Women's Wellness Centers – Assessment Report

September 25, 2001

Submitted to the

American International Health Alliance (AIHA)
Washington, DC

(Contract 01-0343)

UIC

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Acronyms and Foreign Terms

AIDS	Acquired immune deficiency syndrome
AIHA	American International Health Alliance
BSE	Breast self-examination
CEE	Central and Eastern Europe
CQI	Continuous quality improvement
HIV	Human immunodeficiency virus
NIS	New Independent States
NGO	Non-governmental organization
PHCs	Primary health centers
STD	Sexually transmitted disease
STI	Sexually transmitted infection
UIC	University of Illinois at Chicago
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WWC	Women's Wellness Center

Key Word Definitions

Benchmarking: *The identification of "best in class" performance and analysis of the process by which that performance is achieved* (M. Sinoris and K. Najafi, "Epidemiology and Health Care Management" in *Epidemiology and the Delivery of Health Care Services*, ed. D. Oleske, New York: Plenum Press, 1995).

Primary health care: *The provision of integrated, accessible care services by clinicians who are accountable for addressing a large majority of the personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community health* (Institute of Medicine, *Primary Care: America's Health in a New Era,* Washington, DC: National Academy Press, 1996).

Stakeholder: an entity (individual, group, or organization) that has an interest in or influence on a specified organization. Stakeholders include: patients, governmental units (e.g., a Ministry of Health) and governmental officials, regulating bodies, organizations providing financial support or other assistance (e.g., a non-governmental organization or NGO).

Quality improvement plan: A formal plan that states an organization's objectives (in measurable terms) and strategies for improving quality. Such a plan can also be considered a tool for helping an organization meet expectations and improve performance relative to specific quality indicators.

Women's health: *Women's health involves women's emotional, social, cultural, spiritual and physical well-being; and is determined by the social, political, cultural and economic context of women's lives, as well as by biology* (*Women's Health Office Newsletter* issued by the Faculty of Medicine, McMaster University, Hamilton, Ontario, 1991).

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[1] Individual reports for each WWC were included in the original report to AIHA. The introduction and format for these reports may be found in Appendix 1, but actual reports were designed as feedback to each WWC.

Women's Wellness Centers – Assessment Report

Executive Summary

Objectives

During June and July of 2001, staff and faculty of the University of Illinois at Chicago (UIC) conducted on-site assessments of ten Women's Wellness Centers. These Centers--all of which had been in existence for more than a year--were initiated under partnership activities sponsored by the American International Health Alliance (AIHA) and funded primarily by the United States Agency for International Development (USAID).

The primary objectives delineated for the assessment project follow below.

- *To compare the current status of each Center to the WWC model, and the original goals and objectives established for WWCs*
- *To assess strengths and weaknesses—in the context of opportunities and threats of each WWC's environment; and especially to assess sustainability*
- *To determine if WWCs are practicing evidence-based medicine and using appropriate guidelines for the delivery of preventive and primary health care to women of all ages*
- *To gather information useful for quality improvement*

Assessment Methods

The assessment team collected primary data utilizing two questionnaires created specifically for this project: a *WWC Services Checklist* and an *Organizational Analysis Questionnaire.* The team also relied heavily on observations and interviews occurring during on-site visits to WWCs. Various reports provided by AIHA (including statistical summaries of WWC activities) were utilized as secondary sources of information.

Visits to WWCs occurred over two trips, each two weeks in duration. The June 2001 trip had four team members; the July trip had three. The project director, Dr. Fran Jaeger, and Dr. Ashlesha Patel, an obstetrician-gynecologist, went on both trips to ensure continuity and consistency in the assessment process. A list of team members, with University titles, follows on the next page.

Assessment Team Members

Fran Jaeger, MA, DrPH, Administrator, UIC Perinatal Center/Network, Title X Family Planning Program and MCH Projects

Ashlesha Patel, MD, Clinical Assistant Professor and Fellow in Family Planning and Women's Health

Stacie E. Geller, PhD, Assistant Professor and Health Services Researcher

Louise Simonson, RNC, MS, WHCNP, Outreach Coordinator, Perinatal Center

Cheryl Moran, RN, CNM, PhD, Nurse Midwife and Clinical Assistant Professor

The areas assessed during site visits and utilized for organization of findings are:

- Staff, staffing patterns and roles,
- Facilities and equipment,
- Stakeholder (or sponsor) support and sustainability issues,
- WWC services and consistency with the WWC model,
- Management and quality monitoring.

The assessment team received assistance with travel and site visit arrangements from staff of the AIHA central office. AIHA regional staff provided local logistical support and accompanied reviewers to Centers, but they functioned only as observers during the site visits. Executive Directors and staffs of all WWCs were exceedingly cooperative and enthusiastic as they discussed the status and accomplishments of their Centers.

Key Findings and Recommendations

This section summarizes key findings and recommendations. The body of the full report includes data tables and other supporting information. The full report also includes an Appendix with site-specific summaries of observations and categorization of variables in a modified SWOT (strengths, weaknesses, opportunities, and threats) format. The assessment team has prepared these summaries so that they can be provided to WWC Directors. The team recommends that Directors share the summary for their respective Center with staff, utilizing it to conduct their own self-assessment.

WWC Distinctions

WWCs have distinguished themselves in the following ways:

- They are "patient-centered" and considerate of patient needs as defined by them. Staffs have been oriented to ensure "patient-friendly" environments.

- They are places distinguished by the quality of care they deliver and the quality and professionalism of their staffs. Several patients interviewed during the assessments made statements such as: "The WWC has the best doctors."

- They offer a comprehensive range of services to meet the needs of women of all ages. WWCs also feel a responsibility for integrating services and ensuring continuity of patient care.

- They focus on prevention, early detection, education and counseling. Patients said that the WWC provides services that are not generally available elsewhere.

WWC Staff, Staffing Patterns, and Productivity Issues

- While WWCs have variable arrangements for primary and specialty care, all are concerned about assuring *comprehensiveness* and *continuity of care*.

- The majority of physicians working in WWCs are general obstetrician-gynecologists. Family planning and internal medicine physicians also work in WWCs on a regular basis. WWC Directors report that 2-14 primary care physicians work in Centers on a full-time or part-time basis.

- WWCs have variable arrangements for specialty services. Some Centers identified specialists as members of their staffs. One Center reported 6.5 specialists, but most WWCs have fewer. Sometimes non-staff specialists utilize the WWC to see patients, and sometimes patients are referred to specialists associated with a sponsoring hospital.

- Six WWCs have at least a part-time psychosocial staff position. The remaining WWCs all expressed a desire for such a position. Generally, Centers with psychosocial personnel are able to offer a fuller array of services — especially services related to mental health, substance abuse, and domestic violence.

- Expanded nursing roles and responsibilities are evident within the majority of WWCs. Midwives and general nursing staff are recognized as vital to the success of Centers, and they have significant roles in clinical care, patient education, and health promotion and prevention activities. Some WWCs are helping to educate and train nurses.

- A few WWCs monitor productivity and furnish sponsors with productivity data.

- Some WWCs want to attract more patients, but others believe they cannot serve more patients without increasing their staffs (and sometimes space as well).

Recommendations Regarding Personnel Issues:

- WWCs represent "models" for delivery of preventive, early detection and primary care services. Therefore, WWCs are encouraged to participate in the education and training of those preparing to become physicians, nurses, and allied health workers. This will help ensure that future health professionals understand the importance of prevention and promotion of health and "wellness."

- While the roles of nurses have generally been upgraded and expanded, WWCs are encouraged to use nurses even more effectively. Additionally, WWCs should consider designating nurses as care (or case) managers who facilitate continuity of care and coordination of services for a defined patient group. This would enable WWCs to appropriately serve more complex patients, ensure coordination of care (especially when it is necessary to refer patients for specialty care delivered elsewhere), and help maintain stability in the patient base.

- WWCs not yet having psychosocial personnel are encouraged to add them to their staffs. When this is not possible, a Center should have arrangements with a provider of such services. All WWC medical and nursing personnel should have sufficient training to recognize psychosocial needs among patients and facilitate referral and access to psychosocial services.

- As a measure consistent with the efficient and effective use of resources, it is recommended that WWCs monitor and ensure adequate productivity, applying a continuous quality improvement approach to do this. Each WWC should, at a minimum, establish measures for clinical activities and educational offerings.

WWC Facilities and Equipment

- WWCs have done well making their Centers visible to the public (e.g., through use of effective signage). In addition, Centers have publicized their origins as the result of partnership cooperation.

- Most Directors report that they, their staffs and patients are satisfied with the WWC building; the majority of WWC Directors are satisfied with equipment as well.

- WWCs have made their Centers comfortable and attractive places--inside and out. The focus on education and information is obvious; educational materials and informational resources are everywhere.

- WWCs have equipment characterized as "new, better or more advanced" than equipment available elsewhere in the surrounding community. However, nearly all WWCs report that equipment repair, replacement, and acquisition are problematic due to insufficient resources.

Recommendations Regarding Facilities and Equipment Issues:

- WWC Directors and staff are encouraged to continue their attention to creating an accessible, attractive and comfortable place for women to receive care.

- Each WWC should develop the means for equipment repair and maintenance; this may require designation of a specific line item in annual budget allocations (as well as negotiation with sponsors that control budgets).

- WWCs (and sponsors) should consider developing a capital reserve fund for the future acquisition of equipment. This is necessary to ensure that WWCs maintain the perceived quality edge due to modern and appropriate equipment.

- While equipment "wish lists" will likely remain a constant phenomenon, WWCs should ensure that basic equipment needs (and accompanying supply requirements) are met so that capabilities for providing services most essential to the "WWC model" are maintained.

Stakeholder Support and Sustainability Issues

- Nearly all WWCs remain components of the government-supported, public health system.

- Patient fees and private (or voluntary) insurance do not yet represent significant sources of revenue for most WWCs. However, health care financing is in a transitional phase in many of the countries having WWCs.

- Among WWCs visited, five Centers already have contracts with employers under voluntary arrangements; other Centers believe that more employers will provide health benefits in the future.

- Most WWCs have STRONG support among hospital and governmental sponsors.

- Replication of WWCs is occurring, with additional Centers based on the WWC model being opened and other ambulatory sites restructuring to look like WWCs. Such replication suggests broad commitment to the WWC model--a factor considered by the assessment team to increase the probability of sustainability.

- WWCs are influencing the delivery of care and raising standards in their respective regions. For example, some are stimulating development of primary health centers (PHCs) and training staffs for these and other delivery sites.

- Most WWC Directors discussed the need to be proactive and create a better future. They recognize the need to have well-trained and qualified staff, and they look forward to improved financing arrangements.

Recommendations Regarding Stakeholder Support and Sustainability Issues:

- WWCs should work to gain or maintain distinctions related to high quality and high productivity. These distinctions should ensure continued support from funding and governmental sponsors.

- WWCs should ensure the means of assessing the expectations of key supporters (or stakeholders) such as government and hospital/health system sponsors, and they should ensure capabilities to meet these expectations.

- WWCs are encouraged to find allies among Ministries of Health, local governments, employers, NGOs, and others and to "partner" with them to improve financing of health care.

WWC Services and Consistency with the WWC Model

- AIIHA data reports suggest that the majority of first time WWC patients have visits categorized as "problem-oriented." However, these patients also receive screening and preventive services during first and subsequent visits. Furthermore, WWCs devote considerable time and effort to the provision of education and counseling, and many patients take advantage of these services.

- The operation of WWCs is very consistent with the original WWC model. The services provided by all WWCs visited include:

    - Family planning/reproductive health
    - Testing and treatment (sometimes with limitations) of sexually transmitted infections (STIs) or diseases (STDs)
    - Breast/cervical cancer screening
    - Mental health counseling and education services
    - Chronic disease counseling and management
    - Services to older women.
    - Services directed to adolescents

- While the majority of WWCs (i.e., eight of the ten Centers visited) provide prenatal care, some WWCs have limitations regarding the type of care they can provide due to regulatory or licensing provisions.

- All WWCs do testing for sexually transmitted infections—some routinely for purposes of screening, others upon indication of a problem. However, there is variability in the types of tests done within Centers, sometimes attributable to lack of supplies or personnel capabilities and sometimes attributable to the low incidence (perceived or real) of a problem in the targeted population.

- Not all WWCs indicate involvement in AIDS prevention activities (such as education and testing). Treatment for HIV/AIDS is sometimes the responsibility of a specialized treatment facility, and referral for treatment is sometimes mandated.

- There is variation in testing and diagnostic practices among WWCs—for example, in terms of breast and cervical cancer. While practices sometimes deviate from US guidelines, WWCs necessarily adjust practices due to unavailability of testing supplies or lack of specific equipment.

- All WWCs provide counseling for nearly every health-related problem potentially experienced by women. WWCs having designated staff for the provision of psychosocial services tend to report greater availability of formally structured courses related to mental health, substance abuse, and domestic violence. Approximately half of the WWCs visited have well-developed programs in these areas.

- While all WWCs report health promotional programs--at least in terms of counseling and education--programs are less developed in the following areas: management of menopause, nutrition, diet and exercise; prevention of cardiovascular disease; drug and alcohol abuse, and smoking cessation.

- Among all WWCs visited, the highest percentage of women being served is associated with the age group 20-35. The next largest category of women served is in the group aged 36-50.

- Most WWCs report limited success in serving older women (defined as women over 50). Many WWCs expressed a need for additional training of health providers to promote increased capabilities for serving women past their reproductive years.

- WWCs vary in the level of services provided at their Centers to teens aged 13-19. However, several WWCs report involvement with the schools, participating in the development of sex education curricula and the training of teachers.

Recommendations Regarding Service Issues:

- WWCs should maintain a focus on prevention, early detection, health promotion and education. They should continue to be recognized as providers of comprehensive and coordinated care that addresses the health needs of women broadly defined (physical, mental, and spirit-related).

- WWCs providing well-developed programs in mental health, substance abuse and domestic violence are encouraged to continue them. At a minimum, other Centers should ensure that they have well-trained staffs to assess and detect psychosocial problems and to facilitate referral to treatment resources.

- WWCs are encouraged to work with local public health officials to assess the significance of unhealthy behaviors (such as smoking, lack of exercise, poor eating habits, unprotected sex) in the populations they serve. WWCs should consider development of more formal programs to address serious health problems caused by such behaviors when current efforts are judged insufficient.

