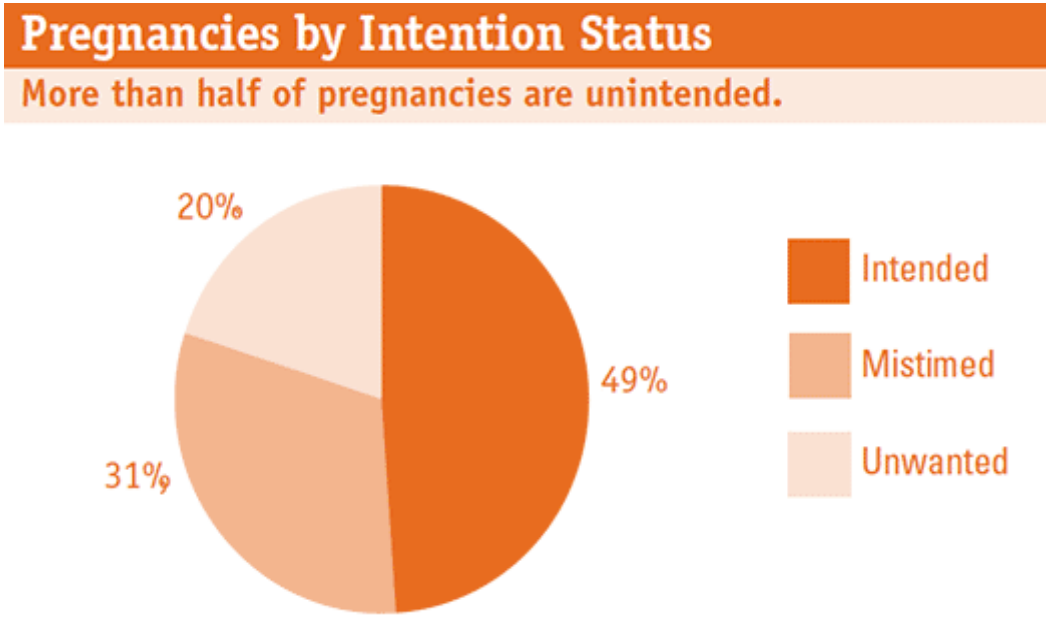
Sexual and Reproductive Health Workforce Project

Smart pathways to high quality sexual and reproductive health care
in the primary care setting

Disclosure Declarations

Name	Disclosure
Helen Bellanca, MD	Nothing to disclose
Joyce Cappiello, PhD, FNP-BC, FAANP	Dr. Cappiello reports ownership interests with Bioceptive
Melissa Nothnagle, MD, MSc	Nothing to disclose
Erin Saleeby, MD, MPH	Nothing to disclose
Jacki Witt, JD, MSN, WHNP-BC	Nothing to disclose

Healthcare Reform and the ACA: Challenges and Opportunities



Guttmacher Institute, 2013

The changes in the health care system brought on by the Affordable Care Act provide an unprecedented opportunity to improve access to quality sexual and reproductive healthcare by focusing on **primary care and prevention**

"Increasing the capacity of US clinicians to provide high quality sexual and reproductive health care is an urgent public health priority"

MISSION

Increase access to high quality sexual and reproductive health care in the United States

ARHP believes that impactful change only comes from the collective action of a broad coalition of stakeholders

The Workforce Project unites dozens of non-profits, foundations, government agencies, researchers and providers under one mission: **improving access to sexual and reproductive health care**

ARHP and its allies are informed by the five conditions for collective success:

- Common Agenda
- Shared measurement system
- Mutually reinforcing activities
- Continuous communication
- Backbone support organizations

http://www.ssireview.org/articles/entry/collective_impact

Making History: *The Workforce Project* Timeline

2010-2011: Seeing an opportunity for comprehensive reform, ARHP, Diana Taylor, and Tracy Weitz worked on identifying goals and building coalitions to increase access to high-quality family planning care

January 2013: ARHP convened the *SRH Workforce Project Summit*, a multiday high-level strategic discussion among forty experts across disciplines and fields to develop recommendations for action

July 2013: Summit leaders formed three high-priority working groups to ensure strategic action on recommendations

March 2014: Leaders from the Workforce Project met to discuss the status and outcomes of the working groups, new OPA/CDC guidelines, and readiness for healthcare systems change

October 2014: Working groups present their findings at *Reproductive Health 2014*

2015 and beyond: Pilot projects based on working group recommendation will be implemented in community health centers across the county

Workforce Project leaders used recommendations from the 2013 Summit to form three working groups to take strategic action on high-priority goals

