

JSI RESEARCH AND TRAINING INST

Moderator: Katie Saul
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Operator: This is Conference #64764286.

Operator: Good afternoon. My name is (Robbie) and I will be your conference operator today. At this time I would like to welcome everyone to the Performance Measurement Learning Collaborative Webinar.

All lines have been placed on mute to prevent any background noise. After the speaker's remarks there will be a question and answer session. If you would like to ask a question during this time simply press star followed by the number one on your telephone keypad.

If you would like to withdraw your question press the pound key. Thank you. Katie Saul, you may begin your conference.

Katie Saul: Great. Thanks (Robbie). Hi everybody. Thanks for joining us. This is Katie Saul from The Family Planning National Training Center for Quality Assurance, Quality Improvement, and Evaluation.

Today we're going to talk a little bit about the performance measurement learning collaborative that just concluded about a month ago and we're very eager to share both the results and some lessons learned from this experience as well as some of the resources that have come out of that process.

And just to know before we get too much further I'm joined by my colleagues at the training center both Katie DeAngelis here as well as Jennifer Kawatu

who is also on the phone. Jennifer is going to present as well and then we have two presenters from -- two of our teams actually today at the -- who will present at the end of the presentation.

So this is just a brief outline of what we hope to cover. We're going to talk a little bit about the change package and the process of the learning collaborative as well as the objectives.

We're going to go through the results in some of the lessons learned. As I mentioned, we're going to hear from two PMLC teams and then talk a little bit about the resources.

And as (Robbie) said at the start, I think we're going to try and hold all the questions until the end today. We have a bit of material that get through but please feel free to chat in your question on the Webinar at any point or you can queue up with (Robbie) on the phone as well.

OK. So I think for those of you who are Title X, these performance measures are probably pretty familiar with you right now or by now. Our learning collaborative focused on contraceptive, increasing contraceptive access. So we looked at the percentage of women aged 15 to 44 at risk of unintended pregnancy who adopt or continue use of the most effective methods as well as the percentage of women, 15 to 44 who adopt or continues of LARC.

And just a quick note about this, as some of you know these are under review by NQF right now and look like they're going to be finalized and indorsed shortly if not already I think they're still in public comment.

But a quick note about the second -- the second one, the sub measure around (LARK) and we might touch on this a couple of more times throughout the presentation but just want to make it very clear that we didn't set any benchmark through this and that really this LARC measures reviews in this learning collaborative as a way to monitor access to LARC.

We didn't give anyone a goal. This was really about making steps to make long acting reversible methods of contraceptive more accessible to patients.

OK. So the learning collaborative used a change package and the change package is an evidence-based set of best practices that served as, kind of, a guiding document for the teams. It included a strategy of best practices and strategies for QI processes. And the best practices we had four of them. They included ensuring access to the broad range of contraceptive methods, FDA approved methods.

The second one was to support women through patient centered counseling and reproductive life planning, supporting same day delivery of all contraceptive methods and utilizing diverse payment options to reduce cost as a barrier.

And we'll talk a little bit more about these and as Jennifer discusses some of the results and lessons learned you'll hear a little bit more about how this played out but just for you all to know that there was this guiding document that we actually structured the learning collaborative around and I'll talk about the structure in just a moment.

And the objectives of the learning collaborative were to support grantees to facilitate achievement of their performance on -- sorry, their performance goals on two contraceptive measures to identify the lessons learned to develop a final change package for dissemination in the Title X community and beyond and to increase grantee staff capacity to conduct QI.

And then we have kind of two sub objectives which were to foster collaboration among grantees and service side and to identify ways to better support grantees in their QI efforts. And we'll talk about the first objective and this was to support grantees to facilitate achievement of their performance goals.

We had 12 teams participate in this initiative and these are actually the grantees -- this is the list of the grantees and each of the grantees chose one

service side in their network to work with and we did this because we felt like it would -- it would be a little bit easier to focus specifically on one side although during the learning collaborative several of the grantees were already replicating some of the activities and strategies with additional sites.

