prevent pregnancy [until then]?

Open-ended

Timing/staff:

PATH is a series of non-linear questions; as such it is a screener best used verbally by a clinician. If you are going to use PATH, PICCK suggests **further reading** on how best to use it.

B. PATH question framework (continued)

Pros	Cons
Is both a pregnancy intention and contraceptive needs screener (PICNIC)	Focuses on what patients plan to do and not on service provision
Intended to facilitate a broader conversation between patient and clinician	Many patients respond “unsure” necessitating discussion of both preconception and contraception topics, adding a longer conversation to the visit. Focuses on patient desires, which many patients have not clearly defined
Ascertains importance of effective pregnancy prevention	Not a simple screening question
Allows each patient to feel seen as a person with family goals, not just a person who can become pregnant	Difficult to implement by a non-clinician
	Not ideal for self-screening (written)
	Questions branch and must be customized based on previous question
	It would be difficult to use this screener in settings such as Emergency Departments or Urgent Care

C. One Key Question®[11]

One Key Question® was developed to provide a framework to assess pregnancy intentions and improve perinatal equity and maternal child health. It is used by providers in approximately 30 states, including clinicians, community health workers, and home visiting nurses at health systems, and public health departments.

Would you like to become pregnant in the next year?

Answer choices:

- Yes
- No
- Okay either way
- Unsure

Timing/staff:

While One Key Question® was designed to be asked verbally by an MA/RN or clinician, it could be used as part of a written pre-visit screener or intake form. Is not suggested for a scheduler.

Pros	Cons
Intended to facilitate a broader conversation between patient and clinician	Focuses on what patients plan to do and not on service provision
Most research available, most in use	Only screens for pregnancy intention
Designed with patient input	Now patented, requires purchase for full use and implementation
	Many patients respond “unsure” necessitating discussion of both preconception and contraception topics, adding a longer conversation to the visit. Focuses on patient desires, which many patients have not clearly defined
	Even if patients want to become pregnant months from now, they still may not desire pregnancy in the near future and may be interested in contraception today. This nuance is not clearly distinguished by this screening question
	Not a good screener for postpartum or adolescent patients
	Not a good screener to be used by a scheduler

D. PICCK contraceptive needs screener

This question was developed to focus solely on contraception needs. It may be suitable for practices that want a targeted question to elicit the need for contraceptive counseling and provision, without beginning a conversation about pregnancy intentions. It reflects that while patients may feel ambivalent about desiring pregnancy, they are likely to be more certain about whether or not they want to use contraception to avoid it.

Do you want something to prevent pregnancy today?

Answer choices:

- I am already doing something to prevent pregnancy that is working well for me
- I am already doing something to prevent pregnancy, but I would like to discuss alternative options
- Yes, I want to start preventing pregnancy
- No, I don't want to prevent pregnancy
- I am unsure whether or not I want to prevent pregnancy
- I prefer not to answer
- This question does not apply to me

Timing/staff:

Can be asked verbally by an MA/RN or clinician. Can also be adapted to use on a written intake form or pre-visit screener. Is not suggested for a scheduler.

Pros	Cons
Specific to the current visit	This question has not yet been evaluated
Focuses on service provision and not on what patients plans to do	Only screens for contraceptive needs
Intended to facilitate a broader conversation between patient and clinician	
Allows for focused triage of if contraceptive counseling should happen during the visit	
May be most appropriate for postpartum patients	

E. Adolescents

It may not be appropriate to ask adolescents the above PICNIC questions. Pregnancy and contraceptive needs are often, but not always, relevant for adolescents. These questions need a developmentally-appropriate grounding and it therefore makes sense to first assess relationships and sexual behaviors before asking more direct questions about pregnancy intentions and contraception. Instead, below is a sequence of questions that may be most age appropriate to screen for sexual health services:

Have you ever had any type of sex (oral sex, vaginal sex, anal sex)?
If yes, when was the last time you had sex? When was the last time you had unprotected sex?
Are you currently trying to become pregnant?
If no, what are you doing to prevent pregnancy? Do you need help with that?
Do you share information about birth control use with any trusted adults/parents?