- At a minimum, all WWCs should provide HIV/AIDS prevention, education and counseling.

- WWCs are encouraged to develop creative approaches to serve the hard-to-reach. WWCs should especially assess how to introduce older women to their services. Involvement with the school-age population is also encouraged since prevention is most effective when initiated early.

Management and Quality Issues

- WWC Directors and staffs have participated in extensive training and educational programs. Many of these programs are associated with AIHA partnership programs, but not exclusively. The distinction of a competent and professional staff is attributed to such training and education.

- WWCs recognize a need to maintain constant vigilance in the area of infection control.

- Directors of several WWCs identify the following needs: training of laboratory personnel, increased oversight and quality monitoring of laboratory services and specialized services requiring accurate interpretation of tests and procedures.

- All WWCs express familiarity with clinical practice guidelines and a few report procedures (such as chart audits) for monitoring care against these guidelines.

- Some WWCs periodically obtain feedback from patients through a patient satisfaction survey or some other systematic approach.

- Most WWCs utilize the software provided by AIHA in some fashion, but some WWCs find it difficult to use. Several WWCs have established parallel systems (manual or otherwise) to meet their needs. Most WWCs are giving attention to improving their management information system(s).

- AIHA has a quarterly *WWC Data Report* that could be used for tracking growth and changes in WWC activities and for benchmarking. However, assessment team members noted inconsistencies that suggest the need for review of reporting procedures. Distribution of clear instructions may also facilitate compilation of more uniform data.

Recommendations Regarding Management and Quality Issues:

- WWCs should pursue continuing education opportunities to maintain competency in managerial and leadership skills. WWCs with specialized competencies are encouraged to offer training and education programs to other WWCs.

- Each WWC is encouraged to assess the possible need to develop more formal approaches (such as chart reviews) for continuous quality improvement (CQI), including monitoring actual practices against clinical guidelines and principles of evidence-based medicine.

- Each WWC is encouraged to review the adequacy of quality control measures and record-keeping for laboratory services and other services requiring accurate interpretation of tests and procedures.

- WWCs are encouraged to utilize patient satisfaction surveys and other tools for assessing strengths and weaknesses of their Centers.

- WWCs are encouraged to develop a management information system that supports internal needs and enables compliance with all reporting mandates.

- WWCs should cooperate with AIHA to refine a WWC data set that enables tracking trends, quality monitoring and benchmarking. It is also recommended that reports (as updated and revised) continue to be provided to AIHA so that it can facilitate benchmarking.

- WWCs with a defined catchment area should work with local public health officials to assess the impact of their Center on the health status of women within this area. Measurement of intermediary outcomes among patients is also recommended (as changes in the general population may be difficult to measure if penetration is low or if a change in health status requires many years before manifestation).

- WWCs are encouraged to utilize their own staffs and apply a team approach to the tasks of developing and implementing quality improvement plans. Leadership of WWCs should recognize a responsibility for promoting a commitment to continuous quality improvement and the implementation of such plans.

Overall Recommendation:

It is recommended that a process be delineated for WWC Directors and key staff members to participate in periodic assessments of other WWCs. Such reviews could be a means to promote quality among WWCs and facilitate dissemination of good ideas and creative approaches to care.

Reviews need not occur more frequently than every 3-5 years. Although the review process should be carefully structured and administered in a uniform manner, it should not be burdensome or beyond the resources available to support the process.

Limitations of the Assessment Process

The assessment team covered substantial territory in relatively short periods of time. Yet team members felt that they gained adequate familiarity with each Center to accomplish the intended purposes of the project. A number of limitations must be recognized, however. These limitations are noted below:

- A site visit day is not necessarily a typical day.

- Misunderstanding and misinterpretation are possible – especially when languages and cultural experiences differ.

- Reviewers base findings and interpretations upon a moment in time, limited data, what they hear, and what they think they see—perceptions may vary unintentionally with reality.

- Methods and study design affect findings. The assessment of WWCs was undertaken for the first time without benefit of a learning curve.

Words of Appreciation

The assessment team expresses appreciation for the cooperation and interest of all the WWCs visited during this project. We also wish to thank AIHA headquarters and regional office staffs for the assistance provided before, during, and after our trips.

The commitment of WWCs to improving the health of women they serve was obvious during the site visits associated with this project. We hope that this report will contribute positively to future efforts.

Women's Wellness Centers – Assessment Report

I. Introduction

In early 2001, the American International Health Alliance (AIHA) issued a request for a proposal for the conduct of assessments of the Women's Wellness Centers (WWCs) that had been established in conjunction with its partnership program, with the financial assistance of the United States Agency for International Development (USAID).

The Project Director for this project, a staff member of the Department of Obstetrics and Gynecology, University of Illinois at Chicago (UIC), was notified in May that the proposal submitted by her had been selected for implementation by AIHA.

A. Purposes and Objectives of the Assessment Project

The UIC application proposed that assessment be done for the purposes of—

- Providing a status report on the development of each Center, comparing each WWC's original goals and objectives and its actual achievements in terms of management, operation, staffing patterns and training, and range of clinical and educational services available;

- Assessing the management and operational aspects of the WWCs to determine their consistency with principles of good management and the ability of each center to ensure sustainability (through fee-for-service or other stable financing arrangements);

- Preparing a SWOT analysis for each Center (or a statement indicating the perceptions of the review team and each Center's staff regarding strengths and weaknesses as well as opportunities and threats that each Center's current and future environments are likely to present—with consideration of political, economic, social, and technological factors);

- Evaluating the clinical components of each of the Centers, identifying the range of women's health services that are actually available (and comparing these to the comprehensive list originally envisioned for WWCs) and assessing whether the services offered by each Center are consistent with principles of evidence-based medicine;

- Developing a list of recommendations (addressing operational and clinical issues as appropriate) for each center and for AIHA, based upon the review team's observations; and

- Preparing a final project report for submission to AIHA that summarizes findings and recommendations from the visits to the WWCs and recommends future strategies for AIHA and its Women's Health Initiative.

The UIC application also stated this intent:

- *To utilize the evaluation of WWCs as a means for increasing understanding among WWCs of the principles of continuous quality improvement and the benefits of program evaluation (incorporating a self-assessment aspect) for assuring continued successful operation.*

B. Qualifications of the Assessment Team

Fran Jaeger, MA, DrPH served as Project Director. Currently, she is Administrator of the UIC Perinatal Center and the University's Title X Family Planning Program. Her educational background includes a masters in social work as well as a masters and doctorate in public health administration. She has participated in an AIHA partnership (with Tashkent, Uzbekistan), and she has extensive experience in health planning, management consulting and program evaluation. In addition to her work at the University of Illinois, she also teaches in the Health Systems Management Program of Rush University (Chicago) and the Masters of Public Health Program, Graham School of Management, St. Xavier University (Chicago).

Stacie E. Geller, PhD, is as staff member of the UIC Perinatal Center and an Assistant Professor in the Department of Obstetrics and Gynecology and the School of Public Health. Dr. Geller is the Director of Research for the University of Illinois Center of Excellence in Women's Health and she has extensive experience in maternal and women's health issues as well as health policy, health evaluation, and medical decision making. She currently serves as Project Director for several federally-funded and state-funded projects concerned with menopause, osteoporosis, and maternal mortality. Previous to entering academia, Dr. Geller was a lay midwife as well the Executive Director of the Chicago Women's Health Center, where she administered clinical operations and coordinated community efforts to ensure access to medical care for under-served populations of women and children.

Cheryl Moran, RN, CNM, PhD is a certified nurse midwife who delivers care in several ambulatory sites within the University of Illinois system. She is also a faculty member of the UIC College of Nursing. She has teaching responsibilities as well as responsibility for clinical supervision of nursing and midwifery students.

Dr. Moran serves on the Family Planning Advisory Council, a group charged with oversight of the Title X Family Planning Program operated within the State of Illinois. She has also served with the national Association of Certified Nurse Midwives in a leadership capacity.

Ashlesha Patel, MD is a recent recruit to the University of Illinois having completed her residency at Jackson Memorial Hospital, University of Miami. She was selected for a prestigious Women's Health Fellowship that includes advanced clinical training in women's health, international work, and the opportunity to complete a masters degree in public health. She was a member of the UIC delegation that visited Uzbekistan in September 2000 to assess the status of the two Women's Wellness Centers operated by Second Tashkent State Medical Institute. Dr. Patel provided several lectures to physicians and medical students while in Tashkent and she spent several days observing the care provided in the WWCs.

Louise Simonson, RNC, MS, WHCNP is Outreach and Education Coordinator for the UIC Perinatal Center. In this role she coordinates professional education activities, perinatal transports, and quality improvement activities between UIC and its Network of hospitals. Her most recent academic achievement is completion of educational requirements for certification as a Women's Health Care Nurse Practitioner. She obtained the clinical experience required for this certification in a variety of public and private clinical sites devoted to women's healthcare.

Ms. Simonson has a wealth of international experience in health projects related to perinatal and/or women's health in countries such as Poland, Lithuania, and Uzbekistan (where she has been three times). She also assisted with the training of medical/nursing teams at UIC from countries such as Morocco and India.

II. Assessment Methods and Limitations of the Process

A. Methods

Washington, DC staff of AIHA facilitated selection of Women's Wellness Centers for participation in the assessment process. Ten WWCs were selected and all have been in operation for more than a year (most have functioned much longer). The Centers were scattered between NIS countries (or New Independent States of the former Soviet Union) and countries in Central and Eastern Europe (CEE).

Visits to WWCs occurred over two trips, each two weeks in duration, during June and July 2001. The first trip had four team members; the second trip had three. Dr. Jaeger served as team leader, participating in both trips along with Dr. Patel, the obstetrician/gynecologist member of the review team. Other members each participated in one trip. When possible, site visits occurred over two days. However, the total time spent at some Centers was less—with the shortest visit being approximately six hours.

The staffs of AIHA regional offices assisted with scheduling visits and other local arrangements. However, AIHA staff did not participate in site assessments, except as observers. All findings, interpretations and recommendations are entirely those of the assessment team.

Various reports provided by AIHA (including statistical summaries of WWC activities) were utilized as secondary sources of data. Prior to site visits, each WWC completed two questionnaires prepared by the Project Director for this project—one called an *Organizational Analysis Questionnaire* and one called a *WWC Services Checklist*.

Evaluators relied heavily on interviews and direct observations for the formulation of findings and conclusions. During site visits, members of the assessment team met with the Director and Nurse Manager (or chief supervising nurse) of each Center, and usually other staff members such as psychologists, nurses, and physicians serving in generalist or specialist roles. A few Centers scheduled meetings between reviewers and non-governmental organizations (NGOs) working with their WWCs, and several provided opportunities to talk to patients.

With only two exceptions, each WWC arranged appointments with the Director of a sponsoring hospital and/or a representative of the governmental unit responsible for the WWC's budget allocation. While interviews were relatively brief, they generally confirmed what WWC Directors usually said—that these hospital and governmental sponsors were very supportive. It was obvious to reviewers that some of these sponsors had been involved in partnership activities and the WWC even during the planning phase.

The areas assessed during site visits and utilized for organization of findings in this report are:

- Staff, staffing patterns and roles,
- Facilities and equipment,
- Stakeholder (or sponsor) support and sustainability issues,
- WWC services and consistency with the WWC model,
- Management and quality monitoring.

B. Limitations of the Assessment Process

There are several limitations that may contribute to formulation of inaccurate conclusions as a result of the assessment process. First, site visits were 1-2 days in duration—a relatively short period of time in the life of a WWC. Second, the day of a Center's site visit was not necessarily a typical day. For example, preparations for the visit of Pope John Paul II resulted in a nearly complete shutdown of city services in L'viv. Patients were unable to utilize public transportation, and most appointments had to be rescheduled for another day. Even the assessment team experienced difficulty as it tried to reach the Center due to blockage of many streets.

While the assessment team agreed that the interpreters provided during site visits were excellent, there is always the possibility of misinterpretation and misunderstanding due to language differences between those asking questions and those answering them. Further, even without intent, reviewers may be affected by their own cultural biases.

Members of the assessment team have based conclusions on what they think they heard and what they believe they saw; perceptions are not necessarily reality. While the assessment process was designed to obtain data from multiple sources (both primary and secondary in nature) and to minimize error and confusion, it nevertheless captured a moment in time and generated findings based upon limited data.

Individual WWC reports, included in the Appendix, summarize information about Centers gained during interviews as well impressions and observations of the reviewers. Generally, team members met at the conclusion of each visit to compile their notes and discuss findings—recording these in a laptop computer so that they would not be forgotten or confused with those for another WWC. During debriefing sessions, it became apparent that each reviewer had generally noted the same concerns and features despite having been independently engaged during at least some of the time spent in a WWC. Unanimity among site assessors, however, does not necessarily ensure total accuracy all the time.

The assessment team attempted to focus on facts, to avoid misinterpretation and maintain objectivity. However, the assessment process necessarily involves some level of subjectivity—for example, in categorizing a specific WWC feature as either a strength or weakness or in citing a situation as a potential threat or opportunity related to sustainability.

III. Characterization and Distinctions of WWCs

Women's Wellness Centers in the following locations were visited: L'viv and Odessa, Ukraine; Chisinau, Moldova; Iasi, Romania; Moscow and Dubna, Russia; Almaty, Kazakstan; and Yerevan, Armenia (a Center and a Satellite).

Many of these WWCs are associated with a hospital and/or health care system (such as the Railway System). Nearly all WWCs are components of the public health care system, and thus they are governed by the rules associated with the public system of their respective countries. However, the WWC in L'viv is considered part of the Railway System, and the WWC in St. Petersburg resembles what would be called a "private" facility in the United States. One other WWC in Yerevan is operated like a private facility, although its staff are associated with a medical center that receives some government funds. All WWCs exist in environments undergoing considerable transition.

As noted in the Executive Summary, the WWCs can be described as:

- Patient centered and respectful of patients and their needs,
- Places where you find –
    - The best doctors and well-qualified staffs,
    - A full range of comprehensive and coordinated services to meet the needs of women of all ages,
    - Services that focus on prevention, early detection, education and counseling.

The assessment team agreed that all the WWCs participating in the assessment are essentially consistent with the model utilized for the development of Women's Wellness Centers. At the same time, each WWC has unique features and varied strengths. While the assessment team also uncovered some weaknesses—generally, those well-known and identified by the Centers themselves—the overall impression resulting from the team's assessment of WWCs is a very positive one.

