Webinar Transcript:
Contraceptive Performance Measures: Striving for Patient-Centered Contraceptive Access

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Hello everyone, and welcome. This is Katie Quimby from the Title X Family Planning National Training Center, and I am so pleased to welcome you all to today's webinar about Contraceptive Performance Measures: Striving for Patient-Centered Contraceptive Access. I have a few announcements before we begin. First, everyone on the webinar today is muted given the large number of participants. We will have some time for questions at the end of the webinar today, so please queue up your questions and ask them at any time using the Q&A pod on the side of your screen. Recording of today's webinar along with the slide deck and a transcript will be available on spntc.org within the next few days. This activity has been approved for one continuing nursing education or CNE contact hour. To receive your certificate, you will need to complete the evaluation at the end of the webinar.

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And finally, this presentation was supported by the Office of Population Affairs or OPA. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of OPA and HHS. So let's get started. I would like to introduce our speaker today. Dr. Christine Dehlendorf is a family physician with advanced training in family planning and a master's degree in clinical research. She is the director of the Person-Centered Reproductive Health Program at the University of California San Francisco, which develops, evaluates, and disseminates interventions to meet women's reproductive needs and preferences and conducts research to better understand women's contraceptive experiences, social communication about contraception, and disparity in contraceptive use and counseling. Dr. Dehlendorf is the vice chair for research in the Department of Family Community Medicine at UCLA. With that, I would love to turn it over to you, Dr. Dehlendorf to get started.

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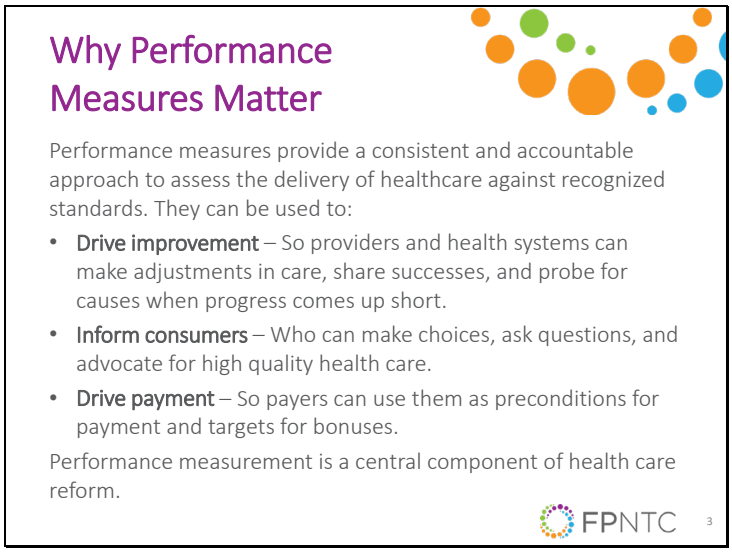

Thank you so much. It is a pleasure to be here and speak to all of you today. I first just want to start by giving a brief overview about why we're talking about performance measures at all, why they matter. So what do performance measures do for us in the healthcare system? Well, one thing they can do is to identify gaps in quality that can allow us to do a better job of providing quality healthcare. Another way that they have been used is to inform consumers so the consumers can make informed choices about where they get their healthcare. And then in some cases, but by far away not the majority performance measures are not used this way, they can be used for payment decisions in terms of incentivizing quality care.

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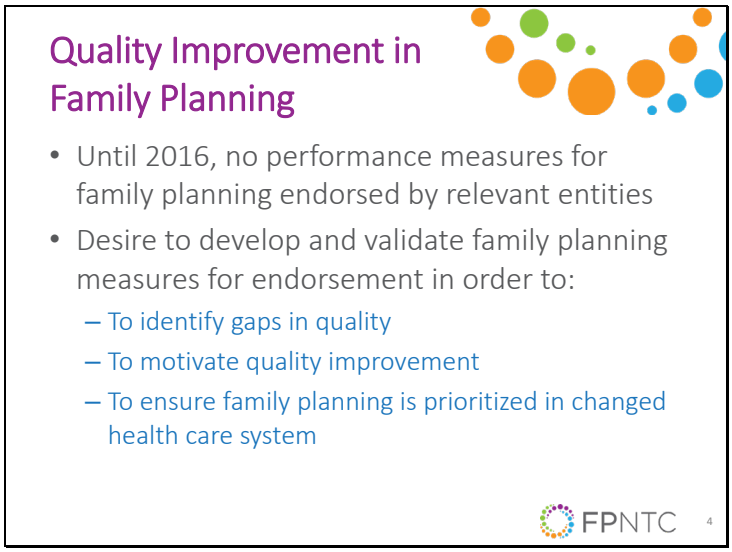

So although performance measures are now an integral part of our healthcare ecosystem, it's actually a relatively new development using standardized performance measures to measure quality and hold healthcare systems accountable. And it has really risen to prominence in the past few decades. And with healthcare reform under Obama, it actually gained increased importance as there was a focus on this under the Affordable Care Act, including a focus on pay-for-performance and approaches to incentivizing quality. So when performance measures started, they really focused a lot on hospital-based measures. And increasingly over the past decade or so, they've moved into the outpatient setting, focusing a lot on chronic disease issues.

So what that means, the relatively recent movement into the outpatient setting means that in fact there hasn't been a lot of development of performance measures related to non-chronic care conditions, and that includes family planning. And so what we saw in early 2010 is that there was no performance metric at all related to family planning. And this led to interest among multiple working groups of trying to develop these types of metrics for family planning based on a desire to both identify gaps in quality to drive improvement, but also based on the recognition that what gets measured gets done. And that if we don't have a metric to talk about family planning, then we're going to be deprioritize an evolving healthcare system that is paying attention to the things that have quality metrics associated with them.

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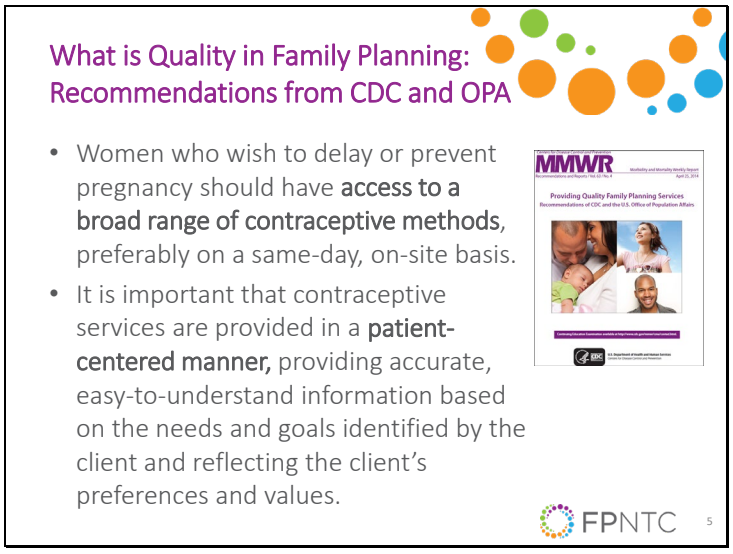

So in order to develop metrics in family planning, we need to think about what in fact is quality, what should we be measuring to be able to do a good job of developing performance metrics? And so to define quality, we have can look of course to the quality in family planning guidelines developed by the CDC and OPA, which I'm sure you are all very familiar with. And of course, this is a relatively long document that includes a lot of different information. But if we boil it down, there are two aspects of quality that really rise to the surface. One is having access to a broad range of contraceptive methods, preferably on a same day basis, and also providing contraceptive services in a patient-centered manner.

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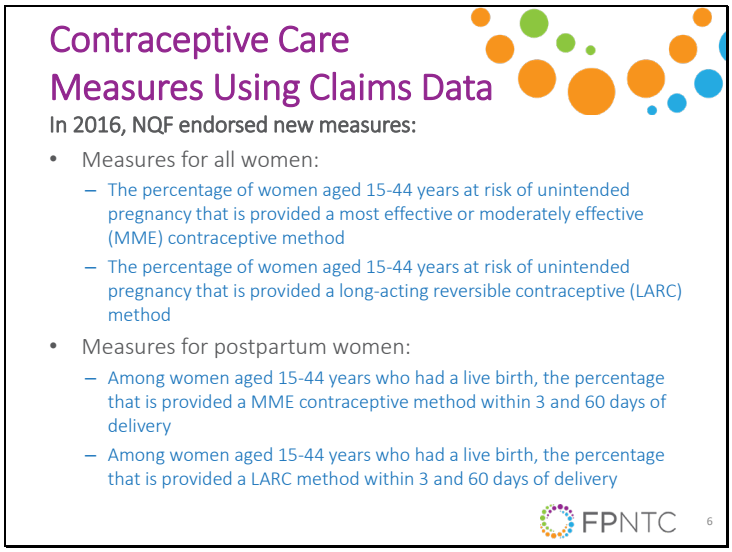

So the first performance metrics, efforts in family planning really focused on that first bullet, working to incentivize, measure gaps in quality and providing access to methods and to incentivize clinics to do a better job of providing the access to methods. And so the group of people, including CDC, OPA, Planned Parenthood and other stakeholders worked together to define and validate a measure looking at contraceptive provision on a facility and health system level. And so these measures were endorsed by NQF, found to be reliable and valid. And as you can see here on this slide, actually, it's defined as three different measures, but it's actually four bullet points. And there's measures for all women, which are women aged 15 to 44 that are provided most or moderately effective contraceptive methods. And it's equivalently the percentage of all women who receive a long acting reversible contraceptive method. And this is performed in a calendar, this is measured in a calendar year. And then there are equivalent measures in the postpartum context.

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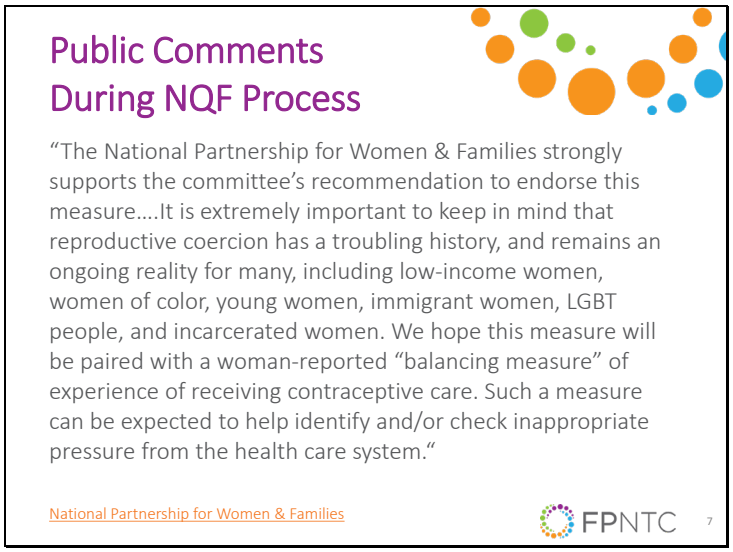

So when this measure, these measures rather was being evaluated by NQF, there's always a public comment process. And NQF is a National Quality Forum that really serves as the good housekeeping seal of approval for performance metrics that then allows these measures to be used in a range of quality improvement reporting processes. And during the public comment period for the National Quality Forum consideration of these measures, there was concern expressed about the fact that these measures focused on most or moderately effective methods or LARC methods alone. And the concern was that this could incentivize non patient-centered care and in fact work against the bullets, the second bullet that I listed from QFP and negatively impacts the patient-centeredness of care that was provided.