The working groups have been putting the recommendations from the SRH Workforce Summit into action by producing concrete deliverables and developing innovative pilot project for improving family planning care in the primary care setting

Audience Polling Question

Which best describes your professional category?

a) Physician assistant
b) Physician
c) Pharmacist
d) Registered nurse
e) Nurse practitioner
f) Certified nurse midwife
g) Other

Audience Polling Question

Which best describes your primary professional responsibility?

a) Teaching
b) Clinical practice
c) Research
d) Administration
e) Other

Audience Polling Question

What best describes your clinical practice setting?

a) Private practice
b) Academic practice
c) Community-based practice/community health center
d) Title X clinic
e) VA
f) Other/non-clinical

Audience Polling Question

What percent of your work time is focused on reproductive health?

a) 0-25%
b) 26-50%
c) 51-75%
d) 76-100%

The New Norm: Integrating Quality Sexual + Reproductive Health with Primary Care

September 19, 2014

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About California Family Health Council

CFHC champions and promotes **quality** sexual and reproductive health care for all through:

- Clinic Support Initiatives
- Provider Training
- Advanced Clinical Research
- Advocacy
- Consumer Awareness + Patient Education

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What is Sexual + Reproductive Health?

- Birth control and sexually transmitted disease (STD) prevention
- Sexual behaviors and STD risks
- Sexual orientation and gender identity
- Pregnancy history and intentions or goals
- Pregnancy and preconception care
- Sexual function, issues, concerns
- Sexual and relationship satisfaction and health
- Cancer screening

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IOM: Current recommendations for Sexually Active Women

