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Megan: Hello, everyone, and welcome to The Healthy Start and New Recommendations for Proving Quality Family Planning Services webinar. I'm Megan Huebner with the Healthy Start EPIC Center, and I'll be moderating today's webinar. We have approximately 60 minutes set aside, and the webinar is being recorded. The recording along with the transcripts and slides will be posted to the EPIC Center website following the webinar. Before I introduce your great speakers for today, I do have a couple of housekeeping announcements. We really want your participation today, so at any point, if you have questions or comments, please chat them in at the bottom left corner of your screen.

We're only taking questions via the chatbox, but we will be breaking at the end of the presentation to answer those questions. If we don't get to all of them, we will be including them in a Frequently Asked Questions document that we will also post to the EPIC Center website with the webinar material. That website is healthystartepic.org. So now, let me introduce your great speakers for today. First, is Miss Sue Moskosky. She is the acting director of the Office of Population Affairs, which is responsible for the administration of the National Family Titles and Family Planning program. And she's been in leadership at the Office for Population Affairs for over a decade. Recently, she and her team [inaudible 00:01:29] have worked closely with the Center for Disease Control and Prevention, to develop the first evidence based recommendation for family planning, the Quality Family Planning recommendations, which is the focus of today's webinar.

So that leads me to introduce our next speaker, Dr. Lori Gabin. She's currently on detail with the Office of Population Affairs, but most recently, she's worked as a senior Health Scientist with the Center for Disease Control and Prevention. And she has really worked tirelessly along with Susan Moskosky to shepherd through and release the Quality Family Planning Recommendation. But lastly - and I apologize that I do not have this third speaker's picture posted to the site - but your fellow peer, Healthy Start grantee, Miss Faye Johnson, with the Magnolia Project in Northeast, Florida. She's the Project Director there. She's gonna describe her on-the-ground example of how she is using the Quality Family Recommendations in her Healthy Start Program. So we're grateful to have her on the webinar, as well.

Let me give a brief overview of our session objectives for today, which are to review the process that went into providing Quality Family Planning services, the

QFP, discuss some key recommendations from the QFP, and plans to support the implementation of QFP. We did want to get a little bit of background about who is on the webinar today, so we have a poll posted right now. If you'll click in on the radio buttons, either a yes or no, have you heard about the Quality Family Planning Recommendations? So go ahead and on your computer, on the webinar screen, if you click in a yes or no if you've heard about the QFP. And I think folks are weighing in right now.

Let's see, it looks like a few of you have heard. But the majority, almost 80% of you, have not. So that's really helpful as our speakers can give you a great deal more information on that. Now, the second question we want to know is if you are using the QFP. I know quite a few of you said you weren't familiar with it. I'd be curious to know. Okay, it looks like we've weighed in. Let's see, it looks like many of you said that you are, but a majority said you're not. So again, that's very helpful for us as we move this webinar forward. Sue and Lory, I think I'll turn it over to you right now. Now knowing about who you have on the webinar, I'll turn it over to you to continue this presentation.

Sue: Thanks, Megan. This is Sue Moskosky, and I want to first thank you all for joining the webinar today. Lori and I have been on the road over the last year, making sure that we make people aware of these new recommendations. So it sounds like this will be new information for you all. We were hoping that it wouldn't be a repeat to everybody that already knew about them, so it sounds like it's gonna be new news to many of you all. So just by way of background, every year in the United States, more than half of pregnancies are unintended, which is more than three million pregnancies every year, more than 700,000 teens become pregnant, and 1 in 8 pregnancies results in a pre-term birth, and 1.5 million married women are infertile.

That's some background in terms of the reproductive health burden in the United States, and one of the reasons why we developed these recommendations. To talk a little bit about why this is important to you all as Healthy Start grantees, we know that you as Healthy Start grantees are working to prevent infant mortality, as well as low birth weight, and pre-term birth, as well as maternal morbidity and mortality. And one of the keys to doing that is to improve women's health, both before and during, as well as after pregnancies. Part of that is making sure that

people are aware of the importance in [inaudible 00:05:49], time, and space their pregnancies appropriately.

You can see from this slide that in the United States today, about 35% of pregnancies have an inner pregnancy interval that's less than 18 months, which is not optimal in terms of having a healthy pregnancy and a healthy birth. Also, too long of a pregnancy interval, which would be more than 60 months between pregnancies, about half of all pregnancies that are not adhering to birth interval spacing that would be ideal in terms of presenting some of those unfortunate morbidities that I described previously. The Quality Family Planning Recommendations were published in April of 2014 as an NMWR, which is a CDC publication. It came out as one of their recommendations and reports on April 25. The QFP, as we're calling it, is one years old - we actually had a birthday party for it a couple of weeks ago - and it includes recommendations for how to provide family planning in an evidence based manner.