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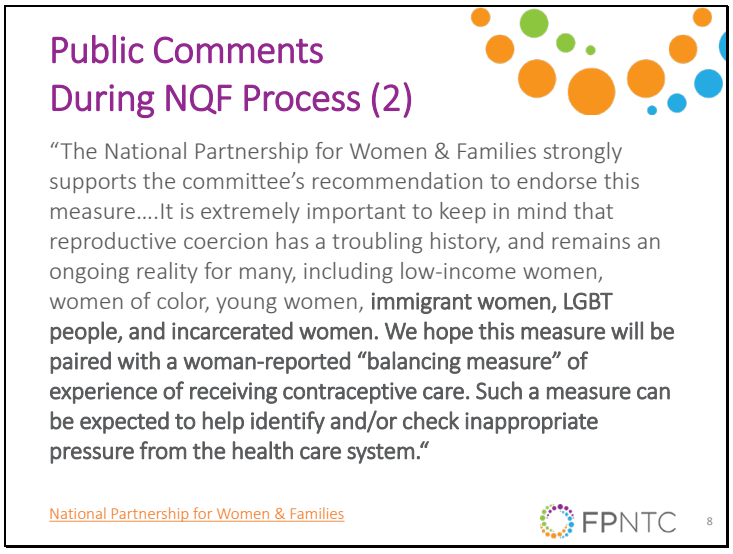

And this perspective was summed up very well by one of the comments that was submitted during this process. And it says, while the National Partnership for Women & Families strongly supports the recommendations to endorse this measure, it's extremely important to keep in mind that reproductive coercion has a troubling history and remains an ongoing reality for many including low income women, women of color, young women, immigrant women, LGBT people, and incarcerated women. We hope this measure will be paired with a woman reported balancing measure of experience of receiving contraceptive care. Such a measure can be expected to help identify and/or check inappropriate pressure from the healthcare system.

The National Partnership for Women & Families
https://www.nationalpartnership.org/about-us/

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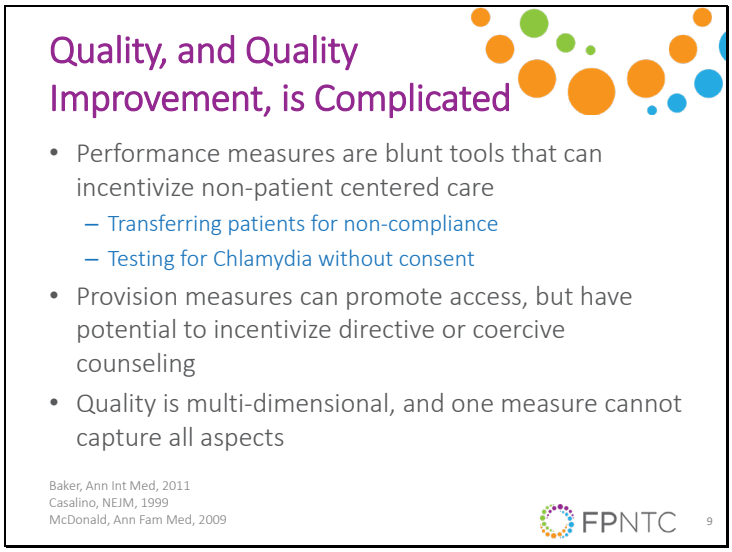

So in thinking about the potential for negative unintentional consequences of the NQF endorsed measures looking at methods provision, it's important to recognize that this is not a problem that is unique to contraception. And in fact, performance measures universally are blunt tools that have been documented to in some cases incentivize or to have adverse outcome on other aspects of quality and what they are directly measuring. And on this slide, I give you two examples of studies that have looked at this, including one study that showed that patients were forcibly transferred out of practices if they were noncompliant so as to facilitate high scores on specific metrics related to, for example, hypertension or diabetes. And another study that found that women were being tested for chlamydia without consent in order to meet chlamydia testing metrics. So it's really important to recognize that the measures that were endorsed by the National Quality Forum in 2016 have the potential to promote access, which is their goal, to make sure that women have access to highly effective and moderately effective contraceptive methods.

But they do have the potential to incentivize counseling towards those methods in a way that deprioritize women's own values and preferences, especially if those values or preferences are for a method that does not fall into the highly or moderately effective category like condoms or fertility awareness based methods. And then the last point on this slide is just to recognize that this is not a surprise, we know that quality is multidimensional. And anytime we try to boil quality down to one measure, it's going to be complicated and we're going to have to think about the consequences of that and think about if there are other measures that can be used to allow us to do a better job of incentivizing the care that we want to provide.

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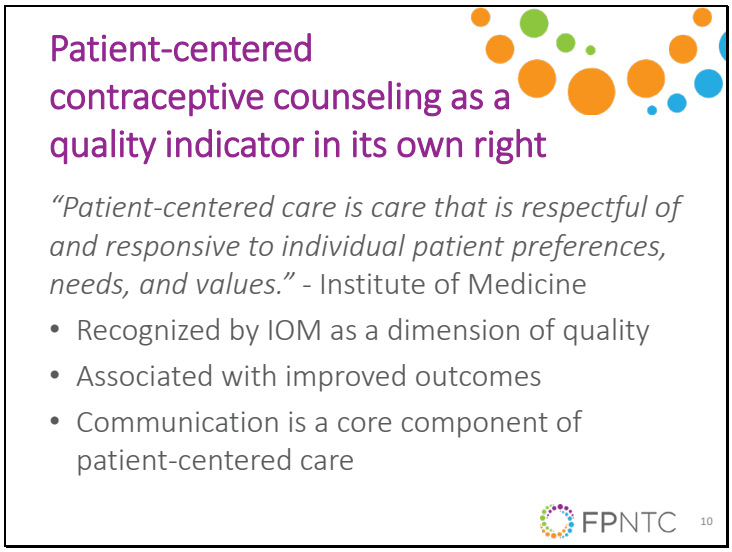

It's also important to recognize though while the comments I read from the NQF process focused on a Patient-Reported Outcome Measure of contraceptive counseling as a response to the potential for the method based measures, the measures based on whether women receive the highly or moderately effective method. In fact, it's important to recognize that this is an aspect of patient-centered care and whether people are getting care that meets their needs. It's not just something that matters because we're worried about it in the context of these other performance measures, but it's something that we care about in its own rights as an ethical mandate of the healthcare system regardless of these other measures and their potential impacts. And this was really something that has been again, increasingly recognized, the importance of patient-centered care in the past two decades.

And it was really catalyzed by a 2001 Institute of Medicine report called Crossing the Quality Chasm where they defined patient-centeredness as one of the core dimensions of quality care. In addition, importantly, it's also really important to recognize that patient-centeredness is actually associated with improved outcomes on the things that we care about as a clinical system. And an example I often use is diabetes, in that when we just try to push insulin on people and they don't want to be taking insulin for various reasons and we don't hear them, then they end up having higher hemoglobin A1Cs because they don't use their insulin the way that we would like them to. But if we listen to them and if we talk to them and address their concerns related to pill burden or pain with injections or whatever it might be, then we develop a better therapeutic relationship that allows them to meet their needs and have lower hemoglobin A1C at the same time.

In general, in terms of patient-centered care, it's really important to recognize that communication is central to being able to provide patient-centered care. And that is because we need to be able to communicate with patients in order to elicit their values and preferences. And we need to have quality communication to allow us to respond to those preferences and integrate those preferences with what we know about the evidence related to the care that we are providing.

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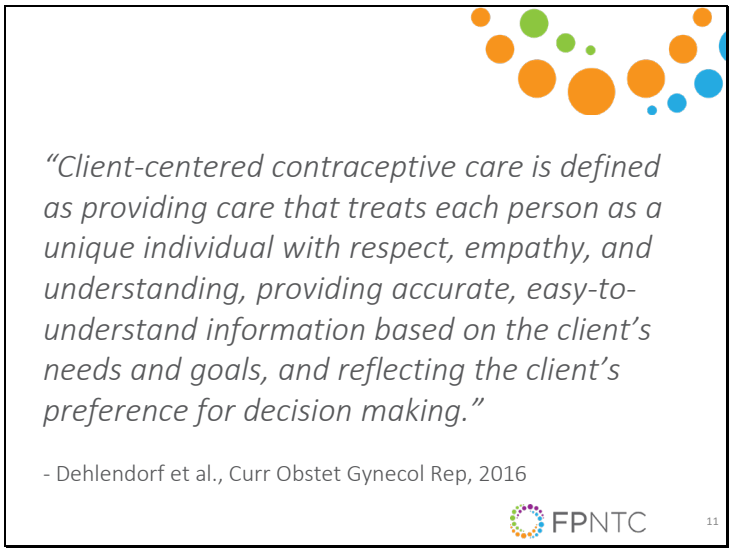

So the quality in family planning guidelines give a general definition of how we think about patient or client centered contraceptive care. We expanded on this in our team at the Person-Centered Reproductive Health Program a few years ago in a publication in the current obstetrics and gynecology reports. And so I just wanted to use this as a foundation for the conversation about client-centeredness or patient-centeredness and contraceptive care. And we defined it as providing care that treats each person as a unique individual with respect, empathy, and understanding, providing accurate, easy to understand information based on the client's needs and goals and reflecting the client's preferences for decision making.

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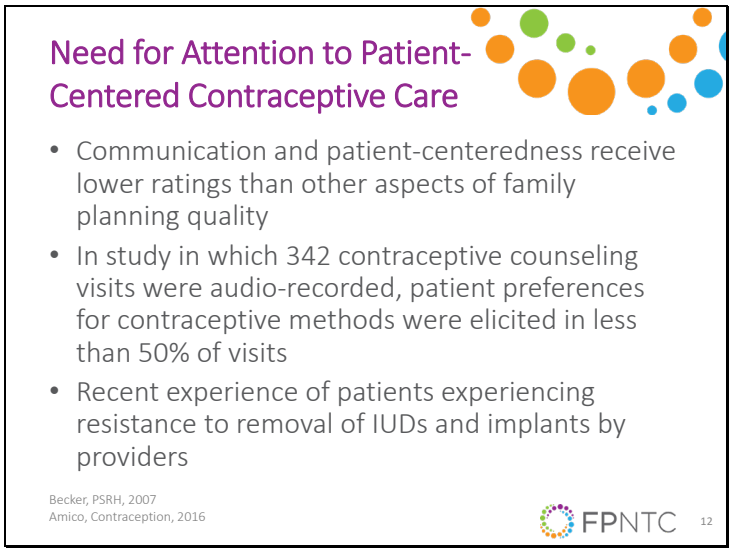

So what do we know about patient or client-centeredness in contraceptive care? So is there a gap in quality? Is this something we need to be worried about? It's always the question when you're thinking about performance measurement and performance improvement. And unfortunately, the literature that's available on this subject suggests that there is a lot of room for improvement in the patient-centeredness of the care that we provide. So systematic reviews and survey studies have found that communication in general and patient-centeredness specifically receive the lower ratings than other aspects of family planning quality. So if you survey people on quality, like access to care, cleanliness, the range of different things that have been measured with respect to family planning quality, communication and patient-centeredness are the things with the most need for improvement.

