Coordinator: Welcome and thank you for standing by. At this time all participants are in a listen-only mode. During the question and answer session please press Star 1 and record your name as prompted. Today’s conference is being recorded. If you have any objections you may disconnect at this time. I would now like to turn today’s meeting over to Susan Moskosky. Thank you, you may begin.

Susan Moskosky: Thank you so much (Carolyn) and welcome to everybody for joining the Webinar this afternoon on clinical performance measures for contraceptive care. We specifically, you know, planned this Webinar to help clarify with grantees any of their misconceptions or to clarify, you know, what the measure is intended to do and how it’s intended to be used as well as how it’s not intended to be used. So I want to thank everybody for joining this afternoon.

So what we’ll be doing, you know, we did an earlier Webinar that hopefully a lot of you joined as well where we talked about the measures. But we’re going to reintroduce some measures today and talk about why they matter and also what NQS endorsement means and why it matters so much. And then you’ll also be hearing from three grantees to get their perspectives, Cynthia Harris
from the Washington Department of Health who’s also the chair of FSPA, Callie Wise from the Louisiana Department of Health and (Darren Eichner) from the National Family Planning and Reproductive Health Association. And then finally you’ll be hearing about some of the resources that are available to Title X grantees to help you with implementing the measures.

So these are the three contraceptive care measures submitted for NQS endorsement. The first measure evaluates the percentage of women at risk of unintended pregnancy who were provided a most or moderately effective contraceptive method which is an intermediate outcome measure because it represents a decision that is made at the end of a clinical encounter about the type of contraceptive method a woman will use and because of the strong association between the type of contraceptive method used and the risk of unintended pregnancy.

So the second measure evaluates the percentage of women at risk of unintended pregnancy provided a Long Acting Reversible Contraceptive method, a LARC method which is an access measure because it’s intended to identify situations in which women do not have access to LARCs and we’ll talk a lot about how that measure should not be used and that you shouldn’t be setting a high bar. And we want to at all costs avoid any perception or actuality of coercion. And, you know, a lot of the initiatives that are being - that we hear about across the country make us a little bit nervous when we hear all about LARC initiatives just because we don’t want people to be pushing these methods coercively either intended or not intended.

So the third measure evaluates the percentage of women who had a live birth provided - who were provided with the most or moderately effective contraceptive method both within three days and also within six days of delivery. So this is not one that’s probably going to be used by many Title X
grantees since you’re not doing deliveries and you’re not for the most part - well you’re not seeing pregnant women as part of Title X. Obviously some of you may be seeing pregnant women in other capacities and you’re not in the hospital providing postpartum care. But you may be seeing postpartum women within 60 days of a pregnancy ending. But also your state Medicaid or other maternal child health programs in your state might be using this measure so we would want you to be aware of it and also a number of insurance companies may be picking up on it.

So the sixty-day period reflects ACOG recommendations that women should receive contraceptive care at the six week postpartum visit. And the three-day period reflects CDC and ACOG recommendations about immediate postpartum, the immediate postpartum period at delivery or while the woman is still in the hospital which is a safe time to be able to provide some contraceptives which may offer great convenience to the clients and avoid missed opportunities to provide contraceptive care. So I’m going to actually turn it over to Brittni Frederiksen who’s going to talk about the data that are - can be used or are used to calculate the measures and she’ll talk about that.

Brittni Frederiksen: Awesome thank you. Hi everyone. So yes I’ll - we’ll just go over a few details about the measures. And we’re definitely open to any questions or concerns you still have after the Webinar so we look forward to hearing from you. So what’s really great is we can calculate these measures using three different data sources. We have our Title X program data which is excellent from the SPAR because we can really get at a denominator of women at risk of unintended pregnancy.

We have questions about seeking pregnancy and women who are pregnant. We also have abstinence included which is something we can’t capture using billing and claims data. So the Title X data is a great resource for calculating
the measures. The other data source we’ve been working with is the billing and claims data from Medicaid. We can also use data from private providers and health plans. And this would actually be using diagnosis and procedure and drug codes to calculate the measures. It’s a little more intricate than our FPAR data but it’s a great way to look at the measures. And then we’re really excited because in the future we’re hoping to have standardized data elements through FPAR 2.0 that would be included in the EHR. And then we could get these standardized elements to calculate the measures. So that’s kind of looking forward.

So just as a reminder these measures are based on method effectiveness. We know that this is only one aspect of a contraceptive method but it’s an important one because the effectiveness of the method is directly associated with the woman’s risk for unintended pregnancy. And so, you know, we’re focused on women having access to the most and moderately effective method so that top-tier the most effective method include implants and IUDs as well as sterilization. And then that second tier, the moderately effective methods include injectables, pill, patch ring and diaphragm. So the first measure focuses on those top two tiers and then the (unintelligible) measures focus just obviously on implants and IUDs.