IV. Presentation and Discussion of Findings

A. Staff, Staffing Patterns and Roles

Table 1 below summarizes the number of professional staff positions for each WWC as well as the number of total visits and new patient visits included in a recent quarterly report. The report was provided to the assessment team by AIHA headquarters staff prior to site visits.

The number of visits for the quarter is utilized as an indicator of the magnitude of WWC activity—but only in the area of clinical patient care. The quarterly report also indicates the number of recipients of educational courses or individualized teaching sessions as reported by each WWC. Table 2 indicates the range of recipients served, as well as the average, for the educational categories utilized in the quarter report. Taken together, however, the two tables do not fully represent all the activities undertaken by professional staffs of WWCs. The tables suggest magnitude and variability in the areas of clinical care and patient education, but they cannot be utilized for judging productivity, especially since no standard time is represented by the terms full- and part-time.

Table 1: WWC Visits and Staffing Patterns

Center	Total Patient Visits Jan-Mar 2001	New Patient Visits Jan-Mar 2001	Number of OB/GYN, FP, Other Primary Care MDs	Number of Specialist MDs (1)	Number of Psychosocial Personnel(2)	Number of Midwives And Nurses
1	8,440	3,759	5	6.5	1	8
2	16,794	9,317	12 part-time 2 full-time	6	1 part-time	18 full- and part-time
3	1,484	533	5	1	1	5
4	3,445	3,582	4	1 part-time		4
5	1,098	505	2	All available, consulting basis		7
6	2,054	983	4	1 full-time others, consulting	1 MD in dual role	9
7	6,082	5,112	3 full-time 3 part-time		1 part-time	2 full-time 1 part-time
8	9,015	2,221	6 full-time 2 part-time		1	5
9	1,616	203	6 part-time	4 part-time		3 full-time 8 part-time
10	589	166	3 part-time	2 part-time		4 part-time

(1) The term "specialist" may include a non-generalist obstetrician-gynecologist if the position was identified with a specialty such as perinatology or oncology.
(2) The term "psychosocial personnel" refers to an MD with psychology expertise and dedicated to psychosocial services, a psychologist or (infrequently) a social worker.

Sources: January-March 2001 Data Report for Women's Wellness Centers (visit number)
WWC Organizational Analysis Questionnaire, Summer 2001 (staff numbers)

Table 2: WWC Educational Offerings
Range and Average Number of Recipients

Educational Offering	Number of Recipients Low versus High Number		Average of Numbers Reported (excludes N/As)	Number of WWCs Reporting N/A
Childbirth education	24	2,147	392	0
Prenatal education	13	1,405	325	3
Family planning education	19	2,278	525	2
Breast self-exam training	166	4,683	1,350	0
Menopause education	10	1,230	195	1
Breastfeeding education	13	1,878	323	1
Adolescent programs	15	1,140	250	1
Other outreach activities	60	64	62	8

Source: January-March 2001 Data Report for Women's Wellness Centers

As indicated by Table 1, the number of primary care physicians (defined in this report to include generalist obstetrician-gynecologists, family and internal medicine physicians, and family planning physicians) working full- or part-time in WWCs ranges from 2 to 14 physicians. Most physicians are obstetrician-gynecologists, but some Centers report having family planning and internal medicine physicians as well. Physicians primarily deliver clinical care, but many of them also participate in educational offerings. Several of them are also available for outreach into the community (working with school systems, for example).

WWCs have variable arrangements for the provision of specialty services to women. Some frequently used specialists are on the staffs of WWCs (oncologists and endocrinologists, for example). Sometimes specialists, although not identified as regular staff, come on-site to see patients—an arrangement that enables a WWC to claim a wide range of services "under one roof." Sometimes WWCs have referral arrangements that result in referral of patients to a specialist in the sponsoring hospital. This latter arrangement generally offers easy access because the hospitals are literally "next door."

The assessment team was often told about arrangements for avoiding fragmentation and ensuring continuity of care. For example, a WWC Director said that its physicians visit their patients in the hospital whenever hospitalization is necessary.

The work of AIHA and partners to improve nursing education, increase the professionalism of nurses, and expand nursing roles and responsibilities is evident within most WWCs. Midwives and general nursing staff are recognized as vital to the success of the WWCs, and they have significant roles in the provision of clinical care, patient education, and health promotion and prevention activities. In a few WWCs, nurses (especially those classified as midwives) appear to provide certain categories of visits independent of physicians. In nearly all WWCs, at least some members of the nursing staff assume independent responsibility for educational offerings.

Productivity Notes:

The assessment process was designed to assess many aspects of WWCs at one time. However, 1-2 day site reviews—even when supplemented with information from primary and secondary sources of data—did not enable a comprehensive assessment of areas such as financial status and productivity. And indeed, the charge specified by AIHA did not include a comprehensive assessment in these areas.

However, the assessment team knows that promoting the efficient and effective use of health resources has been one of the primary objectives of partnership activities. Further, the assessment team heard WWC Directors and Center sponsors and supporters discuss the need for better utilization of health resources because these resources will certainly remain *scarce* for sometime into the future. One Center has already experienced the withdrawal of positions by the hospital with which it is affiliated, and several Directors noted that sponsors require information pertinent to productivity. WWC Directors suggested the need to justify and negotiate adequate budgets; they are not assured! And some Directors also noted that they do not have the ability to add a position to their staffs, but sometimes they are able to "trade" one position for another. These situations suggest a need for WWCs to proactively establish productivity standards and then work toward acceptable performance against these standards.

The assessment team lacked adequate information and data to reach accurate conclusions about productivity of one Center compared to another. Some Centers noted that they submit provider productivity data to sponsors, but the team did not view the format for this data. And it was not evident that other WWCs regularly assess productivity against well-designed standards--but perhaps this was simply missed during the assessment.

Thus, it is recommended that WWC Directors and staff ask several questions: Do appropriate productivity standards exist or should they be developed? Do hospital and governmental sponsors have expectations pertinent to productivity? If so, what are they and can the Center meet them? Will such stakeholders have expectations in the future? If my WWC is proactive in establishing appropriate productivity standards and then successful in meeting them, will this decrease the risk of standards being imposed externally? Will data demonstrating productivity provide an advantage in securing future resources for the Center?

Should there be consensus that productivity is an issue to be addressed, then it should be done through a quality improvement approach. This approach would involve staffs in defining the unique mission of the WWC and delineating the appropriate emphasis for each sphere of activity—for example, clinical care, patient education, off-site outreach and education, and other health promotional efforts. Then, productivity standards for each realm should be developed.

For clinical care, a standard might be 3 routine patient visits per 1 hour of provider time. However, a different standard may be appropriate for complicated cases—perhaps only 2 patient visits per hour of actual time available. Variable standards for first time versus return visits may also be considered. For example, a first time visit that includes a thorough explanation of the benefits and techniques of breast self-examination may warrant a longer visit time than a return visit for a patient scheduled for a hormonal injection for contraceptive purposes.

WWCs should likewise customize standards for educational activities. Some courses are designed for large audiences and some are intended to involve only a few participants. The establishment of standards—even if variable between different offerings—will nevertheless permit a WWC to determine which courses have participation consistent with predetermined expectations (or the productivity standard) and which do not. A continuous quality improvement approach necessarily involves assessment of various solutions once a problem is identified. For example, should the WWC drop an educational offering not achieving a standard? Is the problem lack of interest or is greater marketing required so that more individuals become aware of the availability of the course?

B. Facilities and Equipment

WWCs have done well identifying themselves, or making themselves visible to the public. Most have good signage and the WWC logo can be found everywhere. In addition, WWCs have maintained wall boards, signs and displays crediting AIHA, the US Agency for International Development, US partners, and their own local supporters for the assistance provided. In this way, WWCs have "branded" themselves as distinct; and this is consistent with good marketing.

Patients and staff of almost all WWCs (as reported by the WWC Directors) are satisfied with the physical facility in which the WWC is located. A few WWCs plan on expanding their Centers (taking more space in the same building or taking over nearby space in a contiguous building). Only one WWC moved from its original space, and this was done to ensure greater accessibility for patients and potential users.

Table 3: Satisfaction with the Building and Equipment

Question: Are you, your staff, and patients of the WWC satisfied with the building and equipment of the WWC?

Center	Yes	No	Comment
1	√		
2	√		
3	√		Not enough heat in winter.
4			Lack of some equipment is a problem.
5	√		
6		√	Not enough up-to-date equipment.
7	√		
8	√		MDs lack computers; no breast ultrasound machine.
9	√		
10	√		

Source: WWC Organizational Analysis Questionnaire, Summer 2001

Table 4: Facility Expansion Plans
Question: Are there any plans for changing or expanding the WWC in the future?

Center	Comment
1	"We plan on expanding the center."
2	"Opening of satellite centers throughout the oblast…."
3	"Yes."
6	"Yes" conditional on approval of equipment purchases and an increase in positions.
8	"We are going to expand the center and increase paid services."
9	Additional equipment is wanted. "It is advisable to use the Center gym for setting up a fitness center and establishing affiliations of the center in regions close to the city."

Source: WWC Organizational Analysis Questionnaire, Summer 2001

Table 3 and 4 are based upon questions asked in the *Organizational Analysis Questionnaire.* With only one exception, discontent is associated with equipment not the building. Site reviewers found WWCs attractive and well-kept. In addition, many appear superior to the buildings surrounding them. WWC staffs reported that their Centers are generally more attractive than other health facilities of their respective areas.

WWCs have become popular for many reasons--staff, the comprehensiveness of services, the comfort and attractiveness of the facility--as well as the competitive edge resulting from state-of-the-art equipment. Generally, WWCs have equipment described as new, better or more advanced than equipment available in traditional polyclinics and women's consultation centers. However, Table 5 suggests that WWCs may lack the means for purchasing new equipment or even repairing that which currently exists. For example, one Center with a mammogram unit re-tapes a broken compression tray each week--although it is not clear if cost or availability of the part prevents replacement. Reviewers observed other pieces of equipment that were characterized as unusable or limited in function due to the need for repair.

Most WWCs have limited collections in terms of patient fees and "donations" (or the voluntary contributions made by patients when a Center is unable to charge for a service). Further, money collected at Centers does not necessarily stay under the control of WWC personnel. Sometimes cashiers are employees of a sponsor (a hospital or city administration, for example). Not all Directors receive information to ascertain the amount of funds actually collected, and many WWCs have no mechanism for holding funds in a capital reserve account for future use.

On a more optimistic note, assessment team members were given examples of sponsoring institutions purchasing or obtaining equipment for the benefit of their WWCs. Some WWCs expressed confidence that equipment needs will get addressed by sponsors—somehow. But the uncertainly of the situation is reflected in the fact that only half of the Directors provided a definitive yes or no answer to the question reflected in Table 5 (despite the question being designed to yield a simple yes or no response).

Table 5: Equipment Purchase and Replacement Capability

Question: If equipment breaks or new equipment is needed, does the WWC have funds to replace equipment or purchase new equipment?

Center	Yes	No	Comment
1			The Center is part of a multidisciplinary establishment, which provides funding.
2			Practically no funds.
3	√		Yes, partially.
4		√	
5	√		
6		√	No, the hospital can make small repairs of WWC equipment, but there are no funds for purchasing new expensive equipment.
7			Replacement and repair of all equipment is made by the [sponsor] hospital.
8		√	
9			The Center has resources to repair and replace old equipment or purchase new equipment…if it is not too expensive.
10			The Center has resources to repair and replace old equipment or purchase new equipment…if it is not too expensive.

Source: WWC Organizational Analysis Questionnaire, Summer 2001

While the Executive Summary provides a recommendation that WWCs begin placing resources into capital reserve funds, it is recognized that implementation of the recommendation will require approval beyond WWC Directors. If a fund cannot be established, then other remedies should be considered—such as fundraising or solicitation of assistance from NGOs or other donors.

WWCs repeatedly stated that their distinctions revolve around prevention, education and high quality professionals. High technology equipment cannot be a substitute for qualified and caring personnel. However, the assessment team and those participating in the assessment process appear to have the same understanding of the ideal scenario: highly qualified and caring professionals with access to equipment that enhances capabilities for providing the detection and treatment services that are encompassed within the WWC model.

C. Stakeholder (or Sponsor) Support and Sustainability Issues

Among the ten WWCs visited, only two Centers (one in St. Petersburg and one in Yerevan) resemble what would be considered a private facility in the United States. Both these WWCs receive revenues solely from patient fees and insurance contracts, and both WWCs responded

affirmatively to a question asking if revenues are adequate for coverage of all WWC expenses. Seven Centers remain components of the government-supported, public health system, and one is sponsored by the Railway System (also a government-related system). While this provides a certain level of financial support—the support is generally considered inadequate. Patient fees and private insurance represent less significant sources of revenue (compared to public monies) for the majority of WWCs. However, several WWCs anticipate that employer-sponsored insurance will become more significant in the future. Table 6 summarizes responses of WWC Directors to a question pertinent to who pays for services at their WWCs.

Table 6: Sources of Payment for Services

Question: Who pays for the services provided by your Center?

Center	Government	Patients(1)	Insurance	Donors	Other	Sufficient for ALL Expenses?
1	√	√	√	√	√ (2)	No
2	√		√	√		No
3	√	√				No
4	√	√				No
5		√	√			Yes
6	√	√				No
7	√	√	√			Not Answered
8	√	√				No
9	√ (3)	√			√ (3)	No
10		√	√			Yes

(1) Generally patients paid directly only for a limited number of tests, procedures or supplies not covered under the benefits of the public system).
(2) Railway System
(3) Hospital Medical Center (having some governmental funding)

Source: WWC Organizational Analysis Questionnaire, Summer 2001

Reviewers conclude that most WWCs are NOT independent in terms of developing budgets, deciding how to allocate resources among staff positions, implementing fees and financial policies, and determining use of collections. Further, some Centers are constrained by regulations that discourage self-sufficiency.

However, WWCs characterized support as "strong" among the directors of sponsoring hospitals and the city and Ministry-level administrations that pass on public monies to the WWCs. And several WWCs cited governmental support for replication of WWCs to serve additional parts of the city and country. Such replication is considered by reviewers to be evidence of sponsor or stakeholder commitment and a factor likely to improve the probability of sustainability.