In addition, in a study that we did here in the San Francisco Bay Area, we audio recorded contraceptive counseling visits because it's often hard to know what's happening if you're not actually in the room. And it obviously changes things if you're in the room. So we wanted to do the best that we could to understand what was actually happening during contraceptive counseling visits. And we did that by audio recording contraceptive counseling. And what we've found is that patient preferences were infrequently elicited. So patient preferences related to what methods they wanted to use, how they felt about method characteristics. And they were elicited in less than 50% of visits. And I just want to comment that I know many of these providers that were involved in this study, and there are many, or I would say all of them are wonderful providers that are motivated by all the things that we all are motivated by about meeting people's needs, about taking care of women, about reproductive autonomy. And yet, this was still the case.

And I think this reflects a number of different issues including time pressure and also training. So there is a gap in quality here that is not related to people's motivation to provide a good job but a lack of attention in the healthcare system to patient-centeredness as an end in and of itself. In addition, this study that we did was in 2008 to 2010. And since that time, we've actually seen some concerning shifts in the healthcare system that I'm sure you are all aware of related to a shift towards and enthusiasm for IUD and implants to the point where that leap can potentially lead to enthusiasm for those methods eclipsing a focus on patient preferences. And this is not just a theoretical concern. In fact, the literature has borne this out, as done studies that have documented that women are experiencing this enthusiasm that many of us have for these very highly effective methods that I always say I'm a big fan of. It's not that I don't think they are great methods, I just don't think they're the best methods for everyone.

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And so to give you an example of some of the literature about this, this is from a study in South Carolina in the context of a peri-partum, immediate postpartum LARC initiative that was happening there. And this was a qualitative study interviewing women who had gotten LARCs in that context, IUD specifically immediately after delivery. And this woman said, "They just keep promoting these long-term methods, it's like they're getting a commission or something. I always wonder that, they were really, really trying to push this product. It was like they were selling me like, 'You should try it.' No, I don't want to." So this woman's experience, even if the provider was likely, I don't know this provider personally, but I imagine this provider was likely motivated by a desire to make sure this woman knew about her option for a highly effective method of contraception. The way that the woman experienced it was that she was having something sold to her that she didn't want to have and that negatively impacted her experience both immediately, and I would argue also potentially in the long term her trust in reproductive health providers.

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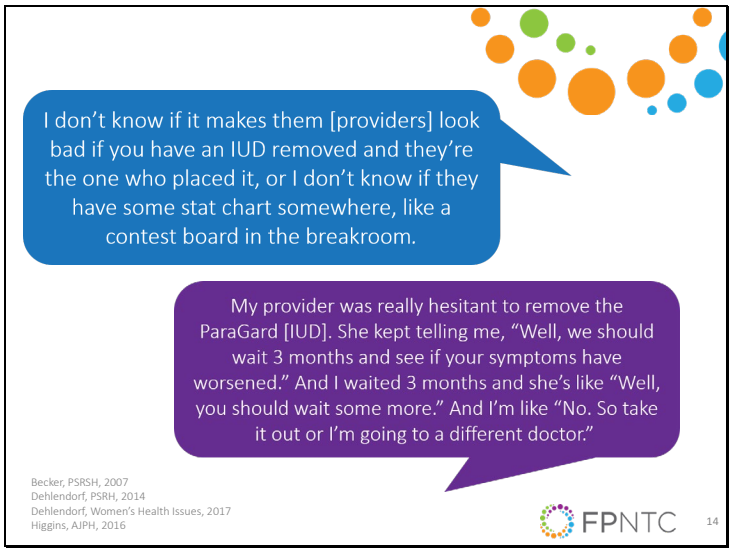

We've similarly seen this not just around IUD and implant provision, but also around removal of these methods. And that the enthusiasm for these methods has led providers to place barriers to removal of these methods because again, not because providers are motivated by malice, but because they're so enthusiastic about this method that they don't understand or can't understand why someone would want to have it removed and have a difficult time honoring patients' desire for removal. There's been a couple of studies on this. This is one that said, "My provider was really hesitant to remove the Paragard IUD. She kept telling me we should wait three months and see if your symptoms have worsened. And I waited three months, and she's like, 'Well you should wait some more.' And I'm like, 'No, so take it out or I'm going to a different doctor.'"

And another woman said, "I don't know if it makes them providers look bad if you have an IUD removed and they're the one who placed it or I don't know if they have some stat charts somewhere like a contest board in the break room." So what these quotes in the qualitative studies they represent really tell us is that in addition to just in general that there is a concern around patient-centeredness and the care that's being provided in the family planning context that this recently with the enthusiasm for IUDs and implants, there is added reason that we should be paying attention to this.

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And I want to point out that this is a particularly important to pay attention in general, to the importance of patient-centeredness and contraception. Number one, because contraceptive choice is a very personal, sensitive thing that has to do with fertility and sexuality and relationships and our bodies. And also because non patient-centered care has the potential to specifically impact populations that have been subject to reproductive coercion in the family planning setting in the past. So we all know that there is a history of family planning providers being complicit with reproductive injustices and reproductive oppression. And this includes things like the non-consensual sterilization of poor women and women of color throughout the 1900s. And this was particularly my state of California, was a particularly bad actor in that context. We also saw it in the 1990s with targeted marketing of Depo-Provera to urban black women.

We also saw it with the pill. When the pill was being developed, it was tested in Puerto Rico without women's knowledge or consent. And then the last example I have up here is just to let you know that this is something that, the systematic reproductive oppression is something that is still an issue today. And that even in the past decade, it happened in California with women in the penal system being coercively sterilized. But beyond just that institutionalized reproductive oppression, we have to recognize that more subtle forms of reproductive oppression specifically targeting women of color is something that's not just in the distant past. And we've seen this in research that's been done that has included research that's found that low income women of color are more likely to report being advised to limit their childbearing than are white women.

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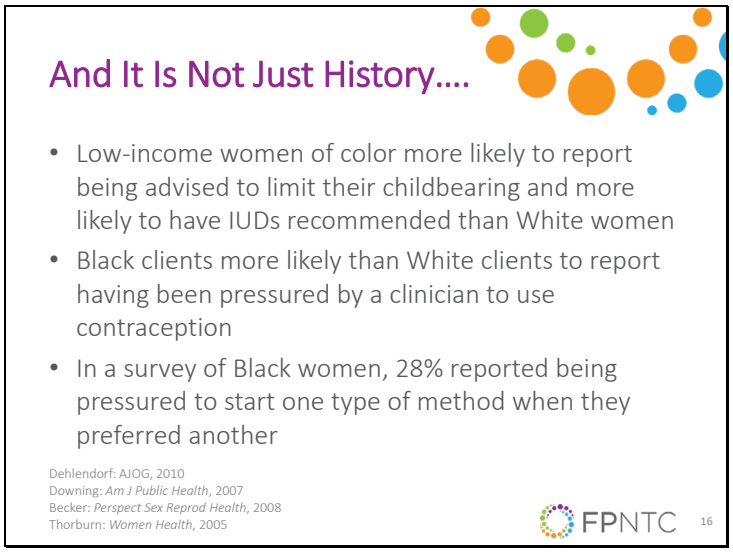

And there was also a study that we did, and again out of our group using standardized patients. So completely controlling for any potential variables that could influence provider recommendations. We found that black and Latino women were more likely to have the IUD recommended by clinicians than were white women. Other studies have found that black clients are more likely than white clients to report being pressured to use contraception. And a study of 500 black women found that over a quarter of them, this was only black women, so there was no comparative group, over a quarter of them reported being pressured to start one method when they in fact preferred another. And I think we can all agree that anyone feeling that they're being pressured to use a method is not a positive patient-centered outcome.

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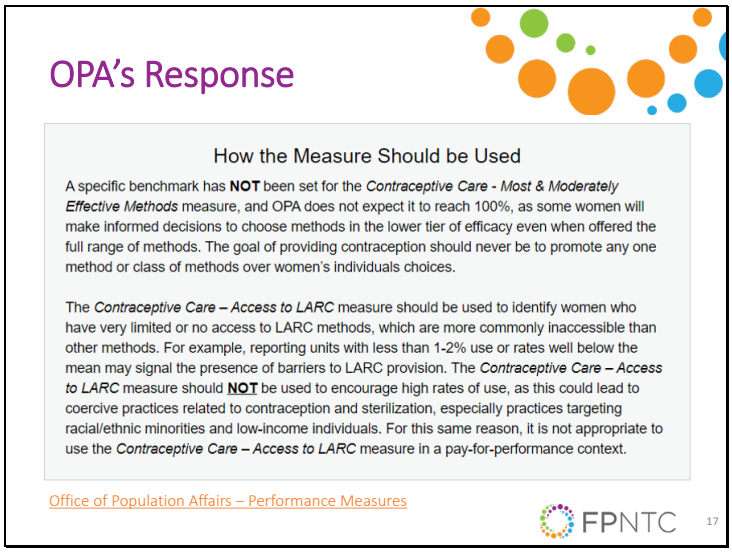

OPA who the steward for the currently endorsed NQF measures that I mentioned that are focused on whether or not someone receives a highly or moderately effective method or whether they receive a LARC method. So the Office of Population Affairs, in the process of getting these measures endorsed by the National Quality Forum, they very much heard these concerns and recognized them. And so as a result, they provided explicit guidance about how these measures should be used as one attempt to mitigate any potential impact on non-patient-centered care. This is from their website. And for example, what they say is that for the most and moderately effective method measure, they do not expect it to reach 100% as some women will make informed decisions to choose methods in the lower tier even if they are offered access to the methods, which is again, the goal of this measure is to make sure people are offered access to the full range of methods. So they're saying don't expect to reach a hundred, and reaching a hundred in fact may not be a good thing.

In addition, and I think even more important, in the access to LARC measure, they've made it very clear that this was an access measure, this was not a more is better measure. And most measures in performance measurement are always more is better, more vaccinations against flu is better, more people reaching your hemoglobin A1C target is better. And they made it very clear that that was not the case with the LARC measure, and that in fact they wanted to use it as what's called a floor measure, which they just wanted to make people were not providing it at all and that at least there was some provision of LARC that individual facilities or health systems would report. They also importantly said at the bottom that it's very important that the LARC measure not be measured in a pay-for-performance context.

