



2007 Family PACT Medical Record Review

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Medical Record Review:

- Part of a comprehensive Family PACT evaluation
- One of the few data sources on quality of care and clinical outcomes
- Guides OFP in policy development and the design of interventions to improve quality of care and enhance program performance



2007 MRR Evaluation Questions

- Are reproductive health services provided under Family PACT consistent with the program standards?
- Are there differences in the scope and quality of services delivered by public and private providers?
- Has the quality of services delivered under the program changed over time?

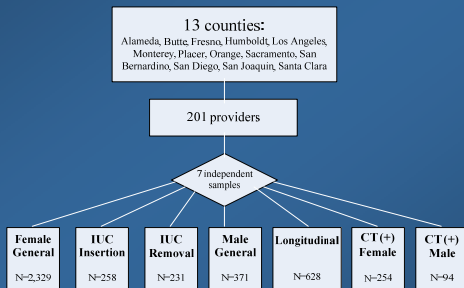


Seven Samples

1. Female General
2. Male General
3. Female Longitudinal
4. Female Chlamydia Positive
5. Male Chlamydia Positive
6. IUC Insertion
7. IUC Removal



Sampling Framework



Data Collection

- Subcontract with Barbara Aved Associates
- Data collection by ten nurse abstractors
- Data entered onsite, into encrypted laptops
- Data quality measures: Abstractor training, weekly abstractor meeting, periodic in-field re-abstractation from BAA and UCSF
- Exception log to record any deviations from abstraction protocol



Provider Characteristics (n=201)

Provider Sector		
Private		57%
Public		43%
Office Practice Type		
Solo Medical Practice		29%
Group Medical Practice		24%
Community Clinic/Neighborhood Health Center/Free Clinic		24%
Planned Parenthood		7%
Hospital-Based Outpatient Clinic		6%
FQHC/RHC/Indian Health Center		6%
College-Based Student Health Center		1%
High School-Based Student Health Center		1%
County or City Health Department Clinic		<1%
Primary Specialty		
OB/GYN/Women's Health		28%
Family Planning		9%
General Primary Care		48%
Multi-Specialty		11%
Pediatrics/Adolescent medicine		2%
Other		<1%
Total		100%

Source: 2007 Family PACT Medical Record Review and Provider Enrollment Records



Client Demographics

	Female General (n=2,290)	Male General (n=366)	IUC Insertion (n=240)	IUC Removal (n=220)	CT Positive Female (n=249)	CT Positive Male (n=93)	Longitudinal (n=624)
	%	%	%	%	%	%	%
Race/Ethnicity							
Latino	75%	68%	78%	88%	58%	45%	75%
Asian/Pacific Islander	5%	5%	3%	2%	10%	2%	10%
Black	4%	10%	1%	1%	12%	23%	3%
White	11%	13%	15%	7%	16%	28%	10%
Multi-Racial/Other	3%	4%	3%	1%	3%	2%	3%
Primary Language							
Spanish	60%	55%	68%	83%			
English	36%	39%	29%	16%			
Other	4%	6%	4%	2%			
Age							
19 and under	18%	19%	6%	4%	31%	18%	14%
20 to 24	27%	30%	27%	21%	37%	45%	28%
25 to 29	22%	19%	26%	32%	17%	25%	20%
30 to 34	15%	13%	21%	22%	8%	9%	18%
35 and over	19%	20%	20%	20%	7%	3%	19%
Parity							
0	37%		8%	3%	54%		
1-2	43%		62%	65%	34%		
3+	19%		30%	33%	11%		



Outline

- Use of contraception with emphasis on use of high-efficacy contraception
- IUC insertions and continuation
- Chlamydia testing and case management
- Primary care referrals and provision
- Counseling and education
- Services to Limited English Proficient clients



Contraceptive Services

Presented by Daria Rostovtseva, MS



Methodology

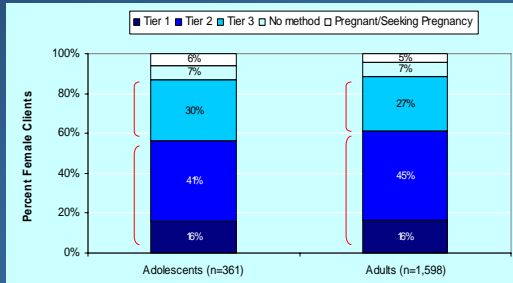
- Most effective method assigned as primary
- Methods grouped into tiers by efficacy*
 - most effective {
 - Tier 1: Sterilization, IUC, Implant, Injection
 - Tier 2: OC, Patch, Ring
 - less effective {
 - Tier 3: Condoms and other low-efficacy methods
 - No Method
 - Pregnant/Seeking Pregnancy
- For cross-sectional analysis, looked at methods at the first abstracted visit

*Adapted from Nelson A, et al. (2006). Intrauterine Copper Contraceptive: Update and Opportunities. Supplement to *The Journal of Family Practice*, October 2006, pp. S1-S8.