So we also know that women care about effectiveness too. A recent study of women and family planning in abortion clinics across the US were asked what characteristics of a contraceptive method were extremely important to them. And there were 23 items and effectiveness of the method of providing pregnancy was the item that most women said was extremely important. Eight-nine percent of women said that they wanted an effective form of contraception.
The next most important characteristic were that the method’s easy to get, that it’s affordable, but it’s easy to use. So I’d definitely recommend checking out this study. And this is, you know, part of the reason why we wanted a measure focused around effectiveness.

So why do the measures matter? I’m sure all of you have heard a lot about the Triple Aim. We are interested in looking at health outcomes, client experience and cost savings. And so recent initiatives in healthcare really focused on this Triple Aim. And like the QFP the contraceptive care measures are part of an effort to improve the quality of contraceptive care.

We also know that we have a number of clinical recommendations around providing quality contraceptive care. And we put a few here but just going back to QFP the MEC and the SPR published by CDC and then ACOG has guidelines around providing most and moderately effective methods that these are safe methods and that they should be provided in a client centered way.

So why do we measure performance? And I love this quote from Peter Drucker. It says what gets measured gets done. And I think that’s kind of until we start measuring things we don’t know how well we’re doing. And it’s really important to see where we’re at and then see if there are ways that we can improve. So performance measures a critical component of efforts to improve healthcare quality. And there’s a lot of evidence that shows that it can motivate health systems to adopt change.

So how can a performance measurement help healthcare providers? We think that they can answer some of these questions. Like I said how well is your program performing? You can use these measures to look at that. You can also say how can we be sure we’re doing the right thing or what programs should my agencies be funding the public’s money on? How can I motivate
staff to do the things needed to improve the public’s health? What is working or not working? Until you start looking at your numbers you don’t know what’s working or where it’s working and what can we do differently to improve performance?

So here are a few studies that I’d recommend checking out too. This is the evidence that shows the performance measures can work and performance measure being an intervention to change practice. So this classroom review actually look at 140 studies on audit and feedback and showed that by incorporating audit and feedback with quality improvement processes this can have - it showed a small to moderate impact on provider practice in the study and it depended on what was the baseline level of performance and how the feedback is provided.

And then the study by (Bennett) looked at quality improvement and maternal care during pregnancy. And they used quality improvement in ten maternity care institutions. And one of the measures they were interested in looking at was postpartum contraception counseling. And just by incorporating continuous quality improvement they increased postpartum contraception counseling from 60% to over 80%. So we do have evidence that by measuring performance we can make some change.

So how do we think the measures will improve care? We are hoping that by incorporating these measures into a provider’s practice more providers will be motivated to screen women about their pregnancy intention and then offer contraception to those who need it or, you know, women are planning a pregnancy to offer preconception care. More providers we hope will offer women a wide range of methods, a full range of contraceptive methods in accordance with the QFP recommendations. And we hope that women will have greater access to the method of their choice.
So we want to take a minute just to talk about coercion. This comes up a lot when we’re talking about the measures. And we really do want to address any concerns you all have. And love to hear from you if you feel like this is leading to coercive practices and what we can do to mitigate that. So for the most and moderately effective methods there are nine methods included in that numerator. So women have many methods to choose from. And these methods are all equal in terms of their value to the measure. So it’s not like we’re saying the top-tier is more important than the second tier. All these methods are treated equally.

And we - we’ve seen the research shows a high percent of these women want these methods. And when counseled about them when they know that all of these methods are available they and that they’re readily accessible they will choose these methods. We want to note that a benchmark has not been set for this measure. Neither of the measures of the benchmark been set. But we know that - we don’t think provision will be expected to reach 100%. We know that some women will continue to choose methods in the lower tiers and or may not want to use a contraceptive method at all. And we respect that and want women to fill supported in that choice.

As far as the LARC measure I think that’s where it gets a little trickier. And we want to focus on the low levels of use so we’re not looking ever at the higher end of the distribution. This measure is designed so that women have access. There are a lot of barriers to getting the access to a LARC method. And so if levels are at 0% women may not have access to those methods. So these methods should not be promoted over any of the other methods. Women should have a choice and they should be offered in a client centered way. And QFP if you’re wondering you can go back to QFP and their recommendations on how to offer these methods in a client-centered manner.
The other very exciting piece of this is we’re currently funding the development of a patient recorded outcome measure for contraceptive use. And this will be a great companion measure to these contraceptive measures. It’s an 11 item scale we funded UCSF to create this measure and submit it for NQF endorsement in the next three years.

And all these questions get at whether a woman felt respected, whether she was able to ask questions, whether she had a part in making the decision about her contraceptive method. So we’re currently working on assigning that scale. But we think it’ll be really valuable as a component to this measure so we can identify if practices are coercive. So that’s what we’ll say about coercion but if others have comments on this please bring them up at the end of the call.

And so responsible use of the measures. This is OPAs utmost priority. We are the measure stored. And so as part of that we will maintain a Web page describing how to use the measures appropriately. And we have this Web page up. If you haven’t checked it out yet I think it’s a great place to see each of the measures. And we try to highlight how the measures should be used, how these measure scores should be interpreted.