Cervical Cancer Screening

STI/HIV Counseling

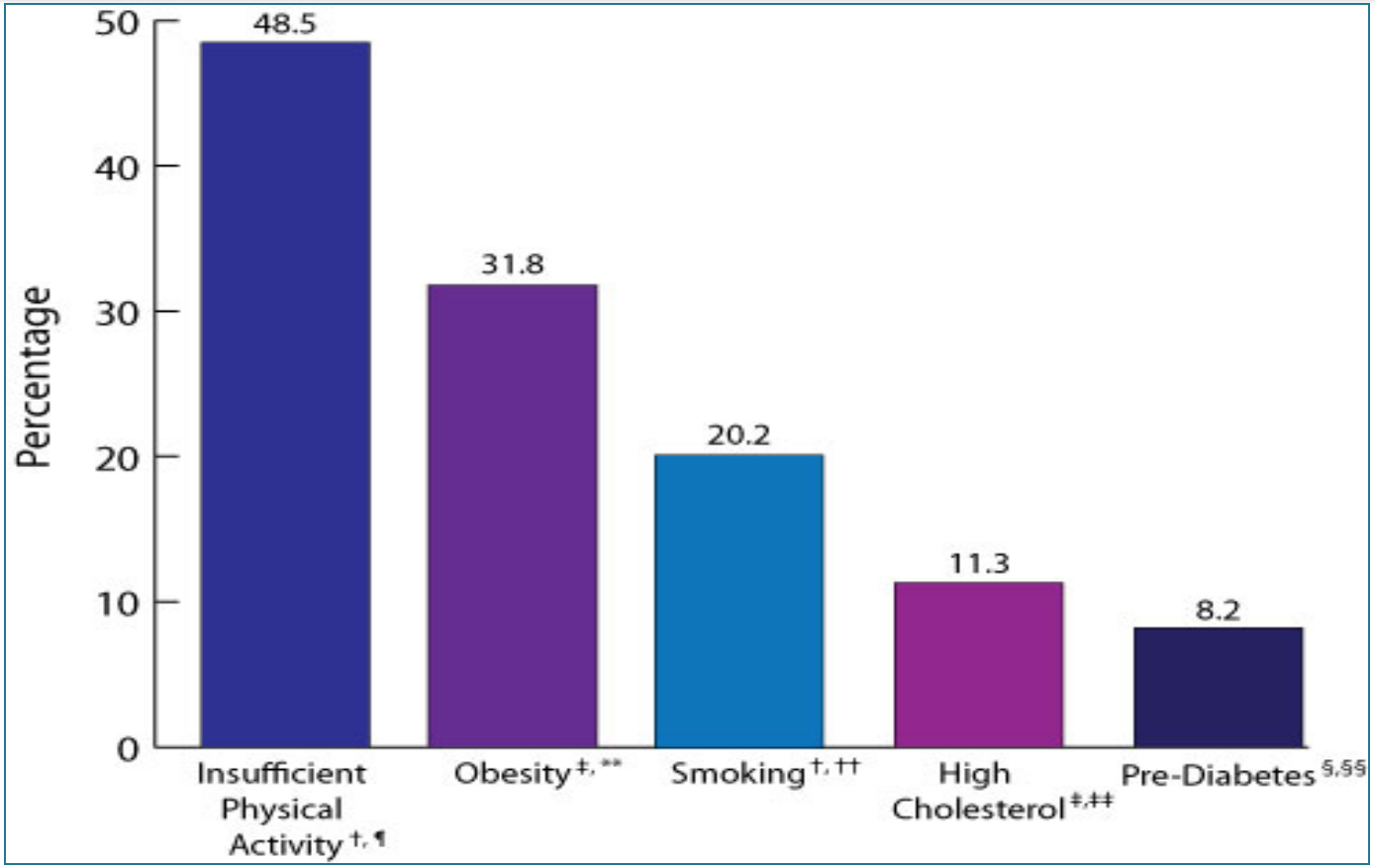
TOO LIMITED

Source: IOM, 2011

IOM: Women's Unique Health Needs

Reproductive Health	Cancer	Healthy Behaviors	Pregnancy related	Immunizations	Chronic conditions
STI and HIV counseling ; all sexually active F)	Breast Cancer •Mammography	Alcohol S&C	•Alcohol S&C	•TdaP, Td booster, •MMR, varicella	CV: HTN, lipids
Ct, GC, Syphilis screening	•Genetic S&C	Tobacco C&I	•Tobacco C&I	Influenza	T2DM screen
HIV screening (adults at HR; all sexually active F)	•Preventive medication counseling	Diet counseling if CVD risk	•Folic acid supplement	•Hepatitis A, B •Meningococcal	Depression screen
Contraception (women w/repro Capacity)	Cervix: • Cytology • HPV + cytology	Interpersonal and DV S&C	•GDM screen •Rh screen •Anemia screen	•HPV (women 19-26)	Osteo-porosis screen
	Colorectal: • FOBT, • Colonoscopy, • Sigmoid	Well-woman visits	•STI screen •Bacteruria screen	•Pneumococcal •Zoster	Obesity screen; C&I if obese
			•Lactation Supports		

Women of Reproductive Age: Chronic Disease Risk Behaviors and Risk Factors



http://www.cdc.gov/reproductivehealth/womensrh/ChronicDiseaseandReproductiveHealth.htm

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Medication and Birth Defects

What percentage of women get pregnant while taking a teratogenic medication known to cause birth defects?

a. 1%
b. 3%
c. 6%
d. 12%

Medications and Birth Defects

- 11.7 million women of childbearing age are prescribed FDA category D or X medications each year

- 6% of US pregnancies occur in women taking medications with known teratogenic risk

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Andrade SE, et al, 2006
Schwartz EB, et al 2005

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Recognizing Ambivalence

Contraceptive counseling and pregnancy intention in PC setting

- 26% of women ages 18-50 were ambivalent, thus less likely to:
  - Use condoms or birth control pills
  - Have used contraception at last intercourse
- Less likely to be ambivalent if at last visit MD had:
  - Discussed birth control
  - Answered their questions about birth control
  - Felt more satisfied with the contraceptive counseling they received

Schwarz, et al, Contraception, 2009

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“Contraceptive Vital Sign”

Documentation of the “contraceptive vital sign” refers to notation about what form of birth control the patient is using?

a. True
b. False

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The "Vital Sign" of Sexual + Reproductive Health

Last Menstrual Period (LMP)

Sample Form for Recording Menstrual History
1. Date of last menstrual period:
2. Periods come every ___ days and last ___ days.
3. Periods are: ❑ Regular ❑ Irregular ❑ Painful ❑ Light ❑ Moderate ❑ Heavy
4. ❑ Yes ❑ No Do you have bleeding or spotting in between your periods?

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“One Key Question”

Home | Ask Yourself | Clinicians | Public Health Advocates | Donate | Take Action | Events | Why? | About OFRH

One Key Question ®

Would You Like to Become Pregnant in the Next Year?

Do I want to become pregnant in the next year?

www.onekeyquestion.org

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Integrating Quality Sexual + Reproductive Health and Primary Care in Diverse Settings

CFHC's Learning Exchange offers an interactive in-person training for health care providers interested in learning how to:

- Integrate high quality SRH services and primary care from front office to exam room
- Apply evidence-based guidelines for SRH and primary care
- Include SRH screening in routine medical histories
- Provide Comprehensive, Patient-Centered Contraceptive Counseling

Manual available with tools, tips + resources

Learn more at cfhc.org

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Questions?

