Learning Objectives

Upon completion of this webinar, participants will be able to:

• Describe the four National Quality Foundation (NQF)-approved Office of Population Affairs (OPA) contraceptive care measures
• Detail the two main ways use of these performance measures will increase access to contraception
• Identify at least two tools for use in implementing the contraceptive care measures into clinical care settings

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ALL OTHER PLANNING COMMITTEE MEMBERS HAVE NO DISCLOSURES TO DECLARE

Unintended Pregnancy in the US

Introduction

• Recent initiatives in healthcare have highlighted the role that healthcare quality can play in improving outcomes (IOM 2001), i.e., health outcomes, client experience, and cost savings (Berwick 2008).
• This presentation describes recent efforts to introduce performance measurement into contraceptive care.
Why measure performance?

Performance measurement is a critical component of efforts to improve healthcare quality – and there is good evidence that it can motivate health systems to adopt change (Ivers 2012).

“What gets measured gets done.”
Peter Drucker

How can performance measurement help healthcare providers?

They can help improve programs by answering these questions:

1. How well is my program performing?
   - How can I be sure we are doing the right thing?
   - On what programs should my agency spend the public’s money?
   - How can I motivate staff to do the things needed to improve the public’s health?
   - How can I convince external funders that we are doing a good job?
   - What is working or not working?
   - What can we do differently to improve performance?

2. They can help consumers know where to get the best care.

Evidence that use of performance measures can work

Performance measures as an intervention to change practice

- Cochrane Review (Ivers 2012)
  - 104 studies included
    - Small to moderate impact on provider practice
    - Size of impact depended on baseline level of performance and how the feedback is provided

- QI and maternal care during pregnancy (Bennett 2009)
  - Use of QI in 10 maternity care institutions, 2003-2007
  - Monthly conference calls and semi-annual meeting
  - Postpartum contraception counseling increased from 50% to >80%
THE OPPORTUNITY TO IMPROVE CONTRACEPTIVE CARE IN AMERICA

Room to Improve Reproductive Health

- 45% of pregnancies are unintended (>3 million per year) (Finer 2016)
- Interpregnancy intervals (Gemmill 2013):
  - 35% <18 months
  - 50% 18-59 months
  - 15% ≥60 months
- A study in California's Family PACT program found:
  - The direct medical cost of births resulting from unintended pregnancy is estimated at $21 billion per year (Sonfield 2015)

Consequences of Poor Contraceptive Care

- Infant health:
  - Preterm birth
  - Low birth weight
  - Birth defects
  - Infant mortality
- Maternal health:
  - Obstetrical complications
  - Pregnancy delay/planning/spaceing
  - Differing pregnancy-related behaviors and outcomes
  - Improved physical health/noncontraceptive and general health benefits
- Life course trajectory:
  - Complete education, establish career, income, live in safer neighborhoods with more recreational opportunities and food security, develop social cohesion, greater access to care
 Calls to Improve America’s Reproductive Health

The prevention of teen and unintended pregnancy and improved rates of birth spacing have repeatedly been identified as national priorities:

• In 2015, the Institute of Medicine (IOM) included unintended pregnancy as one of 15 core “vital signs” for the nation’s health and health care – this includes women’s knowledge about and access to tools for family planning.

• The US National Prevention Strategy (National Prevention Council) and Healthy People 2020 Objectives include several objectives focused on unintended pregnancy and use of contraception - in 2015, a new Healthy People 2020 Objective was approved aligned with the clinical performance measures.

• The HRSA-supported Women’s Preventive Services Initiative recommends that adolescent and adult women have access to the full range of female-controlled contraceptives to prevent unintended pregnancy and improve birth outcomes.

Clinical Recommendations Define Quality Contraceptive Care

NEW PERFORMANCE MEASURES FOR CONTRACEPTIVE CARE
Three Contraceptive Care Measures Endorsed by NQF

- NQF 2903: The percentage of women at risk of unintended pregnancy that is provided a most or moderately effective contraceptive method (Intermediate outcome measure)
- NQF 2904: The percentage of women at risk of unintended pregnancy that is provided a long-acting reversible contraceptive (LARC) method (Access measure)
- NQF 2902: The percentage of women who had a live birth provided a
  - Most or moderately effective contraceptive method
  - LARC method (in the 3 days and 60 days after delivery)

Women care about effectiveness too!

- A 2016 study asked women in family planning and abortion settings across the United States what contraceptive method characteristics were “extremely important” to them:
  - Of 23 total items, most (89%) women reported “effectiveness of the method at preventing pregnancy” was “extremely important”.
  - The next most important characteristics included “the method is easy to get” (81%), and “easy to use” (80%).

How the measures will improve care

• More clinicians may be motivated to screen women about their pregnancy intention, then offer contraception to those in need
• More providers will offer women a wide range of methods, in accordance with QFP recommendations
• Women will have greater access to the method of their choice

Interpretation

Provision of Most/Moderately Effective Contraception and LARC
All Women at Risk of Unintended Pregnancy

• Most or moderately effective methods
  • No specific benchmark has been set, but it is not expected to reach 100%, as some women will make informed decisions to choose lower tier methods even when offered the full range of methods.
• LARC
  • Identify very low rates of LARC provision (e.g., below 1-2%).
  • Efforts to identify whether barriers to LARC access exist among reporting units with very low rates of LARC provision.