But for the purposes of the collaborative we just focused on the one -- the one site throughout. So this is a high-level look at the data. You'll see and I'll go into a little bit more detail on these in just a moment but overall for the most and moderately effective methods we saw an increase from 70.3 percent to 78.5 percent and for LARC we saw an increase from 9.6 to 12.9 percent.

OK. So for the most and moderately effective methods, nine of the 12 teams improved on this measure and this is just a rough estimate based on average across the site. The group average percentage increase from 70.3 in October to 78.5 in May and in 2013 which is kind of the most recent national data that we had at the time, the medium percentage across all Title X grantees was 74.9 percent.

So we actually went from below the national median to above the national median. And then for LARC nine of the teams improved on the LARC measure. The cohort average percentage increased from 9.6 in October to 12.9 percent in May. And again we went from below the national median to above the national median.

So a little bit about the learning collaborative process and how this worked before we dig, you know, deeper into some of the results and what we learned, the learning collaborative is based on the breakthrough series model created by the Institute for Healthcare Improvement or IHI and it started with an initial face-to-face meeting with the teams in November.

And at that meeting the teams came together to identify some areas that they wanted to improve on. They did some brand storming and planning and we also just, kind of, laid the ground work on QI for all the participants so that we all have a shared understanding of what plan do study cycles were and some

of the QI terminology that we'd be using throughout the learning collaborative.

The rest of the learning collaborative was held online through monthly learning sessions and during those sessions we talked about the best practices included in the change package.

We had expert presentations and then we tried to really dedicate most of the time on the sessions to hear from the participants and to learn more about, you know, what strategies they were implementing how they were making changes and allowing for some discussion among the teams to talk about challenges that were facing and just really works through some of these changes together.

So you'll see in between these learning sessions are the PDSA cycles and the action periods and then at the end in June we held a face-to-face meeting again which -- during which the teams conducted presentations and we talked a little bit more about the model and the best practices as well as the change package and made some changes to the change package as well. So these are couple of the tools that we used during the learning collaborative.

You'll see on top is the PMLC improvement plan and you'll see in the left column this is broken down by the best practices and across the top is all of the elements of Plan-Do-Study-Act and this is pretty detailed but for a reason we really designed this as a tool that would really help the teams kind of think through all of the elements that are involved in QI and to take a very, sort of, thoughtful and purposeful approach to change and this plan was updated monthly by the teams according to, you know, what they had been implementing and new changes that they added and then below you'll see is the monthly contraceptive access performance report.

And the only data reporting that we did on a monthly basis was on those two performance measures. So the teams each sent these into us on a monthly basis and we kept track and seeing these improvement plans was also a way for us as facilitators to, kind of, know where everyone was and what they were

doing so that when we had the online sessions we could sort of connect the dots for everybody.

Now this is a very busy slide and it's more just meant to be a visual of, kind of, the volume of change initiatives or change efforts by best practice and you'll see that for best practices one in two we had eight teams focused on those.

Best Practice 3 which was developing systems for same day provision of methods was actually the most popular or the area where most of the teams need for improvement in 11 of the 12 teams conducted at least one PDSA in this area and then the fourth was around payment options which was a little bit less of a need among the participating teams.

OK. So as I said, we're going to go into a little more detail on each of the best practices, the lessons learned and some of the results and I'm going to hand it over to Jennifer to do this part.

(Jennifer Kuwatu): All right. Yes. So I'm going to talk just a little bit about the lessons learned and results for each of the best practices and then, you know, obviously there is a lot here and the teams did a lot of work. So if there is anything that you want to talk about in more detail we can do that at the end.

We can have a discussion about any of details at the end, but we'll start with the best practice one which is just the full range of all FDA approved methods knowing that you have all methods stocked on site and available immediately is a real key to access for patient.