So we thought to make these as evidence based as possible. Although the evidence in some cases was quite thin, we did the best we could in terms of actually basing this on the best possible evidence out there. The reason that we developed, and the purpose of the Quality Family Planning Recommendations is to define what services should be offered as part of a family planning visit, and to describe how to do that. The support consists of application of quality care across different types of settings and provider types. So we weren't looking for these to be applicable just in the Family Planning Clinic, we were looking at them as a way to deliver Quality Family Planning services across any kind of provider settings, whether it's primary care, or private physician, or what have you.

And then finally, we were looking to translate research into practice so that the most evidence based approaches would be used in providing care. As I mentioned previously, the intended audience was all providers of Family Planning services, including primary care, as well as Title Ten. Which of course, Title Ten Program is the program that this office is responsible for directly. They were put out as a CDC and NWR, not as an OPA publication. So while it was a joint project, it was actually put out in a way that we hoped would get the broadest possible uptake. This figure provides a visual image of how the QFP is related to other guidelines,

such as CDC's STD treatment guidelines, as well as the Medical Eligibility Criteria for contraceptive use, and the Selective Practice recommendations.

We actually complement the existing guidelines in two ways. And that's by integrating existing guidelines that are appropriate to be using in family planning settings. And before this, those guidelines were frequently used in a siloed [SP] manner. We hoped that by integrating them into one document, that it'll make it easier and more accessible for providers to be able to meet all of the guidelines together, in terms of providing the best possible quality care. But also, the QFP goes a step further and fills gaps where existing guidelines don't address how to provide contraceptive counseling or how to provide care for adolescents, or how that care can be integrated along with the MEC and FPR; QFP does that.

Also, QFP has an entire section, and actually adjusts the family planning needs and services for male clients, as well as female clients, and addresses those pregnancy preventions, as well as services for achieving healthy pregnancies that lead to healthy birth outcomes. I think that that's really important contributions of QFP, and it's actually much broader. I think a lot of people use the words "family planning" synonymous with pregnancy prevention or contraception, where these guidelines actually establish that family planning is much broader than that. It defines a whole scope of services that are involved in those achieving healthy pregnancies, as well as preventing unintended pregnancies.

Just a couple of minutes on how we developed these recommendations. First of all, both CDC and the Institute of Medicine are engaged in efforts to strengthen processes by which clinical guidelines are developed. And we tried our best to stay as close to those recommendations as we could, so that these guidelines would have the highest amount of integrity and rigor in terms of development. We did that in the best way we could. These efforts emphasize the use of evidence to the extent possible, as well as complete transparency in the process that seeks to develop the recommendations. So it's just a few of the things that are most noteworthy about the process that we use.

We had an expert workgroup that we relied on to provide us with individual feedback throughout the entire process. And that expert workgroup was made up of folks from organizations like AHOC [SP], Planned Parenthood Federation of

America, the number of the Title Ten grantees, people from the Primary Care World, people from the Maternal Child Health World. So we had an expert workgroup of about 20 people that actually helped us shepherd these through and provide us with their best advice on how to interpret the systematic review information that was obtained as part of this process, and gave us feedback as we were developing the recommendations in terms of how feasible they were in a practice environment and how focused they were on the greatest needs in the field.

As part of this process and gathering the evidence, we conducted ten systematic reviews of the literature in four different priority areas, including counseling and education, adolescent services, quality improvements, and community education and outreach. And then, we conducted a comprehensive synthesis of existing clinical recommendations from a number of professional medical associations and federal agencies. We identified where there were conflicts between these recommendations, and then developed a process for reconciling where those conflicts or inconsistencies existed. Our goal was to draw on existing recommendations whenever that was possible, but also to fill important gaps that we knew existed.

So with input from our expert workgroup, the recommendations were developed after a consideration of both the evidence, as well as the potential harms and benefits of implementing the recommendations. And we made a tremendous effort to be transparent in documentation of the process, and there is actually a supplement that actually is almost ready to be released. That's gonna be published in the American Journal of Preventive Medicine. That will be an entire supplement of all of the different systematic reviews, and the process that was used to develop these recommendations. So stay tuned for that, it should be coming within the next few months. A central premise underpinning the guidance, is that by improving the quality of the care, it will lead to improve reproductive health outcomes, such as lower rates of teen and unintended pregnancy, as well as reduced maternal mortality and morbidity, and infant mortality.

This next slide shows how we can sectionize [SP] family planning services. And as I've mentioned before, our definition of family planning services includes services for both preventing pregnancy and achieving pregnancy. We identified six core services as part of core family planning services. And those include these that are

in this orange - or whatever color that looks like to you - on your screen. So it's contraceptive services, pregnancy testing and counseling, services to help clients achieve pregnancy, basic infertility services, preconception health, and STD services. Preconception health was included because in 2006, when CDC came out with their preconception health recommendations, they recommended that preconception health services should be integrated into all primary care settings.