All WWCs exist in turbulent environments. WWC leadership and governmental stakeholders generally agree that resources for health care will remain less than ideal for sometime. Nevertheless, there is recognition of the need to support prevention and early detection—the programs encompassed by WWCs. According to a local public health official: "The health of a nation is more important than the wealth of a nation."

D. WWC Services and Consistency with the WWC Model

WWCs have done very well at implementing services based upon the original model of prevention, early detection, and primary health services. While Table 7 suggests that women tend to come to WWCs for a first visit that is problem-oriented, women also initiate service at a WWC for family planning and preventive services as well.

Table 7: Type of First Visit to the WWC

Center	% Problem-oriented	% Family Planning	% Preventive
1	7.1	20.8	72.1 ✓
2	70.3 ✓	21.2	8.5
3	59.9 ✓	14.6	25.4
4	N/A	67.7 ✓	32.3
5	48.1 ✓	40.0	11.9
6	55.8 ✓	33.4	10.8
7	37.5 ✓	28.5	34.0
8	44.0 ✓	14.0	41.9
9	63.5 ✓	14.8	21.7
10	74.7 ✓	6.0	19.3

✓ = highest percentage among categories for this WWC

Note: Some WWCs double-counted visits, some did not. The denominator for the calculation for each WWC is the total for numbers reported in each column.

Source: January - March 2001 Data Report for Women's Wellness Centers

Table 8, which follows on subsequent pages, summarizes responses to the *WWC Services Checklist*. The Table confirms that each WWC provides a fairly comprehensive array of services.

Most WWCs provide prenatal care to both low-risk and high-risk patients. However, during site visits, several WWCs indicated that women are still required to get routine prenatal care somewhere else (in a polyclinic, for example). Thus, the WWC is limited to a consultative role for patients seeking consultation on their own or patients referred because the Center has a high-risk perinatal service.

Table 8: Service Availability as Indicated by *WWC Services Checklist*
Women's Wellness Centers, Assessment Project, Summer 2001

Major Category/ Specific Service	WWC 1	WWC 2	WWC 3	WWC 4	WWC 5	WWC 6	WWC 7	WWC 8	WWC 9	WWC 10
Family Planning/ Repro. Health										
Fertility education	√	√	√	√	√	√	√	√	√	√
Contraceptive services	√	√	√	√	√	√	√	√	√	√
Infertility services	√	√		√	√	√	√	√	√	√
Prenatal and Perinatal Care										
Prepared childbirth	√	√	√	√		√	√	√	√	√
Breastfeeding	√	√	√	√		√	√	√	√	√
Parenting education	√	√	√	√		√	√	√	√	√
Low-risk prenatal	√	√	√	√		√	√		√	√
High-risk prenatal (1)	√	√	√	√		√	√		√	√
Referral/high-risk	√	√	√	√		√	√		√	√
STDs/STIs Services										
Counseling/education	√	√	√	√	√	√	√	√	√	√
Screening/testing		√	√	√	√	√	√	√	√	√
Treatment/management	√	√	√	√	√	√	√	√	√	√
AIDS prevention			√	√	√	√	√	√		
AIDS treatment				√		√		√		
Cancer Services										
Pap/other cytology	√	√	√	√	√	√	√	√	√	√
Colposcopy	√	√	√	√	√	√	√	√	√	√
Clinical breast exams	√	√	√	√	√	√	√	√	√	√
Mammography	√	√								
BSE education	√	√	√	√	√	√	√	√	√	√
Other education/screening		√	√	√	√	√	√	√		
Mental Health Services										
Education/counseling	√	√	√	√	√	√	√	√	√	√
Support groups	√	√	√		√	√	√			
Treatment for depression	√				√	√		√		
Rape/domestic violence	√	√	√			√		√		

Table 8: Service Availability as Indicated by *WWC Services Checklist*, continued
Women's Wellness Centers, Assessment Project, Summer 2001

Major Category/ Specific Service	WWC 1	WWC 2	WWC 3	WWC 4	WWC 5	WWC 6	WWC 7	WWC 8	WWC 9	WWC 10
Substance Abuse Services										
Screening/identification										
Education/counseling		√	√		√	√				
Support groups		√	√							
Tobacco education/ prevention	√	√	√		√	√			√	√
Smoking cessation						√			√	√
Chronic Disease Services										
Screening/detection	√	√	√	√	√	√	√	√		
Education/counseling	√	√	√	√	√	√	√	√	√	√
Treatment/management	√	√	√		√	√	√	√	√	√
Services to Older Women										
Postmenopausal Services	√	√	√	√	√	√	√	√	√	√
Hormonal replacement therapy	√	√	√	√	√	√	√	√	√	√
Education/counseling on aging	√	√	√	√	√	√	√		√	√
Health Promotion Services										
Nutrition education/counseling	√	√	√		√	√			√	√
Weight control		√			√	√			√	√
Exercise counseling	√	√		√	√	√			√	√
Other healthy lifestyle						√				
Other Special Program										
Adolescent health	√	√	√	√	√	√	√	√	√	√
Breast health	√	√	√	√	√		√	√	√	√
Other		√			√			√	√	√

While visiting Centers, members of the assessment team toured laboratory space and discussed the tests available at each WWC for detecting sexually transmitted infections. Nearly all WWCs do testing within the WWC; one sends patients to the hospital's polyclinic adjacent to it (because the tests can be done there without charge). However, there is variability in the tests routinely provided for purposes of screening.

Not all WWCs indicate involvement in AIDS prevention, and several WWCs stated a requirement for treatment of HIV-positive patients at a centralized treatment facility. Yet site reviewers saw several posters with AIDS messages displayed on the walls of several Centers. Brochures providing information on AIDS and preventive measures were also accessible at many sites. One WWC had recently enlisted the support of an NGO to enhance its AIDS prevention activities.

All WWCs provide screening for cervical cancer—but not usually applying the same cytological procedures associated with the Papanicolaou (or Pap) test as performed in the United States. Most WWCs have colposcopy capability, and some WWCs were observed to use it simultaneously with cytological screening without indication of a problem—a practice not appearing necessary to reviewers.

Notably, the services most often missing from a Center's list of available services are those considered psychosocial in nature. WWCs with no psychologist or other psychosocial position and Centers with only a part-time position were less likely to indicate the availability of defined programs and support groups for mental health, substance abuse and domestic violence. The position of psychologist was on the "wish-list" of many Centers.

Reviewers were very impressed with the domestic violence programs organized at some WWCs. For example, the WWC at Chisinau has the capability of obtaining assistance in domestic violence cases from a panel consisting of a psychologist, an attorney, a police officer, and a social worker. Other Centers have hotlines that function to provide information as well as crisis intervention for a variety of problems.

All WWCs report health promotional programs—at least in terms of counseling and education. However, programs do not appear well-developed in the following areas: nutrition, diet and exercise; prevention of heart disease; substance abuse (drugs and alcohol) and smoking cessation. Especially the lack of attention to the reported increase in smoking rates among women in many of the countries where WWCs are located is disappointing to reviewers.

Table 9 (on the next page) indicates the age distribution of patients as reported by Centers for January-March 2001. Among all WWCs visited, women in the age group 20-35 represent the largest group served during the quarter compared to others. The next largest category is women aged 36-50. During site assessments, WWC staffs often reported limited success in serving older women (defined as women over 50), and some expressed a need for additional training of health providers to promote increased capabilities for serving women past their reproductive years.

WWCs vary in the level of services provided to adolescents or teens aged 13-19. However, reviewers were provided examples of WWCs helping to develop sex education curricula and

training teachers so that they can effectively implement sex education courses appropriate to varied grade levels.

Table 9: Distribution of Patients by Age Among WWCs

Center	% Teenagers 13-19	% Adults 20-35	% Adults 36-50	% Older Women >50
1	N/A	N/A	N/A	N/A
2	18.3	41.0	34.7	6.0
3	10.6	62.2	22.9	4.3
4	13.4	61.9	20.6	4.1
5	6.2	50.5	37.9	5.4
6	32.6	49.6	16.6	1.2
7	6.6	50.0	32.8	10.6
8	25.2	70.5	4.0	0.3
9	7.4	70.4	14.8	7.4
10	9.0	54.2	30.7	6.1

Note: Some WWCs reported based on all visits; others reported for new patients only.

Source: January - March 2001 Data Report for Women's Wellness Centers

E. Management and Quality Monitoring

Notable Accomplishments of WWC Leadership

A WWC Director developed and submitted a proposal to the United Nations Population Fund (UNFPA) to train personnel of other Centers being developed in other parts of the country. UNFPA funds were granted for the "train the trainer" program and the WWC will gain contraceptive supplies through the arrangement as well.

Another Director developed a business plan that gives attention to the WWC's sustainability. This WWC is achieving its financial objectives and generating enough revenues to cover all the Center's expenses.

Several WWC Directors have contributed to making their Centers key components in the educational development of health professionals. The combination of clinical activities with an educational mission has created a synergistic relationship for these Centers and contributes to sustainability.

The assessment team found enthusiastic and energetic WWC Directors at every site. Most Directors had experience with partnership activities and the opportunity for training in the United States prior to assuming their roles, with a few exceptions. Several Directors with entrepreneurial skills have put them to good use for the benefit of their Centers (see box above).

Many examples of notable accomplishments of WWC leadership can be found in the individual summaries included in the Appendix.

During site visits, reviewers were told repeatedly that competent and professional staffs are a distinguishing feature of WWCs, and that the training and educational opportunities provided through partnership activities are responsible for this. This was said not only by WWC Directors, but also by the hospital and administrative officials to whom many Centers have accountabilities.

Table 10 below summarizes the results of a question included in the *Organizational Analysis Questionnaire* used in this project. The responses reflect the important and valid emphasis on training and education of personnel so that they can achieve a quality distinction.

Table 10: Continuous Quality Improvement Projects

Question: Describe any continuous quality improvement projects in which your WWC has participated.

Center	Comment
2	"Work with community, development of a business plan, quality training of staff."
3	Extensive 3-page list of training programs provided.
4	"Courses for general medicine physicians and nurses."
5	"The WWC staff has been invited to all AIHA-sponsored workshops and conferences related to women's health and primary care in general."
7	"WHO syndrome approach to STI diagnosis and treatment, infection control of medical waste, domestic violence, breast cancer prevention, breast feeding, Mother and Child Forum: family planning and safe maternity."
8	"Programs on reduction of maternal and perinatal mortality, family planning programs, early detection of breast cancer and breast self-examinations, program of Lamaze school."
9	"Monthly seminars for doctors and nurses." Reference was made to a list of advanced training courses "previously provided."
10	"Monthly seminars for doctors and nurses." Reference was made to a list of advanced training courses "previously provided."

Source: WWC Organizational Analysis Questionnaire, Summer 2001

While the emphasis on staff education and training should be continued, neither the questionnaire nor site visits generated as many examples of quality monitoring and organized quality improvement projects as might be expected. But there are some examples. One WWC Director and the Deputy Head of the sponsoring medical institute described a well-developed chart review process to assess if clinical practice guidelines had been used and the consequences of treatment. Another Director indicated that the Center became aware of an unsatisfactory level of false negatives associated with cervical cancer screening. As a result, workshops were

organized to train staff on proper procedures; subsequent quality monitoring suggested correction of the problem.

The time and opportunities were limited for reviewers with clinical backgrounds to actually observe the delivery of care to WWC patients. Staff interviewed during the assessment process all expressed familiarity with the clinical practice guidelines distributed previously by AIHA, and inconsistencies with these guidelines were not notable during the limited observations. One of the WWCs had placed care guidelines (in protective plastic) in each exam room to ensure that clinicians would remember to use them. But, except for the chart reviews mentioned previously, it was not evident that all WWCs have instituted the procedures to confirm that actual practices are consistent with the guidelines.

The assessment team was impressed that WWCs had implemented many infection control measures emphasized during the initial development of WWCs. For example, liquid soap and hand dryers were found in washrooms of many WWCs (but not necessarily in those of surrounding buildings). Handwashing signs were posted and gloves were generally used when considered appropriate during the limited clinical observations that occurred during the assessment process.

WWC Directors and other staff were insightful, in the opinion of reviewers, in identifying needs for additional quality monitoring and control measures for laboratory services and other services requiring accurate interpretation of tests and procedures. In some WWC locations, STI testing was previously centralized at one facility; only a limited number of individuals associated with the centralized facility received training in laboratory techniques.

Many WWCs reported highly skilled cytologists, ultrasound specialists and radiologists. However, individuals serving in these roles often have no peers available for the provision of back-up or assistance with interpreting ambiguous test results. Quality control measures, as required in the United States, would be difficult to implement in some of these situations. However, the assessment team was told about creative approaches when the ideal was impractical. For example, one physician who interprets breast films said that she has a schedule for re-reading her own interpretations. If she fails to reach the same conclusion when reading a film a second time, she will initiate action. Either she will seek advice from another specialist (who is available for consultation on a few cases) or she will bring the patient back for additional work-up in order to avoid reliance on a false negative.

A few WWCs are periodically obtaining feedback from patients through a patient satisfaction survey, but others gave no evidence of seeking patient input in a systematic manner. Site reviewers were supplied quality improvement plans that had been written by some WWCs in the past, yet neither these plans nor quality improvement projects associated with implementation of them were evident during the assessment process. Members of the review team simply had insufficient time to uncover everything positive about WWCs, so it can only be said that neither questionnaires nor site visits uncovered an example of an active and meaningful quality improvement plan.

Most WWCs utilize the software provided by AIHA in some fashion, but some WWCs find it difficult to use. Several WWCs have established parallel systems (manual or otherwise) to meet their needs. Most WWCs are giving attention to improving their management information system(s), and some of these efforts are being done in cooperation with governmental officials to ensure that a new system will meet their reporting expectations. Reviewers considered this a wise approach.

Assessment team members had a difficult time interpreting some of the data contained in the AIHA quarterly *Data Report for Women's Wellness Centers,* and several inconsistencies were noted. However, the report should not be discarded. Rather, it should be reviewed, revised, and circulated with a clear set of instructions. The addition of staging information for cancers detected by Centers and the reporting of other test results may also be useful for documenting that WWCs are achieving the intended impact. A report is included in the Appendix that provides specific recommendations pertinent to this *Data Report.*

V. Recommendations Offered by the Assessment Team

The following recommendations are the same as those following each category of findings summarized in the Executive Summary.