I will say that the OPA Web page is focused primarily on the clean space measure and then our FPNTC has just put up a page dedicated to calculating the measures in FPAR. But check out both of them because they both have really valuable information. We will monitor the use of these measures through FPAR and through other initiatives that are going on that I’ll talk about later.

We’re also convening an advisory group to reflect on the measures used and consider improvements over time. So now that the measures have been
endorsed we have the next three years to make improvements to the measures and we definitely want to hear your feedback on how they can be improved and we’d love to involve you in this process. And then again funding this development of a patient reported outcome to balance the contraceptive care measure. And we’re also working on an 3-measure that better identifies women at risk for unintended pregnancy.

So just a little bit about the e-measure. The claims based measure like I said uses billing and claims data, your diagnosis procedure and drug codes but we know that it has some limitations. We can’t get at women seeking pregnancy. We can’t get at sexual activity. So if we develop an e-measure which we’re planning on doing we can get a better denominator for that measure because you all collect pregnancy intention, your EHRs and sexual activity so richer information and hopefully easier to calculate.

So this is just a screenshot of one of the Web pages for the measures. And so it’ll highlight what the measure is and then how the measures should be used. And we hope this helps people in understanding if people are directly jumping through these measures are coercive. We hope that this box and we tried to bold it and make it noticed that people can see how to interpret them.

And so for example this is from the LARC page. It says this measure should be used as an access measure to identify very low rates of LARC use. This would be like less than 1% to 2% which may be signs of barriers to LARC’s provision. The LARC measure should not be used to encourage high rates of use and it is not appropriate to use the LARC measure in a pay-for-performance context. So yes definitely check out the Web site. And you can direct your colleagues to the Web site too if they have questions about the measure.
So just a little bit more about the National Quality Forum. We’ve got some questions about that. What is NQF? What does this mean? So these measures have been under development for a number of years as you all know. And we submitted them last winter to NQF and they’ve been under review for this entire year. So they go through a very rigorous process and they were finally endorsed in October, went through a 30 day appeals process another officially endorsed at the end of November.

So NQF is a body that is kind of considered the gold or is considered the gold standard for measure development. And so like I said the measures go through this rigorous review process. They were reviewed by a 27 person committee of perinatal and reproductive health experts, subject matter experts. And this review group only meets about every three years. And so we were really lucky to have the opportunity to submit them at this round. And then like I said we’ll have three years to make improvements to them and they’ll be resubmitted for maintenance in another three years. So this body usually endorses measures and then they can go on. A lot of health plans are likely to pick them up once they’re NQF endorsed.

So we hope that by having this NQF endorsement that efforts to prevent unintended pregnancy will be strengthened by integrating quality improvement processes into a wide variety of private and public providers. So we’re not just focused on our Title X clinics here. We want these to be used by all health plans and health centers, all healthcare delivery systems.

And so like I said once a measure has NQF endorsement it’s kind of that standard that many health plans and other payers require before adopting a measure. These are the first NQF endorsed members for contraceptive care. And this has been a huge gap area. So we’re really excited to have anything related to family planning in this set of NQF endorsement measures. And
thank you all for your participation in developing these measures. We really appreciate all the feedback you’ve provided over the last couple of years.

So the NQF measures are evaluated on five criteria. One is importance. And we had to show that there’s evidence that these performance measures will implement outcomes and that there’s a performance gap and that these are - this is a high priority area. We oh - showed that they were reliable and valid and that they can be - that they are usable by different health plans or different entities, that they are feasible to measure and calculate and that we had to show if they were compared to any other measures. We got off easy on this one because we didn’t have any other measures to compare to.

So as far as room for improvement I just wanted to highlight a few estimates from national surveys just so you can get kind of a lay of the land for what’s currently the status in the US. So using the National Survey of Family Growth from 2011 to 2013 63% of adults and 43% of adolescent women who were at risk for unintended pregnancy were using a most or moderately effective method of contraception. So we think that there is essential room for improvement here. And we identified women at risk for unintended pregnancy if they’d ever had sex, were not pregnant were seeking pregnancy and (unintelligible). And then from (unintelligible) in 2011 2012 63% of postpartum women ages 15 to 44 were using a most or moderately effective method of contraception in the two to six months after delivery. And I think this is an important estimate to keep in mind if you are dealing with postpartum women because, you know, we do have recommendations to have an interpregnancy interval of 18 months. And so we, you know, it’s - women should be using a contraceptive method if they don’t want to have post (unintelligible) pregnancies.
So these are just the Title X numbers from FPAR 2015. And you see we have a wide range across our grantees. We had some grantees that have around 35% most to moderately affective method used and then we have grantees that are just close to 100%. So I’m sure you all know where you stand here and it’s just good to see how we look as a network.