We think that family planning includes planning for healthy pregnancy. And the family planning visit is an excellent time to reach women of reproductive age with preconception and other preventive health services that improve their health, regardless of whether they're intending to become pregnant or not. You see in this blue circle the related preventive health services that we identified, which are services that are considered to be beneficial to reproductive health and appropriate to deliver in a family planning setting, but they don't contribute directly to achieving or preventing pregnancy. So cervical cancer screening and breast cancer screening are two of the services that are frequently provided in a family planning setting that we thought were appropriate to include there.

And then in this outer circle, the purple circle, are other preventive health services that are important in a primary care setting but probably not services that would be provided as part of a family planning visit or in a family planning only setting. So colorectal cancer screening or skin cancer screening might be examples of those types of services that would be provided if you were in a primary care setting. This figure makes another key point in QFP, which is that we're trying to address the family planning needs of all individuals who needs services related to preventing or achieving pregnancy, regardless of if that's the reason that brought them into the healthcare setting.

On the left hand side of this diagram, it shows a flow chart of services to be offered to clients who come to a service site, seeking a service specifically related to preventing or achieving pregnancy. Once their initial request is addressed, then this diagram shows that their need for STD services, or preconception, or related preventive health services should be assessed and that appropriate services is offered in accordance with clinical recommendations. It doesn't mean that they would all have to be provided in that day, but they should be deemed offered those services per recommendations. So for instance, if somebody comes in for

contraceptive services, and is a 17 year-old who is sexually active, then you should be making sure that you do appropriate STD screening, such as Chlamydia and Gonorrhea screening.

They're not a client that you would be providing a pap test to, for instance, because they're too young for that. So it's always thinking about what services would be appropriate for that client, as well as meeting the need that she came in or he came in for. The right hand side of this diagram actually is an important contribution when QFP was going through the clearance process. One of our primary care providers who reviewed QFP for us, provided us with some insight that actually, I think, improved the QFP quite a bit. And that was to make the point that clients that are coming in to a setting, like a primary care setting, for a service not related to preventing or achieving pregnancy, should also be asked about their needs for services related to preventing or achieving pregnancy. And this is where Reproductive Life Plan, or the One Key Question comes in, so that if somebody comes, let's say they're coming in for management of their hypertension in a primary care setting, finding out whether they're planning to become pregnant or wanting to have a baby in the next year is an important thing to consider. And it probably has a bearing on some other aspects of their health.

We hope that by providing this flow diagram, that primary care settings would be thinking to ask clients who come in to a primary care setting for some other reason, would be screened to see if they need services related to preventing or achieving pregnancy. We know that addressing those needs, or screening for those needs, won't always be possible in a primary care setting, depending on the nature of the visit, but in many cases, it will. And it's something that we hope folks will think about more often than maybe they have done in the past. Now I'm gonna talk about a few of the key recommendations about clinical services that we think are appropriate for helping Healthy Start grantees to think about. Contraceptive services is the first of the family planning services addressed in the recommendation. And there were very few existing recommendations for how to provide contraceptive services, so we think this section is a unique contribution to the field.

We drew heavily on the literature reviews we conducted, as well as existing recommendations like the MEC, the Medical Eligibility Criteria of Contraceptive

Use, and the Selective Practice Recommendations, or the SPR. Some of the key points in this section are to remove medical barriers that are often viewed as a prerequisite for providing contraception. There are a number of barriers, or a number of things that have routinely been required of clients before contraception has been provided, but they're really not related to providing contraception safely. For instance, a pelvic exam is not routinely needed unless you're putting in an IUD or fitting a diaphragm. There's really nothing you're gonna learn on a pelvic exam that's going to inform on what contraceptive methods are safe for someone.

Also, cervical cytology, a pap smear is not needed to provide contraception safely. And routine HIV screening, although it may be important as part of that visit, it's not important in terms of contraceptive method provision. Some of those barriers should actually really be removed and not forcing clients to have those services as a prerequisite for contraception, but they are services that might be important in their own right for other reasons. Also, we think it's important that a full range of FDA approved methods is available, optimally on-site, as well as use of an evidence based informed counseling process, which is client-centered and includes information about contraceptive effectiveness. There's been a lot of emphasis lately. I'm sure that you all have heard the buzz about LARC methods and that they are the most effective method that is reversible of contraception.

So there's been a lot of folks talking about LARC methods, a lot of buzz about them, and how great they are. We too think that they're great methods, if it's the best method for a client to use. As part of the QFP, we actually talk about what are the principles of quality counseling. But whether you're doing contraceptive counseling or other types of counseling, that it really is important to talk with the client, establish rapport with the clients first, assess what their needs are, work with them interactively to establish a plan, provide materials that could be understood and retained by the client, and the confirmed client understanding. For many clients, this is really a client-centered counseling model. So we think it's very important to follow the counseling recommendations at whatever kind of counseling that you're providing. But we want to make sure that as the interest in LARC increases across the nation, it's important to encourage clients to consider all of the things that they're wanting in a method of contraception, including effectiveness.

