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Memo

November 17, 2020

To: Consensus Standards Approval Committee (CSAC)

From: Perinatal and Women's Health Project Team

Re: Perinatal and Women's Health Fall 2019 Track 2 Measures[a]

COVID-19 Updates

Considering the recent COVID-19 global pandemic, many organizations needed to focus their attention on the public health crisis. In order to provide greater flexibility for stakeholders and continue the important work in quality measurement, the National Quality Forum (NQF) extended commenting periods and adjusted measure endorsement timelines for the fall 2019 cycle.

Commenting periods for all measures evaluated in the fall 2019 cycle were extended from 30 days to 60 days. Based on the comments received during this 60-day extended commenting period, measures entered one of two tracks:

Track 1: Measures that Remained in Fall 2019 Cycle
Measures that did not receive public comments or only received comments in support of the Standing Committees' recommendations moved forward to the CSAC for review and discussion during its meeting on July 28-29, 2020.

- **Exceptions**
  Exceptions were granted to measures if non-supportive comments received during the extended post-comment period were similar to those received during the pre-evaluation meeting period and have already been adjudicated by the respective Standing Committees during the measure evaluation fall 2019 meetings.

Track 2: Measures Deferred to Spring 2020 Cycle
Fall 2019 measures that required further action or discussion from a Standing Committee were deferred to the spring 2020 cycle. This included measures where consensus was not reached or those that required a response to public comments received. Measures undergoing maintenance review retained endorsement during this time. Track 2 measures will be reviewed by the CSAC at its meeting in November.

During the CSAC meeting on November 17-18, 2020, the CSAC will review fall 2019 measures assigned to Track 2. Evaluation summaries for measures in Track 2 have been described in this memo and related Perinatal and Women's Health draft report. A list of measures assigned to Track 1 can be found in the Executive Summary section of the Perinatal and Women's Health draft report for tracking purposes and can also be found in a separate report.

[a] This memo is funded by the Centers for Medicare and Medicaid Services under contract HHSM-500-2017-00060I Task Order HHSM-500-T0001.

CSAC Action Required

The CSAC will review recommendations from the Perinatal and Women's Health project at its November 17-18, 2020, meeting and vote on whether to uphold the recommendations from the Committee.

This memo includes a summary of the project, measure recommendations, themes identified, responses to comments received from members and the public, and the results from the NQF member expression of support feedback tool. The following documents accompany this memo:

1. **Perinatal and Women's Health Fall 2019, Track 2 Draft Report**. The draft report includes measure evaluation details on all measures that followed Track 2. The complete draft report and supplemental materials are available on the project webpage. Measures that followed Track 1 were reviewed during the CSAC's meeting in July.
2. **Comment Table**. This table lists one comment received during the post-meeting comment period. comment received during the post-meeting comment period.

Background

The NQF's portfolio of measures for Perinatal and Women's Health includes measures for reproductive health; pregnancy, labor and delivery; high-risk pregnancy; newborn, premature, or low birthweight newborns; and postpartum patients. Some measures for other aspects women's health are reviewed by other Committees, e.g., a perinatal vaccination measure is in the Prevention and Population Health Standing Committee portfolio.

During the February 7, 2020 web meeting, the NQF Perinatal and Women's Health Standing Committee evaluated one new measure for endorsement consideration, *3543 Patient-Centered Contraceptive Counseling (PCCC)*.

Draft Report

The Perinatal and Women's Health Fall 2019, Track 2 draft report presents the results of the evaluation of one measure considered under the Consensus Development Process (CDP). The measure reviewed was recommended for endorsement.

The measures were evaluated against the 2019 version of the measure evaluation criteria.

	Maintenance	New	Total
Measures under consideration	0	1	1
Measures recommended for endorsement	0	1	1

CSAC Action Required

Pursuant to the CDP, the CSAC is asked to consider endorsement of one candidate consensus measure.

Measure Recommended for Endorsement

- **NQF 3543** Patient-Centered Contraceptive Counseling (PCCC) (University of California San Francisco)

Overall Suitability for Endorsement: Yes-18; No-1

Comments and Their Disposition

NQF received 25 comments from eight member organizations and 17 individuals pertaining to the draft report and to the measure under consideration.

A table of comments submitted during the comment period, with the responses to each comment, is posted to the Perinatal and Women's Health project webpage.

Comments Received and Responses

Themed Comments

Theme 1 – Consideration of disparities during measure development

One commenter expressed concerns that the measure did not adequately validate disparities and that certain communities of patients and providers were not part of the development of this measure. Specifically, the commenter found it problematic that the researchers have not named their own identities and positionality with respect to the measure concept. Further, without reassurance that communities of color were part of shaping the PCCC instrument, the commenter suggested that the measure falls short of what could have been produced if people and practitioners of color had been part of the investigative team.

Measure Steward/Developer Response:

We appreciate the comments by Bold Futures and their work to hold us accountable. Below we respond to their specific concerns.