F. Postpartum patients

It may not be appropriate to ask pregnant/postpartum women the above PICNIC questions. Some situationally appropriate options are:

- Postpartum visit soon after giving birth:

A person can get pregnant again as soon as one month after giving birth.
Would you like to talk about birth control today?

- Visit 1 year or more after giving birth: start using a **standard PICNIC** question.

Step 6: Preparing to respond: *How will you respond to various PICNIC answers?*

Perhaps more important than asking a PICNIC question is how the clinician and staff respond to the answer.

Respond without judgement. Of utmost importance is to withhold judgement. Some responses may feel uncomfortable or outside the staff/clinician's comfort zone. *Is a 16-year-old patient sharing that they would like to become pregnant in the next year? Is a patient with a chronic illness exacerbated by pregnancy desiring a pregnancy? Is a 40 year old patient saying they would like to get pregnant, but would like something to delay pregnancy for the next few years?* It is not the staff/clinician's responsibility to change the patient's desires. Instead, it is the clinician's role during counseling to provide medically relevant information and referral.

Clarify, if needed. If a patient's answer is not clear, a clinician can respond by clarifying the question or following up with value clarification questions. If a patient responds "I don't know" to an MA, the MA could be coached to respond with something like, "It can be a complicated question for many people. I will let the clinician know you might want to discuss it further and they can talk with you about it." If the question is asked by a scheduler, your practice may decide that the scheduler should note but not clarify an unclear response.

Affirm desire. It is important to echo back and affirm a patients desire for contraception or pregnancy planning so that they do not feel unheard after sharing something personal. The role of the screener conducting PICNIC is to be an active listener in the discussion. Responding with statements that begin with, "What I'm hearing you say is…" or "What I think you're saying you want/don't want is…" creates space for the patient to express their desires and articulate back to them what you are understanding to gain clarity and affirm desire.

DEVELOPING YOUR PICNIC

Ask pertinent follow-up questions. Some possible probes for the clinician after screening are:

If a patient is **NOT** desiring pregnancy:

- *Do you ever have, or may have in the future, penile-vaginal sex?*
- *If so, are you using a contraceptive method? Are you having any difficulties using it? Are you happy with it?*
- *If not, would you want something else?*
- When short on time, offer information sheets on contraception and information on local sites for family planning counseling visits

If a patient **IS** desiring pregnancy:

- Talk about key preconception counseling points: prenatal vitamins, controlling chronic diseases, medications review for those contraindicated in pregnancy, addressing alcohol and substance use
- When short on time, provide printed material on preconception planning, and offer a separate preconception clinician visit if a patient has any comorbidities

If a patient **is not sure** what they prefer at this time:

- Affirm to the patient that there is no need to make a decision at this time—do not insist they make a choice
- Offer a follow-up visit to discuss
- Refer to a family planner, OB/GYN, family medicine, or PCP for a visit
- Provide a handout on emergency contraception (or prescriptions for emergency contraception and condoms) in case they need it
- Ensure they understand their chances of getting pregnant and the benefits of taking folic acid and of abstaining from alcohol, tobacco, and other substances

Explain next steps. Staff should explain that their role in the PICNIC workflow is to begin the conversation—asking PICNIC, documenting it, and handing off the response to the clinician—so patients understand what staff will do with the information they shared. Staff can say something like, “Great, I will note your desire to discuss [insert need] for the clinician who will try to assist you today with [insert need].”

Begin education around contraception (if indicated). If you are a family planning counselor, RN, or MA trained to start contraception education with a patient, you can begin education after conducting PICNIC. You should explain that you are going to start by discussing their options with them, but that a clinician will continue the conversation to assess what methods might work for their health history and to answer any questions. Using a **decision aid** is a great way to share information with the patient. PICCK has a variety of **contraceptive method information materials** for you to use when conducting education.

Transition into counseling. Likely, only a clinician will conduct full contraception or preconception counseling. PICCK encourages the use of the PICK ONE framework to conduct shared decision-making in contraception counseling in roughly five minutes. View our **PICK ONE Framework** and **Video**.