We don't want to appear that we're coercing or that we're leading clients to accept a particular method. We really want them to think about what are the other factors that are important to them in a contraceptive method, in terms of protection from STDs, or side effects as part of those methods, or anything that's gonna make it easier or make that be the best method for a person to use. So we want to make sure that we're not coercing or appearing to force clients to use any particular method or accept a particular method. In terms of key steps in providing contraceptive services, which are closely related to the sensibles of quality counseling, would be establishing and maintaining rapport with the client, obtaining appropriate clinical and social information for the client, and then working with the client interactively to select the most effective and appropriate contraceptive method for him or her.

Also, conducting whatever physical assessment as related to contraceptive use when warranted. In most cases, depending on what the method is, if the client comes in and it's decided by the client, as well as by the provider, that oral contraceptive or a contraceptive ring is the best method that's gonna best meet her needs, then the only physical assessment that would be required for that patient actually would be in QFP. You can look up what would actually be required in connection with that particular method, would be checking the blood pressure, as well as a BMI. And then depending on their age, it might be appropriate to do a pap smear, but it's not related to whether you can provide the contraception to her that day. Physical assessment in terms of what the requirements are now or what the recommendations are, are very much different than they were 10 years ago, or certainly back when I was in clinical practice myself when we did pelvic exams on everybody that walked in the door.

And then finally, the fifth step in that process is to provide the contraceptive method along with specific instructions about how to use that method consistently and correctly, and helping the client to develop a plan for using that method and for follow-up. And making sure that she or he understands how to use the method, as well as when they need to come back in to ask questions or make a phone call, or if they're having any kind of problems. For them to be able to anticipate reasons why they might not be able to use it well, or what they would do in an instance where let's say, they didn't have their pills with them. They went away for the weekend, forgot their pills. That's the method they're using, kind of anticipate

things that might come up that might make it more difficult for them to use the method consistently.

So finally, the QFP recommends including the discussion of the effectiveness of contraceptive methods as part of the counseling process. It's not the only consideration, but it is an important consideration. And the clients need to be told about contraceptive method effectiveness. And there's a study out there, you're probably familiar with the choice study where they had a specific counseling technique where they presented information on the most effective methods first, before presenting information on the other contraceptive methods. So this figure emphasizes the effectiveness of each of the methods. So you see that on the very top tier are the most effective methods of contraception. So the reversible ones would include the intrauterine device and the implant, as well as permanent methods like sterilization for both males and females. And then the moderately effective methods of contraception where you have 6 to 12 women becoming pregnant every year out of 100 women every year, would be the injectable or the pill, the patch, the ring, and the diaphragm.

And then the least effective methods, including condoms, female condoms, withdrawal and the sponge. Just as a reminder though, providing information on those methods in terms of effectiveness, but also doing it in a client-centered manner so that clients aren't feeling pressured, of course, to use a particular method of contraception is extremely important. So Preconception Health Services, and I know some folks have questions why this is important in a family planning setting, or, "Why should we be providing?" Are we always thinking that it's only appropriate to provide preconception counseling to folks that are trying to become pregnant or want to become pregnant? But in fact, the first slide that I showed, showed that half of pregnancies in this country are unintended. There's many people that aren't using an effective method of contraception. About half of unintended pregnancies are among people who are using a contraceptive method, but for whatever reason, still become pregnant. Probably because they may not be using one of the highly effective methods, or may not be using the method consistently or correctly.

So it's really important to be thinking about preconception health messages, regardless of whether somebody specifically says they're trying to become

pregnant. The preconception health services should be offered to female clients, as well as male clients. I think that a lot of the preconception health services, which I'm gonna show on the next slide, are services that aren't just services that are specifically related to the services you're probably providing anyway in a clinical setting, regardless of whether somebody is trying to become pregnant. So things like screening for intimate partner violence among females, alcohol and drug use, use of tobacco, their immunization status, whether they have a history or a current history of depression, their height, weight, and body mass index, blood pressure, and screen for diabetes. Those are all important just for general health, but they also contribute to being able to have a heathy pregnancy, should somebody become pregnant.

Also, discussion of Reproductive Life Plan, which I know you just had a webinar prior to this. Not today, but within the last few weeks. So it was another webinar on Reproductive Life Plan. And we believe that it's important for every woman and man to be asked about their reproductive intentions when they're receiving clinical services, so that appropriate counseling can be provided. This list that's up here, was developed by a select committee on preconception health and was published in 2008. And for the most part, QFP cites CDC and/or the U.S. Preventive Services Task Force Recommendations for how to provide each of these services. We also address and provided a list of the preconception health services that are appropriate to provide for men. And the evidence based for many of the recommendations for men is a little bit less rigorous than for women, but we actually did look to the literature so that we weren't recommending things that we couldn't back up by research.