Core Competencies Working Group

Developing core professional competencies in sexual and reproductive health

Working Group Members

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Working group members

- Representatives of six professions
  - Pharmacy
  - Nursing
  - Midwifery
  - Nurse Practitioners
  - Family Medicine
  - Physician Assistants

We developed a draft using common language for all professions and an initial set of competencies

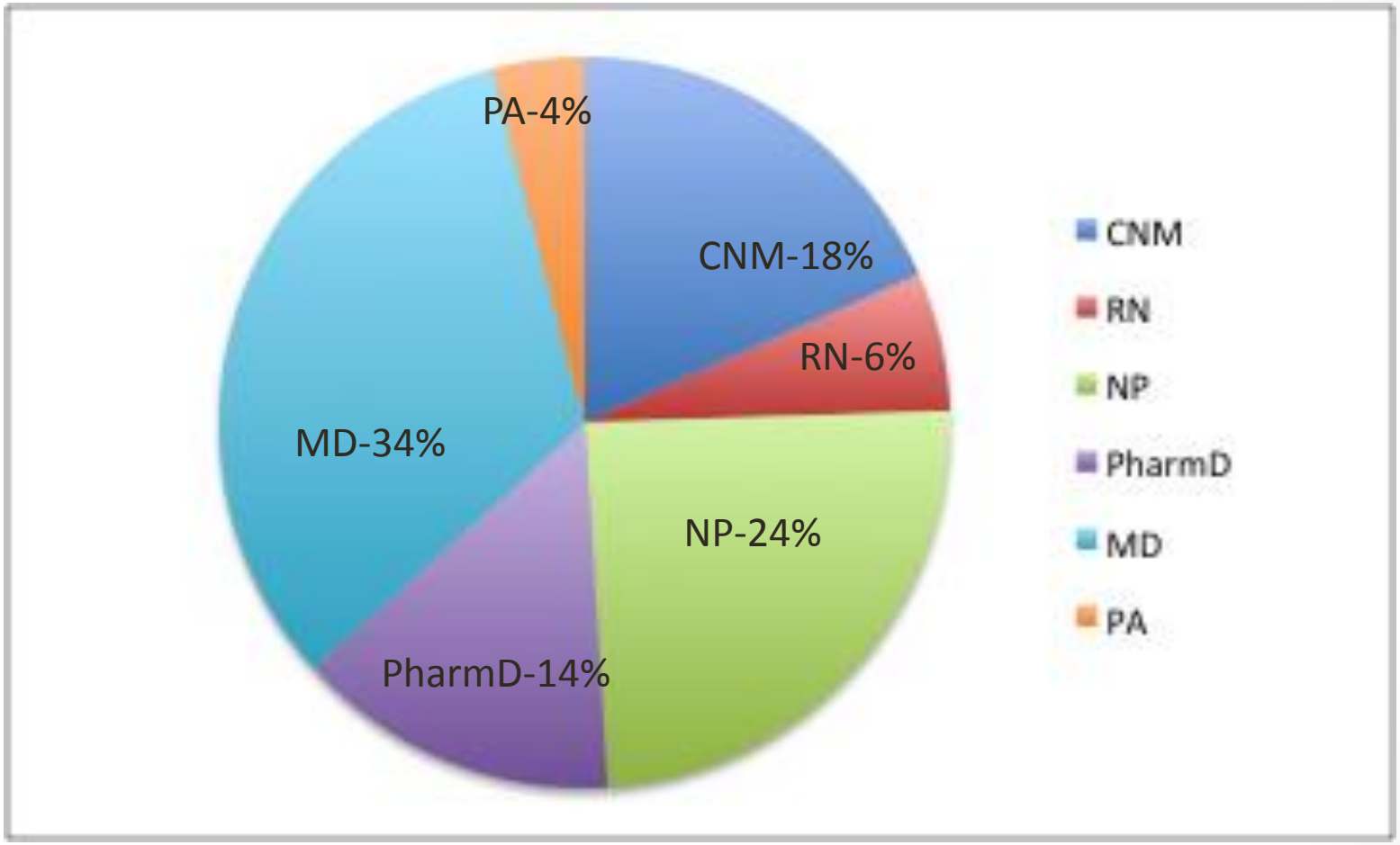
Polling Question

1. Which professions were represented in the Delphi survey used to develop the core competences?
   a) Family medicine physicians
   b) Physicians assistants
   c) RNs, NPs, and CNMs
   d) Pharmacists
   e) All of the above