PROVIDING QUALITY CARE

Ensure your practice is equipped with skills and supportive services as you initiate PICNIC screening.

Education and counseling

Some practices may prefer a workflow where a staff person, like a family planning counselor or MA/RN, begins education and then hands off to the clinician for counseling after an overview of methods.

Education

The purpose of education is to help a patient understand their options. It is not to assess if a method is right for them or to decide which method they will use. It is helpful to use **patient-facing materials**, like a **decision aid**.

Counseling

We encourage clinicians to use shared decision-making when conducting contraceptive counseling. PICCK has developed a mnemonic PICK ONE to help clinicians conduct shared decision-making in as little as five minutes. To read more about PICK ONE check out our **Framework** or watch our **Video**.

Special considerations for LARC

If providing LARC methods will be a new service offered by your practice, clinicians should undergo formal **training**. If clinicians do not feel comfortable providing the full range of methods, PICNIC may be appropriate for your practice followed by a referral to a family planning clinician.

Providing same-day access to LARC

Providing a patient's desired method the same-day as counseling is a best practice. Same-day provision of LARC can be difficult if the office does not have the proper equipment or devices stocked, flexibility of schedules and room allocation, or needs insurance verification. If interested in establishing same-day services, see PICCK's **Same-Day LARC Toolkit**.

Referrals

Even if your practice cannot provide some or all contraceptive methods, using PICNIC can help facilitate a patient's access to care. Consider including in your PICNIC workflow a standard protocol for family planning referrals—whether for any method or just for IUDs and implants.

Motivational interviewing

Principles of motivational interviewing can be helpful as clinicians guide a person's decision-making. Here are the main principles with examples that may arise when discussing pregnancy or contraception:

- **Express empathy through reflective listening.** *"I hear you really want to be pregnant, but that it would be dangerous with your medical condition(s). That sounds like a really hard place to be."*
- **Identify discrepancies between patients' goals or values and their current behavior.** *"I hear you really don't want to be pregnant, but you also don't want to do anything to prevent pregnancy when you are sexually active with men. What do you think about that?"*
- **Avoid argument and direct confrontation.**
  - Avoid "*You want to be pregnant at 16? That could really ruin your chance at a good future."*
  - Instead, *"I hear you say that you would like to be pregnant. Have you thought about what having a baby would be like?"*
- **Adjust counseling to the patient's values and preferences.** *"I hear that you don't want a method that stays in your body. Let's talk about other methods you may be interested in if that is important to you."*
- **Support self-efficacy and optimism.** *"This is a hard decision, but I know that with time you will make the right decision for you and your family."*

BILLING

If PICNIC leads to full contraceptive counseling, ensure you bill for the work provided, even if the patient declines to start a contraceptive method. Three codes include counseling. The first is to be used when providing a method that is not an IUD or implant and can also be used on its own, even if a method is not provided, as long as counseling is conducted. The second is for the provision of an IUD, which is inclusive of counseling. The third is for the provision of an implant, which is inclusive of counseling.

- **Z30.0**: Encounter for general counseling and advice on contraception
- **Z30.014**: Encounter for initial prescription of an IUD (this code includes the initial prescription of the IUD, counseling and advice, but excludes the insertion)
- **Z30.017**: Encounter for initial prescription and insertion of an implant. This includes: initial prescription, counseling and advice, and insertion of device (even if it happens at a different encounter)

SUSTAINABILITY

As new staff and clinicians are hired, they will need to be trained on PICNIC and workflow, education, and counseling as relevant to their job type.

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10. How to Use the PATH Framework to Discuss Reproductive Goals with Patients. Envisionsrh.com. https://www.envisionsrh.com/path-questions-examples/. Accessed July 17, 2020.