We actually considered men as partners in both preventing and achieving pregnancy, including their direct contributions to infant health and fertility, as well as their role in improving the health of women. All of these services, as for women, improved the health of men, regardless of whether they're planning to become or wanting to become a father any time soon. So again, it includes discussion of Reproductive Life Plans, appropriate medical history, a sexual health assessment, and then screening for alcohol and drug use. It's the same set of services with the exception of, you'll notice that screening for intimate partner violence is not up here. The reason it's not included is because the USPSTF recommendation on which the QFP recommendation for women was only applied

for women, so there's not currently a recommendation by USPSTF. We're hoping that maybe in the future at some point, there will be a USPSTF recommendation and we'll include it in one of the next versions of QFP.

And also folic acid, of course is not included for men for obvious reasons, because it affects infant health through the maternal course of folic acid. The recommendations that are included for STD services are consistent with the CDC recommendations, including STD treatment guidelines, as well as the HIV testing recommendations, the Reproductive Health related vaccinations and Hepatitis C vaccinations. So as you're probably aware, CDC is about to release new STD treatment guidelines, and we'll update the QFP accordingly. This slide just shows female clients screening recommendations according to CDC for each of these. And we also have a chart that shows the STD services for men that should be provided in accordance with CDC recommendations.

Similar to women for each aspect in QFP, where we have recommendations or a set of services that should be screened for, or should be provided to women, we have an equivalent slide that shows what should be provided to men. Finally, as I noted previously, a select related preventive health services are recommended for delivery in a family planning setting. So for women, the QFP recommends screening for cervical and breast cancer, unless women are getting those services in a different setting. So they shouldn't have to be provided twice if they've already had those services provided by another provider. The screening for cervical cancer, which is a USPSTF recommendation, and now all of the major medical organizations or professional organizations are fairly well lined up with their cervical cancer screening recommendations. And they include no screening for women less than 21 years of age, regardless of sexual history. If you're doing a traditional pap, they should have that every three years between the ages of 21 and 65.

Or starting at age 30, they can have the pap plus HPV testing, which would be performed only every five years. The breast cancer screening was a little bit more problematic because AHOC has one recommendation where American Cancer Society has a different recommendation. We reconciled that by recommending that a clinical breast exam is probably good to perform every few years, at least, for women age 20 and older. And then the mammography for women ages 50 to 74 on

a biannual basis, and under age 50 if there's other conditions that would make that appropriate. In terms of quality improvement, QFP includes recommendations for [inaudible 00:32:43] to quality improvement, but it's become a very central part of our implementation strategy. So the primary recommendation in QFP quality improvement, is that family planning programs should have a system for quality improvement which is designed to review and strengthen the quality of services on an ongoing basis.

And that they should select, measure, and assess at least one outcome measure for which these service sites can be accountable. So this recommendation reflects the fact that performance measurement and quality improvement processes is a strongly evidence based strategy to improve the quality of clinical care. Within QFP, the focus is on helping service sites and providers of direct care with data tools needed to monitor the care they provide, and to use that data on site to improve care over time. Over the course of developing QFP, we realized that there were no National Quality Form, or NQF, endorsed measures for contraception services. So we also wanted to emphasize the need to think about outcome measures for which the service site can feel responsible.

For example, many providers had told us that they don't feel they can fully control a client's pregnancy, whether they have a pregnancy or not, because there are so many factors outside the clinic that come into play that affect whether somebody becomes pregnant. But they can feel some accountability for the type of contraceptive method that a client leaves with. This slide shows two measures that we think may be excellent candidates, and Laura Gavin actually is leading efforts to get this particular measure, or these measures, endorsed by NQF. So these measures are based on the fact that some methods are more effective than others at preventing pregnancy, but they're also measures for which providers say they can feel some accountability. So we also liked it because it allows for a lot of client choice. And providers will not have any more incentive to prescribe the pill, the patch, or the ring, than they will to provide [inaudible 00:34:47] sterilization.

The primary measures that we're looking at is the percentage of female clients aged 15 to 44 who are at risk of unintended pregnancy, who adopt or continue use of an FDA approved method of contraception that is most or moderately effective. We consider that as intermediate outcome measure because it reflects what happens at

the end of a clinical encounter, and because another choice is closely associated with risk of unintended pregnancy. We haven't set a benchmark for performance as yet, but most family planning providers agree that a high percentage of women at risk for unintended pregnancy should be using a most or moderately effective method of contraception at the end of a visit if they're really not wanting to become pregnant. At some measure, we're really looking at the next one that's in dark blue, which is focused on use of LARC. We're actually looking at this one very differently. We're not actually looking at this in terms of setting a bar of what we expect everybody should be at.

We don't want to set some arbitrary bar to say every 10% of all clients should be on a LARC measure who don't want to become pregnant. But we're looking at it as an access measure. Especially across the Title Ten System for which we're responsible, we want to see other sites where the percentage of clients that are using LARC is zero or one. And if that's the case, is it an access issue? Is it an issue of not being able to afford the method? Not having providers that are trained to provide it? To actually look at, "Are there things that we can help them with in terms of making sure that those methods are available to folks?" But not in a way that we're promoting some high bar, in terms of expecting everybody to have a certain percentage of the clients on a LARC method. We'll spend the next few minutes just talking a little bit about plans that we have to support implementation of quality of QFP.

