November 14, 2011, 1:00-2:00 pm EDT

Participants

Evaluators: Ruth Eudy (AR): Candace King and Jeff Roth (FL); Kathleen Adams (GA); Ginny Zawistowski (MN); Dave Murday (SC); Kristin Christensen (TX)

State Staff: Regina Wiggins (FL); Regina Williams (LA); Andrea Phillips and Marcia Swartz (NC); Margaret Major (TN); Alex Melis and Laurie Vanhoose (TX)

Other: Adam Sonfield (Guttmacher Institute), Julie DeClerque and Ellen Shanahan (Sheps Center)

MINUTES

Approval of Minutes: Minutes of the October meeting were reviewed, and approved with clarification re: OPA/CDC evaluation indicator updates, and may be posted on public side of the web page.

Further Discussion of Presentations from October Call

Jeff reported that in Florida, data show that women who are parity 0 are at higher risk of having PTB, so he strongly urges that these women are included in any comparisons of participants and non-participants.

Have other states started focusing services on higher-risk groups similar to efforts in Georgia? Ruth reported that MS folks presented at APHA on a post-partum case management program for Medicaid moms that includes FP and reproductive life planning (the *DIME and MIME* projects). Colorado may have started working toward a similar plan, and Kathleen may have an update at our next meeting about other projects she has heard about. Jeff highlighted that the motivation of most FP Waiver evaluations is broad-based and focused at the population-level (as opposed to tracking individual outcomes). Future evaluations may be more finely tuned on sub-populations and likely to be undertaken by University colleagues assessing effects on birth outcomes and health benefits. For example, Georgia (Emory) is investigating primary referrals as part of parallel benefits of enrollment, and whether they result in increased access (beyond cervical cancer screening and breast exams).

Discussion about other related work revising FP/Medicaid FP Waiver evaluation indicators

We reviewed the summary from last month's minutes, covering OPA and CDC-P work on revising FP program guidelines including evaluation indicators that would be tracked over time. (As a housekeeping item, we clarified that the summary in last month's minutes should be listed as an addendum as they were not formally discussed during the call last month).

There are two separate but related efforts underway relevant to work we are doing on tracking indicators of public FP services and users. We clarified that the two efforts are:

1. OPA through its Office of Family Planning (led by Susan Muscosky) to revise Title X standards of care including FPAR data and performance indicators; and
2. CDC through its Div of Repro Health (led by Lorrie Gavin) to revise (national) FP Program Guidelines.

While overall effort is mostly reviewing content and infrastructure of clinical programs, one area includes indicators to track progress, both process and outcome/impact. This is the topic of one of their six workgroups, and is called *Quality Assurance and Quality Improvement*. We will try and get more details about their work and the indicators they are considering for reporting.

Several questions arose relating to extent of coordination between CMS and these OPA/CDC-P efforts:
Since CMS has moved away from requiring calculation and evidence of budget neutrality, then going forward, what indicators are they going to be using to measure progress?
Does CMS think that some of the clinical indicators OPA is looking at might also be useful to CMS?

The group discussed reactions to efforts: one big question being, what about outcomes? Could we recruit anyone from OPA or RTI re: sharing some of their details on indicators. Maybe on the 12th December?

Questions that have been raised on Final measures for our Clinical Indicators:
What is the best/most reasonable/ feasible number of months to "bracket" for individual year-to-year participation rates?

- SC started using 9 -15 months, after which they searched for another annual visit. Do others have good measures they like for continuation rates and "clinical care"?

- Ruth mentioned they are linking women longitudinally to do survival analysis. They also had the same question, wondering whether there is a standard definition or expected periodicity (i.e., 9-15 months).

- Adam: better to get at more consistent contraceptive use, and gaps coverage, rather than simply periodicity of visits (months of continuous coverage).

- CA looked at a12-month supply "frame" and a 3-month supply frame, and if the difference in time frame had any effect on resultant visits. Is it a useful measure?

Is it better to refine, or better to drop this indicator? If a key component of a FP program is that where women are eligible for two years (as in FL) to have improved birth spacing…we don't really strongly incentivize women to participate for a full two-year period. What is the best measure to capture effective service? Measure of program success?

- Guttmacher has suggested using "% women using effective contraception".

Is there any way to define effective contraception?

- Dave found one measure with long list and wide range of methods…
- Is it simply LARCs?
- PA divides use into 4 categories: abstinence, non-use, more effective (hormonal, IUDs and sterilization), and less effective (everything else).
- CA has 4 tiers (I: implants and sterilization; II: hormonal; III: condoms; IV: Other).
- Case to be made between LARCs and patch and rings in everyday effectiveness, and then between hormonals and condom group… another big gap. If one focuses only on top tiers, the numbers are small and do not necessarily focus on most often provided program services.

. Manufacturers have to get FDA approval and establish level of effectiveness in population, with product packaging that was produced "scientifically" to bring it to market. Typical and perfect use rates terminology gets around those method claims.

How to frame this? Instead of solving the effective vs not-effective issue… for program evaluation we'd want more users to move generally toward Tier I and II groups… another way to look at it is to collapse into an effectiveness index taking typical use failure rates and weight according to how many users there are in the program, and use these results.

We will continue this important topic next call, and will include discussion of fertility outcomes. Which ones will we be using taking into account many states' pending decisions about most useful activities going forward for both SPA- and Waiver-delineated programs. For example with selected clinical outcomes like PTB: which is best to use, <37 weeks or <32 weeks? Or is it (even) appropriate to expect impact on VLBW and PTB given other risk factors at play? Isn't a key factor of family planning the healthy spacing and intentionality of the pregnancy that subsequently increases odds of having term delivery at normal weight?

The next call will be on Monday, December 12th, 1 pm EST (noon CST) using the regular telephone number: (919) 962-2740.