Delphi Survey

- A 3-round Delphi study was designed to reach consensus among participants
- A draft list of SRH core competencies was developed by the WG after review of pertinent documents
- The survey was distributed to an expert panel comprised of representatives from each profession identified by the WG

Professional Background of the 50 Participants



Results of Round One

- Results: 508 comments were made re: 33 competencies
- Feedback to be presented to participants in round two includes:
  - levels of agreement for item inclusion as written
  - 13 competencies that met the 75% agreement level set by the researchers (with minor edits)
  - major themes seen in panelists' edits and comments
- Process repeats for three rounds

Dissemination of Findings

- Publish results
- Present at conferences and meetings
- Meet with academia professionals to build competencies into curricula
- Determine how to gain endorsements and identify motivators for providers to implement competencies
- How can you help?
- Your ideas?

National Sexual and Reproductive Health Training Collaborative

Building the essential clinical skills for effective contraceptive care

Working Group Members

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National SRH Training Collaborative

- Goal: to increase effective IUD insertion training for providers across the country by:
  - building on existing training networks that are shown to be effective
  - employing cutting-edge techniques to use mobile technology to bring expert guidance to rural communities across the country
  - developing open access resources to include best practices, clinical pearls, sample curricula, and many other helpful tools to improve quality of care
- The group is recommending two cost-effective regional pilot projects with a particular focus on local and regional clinical interventions

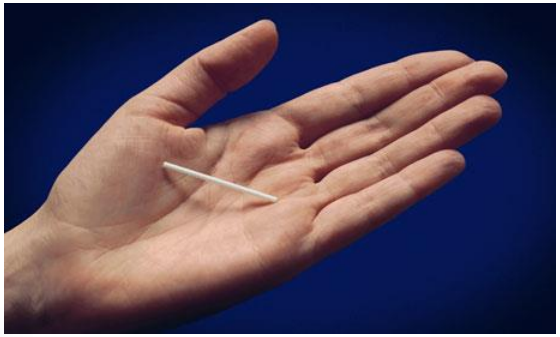
Training Collaborative Pilot Project: Increasing Information and Access

Training Collaborative In Action

All members of the CHC health care team receive comprehensive training in contraceptive counseling and LARC provision throughout the project

Patients receive comprehensive contraceptive counseling

If a patient decides she wants an IUD or implant, she makes an appointment to return for insertion. She leaves the clinic with a quick-start method to use until she returns



Patient returns for insertion on a designated day when the clinic will have IUDs and implants available

Training Collaborative Pilot Project

TEAM Training

The Targeted Education and Assessment Model (TEAM) of training is an innovative way to prepare community health centers to provide high quality family planning care

What does it mean to be a TEAM?

- *Targeted*: A training coalition is assigned to a single CHC to do a thorough assessment of current capacity, then designs a training and education intervention for that specific clinic
- *Education*: The coalition works with all members of the health care team at the CHC to improve provision of family planning
- *Assessment:* Progress is monitored and analyzed throughout the TEAM Training process
- *Model:* This innovative method of increasing capacity can be used at any CHC to produce an unique intervention plan for SRH care

Polling Questions

Do you offer IUD or implant services?

a) Yes
b) No

Polling Question

What do you see as the biggest barrier to providing IUD or implant services?

a) Financial/insurance barriers
b) Lack of provider training in counseling or knowledge about the methods
c) Patient resistance
d) Institutional barriers or administrative resistance
e) Other

Contraception Metrics:
Measuring quality, improving access

HELEN BELLANCA, MD, MPH

ARHP METRICS AND PERFORMANCE WORKING GROUP

SEPTEMBER 2014

Disclosure

- I have no industry relationships to disclose
- I am the co-creator of the One Key Question® initiative, and have worked as an employee and been a board member of the Oregon Foundation for Reproductive Health, which owns OKQ.

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Goal of Metrics Working Group