Recommendations Regarding Personnel Issues:

- WWCs represent "models" for delivery of preventive, early detection and primary care services. Therefore, WWCs are encouraged to participate in the education and training of those preparing to become physicians, nurses, and allied health workers. This will help ensure that future health professionals understand the importance of prevention and promotion of health and "wellness."

- While the roles of nurses have generally been upgraded and expanded, WWCs are encouraged to use nurses even more effectively. Additionally, WWCs should consider designating nurses as care (or case) managers who facilitate continuity of care and coordination of services for a defined patient group. This would enable WWCs to appropriately serve more complex patients, ensure coordination of care (especially when it is necessary to refer patients for specialty care delivered elsewhere), and help maintain stability in the patient base.

- WWCs not yet having psychosocial personnel are encouraged to add them to their staffs. When this is not possible, a Center should have arrangements with a provider of such services. All WWC medical and nursing personnel should have sufficient training to recognize psychosocial needs among patients and facilitate referral and access to psychosocial services.

- As a measure consistent with the efficient and effective use of resources, it is recommended that WWCs monitor and improve productivity, applying a continuous quality improvement approach to do this. Each WWC should, at a minimum, establish measures for clinical activities and educational offerings.

Recommendations Regarding Facilities and Equipment Issues:

- WWC Directors and staff are encouraged to continue their attention to creating an accessible, attractive and comfortable place for women to receive care.

- Each WWC should develop the means for equipment repair and maintenance; this may require designation of a specific line item in annual budget allocations (as well as negotiation with sponsors that control budgets).

- WWCs (and sponsors) should consider developing a capital reserve fund for the future acquisition of equipment. This is necessary to ensure that WWCs maintain the perceived quality edge due to modern and appropriate equipment.

- While equipment "wish lists" will likely remain a constant phenomenon, WWCs should ensure that basic equipment needs (and accompanying supply requirements) are met so that capabilities for providing services most essential to the "WWC model" are maintained.

Recommendations Regarding Stakeholder Support and Sustainability Issues:

- WWCs should work to gain or maintain distinctions related to high quality and high productivity. These distinctions should ensure continued support from funding and governmental sponsors.

- WWCs should ensure the means of assessing the expectations of key supporters (or stakeholders) such as government and hospital/health system sponsors, and they should ensure capabilities to meet these expectations.

- WWCs are encouraged to find allies among Ministries of Health, local governments, employers, NGOs, others and to "partner" with them to improve financing of health care.

Recommendations Regarding Service Issues:

- WWCs should maintain a focus on prevention, early detection, health promotion and education. They should continue to be recognized as providers of comprehensive and coordinated care that addresses the health needs of women broadly defined (physical, mental, and spirit-related).

- WWCs providing well-developed programs in mental health, substance abuse and domestic violence are encouraged to continue them. At a minimum, other Centers should ensure that they have well-trained staffs to assess and detect psychosocial problems and to facilitate referral to treatment resources.

- WWCs are encouraged to work with local public health officials to assess the significance of unhealthy behaviors (such as smoking, lack of exercise, poor eating habits, unprotected sex) in the populations they serve. WWCs should consider development of more formal programs to address serious health problems caused by such behaviors when current efforts are judged insufficient.

- At a minimum, all WWCs should provide HIV/AIDS prevention, education and counseling.

- WWCs are encouraged to develop creative approaches to serve the hard-to-reach. WWCs should especially assess how to introduce older women to their services. Involvement with the school-age population is also encouraged since prevention is most effective when initiated early.

Recommendations Regarding Management and Quality Issues:

- WWCs should pursue continuing education opportunities to maintain competency in managerial and leadership skills. WWCs with specialized competencies are encouraged to offer training and education programs to other WWCs.

- Each WWC is encouraged to assess the possible need to develop more formal approaches (such as chart reviews) for continuous quality improvement (CQI), including monitoring actual practices against clinical guidelines and principles of evidence-based medicine.

- Each WWC is encouraged to review the adequacy of quality control measures and record-keeping for laboratory services and other services requiring accurate interpretation of tests and procedures.

- WWCs are encouraged to utilize patient satisfaction surveys and other tools for assessing strengths and weaknesses of their Centers.

- WWCs are encouraged to develop a management information system that supports internal needs and enables compliance with all reporting mandates.

- WWCs should cooperate with AIHA to refine a WWC data set that enables tracking trends, quality monitoring and benchmarking. It is also recommended that reports (as updated and revised) continue to be provided to AIHA so that it can facilitate benchmarking.

- WWCs with a defined catchment area should work with local public health officials to assess the impact of their Center on the health status of women within this area. Measurement of intermediary outcomes among patients is also recommended (as changes in the general population may be difficult to measure if penetration is low or if a change in health status requires many years before manifestation).

- WWCs are encouraged to utilize their own staffs and apply a team approach to the tasks of developing and implementing quality improvement plans. Leadership of WWCs should recognize a responsibility for promoting a commitment to continuous quality improvement and the implementation of such plans.

Overall Recommendation – Future Program Evaluation of WWCs:

It is recommended that a process be delineated for WWC Directors and key staff members to participate in periodic assessments of other WWCs. Such reviews could be a means to promote quality among WWCs and facilitate dissemination of good ideas and creative approaches to care.

Reviews need not occur more frequently than every 3-5 years. Although the review process should be carefully structured and administered in a uniform manner, it should not be burdensome or beyond the resources available to support the process.

Appendix 1

Individualized WWC Report
Women's Wellness Center Assessment Project
Summer 2001

Note to the WWC Director and Center Staff

The following report includes the observations and findings of the assessment team visiting your Women's Wellness Center this Summer. Although we tried to be accurate in our assessment, our time in your Center was limited. Our categorization of a situation, characteristic, or variable as a strength or weakness (or sometimes as both) is subjective. While this summary and the other nine resulting from our efforts affected our overall interpretation of strengths and weaknesses of WWCs as a class, YOUR assessment of your Center should certainly outweigh ours.

Thus, we recommend that you review this assessment report and provide your own judgment. In addition to identifying strengths and weaknesses, we suggest you also consider whether there is an opportunity (O) -- either for taking full advantage of a perceived strength or for correcting a weakness (thus turning it into a strength), thereby improving the position of your WWC. You may also consider a situation, characteristic, or variable a threat. You may not immediately be able to address the threat or change it into an opportunity, but at least the recognition of its existence can provide some protection from future damage. And your awareness may enable you to recognize solutions in the future.

And thank you all. We wish the best of health to you and all your patients!

Sample Format for Individualized Report

[NAME OF WWC]

Observed/Documented Feature	Strength	Weakness	Your Rating **S or W? O or T?**	Comment
Personnel/Health Professional Development Activities: • • • **Facilities/Equipment:** • • • **Stakeholder Support/Adequacy of Resources for Sustainability:** • • • Range of Services/Extension of Care to All Patient Categories/Notable Service Features: • • • Management Systems and Quality Monitoring: • • • Focus on the Future/Other: • • •				

Appendix 2

WWC Organizational Analysis Questionnaire

Name of Center: _____

Location: _____

This questionnaire should be completed by the Center Director. Other staff may also contribute to providing the information. If possible, the questionnaire should be completed prior to the beginning of the site visit. Some of the questions will also be discussed during the visit.

Information about Staff

1. List the positions of individuals who work at the WWC and indicate if they are full-time or part-time.

Position Title:	**Check one:**	**Full-time**	**or Part-time**
_____		_____	_____
_____		_____	_____
_____		_____	_____
_____		_____	_____
_____		_____	_____
_____		_____	_____
_____		_____	_____
_____		_____	_____
_____		_____	_____

2. Are there any positions that you would like to have at the WWC but don't? Why are you unable to have them? Please answer these questions below:

WWC Organizational Analysis Questionnaire, page 2

Financial Information

3. Who pays for the services provided to patients at your WWC? Check (X) all that apply:

   ____ The government

   ____ Patients

   ____ Insurance

   ____ Donors/contributors

   ____ Other, please explain _____

   _____

4. If a patient has no way to pay for services, is your WWC able to provide services anyway? Please explain your answer.

_____

5. Does your WWC have a sufficient level of revenue to cover ALL the expenses of your WWC?

   _____ Yes _____ No

   If no, how do the expenses get paid? (Indicate, for example, if a sponsoring medical institute covers some of the expenses or if the WWC is carrying a debt.)

   _____

   If the WWC is not currently collecting enough revenue to cover all its expenses, do you think it will be able to do so in the future? And when? Explain.

   _____

6. Do you have a staff person at the WWC who

   a) records financial data or "keeps the books" _____Yes _____ No

   b) enters financial data into a computer _____Yes _____ No

   c) prepares financial reports for your review on a regular basis? _____Yes _____ No

WWC Organizational Analysis Questionnaire, page 3

If no one does these tasks at the WWC, is there someone else who does this for your WWC (such as your sponsoring medical institute)?

_____ No _____ Yes If yes, who? _____

Facilities and Equipment

7. Are you, your staff, and patients of the WWC satisfied with the building and the equipment of the WWC?
   _____ Yes If anyone is not satisfied, explain what is unsatisfactory.
   _____

   _____

   _____

8. Are there any plans for changing or expanding the WWC in the future?

_____

9. If equipment breaks or new equipment is needed, does the WWC have funds to replace equipment or purchase new equipment?

_____

Management Information and Systems

10. Do you use the software created by AIHA for use in WWCs?

    _____Yes _____No If no, why not? _____

11. Please describe the reports that are prepared to help you assess how well the WWC is doing. For example, are statistical reports showing information about visits, diagnoses/problems, procedures issued on a monthly, quarterly or other regular basis? Describe financial reports if these are prepared regularly. Identify and describe any other reports.

_____

_____

_____

_____

_____

_____

12. Can you identify any reports that are NOT prepared that you would like to have prepared?

_____

13. Describe any continuous quality improvement projects in which your WWC has participated.

_____

_____

_____

14. Has your WWC provided any staff education or training sessions? Please list and describe these.

_____

_____

_____

15. Can you identify any education or training sessions that you believe your staff need?

_____

_____

_____

Other

16. Please use the space below to tell us anything else about your WWC that you think is important for the site review team to know.

_____

_____

_____

_____

Appendix 3

WWC Services Checklist

Name of Center:

_____

Location:

_____

___

Check (X) if a specified service is available and provide comments as appropriate.

____ Family planning and reproductive health

____ Fertility education
____ Contraceptive services
____ Infertility services

Comments: Identify the most frequently used contraceptives and the range of contraceptives available. What contraceptives are not available or not requested by clients (and reasons)?

____ Prenatal and perinatal (high-risk) care

____ Prepared pregnancy and childbirth classes
____ Breastfeeding
____ Parenting education
____ Low-risk prenatal care
____ High-risk prenatal care
____ Referral for high-risk care

Comments: Indicate what type of pregnancy-related care is provided—that is, low-risk, high-risk or both. Discuss how risk status of maternal patients is determined and the arrangements for referral of high-risk patients to specialists outside the WWC.

____ Sexually transmitted infections/disease services (STIs/STDs)

____ Counseling and education about STIs/STDs
____ Screening and testing/detection
____ Treatment and management
____ AIDS prevention and treatment

Comments:

____ Cancer screening and education; diagnostic services

____ Pap smears
____ Colposcopy
____ Clinical breast examinations
____ Mammography screening
____ Education in breast self-examination
____ Other cancer screening and education services (explain)
_____

Comments: If pap tests are not done, indicate why. If clinical breast examinations are not done, indicate why. If education in breast self-examination is not done, indicate why.

____ Mental health services

____ Education and counseling
____ Support groups
____ Treatment for depression
____ Services related to rape, family/domestic violence

Comments: If the WWC does not provide mental health services but has referral arrangements for such services, indicate this.

____ Substance abuse services

____Screening and identification
____ Education and counseling
____ Support groups
____ Tobacco education/prevention services
____ Smoking cessation program

Comment: If the WWC does not provide mental health services but has referral arrangements for such services, indicate this.

____ Chronic disease services

____ Screening and detection
____ Education and counseling
____ Treatment and management

Comments: Indicate any diseases given special attention in the WWC's program (for example, diabetes, hypertension, anemia, heart disease, hepatitis, and osteoporosis).

____ Services to older women

____ Postmenopausal services
____ Hormonal replacement therapy
____ Education and counseling regarding aging

Comments: If the WWC does not have any of the above services, discuss why.

____ Health promotion services

____ Nutrition counseling and education services
____ Weight control program
____ Exercise counseling
____ Other healthy lifestyle program, describe:
_____

Comments:

____ Special program (population or disease-specific, education-oriented)

____ Adolescent health
____ Breast health
____ Other, describe: _____

Comments:

Appendix 4

Recommendations Regarding Data Collection and
Women's Wellness Centers

Introduction

During the Summer of 2001, an assessment team composed of members of the Department of Obstetrics and Gynecology, University of Illinois at Chicago, had the opportunity to visit ten Women's Wellness Centers initiated in association with the Women's Health Initiative of the American International Health Alliance (AIHA). The team was requested to provide recommendations pertinent to what data should be collected by Women's Wellness Centers (WWCs), and this report attempts to respond to that request.

Objectives for Data Collection

In order to determine what data WWCs should collect, it is important to first address this question: For what purposes should data be collected? There are multiple reasons that can be proposed and some of these are discussed below:

- To support the delivery of quality patient care

Patient-specific information is required to serve patients appropriately. For example, data on variables such as sex, age, health history, and current complaints are obtained from patients or prior medical records to help clinicians assess patient needs and design appropriate interventions. This information, together with tests results, current diagnoses, and provider recommendations are generally recorded in patient medical records to facilitate follow-up and the future availability of the information. Upon a patient's return, the medical record is also used for recording treatment results and updated data on current health status.

- To meet reporting requirements of external entities

External entities may include—

- Governmental units, e.g., a country's Health Ministry or a city or regional public health department
- Accrediting, regulatory, or quasi-regulatory bodies--such as the Joint Commission on Accreditation of Healthcare Organizations (United States)
- Professional associations or organizations of peers (e.g., the American Hospital Association)
- Other organizations—such as the American International Health Alliance.

Reporting to external entities may be mandatory and required by legislation and/or regulation, or reporting may be done on a voluntary basis. When reporting is voluntary, it is usually done with the expectation of gaining some benefit—such as gaining or maintaining accreditation. Another benefit may be access to a broader data set that can be used for *benchmarking*, a quality improvement tool that enables identification of best practices and analysis of factors that contribute to high-level performance.