What methods did women leave the visit with?

Teens vs. Adults

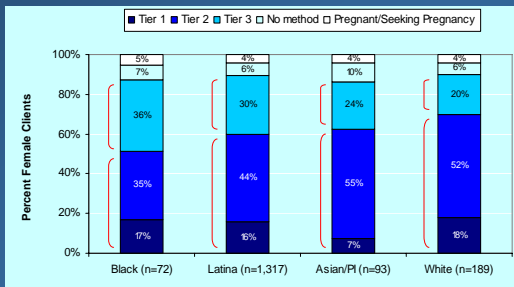


Source: 2007 Family PACT Medical Record Review, Female General Sample



What methods did women leave the visit with?

By Race/Ethnicity



Source: 2007 Family PACT Medical Record Review, Female General Sample



Program impact: Methods before and after the visit



Source: 2007 Family PACT Medical Record Review, Female General Sample



Intrauterine Contraception Services

Presented by Heike Thiel de Bocanegra, PhD, MPH



Background: IUC Use

- 1.6% of all female clients received an IUC insertion in FY 2005-06 (1.9% in 2006-07)
- Proportion of women who receive IUC-related services has been consistent since program inception at 5% (6.1% in 2006-07)
- What are the reasons of low IUC insertions?
- What is the IUC continuation rate among Family PACT clients?

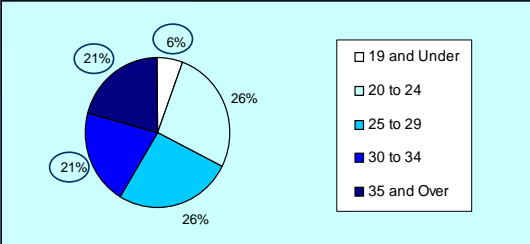


IUC Candidate Selection Criteria

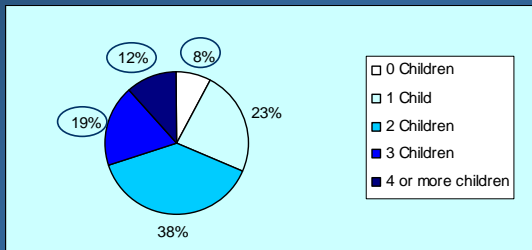
- Initial IUC candidate selection criteria were relatively conservative:
 - Inappropriate candidates:
 - Nulliparous women,
 - Adolescent women or
 - Women with an STI history or at risk of an STI
- By 2004, clinical eligibility criteria for IUC insertions had become more inclusive



What proportion of IUC insertions were performed to adolescent women?



What proportion of IUC insertions were performed to nulliparous women?



IUC Insertion Clients

- Only 2% of women had a history of an STI and 4% had documentation of a new or multiple partners
- Data suggest that providers adhered in 2005 to conservative eligibility criteria for IUC which limits pool of candidates



IUC Continuation

- IUC insertion sample:
 - Continuation rate of 69% at 18 months
- IUC removal sample:
 - Average duration of use = 35 months
 - Range 2 weeks to 13 years
- Data suggest appropriate length of IUC use



Providers of IUC Services

Insertions

- ⇒ ■ 29% by private sector providers
- ⇒ ■ 32% at Primary Care/Multispecialty providers

Removals

- ⇒ ■ 48% by private sector providers
- ⇒ ■ 42% at Primary Care/Multispecialty providers

Consider targeting providers who exclusively remove IUCs for IUC insertion training



Chlamydia Screening & Treatment

Presented by Joan M. Chow, MPH, DrPH



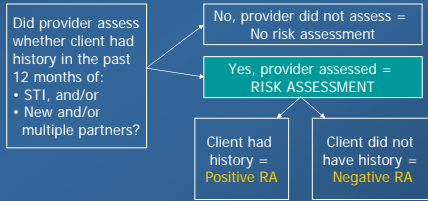
Overview

- Sexual Risk Assessment
- Chlamydia (CT) Screening
- Timeliness of Treatment
- Partner Management
- Re-Testing and Re-Infection
- Conclusions



