

Northwest Partnership for Public Health

*Clinic Efficiencies in Family Planning Project
Evaluation Report*

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by:

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Background

The North Carolina Institute for Public Health has been contracted to conduct one program evaluation per Incubator Collaborative per fiscal year. For fiscal year 2007-2008, the Northwest (NW) Partnership for Public Health chose to evaluate the Clinic Efficiencies in Family Planning project. The goal of the evaluation was twofold: 1) to examine the extent to which the agencies have implemented four of the HealthMETRICS recommendations (reduction of patient education materials, reduction of labs administered, adoption of patient self-history taking form, and implementation of open-access scheduling); and 2) to determine if additional resources were needed to assist with the implementation of the recommendations.

Methods

Two data collection methods were used to provide an opportunity for two different types of staff members to provide feedback on the Clinic Efficiencies in Family Planning project: a telephone interview with the Director of Nursing (DON) or Clinic Supervisor at each health agency and an on-line survey administered via SurveyMonkey to Lead Family Planning Nurses (LFPN). Evaluation participants were identified by agency health directors.

Qualitative responses from both instruments (interview responses and open-ended responses from survey items) were coded according to evaluation questions and other themes that emerged during analysis. Qualitative responses that were quantified and quantitative items from the survey are presented as frequencies. Since there were 10 or fewer respondents for each instrument, frequencies are presented as numbers instead of percentages. For the five agencies that had participants for both the survey and the interview, responses by county were also compared to determine the extent of respondent agreement (i.e., nursing supervisor responses were compared to LFPN responses).

Results

Response Rates

At least one person from all ten health agencies participated in the evaluation (Table 1). Nine out of ten individuals invited to participate in an interview completed an interview and all seven individuals who were administered the survey started it. One survey respondent dropped out after the first question as she had never heard of the HealthMETRICS recommendations, and another dropped out after Question 4 which asked about her familiarity with the four recommendations.

Table 1. Evaluation Participants by Northwest Partnership County

County	Interview	Survey
1. Alleghany ^a	X	n/a ^b
2. Ashe ^a	-	X
3. Watauga ^a	X	X
4. Davidson	X	X
5. Davie	X	X
6. Forsyth	X	X
7. Stokes	X	n/a
8. Surry	X	n/a
9. Wilkes	X	X
10. Yadkin	X	X

^a Alleghany, Ashe, and Watauga counties comprise the Appalachian Health District.

^b “n/a” – not applicable either because no name was given or because LFPN participated in interview.

Comparison of Respondent Types

For the five health departments where an interview was conducted and a survey completed, responses were compared. Results within agency were similar to each other in that Directors of Nursing/Clinic Supervisors and LFPN reported making similar changes in accordance with the recommendations. In the instances where there were differences, all but one involved the LFPN indicating yes to the change and the Director of Nursing indicating Not Applicable. This was mostly due to the fact that interviewees thought the change was made prior to the HealthMETRICS project, whereas the survey respondent attributed the change to the project. Responses may have varied because of data collection methodology, as interviewing allows for probing of responses.

Summary of Survey and Interview Responses

Many evaluation participants were satisfied with their involvement in the Clinic Efficiencies in Family Planning Project, indicating they enjoyed attending and benefited from the meetings held by Charlie Moore and Candice DuVernois. Furthermore, they indicated there was Health Department support for implementing the recommendations. Many of the recommendations were implemented, though there is room for improvement regarding implementation.

At the start of the evaluation, Ms. DuVernois provided the evaluator with two tables (Appendices A and B) illustrating the amount of time it takes to review patient education with clients and the number of labs being administered at each agency. This information was compared with interviewee responses regarding implementation of these recommendations (Table 2).

Four of the agencies made reductions in their patient education materials and one agency did not need to make a change. Three of the agencies who were suggested to make changes, did not make them. When asked what challenges existed to implementing this recommendation, three interviewees responded. Two respondents stated that cutting down on educational materials was not an important issue in their department. One stated that they can always go back and order more materials if needed and another indicated they will try to minimize materials, but that “it is not a major deficiency in clinic...it is not slowing them down. It's more about cost savings.”

Five of the agencies did modify the number of labs they were requiring and one agency did not need to make changes. One agency did not make any changes, and another indicated that they did not need to make changes, though evidence indicates they were conducting two tests beyond what is required.