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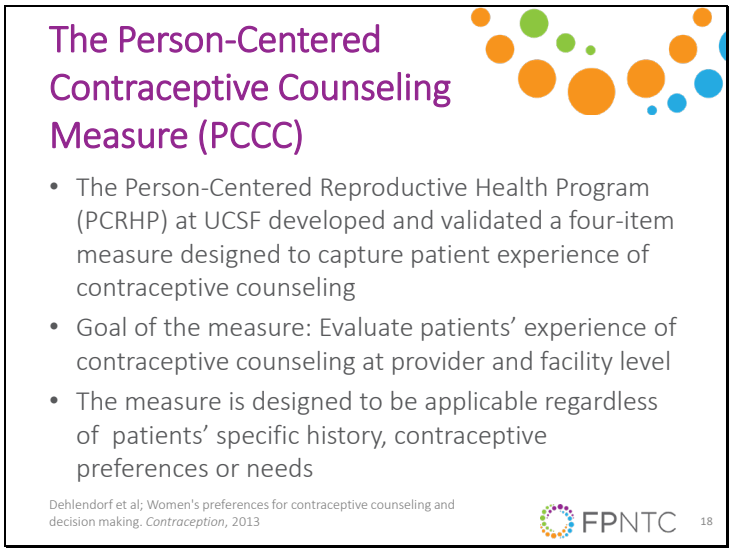

So in addition to providing this guidance designed to mitigate the impact on patient-centered care and counseling, they also recognized that having a patient-reported measure that measured in fact itself the patient-centeredness of counseling would be valuable in the same way that I mentioned the NQF comment period elicited that request to have a patient-reported measure. And so in response to that, they funded us at the Person-Centered Reproductive Health Program to develop and validate a measure and submit this NQF. Our funding was ended in 2017 two years early from that, but we have continued to work with OPA on this measure and have received private foundation funding to continue this work.

So the goal of our measure is to evaluate patients' experience of contraceptive counseling at the provider and the facility level. And importantly, one of the things that we really wanted to focus on in validating this measure is to make it specific to the contraceptive context but also universal with respect to what women want. So we didn't want it to be a measure that was only right for women who had already had babies or for women who already have had a lot of counseling in the past or for women who had never had counseling before, but to find questions that captured a measure that represented quality care regardless of a patient's specific history, contraceptive preferences or needs.

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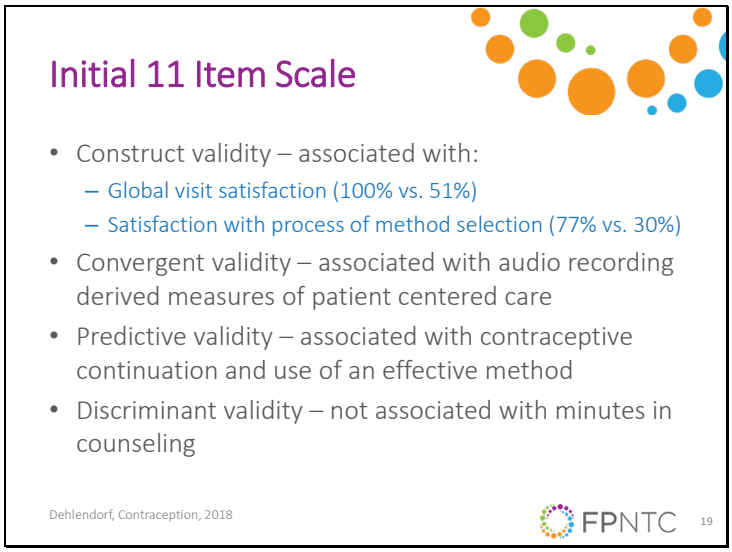

So to develop this measure, we started with an 11-item scale that we had previously developed for the purpose of research drawing on patient-centered scales and other medical conditions and the broader literature on patient-centered communication. And we had found that this, I won't bore you with the details of measure development and psychometrics, but I will just tell you that we had found that it had what's called construct validity, that it was aligned with other measures of patient experience that we found. We compared it to the actual audio recording of contraceptive counseling visits and patient-centered communication that we could objectively measure in that context and found it to be associated with those audio recording derive measures. And we also found that it was associated with contraceptive continuation and use of an effective method. And importantly, it was not associated with the minutes spent with counseling. So it wasn't something that was about it just provides more counseling meant that you would get a higher score. It's about the quality of the counseling that it provided and whether it meets that specific patient's needs.

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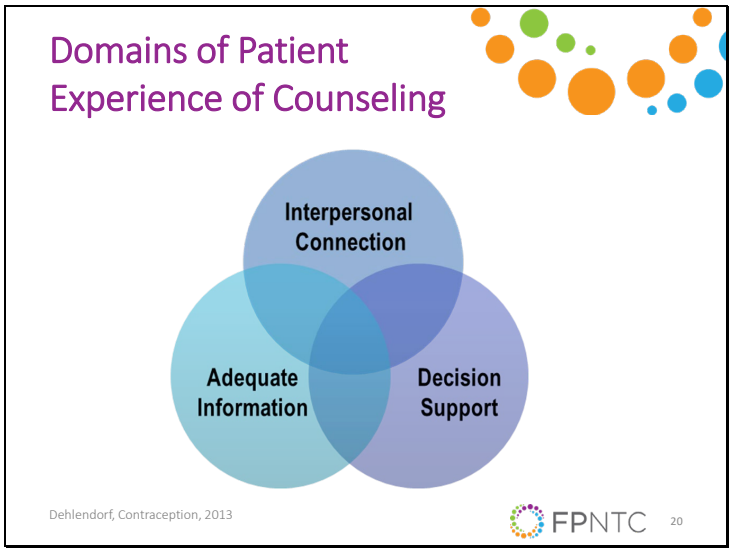

And we wanted to reduce this scale down from 11 items, which felt too long for the purpose of performance measurements. And in doing so, we wanted to pay attention specifically to the domains of counseling that we had found to be important to patients in qualitative work that our team had done previously. And these three domains that we had found to be important are on this slide, interpersonal connection, adequate information, and decision support. And just briefly, I'll say that interpersonal connection, people really felt this is something that's really sensitive to talk about. And being able to really make sure that people feel comfortable with disclosing personal details was really important. And then decision support, women really wanted to feel like they were getting engagement from their provider while they ultimately wanted to be able to make the decisions on their own.

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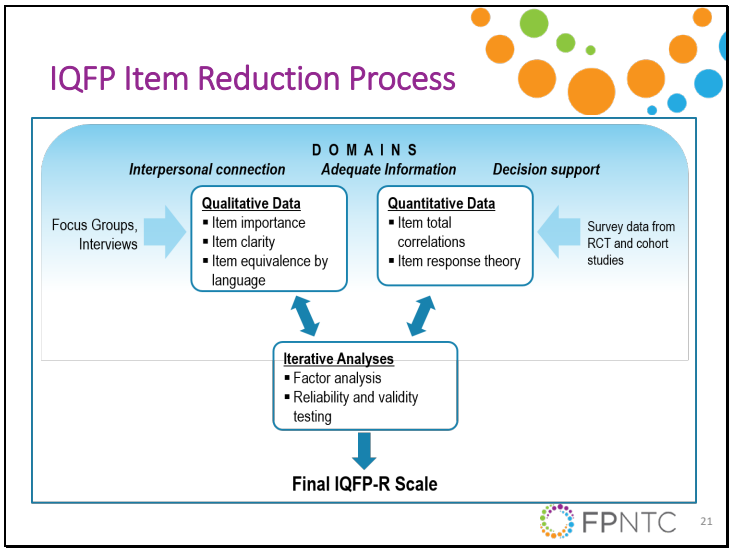

So in order to define a smaller set of questions from the original 11-item scale, we did an iterative process where we made sure, as you can see across the top that all the three domains were represented in the final measure. And then we used qualitative and quantitative data to triangulate which specific items were both most important and clear for patients and retained the validity and reliability of the original 11-item scale.

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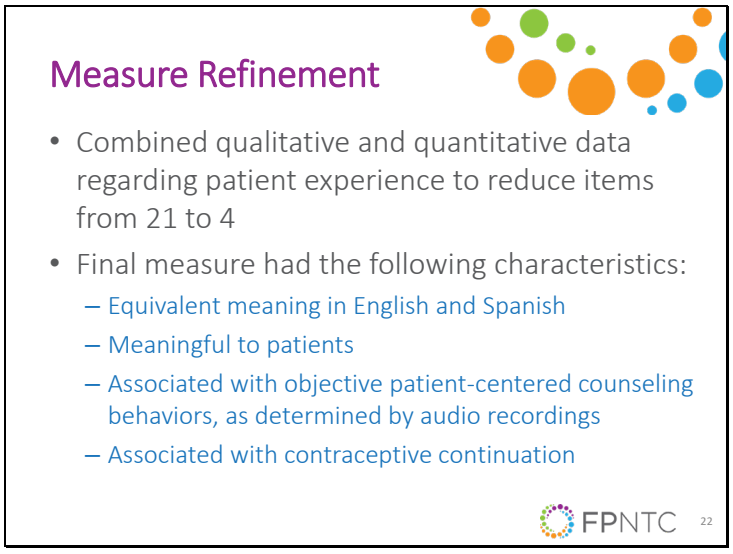

And in that process, we came up with a four-item measure. And this measure, the final measure had equivalent meaning in English and Spanish because we hadn't tested that in our qualitative work with women. We found that these were the four items that were most meaningful to patients in terms of what they wanted out of contraceptive counseling and also was associated, like I said, with these audio-recorded objective measurements of patient-centered contraceptive counseling. And importantly, it was also associated with contraceptive continuation. So it retained that predictive validity that we had found previously.

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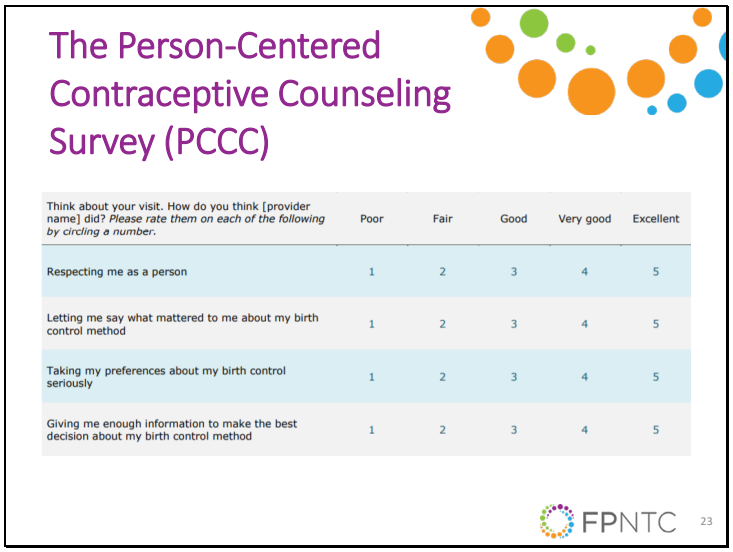

So this is the survey that we ended with. And as you can see, it says, think about your visit today, this is a visit specific measure. How do you think your provider did it? Respecting me as a person, letting me say what mattered to me about my birth control method, taking my preferences about my birth control seriously, and giving me enough information to make the best decision about my birth control methods. And again, this is giving me enough information. It's really important to recognize that will vary by people, what is enough information for an individual person. And so this is about whether that individual got enough information not some universal standard for what enough information is. And I will also share with you, which I'm sure is not surprise to anyone here, is that respecting me as a person was definitely far and away the most important thing that we heard from patients is that that was the thing that they both felt was most important and that they felt was often lacking.