Over the last several months since QFP got out, as I've mentioned, we've been on the [inaudible 00:37:00] making sure that folks are aware of it. But we know that making sure that people are aware that QFP is out there is not enough. We need to actually do whatever we can to help them actually take it up and be able to use it. One of the things, is that we want to make sure that the QFP and the recommendations in it are always current. So we intend to do a full list update on the QFP every year. But we intend to take steps to make sure that on an ongoing basis, that there are recommendations that change, or if there are things in it that are wrong, that we make those corrections right away. But we're already starting to think about the next version of QFP. So we're already making plans to do the next reversion, which will be identifying additional priority areas to do systematic reviews.

And we plan to probably have the first ADHOC update, which we'll be doing on an annual basis. We'll probably have the first annual update, which will just include minor revisions, such as integrating the new STD treatment guidelines that'll be coming out in a few weeks, we expect. We'll be doing that on an annual basis, and then we'll be doing ADHOC updates as needed if there's new major clinical recommendations or some sort of research finding that gets released. So stay tuned for that. In terms of other efforts to implement and strengthen QFP, in addition to the dissemination efforts, we have a number of training grantees that are supported with Title Ten funds that have a Family Planning National Training Center website, where there are a number of resources that can be used by anybody. They don't have to be Title Ten providers. So there's a number of training resources, webinars, online learning tools, as well as just some implementation tools that can be used for implementing QFP that are on the FPNTC website.

I'll show you a screenshot of that in just a minute. Also, we're looking at doing a surveillance summary that is under development, that will hopefully soon be available, that will cover some of the services that are included on QFP. And then, there's a number of research areas and research gaps that were identified as a result of us doing the Quality Family Planning Recommendation. We're hoping both, here from our offices as well as some of the other offices that support research efforts, will take that up and be able to strengthen the evidence based that we'll be able to use in the future for developing new recommendations for QFP. This is a screenshot of the link to the FPNTC website where a number of different resources and tools are available. And any of the webinars that are up there, they're free for you all to use. And we hope that you'll access them as well, because there's a whole host of things up there that we think would be useful to you. Additionally, we're planning several efforts to evaluate the impact of QFP.

And one of the activities is already under way. We did a baseline survey of providers and service sites that was already done, and hope that they are being evaluated right now, or analyzed right now, to actually document baseline provider knowledge, attitudes, and practices related to QFP recommendations, as well as some characteristics of the service delivery infrastructure. We're hoping to release those baseline findings within the next year. And then we're planning, in the next two to three years, to do a follow-up survey to see whether those practices and attitudes have changed over time since the release of QFP. In summary, the QFP

recommendations, we hope will have introduced a consistent set of evidence and form recommendations for all providers of family planning services.

We hope that they'll strengthen the delivery of contraceptive services across this country, support the use of the family planning visit to provide other preventive services for women and men, and encourage more research to strengthen the evidence base for specific strategies and services. I'm gonna turn it back over to Megan. I don't think we're gonna take questions just yet. Here's contact information for myself, as well as for Gabin. And we'll both be answering whatever questions come in at the end. But thank you, Megan.

Megan: Thank you so much, Sue. That was great. You can see how much work and thought has gone into that, so thank you for sharing that. Now, everyone, I'm gonna turn it over to Miss Faye Johnson, who is gonna tell you more about how they're implementing the QFP at their Healthy Start Program. Faye?

Faye: Hi, everyone. I should say my name is Faye Johnson. I'm the Project Director of the Magnolia Project, an initiative of the Northeast for the Healthy Start Coalition located in Jacksonville, Florida. We are a Federal Healthy Start grantee. I think this is our second or third round. But we implemented the plan, as well as the Quality Family Planning a while back with services starting back in, I think it was 1999, or 2000. And gradually, we've evolved quite a bit and made quite a few changes and thing like that. But the services offered at the Magnolia Project are comprehensive service delivery model for our participants, and it is truly client-centered. Because at the end of the day, it's based on need, but it's also based on their desires as well. It's important to develop a relationship with the participants as they come in. We have a clinical model here at Magnolia, but we also have a case management model outreach sssessment, mental health. And recently in this last year, we have added a pilot primary care part to the Service Delivery Model as well.

Historically, we are a Preconception and Interconceptional [SP] Model, also serving pregnant women in our clinical areas. And now we've expended the care coordination services to our prenatal women as well. But like I said, historically, we were a Preconception, Interconceptional Model for our participants, which is very, very important. I'm glad to see that the preconception thesis is here because

we know a women's body is impacted long before she becomes pregnant, preconceptionally. And therefore, it's important to assess her medical history at that time, and also the partner's history at that time, to develop a Reproductive Life Plan, whether they have decided to become a pregnant family or not. It's important to definitively conduct an assessment. At the Magnollia Project, the clinical components, service delivery services that we deliver at Magnolia are everything from STD screening, education, assessment, like I said, with the medical history.