11. One Key Question. Powertodecide.org. https://powertodecide.org/one-key-question. Accessed July 17, 2020.

APPENDICES

Appendix 1: Additional resources

The American College of Obstetricians and Gynecologists (ACOG)

Prepregnancy counseling. ACOG Committee Opinion No. 762. American College of Obstetricians and Gynecologists. Obstet Gynecol 2019;133:e78–89.
https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2019/01/prepregnancy-counseling

American Academy of Pediatrics (AAP)

Adolescent Sexual Health: Delivering Reproductive Health Care Services.
https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/adolescent-sexual-health/Pages/Delivering-Reproductive-Health-Care-Services.aspx

Family Planning National Training Center (FPNTC)

Client-Centered Reproductive Goals & Counseling Flow Chart. FPNTC. Published July 1, 2019.
https://www.fpntc.org/resources/client-centered-reproductive-goals-counseling-flow-chart

One Key Question®

One Key Question® Provider Portal. Power to Decide. 2020.
https://powertodecide.org/one-key-question

PATH Question Examples

Envision SRH PATH Questions Examples. envisionsrh. 2020.
https://www.envisionsrh.com/path-questions-examples/

The Institute for Family Health

Shah SD, Prine L, Waltermaurer E, Rubin SE. Feasibility study of family planning services screening as clinical decision support at an urban Federally Qualified Health Center network. Contraception. 2019;99(1):27-31. doi:10.1016/j.contraception.2018.10.004.
https://www.contraceptionjournal.org/article/S0010-7824(18)30463-3/fulltext

Appendix 2: PICCK resources

PICCK has developed resources to support the adoption of PICNIC. On the following pages you will find:

A checklist of activities for a Champion to ensure all of the components of a successful PICNIC are established.

> Champion Checklist for Successful Implementation of PICNIC
> **https://picck.org/resource/picck-checklist-for-champion-picnic/**

PICCK's PICK ONE Framework for Shared Decision-Making to be used by clinicians who conduct contraceptive counseling as a result of PICNIC.

> PICK ONE Framework for Shared Decision-Making
> **https://picck.org/resource/shared-decision-making-infographic/**

> A video example of PICK ONE can be found on our website.
> PICK ONE Framework for Shared Decision-Making Video
> **https://picck.org/resource/shared-decision-making-video/**

For those who may want to post a flyer in their waiting room to encourage patients to begin thinking about if they would like to discuss contraception or pregnancy planning, PICCK has made a flyer.

> PICNIC Flyer for Posting
> **https://picck.org/resource/picnicflyer/**

CHAMPION CHECKLIST

Pregnancy Intention and Contraceptive Needs Intervention for Clinics (PICNIC)	
Goals/Tasks	**PICCK Contribution**
Providers: ❑ Learn where to find PICNIC results ❑ Become comfortable with SDM approach to address patient's needs	• Grand rounds • Webinar
Staff: ❑ Train staff in PICNIC workflow	• Training presentation • PICNIC flyer
Practice Leadership Decisions: ❑ Decide which staff will be screening ❑ Implement PICNIC protocol, including where to post it ❑ Decide on EMR build	• Toolkit • Sample protocol
Champion: ❑ Work with leadership to choose a screening question ❑ Coordinate training for screening staff ❑ Work with practice leadership to determine workflow ❑ Work with practice leadership to determine documentation ❑ Determine feasibility of EMR build ❑ Determine how to ensure all staff members trained ❑ Communicate with other departments re: PICCK training opportunities ❑ Decide on patient-facing resources to make available	• Trainings for other departments, as desired • Patient-facing resources
Sustainability: ❑ Train new staff on PICNIC ❑ Train new providers on PICNIC	• Best practices overview

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SHARED DECISION-MAKING APPROACH TO CONTRACEPTIVE COUNSELING

Use this mnemonic
- PICK ONE -
to remember the elements of
shared decision-making
for person-centered
contraceptive counseling,
leading to
a more satisfying encounter
for you and your patients