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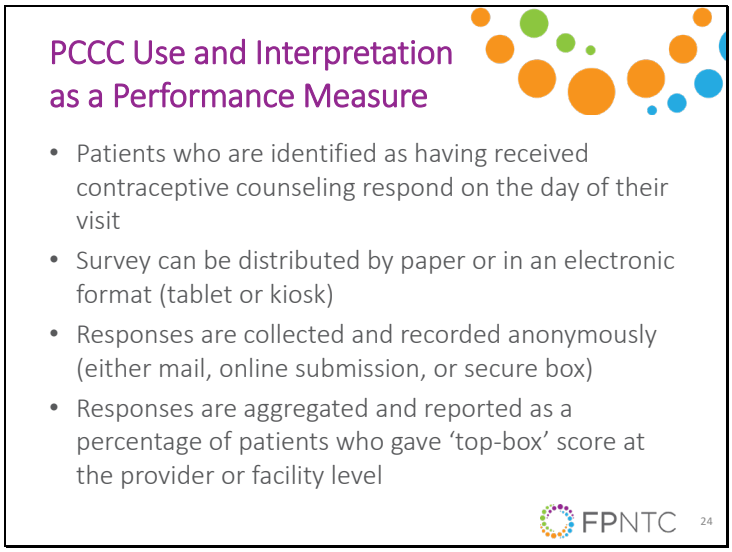

So how is this survey designed to be used as a performance measure specifically? So it was collected the day of the visit by patients who had been identified as having received contraceptive counseling. We validated it using both paper or electronic format. So you can use a tablet or a kiosk to collect the data. And the data is collected anonymously. The responses are then aggregated and reported on a provider and a facility level as the percentage of patients who gave what's called a top-box score. So just to define that briefly, this is the same strategy that's used for the CAP survey, which I'm sure many of you are familiar with, which is the most well-known Patient-Reported Outcome Performance Measure, which is the term which is called a PROPM. It's the most well-known PROPM, it's endorsed by NQF and is often used to measure client or patient experience. And they also use this top-box approach.

And so what this top box means is that a patient will have a positive findings, a positive score if they give five on this scale across the board, and they will have a non-positive score if they give anything less than five on any of these four items. Importantly, and I'm sure many of you are thinking this right now, there's a concern that this was too high a standard to hold providers to because you have to be perfect. And in fact, that's not the case. And the reason for that is that we know that there's social desirability bias and that patients, it's very hard to get patients to express dissatisfaction with providers. And that is true across the board regardless of context. And that therefore any expression of something less than excellent is a meaningful gap in quality. And I'll come back to that issue in a second.

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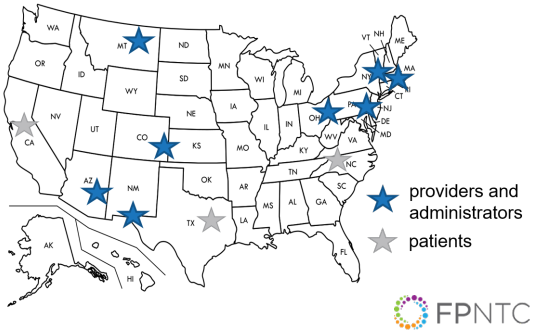
Validity and Reliability of PCCC

Face validity testing conducted with patients, providers, and clinic administrators across the country



FPNTC

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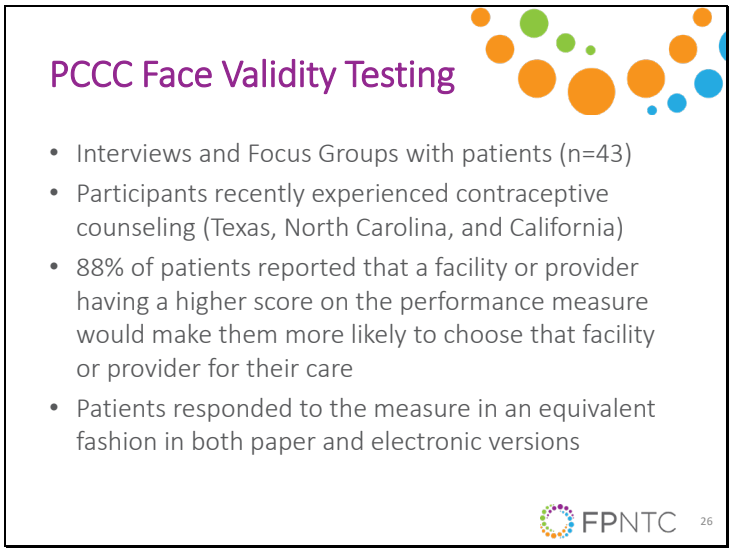

So in order to test the validity and reliability of this measure, this new patient-centered counseling scale, the PCCC as we call it, we did first a base validity testing with patient providers and clinic administrators across the country, recognizing that San Francisco and the Bay Area is not the rest of the country. We wanted to make sure that we gained information from a wider swath of the community. And so we did base validity testing with interviews and focus groups with patients in Texas, North Carolina, and California. And we found that the vast majority of patients felt that this was a meaningful measure that would help them to make decisions about their healthcare. And also importantly, as I said before, we compared the tablet versus the paper version and they felt that it was equivalent.

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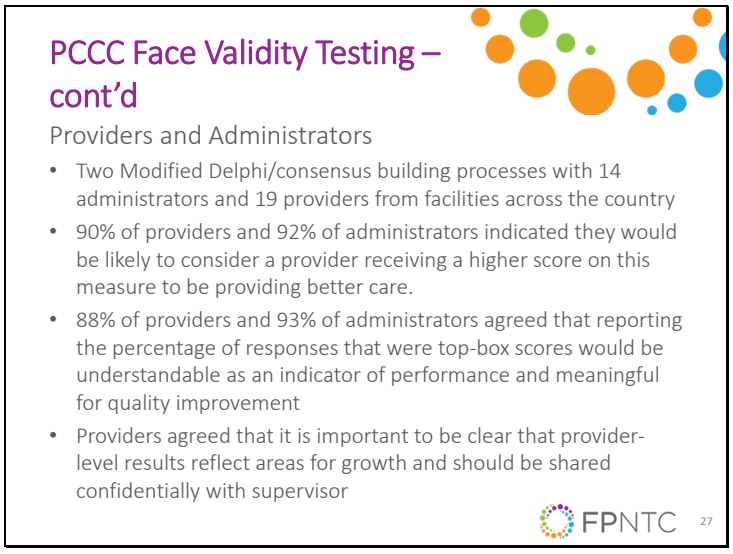

In terms of providers and administrators, we did this using an online process called a modified Delphi process, which is consensus building. So we were able to have a broad representation from around the country from administrators and providers. And what we found using the Delphi process was that you were able to achieve a high level of consensus, which was the goal of the Delphi process? We were able to achieve a high level of consensus that a high score on this represented better care and that it would be useful for them as an indicator of performance and meaningful for quality improvement. We also found that providers felt that it was very important that their responses or their scores on the measure not be used in a punitive way and that it would be used as a opportunity for improvement and not for a negative performance review, for example.

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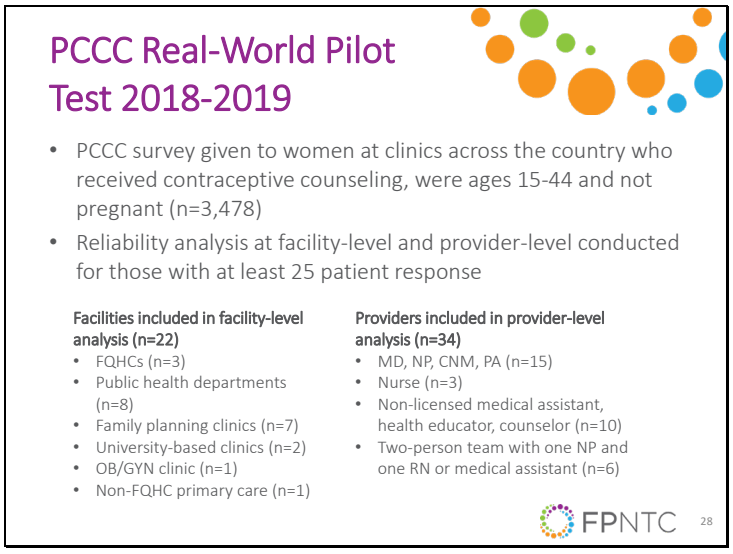

So building on the base validity, we then did quantitative testing of the reliability and validity of this performance measure, working with clinics across the country again to do this. And as you can see, we also worked with a broad variety of types of facilities and types of providers recognizing that there is a broad range of contexts in which family planning care is provided in the United States. And so we include FQHCs, public health departments, the broad range. And we also worked with licensed providers, and we intentionally included non-licensed providers as those being assessed recognizing that in many contexts this is how contraceptive counseling is provided. And we also included dyads in cases where a medical assistant would hand off counseling, for example, to a nurse practitioner.

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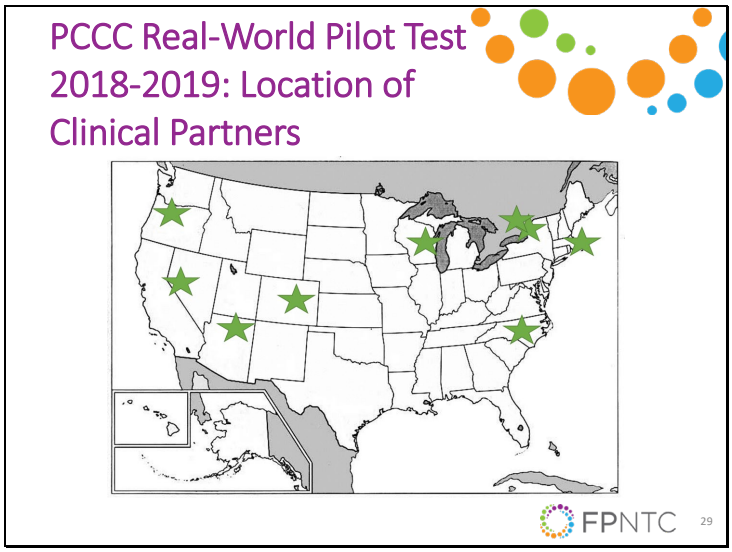

These are the clinical partners we worked with from around the country.