Response to Concern 1: The first question queries the person-centeredness of the fourth question in the PCCC, related to adequate information provision. We agree that we need to dismantle the power dynamic and narrative that is currently entrenched in our medical system wherein providers hold the "answers" and all the knowledge. The purpose of this measure is to highlight that patients hold knowledge about themselves, their lives, their preferences, and their experiences, and that providers must listen to these things, respect them, and center them in the conversation. In crafting the question regarding information provision, we drew from existing literature on person-centered care, and worked to ensure that the questions did not make assumptions about what patients need or want. In the context of this particular question, the language is designed to have the patient reflect, for themselves, whether they received "enough information". In responding to this question, patients can consider the extent to which they wanted information from their provider, what information they wanted from their provider, and what other sources of information they were considering. During the "think aloud" portion of our cognitive interviews with patients used to select items of inclusion in the PCCC, participants were asked to comment on the clarity/difficulty understanding each item, their understanding of its content/theme, and reasons for the score they gave their provider on that item. With respect to this item, participants responded using their own metric of what it looked like to get "enough information" for themselves. Answers ranged from having all their questions answered, getting information about the specific method they were interested in, getting information about all of the methods, having information presented clearly, and getting information that was relevant to their specific situation. This range of responses supports that this measure assesses whether the provider met the patient's information needs from the patient's perspective, without the definition of "enough information" being subject to an externally defined information standard. Similarly, the framing of the question related to whether this information was adequate to allow the respondent to make the "best decision" about their birth control method relies on patients themselves reflecting on what the "best decision" is. We consider the best decision to be the one the patient identifies, rather than anything the provider or other external entity determines. While we appreciate that individuals may interpret this question differently, the validity testing we conducted with patients as part of

our measure development process indicated that this question was understandable and considered highly important.

Response to Concern 2: We agree with the need for meaningful attention to diversity of participants in all research, and consider it of the utmost importance in the context of contraceptive care, given the history of reproduction oppression of individuals of color that has occurred in family planning care contexts, such as coercive sterilization. Due to the large number of different samples and data collection strategies in our application to the NQF, we did not include participant characteristics for all phases of the formative and validity and reliability testing. As described in our application, the validity and reliability testing sample for our provider-level testing included 29% Black and 25% Latina or Hispanic participants. We also reference in the application the demographics of participants included in the initial qualitative work, with 24% Black Non-Hispanic/Latina, 24% White Non-Hispanic/Latina, and 52% Hispanic/Latina (see application for further information and other samples). We understand the desire for additional information about the demographics of other phases of the research process, and plan to include in this information in published manuscripts in the future. For the cognitive testing of the measure that informed our selection of specific items for inclusion in the measure, our sample consisted of 9% Black, 76% Hispanic or Latina, 6% American Indian/Alaska Native, 6% Asian/Pacific Islander, and 9% White participants (Note that numbers do not add to 100% as participants could indicate multiple options, and we included an oversample of participants identifying as Hispanic or Latina in order to assess for item equivalence by language).

Response to Concern 3: We agree that recognizing the influence of positionality is critical. The Person-Centered Reproductive Health Program, which led this work, is an academic program directed by Dr. Christine Dehlendorf, a white woman. While we worked to include a range of perspectives in the measure development work, including through collaboration with a patient advisory group, we recognize that having researchers of color lead this work could have resulted in a different result. As a white woman-led program, we are committed to continue to strive to collaborate, step up, and step back, with the goal of lending our voices and effort to the broader effort to advance person-centered, equitable care, and racial justice more broadly.

Committee Response:

Thank you for your comments. The Committee reviewed these comments during its deliberations on the Post-Comment Call on June 26, 2020.

Theme 2 – Measure to support pregnancy intentions

Several commenters expressed the need for a measure that captures information regarding women's pregnancy intentions. Specifically, commenters underscored the importance of identifying situations where a woman does not wish to have a family planning method but would rather become pregnant.

Measure Steward/Developer Response:

We appreciate the call for attention to the experience of women who desire pregnancy. This current measure is designed to evaluate the experience of women who receive contraceptive counseling during a specified visit and is focused on that component of care. We agree that many patients, including some patients who receive contraceptive counseling, would want to receive information about achieving healthy pregnancies as well, and the resources suggested are highly valuable. We also agree that future work could focus on additional performance measures that would provide standardized approaches to evaluating the provision of care focused on healthy pregnancies as another component of the experience of reproductive health care.

Committee Response:

Thank you for your comments. The Committee reviewed these comments during its deliberations on the Post-Comment Call on June 26, 2020.

Theme 3 – Utility and framing of survey questions

Two commenters expressed concerns regarding the questions used within the measure. Specifically, one commenter stated that the questions were not helpful and that the questions do not include any information related to whether the provider inquired about history of family planning or any previous unintended pregnancy. The commenter further mentioned that the questions do not ask patients about their sources of information for contraception. Additionally, another commenter had concerns that the framing of certain questions implies that the provider holds the information needed for the patient to make decisions, and this contrary to the patient-centered dynamic.