So by the end of the learning collaborative, all teams reported stocking the pill, the injection, implant and IUD by the end. In fact the method that was stocked the least was actually the patch which was a little bit of a surprise but we were successful and increasing the number and variety of methods to be stocked and some that didn't have any LARC methods on site by the end did and then others added specific methods.

They were quite successful in meeting their goals there and some of the lessons learned are not surprising, but that, you know, obviously the implant and IUD and the patch actually and for that matter are expensive and can be challenging to stock but that little cost will later increase the site's capacity to stock IUDs and that there are, you know, ways to do it.

So let's talk about challenges, the stock out and with monitoring inventory and that's an area that's kind of ongoing and that I think teams would like to do some additional training and get some additional resources on they're interested in.

That's all the things, new methods to forecast and track supplies. So actually I was going to just make a plug for any of you who have tools or resources or approaches that you take to doing this to forecasting monitoring and tracking supplies that sharing those on the QI community of practice would be great because I think that's an area that a lot of grantee struggle with and, you know, would love to talk to the peers more about.

Katie Saul: And I'll just jump in and say we'll talk about a little bit about some of these tools and where you can find them at the end as well.

(Jennifer Kuwatu): Great. Yes. Thanks Katie. And then the second best practice was to access for reproductive or pregnancy attention and to support patient through evidence informed and patient centered counseling that enables our patients to choose four range of method that they don't desire pregnancy presently.

And so most of the teams in the learning collaborative implemented at least one activity or one PDSA around this area. We had both Christine Dehlendorf talk about patient center counseling and Patty Casen talk about assessing pregnancy intention.

And so a lot of teams worked on improving their documentation of pregnancy intention assessment or reproductive life planning. The two are, kind of, interchangeable but I know that some of the teams found that talk about reproductive life planning and talking about the idea of planning with

something that were, kind of, getting it away from and talking more about assessment of pregnancy intention, but a lot of this centered around documentation and, you know, that is really, kind of a challenges documentation tracking through EHRs in particular, but there was an increased awareness I think and increased emphasis on doing patient centers counseling and taking a shared decision making approach, the contraceptive counseling.

So some of the lessons learned included again that pregnancy intention versus planning was a distinction that resonated. The teams, kind of, learned and increased their ability to increase, to integrate effectiveness into patient center counseling and not to focus exclusively on effectiveness but one of many criteria in contraceptives counseling.

And then one of the other lessons learned I guess is just that tracking and documentation is challenging and that potential bias and counseling is very hard to document.

And so hard to identify but teams are exploring different ways to track provider prescribing habits that maybe away to identify potential bias that might be happening. Yes. So I guess we'll go on to best practice free which is same as a provision.

So enabling systems for the provision of all contraceptive method at all visit types that enabled patients including those interested in LARC to leave the visit with the method of choice. It's what the patient wants that day.

You know as we know the research shows that providing immediate availability of all methods is really a key to increase and just full access and asking patients to come back for multiple visits is a real barrier to care. So there is a lot of focus on this best practice and I think there was a lot of change in this on this best practice because there was -- that was the most change to make.

This is a little bit of a new change in practice and so, you know, although challenging it is definitely doable and there was a lot of great work and great improvement in this area.

So most of the teams worked on this and some of the things that they found is that, you know, tracking same visit placement is a challenge. Surprisingly, it seems like it should be a no brainer. Seems like, it would be simple. This (come the) same day, it's not that's on the same day, isn't that easy but it's actually surprisingly not that easy to track at least through the EHR and on the large scale. So that's definitely a lesson learned.

I think that we found that using the language of Quick Start provision or a same visit provision hope to clarify the goal of just, you know, that we're looking to Quick Start. People were looking to provide the method immediately rather than asking pictures to return even if they were asking them to return in the afternoon for instance for, you know, insertion of a LARC or provision of a method, something like that. That still is a barrier for that patient.