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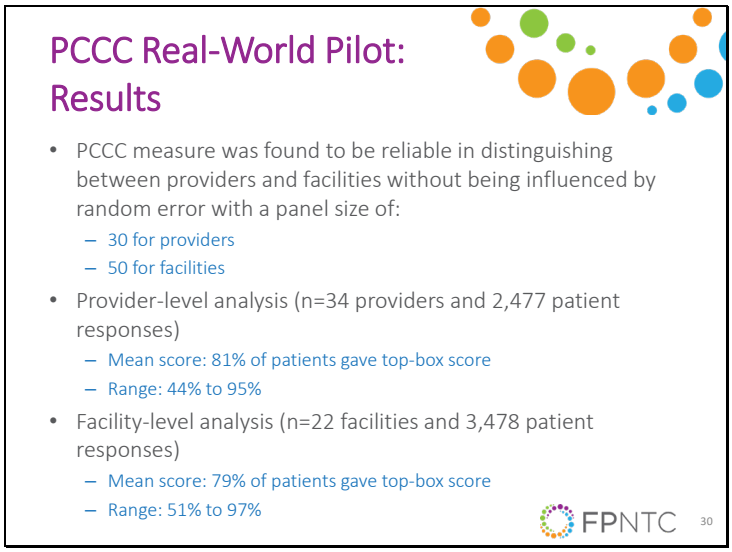

And what did we find using these sites? So what we found is that PCCC was reliable in distinguishing quality of care in a way that you could tell the signal above and beyond just from random noise. Because that's always the concern with any quality metric is to what extent is there variability just because there's a broad range versus it's in fact representing true differences in quality. And we found that with a panel size of 30 for providers and 50 for facilities, we were able to have adequate reliability to in fact identify differences in quality. In terms of the results that we got on the surveys, we found that using a provider level analysis on average, 81% of patients gave a top-box score.

And so I want to harken back to what I said about whether or not the top-box score was too rigorous. And I think this tells you with this 81%, is in fact the vast majority of patients gave their providers a top-box score, which indicates that it is not too high as standard. And in fact, as you can see here, some providers got as high as 95%. And then on facility level analysis, we similarly saw 79% of patients gave a top box score and there was also a broad range from 51 to 97%.

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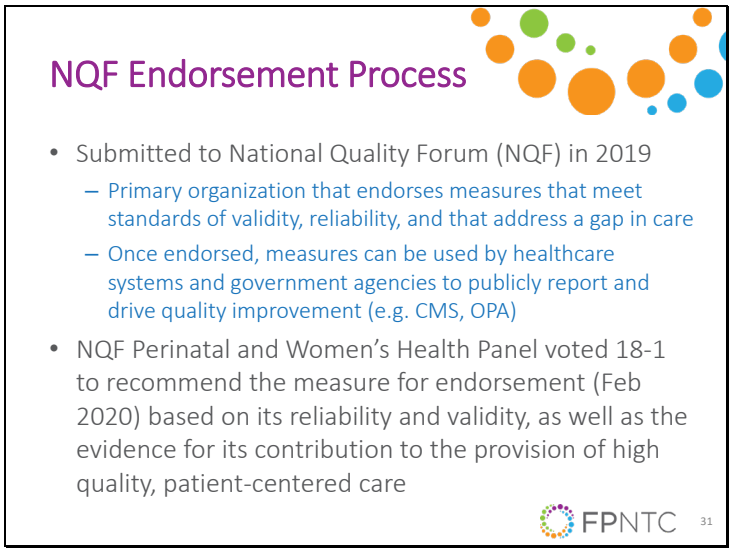

So using these results, we have submitted to the National Quality Forum again in order to obtain the field approval from them with the hopes that this will be integrated into quality programs in the future. And so this will be, for example, CMS or OPA could use these to drive quality improvement. So we submitted it in 2019, and in February, there was a vote by the NQF perinatal and women's health panel and they voted 18 to 1 to recommend the measure for endorsement. And in doing that, they both indicated that our statistical methods indicated this measure's reliability and validity as well as the fact that it represented an important area where we should be prioritizing our quality improvement.

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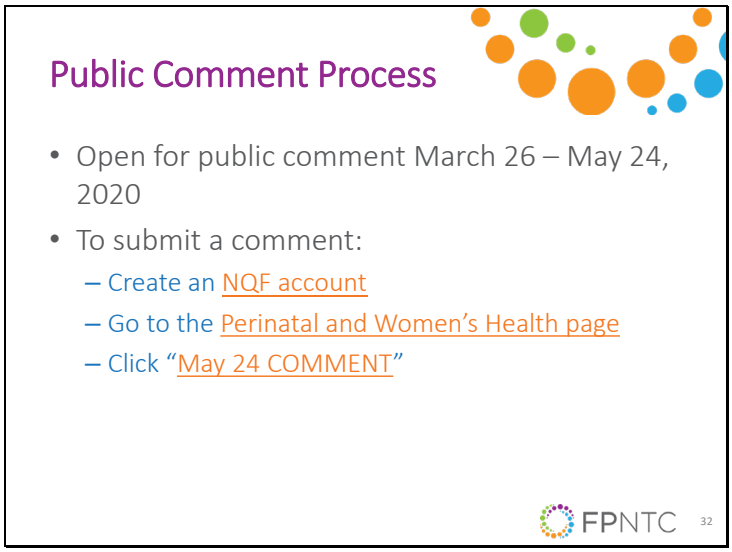

So I want to just pause for a moment and let you know that this is currently in the public comment period that I mentioned earlier. Our measure is currently in that period pending. And then after the public comment period is over on May 24th, that will allow us to proceed to the next stage. So I encourage you all to submit comments. There's an NQF account that you have to create, but it's a relatively simple process. And then you go to the perinatal and women's health page. I want to take a moment to talk about implementation of the measure because that is something that we've spent a lot of time talking about and thinking about, and I think is often a concern, especially for providers or for administrators.

To submit a comment: (1) Create an NQF account, (2) Go to the Perinatal and Women's Health page, (3) Click "May 24 COMMENT"

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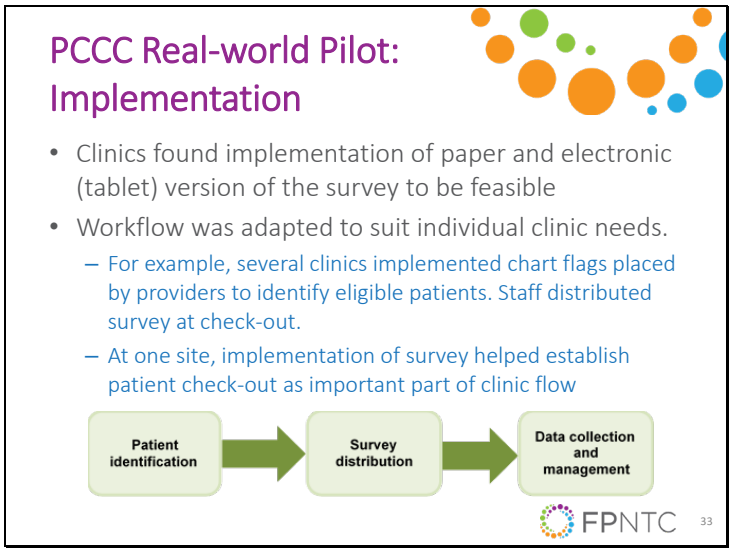

So as I said, there is the opportunity to implement the measure, you think either paper or electronic versions. We are interested in the future of thinking about pushing this out, for example, on portal. So we have not yet evaluated that modality. We worked a lot with clinics around the country to understand their processes for implementing this as part of our pilot study. And we're able to understand certain approaches that could be used and implemented in multiple different settings to do this in a customized but yet overall standardized way. So for example, just to give you one way a clinic did it was they had chart flags that were placed by the provider who performed contraceptive counseling, which then at checkout led to the person doing checkout giving the survey to the patient.

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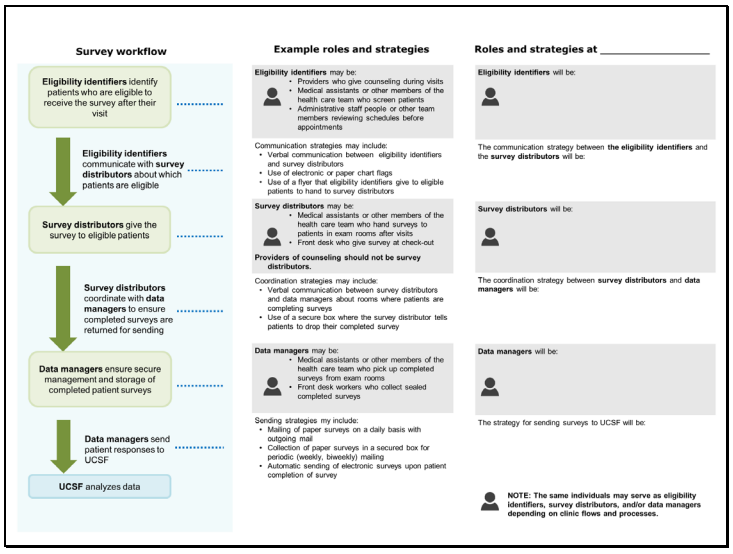

In thinking about implementation and how to make it both customized and standardized, we defined three basic jobs that had to be done to be able to successfully implement this measure. And that was patient identification, a person has had contraceptive counseling; and then distributing the survey to that patient; and then data collection and management.

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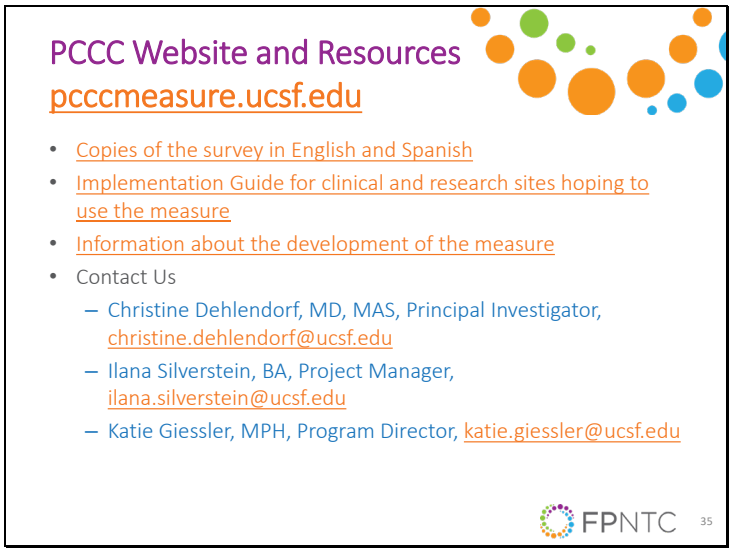

And so in order to assist sites in the future in implementing this measure, we have created implementation materials to allow people to think about how to map that on to their specific context and clinical flows. And so for example, here we have the survey workflow on the left identifying who needs it, survey distribution, and data managers. And then we have example roles and strategies in the middle, and then a worksheet for individual clinics to fill in on the far right. All these implementation materials are available free of charge at our website, the pcccmeasure.ucsf.edu. If you just search me, you'll be able to find that as well. So that concludes my overall conversation about the PROPM or Patient-Reported Outcome Performance measure that we've been working on. I just want to take a moment to talk about the next steps in performance measurement in family planning because even though we now are looking at potentially having two NQF measures of quality, of course, there's always more work to be done.