Measure Steward/Developer Response:

We appreciate this comment, and agree that person-centered reproductive health care requires respect for and attention to the full range of preferences and desires related to reproduction. This particular measure is designed to focus on the experience of those individuals who receive contraceptive counseling, and the extent to which this care is person-centered, including being respectful and responsive to their preferences (which would include preferences related to how to prioritize method effectiveness in relationship to other method characteristics). We agree that an additional consideration for person-centered reproductive health care is how patients' desire for contraceptive counseling is assessed prior to providing this counseling, which is related to the commenter's point about respect for pregnancy intentions, including ambivalent intentions. We encourage additional work to develop measures to assess person-centeredness across the spectrum of engagement with reproductive health care.

The goal of this measure is to capture patients' perspectives on what is important to them about contraceptive counseling, as determined by an extensive process of formative research, stakeholder engagement, and face validity testing. Consistent with other measures evaluating provider behaviors and communication, the intent is to provide a standardized metric of performance providing the opportunity for quality improvement, and not to in any way produce a sense of the provider and the patient being in conflict. The appropriateness of this approach is further supported by face validity testing we conducted with providers, using a modified Delphi process, as described in the NQF application. This process demonstrated consensus that this measure was meaningful and appropriate for use as a performance metric from the perspective of providers.

This comment also references a range of considerations that can contribute to contraceptive counseling and decision making, including sources of information, previous history of contraceptive use, and previous reproductive experiences. While these are important to consider, the current measure is designed to be appropriate for patients to answer regardless of these individual factors. As an example, the measure includes an item assessing whether the provider gave them enough information to make the best decision about birth control. The amount of information that is necessary and appropriate to score highly on this item is determined by the patient, taking into account their history and other sources of information. Similarly, questions about demonstrating respect for the patient, allowing the patient to indicate their preferences, and taking those preferences seriously are all applicable to patients across the range of preferences, experiences, and information sources.

Committee Response:

Thank you for your comments. The Committee reviewed these comments during its deliberations on the Post-Comment Call on June 26, 2020.

Member Expression of Support

Throughout the continuous public commenting period, NQF members had the opportunity to express their support ('support' or 'do not support') for each measure submitted for endorsement consideration to inform the Committee's recommendations. No NQF members provided their expression of support or non-support (appendix C).

Appendix A: CSAC Checklist

The table below lists the key considerations to inform the CSAC's review of the measures submitted for endorsement consideration.

Key Consideration	Yes/No	Notes
Were there any process concerns raised during the CDP project? If so, briefly explain.	No	
Did the Standing Committee receive requests for reconsideration? If so, briefly explain.	No	
Did the Standing Committee overturn any of the Scientific Methods Panel's ratings of Scientific Acceptability? If so, state the measure and why the measure was overturned.	No	
If a recommended measure is a related and/or competing measure, was a rationale provided for the Standing Committee's recommendation? If not, briefly explain.	N/A	
Were any measurement gap areas addressed? If so, identify the areas.	No	
Are there additional concerns that require CSAC discussion? If so, briefly explain.	No	

Appendix B: Measures Not Recommended for Endorsement

All measures in the Perinatal and Women's Health fall 2019 track 2 cycle were recommended for endorsement.

Appendix C: NQF Member Expression of Support Results

No NQF members provided their expression of support for the measure under consideration.

Appendix D: Details of Measure Evaluation

Measures Recommended

3543 Patient-Centered Contraceptive Counseling (PCCC) measure

Submission

Description: The PCCC is a four-item patient-reported outcome performance measure (PRO-PM) designed to assess the patient-centeredness of contraceptive counseling at the individual clinician/provider and facility levels of analysis. Patient-centeredness is an important component in all areas of health care, and is uniquely critical in the personal and intimate process of contraceptive decision-making. The PCCC is intended to provide health care organizations with a tool to measure the quality of interpersonal communication between clinician/provider and patient—a core aspect of patient-centeredness—in the context of contraceptive care specifically.

The PCCC is specifically designed to capture three key domains of contraceptive care quality, as described as high priorities by patients themselves in previous qualitative research conducted by our team [1]. These domains include interpersonal connection between health care provider and patient, support in the contraceptive decision-making process, and adequate information to make such a decision. The four-item PCCC captures the three domains of quality contraceptive quality and retains validity and reliability of the original 11-item scale. Patients are asked to rate how well their individual health care provider did at each of the following, with each item presented on a 5-point Likert scale with responses ranging from 1 ("Poor") to 5 ("Excellent"):

- Respecting me as a person
- Letting me say what matters to me about my birth control
- Taking my preferences about my birth control seriously
- Giving me enough information to make the best decision about my birth control method

The target population for the PCCC is patients age 15-45, who were assigned female at birth, and who have received contraceptive counseling as part of their recent visit. The PCCC is visit-specific, and is given to patients who have been identified as having received contraceptive counseling during their visit.

An individual provider's score is determined by the proportion of patients who gave the highest rating for all four question on the survey. Likewise, a facility's score is calculated as the percentage of facility patients who gave the highest rating for all four questions.