And so it's not same day so much as, you know, just providing it within the same visit. If they're there they want a method then just, you know, do it all at once. It's, kind of, a goal for patient-centered care. Some providers definitely remain concerned and there is push back from some providers who are uncomfortable with the new guidelines and this site the national recommendations and national guidelines this is a challenge for some site and some providers and then, you know, that's clearly clinic flow is still challenging.

It isn't easy. You know this can be a big change for site and for clinic flow but that is possible. We definitely heard from providers who hesitated at the beginning or who were nervous about it but once they really got their system going that's their reduction of role and got everything going very efficiently. They were able to do it and found that it actually was not as challenging as they thought it might be.

And then the last of the best practices is utilizing the payment option to reduce cost as a barrier for both the patient and the facility.

Now being Title X, there was a high base line performance from most teams in this area but nevertheless teams work on their reimbursement insurance enrollment contracting improving coding and basic revenue cycle management processes.

So, and just to note that despite the decrease in the data here going from 10 to 9.6 without data there actually was any reduction in providing services regardless of the ability to pay but I think that throughout the process of working through quality improvement processes they, kind of, recognized opportunities for improvement and they may have rated themselves a slightly lower level in terms of their capacity but they did work to improve their systems and successfully did so.

Some of the challenges and lessons learned were just that, you know, they realized that there was a lot of opportunities for improvement. There is a lot of room for improvement in terms of active billing coding and engaging providers in all levels of staff was seen as really critical.

So at the beginning I think there was a lot of concern that they're pretty coverage of same visit LARC was not going, you know, that they weren't going to get reimbursed, but over time and through working on this systems accurate coding and effective billing and their QA processes around coding they realized that it is possible to do this and to get reimbursed for those with coverage.

And that all of these processes and changes in the systems are a way to include access to all methods and (reduce various care) for all of the patients. So I think there were a lot of successes and real (improvement and access to service).

And Katie I think you're going to talk about capacity for QA.

(Katy Theangelist): Right. OK. So as we mentioned at the start of this, one of our objectives was to increase grantee capacity to conduct QI and actually it should be grantee and service side capacity to conduct QI. And both of these groups had different roles. So the service site really is where the changes were happening and being tested and the grantees really took on a very supportive role and it facilitated some of those changes with and for the service site as well.

So we measured quite a few aspects of QI, the first being the team confidence to conduct QI and you'll see that most of the change that we -- that we thought had was around conducting PDSA. So measuring the impact of PDSA, conducting one, scaling up improvement et cetera. You'll see that at the very bottom there was one measure where we did not see improvement and that was around collecting performance data and we think and you'll see this in the next couple of slides that this was likely due to I guess the teams maybe not really knowing what they didn't know.

So we did a baseline assessment at the outset of the PMLC and then an assessment at the very end and I think what folks have done was that they maybe as they've been doing this, some of these things to the extent that or have previously been doing some of these practices to the extent that they were in the PMLC and realized, "Oh, well, maybe we actually weren't as good at this or didn't know as much about this as we thought we did."

So around QI approaches and processes in terms of these they all improved except for two measures. The biggest improvements related to knowledge and understanding of quality and using continuous and methodical QI processes. And again at the bottom, you'll see that viewing mistakes as learning opportunities and having a strong customer focus both decreased and again I think for the same reason of maybe not having a full understanding of what those were at the outset.

And then a note about replication. So as I mentioned earlier several of the grantees had already begun replicating some of these activities and sharing the change package and some of the strategies that the service site was using with other service sites and their networks but at this last face to face meeting in

June it was really a chance for the teams to come together and to talk about ways to spread improvement and to scale up some of these efforts.

So all of the participating teams have plans to replicate this process in one way or another. Three of the grantees have plans to adapt the whole model with their entire network. So they plan on doing either monthly or frequent, kind of, checking in around the change package and really treating this as a training and technical assistance activity.

But most of them will use some kind of combination of technical assistance and existing meetings and conferences and other either existing or new modes of communication to share what was learned.