Table 2. Need for Recommendation Changes Compared with Recommendation Implementation

	# of Minutes for Patient Education	Made Change	# of Labs Over Recommended	Made Change
Agency A	38.5	Y	-1 ^a	Y
Agency B	38.5	- ^b	-1	-
Agency C	38.5	N/A	-1	Y
Agency D	23 to 31	N	-1	N
Agency E	49 to 55	Y	0	N/A
Agency F	11	NA	2	Y
Agency G	26	Y	2	Y
Agency H	41	N	2	N/A
Agency I	46 to 60	N	3	N

	# of Minutes for Patient Education	Made Change	# of Labs Over Recommended	Made Change
Agency J	21.5	Y	5	Y

^a “-1” indicates they were missing Syphilis Serology

^b No interview was conducted with this County and the LFPN did not answer questions related to implementation.

Five agencies reported implementing patient self-history forms prior to HealthMETRICS and one agency began implementing it afterwards.

Seven agencies indicated they were implementing Open Access Scheduling, with two of those noting they were doing so prior to HealthMETRICS. Many interviewees described using a modified version of Open Access so it is unclear if they are fully following Mr. Moore’s recommendations. That said, three of the agencies have been able to demonstrate an increase in their patient show rates since implementing this form of scheduling. Two agencies are not implementing Open Access. Five interviewees discussed the following challenges their agency faced in adopting the open access schedule: differing definitions of open access; scheduling challenges; understanding the registration process for open-access scheduling; some staff resistance; down-time experienced during the transition to open access; and trying to address some of the things specific to health departments (as opposed to private practice) such as lack of mid-level providers, staff turnover, and paying overtime.

The agencies that experienced staff turnover, particularly in the Director of Nursing role, were less likely to report implementing the recommended clinic efficiencies. In one case, the DON had never even heard of the recommendations, and in some cases, the Lead Family Planning Nurse was not at all familiar with the recommendations or was not sure she had heard of the recommendations.

When evaluation participants were asked what Partnership staff could do to help them implement these recommendations, several indicated that there were things at the state level that needed to be addressed (Appendix C). If the state could standardize required patient education materials and send clear consistent messages regarding required labs, staff would not feel as conflicted in meeting suggestions of state program staff and clinic efficiency recommendations. Simplifying the state’s patient self-history form was also suggested.

Discussion

Between the time of implementation and data collection, three agencies have all operated at some point with interim health directors. Further, one of these agencies has also experienced much turnover in the Director of Nursing position in the past year. This change in staffing poses a challenge to the initiation and follow-through of the Clinic Efficiency recommendations. It is also important to note that in one of the agencies, staff were not aware that the recommendations were officially “approved.” It is evident that these two agencies are implementing the least with regards to the clinic efficiency recommendations.

Preliminary results were shared with the Partnership Coordinator who shared her insight on the findings. Ms. DuVernois was disappointed to learn that not all of the agencies had implemented the recommendations. When prompted about the specific objectives for the project, she indicated the assumption was that there would be 100% compliance. Further, it was apparent that she feels the success of the project falls on her, though she does not have the authority to enforce that these recommendations are made.

While initial meetings were held to disseminate the recommendations, a “roll out” plan for implementation with target goals and dates was not developed, nor were process evaluation activities in place to track progress and address questions/concerns/clarifications of the projects. Further, no mechanism was in place to track staff turnover. Such a tracking system would help ensure that there is a method to inform new staff of the recommendations.

Limitations

Several limitations existed for this evaluation. The last meetings held about the clinic efficiency recommendations were in June 2007, thus there may have been recall bias. While all health directors were asked to provide two names for each agency (one person to be interviewed and one to be surveyed), we ended up with only seven individuals identified for the survey. All seven started the survey, yet only five completed it. A higher survey response rate would have been helpful. Some respondents may not have been forthcoming in presenting all of the challenges related to implementation of the recommendations, as they knew this evaluation was being conducted on behalf of the health directors of the NW Partnership for Public Health.

Recommendations

Recommendations are divided into two sections, items to address for the current Clinic Efficiencies in Family Planning project and items to address for future projects. Recommendations are provided for the Partnership Coordinator and health directors’ consideration.

Current Project

- Executive summary should be shared with all evaluation participants for full transparency. Dissemination methods could include: email, hard-copy, website, or other format. When summary is shared, the Project Coordinator should include key action items that will result from the evaluation, as well as acknowledgement of preliminary successes of the project.
- Review progress made by health agencies to determine if progress being made is meeting Partnership’s standards. If not, determine how to move forward on improving compliance, being careful to address concerns that some of the staff may have on implementation.
- Determine if the modified versions of Open Access Scheduling being implemented are meeting the Partnership’s standards. If so, consider sharing information related to the preliminary successes of Open Access described in this evaluation. If not, consider addressing shortcomings with individual agencies.
- Follow-up on requests for assistance from individual agencies (e.g., send all relevant materials, provide more information about Open Access to those interested, provide recommendations on which patient education materials to use).
- Consider working with stakeholders from this project (i.e., family planning clinic staff, health directors) and possibly from other Partnerships on working with the state to provide consistent standardized guidance on recommendations for patient education and labs. Also work with the state on improving/simplifying the patient self-history form.