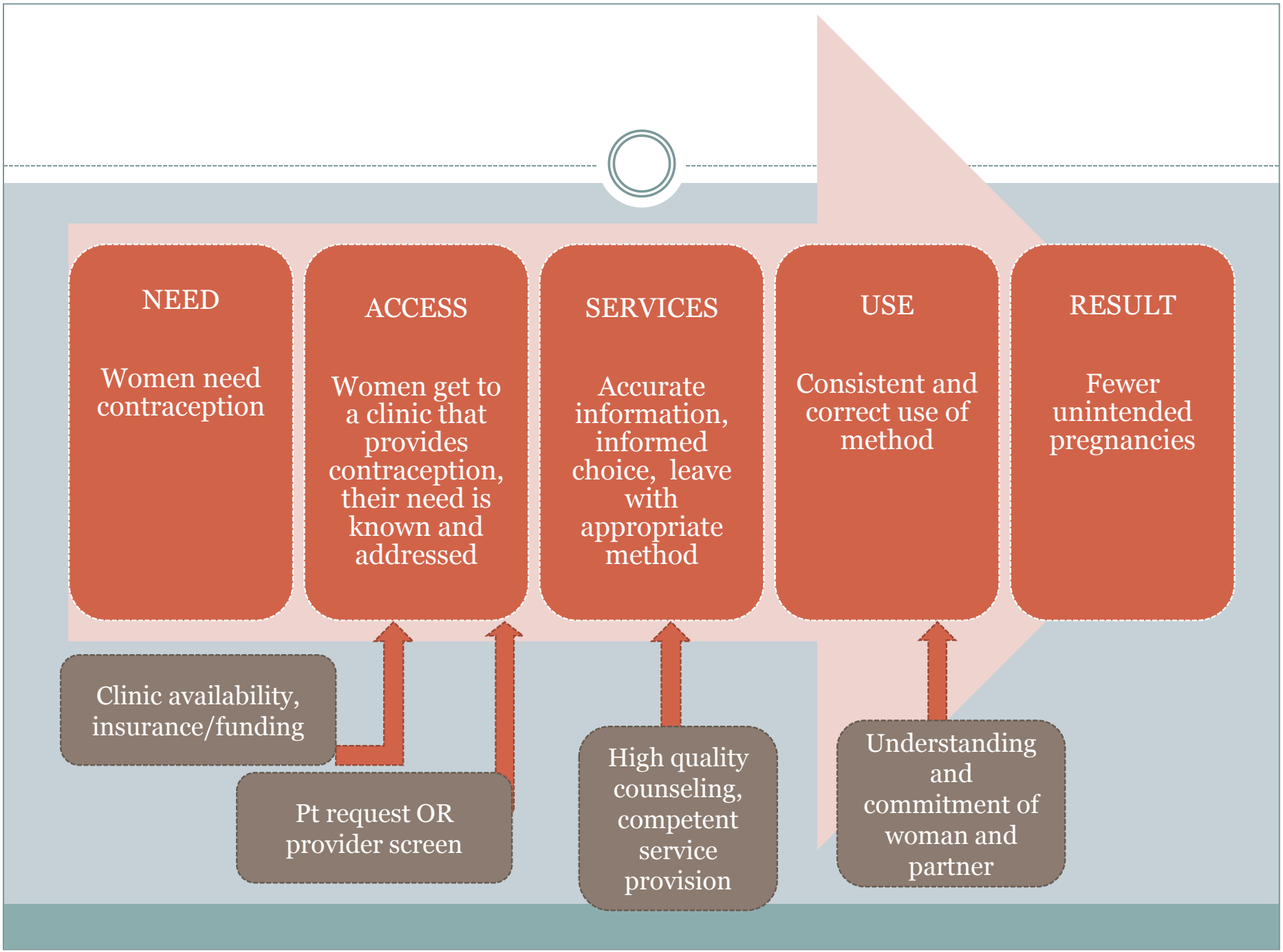
Develop at least one unique contraception metric that will contribute to quality improvement in contraception in current and future health care models

1) Environmental Scan
2) Consensus on at least one metric to put forth for testing/ pilots
3) White paper, presentation, commentary to continue the discussion

The role of metrics

Metrics are tools to address quality

What are the quality gaps in contraception care?


NEED
Women need contraception
ACCESS
Women get to a clinic that provides contraception, their need is known and addressed
SERVICES
Accurate information, informed choice, leave with appropriate method
USE
Consistent and correct use of method
RESULT
Fewer unintended pregnancies
Clinic availability, insurance/funding
Pt request OR provider screen
High quality counseling, competent service provision
Understanding and commitment of woman and partner