OK. So we are going to hand it over to Erica Solis. She is from our team from Texas and I'm actually going to let Erica introduce herself and Erica I will advance your slides for you. So if you are there you can take it away.

Erica Solis:

Great. Thank you, Katie. Good afternoon. As Katie said my name is Erica Solis and I'm the Compliance Specialist for the Women's Health and Family Planning Association of Texas.

Thank you for inviting me to speak about our participation in the PMLC. When they finally decide which sub-recipient would take part in the PMLC we took several factors in the consideration who had the capacity to take on the project and did we have buy in from key staff and leadership. After reviewing these criteria we ask Cameron County, Department of Health and Human Services to partner with us.

To give you a little background Cameron County is located in the southern most bottom tip of Texas along the Mexican border. Ninety-five percent of their clients fall at or below 100 percent of FPL and the significant number of their clients are undocumented immigrants and the search do not qualify for many programs. Cameron County has four subrecipient and one NP who rotates between the clinics.

Monday through Thursday she is at different clinic site each day and Fridays are designated as her admin day. Since we would be working closely with Yvette who has an incredibly busy schedule you can see why staff and leadership buy-in was vital. Yvette was very open to the PMLC process and eager to implement the tools and strategies we learned in D.C. So as you can see from measure one, Cameron County started at the baseline of 53 percent and ended at 71 percent for an overall increase of 33 percent.

The largest increase occurred from December to January where they jumped from 51 percent to 70. On the next flight I'll go into further detail regarding what prompted the significant increase. So looking at measure two Cameron County started at a baseline of 4 percent reached the highest 16 percent in February and ended at 5 percent. Previous to the PMLC the only LARC offered by Cameron County was next one on.

One of Cameron county's goals for the PMLC was to ensure that Yvette was trained in IUD insertion so that they could increase the types of LARC being offered. Originally Cameron County was scheduled for latter training in January but it cancelled.

However, we were able to utilize our network to put Yvette in contact with another sub-recipient in the area who is holding training. Yvette was trained in early February and started inserting IUDs immediately.

You'll notice in March there was a sharp decline. This is because we hit a bureaucratic snag. Cameron County has a Health Department and such has many levels of hierarchy after Cameron County began inserting IUDs. It was brought to their attention and that their consent forms did not have language as referenced who was responsible in the event that removal of the device was required for medical reasons.

So then Cameron County had to draft a new consent form which had to be vetted through the legal department. I'm happy to report that by the start of May they were able to implement the updated forms and resume IUD insertion. On the previous slide we saw that measure one there was an

increase from 51 percent to 70 percent between December and January. The largest contributing factor to this was at 100 percent of clinical staff was trained on the Quick Start process.

Training to place in late December and was implemented in January. Cameron County hold a monthly off-staff meeting where training is provided and it's their belief that everyone should participate in training whether or not it directly impacts their position because it creates buy in, gives everyone a better understanding of what the clinic offers and helps each staff member understand. They are important to the success of the clinic.

As you saw on the chart on the previous slide after implementation of Quick Start number stays steady for measure one. So clients are required to fill out a Quick Start form which was a file in the binder for tracking. Staff reported that there were no issues implementing Quick Start and tracking the information for the PMLC allowed staff to see the correlation between implementing Quick Start and the increase in measure one. Cameron County leadership reported the process also helps staff see that a small change can have a big impact.

So next step from Cameron County includes securing additional funding for LARC especially Nexplanon are costly and can take a large portion of an organization's budget. Overall Cameron County reported that they are confident that they can sustain a success of the PMLC and with the help of tools such as the PDFA, look for ways to further increase access. Great.

Thank you, Katie.

Katie Saul: Great. Thanks Erica. So hopefully for all of you out there listening, that gives you a little glimpse into what was happening on the ground and Texas especially was very successful in this initiative and I think Erica's insights as to why the data was up and down in certain areas is like a perfect reflection of the QI process and what we were hoping to achieve.