And then the next slide shows the percentage of women ages 15 to 44 years provided a LARC method. And you’ll see that we do have some grantees with 0% LARC provision. And so that we really want to focus on that left and of the chart and just being able to identify whether there are barriers there to providing these methods. We also, you know, want to note that we are paying attention to the right-side too and we don’t want to have very high rates of use because that may be an indication that coercion occurred - is occurring.

So as far as feasibility like I said we are able to use our FPAR data. And this makes the measure quite feasible for all of you to calculate. And I know all of you are already calculating this measure and using it probably for quality improvement. So there is going to be this awesome Web site on FPNTC and it’s posted I believe where you can look at a number of resources. And (Katie) from JSI will talk about this in a moment. But there is technical assistance available for calculating the measures using FPAR data and you can find information on the OPA and the FPNTC Web pages.

And then using claims data makes it - the measure pretty feasible to calculate for non-Title X providers. And that information is available on OPA’s Web page. There’s fast code if you’re a programmer. The measured classifications are on the OPA Web page. And we’re hoping to put up an FAQ so we get a lot of similar questions and then that could just be a one-stop shop to see if your question is posted there.
And then usability and use. So a lot of people are already using the measures. And I think there’s a lot of positive energy around them right now. So we’re using them in the Title X program. And some of you may have participated in the FPNTC’s performance measurement learning collaborative. I think 12 grantees participated in this learning collaborative. And we’re hoping to have another opportunity to provide a similar learning collaborative to grantees that are still interested in participating in this. And (Katie) will talk about that in a moment.

Our friends at Medicaid have been really excited about the measures. And they as part of their maternal and infant health initiative they funded 13 states and one territory to report on the measures from 2015 to 2018. So you all are part of those states. And so if you don’t know if you’re a Medicaid agency reporting on the measures last January it’s worth checking. And we’re happy to provide you with those states that are part of the initiative.

But they are planning on reporting a year two so they can start seeing in January so they can see, you know, how the measures have changed over the past year. This is also part of an ASTHO learning community and those states as well as - it’s a total of 25 states now participating in the ASTHO learning collaborative. I know I met a lot of you at the meeting in October. And so I think that’s a great way to use the measures for quality improvement as part of the ASTHO learning collaborative too.

And then our friends at Planned Parenthood have also been using the measures and have integrated them into their quality improvement program for 70% of their affiliates and some of you may be involved in that initiative as well. So lots of people are using the measures. And if you’re not aware of whether your state Medicaid agency is reporting them - on them or not it’s
worth looking into to kind of synergize our different efforts. Okay. I’m going
to hand it back over to Sue to talk about what you all can do.

Susan Moskosky: All right. So just wanted to talk and about you all’s roll of this and what we
actually want your help with. And so the first thing that hopefully this
Webinar as well as a number of the other conversations that we’ve had with
you will help with and that is about for you to be able to learn about the
measures both by participating in Webinars like this as well as visiting the
OPA Web site and the pages on the Web site about the measures and also by
potentially joining one of the Family Planning National Training Center
learning collaboratives on the performance measures.

Also we ask you to please use them in your network of service sites and for
you to look at your own data. And by joining one of the learning - by joining
the learning collaborative it’ll help you in being able to do that and being able
to interpret this data and be able feedback to your sites and work with them
better to address any issues. You know, if you have a site that has like 80%
LARC use that might throw up some red flags or if you have some sites that
are 0% LARC use even though they’re seeing lots of patients that should
show, you know, throw out some red flags or if your sites aren’t able to
calculate. So I think all of those can be really helped by joining a learning
collaborative where the Family Planning Training Center can help you with
that. And then also helping others in your state outside the family-planning
network to be able to use them appropriate. So also, you know, by helping
them to be able to better interpret the LARC measures and to be able to know
what those data mean and to make sure that folks know what the appropriate
use of that measure is.

So now we’re going to actually hear from some of the grantees and hear about
their perspectives on the measures. So first we’ll hear from Cynthia Harris
from the Washington Department of Health who will be followed by Callie Wise from the Louisiana Department of Health and then (Darren Eichner) who’s the Vice President of Healthcare Delivery for NEPHRA. So I’m going to hand it over to Cynthia Harris.

Cynthia Harris: Hi everyone. Nice to talk to you today. I’m just going to - the way I envision Title X grantees the most important role they have of course is implementing these measures in their own clinics but even more importantly is to educate providers outside of the Title X network because I’m sure that you like myself in several meetings either within your network or at meetings you go to nationally run into different kinds of providers.

And it’s important that we get the message that those measures are out there and even more importantly about the final points of the measures. And, you know, there’s been a lot of concern and I was definitely on that train of concern about the LARC measure only because it, you know, I want to make sure that people’s perception of the performance measure doesn’t get clouded by wanting to get a gold star by providing more and more LARC and perhaps putting the woman’s choice second. Of course I would love for everyone to be on LARC so I would love to be on LARC’s because it’s their choice. So it’s important for us to number 1 get that message out there.