P ASK PAST HISTORY WITH CONTRACEPTION

I ASK IMPORTANT FACTORS IN A METHOD

C EXPLORE CONTRAINDICATIONS TO METHODS

K SHARE KNOWLEDGE ABOUT METHODS WITH DECISION AID

O EXPLORE OBSTACLES TO DECISION-MAKING

N ASK IF THE PATIENT IS READY TO MAKE A DECISION NOW

E EXPERIENCE THE METHOD AND RETURN IF NEEDED

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P — ASK PAST HISTORY WITH CONTRACEPTION

Ask about their **past** history with birth control—what methods they have tried, liked, and disliked. Knowing specifically what worked for them and what didn't in the past can help guide counseling. This question should be seen as information-gathering, not an opportunity to discuss the biological plausibility of side effects they experienced with different methods. Validate their experiences (without committing to causality) to build trust in the encounter.

I — ASK IMPORTANT FACTORS IN A METHOD

Ask what the patient thinks is **important** about their birth control method. Providers tend to focus on efficacy, but patients often think more about other factors, such as the effect on their monthly bleeding, their control over stopping and starting the method, and possible non-contraceptive benefits. Understanding the patient's values is vital for individualized counseling that takes into account their preferences.

C — EXPLORE CONTRAINDICATIONS TO METHODS

Next is to assess **contraindications** to any contraceptive method. If you don't know this patient's history, now is the time to ask pertinent questions about their medical history to determine medical eligibility for the various methods.

K — SHARE KNOWLEDGE ABOUT METHODS WITH DECISION AID

Now it's time to share your **knowledge** with the patient about their contraceptive options. Research shows that patients value a conversation with their clinician over other ways of getting this information. We find it helpful to use a visual aid that includes information about the various methods. As you counsel, you can indicate which methods may or may not be appropriate for the patient. This approach is especially helpful if a patient doesn't know about all the options available to them. The PICCK website has links to multiple decision aids that you can consider using with your patients.

O — EXPLORE OBSTACLES TO DECISION-MAKING

Explore **obstacles** to method use. Patients may have conflicting values about what they want in a contraceptive method, but you shouldn't try to resolve these conflicts. Only the patient knows what value is most important to them, so explore any conflicts with them. Hearing a provider reflect back what they are saying, and showing what kinds of decisions need to be made, can help a patient select a method more confidently. Other obstacles may include cost/lack of insurance coverage or the need to keep use of a method private.

N — ASK IF THE PATIENT IS READY TO MAKE A DECISION NOW

After counseling about methods and answering the patient's questions, inquire whether or not they have enough information to make a decision **now**. They may be ready to make a choice today, or may want to think about their options. Offer to provide written or electronic information about methods that they are interested in. You can also offer a bridge method of birth control until they return for a follow-up appointment. This bridge method could be a pill pack, a box of patches, a Depo-Provera shot, or a supply of condoms and a prescription for emergency contraception.

E — EXPERIENCE THE METHOD AND RETURN IF NEEDED

Finally, the patient is ready to try out their method. After they've used their birth control method for some time, they may want to return to your office or touch base with you to discuss their **experiences**. Keep the door open to them, and let them know that you're always available to answer any questions, allay their concerns, and to change their method at any time.

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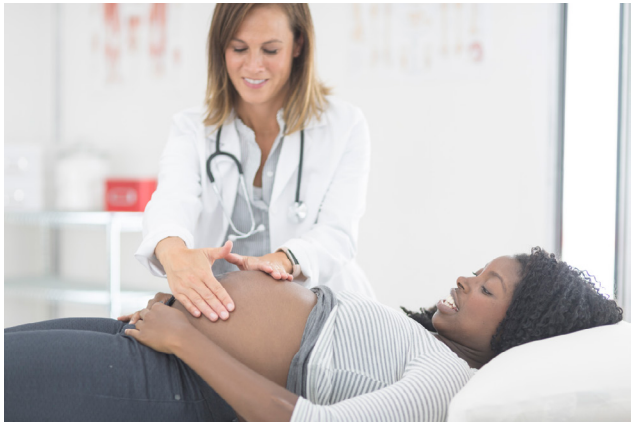
DO YOU WANT TO GET PREGNANT?



DO YOU NOT WANT TO GET PREGNANT?