Numerator Statement: The PCCC is a visit-specific measure of patient-centeredness in contraceptive counseling. It specifically measures how many patients report a top-box (i.e., the highest possible) score of patient experience in their contraceptive counseling interaction with a health care provider during their recent visit.

Denominator Statement: The target population for the PCCC is patients age 15-45, who were assigned female at birth, who are not currently pregnant, and who received contraceptive counseling as part of their recent visit.

Exclusions: Pregnant patients are excluded from the denominator, based on two reasons. First, contraceptive counseling in the context of pregnancy is distinct from that provided to non-pregnant individuals. Specifically, perinatal contraceptive counseling often includes multiple conversations touches over the course of prenatal care and immediate postpartum care. This is appropriate as women, when pregnant, are not immediately at risk of an undesired pregnancy, and therefore there is less time sensitivity to this counseling, and is also consistent with women's preferences for this care [1]. Given this difference in structure of counseling for pregnant women, the use of a visit-specific measure for contraceptive counseling is not appropriate.

Second, given distinct issues related to post-partum contraceptive use, including increased risk of blood clots, effect on lactation, and the health impact of birth spacing, counseling pregnant women about future contraceptive use has components distinct from that of non-pregnant women. For these conceptual reasons, the PCCC was designed for use with non-pregnant patients and has not been extensively tested with pregnant patients to determine whether it accurately captures their needs and desires for counseling.

Adjustment/Stratification: No risk adjustment or risk stratification

Level of Analysis: Facility, Clinician: Individual

Setting of Care: Outpatient Services

Type of Measure: Outcome: PRO-PM

3543 Patient-Centered Contraceptive Counseling (PCCC) measure

Data Source: Instrument-Based Data

Measure Steward: University of California, San Francisco

STANDING COMMITTEE MEETING [02/07/2020]

1. Importance to Measure and Report: <u>The measure meets the Importance criteria</u>

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **Pass-14**; **No Pass-2**; 1b. Performance Gap: **H-10**; **M-7**; **L-2**; **I-0**

<u>Rationale</u>:

- The Committee noted that evidence presented by the developer suggests a need to measure the contraceptive counseling experience of patients.
- The motivation for this measure grew from two previously endorsed measures of contraceptive provision: *2903 Contraceptive Care – Most & Moderately Effective Methods* and *2904 Contraceptive Care – Access to LARC*.
- This Committee raised concerns that these measures increase provider incentives to adopt specific contraceptive approaches. This measure aims to balance these two measures.
- The Committee agreed that the quality of patient care and experience of care is important to measure and report. It noted that this concept of patient care includes an interpersonal connection between healthcare provider and patient, support in the contraceptive decision making process, and adequate information to make the decision.
- The Committee reviewed the accessibility of the instrument for patients with different levels of literacy, especially for patients who are blind or do not speak Spanish, the only language other than English for which testing was conducted. The measure developer noted that it had reservations about live translation of the instrument due to the fact that a translator might not be specifically familiar with concepts of patient-centeredness and, therefore, the approach to translation would not be standardized. The developer indicated it would like to do additional testing for languages other than Spanish and English if this measure is endorsed.
- The developer constructed the measure so that it would reflect that patient preferences were met, rather than that certain actions were met. The purpose of this was to ensure that the instrument could be applicable to a wide variety of patients rather than being prescriptive about what constitutes a positive contraceptive counseling experience.
- One Committee member raised a concern that this measure is related to measures of contraceptive availability. The measure developer agreed that the concepts of availability of contraceptives and patient-centered counseling are tied together, but that this measure aims only to evaluate patient-centeredness and not the availability of maximal choice of contraceptives.
- The Committee agreed that the developer demonstrated a performance gap, and that it was especially distinct when examining disparities by race and ethnicity—Spanish-speaking patients on average rated their providers lower than English-speaking patients. The Committee clarified that these data came from the Spanish-language version of the survey, and the developer confirmed this was the case.

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u>

(2a. Reliability precise specifications, testing; 2b. Validity testing, threats to validity)

2a. Reliability: **H-5**; **M-1**; **L-0**; **I-0**; 2b. Validity: **H-5**; **M-1**; **L-0**; **I-0 (votes of the Scientific Methods Panel)**

<u>Rationale</u>:

- The Committee appreciated the use of Cronbach's alpha to demonstrate reliability of the measure's data elements.
- The Committee also appreciated the use of signal-to-noise testing to demonstrate reliability of the measure score.
- Validity testing was done on both the paper and electronic versions of this measure. They were deemed equivalent, and Committee members agreed with this conclusion from the testing results.
- Convergent validity testing of the measure score was done at both the facility and patient levels. The PCCC was highly correlated with other measures of patient satisfaction (birth control method satisfaction and satisfaction with provider help). Committee members agreed with this conclusion from the testing results.
- After this brief discussion, the Committee voted to accept the SMP's vote for reliability and validity.

