The New National Quality Forum (NQF)
Contraceptive Care Measures Through
A Reproductive Justice Lens

Donna Burkett, MD
Maura Graff, MPH
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Planned Parenthood of Northern New England (PPNNE)

Mission Statement

To provide, promote, and protect access to reproductive health care and sexuality education so that all people can make voluntary choices about their reproductive and sexual health.
Who We Are

- Donna Burkett, MD
  Family Physician, Medical Director, PPNNE

- Maura Graff, MPH
  Director of Population Health, PPNNE
Presentation Objectives

• Introduce the new OPA/NQF contraceptive care measures, including history and development.

• Provide overview of reproductive justice and community response to the new measures.

• Provide illustrative examples of how the new measures can be used by medical practices and for state initiatives.
THE NEW NATIONAL QUALITY FORUM (NQF) CONTRACEPTIVE CARE MEASURES
The New NQF
Contraceptive Care Measures

ALL WOMEN

Most & Moderately Effective Methods: The percentage of women aged 15-44 years at risk of unintended pregnancy that is provided a most effective (sterilization, implants, intrauterine devices or systems (IUD/IUS)) or moderately effective (injectables, oral pills, patch, ring, or diaphragm) contraceptive method. (NQF #2903)

Access to LARC: The percentage of women aged 15-44 years at risk of unintended pregnancy that is provided a long-acting reversible contraceptive (LARC) method (implants or IUD/IUS). (NQF #2904)
POSTPARTUM WOMEN

Postpartum Most & Moderately Effective Methods: Among women aged 15-44 years who had a live birth, the percentage that is provided a most effective (sterilization, implants, IUD/IUS) or moderately effective (injectables, oral pills, patch, ring, or diaphragm) contraceptive method within 3 and 60 days of delivery. AND

Postpartum Access to LARC: Among women aged 15-44 years who had a live birth, the percentage that is provided a LARC method (implants or IUD/IUS) within 3 and 60 days of delivery. (NQF #2902)
Across northern New England, nearly half of pregnancies are unintended.

VT = 46%

NH = 43%

ME = 48%

(USA = 45%)

Many unintended pregnancies are welcome, and result in happy, healthy mothers & babies.

Increase percent of pregnancies that are planned among women ages 15-44 to 56 percent.

“Unintended pregnancies are associated with many negative health and economic consequences.”

Source: Healthy People 2020: www.healthypeople.gov/2020
Equitable access to the full range of birth control options is critical for:

• Preventing unintended pregnancy
• Improving health and well-being
• Building pathways to opportunity
LARC Is Safe, Easy To Use, 99% Effective

ACCIDENTAL PREGNANCIES OUT OF 1,000 WOMEN

the PILL

the IUD

LARC Continuation Rates Are the Highest of All Reversible Methods

Barriers to LARC Access & Use

- Misinformation
- Expensive
- Multiple Patient Visits
- Stocking Barriers
- Provider Time
- Low Reimbursement
- Bad History
- Provider Risk
National Quality Forum (NQF)  
Contraceptive Care Measures

- NQF: A non-profit, nonpartisan, membership-based organization that improves healthcare by approving measures and standards for care.

- November 2016: NQF endorsed 4 contraceptive care measures developed by the Office of Population Affairs (OPA).

- Measures designed to assess contraceptive access to the most effective and moderately effective methods of contraception.
History & Development

• Title X/OPA has long had a contraceptive measure and required reporting of this by grantees
  – “beginning method”
  – “end method”

• Reported annually on FPAR

• No claims data
PPFA data

- Planned Parenthood of America (PPFA) in 2014
  - 66 independently incorporated affiliates,
  - 700 health centers in the United States,
  - 2.7 million patients.

- In August 2012, PPFA
  - Clinical Quality Improvement (CQI) Department
    - a set of core reports were built as key measures of quality of care and health outcomes including use of contraception services.
    - Nearly 70% of the affiliates participation in key clinical measures as well as technical assistance for quality improvement activities.