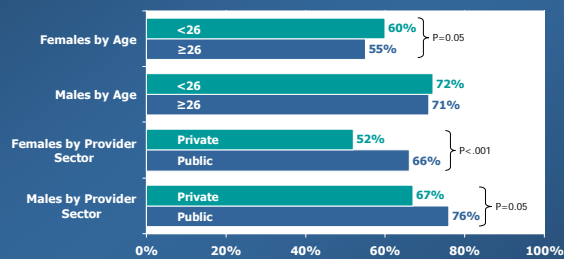
Sexual Risk Assessment

- Family PACT Standard: At least one sexual risk assessment every 2 years
- Determination of risk assessment (RA):



Sexual Risk Assessment

Percentage of Clients with Documented Risk Assessment



Percentage of Female Clients Tested for Chlamydia

Provider Sector	2002 MRR % Tested	2007 MRR % Tested	2005 Claims % Tested
Total	61%	62%	68%
Private	60%	60%	73%
Under 26	55%	60%	74%
26 and Over	64%	60%	72%
Public	62%	64%	65%
Under 26	64%	63%	67%
26 and Over	61%	66%	63%



Screening and Risk at Visit Level, Females

	# of total visits	% with CT test
No risk assessment	2,248	15%
Negative risk assessment	1,811	38%
Positive risk assessment	240	39%

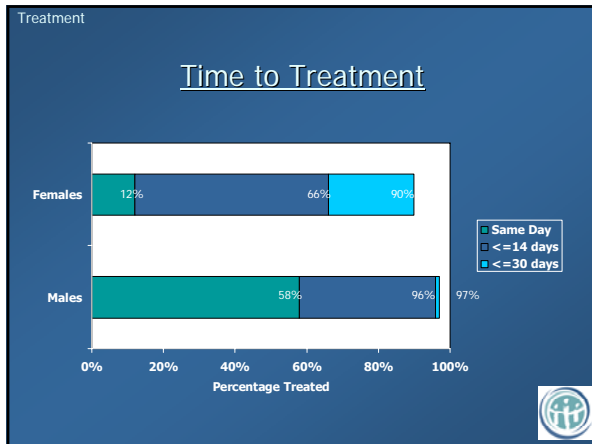
- Did not differ by age group or provider sector
- At 31% of female visits with a CT test, the client presented with symptoms or STI contact




Treatment

- CDC performance measures for timely CT treatment:
 - Proportion of female CT cases that are treated within
 - 14 days of specimen collection; and
 - 30 days of specimen collection
- Of 397 total CT cases from general sample and Quest data:
 - 89% (N=353) had documented treatment in the medical record
 - 84% (N=332) had both a test date and treatment date






- ### Partner Management
- Defined as any one of the following:
 - Client instructed to tell partner to get treated or to bring partner in (patient self-referral)
 - Clinic staff contacted partner directly
 - Client referred to LHD for help with partner notification
 - Client given patient-delivered partner therapy (PDPT) to administer to partner
 - Partner came into clinic with client for testing
 - Client presented as contact to a diagnosed case
- 

Partner Management

Percentage of Cases with Documented Partner Management

	2002 MRR	2007 MRR	
	Female	Female	Male
Total	90%	69%	72%
Private Sector	81%	52%	77%
Public Sector	91%	74%	70%



Re-Testing and Re-Infection

- 2002 CDC STD Treatment Guidelines:
 - CT cases should be re-tested within 3-4 months of initial infection
- Definition of re-testing in MRR:
 - Proportion of female clients re-tested for CT after one month but within 6 months of initial positive test
 - Re-testing identified in claims data; re-infection identified in Quest laboratory data



Re-Testing

Re-Testing and Re-Infection, Female

	% Clinician Recomm.	% Retested 1-6 mos	% Reinfected 1-6 mos*
Total (N=280)	36%	32%	11%
Private Sector (N=62)	24%	18%	0%
Public Sector (N=218)	40%	36%	13%

*of those retested




Conclusions

- Continued increasing trends in Ct screening in younger women
- Over-screening among "older" women
- High treatment compliance
- Decreases in partner management
- Low levels of re-testing
- Better documentation needed




Primary Care Provision & Referral

Presented by Carrie Lewis, MPH




How many sites provide primary care?