So thanks Erica for presenting.

We also have a team from North Carolina and so I want to see if Cindy Morgan and Donna Holloman are around.

Cindy Morgan: We're on, Katie.

Katie Saul: Great. OK. I'll advance this slide for you. So just let me know when to -- when to move ahead.

Cindy Morgan: OK. Thank you for asking us to present. My name is Cindy Morgan. I'm the system analyst here at the Health Department and my part in this project was to assist with doing the data analysis portion of the project and I'll let Donna introduce herself.

Donna Holloman: I am Donna Holloman. I'm the Women's Health supervisor here at Johnston County Health Department in North Carolina.

Cindy Morgan: OK. You can advance the slide Katie. OK. So these are our major trends and our beginning baseline for measure one was 72 percent. We did have some ups and downs and some of that was due to provider shortage we know in the month of December. Our final percentage was 79 percent and 75 percent in April.

Our beginning baseline for measure two was 10.8 percent and we showed a gradual increase over the course of the learning collaborative and ended at 17 percent in April. OK. You can advance the slide Katie.

Donna Holloman: OK. So most impactful we felt a lot was purchase them and maintain an inventory of LARC say that patients are able to receive the request of LARC on the same day as the visit. We decided to make this change because their patients were requesting LARC and we did not have women start. We had the XXXX and that the patient return for that appointment and that she did not become pregnant while waiting to come back in.

And making this change it involved educating and convincing our finance director, our local board and we can be some of the need, the effect in this and the long-term business at(LARC and same-day insertion instead of return appointment. We met with our health director who is also a physician that was helpful that she had a medical background.

Our finance director and our provider she discussed the need for maintaining the inventory versus ordering as the patient requested. The data we presented was the calls, the reimbursement rate, the number of LARC inserted the previous year, the effectiveness of them and other information as I requested. So to initiate it we began to monitor our inventory unofficially on a daily basis.

We've got a white board in our clinic and so that all of our staff including our providers anyone that was working at clinic that day were aware of the number of Nexplanons and IUDs and we had it listed by the individual mark.

They were available that day for patients who had appointments for that day or were calling for insertion appointments. So no one didn't have to go to the cabinet account or XXXXX. So we began to monitor our inventory officially weekly. We're reconciling previous number with a number of insertions and number of devices available. We educated their clinical staff on the information we need to reconcile it so that that would be easier to do.

We worked closely with our purchasing agent to know our turnaround time after the requisitions completed and if there was any change in the calls because sometimes our -- the change in the calls this quarterly. So we work closely with her also so that we would know when we needed to order some more.

We also audit and charge billing encounters, paper and electronic and we tracked the payment or denial of the insertions removals and reinsertion so that all available revenue was collected from Medicaid and insurance plans to sustain purchase of more LARCs.

We notified providers and their supervisors when encountered for incomplete or incorrect so that we could collect on those.

Cindy Morgan: OK. So how do we measure our change for the same day insertion, the formula is here on the slide that we measure the number of LARCs and start at the same as a physical or when they come in for Care Act or delivery and then we divided that by the total number of LARCs insertion for each.

And then on the graph the blue bar represents the number of LARCs that were inserted same day. The orange bar represents the total LARCs inserted for the month and the green line represents the percentage of the same day inserts versus the total inserts.

So some of our ups and downs as we implemented change was again provider shortages, also inventory we would run into situation where we didn't have enough inventory of the LARCs that the patient would want. And also we ran into some issues with some of the providers not being comfortable with the...

Donna Holloman: Insertion...

Cindy Morgan: ...insertion and so they, kind of, backed off offering IUDs. So that was some of the challenges that we faced when we were implementing. The overall we started out at 36 percent and we ended at 50 percent. So some of our next steps remaining challenges we'll continue to ask administration and our local board to allocate funds for purchase of LARCs so that we can maintain our inventory so they're available today as a visit.