  - The contraceptive measures were further developed in that setting with Title X historical data as backdrop
OPA engaged many partners in development of a set of Measures

- U.S. Office of Population Affairs*
- U.S. Centers for Disease Control and Prevention
- U.S. Center for Medicaid and CHIP Services
- Planned Parenthood Federation of America
- Far Harbor LLC
- Iowa Department of Public Health and Iowa Medicaid Enterprise
- Wisconsin Department of Health
- Illinois Medicaid
- National Contraceptive Quality Measures Workgroup

*NQF Measure Steward
Open Commentary/Feedback period

- 23 comments in favor, of both regular and postpartum moderately and highly effective methods
  - but highlighted the importance of ensuring that women are not coerced into using contraceptives and the need for a women-reported contraceptive access measure.

- LARC Access Measure: 24 comments
  - Concerns:
    - some insurers and health systems restrict access to LARC.
    - different skills between IUD and Implant
    - agreed and disagreed that this is a measure of access;
    - may be misinterpreted and encourage providers to provide LARCs without appropriate counseling.
    - “potential to encourage coercion, which remains an ongoing reality for many, including low-income women, women of color, young women, immigrant women, LGBT people, and incarcerated women. We request that this measure 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 health care system. We understand that OPA is developing such a measure and encourage its rapid completion and submission for endorsement. We recommend that proposed measure #2904 be held back until the measure of the experience of receiving contraceptive care is in place.”
REPRODUCTIVE JUSTICE
Long-Acting Reversible Contraception
Statement of Principles
(Nov 2016)

“We strongly support the inclusion of LARCs as part of a well-balanced mix of options.... We reject efforts to direct women toward any particular method and caution providers and public health officials against making assumptions based on race, ethnicity, age, ability, economic status, sexual orientation, or gender identity and expression.”

Reproductive Justice Framework

Reproductive Health

- Emphasizes necessary sexual & reproductive health services, including STI prevention and treatment, counseling, cancer prevention and treatment, contraception, abortion, sexual education, etc.

Reproductive Rights

- Emphasizes gaining constitutionally framed legal protections for those services.

Reproductive Justice

- Stipulates that reproductive oppression is the result of the intersection of multiple oppressions and cannot be alleviated without strategies to address them all.

Source: PPFA
Reproductive Justice

- Not a synonym for pro-choice, reproductive rights, or abortion.
- Reproductive justice focuses on ACCESS - a person does not have autonomy of their body without access.
- Led by women of color and specifically supports the leadership of marginalized communities.
- Rooted in the recognition of the histories of reproductive oppression and abuse in communities of color.

Reproductive Justice origin and definition taken from Herstory of Reproductive Justice, from http://sistersong.net/reproductive-justice/

Image from becauseiamawoman.tumblr.com
“Reproductive justice will be achieved when all people have the economic, social, and political power and resources to make healthy decisions about their bodies, sexuality and reproduction for themselves, their families and their communities in all areas of their lives.”

– Forward Together
www.forwardtogether.org
History of Coercion and Forced Sterilization

Throughout history, birth control has been used to coercively control childbearing, particularly among women of color, Indigenous women, low-income women, and women with disabilities and mental illness.

History of Coercion and Forced Sterilization

Sterilization Abuse—1970s:
• Women of color in the US were routinely sterilized without their consent as part of government programs in the 1970s. In California sterilization of prison inmates was recorded as recently as 2013.

Norplant—1990s:
• 13 states introduced bills to provide women receiving welfare received cash “bonuses” for choosing Norplant
• Judges in at least 6 states made Norplant insertion a condition of a reduced sentence for a crime
• Removal was difficult to do and hard to access.

Source: Gold 2016
History of Coercion and Forced Sterilization

Women of color are more likely to be report being dissatisfied with their family planning provider.

Women of color and low-income women are more likely to report being pressured to:

- Use a birth control method
- Limit their family size

Institutional Contraceptive Coercion

When pressure to use birth control is applied intentionally - or unintentionally - by those perceived to be in positions of power. For example by:

• Leaders or public and private institutions, such as policymakers, insurers, state entities or efforts, judges, correctional facilities, project or research administrators, etc.