- To support and enable essential management functions

A WWC may require data to enable such internal functions as billing for services, risk management, productivity monitoring, measuring outcomes of care (including patient satisfaction), and quality assurance and improvement. In addition, an organization requires data to evaluate progress in achieving organizational objectives—which, for a health-related organization, should include health status objectives for the population being served. Further, a WWC requires data to support planning and to market its services effectively.

- To support other specialized functions such as research and policy development

A WWC may engage in very practical research—such as research designed to assess if better results are achieved by one form of treatment versus another. A WWC may also provide data to enable assessment of an existing policy or to help formulate recommendations pertinent to the development of new policy. For example, a WWC might cooperate with a governmental unit to determine if mandatory HIV testing of pregnant women is helping to decrease the number of children contracting AIDS. Or, a WWC might work with governmental officials to establish a policy that requires a country's public health system to offer cervical cancer screening as a component of the basic service package provided to women free of charge.

Additional Objectives

The objectives presented above are not exhaustive, nor are they mutually exclusive. Further, the objectives are those relevant to reasons for a WWC to collect data. Additional objectives could be formulated to capture the reasons an entity external to a WWC would mandate or request data from a WWC.

- An employer may seek comparative data from several providers of women's health services to compare costs, the range of services made available, and outcomes. This data might be used to help the employer select a preferred provider of care or to negotiate an insurance contract based upon the services that a specific provider can provide.

- A consumer advocacy organization may generate a "report card" for various service providers. The intent may be to provide consumers with information useful for selecting one provider over another.

- A governmental unit or a regulatory agency may have a mission associated with protecting the public. The focus of its data collection activities could be to ascertain that an organization like a WWC is carrying out certain processes determined to promote or protect health and not contributing to adverse outcomes.

- A governmental agency may sponsor data collection efforts to delineate the disparities in access to services and health status among segments of the population.

- A consortium group may work cooperatively to gather and assess data to provide an analysis of the overall health of women at the national and state level. The analysis may be distributed to policy makers, health care planners and providers, educators, researchers, elected officials, advocates and the public to stimulate thought and action directed at improving women's health.

Focus of this Report and Recommendations

WWCs have variable mandates for reporting of data to governmental entities and hospital sponsors. This report does not address data elements and reporting mechanisms associated with such mandated reporting (although it is believed that the data collected for mandatory reporting overlaps that collected for other purposes). Rather, this report focuses on collection and reporting of data to the American International Health Alliance. It also briefly addresses additional data collection that a WWC might undertake for the purpose of continuous quality improvement. And lastly, this report addresses how a WWC might work with its public health officials to measure the health status of women in its country or a defined geographic area.

I. Reporting Data to AIHA

AIHA has implemented a procedure for collecting data from WWCs initiated in conjunction with partnership programs and its Women's Health Initiative. Presently, data is being compiled into a quarterly report entitled ***Data Report for Women's Wellness Centers.*** Two quarterly reports were reviewed during the assessment of WWCs (occurring in the Summer of 2001). Several inconsistencies became apparent and the interpretation of some of the data was difficult. Problems are summarized below.

- Some WWCs provided age data for all visits; some appear to have provided it for only new patients. The report did not note the variation, nor was it obvious from the report what should have been reported. "Age" was the descriptor used, but without reference to the group being categorized—that is new patients or all patients visiting the WWC during the reporting period.
- Subtotal numbers for subcategories of visits ("first-time patients" and "repeat patient visits") did not consistently total among WWCs to the "total number of visits."
- The pattern for further sub-categorization of visits was not consistent. Some WWCs evidently double-counted a visit (if it was for multiple purposes), some counted a visit only once—but the basis for classification was not evident from simply viewing the report.
- The meaning of "STI screening" was not evident. The numbers provided by WWCs possibly represented each distinct screening test performed during the reporting period, or perhaps the numbers referred to visits during which one or more screening test was done. It could not be confirmed that WWCs report in a consistent manner.
- Contraceptives are reported under a heading "contraceptives selected." Does this mean that contraceptives are reported only if a woman first selects a contraceptive method or if she selects a different one than selected previously? For the category "condom," does the number represent single condoms distributed or the number of women depending on condoms as a contraceptive method?
- Do the numbers reported for health education categories represent individuals participating in a class or an educational session that is separate from a clinical visit? Do some of the numbers encompass counseling provided within the context of a visit with a clinician? For example, do the numbers provided for "menopause education" represent women participating in group educational sessions or women who are individually counseled during a visit with a clinician, or do they represent both? Do WWCs report in a consistent manner?

Objectives for the WWC Data Report

AIHA has reporting responsibilities to the US Agency for International Development and other entities that are providing or have provided financial support for the development of WWCs. Further, AIHA retains accountability (due to a mandate or simply because it is expected by stakeholders) for reporting the results of efforts to Ministries of Health, other CEE and NIS governmental officials, and the many health care providers on both sides of the ocean who have made WWCs successful. AIHA may undertake collection of WWC-related data to assess progress in fulfilling program objectives or to meet funding conditions that are still applicable. It may also voluntarily compile and distribute reports to maintain goodwill and promote cooperation in current and emerging initiatives. And indeed, AIHA has a need to promote its accomplishments so that it will be recognized as an organization worthy of receiving public and private funds to maintain its efforts in the future.

During the assessment of WWCs, those interviewed frequently told members of the review team that they hoped that AIHA would continue to be involved with WWCs. While a range of roles was proposed for continuing AIHA involvement, most were associated with quality improvement. Thus, there is evidence that WWCs consider the American International Health Alliance to be a suitable organization for guiding and directing quality improvement efforts. Further, the site assessment team believes that some of the resources provided to AIHA are for the purpose of enabling this role.

Thus, these reasons are proposed for AIHA to collect data from WWCs:

- To enable AIHA to assess its progress in meeting its organizational objectives,
- To fulfill mandated and voluntary reporting responsibilities (thereby meeting quality expectations of stakeholders or supporters),
- To enable AIHA to document results and publicize accomplishments (as this is necessary if it is to gain the resources it needs to maintain and enhance its work), and
- To support the role of AIHA as a focal organization for promoting the continuous quality improvement of the WWCs that it has helped establish.

It is recommended that AIHA headquarters staff review the above list. Consensus on the reasons AIHA wishes to collect data is required to judge the adequacy of any plan for data collection (since adequacy of data should be evaluated against the question of whether it fulfills intended purposes).

Questions That Can Be Answered by the WWC Data Report

The WWC Data Report, with some modification, appears capable of facilitating answers to these questions:

- Are WWCs (collectively and individually) serving sizable numbers of women of all ages?
- Are WWCs growing or at least maintaining a patient base over time? [This question requires comparisons over time.]
- What is the predominant reason for visits to a WWC? And what's the next most common reason, etc? Are there changes occurring over time?
- Are WWCs engaging in health promotional, educational and outreach activities that promote health and prevent disease (primary prevention)?

- Are WWCs providing a comprehensive range of secondary prevention services (or early disease detection) and primary care consistent with the WWC "model" (including health education and counseling, prenatal care, reproductive health services, and treatment of common problems)? What is the relative magnitude of services compared to each other?
- Are WWCs providing, and are women taking advantage of, specific secondary prevention measures, such as the screening tests and diagnostic procedures utilized for detecting specific health problems, such as cancers and STIs?
- Are screening and diagnostic procedures resulting in significant health problems being found, and are these problems being detected earlier as time passes? [This question requires comparisons over time.]
- What are the most common forms of contraception selected by WWC users?
- Does the activity of specific WWCs suggest growth, maintenance, or decline over time (based upon comparison of data over reporting periods)?

For the most part, the current WWC Data Report presents data related to the ***processes*** of delivering primary and secondary prevention services and primary care. The report does not provide data regarding treatments, impact and outcomes of these services--except that the April – June 2001 has an additional section for Breast Health Programs that suggests that an impact of these programs is the diagnosis of breast cancers. In the future, comparison of data over reporting periods will permit Breast Health Programs to determine if they are affecting a change toward earlier versus late detection of breast cancers.

Questions That Cannot Be Answered by the WWC Data Report

- Do women served by the WWC improve health behaviors and practices over time (for example, eating better, exercising more, and smoking less)?
- Are treatments initiated when health problems are detected, and what are the consequences of treatments?
- Are morbidities and early deaths (among patients or women in the catchment area) being reduced?
- Are unintended pregnancies being avoided and infertility problems being reduced?
- Are the numbers of days women perceive their mental health to be "not good" decreasing?
- Are STIs decreasing or increasing as evidenced by cases detected?
- Are WWCs utilizing resources well and meeting productivity standards?
- Are WWCs providing high-quality care and do patients perceive that such care is being provided?
- Are patients generally satisfied with the WWCs, the services provided, and the clinical and non-clinical aspects of care?
- Are the costs associated with the delivery of services reasonable?

There are many other questions not answered by the WWC Data Report. This is not a criticism of the report because it was not designed to be a complete source of information about WWCs. The above questions may be worthy of asking, but the means to answer them is not provided by the WWC Data Report as presently formulated. Individual quality improvement projects are probably the best means for answering these questions and many others as well.

Recommendations for Reporting to AIHA

AIHA should essentially continue to request the same data from WWCs but there should be clear instructions issued, along with definitions, to increase uniformity in reporting data and to facilitate interpretation and use of the data.

A few additional data elements should be added to the data requested by AIHA from WWCs. But unless there is some specific unmet data need (specified by AIHA or by WWCs), then additions should be minimal so that the reporting burden remains reasonable.

Specific recommendations suggested for improvement of the WWC Data Report follow.

Age Profile of Clients

Recommendation 1: **Age data should be collected for visits in the following manner:**

Category	a. Number in Age Category First Time Visits	b. Number in Age Category Repeat Patient Visits	c. Total Visits (c = a + b)
Teens (13-19)			
Adults (20-35)			
Adults (36-50)			
Older Women (50+)			

Total patient visits for each age category would be determined by adding column a and column b. Total visits for the entire reporting period could be obtained by summing the numbers placed in column c.

During the assessment of WWCs (Summer 2001), a few WWCs indicated that the AIHA software is being used to enter new patients into the database but not to enter information on returning patients. One WWC said that it was not able to extract age data from the software. For whatever reason, if a WWC cannot provide age data for both new patients and returning patients (completing both columns a and b), then it should report whatever age data it has in a correctly labeled column (a, b, or c). This would avoid an incorrect interpretation.

It should be noted that the table above would not provide the number of unduplicated patients. If a WWC has software to facilitate an unduplicated count, this information would be useful for assessing stability of the patient base. But if tabulations are done manually (as they appear to be at some WWCs), then achieving an unduplicated count may be problematic.

Visit Breakdowns

Recommendation 2: **A visit should be clearly defined.**

A suggested definition follows on the next page.

A visit is as a face-to-face interaction between a patient and a medical provider. It may occur for any of the following purposes—

- To assess health risks and health status (through physical examination, health screenings, collection of medical history),
- To address a medical complaint or problem,
- To confirm or rule out pregnancy,
- To provide prenatal or postpartum care or a perinatal consultation,
- To provide a family planning service, and/or
- To provide individualized patient education or counseling on a health or mental health concern.

Recommendation 3: **Definitions should be provided for each subcategory of visit and instructions should be provided to assist WWCs categorize visits by primary purpose.**

While patients may receive a visit for multiple purposes, the visit should be classified by primary purpose and counted only once. Recommended definitions are provided below, along with some guidance for determining primary purpose.

Problem-oriented visit is a classification for visits during which the patient answers this question affirmatively: Do you have any discomfort or health or mental health-related complaint that should be addressed during this visit? Even if the patient scheduled the visit because it was mandated to get or retain a job, an expression of a complaint related to a health or mental-health concern should result in classifying the visit as "problem-oriented."

Preventive health visit is one in which the patient has no specified complaint. The primary reason for the visit is to obtain a health screening or assessment of health status. It may also be a visit that is mandated for employees to meet job requirements (such as an annual health assessment). Categorization of the visit should depend on the patient's response to the question: Do you have any discomfort or health or mental health-related complaint that should be addressed during this visit? If the patient says no, then even if a problem is detected as a result of physical examination or screening test, the visit qualifies as a preventive visit (which may have been mandated or not).

This category should not be used when the visit is motivated by a desire to receive a family planning service or the visit is related to pregnancy (and is motivated by a desired to receive prenatal care/perinatal consultation/post-partum care or assessment of pregnancy status).

[Note: It has been proposed that mandated visits be classified as problem-oriented when a patient identifies a complaint to enable classification of the visit based upon the patient's perspective. However, it is possible that AIHA or WWCs may prefer to categorize mandated examinations as preventive in nature--since prevention may be the motivation for employers to require periodic health examinations. Regardless of how mandated visits are classified, it is important that instructions clearly indicate how such visits should be treated so that WWCs report in a uniform manner.]

Pregnancy-related visit includes a visit provided for any of the following reasons:

- To confirm or rule out pregnancy,
- To receive prenatal care—either routine or high-risk,
- To receive a pregnancy-related consultation (or perinatal consultation) even if a patient receives routine prenatal care elsewhere.

Family planning visit includes a visit where medical and/or counseling services are provided in conjunction with contraception, sterilization, infertility diagnosis and treatment and related care. Patients may come to a WWC for a family planning visit for reasons including—

- Obtaining advice or recommendation pertinent to a contraceptive method to avoid pregnancy,
- Obtaining a contraceptive injection or prescription or receiving contraceptive supplies,
- Assessment and determination of the problems inhibiting pregnancy when it is desired, or help with addressing a known infertility problem,
- Preconceptional counseling or the provision of assistance to promote a healthy pregnancy,
- Emergency contraception or counseling regarding abortion or other options for avoiding or dealing with an unwanted pregnancy,
- Education and counseling regarding responsible sex and measures to avoid unwanted pregnancy as well as sexually transmitted infections/diseases (if provided to a patient of reproductive age by a provider on a face-to-face and individualized basis).

Follow-up on problem visit should be the subcategory used when a patient returns for reassessment of a problem and determination of intervention effectiveness for a problem addressed at the previous visit.