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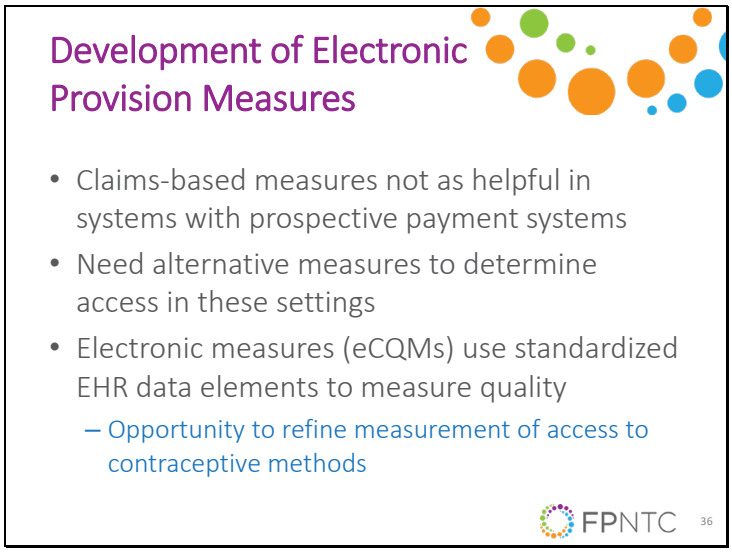

And one particular area where we're working is in figuring out how to develop electronic provision measures. So the current measures that I mentioned that our NQF endorsed use claims data in order to measure whether individual patient in a calendar year received a method. And this is not as helpful in contexts in which there is not fee for service billing such as federally qualified health centers where they use prospective payment systems.

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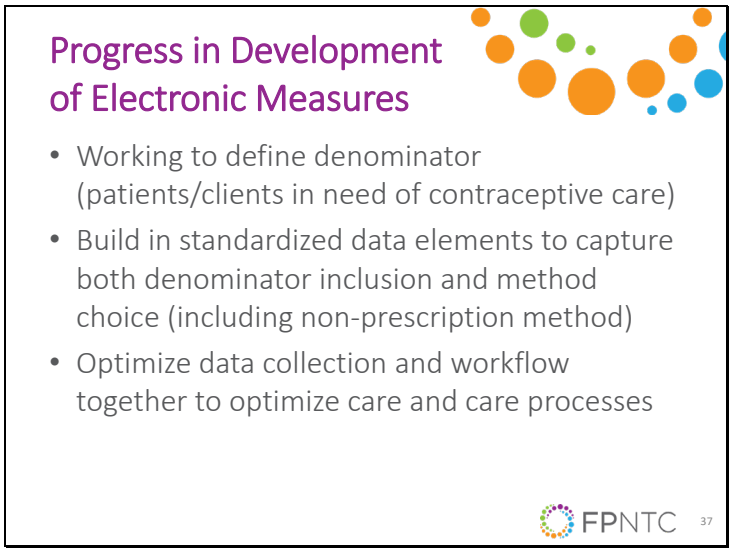

In addition, electronic measures moving away from claims data and using standardized data elements that are part of EHRs provides the opportunity to refine the measure of contraceptive provision and specifically work to define the denominator. So our goal is, we want to make sure that women who need contraceptive care receive it. That's the goal. The current measures endorsed by NQF are all women, whether or not we know if they're sexually active or desiring get pregnant, et cetera, because the claims measure doesn't allow us to differentiate that. And so electronic measures could have the potential to allow us to do a better job of refining the denominator. With funding from the Office of Population Affairs, we're currently working to think about how this electronic measure could be optimized to this end. So for example, the finding the denominator, like I said, and creating standardized data elements to allow us to capture who should be in the denominator as well as whether or not someone received a method.

And also, we're interested in looking at whether or not someone received a nonprescription method because those can't be captured in claims. But it would be great if we could also capture whether someone received condoms as a way to track that as well. And that's something that could be done using the EHR, or was counseled about fertility awareness. And one of the things we're really thinking about when we're doing this is how not to overburden systems. We all know, we all have alert fatigue, we all have too many check boxes in the EHR. So we're really trying to think strategically about how not to just create something that doesn't work for a system, but how to optimize data collection with workflow so that they actually work hand-in-hand in a bi-directional process.

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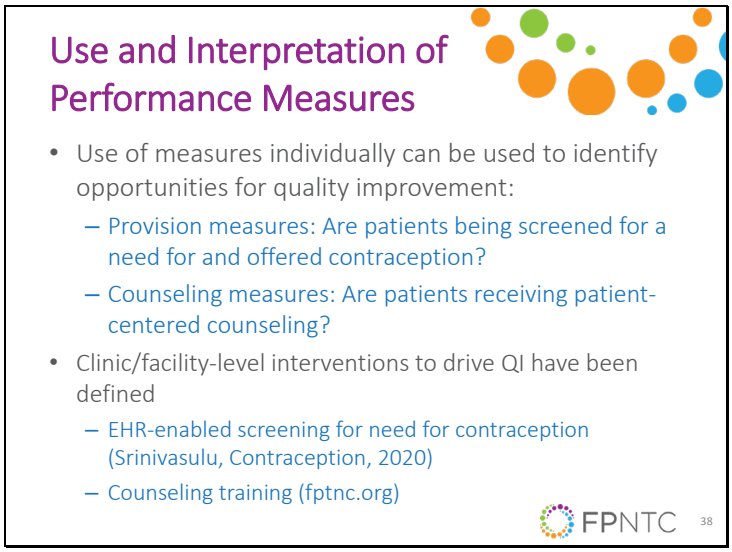

So how can the provision measures whether they are claims or electronic like I mentioned and the PROPM, Patient-Reported Outcome Performance Measure, how can they be used? Well, they can each be used individually to measure quality and track quality, the impact of quality improvement efforts. So the provision measures can be used to screen for are women getting screened for their need for and offered contraception and counseling measures? Obviously, are patients getting patient-centered counseling? And this can drive quality improvement, like I said. And there are defined interventions that can be used to drive QI in these two spaces. So just to give an example, there was a recent publication out of New York that used an EHR enabled screening mechanism that was standardized to ensure that women who wanted, in an FQHC, that wanted contraceptive care were identified. And then for obviously training or patient-centered counseling trainings that have been developed, including those at the FPNTC.

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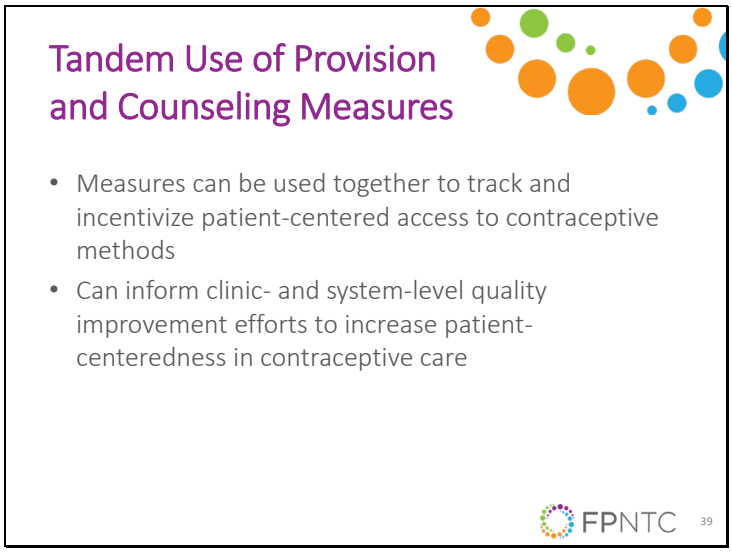

Importantly though, as we talked about throughout this presentation, it's not just about using each one of these measures in isolation, it's also these measures, multifaceted metrics of quality and contraceptive care can be used together to promote the ultimate goal of patient-centered access to all contraceptive methods.

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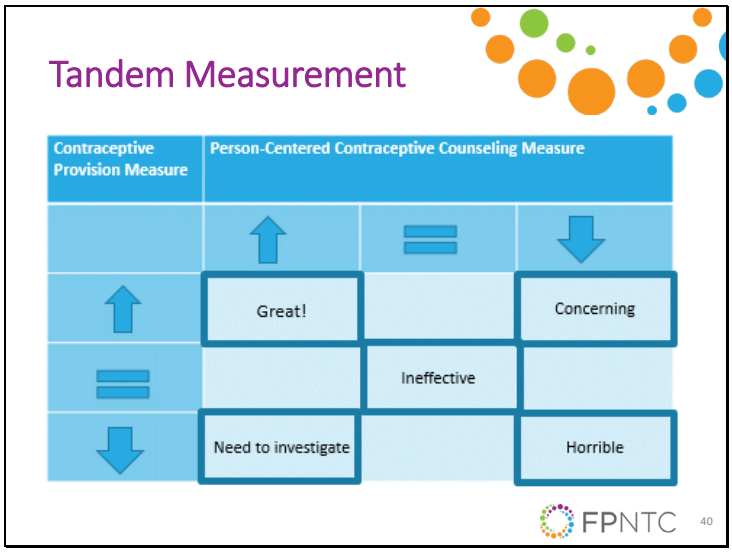

And this can inform clinic and system-level quality improvement. So we're also working on that currently with the National Association of Community Health Centers to think about how we can do that. And in doing that, one of the things we're thinking about is how do we think about tandem use? How do these metrics relate to each other? And I think any specific site if they measure their metrics at baseline, do a quality improvement, intervention and then measure them afterwards are going to see a range of different patterns of how these two different metrics play together.

So for example, they might find that both of them go up, that they have more access and more patient-centeredness. And that's obviously a great outcome. They may find that they both go down, and that's bad. So that's a concerning thing regardless. These two extremes are obviously very clear, their interpretation. What happens if the contraceptive provision measure goes up but patient-centeredness goes down? Obviously, that's concerning and something that needs to be looked into that there may be less patient-centered counseling that's driving the increased provisions. What if the patient-centeredness goes up and the provision goes down? That's an interesting question that would need to be investigated. And particularly, I would want to know, what was the counseling? How patient-centered was the counseling before, and were people being subject to directed counseling and now they're not? That would be one potential avenue of investigation. And then of course, if nothing changed for either one of them, it would just be ineffective.

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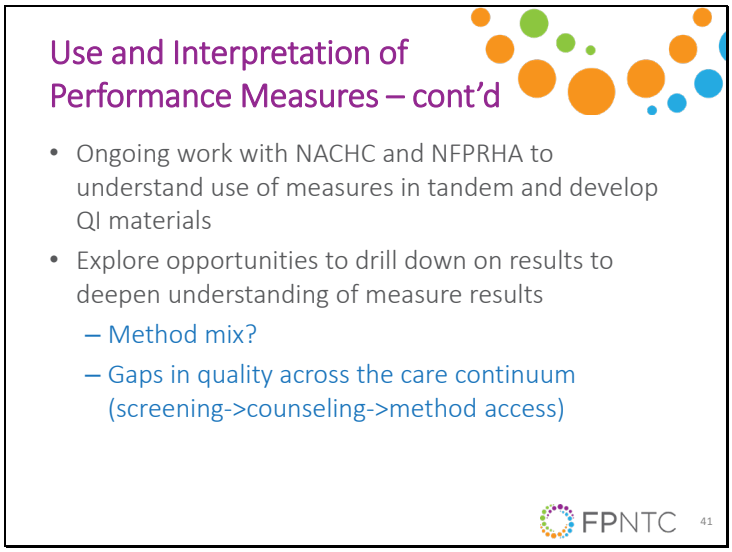

And of course, you can fill in all the other boxes too. But I just wanted to give you a sense of how we're thinking about how to interpret tandem use in the real world context. So like I said, we're currently working with both NACHC, the National Association of Community for Health Centers, which is the membership organization for federally qualified health centers in the United States and NFPRHA to understand this and develop QI materials that would allow for optimal engagement with and responses to the measurement of these two metrics in tandem. We're also thinking about how recognizing that quality measurement is a broad tool and it only gives you just one broad overview of what's happening, how we can provide materials to allow clinics to drill down and try to figure out what's happening if they, for example, have a low score on one of the two quality metrics.