TALK WITH YOUR PROVIDER TODAY!

Your provider can help you chose a birth control method that's right for you or make sure you're healthy for pregnancy

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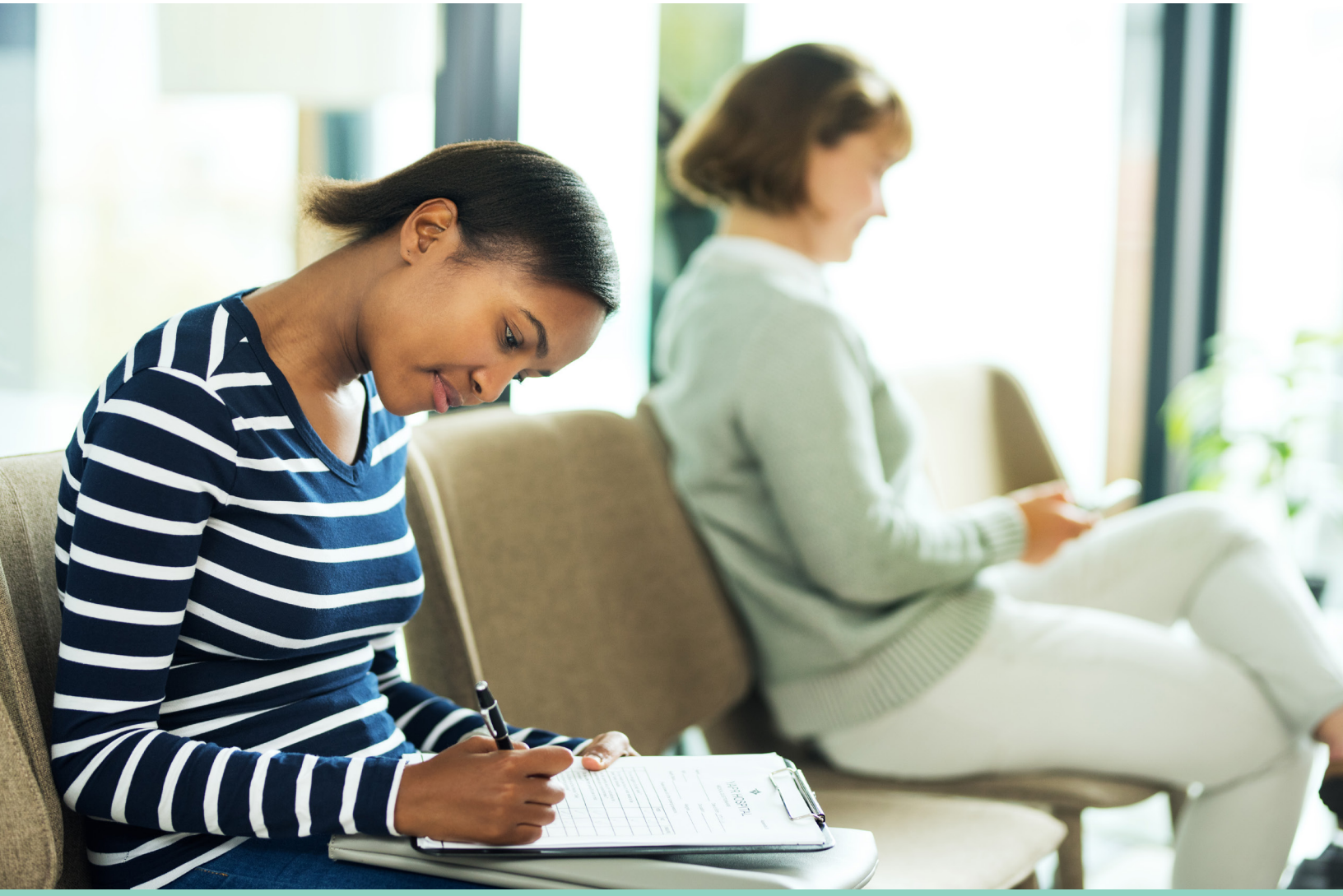

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