Future Clinic Efficiency and Other Projects

- Consider creating a committee or workgroup who is responsible for the project, rather than relying solely on the Project Coordinator. Members could include the Project Coordinator, one to two health directors, and clinic staff. Including staff will help ensure ‘buy-in’ to the project, and involvement of health directors will help ensure accountability.
- Consider developing a roll out plan for project implementation. The plan should have the following components: how recommendations/activities will be disseminated to agencies and within agencies; goals, objectives, and target dates; and clear communication channels. It should also include process evaluation activities and measures to ensure the project is achieving what it intended. Modifications can then be made along the way. Examples of these evaluation measures include a tracking system on implementation progress and a tracking system on staff turnover so materials can be immediately disseminated to new staff.
- Consider creating a packet of materials that includes the roll out plan and expected outputs and targets. Other materials could be handouts for clinic staff, flyers to be posted in clinics, suggested email language that goes out to staff, and other materials that would help disseminate the new information. This will ensure that all participants will have the same information and have a reference. Further, this packet can be distributed to new staff when there is staff turnover.
- In addition to initial meetings/forums where recommendations are presented, additional forums could be held at six months or one year after roll out to provide an opportunity for staff to discuss successes, challenges, and limitations and brainstorm potential solutions.
- As a reminder, clear objectives should be set for the project – for example, recommendations will be fully implemented in three agencies by the end of Year I, or 75% of the agencies will be using patient self-history forms within six months of roll out.

Northwestern Partnership – Clinic Efficiencies in Family Planning
Appendix A: Estimated Time to Review Patient Education Materials, by Agency

Time		1	2	3	4	5	6	7	8
Birth Control and STDs									
5	Birth Control Facts	5	5	5	5	5	5	5	5
5½	STD Facts	5½		5½	5½	5½	5½	5½	5½
Breast Self Exam									
<1	BSE Shower Card	<1					<1		
<1	Know the Facts about Breast Cancer and Breast Health				<1				
1	How to Examine Your Breasts (Triple Touch)		1						
2	How to do a Breast Self-Exam				2				2
2	BSE Technique			2		2			
2	A Woman's Best Defense against Breast Cancer							2	
3½	BSE (Breast Cancer Detection Awareness)	3½							
Emergency Contraception									
1½	Emergency Contraception (yellow)				1½		1½	1½	
Pelvic Exam/Puberty									
1	Having a Female Pelvic Exam							1	
1½	Making the Most of Your Family Planning Visit	1½			1½				
4	Puberty Facts				4				
5	Your Pelvic Exam		5						
6	Female Facts			6	6	6			
Abstinence/Teen Issues									
1½	Am I Ready for Sex?					1½			
1½	What is Abstinence?				1½				
1½	Sex: Ten Best Reasons to Wait			1½		1½			
2	Talking Abstinence			2		2		2	
2	How to Say No and Keep Your Boyfriend							2	
2	Types of Coercive Tactics					2			
3	Are you Ready to hold me...			3					
Folic Acid									
¼	The Busy Woman's Guide to Multivitamins						¼		
1	Folic Acid for Healthy Babies					1			
1	Take Care of Your Body; Take Care of Yourself						1		
2	Love your Body, Love Yourself (folic acid)	2		2	2				
STDs/Other Infections									
3	Yeast Infection	3							
3	HPV & Cervical Cancer	3							
5½	HIV Facts	5½							
Other									

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Time		1	2	3	4	5	6	7	8
1½	Be Smart. Be Ready.	1½							
2½	Stay Healthy & Active! Vaccinate				2½				
2½	Get Moving...Physical Activity for Adults				2½				
5½	Male Facts					5½			
Contraceptive Methods									
1½	Facts about the Patch (1-sided)								
2	Abstinence					2	2		
2	Spermicides	2			2	2	2		
2	Condoms “Rubbers”	2			2	2	2		
2	Diaphragms					2			
2	Birth Control Pills				2	2	2		
2	Depo-Provera Shots				2	2	2		
2	Contraceptive Patch					2	2		
2	IUDs				2	2			
2	NuvaRing					2	2		
2	Natural Family Planning				2	2		2	
3½	How to use a condom					3½			
App District									
	Menstrual Cycle Calendar	✓							
2 est	Birth Control: Talking with your parents	2							
2 est	Vaginal Discharge	2							
Davie County									
2 est	Birth Control: Talking with your parents			2					
2 est	ABE, AHS GED & ESL			2					
2 est	Date Rape: Ten Things you can do to protect yourself			2					
2 est	Emergency Contraception (blue)			2					
6 est	Health Guide for America’s Teens			6					
Forsyth									
<1	Wish				✓				
<1	Female Reproductive System				✓				
1 est	Survival Tips for Victims of Domestic Violence				1				
2 est	No one deserves to be abused				2				
2 est	Chickenpox isn’t just an itchy				2				
4 est	It’s Cool to Care about your Health				4				
Stokes									
1 est	Confidentiality Plan					1			
2 est	Stokes Family Health Center Domestic Violence Assessment Form					2			