- 74% of sites provide primary care
 - 98% of Primary Care/Multi-Specialty sites
 - 34% of Family Planning/Women's Health sites

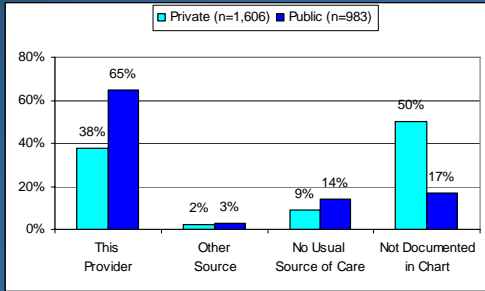


How often is usual source of care documented?

- Evidence of usual source of care:
 - 49% this provider is the usual source of care
 - 2% other source
 - 11% no usual source of care
 - 38% no documentation



Private providers document USC less often.



Documentation on Usual Source of Care Varies

	USC Not Documented in Chart		Total Records
	%	No.	
County or City Health Department Clinic	73%	11	}
Group Medical Practice	58%	614	
Solo Medical Practice	48%	815	
Planned Parenthood	38%	154	
Hospital-Based Outpatient Clinic	29%	119	
Other Community Clinic/Neighborhood Health Center/Free Clinic	18%	670	
FQHC/RHC/Indian Health Center	7%	129	
High School-Based Student Health Center	0%	29	
College-Based Student Health Center	0%	48	



How often were clients referred/rescheduled for primary care?

	Primary Care Available On-Site	
	Yes (n=2,054)	No (n=602)
Referred to Another Provider	3%	2%
Rescheduled with Same Provider	1%	0%
No Referral or Rescheduled Visit Documented	96%	98%
Total	100%	100%



Education & Counseling Services

Presented by Carrie Lewis, MPH



How many clients receive education and counseling?

- 76% of male and female clients received education and counseling
 - Up from 66% in 2002 MRR
- Teens more likely to receive counseling than adults
- Males about as likely to receive counseling as females



Top 3 topics: Visits with Female Clients

Education and Counseling Topic	2007 MRR (n=4,365) %
Method Use/Options	54%
STI/HIV Prevention	34%
Breast Self-Exam	16%

Source: 2007 Family PACT Medical Record Reviews, Female General Samples



Top 3 topics: Visits with Male Clients

Education and Counseling Topic	2007 MRR (n=574) %
STI/HIV Prevention	58%
Method Use/Options	54%
Testicular Self-Exam	15%

Source: 2007 Family PACT Medical Record Reviews, Male General Samples



Is E&C provided when needed?

- **Method Use/ Options**
 - Visits with a new method adopted
 - Teens 80%
 - Adults 71%
- **STI/HIV Prevention**
 - Visits with an STI concern
 - Teens 71%
 - Adults 69%



Documentation Concerns

- 20% (988 of 4,939) of visits had a paid claim for higher level E&C codes
- Of these, 28% lacked supporting documentation to justify claims for E&C visit codes



Conclusions:

- E&C provision is increasing
- Most common counseling addresses key program components
- Improvement warranted in counseling:
 - New methods
 - STI concern
- Charts need justification for coding



Quality of Services to Limited English Proficient Clients

Presented by Heike Thiel de Bocanegra, PhD, MPH

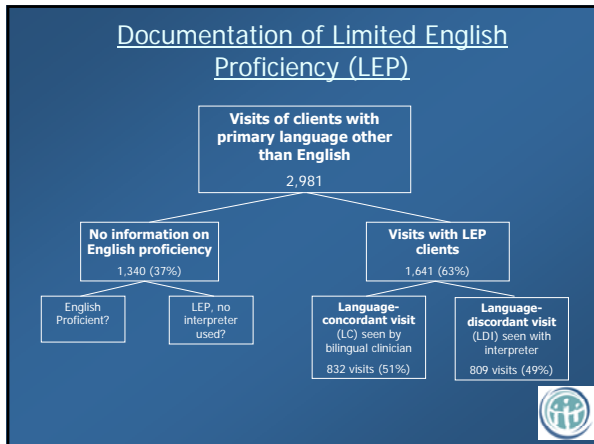


Limited English Proficient (LEP) Clients and Quality of Care

- Monolingual providers seeing LEP clients during language-discordant (LD) visits were found to be
 - Less likely to take comprehensive medical history
 - More likely to order unnecessary medical tests than bilingual providers.¹
- LEP clients were more likely after LD visits than after LC visits to report having outstanding questions about their medical care.²

1. David, R. A., Rhee, M. The impact of language as a barrier to effective health care in an underserved urban Hispanic community. *Mt. Sinai J. Med.* **1998**, *65* (5-6), 393-397
2. Green, A. R. et al. Interpreter services, language concordance, and health care quality: Experiences of Asian Americans with limited English proficiency. *J. Gen. Intern. Med.* **2005**, *20* (11), 1050-1056.