I’m sure you’ve run into providers, private providers, primary care providers who have trouble with they say they don’t want to, it’s too hard to build Medicaid for LARC so they just don’t do or FQHC’s who are very, very busy all the time in trying to fit in contraceptive care and haven’t been able to do it correctly and getting them resources on how that they can do that more easily at their sites.
In Washington what we’ve tried to do is we’re trying to - we’ve just concluded our competitive application and we’re trying to bring some FQHC’s onboard. And part of that work is working with the state organization for FQHCs. And by working with the state organization we reach non-Title X and Title X FQHCs so it’s easy for us to get information out there. It also ties in nicely with our state efforts to increase child health and reduce unintended pregnancy.

I mean, you know, I wish everyone would screen for pregnancy intention. I wish it was as common as checks for high blood pressure, maybe someday. But I think there’s a lot that we could do within our states and outside of our states to educate people about the providers and the properties of them. Thanks.

Susan Moskosky: Okay. Now we’ll be hearing from Callie Wise from Louisiana Department of Health.

Callie Wise: Hi everyone. This is Callie. And I will just sort of build a little bit off of what Cynthia was just speaking to. So for starters we certainly have been using these measures already to look at performance within our current Title X network and that has been really helpful. But we also similarly to Washington we’re hoping to bring on some new FQHCs in our next grant cycle. And so we want to be measuring this in both our direct service site through our office of public health parish health unit that we use and through new sub recipient clinics.

And I think that’s something that’s been really important for us so far has been to compare and to stratify across different regions and clinics and providers because even if we find that our network overall has a pretty good distribution of what methods women are choosing we found that sometimes
there’s a certain region that, you know, had a provider who wasn’t as comfortable offering a certain method or who intended to more frequently recommend a specific method. And so once we’re able to identify areas where that distribution doesn’t look as spread out or as normal as we might expect we’re able to dig a little bit deeper. And so I think it’ll be important for us to compare across new sites and long-standing sites and make sure that the kind of distribution we’re seeing in a new FQHC site or other contract site is reflective of what it seems like women in that area are choosing when they’re going to an expert Title X provider that we’ve already spent years working on getting to a point where they offer really great access.

So it’s certainly going to be important for quality improvement and performance measurement but then hat I also think it’s going to be really critical to our ongoing collaboration with Medicaid. So Louisiana Office of Public Health has been fortunate to be able to build a pretty strong relationship with our Medicaid program. And so we’re hoping to be able to propose these metrics is something that would be involved in either the next RFP cycle or that at least would become something that’s regularly monitored by our Medicaid program.

We’ve just expanded Medicaid and we now have a lot more women of reproductive age that are part of managed care in Louisiana who previously were not. And so that opens the door for a lot more work around on unintended pregnancy and reproductive health but we have to sort of make sure that we’ve informed our Medicaid program of why this is important, why it matters, why looking at this measure will be beneficial.

And that I think is important both for promoting reproductive health generally in our state but also for us as a Title X network of providers. We’ve talked a lot of times at the different conferences that we all go to about how to create a
sort of value proposition for different payers, how to show your worth as sort of a small fish in a big pond. And I think that getting measures like this on to the radar for Medicaid or other payers is a really important way of us being able to show why we’re helpful to that plan or to that payer and why we might, you know, be a more critical partner than they thought we were because we can show that we are already ahead of the game on meeting these metrics and doing a great job with contraceptive care.

So it’s an important way of showing our value as Title X providers. But for many of us, you know, often the Title X program or the reproductive policy program ends up being somebody who does additional provider training work where there’s lots of new contraceptive access and unintended pregnancy initiatives going on. And Louisiana is also just starting a provider training initiative that is outside of our Title X program and network but is certainly informed by what we know from Title X.

And so having these measures be promoted to providers whether that’s by Medicaid or just as part of a national conversation I think that’s really important for gaining credibility for these issues but also for having something really concrete that we can provide technical assistance and recommendations and quality improvement activities around. It creates more than just sort of something conceptual but something really concrete for us to collaborate on. So we’re hoping to use these measures in a variety of ways to improve our own services but also just elevate the importance of contraception in the state overall. Thanks.

Susan Moskosky: Thanks so much Callie. I think we were just sitting here at OPA observing how useful it is for grantees to be talking about these with other grantees rather than OPA. And just want to thank you for presenting. And now I’d like
to turn it over to (Darren Eichner) who is from as I mentioned before from the National Family Planning and Reproductive Health Association. So (Darren)?

(Darren Eichner): Thank you Sue. So first of all on behalf of the National Family Planning and Reproductive Health Association I want to congratulate OPA on receiving NQF’s of endorsement for these measures and personally thank (Lori) and Sue and the entire OPA team for their hard work and leadership in bringing these measures to the field.

We’re really excited about these measures. I’ve been working in performance improvement for many years now and have spent a lot of time working on performance measurements. And I think that these measures represent just one more step in continuous quality improvement process that’s really going to allow us to understand more about critical contraceptive services provided in all settings. They’re going to allow us to paint the picture of how these services are provided and where there is room for improvement.