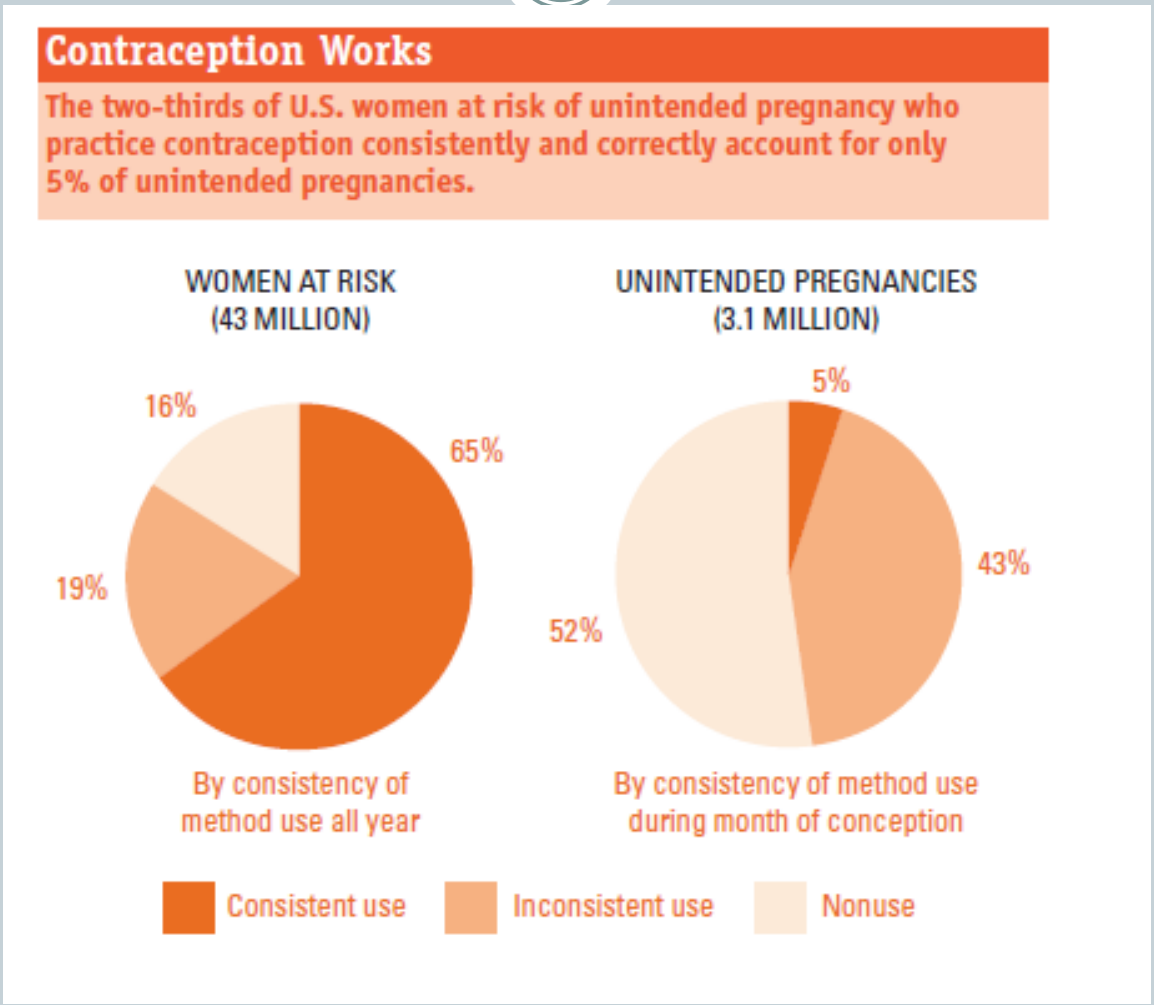
Performance

- When you provide contraception care, are you doing a good job?
  - Comprehensive counseling
  - Patient-centered approach
  - Informed decision making
  - Knowledge about effectiveness of methods
  - Able to provide full range of methods
  - Follow-up on problems or concerns

What if your main gap in quality is in ***access*** to contraception care?

Can a metric promote better access?

Half of women with UIP are **not using any contraception**, the other half are not using a method that works for them