We also, about three years ago, adopted the [inaudible 00:44:38] Project, which is a contraceptive counseling model out of St. Louis. And I think Ana mentioned it earlier. Where [inaudible 00:44:48] we give them the choice - because at the end of the day, it is their choice - to go through contraceptive counseling where we discuss the LARC, Long-Acting Reversible Contraceptives. And we start with the most effective to the least effective, but also in the process of that, with our health educator, it's important for her that she does develop a relationship with our women to go through the whole counseling process to make sure that they understand what the effects are. And at the end of the day, it's their choice, though. It's not something that should be forced upon them.

With that, the whole plan, [inaudible 00:44:25] services that we have implemented all the way across from health education, preconception health, STDs, the whole nine yards, is something that we offer our participants in our clinical setting. But more importantly to add to that, we also have pregnancy testing, counseling, and everything. We do not do infertility services here on site, but we can refer them out through our primary care pilot that we're doing now, which is exciting. And then, the other services that we offer, like I said, is the mental health counseling, case management for our women, and also the health education. Recently, we've added a male component for preconception health and education. We do not have the medical services for our men, but we screen our men through our women, based on information that our women give us. And then we're able to engage our men. But primarily at the Magnolia Project, we have an array of services. It's a comprehensive service model.

Our women come into the clinic, they go from everything to the pregnancy test. They're not just gonna get the pregnancy test. We do that, but we also educate them and counsel them all, whether negative or positive. We give them choices to make

at the Project, and continue the services all way through, from the medical history on down to referring them out if it's chronic illness that they have. We can link them to a provider. Our primary care pilot piece is one day a week now, because we did not offer primary care before. But we realized that that is a piece that we wanted to include on-site instead of referring them out. So it's a well-rounded system that we have. We're growing, we're learning. But I think that the information that was presented is an excellent model. It's the right [inaudible 00:47:18] to me.

And we see that in the results of our women that come in and come back, and want to be a part of the Magnolia Project and receive services. I think, too, like she said earlier, it's so important to make sure that it's client-centered. That's real important. We're not here to force things on them, we're here to educate them so they can make informed decisions. And that's what we try and do. But we're growing and still learning. We're excited with the services that we're currently delivering, and the Quality Family Planning Plan is excellent. You can adopt and incorporate it into the services that we model, take small steps but eventually grow to the entire model. Because it is the comprehensive way to deliver services for family planning.

Megan: Thank you so much, Miss Johnson. That was a great description of how you're actually using the recommendations in your program. And I really do also appreciate how you gave the key points that help Healthy Start grantees should really think about in implementing the recommendations. So now everyone, we have about 11 minutes left in our webinar. I'd love to take some of your questions or comments for the speakers today. Please type them into the chatbox in the lower lefthand corner of your screen, and we can have some dialogue about this. The first question I have is for Sue and Lori: Where can I get more training about the QFP? And I know earlier you shared the FPNPC website up here.

Susan: Right. That would be where I would urge you all to go, that would be the go-to place. And you can see the website includes key resources. There's actually a resource catalog that for all of the different sections of QFP, different resources are identified within that resource guide for what resources are available, for instance, for doing pregnancy test counseling. Or what resources are available for providing contraceptive counseling. Or there's also checklist of Family Panning Services for

women or men of reproductive age. If somebody is coming in for a contraceptive visit, what type of services should be provided? All of the different resources for implementing QFP that are currently available up there on the npfntc.org website.

Lori: And let me say one thing. This is Lori. There is a lot already on that website. A number of really exciting products are in the works also right now. So check that, because in the near future, an increasing number of other products will be up there. It's a work in process and new stuff being added all the time.

Susan: One of the things that's exciting is that there is a process of developing a QFP app that will be available for both Android and Apple devices. [inaudible 00:50:36] not until later this summer, so that's just an example of one of the things that's under development right now. But a lot of other things, as Lori said, are under development, so check back periodically. Other things that are on that website are also available to you, whether they're related to QFP or not.

Megan: So another question is: Why is preconception care a new concept in family planning?

Susan: I actually don't think that it should be a new concept for family planing, but I think that for some folks, they see it as not being something the family planning providers have provided previously. When if you really look at the set of services that I listed on that one slide in terms of preconception health services, like hypertension screening and weight, height, and BMI, some of those screening for alcohol and drug use, all of those are actually services that are provided anyway, pretty much as part of a family planning visit. But I don't think that folks necessarily see them as being a preconception health service. Because they don't necessarily see them as having a direct connection with having a healthy pregnancy. But I think that, like I pointed out, the services are all important just for general health and screening for those types of things, contribute to providing the appropriate counseling or services that contribute to overall good health.