Most importantly the data from these measures can be used to focus improvement efforts whether that can be improved counseling to ensure that women are receiving the most effective contraceptive method that is right for them or tackling systems or structural barriers that are preventing access to all methods of contraception. In addition NFPHRA can use these measures to inform our advocacy efforts as we work on your behalf to secure continued funding for critical safety net services.

NFPHRA has been a part of the workgroup that has helped to develop these measures and we are thrilled that we have come so far in the development of national measures related to the provision of contraceptive services. We look forward to continue to be a part of this important effort moving forward. Thank you.
Susan Moskosky: Thank you (Darren) and thank you again to all of you for being willing to be part of this Webinar. I think as this point we’re going to turn it over to Family Planning National Training Center. Are you going to talk about that first a little bit Brittni...

Brittni Frederiksen: I can talk about...

Susan Moskosky: ...about the measurement...

Brittni Frederiksen: Yes.

Susan Moskosky: ...specifications and then we’ll talk - then we’ll turn it over to the Family Planning National Training Center to talk further about resources.

Brittni Frederiksen: Perfect, thanks Sue. Yes so just a little bit of additional resources. We have the measure specification posted on our Web site like I mentioned and then some guidance on how to interpret the results and how - and you’re welcome to ask questions if you need more information about the measures. So that is the Web address for those. And then here is some key references.

We hope that you can take the slide presentation -- it will be posted -- and you can use this with your colleagues in communicating about the measure so a few resources if they want additional information or if you want additional information. And now I’ll head it over to (Katie) at the FPNTC.

(Katie): Great, thank you. So first I just want to remind you all that we’ve just created a contraceptive care resource page on fpntc.org that went live this morning. And I think Brittni mentioned that earlier. And that has lots of information about the definition of the measure, how to use it and many of the aspects of
the measures that Brittni spoke about earlier in the Webinar. So please check that out. But I want to spend a little bit more time talking about the contraceptive access learning collaborative that we’re offering.

As Brittni also mentioned last year the NTC conducted a performance measurement learning collaborative to improve performance on these two measures. And we had 12 grantee service site teams participate. And now given the NQF endorsement we thought it would be a great time to offer this opportunity again and get you all involved.

So the Contraceptive Access Learning Collaborative which we’re calling the CALC for short it’s a little bit less of a mouthful, it’ll be based on what we did last year but we’re considering it to be sort of a new and improved version that incorporates the experiences and lessons learned from last year’s cohort. And we’ve also updated a bit of the content as well.

Can you guys go back a couple of slides to the primary objective for me? Great, thanks. So just a little bit more about the purpose of the collaborative. It will take place over an eight month period and will provide a combination of training and technical assistance and facilitated discussions that will help you improve performance on the two measures. The next slide please. Oh, great. We also hope to increase grantees’ capacity to conduct data driven QI including planning and sustaining changes using plan do study act cycles. We want to foster collaboration and give you all a chance to talk to one another a lot more since many of you share a lot of the same challenges around providing access to contraceptives. And then finally we hope to support you in the spreading these QI efforts and those successful strategies to other sites in your network.
Next slide. So the contraceptive - the change practice slide. Sorry w- I think these are a little bit out of order, great. So the learning collaborative is based on four best practices identified in the literature to improve access to contraception including stocking a broad range of methods, supporting patients through patient centered counseling, offering same visit provision of all methods and reducing cost as a barrier.

And more information on these best practices as well as strategies for achieving them are included in what we call a change package. And this change package is the guiding document for the collaborative. It’s we actually just updated it last month to include case studies from last year’s team as well. So this is available for download on FPNTC so please check that out.

Okay next slide. Great, so I mentioned a little bit earlier the learning collaborative teams are made up of representatives from both the grantees as well as one service site from your network. The application must be submitted by the grantee but we do highly encourage you to work with the service site to complete this application together and to ensure that you all form this team as part of the application process itself.

Next slide. As I mentioned this is a new and improved version of what we did last year. Here are just a couple of testimonials from some past participants that we thought you might be interested to see. Next slide. And then finally how to apply? So the application is now available on spntc.org. Please note that this is an online application so there’s a Survey Monkey link that provides more information about the learning collaborative, the structure, how it works, who should apply, who should be part of your team and everything you need to know. And the Survey Monkey link actually allows you to close out of it and come back to it as many times as you’d like. So just know that when you start it. And we’ve also included a PDF of the application that you can use for
reference when, you know, consulting various members of your team and your service site.

And then finally the application deadline is January 13. We tried to allow enough time with the holidays and everything else that’s going on this time of year but we really kept the application pretty straightforward and streamlined this time around so that it wouldn’t be too burdensome. And then we finally we hope to let grantees know probably about a week later so sometime mid-January about who’s going to be involved and how we’ll move forward. So I think that’s it. If you have any questions please feel free to email us at the Training Center at spntc@jsiI.com or we’re also just happy to take questions as part of the Q&A at the end of the session. Thanks.