We'll continue to monitor clinic flows and schedules so that providers continue to have a lot of time for same-day insertion. One of the things we're trying to do is put notes on the appointment, that's in the computer at the patient when they call if they're requesting LARC or if they're requesting to have one removed and another one reinserted so that we have lot of time for that. Another challenge was purchasing a two months supplies end of the physical year.

Again that went back to convincing our finance person that we needed to purchase enough to get us through so that we could still do the same day visits and do the insertion and also challenges justifying to the Finance Department increasing to monthly order so they become more popular.

We're currently ordering in eight different months and we've already realized that that's not enough. So we are going back and gathering out information again to present to them again and see if they'll increase that order.

And we also have provided reproductive life plan and train into all of our providers who have received it so that we could increase their awareness of how to discuss the reproductive methods with the patient.

And another thing is that our the way we're set up is we have several clinics and one building but we're individual as in our family planning clinic and our providers in the other clinics and our primary care clinic and our clinic where all, say, discuss in reproductive life counseling with the patients when they were seen in their or clinic discussion with the mom while she was there.

We also huddle every morning, our clinical staff say that we can't discuss working through that day. So that's our next staff also and of course always staffing and funding our challenges too.

So that's pretty much what we've done with it. We are continuing to carry on with what we've started and monitoring it. I do believe Sydney Atkinson is our grantee person and that she does plan to provide the training with other counties and have asked us about existing with that and we planned to continue on.

I know we've had one day when we inserted six and one day and that was the most we've ever done and that was about a month ago. So it's -- we've been trying to keep doing what we were doing and increase it and become more XX. That's it Katie.

Katie Saul: OK. Thanks Cindy and Donna. You know, I think you all are great example of how a Health Department really took a pretty big, you know, big issue which was inventory and really broke it down to something, kind of, chewable.

So I think your example of using the white board just starting out and keeping track in a really informal and transparent way that involved a lot of staff was, you know, exactly what, you want to do when you started PDSA, and I think you also have made a great example of working with all staff.

So, you know, at a Health Department sometimes things are slow to change, right? And working with the finance department and your medical director and the providers and really getting everyone involved certainly helped you all move things along and you saw a lot of change.

So I'm glad you are able to share your experiences today.

Female: Thank you for that Katie.

Katie Saul: All right. So we just wanted to point out a few related resources before we finish up here. The first is the contraceptive access change package. So we've noted this like few times throughout the presentation and just a few more words about this.

So we developed this. It's evidence based. It's all drawn from the literature and we drafted this at the start of the learning collaborative and as I said it served as a guiding document throughout the process.

Based on the teams' experiences and changes and the evidence where that has happened and just overall feedback from the teams. We've actually updated this and clarified a few things and also included some examples and success stories similar to what you've heard today for each of the best practices to try and sort of illustrate some of these change initiatives. So we are in the process of finalizing this and hope to have this up on fpntc.org hopefully by early next

week. So keep an eye up for that. We will post it and we'll make sure that that is marketed as well.

We also used this contraceptive performance measure calculator and some of you may have seen this before this actually draws from FPAR table 7 and allows you to produce the two performance measures you'll see at the bottom.

So if you see FPAR table 7 and input on the table on top you'll get those percentages that you saw the teams we're reporting on a monthly basis and the feedback from the teams. This was very helpful for us specially helped us ensure that everyone was working with the same data, especially the same denominator.

So this is available as well and it's posted on as part of the family planning dashboard. So if you were at the Title X meeting last year, you would have seen a presentation on this as well but this title -- sorry, the family planning dashboard is a way for you to log in as a grantee or as a service site if you have your grantees pin and to see how you compare across the country with other grantees and networks with Title X for the most and moderately effective measure, for the LARC measure as well as chlamydia.

So if you are grantee and you don't have your grantee specific pin please e-mail us at ntcquality@jsi.com and we will provide that for you. This is based on a pin for each grantee because the data is actually linked to specific grantee.