While the "follow-up" subcategory of repeat patient visit is useful for assessing if patients are developing a relationship with the WWC, it appears that some WWCs lack the ability to distinguish visits except by the broad categories of first visit or repeat visit. The reasons why visits cannot be reported in greater detail should be assessed.

Screening and Diagnostic Testing

Recommendation 4**: Data should be reported for a limited number of significant screening and diagnostic tests, and any screening and diagnostic data provided by WWCs to AIHA should serve an identified purpose.**

Screening and diagnostic tests are indicative of the focus of WWCs on early detection and secondary prevention. But the list of tests to be reported should periodically be reviewed to determine that there is a good reason for AIHA to obtain the data. Other comments regarding tests and procedures follow.

- The term "Pap smears" should be replaced with a term such as "screening for cervical cancer" or "cytological test for cervical cancer." This is because some WWCs, when visited during the Summer of 2001, said that they do not do Pap tests; rather, they use other cytological testing techniques for detection of cervical cancer.

- "STI screening" should be changed to "visits including STI screening" and counts should be based on the number of visits that include the performance of one or more screening test for the purpose of detecting a sexually transmitted infection. This would mean that a visit would be counted no more than once even if multiple STI screening tests were done during the same visit. A visit would not be counted for this category if no STI testing is performed. The instructions for reporting should also list any of the standard tests that qualify for inclusion in the category of STI screening (including, for example, gonorrhea, syphilis, chlamydia, herpes simplex, hepatitis B, HPV and HIV).

- Mammograms are appropriately reported by WWCs with mammography capability. However, since many WWCs cannot do mammography, it is appropriate for all WWCs to track the number of clinical breast examinations performed (especially since most organizations formulating guidelines for breast cancer screening recommend clinical examinations in addition to mammograms).

- If ultrasounds are to be tracked, directions should be provided to indicate whether the term refers to any type of ultrasound or to a specific type, such as breast ultrasound.

While WWCs may have many reasons for tracking a comprehensive list of tests and procedures, the advantage of reporting data for an extensive list of tests and procedures to AIHA is not apparent. It is probably most appropriate to report screening and diagnostic tests for breast and cervical cancer because there are guidelines pertinent to how frequently women should obtain screenings. Some assessment can be made of a Center's success at getting women to follow screening guidelines by comparing test numbers to the number of visits occurring during a reporting period (although the current report format is not adequate to determine with accuracy the percentage of women following guidelines).

The April – June 2001 *Data Report* differed from the previous quarterly report because some WWCs reported additional data under the category "diagnostic testing," including biopsy, cryodestruction, operations, and electrocoagulation. Some of these additional categories may be for the purpose of treatment rather than diagnosis. Thus, if they are to be reported, this would necessitate changing the name of the category under which they are reported to include treatment procedures as well as screening and diagnostic procedures. But more importantly, the advantage that results from the provision of such data to AIHA is NOT apparent. How will the data be used? What can the data suggest about WWCs? Can the data be used for benchmarking or any other purpose related to continuous quality improvement and WWCs overall? Prior to issuance of revised reporting instructions, these questions should be answered.

Contraceptive Use

***Recommendation 5*: Directions should be provided to clarify what is to be reported for the category "contraceptive use." If AIHA is to be provided data pertinent to the quantity of**

contraceptive supplies distributed by WWCs, then reporting should be done under the category of "contraceptive supplies dispensed."

A number of subcategories appear under the term "contraceptive selected." It is recommended that a contraceptive be reported when a patient initially selects a method during a visit with a clinician at a WWC or when a patient decides to change and select a different method as a result of a clinical visit at a WWC. An additional direction should be provided to specify that the counts refer to the method selected and not to supplies distributed to support a method.

If AIHA and WWCs want to know what quantity of contraceptives supplies are actually being distributed by WWCs (rather than prescribed or recommended), then directions need to specify how dispensed supplies should be reported. For oral contraceptives, reporting might be based on the number of 1-month cycles distributed to patients during the reporting period. In this case, one visit would generate a count of 3 if a patient receives enough pills for three months. For condoms, reporting might be per single condom distributed directly by the WWC. Injectable contraceptives would be reported per injection. Thus, three injections could be reported for the same patient during a 3-month period if Lunelle is used (since it requires monthly injections). If a patient utilizes DepoProvera, then it would be typical for one or two injections to be reported (because DepoProvera requires injections approximately every 70-90 days).

Health Education and Counseling

***Recommendation 6*: Definitions and directions should be provided to clarify the nature of data provided in the health education section.**

For health education, it is recommended that directions be provided to clarify that counts refer to the number of individuals (potentially males as well as females) that participate in ***group*** educational sessions associated with each topic. Perhaps only sessions meeting a minimum time requirement (such as "at least 15 minutes in duration") should be reported.

Counts could also be provided on the number of sessions held during a reporting period. Directions must be specific regarding whether counts refer to people or sessions.

If data is desired pertinent to the number of individuals counseled on a specific topic, then specific directions should be provided regarding counseling. Counseling can be done within the context of a patient's visit with a clinician. In this case, counseling numbers would be duplicative of numbers provided for visits. Theoretically, counseling can also be provided in groups—but classification of group sessions as educational sessions might be more appropriate. At least, individuals should not be double-counted in courses and counseling sessions (for the same block of time).

If counseling is to be tracked by WWCs, potential categories relevant to women's health include: management of menopause, smoking cessation, alcoholism and drug abuse, nutrition and weight control, cardiovascular risk reduction, and management of specific chronic diseases (diabetes and arthritis, for example). The advantage of reporting counseling delivered during visits is to enable assessment of what topics are covered more frequently than others. If counseling is reported by age classification of patients, then it would also be possible to determine if women are receiving counseling on the topics most pertinent to their age group. A question such as this

could be answered: Are a significant percentage of WWC patients aged 50 and beyond receiving counseling on menopause management at this Center? Reporting this data to AIHA could facilitate benchmarking purposes because Centers doing better (as a result of counseling high percentages of 50+ patients) could be distinguished from those providing such counseling to smaller percentages of patients in this age group.

Additional Reporting to AIHA

Breast Health

The April – June 2001 *Data Report* contained an additional section for statistics from Breast Health Centers. The following recommendations are offered for this section:

- The term "number examined" does not have an obvious meaning and should be defined or replaced with another term. Likely to be of interest is the unduplicated number of women receiving one or more breast screening or diagnostic procedure during the reporting period.

- The numbers of mammograms, breast ultrasounds, cyst aspirations, and biopsies document procedures relevant to the detection of breast cancers. Reporting the number of breast cancers confirmed during the reporting period is also recommended because this would document the results or impact of detection efforts.

- Reporting instructions should clarify that a WWC should take credit for identifying a confirmed breast cancer as long as one of its clinicians detected an abnormality or suspicious finding requiring follow-up and someone on the WWC staff made a referral or guided the patient through the diagnostic process. Obviously, the WWC must receive diagnostic information in order to report a confirmed case, and the receipt of such information is necessary if the WWC is to monitor and support the patient during treatment and rehabilitation.

- Confirmed cancer cases should be reported by stage. However, a category of "not yet staged" should be added to the reporting subcategories. If cases previously reported but not staged are captured in a later report, they should not be reported as if they were new cases (as this would suggest that WWCs are finding more cancers than they actually are). Possibly these cases could be reported under a category of "previously reported/recently staged."

  To ensure uniformity of data, reporting instructions should delineate the meaning of the staging categories. Comparison of staging data over time can determine if WWCs are helping to detect breast cancers in earlier versus later stages.

Additional Reporting Items

Additional reporting should be considered for the following data items:

- Number of primary care physicians working at least 50% time as staff of the WWC, including generalist obstetrician-gynecologists, family planning physicians, family medicine and internal medicine physicians

Rationale: While primary care physicians are only one element of the staff of a WWC, the number staffing each WWC would be suggestive of whether a WWC is large or small. Further, the monitoring of the numbers provided by each WWC over time would enable assessment of growth and stability or provide a sign of downsizing. The numbers and types of nurses would also be useful, except that definition of nurse categories may be more complex than the definition of a primary care physician.

- Confirmed cases of cervical cancer
  Rationale: In addition to reporting the number of cervical cancer screenings performed during a specific time period, it would be advantageous for WWCs to report the number of tests with abnormal findings as well as the number of confirmed cases of cervical cancer diagnosed during the same reporting period. While it may be beneficial to have abnormal cytology findings classified, WWCs may not be using the same classification scheme to enable uniform reporting. Staging information for confirmed cases of cervical cancer may be useful—but the categories of invasive or *in situ* may be adequate for reporting to AIHA.

- One or more sexually transmitted infection (detected as a result of STI screening by the WWC)
  [Note: Reporting should include both the number of tests performed for a defined STI and the number of positive tests found so that both numerator and denominator are available.]
  Rationale: There may be an advantage to reporting the number of cases detected for a sexually transmitted infection if WWCs can agree on one or two that are of high incidence in the population and important to detect early to avoid more serious complications. In the US, chlamydia is such an infection—at least in the population under 25. Family planning programs receiving federal dollars are therefore required to report the number of screenings and the number of positive cases to state oversight agencies. This enables such agencies to monitor the effectiveness of family planning programs related to detecting an STI that can have serious consequences if untreated.

  While it is certainly important for each WWC to track STIs it detects (and governments may require reporting as well), the advantage of reporting such data to AIHA is debatable. Primarily, the data could be used to document that detection *processes* yield results. WWCs could use such data to characterize the problems most prevalent among patient groups or to assess prevention efforts of their WWC over time.

- One or more chronic condition advantageous for early detection and intervention
  Rationale: Examples of problems that may be advantageous for reporting are cases of diabetes, hypertension or osteoporosis. These problems are noted because they are problems seriously under-diagnosed in many populations. Yet if detected early, intervention may lead to improved quality of life for many women.

  The reason for reporting one or more chronic condition is to provide data to demonstrate the value of WWCs for early detection and prevention. Such data can be used by WWCs to help build support among sponsors, but the potential advantage of additional reporting to AIHA should be weighed against potential disadvantages. Data on diagnosed conditions may be useful for benchmarking and identification of best practices, but a request for transmission of additional data should be accompanied by concrete plans for analysis and use.

Data Collections Methods

The University of Illinois at Chicago assessment team did not evaluate the adequacy of the software developed by AIHA when it visited WWCs during the Summer of 2001. While the software is known to capture patient-related data and some data relevant to services, some WWCs do not enter all patients and visits into the software, and some WWCs appear not to use it at all.

A standardized encounter form or visit record is a means for enabling clinicians or nursing staff to quickly "check off" patient information and visit-related data that are needed for reporting. WWCs having well-developed management information systems can enter data from the forms and run reports with the data requested by AIHA. Or WWCs without this capability could tabulate results using the forms. Ideally, every WWC will utilize a computer to facilitate tabulations even if AIHA software is not used. Otherwise, the tabulation task could be very burdensome, especially for larger Centers.

A sample data collection form utilized by Title X family planning programs in Illinois is included in this report (see page 16). This is not a form ideal for use by WWCs. However, the form is suggestive of one that could be designed to collect all the patient-specific data required to report to AIHA. The form could be modified to enable collection, via easy check-off method, of data pertinent to type of visit, tests, procedures, counseling topics, and certain results and diagnoses of interest.

II. ***Data Reporting for Quality Assurance***

This section suggests a number of indicators or measures that could be identified for use by WWCs in continuous quality improvement (CQI) projects. WWCs might consider some measures so important that they would collect data relevant to the indicators on an on-going basis (and the data element should thus be included on the standard "clinic visit record" completed for each patient). However, WWCs could also elect to implement CQI projects, collecting data for short periods of time or collecting data at specified time intervals but not constantly.

Measures Related to Women's Health

Health status indicators have been jointly developed by the National Women's Law Center, FOCUS on Health & Leadership for Women at the Center for Clinical Epidemiology and Biostatistics of the University of Pennsylvania School of Medicine, and the Lewin Group. The indicators are presented in a publication entitled *Making the Grade on Women's Health: A National and State-by-State Report Card* (published by the National Women's Law Center in 2000 and found by accessing its web page at http://www.nwlc.org/health.cfm?section=health). FOCUS, it should be noted, is a National Center of Excellence in Women's Health—a designation provided by the Office of Women's Health, US Department of Health and Human Services.

Some of the measures of the group identified above are appropriate for application to the patient population of WWCs. Some measures are more appropriate for measuring women's health and the impact of services in the broader community.

Another US entity issuing relevant health indicators is the National Committee for Quality Assurance. It has developed a set of standardized performance measures to ensure that purchasers

and consumers have the information they need to reliably compare the performance of managed health care plans. The performance measures contained in the set are known as the Health Plan Employer Data and Information Set or **HEDIS**. The latest HEDIS indicators follow (see page 17). Indicators related to women's health are highlighted.

Examples of how some of the indicators of these organizations could be used within WWCs follow.

Breast cancer screening
- Percentage of first-time patients who have a clinical breast examination during their first or second visit to the WWC
- Percentage of first-time patients who receive training in breast self-examination during their first or second visit to the WWC
- As mammography capabilities increase, percentage of women 50 and over who visit a WWC and have an initial screening mammography
- Once general mammography screening becomes possible, percentage of WWC patients 50 and over who have had a mammogram within the past two years

Cervical cancer screening
- Percentage of first-time patients who have a cervical cancer screening during their first or second visit to the WWC (unless a recent screening was done and documented elsewhere)
- Percentage of WWC patients age 18 and over who have had a cervical cancer screening within the past three years

Colorectal cancer screening
- Percentage of women 50 and over who present to a WWC and are offered and accept a sigmoidoscopy

High Blood Pressure
- Percentage of visits where blood pressure is taken to detect hypertension or to assess control of high blood pressure
- Percentage of WWC patients known to have high blood pressure who are adequately controlled (as evidenced by blood pressure readings within acceptable limits)

Diabetes
- Availability of comprehensive diabetes care

Smoking
- Percentage of patients who smoke who are counseled not to smoke

Pregnancy
- Percentage of pregnant women who present to the WWC for pregnancy confirmation and initiation of care within the first trimester
- Percentage of prenatal care patients who comply with a recommended schedule for prenatal care visits

Menopause
- Percentage of women 50 and over who present to a WWC who are provided information and counseling regarding options for management of menopause

III. Data to Measure Impact in the Community

The National Women's Health Law Center, FOCUS and the Lewin Group received funding from a number of private sources to undertake the work associated with the *Report Card.* The Office on Women's Health of the US Department of Health and Human Services provided support for the compilation of data used to measure states against specific indicators. The *Report Card* indicates that the purpose of the indicators is to determine: "women's access to health care services, the degree to which they receive preventive health care and engage in health-promoting activities, the occurrence of key women's health conditions, and the extent to which the communities in which women live enhance their health and well-being" (p.1 of *Making the Grade…).* A set of policy indicators was also identified to enable comparison of the statutes, regulations, policies and programs that address problems identified by health status indicators. The list of *Report Card* indicators may be found on pages 18 and 19.