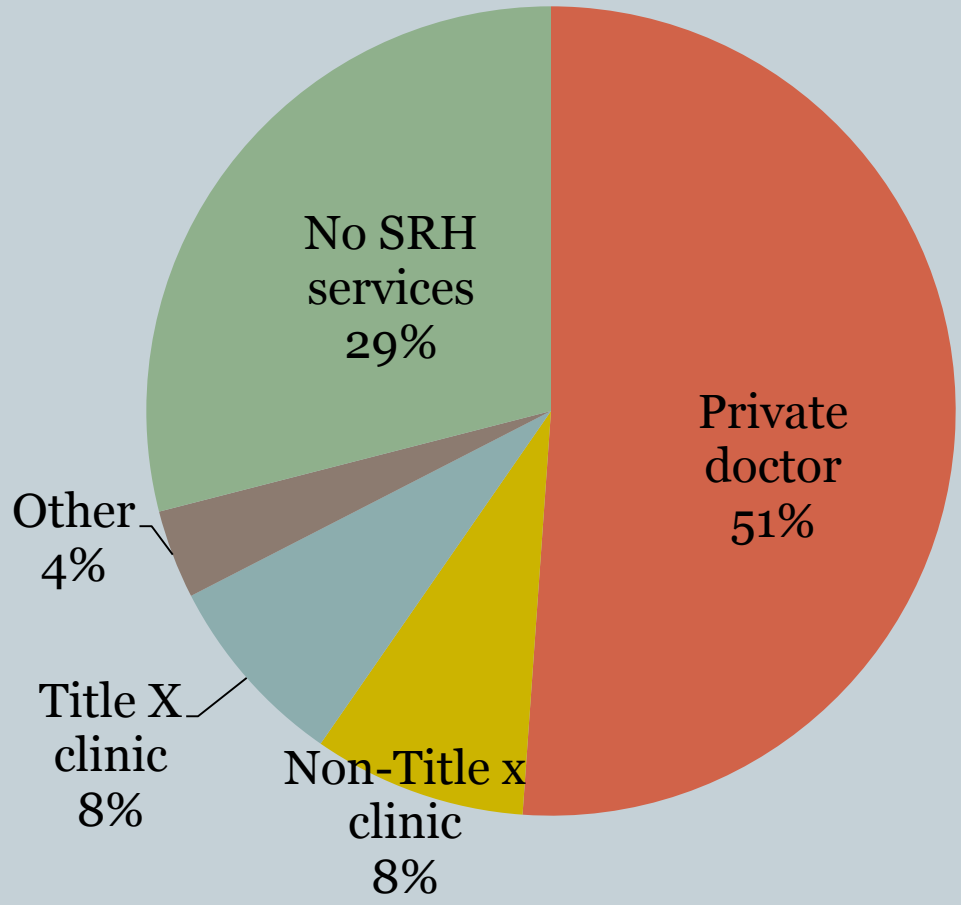


Guttmacher, Unintended Pregnancy in US, 2012

Access

- Do women, men and adolescents have access to contraception care?
  - Are there clinics that provide contraception?
  - Do people who need contraception have coverage to pay for it?
  - Do providers have the knowledge and skills they need to offer services?
  - Are there system supports for contraception care (questionnaires, EHR prompts)?
  - **In a primary care setting, do the providers know which of their patients need contraception?**

Where women get SRH care
NSFG 2006-2010



Two options for access metrics

Women age 15-50 screened for their pregnancy intentions

Women age 15-50 screened for their need for contraception

Screen for *pregnancy intentions*

Women age 15-50 screened for their pregnancy intentions

- **Denominator**

  Women 15-50 with no hysterectomy or tubal ligation who are not currently pregnant and are sexually active with men

- **Ask**

  "Do you want to get pregnant in the next year?"

- **Numerator**

  If question was asked provider gets credit, regardless of the answer

PROS:
- more politically palatable
- promotes preconception care as well as contraception

CONS:
- not as directly tied to the outcomes we care about
- difficult to do with claims

Screen for need for *contraception*

Women age 15-50 screened for their need for contraception

- **Denominator**

  Women with no hysterectomy or tubal ligation who are not currently pregnant and are sexually active with men

- **Ask**

  "Do you want to get pregnant in the next year?" *If not*: "Are you using contraception that you are happy with?"

- **Numerator**

  Any contraception care

PROS:
- More closely linked to contraception outcome
- More feasible with claims data

CONS:
- Needs 2 questions to keep it patient-centered
- Will likely be shortened to "do you need contraception?"

Poll questions

1. Do you think that if providers screen women for their pregnancy intentions or their need for contraception, rates of unintended pregnancy will go down?

a. Yes, definitely
b. Yes, possibly
c. I don't know
d. No, probably not
e. No, definitely not

Poll questions

2. Which is the better access metric:

a. Women age 15-50 screened for their pregnancy intentions
b. Women age 15-50 screened for their need for contraception
c. I think they are equally good
d. I think neither will help us with access

Poll questions

3. Would you be willing to test one or both of these metrics at your clinic?

a. Yes, I want to test the pregnancy intention metric
b. Yes, I want to test the need for contraception metric
c. Yes, I want to compare both metrics so that we can see how the results differ
d. No, I don't want to test either metric

Acknowledgments

SRH Project Founding Advisor

- **Diana Taylor, RNP, PhD, FAAN**, Advancing New Standards in Reproductive Health Program, UCSF

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