3543 Patient-Centered Contraceptive Counseling (PCCC) measure

3. Feasibility: H-5; M-10; L-4; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/ unintended consequences identified; 3d. Data collection strategy can be implemented)

Rationale:

- The developer noted that it worked to enhance this measure's feasibility by reducing the initial 11-item instrument to a four-item instrument.
- The Committee asked for clarifying information regarding the implementation of the measure within facilities. The developer responded that an implementation guidebook was provided to facilities to ensure successful use of the measure, which is developed in association with the National Family Planning & Reproductive Health Association and the National Association of Community Health Centers.
- The PCCC instrument is intended to be delivered on the same day as a visit in which contraceptive counseling takes place. The Committee agreed that the implementation of this survey on the same day might differ from implementation via mail or email several days post-visit.
- When testing feasibility, the developer collected and aggregated data for the facilities. Committee members had some concerns about the long-term feasibility of the measure regarding facility evaluation. However, the developer noted that one facility did begin to collect and aggregate the data itself. Although the developer viewed this as evidence that feasibility is high for this measure, the Committee expressed concerns about feasibility in many types of facilities where contraceptive counseling is performed.
- Committee members were also concerned about the feasibility in facilities that are dissimilar from those where testing was done. Testing was primarily done in family planning centers and federally qualified health centers, and one Committee member mentioned that her work in a large integrated health system might not be amenable to this type of measure because contraceptive counseling is embedded in other visit types. She also mentioned that the facility does not have a checkout feature, and was concerned that facilities would miss the opportunity to use the PCCC instrument without it. Other Committee members were concerned that all patients would not be captured by the measure, and the developer did acknowledge that 100% of visits would not be captured. Although Committee members had concerns about the use of this measure in larger health systems, they agreed that the measure should pass on feasibility.

4. Usability and Use:

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

4a. Use**: Pass-18; No Pass-1**; 4b. Usability: **H-7; M-12; L-0; I-0**

Rationale:

- The Committee agreed the developer presented a reasonable plan for use of this new measure and voted Pass on this criterion.
- Regarding usability, NQF staff clarified to the Committee that in order to pass, the measure does not have to be considered usable by *all* health systems; it must be usable by some or many health systems.
- Although the Committee felt that there were limited data for this measure, it also agreed that further evaluating usability during a maintenance review would be more appropriate. The measure passed usability.

5. Related and Competing Measures

- This measure is related to *2903 Contraceptive Care – Most & Moderately Effective Methods* and *2904 Contraceptive Care - Access to LARC.*
- It serves as a balancing measure to address concerns regarding provider coercion in contraceptive method selection.

Standing Committee Recommendation for Endorsement: Yes-18; **No-1**

6. Public and Member Comment

3543 Patient-Centered Contraceptive Counseling (PCCC) measure

- NQF received 25 comments on the draft report from eight NQF member organizations and 17 members of the public during the extended 60-day commenting period. These comments were discussed at the June 26 post-comment meeting and addressed three themes.
- Theme 1 - Consideration of disparities during measure development – a commenter highlighted that the submission contained a limited description of the diversity within study samples, nor was the measure explicit about the inclusion of marginalized communities in the development of the measure.
    - In response, the developer plans to include additional descriptions of disparity considerations during measure development in future published manuscripts about this measure.
    - The developer also acknowledged that the inclusion of researchers of color in the measure development team might have led to a different result during measure development.
    - The Committee had no concerns regarding this theme or to the developer's response.
- Theme 2 - Capturing pregnancy intendedness – commenters noted that the measure does not account for situations where the patient would like to become pregnant, nor are there questions about pregnancy intendedness, so that the measure cannot assess the patient-centeredness of visits where contraception is not desired.
    - In response, the developer explained that this measure is not meant to capture pregnancy intendedness. Rather, it is meant to focus only on visits where contraception is discussed in relation to preventing pregnancy.
    - The Committee generally agreed with this response, but also expressed interest in the development of another measure to capture pregnancy intendedness.
    - The Committee highlighted that the high rate of unintended pregnancies in the U.S. signals an opportunity to improve counseling for pregnancy intendedness, which is especially important due to its influence on pregnancy outcomes.
- Theme 3 - Utility of survey questions – commenters also noted that question four of the measure, which asks whether patients received enough information to make the best decision about their birth control method, implies that providers hold all knowledge and expertise needed for a patient to make their 'best' decision and that this perspective is not patient centered.
    - In response, the developer reported that the final question of the survey/instrument was determined to be important for the purposes of the measure through testing.
    - The developer demonstrated that during measure testing participants were answering the question from their own perspective and not from an externally defined standard, multiple stakeholders signaled that the question was important to assessing patient-centeredness, and that the question captured an important aspect of measuring quality from a patient's perspective.
    - The developer highlighted that the measure is meant to assess the patient's perspective and the primary aim of the question is not focused on the content of the visit, but rather the patient's understanding of their ability to make the 'best' decision.

The Committee had no concerns regarding this theme or to the developer's response.

7. Consensus Standards Approval Committee (CSAC) Endorsement Decision: Yes-X; No-X (November 17-18, 2020: [Endorsed or Not Endorsed])

The CSAC upheld [or did not uphold] the Standing Committee's decision to recommend the measure for endorsement.