• Caregivers working directly with patients/clients, such as providers, social workers, case managers, counselors, teachers, researchers, etc.
Let’s Be Mindful

• A history of coercion understandably results in distrust of health care providers and contraception.

• Efforts to expand access to family planning should be mindful of and avoid the potential for contraceptive coercion.

• A patient-centered approach to “shared decision making” is critical for prioritizing patient need and preference and preventing coercion.

NQF Contraceptive Care Measures: Moderately and Highly Effective Method

• No specific benchmark
• (OPA) does not expect it to reach 100%,
  – informed decisions to choose methods in the lower tier of efficacy
  • even when offered the full range of methods and
  • all logistical or financial barriers to access are removed.
How should the measure be used, per OPA

• The *Contraceptive Care — Access to LARC* measure should not be used to encourage high rates of use as this may lead to coercive practices. This is especially important given the historical context of coercive practices related to contraception.

• For the same reason, it is **not appropriate to use the *Contraceptive Care — Access to LARC* measure in a pay-for-performance context.**
Future Complementary Measures

• OPA recently funded a three-year project to develop
  – a patient-reported outcome performance measure
    • the need for validated measures of client experience with contraceptive services
    • This patient-reported measure will complement the contraceptive care measures.
PUTTING CONTRACEPTIVE CARE MEASURES TO USE: A PRACTICE SETTING EXAMPLE

PLANNED PARENTHOOD OF NORTHERN NEW ENGLAND
How can PPNNE address inequality in reproductive health care?
PPNNE
Shared Decision Making (SDM) in Family Planning

• SDM improves outcomes
• Women want SDM in contraception counseling
• Establish rapport
• Elicit patient perspective during visit
PPNNE
Moving toward
“10 Best Practices in Contraceptive Counseling”

• Evidence-based
• Simplifies choices
• Respects and supports patient in their choice
• Engages patient in management of method shortcomings
PPNNE
IUDs and Implant Access

• Reduce financial barriers.
• Foster shared decision-making:
  – Effectiveness is not necessarily most important to the patient.
  – Control or safety may be more important.
• Respect and support contraceptive choice.
• Make removal readily available.
PPNNE
COMMUNITY PARTNERSHIPS

• Collaborate with broad range of partners to ensure equitable access to family planning.

• Help partners support their patients/clients in making healthy, informed, autonomous decisions about their sexual and reproductive lives.
WHAT DOES THIS LOOK LIKE?
Health Center - Plan

**BMI**

The percentage of members 18-74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year.

- Health Center: 99.44%
- Choice Services: 94.6%
- NCQA 50th percentile: 72%

**Cervical Cancer Screening**

The percentage of unduplicated female clients 18-74 years of age who had at least one visit during the measurement year.

- Health Center: 57.5%
- Choice Services: 52.2%
- NCQA 50th percentile: 64%

**Contraception**

% of unintended pregnancies who adopted approved contraceptive methods.

- Health Center: 56.88%
- Choice Services: 69.49%
- NCQA 50th percentile: 58%

**Chlamydia Screening**

The percentage of unduplicated female clients 16-24 who were identified as sexually active and had at least one test for Chlamydia during the treatment year.

- Health Center: 68.88%
- Choice Services: 69.49%
- NCQA 50th percentile: 58%

**Smoking Cessation**

The percentage of members 18 years of age and older who are current smokers or tobacco users who discussed or were provided cessation methods or strategies during the measurement year.

- Health Center: 65.67%
- Choice Services: 86.49%
- NCQA 50th percentile: 77%
Health Center – PDSA Outcome

Chlamydia Screening NQF

<table>
<thead>
<tr>
<th>Year</th>
<th>2016 Q1</th>
<th>2016 Q2</th>
<th>2016 Q3</th>
<th>2016 Q4</th>
<th>2017 Q1</th>
<th>2017 Q2</th>
<th>2017 Q3</th>
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<tbody>
<tr>
<td>Score</td>
<td>68.31</td>
<td>73.76</td>
<td>69.44</td>
<td>73.99</td>
<td>80.17</td>
<td>78.9</td>
<td>80.11</td>
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</tbody>
</table>
One LARC Enthusiast’s Path
Region 1 Effective or Highly Effective Method Use, 2012