So for example, one option is to look at method mix. If there's non-patient-centered counseling and then you just find out that 90% of people are getting Mirena, you might want to think about is there a provider bias for the Mirena? And we're also thinking about how you can look at gaps in quality across the care continuum. So the ultimate outcome of patient-centered access, there's multiple different points in the care continuum that you can intervene on or that can potentially have gaps that you can think about. So how do we drill down on those different points in the care continuum?

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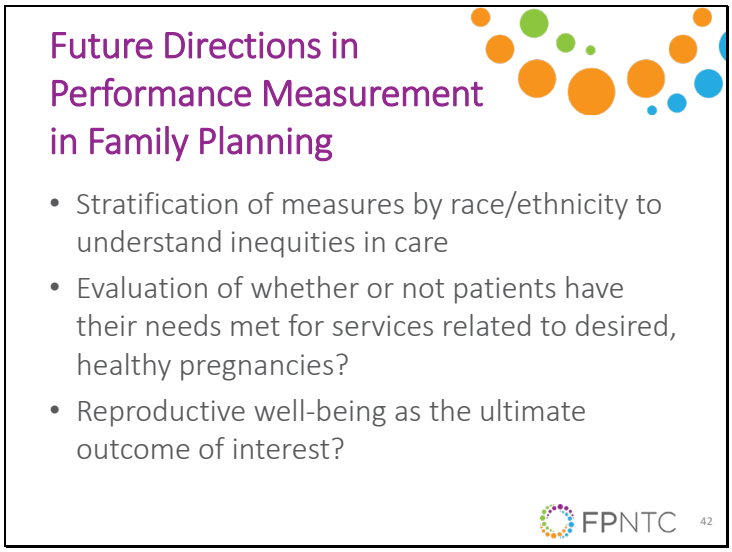

And then finally, I'm just going to end with mentioning future directions in performance measurement. So quality is multifaceted, we need to be thinking about this. How can we do even a better job than the tandem use metric does to allow us to understand and incentivize quality family planning care? Well, one thing we're thinking about is how we can specifically address concerns about reproductive oppression and coercion for our patients of color. And so we are in the future going to think about how we can stratify the measures that currently exist by race, ethnicity to understand inequities in care. I also think we can think about whether or not recognizing the patient's ability to have a pregnancy is part of family planning and is part of QFP guidelines. Are there a way that we can also develop metrics down the road to think about whether patients are having their needs met for services related to desired healthy pregnancies?

And then I'm personally very interested as well thinking about our ultimate goal is not just preventing unintended pregnancy or achieving the pregnancy people want, it's overall people having their reproductive autonomy honored and their reproductive goals met. And so I think down the road thinking about ways that we can define and measure a broader construct of reproductive wellbeing is something that I'm thinking about moving forward with in the future. So thank you very much, and I'm going to hand it back to Katie.

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Katie Quimby: Thank you so much Christine. That was great. We've received a lot of really fantastic questions already. So I'm going to dive in. Of course, we'll accept others through the Q&A chat pod, and we'll get to as many as we can. But like I said, we've already received quite a few. So to start, Christine, can you clarify your comment about the panel of 25 providers being needed for reliability? Does that mean the measure can't be used to evaluate an individual provider?

Christine Dehlendorf: I apologize if that was unclear, I'm trying to navigate my way back to that. So what it means is it's actually a panel of responses, so patient level of responses in order to have adequate reliability. We obviously don't want to a provider to be evaluated solely based on whether or not one patient liked them or not. So how many is enough to get adequate reliability to make sure that what we're measuring is in fact a fair representation of the quality of care that patients are providing? This is actually a statistical question, and so we did statistics that showed that our measure was adequately able to differentiate quality of care from random noise when we had 30 responses for providers. So 30 patient level responses, 30 patients completing the survey. And then for facilities, 50 patient level responses. So 30 patients respond, and the average score is 50% for an individual provider that's valid. For facilities, 50 patients respond, and it's 80% on the facility level, and that's considered reliable.

Katie Quimby: Thank you for that clarification. Second question, is the measure validated specifically with low income and non-white women?

Christine Dehlendorf: So we have in our NQF application, which is available on the NQF website if you want to look it, we have our patient demographics and we had a very diverse population of patients included. We had an over representation of women of color and low-income women because of the sites that we worked with. So we haven't stratified by those findings. And like I said down the road, our plan is to think in a methodical, constructive way about how stratification by race, ethnicity can be used, and we want to do that. But I would say currently it absolutely has been used and validated in those patients. And then down the road, we'll look more specifically at what it looks like in those patients. I will say that we found when we did do some initial, and you can see this as well in the NQF application, when we did some initial tabulations by race, ethnicity and bi-language, we found quite notable disparities with women of color and Spanish speaking women receiving lower quality care.

Christine Dehlendorf: We did not apply for endorsement for stratified metrics yet because we wanted to see how the measures in the real world, how it plays out before going to that point. But I think that there was some very important signals that is consistent with our general understanding of disparities in patient-centered care that we need to pay attention to going forward.

Katie Quimby: Another question, how did you assess for appropriateness of the literacy level of the measure and what advice would you give to sites who are maybe concerned that the literacy level is too high, for example, is it appropriate to change the question?

Christine Dehlendorf: So that's a great question. I believe it's at the fifth grade reading level, so we did work really hard to get it at a low literacy level and that was part of our qualitative work with patients during the measure development process, if you go back to here, is that we really wanted the item clarity bullet under the qualitative data section. We really wanted to make sure this was something that made sense to people. And there was one or more items that we excluded based only on the fact that it was the item clarity, the literacy level was too high. This is a measure that cannot be used by women who can't read and write, we don't recommend that clinics read them to people because that obviously is not going to ... Social desirability bias will be definitely heightened in that context, and the likelihood of getting a reasonable representation of quality is unlikely.

Christine Dehlendorf: I think from an NQF endorsement perspective, the letter of the law, you're supposed to use it as it has been endorsed. But obviously each site can do what they want in terms of making it something that's meaningful for them. How things are implemented in the real world and how it is endorsed are not always aligned. That said, we've done everything that we can to make it useful for people in a broad range of context.

Katie Quimby: Sorry, I'm moving quickly. I know we could discuss a lot further on these questions, but I want to make sure we get to as many as we can. Another question, how can you prevent providers from ignoring these measures if the measures aren't tied to payment and shouldn't be tied to payment? In other words, how do we prevent sites from ignoring without getting into risks of inappropriate pressure?

Christine Dehlendorf: So it's a good question. So going back to the paper performance piece, that was specifically for the LARC metric. That was not designed to be used in a pay-for-performance context because of the concern for reproductive oppression and coercion and non-patient-centered counseling with those methods specifically. There is a broader question of how can the most or moderately effective measure that's currently endorsed by NQF and the PROPM be used in a pay-for-performance context? I personally would be absolutely elated to have the PROPM used in a pay-for-performance context. I think incentivizing people to provide higher quality patient-centered care is only a win, and there's nothing wrong with 100% of people getting patient-centered care that's focused on their needs varying preferences.

Christine Dehlendorf: I think that the most and moderately effective method measure that's currently endorsed by NQF, it's such a blunt tool as in it doesn't exclude patients who want to get pregnant. It doesn't include patients who aren't sexually active, it doesn't exclude patients who are not risk to pregnancy for other reasons, like they already have an IUD in place. That is not captured actually, they are considered a 'failure' in that current measure. So I think that it would be a concern to use it because it's such a blunt measure. I think that if we are able to adequately define at ECQM, I'm sorry, an electronic health record, it's called an Electronic Clinical Quality Metric, the electronic measures that I was mentioning earlier. If we were able to define that in a way that better identifies the numerator and the denominator to reflect what we actually want to measure, which is are people in need of contraceptive services getting that care? Then I would absolutely think that could and should be used in a pay-for-performance context.

Katie Quimby: Great. All right. We have a few more minutes, maybe two more minutes, two maybe more questions. Next question, can you comment on overlap or not of the measures that are used globally and they've provided the example of the Bruce Jane framework, which focuses on clinical provision of family planning, but also other measures out there?

Christine Dehlendorf: So there's been a lot of work on frameworks for quality contraceptive care, particularly internationally, which is the reference that was made. And I think these are very much aligned with those. We do not include in this particular metric specifically negatively worded question around discrimination and coercion, which is prominently featured in a lot of those frameworks because that is a documented concern in family planning both internationally and in the United States. So that's one way that it's different. It's a short measure, the metrics that have been developed by various groups like PSI internationally that are aligned with those frameworks have tens or twenties or hundreds of questions to get at all the different aspects of the framework.

Christine Dehlendorf: I think that gets to the fact that quality is multidimensional, and we really wanted, our goal with this is to really get at one aspect of the care experience, which is contraceptive counseling, recognize that is not the only thing that affects patient's experience of care. But we wanted to drill down on that because of the identified concerns. And we wanted to make it tractable and feasible for clinics to use and patients to respond to. And I will tell you in our pilot, we got about 90%, 88% response rate in our pilot. So this is something patients can do. And so that was really important to us to get something that was psychometrically valid and reliable that could be used. But that doesn't mean that there's not going to be room for other measures in the future that more comprehensively measure the broader range of quality attributes. I'm going to show the resource slide again; I don't know if I can do that; I will try. But yes, next question, Katie. Sorry.

Katie Quimby: Okay. Last question that we have time for and I know we've had others, so apologies if we haven't been able to get to your question. But the last question is, is there work being done so that these measures address quality of contraceptive care for patients who can get pregnant but do not identify as women?

Christine Dehlendorf: Yes, it is a good question. In this measure, we did not differentiate and say that it was not a requirement somewhere I could identify as a cis-gender woman by any means. And so this could absolutely be used in that context. I think there is another question there is whether there is a specific metric that could be used for different populations that might more holistically capture different populations' needs. And I think that's something that...I'm not aware of a performance metric being done on that, there is work being done on just defining what different populations needs are, which is the first step to movement towards metrics to evaluate that.

Katie Quimby: Excellent. Thank you so much Dr. Dehlendorf for answering those rapid-fire questions. We're coming to the top of the hour, so I do just want to say thank you all so much for joining us. We will have a recording of today's session on fpntc.org within the next few days. If you have other questions, you will continue to share those with Dr. Dehlendorf. You're welcome to email us at fpntc@jsi.com. Finally, please complete the evaluation today, it will be emailed to you after the webinar. And again, if you are looking for CNEs, you will need to complete the evaluation in order to receive your certificate. Thank you all so much for joining us; hope you have a great rest of your day. That concludes today's webinar.