So it's a -- it's kind of two step process but let us know if you don't have your pin and we would be more than happy to get you access to the dashboard. The dashboard also allows you to enter in the data on a regular basis and you can see over time it produces a run chart for you so you could do a lot of the same data tracking and monitoring that we did in the learning collaborative through this tool as well.

And then we referred a few times to our quality improvement a learning module. This is a five-part series. I think many of you out there have taken

this. We are about to finish this up in the next two weeks or so but for those of you who don't know we just posted module for yesterday. So I think modules, one, two, three have been quite popular and module four is now up.

So we encourage you to take that. And these modules really provide kind of a background of QI and it's sort of a QI 101 but geared towards family planning settings and from what we've heard from our learning collaborative participants as well is that this was really useful and helping establish a common language and just having a general sense of QI methodologies and how this all works as well as some tips and strategies for making change.

And then finally in addition to the change package and the calculator and the dashboard we have list of tools that we use specifically in the learning collaborative which are linked in the change package as well. So we didn't highlight all those as we went through the best practices today but those are integrated into the change package and certainly our helpful if you are interested in undertaking this initiative on your own.

And I think for now that concludes the presentation. I know that we had a few questions coming by chat.

So (Robbie) on the phone I think we'll take that chat questions first and then maybe we'll bounce back to the phone and see if we have anyone in the queue. So one of the first questions was somebody mentioned that they were really interested in the quality improvement plan and the datasheet.

We don't currently have those posted online but we will put those up on spntc.org we're more than happy to share those and that QI plan while the one that we're sharing is geared towards the best practices in this change package you really could use that plan for any QI initiative.

So we encourage you to download that and adapt it. We'll put it up in its excel form so that, you know, you all can tweak it however you like.

We had another question for Erica actually. Erica, I'm not sure if you're still there. Are you still with us?

Erica Solis: I'm still here.

Katie Saul: OK. Great. So we had a question for you, which was, "How did the most and moderately effective methods increase in the absence of a provider with prescriptive authority and then it says how it Quick Start implemented with other provider present?" Can you elaborate on that or sort of put me on the spot here?

Erica Solis: Sure. So I will too. That's my ability to talk about it because Yvette's not on the line, but my understanding is that they instituted protocols which would allow the our XX to do certain types of medication that they're allowed, any type of LARC placement had to be done by Yvette.

So really where you saw an increase was and that patients didn't have to come back the next day. They try to get them or, you know, come back for other appointment and they try to get them on a method as soon as possible and if there was something that Yvette had to do, they rescheduled it for as soon as her availability was open.

Katie Saul: OK. Thank you. And we had another question chatted in which is, "Where are QI modules? Those are on fpntc.org and you can either search for them if you go to the resources tab and I think you can search by topic which would be QI, and you can search by type which is the eLearning course and they should all pop up.

And we've done our best to link to the other modules in the series on each of the individual modules ages, if that makes sense. But if you have any trouble finding them please don't hesitate us again at the training center where ntcquality@jsi.com.

(Robbie) did we have any questions on the phone?

(Robbie): And at this time I'd like to remind everyone if you'd like to ask a question please press star followed by the number one on your telephone keypad. We'll pause for just a moment to compile the Q&A roster.

Again that's star one on your telephone keypad if you would like to ask a question.

Katie Saul: And if anyone has questions beyond the Webinar today we're more than happy to get in touch -- you know, get in touch with us via e-mail. We can chat by e-mail or give us the call and we can certainly talk more about this process and what it all entails.

So I think that's it for today. So thank you everybody for joining us. We have an evaluation that will pop up at the end of this.

We're really interested to hear your thoughts both on the presentation but certainly on this modality. Like, you know, whether the learning collaborative is something that you'd be interested in and just any thoughts that you have on this as a -- as a training method because I think we're looking to hopefully draw in this experience and maybe do few more of these in the future.

So thanks for joining us and hope you all have a good day.

Operator: This concludes today's conference call. You may now disconnect.

END