The *Report Card* list of indicators includes many of the indicators that are utilized in objectives for *Healthy People 2010*, which is a set of health objectives for the United States to achieve over the first decade of the new century. *Healthy People* objectives were designed for use by "many different people, States, communities, professional organizations, and others to help them develop programs to improve health, according to the US Department of Health and Human Services" (at web site http://web.health.gov/healthypeople/About/whatis.htm). The objectives address ten leading health indicators:

1. physical activity
2. overweight and obesity
3. tobacco use
4. substance abuse
5. responsible sexual behavior
6. mental health
7. injury and violence
8. environmental quality
9. immunization
10. access to health care.

While developing a report card for their communities is beyond the capability of WWCs alone, a similar effort could be undertaken by WWCs in association with local governmental units and Ministries of Health. Ultimately, if WWCs prove themselves effective mechanisms for the delivery of a comprehensive array of women's health services, it should be possible to document progress and improved report card grades over time.

AIHA may be an ideal organization for working with Ministries of Health and other governmental officials who may be interested in developing "Report Cards." The data required for these is quite extensive. Reports prepared for each US state depended on data from the following sources: Behavioral Risk Factor Surveillance System surveys, the National Center for Health Statistics (of the Centers for Disease Control and Prevention), and unpublished data of the National Conference of State Legislatures, and current population reports of the US Bureau of the Census. Some NIS and CEE countries may have comparable sources of data and the capabilities for assessing the impact of women's health programs on communities. However, it is expected that others will need to design national strategies for data availability and monitoring comparable to those being undertaken in the US around the *Healthy People Initiative* and the efforts to produce report cards on a periodic basis.

ILLINOIS FAMILY PLANNING CLINIC VISIT RECORD

Name _____ **Pt #** _____

Address _____ **Phone #** _____

1. FORM NUMBER 492503

SECTION A — ALL VISITS

2. SERVICE SITE NUMBER

3. PATIENT NUMBER

4. DATE OF VISIT — MO | DAY | YR 2 0 0

5. PURPOSE OF VISIT (check one)
- ☐ 1. Initial Medical Visit
- ☐ 2. Annual Revisit
- ☐ 3. Routine Visit
- ☐ 4. Problem Visit
- ☐ 5. Supply Visit
- ☐ 6. Education/Counseling Visit
- ☐ 7. Non F.P. Visit

6. DATE OF BIRTH — MO | DAY | YR 1 9
6a. SSN # ___ – ___ – ____

7. PRIMARY SOURCE OF PAYMENT (check one)
- ☐ 1. Medicaid Only
- ☐ 5. Medicaid / TANF
- ☐ 2. No Fee (0-100%)
- ☐ 3. Part Fee (101%-250%)
- ☐ 4. Full Fee
- ☐ 6. Other

8. BILLABLE MEDICAL SERVICES
- ☐ 01. Minimal Service
- ☐ 02. Brief/Int. Exam
- ☐ 03. Extended Exam
- ☐ 04. IUD Insertion
- ☐ 30. IUD Removal
- ☐ 05. Diaphragm Fit
- ☐ 06. Cervical Cap Fit
- ☐ 07. Hormone Implant Insertion
- ☐ 08. Hormone Implant Removal
- ☐ 29. Depo Provera Injection
- ☐ 32. Lunelle Injection
- ☐ 09. Pap Smear
- ☐ 10. HGB/HCT
- ☐ 11. U/A
- ☐ 12. Pregnancy Test - Negative
- ☐ 28. Pregnancy Test - Positive
- ☐ 13. VDRL/RPR
- ☐ 15. Wet Mount
- ☐ 16. Herpes Test
- ☐ 17. Sickle Cell
- ☐ 18. PP Blood Gluc
- ☐ 19. Cholesterol Level
- ☐ 20. SMA-12
- ☐ 21. Colposcopy
- ☐ 22. Colposcopy & Biopsy
- ☐ 23. Sonography/Lost IUD
- ☐ 24. X-Rays/Lost IUD
- ☐ 25. Chlamydia/GC Test
- ☐ 26. Mammography
- ☐ 31. Urine C/S
- ☐ 27. None

9. BILLABLE COUNSELING SERVICES
- ☐ 1. Indepth/1Hr.
- ☐ 2. Counseling/15 min. to 1 Hr.

10. ROUTINE COUNSELING SERVICES
- ☐ 1. Sterilization
- ☐ 2. Contraception
- ☐ 3. Infertility
- ☐ 4. Pregnancy
- ☐ 5. STD
- ☐ 6. Natural Family Planning
- ☐ 7. Preconceptional
- ☐ 8. Other Medical Svcs.
- ☐ 9. Other Social Svcs.

11. BILLABLE CONTRACEPTIVES/SUPPLIES

	QTY	BRAND			QTY	BRAND	
01.			Orals	10.			Condoms
02.			Creams	11.			Meds/Vag. Inf.
03.			Jellies	11.			Meds/Vag. Inf.
04.			Suppositories	12.			Meds/STD
05.			Foams	12.			Meds/STD
06.			Diaphragms	13.			VC-Film
07.			IUD	14.			Cervical Cap
08.			Basal T&C	15.			Hormone Implant
09.			MEDS	16.			Female Condom
18.			Sponge	17.			Emerg. Contraceptive

AHLERS & ASSOCIATES, WACO, TX

12. PROVIDERS OF MEDICAL/COUNSELING SERVICES
- ☐ 1. Physician
- ☐ 2. Mid-level
- ☐ 3. Nurse
- ☐ 4. Ed/Couns.
- ☐ 5. Nutritionist
- ☐ 6. Social Worker

13. CONTRACEPTIVE METHOD (Complete before and after blocks)

09. Sterilization, 14. Depo Provera Inj., 15. Lunelle Inj., 01. Oral, 12. Hormone Implant, 02. IUD, 04. Foam & Condom, 06. Condom, 03. Diaphragm, 08. Cervical Cap, 10. Sponge, 07. Natural Method, 05. Spermicide, 11. Other, 13. None

Before Visit ☐☐ After Visit ☐☐

14. IF NO METHOD, REASON FOR NONE (check one)
- ☐ 1. Pregnant
- ☐ 2. Infertility
- ☐ 3. Seeking Pregnancy
- ☐ 4. Other Medical Reasons
- ☐ 5. Relying On Partner's Method
- ☐ 6. Other

15. REFERRALS MADE (check all applicable)
- ☐ 01. Sterilization
- ☐ 02. Gynecology
- ☐ 03. Prenatal
- ☐ 04. Other Pregnancy
- ☐ 05. Social Service
- ☐ 06. Contraception
- ☐ 07. STD
- ☐ 08. Other Medical
- ☐ 09. Other F.P. Clinic
- ☐ 10. Infertility
- ☐ 11. Nutrition
- ☐ 12. Other

SECTION B — 1st VISIT, INITIALS, ANNUALS

16. RESIDENCE CODES — ZIP CODE | FIPS

17A. RACE (check one)
- ☐ 1. White
- ☐ 2. Black
- ☐ 6. Pacific Islander
- ☐ 3. Native American
- ☐ 4. Asian
- ☐ 5. Other

17B. ETHNIC ORIGIN — Hispanic ☐ 1. Yes ☐ 2. No

18. GENDER (check one) ☐ 1. Female ☐ 2. Male

19. PREGNANCY HISTORY (Females Only)
- a. Number of times pregnant before this visit? — NUMBER
- b. How many births have you had? — NUMBER
- c. Number of living children? — NUMBER

20. EMPLOYMENT STATUS (check one)
- ☐ 1. Employed
- ☐ 2. Unemployed
- ☐ 3. Not In The Work Force

21. GROSS ANNUAL INCOME (Nearest dollar)

22. FAMILY SIZE

23. SOURCE OF REFERRAL (check one)
- ☐ 01. Other F.P. Clinic
- ☐ 02. Hospital/Health Agency
- ☐ 03. Private Doctor
- ☐ 04. Social/Church Agency
- ☐ 05. School
- ☐ 06. Other Patient
- ☐ 07. Family/Friend
- ☐ 08. Media
- ☐ 09. Hotline
- ☐ 10. Phonebook
- ☐ 11. Other Public Health Program
- ☐ 12. Local DHS Office

24. PRIMARY LANGUAGE SPOKEN (check one)
- ☐ 01. English
- ☐ 02. Spanish
- ☐ 03. Portuguese
- ☐ 04. Vietnamese
- ☐ 05. Chinese/Japanese
- ☐ 06. French
- ☐ 07. Polish
- ☐ 08. German
- ☐ 09. Russian
- ☐ 10. American Sign
- ☐ 11. Italian
- ☐ 12. Greek
- ☐ 13. Indian
- ☐ 14. Other

LOCAL USE SECTION

A	B	C	D

MEDICAID RECIPIENT NO. _____ (optional)

FORM 80 REV. 7/01

HEDIS 2001 Measures

Effectiveness of Care
Childhood Immunization Status
Adolescent Immunization Status
Breast Cancer Screening
Cervical Cancer Screening
Chlamydia Screening in Women
Controlling High Blood Pressure
Beta Blocker Treatment After a Heart Attack
Cholesterol Management After Acute Cardiovascular Events
Comprehensive Diabetes Care
Use of Appropriate Medications for People with Asthma
Follow-up After Hospitalization for Mental Illness
Antidepressant Medication Management
Advising Smokers to Quit
Flu Shots for Older Adults
Pneumonia Vaccination Status for Older Adults (first year measure)
Medicare Health Outcomes Survey
Access/Availability of Care
Adults' Access to Preventive/Ambulatory Health Services
Children's Access to Primary Care Practitioners
Prenatal and Postpartum Care
Annual Dental Visit
Availability of Language Interpretation Services
Satisfaction with the Experience of Care
HEDIS/CAHPS® 2.0H, Adult
HEDIS/CAHPS® 2.0H, Child
Health Plan Stability
Practitioner Turnover
Years in Business/Total Membership
Use of Services
Frequency of Ongoing Prenatal Care
Well-Child Visits in the First 15 Months of Life
Well-Child Visits in the Third, Fourth, Fifth and Sixth Year of Life
Adolescent Well-Care Visits
Frequency of Selected Procedures
Inpatient Utilization—General Hospital/Acute Care
Ambulatory Care
Inpatient Utilization—Non-Acute Care
Discharge and Average Length of Stay—Maternity Care
Cesarean Section Rate
Vaginal Birth After Cesarean Rate (VBAC Rate)
Births and Average Length of Stay, Newborns
Mental Health Utilization—Inpatient Discharges and Average Length of Stay
Mental Health Utilization—Percentage of Members Receiving Inpatient, Day/Night Care and Ambulatory Services
Chemical Dependency Utilization—Percentage of Members Receiving Inpatient, Day/Night Care and Ambulatory Services
Outpatient Drug Utilization
Informed Health Care Choices
Management of Menopause
Health Plan Descriptive Information
Board Certification/Residency Completion
Practitioner Compensation
Arrangements with Public Health, Educational and Social Service Organizations
Total Enrollment by Percentage
Enrollment by Product Line (Member Years/Member Months)
Unduplicated Count of Medicaid Members
Cultural Diversity of Medicaid Membership
Weeks of pregnancy at time of enrollment in the medical care organization

Index of *Report Card* Policy Indicators

Indicator

Women's Access to Health Care Services

Eligibility and Outreach for Publicly Funded Health Care

- Has the state taken strong steps to expand Medicaid income eligibility?
- How much has the state expanded Medicaid non-income eligibility requirements and Medicaid outreach efforts?
- Does the state provide health care coverage for low-income adults not otherwise eligible for publicly funded health insurance?

Overcoming Barriers to Health Care Beyond Insurance Coverage

- Are safety net services for the medically underserved provided?
- Is support for family and medical leave available?
- Does the state provide managed care patient protections?
- Does the state have comprehensive requirements for the provision of appropriate interpretation and translation services to patients with limited English proficiency?

Methods to Improve Access to Specific Health Care Services

- How well does the state assist women in gaining access to prescription drugs?
- Does the state provide for access to quality long-term care services?
- Has the state enacted mental health parity legislation?
- Does the state require private insurance plans to cover diabetes supplies and education?
- Does the state have policies to improve health care services related to mastectomy?
- Does the state provide for access to family planning services?
- Does the state provide for access to infertility services and adequate maternity hospital stays?
- Does the state provide for access to abortion services?
- Does the state have laws to address the health care needs of women subjected to violence?

Addressing Wellness and Prevention

Screening

- Does the state require private insurers to cover annual pap smears and cervical cancer screening?
- Does the state require private insurers to cover testing for chlamydia?
- Does the state require private insurers to cover annual mammograms and breast cancer screening?
- Does the state require private insurers to cover bone density screening for certain high-risk groups?
- Does the state require private insurers to cover colorectal cancer screening?

Prevention

- Does the state require students in grades nine through 12 to take four years of physical education in order to graduate?
- Does the state have nutrition outreach and education programs?
- How strong are the state's anti-smoking policies?
- Does the state have a Comprehensive Capacity Diabetes Control Program that it supplements with state funds?
- Does the state receive federal funds to create an enhanced Community Based Arthritis Program?
- Does the state fund an osteoporosis public education program?
- Does the state require an effective sexuality and STD/HIV education program in public schools?

Key Health Conditions, Diseases and Causes of Death

(Policies addressing key conditions are contained in the other sections)

Living in a Healthy Community

Education and Economic Security

- Does the state have effective policies to increase women's economic security?

Discrimination

- Does the state have comprehensive anti-discrimination laws?

Gun Control

- Does the state have effective gun control laws?

Environment

- Does the state have effective policies to address environmental health risks?

Source: National Women's Law Center, FOCUS on Health & Leadership for Women, and the Lewin Group, *Making the Grade on Women's Health: A National and State-by State Report Card*, Washington, DC, 2000.