8. Appeals

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Perinatal and Women's Health Fall 2019 Review Cycle

CSAC Review and Endorsement

November 17, 2020

Funded by the Centers for Medicare and Medicaid Services under contract HHSM-500-2017-00060I Task Order HHSM-500-T0001.

Standing Committee Recommendations

- One measure reviewed for Fall 2019 Track 2
  - One measures reviewed by the Scientific Methods Panel
- One measure recommended for endorsement
  - **NQF 3543** Patient-Centered Contraceptive Counseling (PCCC) (New Measure)

Public and Member Comment and Member Expressions of Support

- 25 comments received
- No NQF member of expressions of support or non-support received

Questions?

- Project team:
  - Matthew Pickering, PharmD
  - Chelsea Lynch, MPH, MSN, RN, CIC
  - Yemsrach Kidane, PMP
  - Erin Buchanan, MPH
  - Hannah Ingber, MPH
  - Robyn Y. Nishimi, PhD
- Project webpage: https://www.qualityforum.org/Perinatal_and_Womens_Health.aspx
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THANK YOU.

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Perinatal and Women's Health, Fall 2019 Track 2: CDP Report

DRAFT REPORT FOR CSAC REVIEW
NOVEMBER 17, 2020

This report is funded by the Centers for Medicare and Medicaid Services under contract HHSM-500-2017-00060I Task Order HHSM-500-T0001

http://www.qualityforum.org

Contents

Executive Summary

According to the Centers for Disease Control and Prevention's National Vital Statistics System, the 2018 maternal mortality rate was 17.4 maternal deaths per 100,000 live births and increases with age; women aged 40 and older die at a rate of 81.9 per 100,000 births.[1] Women of this age group are 7.7 times more likely to die compared with women under age 25. Additionally, the maternal death rate for African American women was more than double that of white women, and three times the rate for Hispanic women.

Compared with other countries in the World Health Organization's latest maternal mortality ranking, the United States ranked 55th, just behind Russia (17 per 100,000) and just ahead of Ukraine (19 per 100,000).[1] Access to high quality of care for women of reproductive age before and between pregnancies—including pregnancy planning, contraception, and preconception care—can reduce the risk of pregnancy-related complications, including maternal and infant mortality.

The National Quality Forum's (NQF) portfolio of measures for Perinatal and Women's Health includes measures for reproductive health; pregnancy, labor and delivery; high-risk pregnancy; newborn, premature, or low birthweight newborns; and postpartum patients. Some measures for other aspects women's health are reviewed by other Committees, e.g., a perinatal vaccination measure is in the Prevention and Population Health Standing Committee portfolio.

For this project, the Standing Committee evaluated one newly submitted measure against NQF's standard evaluation criteria. The Committee recommended the measure for endorsement. The measure is:

- **NQF 3543** Patient-Centered Contraceptive Counseling (PCCC)

Due to circumstances around the COVID-19 global pandemic, commenting periods for all measures evaluated in the fall 2019 cycle were extended from 30 days to 60 days. Based on the comments received during this 60-day extended commenting period, measures entered one of two tracks:

Track 1: measures that remained in fall 2019 Cycle:

- None of the measures in the Perinatal and Women's Health fall 2019 cycle met the criteria for a track 1 measure.

Track 2: measures deferred to spring 2020 Cycle:

- **NQF 3543** Patient-Centered Contraceptive Counseling (PCCC)

This report contains details of the evaluation of measures assigned to *Track 2* and moved to the spring 2020 cycle. A detailed summary of the Committee's discussion and rating of the criteria for the measure is in Appendix A.

Introduction

Maternal and child health is a public health priority, as pregnancy and childbirth are some of the leading causes of hospitalization for women. Additionally, compared with other countries in the World Health Organization's latest maternal mortality ranking, the United States ranked 55th, just behind Russia (17 per 100,000) and just ahead of Ukraine (19 per 100,000).[1] Moreover, birth-related events are considered to be among the best measures for assessing healthcare quality. For women of reproductive age in the United States, access to high quality care before and between pregnancies—including pregnancy planning, contraception and preconception care—can reduce the risk of pregnancy-related complications, including maternal and infant mortality.[2]

An integral component to improving healthcare quality is understanding the patient experience.[3] This includes various aspects of healthcare delivery that patients value when they seek and receive care, such as ease of healthcare access and good communication with providers. Research shows that improving the patient experience can lead to improved healthcare processes and outcomes, such as adherence to medical advice, better clinical outcomes, and lower utilization of unnecessary healthcare services.[4,5]

Patient experience of perinatal care, such as contraceptive counseling, is highly valued by patients,[6] and can lead to improved engagement with their care.[5,7] This means that patients are more likely to continue engaging with the reproductive healthcare system, not only for contraception, but if and when they become pregnant and/or give birth.[8] As such, positive patient experience of contraceptive counseling can support pregnancy and birth outcomes such as reduced maternal mortality.