Because as we know, half of pregnancies are unintended and half of them that occur are among people that are using contraception. We always, not necessarily need to be viewing women as vessels - and I know that that's been somewhat controversial over the years in terms of always viewing folks as being potentially subject to pregnancy, so to speak. But I think that just keeping in mind that we

need to make sure that should somebody become pregnant, we do want them to be in as good a physical shape as possible, should they become pregnant and want to continue that pregnancy. We want to have every reason for that to be a healthy pregnancy with a healthy birth outcome.

I think family planning settings are particularly appropriate settings for providing those messages, even if it's not in the context of, "Should you become pregnant, or when you want to become pregnant." I think we need to be careful the language that we use, but to provide those messages in a way that's client-centered, that doesn't necessarily put the client off, but to provide those services, regardless. Unless she has been sterilized or unless she's on a highly, highly effective method of contraception, but most of the services are gonna be appropriate to provide anyway, just in the context of family planning visits.

The only ones in this list that are up here now, that I can imagine that you might not standardly be screening for, would be maybe screening for diabetes. But if somebody comes in and has symptoms of diabetes, you'd still be sending them to an appropriate setting where they can get care and get additional screening for diabetes, just for general health. So all of those other services that are up here in terms of screening, referral, and treatment for it, these different types of problems that are up here, I think are things you would provide anyway, but they are also preconception health services.

Megan: Great. And just a reminder to folks that the slides that are up here now will be available in the EPIC Center website in the next few days. So check back to the Healthy Start EPIC Center website and you'll be able to download a copy of these slides. You're also set out with the confirmation of your registration for this webinar. There is one more question that I think we have time for. That question is: Should we promote LARC among teens or other special population?

Susan: As I took some time to describe, promoting is not how we would express. I think we want to make sure that people are aware of methods and that they're aware of the effectiveness of various methods, and that LARCs and the IUDs are the most effective, reversible methods of contraception. We want to make sure folks have all the information that they need, along with their health care provider, to choose the method that's gonna work best for them in their circumstances. We

don't want to promote LARC because it's not gonna be for everybody, but we do want to make sure that folks have access to all the contraceptive methods. And that they, along with their provider, can choose the method that's gonna work the best for them, and that they get the appropriate counseling and support to be able to use the method that will work best for them.

What we don't want to have happen is somebody comes in and says, "I want the pill," that folks are just given the pill without any additional information on other methods that are also available, and that they have all the information so that they can make an informed decision along with their provider. I think we have an obligation to make sure that folks have information on other methods, as well as method effectiveness. So if they have never even thought of different methods that may actually work better for them, and if they're not presented with the information on it, they're never gonna know. I think we do have an obligation to make sure that we're providing full information to clients. I would not probably express it as promoting LARC or targeting clients for LARC use, or those kinds of things.

We want to be very careful. I think that one of the biggest concerns right now out there is that LARCs are gonna be used coercively among certain populations, or that it's gonna be promoted. And that folks are gonna be basically coercing these methods that aren't maybe the best for them, or that's not gonna really meet their needs. So we want to steer away from using terms like "promote" or "encourage the use of LARC." What was the other expression that we were hearing? I forget. There was another expression that was used by somebody. First-line contraception, which basically to me means you're gonna promote that above other methods. I think we need to be real careful with the language that's used. But we do want to make sure that there's access to the methods, including LARC methods, that may work better for people.

Megan: Great. Well, thank you so much. I want to just say, before I do the wrap-up and reminders, thank you so much to Sue and Lori for your expertise and your presentation on this. We'll be sure to share the FPNTC resources, many of them on the Healthy Start EPIC website, as well. Make sure that folks have access to all the great materials there. I also want to do a great big thank you to Miss Faye Johnson for presenting what they're doing at their site with regard to the Quality Family

Planning Recommendations. That was really a nice description of the great comprehensive services that you all are delivering for your Healthy Start Clients. Just a couple of reminders. We do have a few webinars coming up. Again, not mandatory for folks to attend, but for folks to share with their team.

A webinar on breastfeeding, how to talk to parents about breastfeeding, on May the 12, from 3:00 to 4:00 Eastern. A Collective Impact webinar, watching and learning together on May 13, from 3:00 to 4:30 Eastern time. It's actually a 90 minute webinar, and that's a great opportunity for folks to hear more about Collective Impact and become a part of peer learning networks to get more intensive training on Collective Impact. On May the 14, there's a male inclusion, Fatherhood: Hear From Your Peer webinar from 3:00 to 4:00. And on May the 19, there is a Domestic Violence Screening and Follow-up webinar from 3:00 to 4:00 Eastern time.

The website where you can register for all these webinars is healthystartepic.org, and all the webinar recordings, transcript slides are there as well. You're gonna be asked to complete an evaluation form, so please take a moment to do that immediately following this webinar when you have a moment. We really do like your feedback, and we'll take it to heart. That concludes the webinar for today. Again, thank you to our speakers, and thank you so much to you all for your participation. This concludes our webinar. Have a great rest of your day.