Method of Interpretation by Visit Type

Visit Type	Method of Interpretation	No.	%
Language-Concordant	Bilingual Clinician	832	51%
	Bilingual Staff	803	49%
Language-Discordant with Interpreter	Designated Interpreter/ Language Line	5	<1%
	Friend	1	<1%

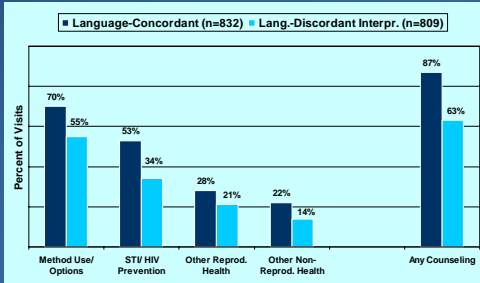
Source: 2007 Family PACT Medical Record Review, Female and Male General Samples

Is history taking and counseling compromised when clients are seen with the help of an interpreter (LDI)?

Clients seen by an interpreter (LDI) were less likely than women seen by a bilingual provider (LC):

- To have STI risk assessment documented (57% vs. 65%)
- To have any education and counseling documented (63% vs. 87%)

Provision of Counseling in Visits with Interpretation, by Visit Type (n=1,641)



Are clients seen by an interpreter more likely to be inappropriately tested?

No difference between LC and LDI visits in:

- Yield and appropriateness of pregnancy tests
- Appropriateness of Chlamydia testing for women < 26 years and > 25 years



Services to Limited English Proficient (LEP) Clients: Analysis Limitations

- Use of language lines and non-staff interpreters does not seem to be documented in the charts.
- Analysis does not assess quality of care of language-discordant visits conducted without interpreters
- Chart review does not measure interpreters' or providers' language proficiency and training in medical interpretation



Take Home Messages

- Consistent documentation of client interpreter is needed in medical charts
- Key aspects of care are compromised when using an interpreter: E&C and STI risk assessment
- Provider training on how to work with interpreters may help to address communication gap
- There is no indication that using interpreters increased inappropriate chlamydia or pregnancy testing



Conclusion & Discussion



2007 Medical Record Review

- Overall program standards are met, but there are gaps in specific areas
- Most quality indicators improved from 2002 MRR to 2007 MRR but the trends for STD quality indicators are mixed
- Differences between public and private provider sector providers are complex; differences by provider discipline provide additional insights for program interventions



Next Steps / Recommendations

- Improve chart documentation
- Provider training / provider interventions
- Complementary data analysis using other data sources (client exit interview; provide referral study)



Next Steps / Recommendations

- Webinar: Improving the Quality of Chart Documentation on January 21, 2009
- Continue to offer targeted provider interventions to improve Ct management – webinar in spring/ early summer 2009 planned
- Evaluate impact of IUC interventions and review whether more interventions are needed



Provider Training:

Ensuring Quality of Care for LEP Clients

- Provider training on how to work with interpreters.
- Encourage assessment of language proficiency of bilingual staff and staff interpreters
- Encourage use of language lines and interpreter training



Provider Training:

Training on Contraceptive Counseling

- Focus on women who stay on low efficacy methods or continue to use no methods
- Focus on clients who discontinue from 1st to 2nd visit
- Counseling for clients adopting new methods should be improved
- Increase the capacity of providers who offer NFP/FAM services



Improve Referrals and Follow-Through

- Interventions since 2005: Seven provider forums on referrals
- Interventions to ensure follow through of referrals and rescheduled visits for Family PACT services
- Consider site visits to review clinic protocol to identify and refer clients in need of a usual source of care



Additional Next Steps

- Additional monitoring of issues and use of complementary data sources to gain complete picture of scope and severity of issue
- Information from 2005 charts is the baseline for interventions from 2005 to 2008; next MRR will measure impact on quality improvement initiatives



Thank you!

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