The Perinatal and Women's Health Standing Committee oversees the vast majority of NQF's portfolio of perinatal and women's health measures. Measures in the Committee's portfolio address reproductive health pregnancy, labor, and delivery; high-risk pregnancy; newborns; postpartum care; and premature or low birthweight neonates.

During this review cycle, the NQF Perinatal and Women's Health Standing Committee evaluated one new measure for endorsement consideration, *3543 Patient-Centered Contraceptive Counseling (PCCC)*. A summary of the Committee's deliberations is compiled and provided in this technical report.

NQF Portfolio of Performance Measures for Perinatal and Women's Health Conditions

The Perinatal and Women's Health Standing Committee (Appendix C) oversees the vast majority of NQF's portfolio of Perinatal and Women's Health measures (Appendix B). The Committee's portfolio contains 16 measures: eight process measures, eight outcome and resource use measures, and zero composite measure (see Table 1 below).

Table 1. NQF Perinatal and Women's Health Portfolio of Measures

	Process	Outcome/Resource Use	Composite
Pre-conception	1	3	0
Birth	6	1	0
Newborns	1	4	0
Total	8	8	0

Additional measures related to perinatal and women's health have been assigned to other portfolios. These include various complications and outcomes measures (Surgery project), perinatal immunization (Prevention and Population Health), and routine breast cancer screening (Prevention and Population Health).

Perinatal and Women's Health Measure Evaluation

On February 7, 2020, the Perinatal and Women's Health Standing Committee evaluated one new measure (Table 2) against NQF's standard measure evaluation criteria.

Table 2. Perinatal and Women's Health Measure Evaluation Summary, Fall 2019 Track 2

	Maintenance	New	Total
Measures under endorsement consideration	0	1	1
Measures recommended for endorsement	0	1	1

Comments Received Prior to Committee Evaluation

NQF solicits comments on endorsed measures on an ongoing basis through the Quality Positioning System (QPS). In addition, NQF solicits comments for a continuous 16-week period during each evaluation cycle via an online tool located on the project webpage. For this evaluation cycle, the commenting period opened on December 5, 2019, and closed on May 24, 2020. No comments were received prior to the February 7, 2020 measure evaluation meeting (Appendix F).

Comments Received After Committee Evaluation

Considering the recent COVID-19 global pandemic, many organizations needed to focus their attention on the public health crisis. In order to provide greater flexibility for stakeholders and continue the

important work in quality measurement, NQF extended commenting periods and adjusted measure endorsement timelines for the fall 2019 cycle.

Commenting periods for all measures evaluated in the fall 2019 cycle were extended from 30 days to 60 days. Based on the comments received during this 60-day extended commenting period, measures entered one of two tracks:

Track 1: Measures Remained in Fall 2019 Cycle
Measures that did not receive public comments or only received comments in support of the Standing Committees' recommendations moved forward to the CSAC for review and discussion during its meeting on July 28-29, 2020.

- **Exceptions**
  Exceptions were granted to measures if non-supportive comments received during the extended post-comment period were similar to those received during the pre-evaluation meeting period and have already been adjudicated by the respective Standing Committees during the measure evaluation fall 2019 meetings.

Track 2: Measures Deferred to Spring 2020 Cycle
Fall 2019 measures that required further action or discussion from a Standing Committee were deferred to the spring 2020 cycle. This includes measures where consensus was not reached or those that require a response to public comments received. Measures undergoing maintenance review retained endorsement during that time.

During the spring 2020 CSAC meeting on November 17-18, 2020, the CSAC will review all measures assigned to Track 2.

The extended public commenting period with NQF member support closed on May 24, 2020. Following the Committee's evaluation of the measures under consideration, NQF received 25 comments from 25 organizations and individuals (including eight member organizations and 17 members of the public) pertaining to the draft report and to the measures under consideration. All comments for each measure under consideration were discussed at the June 26, 2020 post-comment meeting and have been summarized in Appendix A.

Throughout the extended public commenting period, NQF members had the opportunity to express their support ('support' or 'do not support') for each measure submitted for endorsement consideration to inform the Committee's recommendations. Four NQF members provided their expression of support.

Summary of Measure Evaluation: Fall 2019 Measures, Track 2

The following brief summary of the measure evaluation highlights the major issues that the Committee considered. Details of the Committee's discussion and ratings of the criteria for each measure are included in Appendix A. The Committee lost quorum shortly prior to the vote for performance gap. After this point, the Committee continued to discuss the measure, and Committee members attending the call were asked to vote via SurveyMonkey, for which a link was sent; no results were announced. Committee members on the call were informed that those who left early or did not attend would be sent the meeting recording and transcript and be asked to review these prior to their voting via survey. The voting was closed on Tuesday, February 11, 2020.