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Time		1	2	3	4	5	6	7	8
2 est	Being Successful on the Pill					2			
Surry									
1 est	Confidentiality Plan						1		
1½ est	Women’s Preventive Health Services						1½		
2 est	Instructions for Emergency Contraception						2		
Wilkes									
<1 est	Tests received in Family Planning Clinic							<1	
1 est	Welcome to WCHD FP clinic							1	
2 est	Family Planning Educational Needs Assessment							2	
2 est	Nutrition: Tips for Improving your health							2	
Yadkin									
1 est	Emergency Contraceptive Pills (purple)								1
1 est	Half sheets								1
1 est	YCHD FP Program brochure								1
2 est	HIV Testing								2
4 est	NC Health Check and Health Choice								4
Total (3-24 pamphlets)		38½	11	41	49-55	46½ -	23¾ -	26	21½
(11-60½ minutes: Average of 32 minutes)						60½	31¾		

Northwestern Partnership – Clinic Efficiencies in Family Planning

Appendix B: Required Family Planning Labs

Test	4	5	6	7	7	8	9	10
Anemia Assessment R			Hematocrit			Hematocrit	Hematocrit	
	Hemoglobin	Hemoglobin	Hemoglobin	Hemoglobin	Hemoglobin	Hemoglobin	Hemoglobin	Hemoglobin
Gonorrhea R	Gonorrhea		Gonorrhea	Gonorrhea	Gonorrhea	Gonorrhea	Gonorrhea	Gonorrhea
Chlamydia I	Chlamydia	Chlamydia	Chlamydia	Chlamydia	Chlamydia	Chlamydia	Chlamydia	Chlamydia
Pap Test	Pap Smear	Pap Smear	Pap Smear	Pap Smear	Pap Smear	Pap Test	Pap Smear	Pap Smear
Vaginal Wet Mount I		Wet Mount						Wet Mount
Diabetes testing I Urinalysis I (Urine Dip, U/A, Blood Glucose, Hgb A1C)				Urine Dip	U/A	Urine Dip	Random glucose	Glucose
							U/A protein, sugar	Urine Dip
Cholesterol/Lipids I								Cholesterol
Hepatitis B scr I								
Syphilis serology I			Syphilis	Syphilis	Syphilis	Syphilis	Syphilis	Syphilis
Rubella Titer I								
HIV testing I				HIV		HIV	HIV	
Sickle Cell					Sickle Cell			Sickle Cell

Interviewee Suggestions for Partnership Support
<ul style="list-style-type: none"> ▪ Either the Partnership or the State could help by giving suggestions or recommendations for which pamphlets to use. They appreciate having autonomy, but “it’s hard to know if we are doing the right thing” given that they receive so many pamphlets and samples. It “would be good if they could suggest combinations of materials or something like that.” While there is a Family Planning Media Review, they still need more guidelines on what’s been approved. ▪ It might be helpful if you could bring information from other health departments who have gone to open access scheduling and ask them how they did it successfully. Also, ask those HD's if it had an impact on their income - did they lose revenue?
<ul style="list-style-type: none"> ▪ Look at patient history form and help simplify it. It is "not friendly for low literacy folks"
<ul style="list-style-type: none"> ▪ Provide all of the materials related to the recommendations
<ul style="list-style-type: none"> ▪ After HIS has been rolled out (one year from now), work on the state self-history form
<ul style="list-style-type: none"> ▪ Be available for consultation – how to deal with naysayers ▪ Involvement of Candice at the state level to reduce barriers to achieve partnership goals in staff reduction (e.g., problem in that the state is promoting opt-out HIV testing so this adds a lab to the 4 - this is how they got to so many labs - different divisions making recommendations so they keep adding more. There is no unified conformity at the state level. "Can't have it both ways - need unified priorities" - Advocacy on state level
<ul style="list-style-type: none"> ▪ Recognition of staff with what's been accomplished already. Commending staff for making progress - Celebrate success!
<ul style="list-style-type: none"> ▪ Interviewee would like to have seen a final report - she feels like she is already addressing these. She thinks Candice did a great job and she enjoyed the meetings, just didn't know it was all approved.