Coordinator: And are you ready for Q&A at this time?

Susan Moskosky: Yes. At this time I think we’re ready to take some questions so thank you for your help with that.

Coordinator: Thank you. And we will now begin the question and answer session. If you would like to ask a question from the phones please press Star 1. Make sure your phone is unmuted and you must record your name to introduce your question. To withdraw that request you may press Star 2. Once again for a question or a comment press Star 1 at this time. One moment while we stand by for questions or comments.

And again as a reminder for a question or a comment from the phones please press Star 1 on your phone, make sure your phone is unmuted and record your name. And to withdraw that request you may press Star 2. Once again for questions or comments from the phones press Star 1 at this time. One moment
while we stand by for questions or comments. One moment please. And we do have a question or comment coming from (Deborah Dille). Your line is open.

(Deborah Dille):  Hi. I have a question, two questions actually. One is can you explain please how one figures the denominator for these measures? And the second is why was the - why were the age - was age chosen 15 to 44 when FPAR reports on a wider age range than that particularly the - yes just why that decision was made? And I also saw something about reporting 15 to 20 and then 21 to 44 and just that was the first time I’d seen it broken down like that when I want on the FTNTC Web site? Thank you.

Brittni Frederiksen:  Thanks (Deborah). I - so sure I’ll answer I’ll try to answer this one. So which are you talking about using the Title X data using the FPAR denominator?

(Deborah Dille):  Yes.

Brittni Frederiksen:  Okay yes so for FPAR we remove women who are seeking pregnancy, women who are pregnant and then women who have reported abstinence. And so that would be your denominator of women at risk for unintended pregnancy. And then as far as the age groups we wanted to match this with National Survey of Family growth so we had a national estimate and so that survey is done in women ages 15 to 34. And then as far as the age group we were aligning with Medicaid also. So they report 15 to 20 and then 21 to 44.

(Deborah Dille):  So in terms of the denominator we had understood regionally that it was included no method and other method. But what you’re saying is abstinence is the only other part that’s taken out of the denominator in addition to pregnant (unintelligible) pregnancy?
Brittni Frederiksen: Yes. Women with no method would be still included the denominator.

(Deborah Dille): So no method other reason and then other method, okay.

Brittni Frederiksen: Yes and that’ll be - there is a guidance document on that on the FPNTC’s Web site.

(Deborah Dille): Okay great. Thank you.

Brittni Frederiksen: Yes.

Coordinator: Thank you. And again as a reminder for questions or comments it is Star 1. Make sure your phone is on muted and record your name to introduce your question. And it is Star 2 to withdraw that request. Again for questions or comments press Star 1 at this time. Our next question or comment comes from (Kelly Blet). Your line is open.

Brittni Frederiksen: Hi there.

Susan Moskosky: Callie.

(Kelly Blet): I am very new to Title X. I just started on Monday. And I’m getting a lot of stuff crammed into my head. So we had - our teams had a couple of questions. Depo-Provera when we go to fill out a FPAR form they want to know do we call the women as an encounter when they come in for their shot? So they don’t see a provider that day? They just see the MA for their Depo-Provera shot. Is that person counted - is that an encounter...

Susan Moskosky: Definitely.
(Kelly Blet): ...as in other?

Susan Moskosky: Definitely.

(Kelly Blet): Okay.

Susan Moskosky: Definitely because they’re seeing a provider. I mean it may not be of clinical provider according to FPAR definition but still are receiving a service related to preventing or achieving pregnancy and it’s recorded in the medical records. So you might want to go back and review the FPAR forms and instructions - forms and instructions definition of a family-planning user. So anytime somebody comes in and receives the contraceptive method regardless of who - what provider, what level of provider she’s or he are - is seeing if they receive a service related to preventing or achieving pregnancy and there’s a record of it in a medical record then yes it’s a family-planning encounter.

(Kelly Blet): Perfect. Thank you so much.

Susan Moskosky: All right.

Coordinator: Thank you. And I’m currently showing no further questions or comments. Again as a reminder it is Star 1. Make sure your phone is unmuted and record your name. And it is Star 2 to withdraw that request. Again for further questions or comments from the phones please press Star 1 at this time. One moment while we stand by for questions or comments.

Susan Moskosky: So I’m going to - we have a couple of questions that were submitted in the chat box and I’m going to read the first one and then I’m going to turn it over to Brittni who might, you know, want to clarify some things. So the question is, “How would you advise state and local initiatives that continue to use
LARC use rather than LARC access rates as performance measures?” Some state and state/local initiatives are concerned about switching to access rates since use rates are easier to measure.

And I think what we’re talking about to and (Lori) or Brittni jump in to correct me, what we’re talking about is measuring the level of LARC use. But what we are saying is that there should not be a high bar set for LARC use that we’re looking at the rates of LARC use as an indicator of access to that method. So I’m not sure the distinction in your mind is still use of LARC is what is being measured but the way we’re interpreting it as an access measure so we’re looking at places where it appears that use is very low as an indicator of lack of access potentially.