Interpretation

Provision of Most/Moderately Effective Contraception
Postpartum Women

• All postpartum women can be considered at risk of unintended pregnancy given recommendations for 18-month interpregnancy interval.
  • However, future benchmark may not be set at 100%.
• 3 days postpartum meant to capture immediate postpartum provision, 60 days postpartum based on ACOG recommendations for postpartum visit at 6 weeks
• Will the measure discourage breastfeeding?
  • Wide range of methods can safely be used by lactating women (CDC, ACOG)
  • Providing contraception at the 6-week postpartum visit helps ensure the woman is protected when LAM stops or is less effective
Interpretation

Provision of LARC Postpartum Women
Primary focus is on ensuring access rather than encouraging a high rate of provision, due to potential risk of coercion.

- Low rates within 3 days could be due to reimbursement, systems, or training barriers.
- Institutions, health plans, and regions with less than 1-2% LARC provision could be offered technical assistance to evaluate and address barriers.

Special note: Coercion

- Most and moderately effective methods:
  - Nine methods of contraception are included in the numerator, and a benchmark has not been set.
  - Research shows a high percentage of women want to use these methods when counseled about them and they are readily accessible.
  - QFP provides guidelines for how to provide client-centered counseling.
  - Expected to be high, but not 100%.
- LARC methods:
  - Focus is on low levels of use, not higher end of the distribution.
- QFP provides guidelines for how to provide client-centered counseling.
- The OPA is concurrently funding the development of a patient-reported outcome measure for contraceptive use, which can be used to identify coercive practices.

Measures Webpage

This measure 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 type of contraceptive method used and risk of unintended pregnancy.

No specific benchmark has been set for the most or moderately effective method measure, but QFP does not expect it to reach 100%, as some women will make informed decisions to choose methods at the lower tiers of efficacy even when offered the full range of methods.
Measures Webpage

How the Measure Should be Used

This measure should be used also as a success measure to identify very low rates of LARC use that may be signs of barriers to LARC provision. The LARC measure should NOT be used to encourage high rates of use. It is not appropriate to use this measure in a pay-for-performance context.

EXAMPLES OF HOW THE MEASURES CAN BE USED

Example 1: Most or moderately effective contraceptive provision by health plan

% of women 15-44 years at risk of unintended pregnancy provided with a most or moderately effective contraceptive method, by health plan

What are same issues that may be happening here?
Example 2: LARC provision by health center

% of women 15-44 years at risk of unintended pregnancy provided with a LARC method, by health center

What are some issues that may be happening here?

Contraceptive Measures and Zika

- Contraceptive Care Measures will be important in monitoring contraceptive provision in Zika response
- Access to and use of the most and moderately effective contraceptive methods are important in reducing unintended pregnancies at risk of Zika exposure
- LARC – In Zika response, access to most effective methods, including LARC, is especially important

National Survey of Family Growth population level estimates of contraceptive use in women at risk for unintended pregnancy 2013-15

Women ages 15-19
Women ages 20-44
Pregnancy Risk Assessment Monitoring System (PRAMS) data can be used for population level estimates of postpartum contraception use.

**2-6 Month Postpartum Contraception Use**

**PRAMS, 2012-2013**

- Women ≤ 19 years of age
- Women ≥ 20 years of age

**Future Directions**

**OPA’s Role as Measure Steward**

As the measure steward, OPA will:

- Maintain a webpage dedicated to the measures, their appropriate use and interpretation, e.g., no benchmark for LARC
- Monitor use of the measures
- Convene an Advisory Group to reflect on the measures’ use and consider improvements over time
An Electronic Version of the Measures

Development of an e-measure will address limitations of claims data:
• Piloting a hybrid measure in FQHCs and other settings in the coming years
• Working with ACOG to create standardized electronic data elements needed to calculate the measures will electronic data

Client Experience with Contraceptive Care

Patient-reported outcomes (PROs) are defined as “any report of the status of a patient’s (or person’s) health condition, health behavior, or experience with healthcare that comes directly from the patient, without interpretation of the patient’s response by a clinician or anyone else.” (NQF 2012)

• 11 item Interpersonal Quality in Family Planning (IQFP) scale based on:
  • Domains of patient-centered communication
  • Patient preferences for contraceptive counseling
  • Factor analysis
• Preliminary reduced final scale for measure

Please rate the provider your saw with respect to:

- 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
- Giving me enough information to make the best decision about my birth control

Increased Use of Measures for Accountability and Reporting

• Integrate into HEDIS or PCMH
• Health plan adoption of the measures
• Widespread consumer awareness of health plans with better quality of family planning based on measures
Measure Specifications
OPA maintains a webpage that provides detailed information about the measures. This includes:

- Detailed measure specifications
- Guidance for how to interpret the results
- SAS code
- How to ask questions if you need more information about the measures


Training Resources
OPA's Family Planning National Training Center has developed a learning collaborative model designed to help health systems effectively use the measures to improve contraceptive care. These resources include a webinar describing the learning collaborative, a change package, job aids, and a dashboard.

- http://fpntc.org/training-and-resources/contraceptive-access-quality-improvement-plan
- http://fpntc.org/training-and-resources/contraceptive-access-quality-improvement-plan
ACOG LARC Program Resources

The ACOG LARC Program has numerous resources to aid the provision of LARC:

- ACOG LARC Program Website: [http://www.acog.org/larc](http://www.acog.org/larc)
- Advocacy and Policy
- Clinician Education and Training
- Clinical Resources
- Coding and Reimbursement
- Immediate Postpartum
- Patient Resources
- Practice Resources

Key References

Clinical recommendations related to providing family planning services

- CDC (2013). US Selected Practice Recommendations for Contraceptive Use, MMWR Recommendations and Reports, 62(No. RR-5):1-60. Available online at: [http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6205a1.htm?s_cid=rr6205a1_w](http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6205a1.htm?s_cid=rr6205a1_w)