- Region I: 63%
- TH: 44%
- PPSNE: 50%
- ABCD: 62%
- RI: 63%
- HQ: 64%
- FPAM: 67%
- HI: 68%
- NH-DHHS: 76%
- NH - PPNE: 77%
- PPLM: 78%
- VT: 78%
Overall PPNNE LARC rate

21.28%
Q2 2016
Health Center A, LARC Rate

32.38%
Q2 2016
Health Center B, LARC Rate

Q2 2016

16.39%
Barriers to LARC Access & Use

- Misinformation
- Expensive
- Multiple Patient Visits
- Stocking Barriers
- Provider Time
- Low Reimbursement
- Bad History
- Provider Risk

Planned Parenthood of Northern New England
Health Center A, update

![Graph showing the percentage over time from Nov-16 to Oct-17. The graph indicates a slight increase in percentage from 17.88% in Nov-16 to 20.72% in Oct-17.](image-url)
LARC Access Success, HC B

• Confidence that the trend will continue to improve

• Systematic removal of barriers
  – “Team-Centered Patient Care” is just now happening in Health Center B

• Acknowledge that not all populations and therefore HCs will be the same
  – Eg. High proportion of opiate dependent patients in HC B
    • May be more distrustful of HC providers and therefore LARC
PUTTING CONTRACEPTIVE CARE MEASURES TO USE: EXAMPLE OF POTENTIAL STATE APPLICATION

VERMONT BLUEPRINT FOR HEALTH’S WOMEN’S HEALTH INITIATIVE
VT Blueprint for Health’s Women’s Health Initiative (WHI)

• WHI launched in 2016 by Blueprint for Health (Initiative of VT’s Agency of Human Services, Dept of VT Health Access).

• WHI “helps ensure that women’s health providers, Patient Centered Medical Homes, and community partners have the resources they need to help women be well, avoid unintended pregnancies, and build thriving families.”

Source: Blueprint for Health: http://blueprintforhealth.vermont.gov
Women’s Health Initiative (WHI)

Depends on participation from and partnerships between medical practices and community organizations.

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<thead>
<tr>
<th>MEDICAL PRACTICES</th>
<th>COMMUNITY ORGANIZATIONS</th>
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<tbody>
<tr>
<td>Offer enhanced psychosocial care (SBIRT) with embedded social worker.</td>
<td>Offer family planning information to patients/clients.</td>
</tr>
<tr>
<td>Strengthen referral networks.</td>
<td>Offer family planning referrals.</td>
</tr>
<tr>
<td>See incoming referrals within 1 week.</td>
<td>Strengthen referral networks.</td>
</tr>
<tr>
<td>Provide same-day LARC access.</td>
<td></td>
</tr>
</tbody>
</table>

Source: Blueprint for Health: http://blueprintforhealth.vermont.gov
PPNNE WHI Health Center Implementation

• PPNNE has been a WHI partner since the beginning.

• Currently 4 PPNNE health centers receive up-front capacity payment, PMPM ($1.25), and embedded part-time social workers.

• PPNNE offers comprehensive family planning counseling, and full range of birth control, including same-day LARC access.

• Staff offer enhanced psychosocial care for well-person visits, including SBIRT.

• Data captured in EHR (PHQ2&9, AUDIT, DAST, other).

• Social worker receives warm handoffs, provides brief intervention, referral to treatment, follow up care.
**Potential Application**

NQF Contraceptive Care Measures for WHI Evaluation

• Potential use of the contraceptive care measures NQF #2903 and #2902 (percentage of all women and postpartum women ages 15-44 provided with a most or moderately effective contraceptive method).

• Measures could be assessed at the community level and compared to the state (or other) average(s) to identify and work with service areas that have limited access to the full range of contraceptives.
Key Takeaways

Nearly half of pregnancies in NH and VT are unintended, and can increase health risks for mothers and babies.

Ensuring equitable access to the full range of birth control options is critical for health and well-being.

Designed by OPA, new NQF contraceptive care measures were released in 2016.

NQF contraceptive care measures should drive access, not contraceptive coercion.