(Laura): Yes this is (Laura). I just want to reinforce or what Sue is saying and maybe whoever asked the question can clarify things if we’re not understanding it. But I think the measure’s probably - the data is probably the same. It’s how you interpret it. We’re saying focus on where the provision rates are extremely low and people what - I’m understanding is that you’re saying that some people in your state are trying to push the other end of this issue and trying to push it up higher.

And I think if that’s true then I think that is where exactly were Cynthia Harris was saying to the extent that you’re able to do so try to educate them about the importance of not encouraging a high bar by for those methods alone why access is a more important focus for that kind of contraceptive measure then high rates. And if you need assistance in that pleased to the extent that we’re able to, you know, it’s going to be limited but please let us know because if there are ways that we can be helpful even in terms of developing resources or communicating directly if that’s really important at some point please let us know and we could try and help you if you do that.
Susan Moskosky: Okay. So the next question that we have in the chat box is from (Audrey).

And the question is, “Would you please describe exactly how you are getting at the number of women who have been quote provided a method. It seems this will be difficult to measure. If the clinic has almost and moderately effective methods available then wouldn’t 100% of the patients be quote provided with these methods regardless of what method they end up choosing?”

So actually the way that this is being tabulated is what the woman actually leaves with, so the method - and it’s the same way that you document in FPAR what’s the most effective method of contraception that’s provided to that woman at the end of the visit that she leaves with? So for instance if somebody comes in and they after counseling and they decide that the best method for them is oral contraceptives and that person is providing what oral contraceptives as part of that visit then that’s what’s recorded as the method provided.

Now the only thing - the only caveat that I would say is for instance you have patients that come into a family-planning clinic that might have gotten an IUD three years ago and they’re coming in for their cervical cancer screening for instance. So at the end of the visit still you’re not providing her new method but the method that is - the method she’s using would still be tabulated as IUD. And so that’s the method that would be recorded even though you’re not providing it to her that day. So yes (Lori) do you want to clarify something?

(Lori): Yes. And let me - this is a nuance that, you know, a couple years ago and we were just venturing into this field we had to do some learning on our own. And one of the points that I learned that was very important in terms of getting my head around what - how to use the measures was the difference...
was the primary tentative measures not really to measure use. It’s to measure what the providers are doing.

So are they screening for pregnancy intention? Are they recording if the woman’s using a method? Are they offering the method? So it’s really about provider behavior. It gets a little complicated because sometimes we get questions like well how do you know what the woman really used? If she left there she may be given a prescription for pills or three months of pills but we don’t know if she used them. And that’s true.

So the purpose of this measure is to see what, you know, the limits of what we can control which is what the provider does in the clinic? So it’s really - we are also trying to kind of clarify our language and make sure we’re not using use because sometimes it’s the same thing. If they have an IUD they’re using an IUD. It’s, you know, but sometimes like pills you can - the provider can give the pills or the prescription but what the woman actually ends up doing with that is a different question.

So these measures are to kind of monitor your provider’s performance and address things that you can kind of control within the context of the clinical care of the clinical setting. There are important questions about what happens when the woman leaves and that’s beyond the scope of what these exact measures can deal with.

Susan Moskosky: Okay then we had a question from (Sabera) about whether this meeting is being recorded and whether they can get it in an email if so? So it is being recorded. The PowerPoints are posted on the OPA Web site after the fact but will they also be posted on the FPNTC? We actually - anything that gets posted on the OPA Web site has to be made 508 compliant. So there’s some - somewhat of a delay between when the Webinar occurs and when it actually
can be posted just because of the 508 compliance issue. But there definitely will be a copy of it posted on the OPA Web site.

And I don’t know whether the person asking - I know that we had heard earlier in the week that there were some grantees that were are having trouble with accessing the Webinars with being able to access the slides. And so if you’re one of those folks that is having that difficulty and needs to have the slides emailed to you please do let us know and we can help with that.

Brittni Frederiksen: I think those are all the questions we have in our question box. Are there any others on the line?

Coordinator: And I’m currently showing no further questions on the phones at this time. As a reminder if you have a question or a comment it is Star 1. Make sure your phone is on muted and record your name. And to withdraw that request you may press Star 2. Once again for further questions or comments at this time please press Star 1. One moment while we stand by for questions or comment. And I’m currently showing no further questions or comments from the phones at this time.

Susan Moskosky: Okay so I think we are at time. I want to once again thank everybody for joining the Webinar this afternoon. Hopefully you found this information useful. Please do let us know if you have questions and do consider if you haven’t already joining the learning collaborative. And we look forward to working with you on these measures as we move forward. So thank you so much and have a good rest of the day and happy holiday if we don’t talk with you again.

Coordinator: That concludes today’s conference call. Thank you for your participation. You may disconnect at this time.
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