3543 Patient-Centered Contraceptive Counseling (PCCC) measure (UCSF): Recommended

Description: The PCCC is a four-item patient-reported outcome performance measure (PRO-PM) designed to assess the patient centeredness of contraceptive counseling at the individual clinician/provider and facility levels of analysis; **Measure Type**: Outcome: PRO-PM; **Level of Analysis**: Facility, Clinician: Individual; **Setting of Care**: Outpatient Services; **Data Source**: Instrument-Based Data

The Standing Committee recommended this measure for endorsement. NQF 3543 Patient-Centered Contraceptive Counseling (PCCC) is a new patient-reported outcome measure that uses four items rated on a 5-point Likert scale. In its introduction of the measure, the developer noted that it would be a "balancing measure" to contraceptive care measures already in the NQF portfolio. The developer also noted the importance of measuring patients' contraceptive counseling experience and quality of care for ethical reasons that respect the patients and their choices.

In response to a question from the Committee, the developer stated that the measure is focused on the experience of the counseling provided—not on all aspects of the quality of care received during the encounter or whether all contraceptive methods are available. The Committee agreed there are things a facility can do to change the outcomes, and the measure passed evidence. The Committee also agreed there is a gap in care, and the measure passed the performance gap criterion.

The measure was reviewed by the NQF Scientific Methods Panel (SMP) and received a high rating for both reliability and validity. During its discussion on scientific acceptability, the Committee raised some concerns about the survey only being available in English and Spanish, as well as potential barriers for patients with limited literacy levels. Committee members had a number of questions for the developer regarding who participates are in the measure; the ability to monitor for literacy, cultural, or religious factors that could influence either a patient's experience or her decision on contraception; languages the survey is available in; what types of counseling would flag someone for inclusion in the measure; how patients are selected to receive the survey; and applicability of this survey (and overlap with other surveys) when contraceptive counseling was only a part of the clinical encounter. Ultimately, the Committee agreed the measure met both the reliability and validity criteria and accepted the SMP's ratings.

During its discussion of feasibility, the Committee expressed concern about the consistency of data entry and potential challenges with uploading data into an electronic medical record. Committee members also discussed general challenges for facilities in defining the denominator population for the measure. In response, the developer noted that it had favored sensitivity as opposed to specificity, since patients can be filtered out later if they do not fit the denominator; the developer also noted an implementation manual exists, which is revised on an ongoing basis. The developer responded to questions and discussed different methods that clinics can use to implement the measure, which could eventually include delivery via patient portals, flagging patients with ICD-10 or CPT codes, etc. The Committee passed the measure on feasibility.

During the use and usability discussion, Committee members agreed that the questions and the survey tool seem reasonable and would not cause any harm to patients, nor would it cause undue burden. They noted, however, that a place for patients to express specific concerns would be useful. In response to

questions on use of the survey across all healthcare systems, NQF staff clarified that the measure does not need to be usable by *all* healthcare systems to pass these criteria. The Committee agreed that while there are limited data for this new measure, there are credible plans for use. Ultimately, the Committee voted that the measure met the use and usability criteria.

The Committee agreed there are no competing measures and that this measure would act as a balancing measure for *2903 - Contraceptive Care – Most & Moderately Effective Methods* and *2904 - Contraceptive Care - Access to Long-Acting Reversible Method of Contraception (LARC)*, as previously discussed.

References

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3 Wolfe A. Institute of Medicine Report: Crossing the Quality Chasm: A New Health Care System for the 21st Century: *Policy Polit Nurs Pract*. August 2016. https://journals.sagepub.com/doi/10.1177/152715440100200312. Last accessed February 2020.

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5 Anhang Price R, Elliott MN, Zaslavsky AM, et al. Examining the role of patient experience surveys in measuring health care quality. *Med Care Res Rev MCRR*. 2014;71(5):522-554.

6 Dehlendorf C, Levy K, Kelley A, et al. Women's preferences for contraceptive counseling and decision making. *Contraception*. 2013;88(2):250-256.

7 Doyle C, Bell D, Lennox L. A systematic review of evidence on the links between patient experience and clinical safety and effectiveness | BMJ Open. https://bmjopen.bmj.com/content/3/1/e001570. Last accessed February 2020.

8 Gomez AM, Wapman M. Under (implicit) pressure: young Black and Latina women's perceptions of contraceptive care. *Contraception*. 2017;96(4):221-226.

Appendix A: Details of Measure Evaluation

Rating Scale: H=High; **M**=Moderate; **L**=Low; **I**=Insufficient; **NA**=Not Applicable

Measures Recommended

3543 Patient-Centered Contraceptive Counseling (PCCC) measure

Submission | Specifications

Description: The PCCC is a four-item patient-reported outcome performance measure (PRO-PM) designed to assess the patient-centeredness of contraceptive counseling at the individual clinician/provider and facility levels of analysis. Patient-centeredness is an important component in all areas of health care, and is uniquely critical in the personal and intimate process of contraceptive decision-making. The PCCC is intended to provide health care organizations with a tool to measure the quality of interpersonal communication between clinician/provider and patient—a core aspect of patient-centeredness—in the context of contraceptive care specifically.

The PCCC is specifically designed to capture three key domains of contraceptive care quality, as described as high priorities by patients themselves in previous qualitative research conducted by our team [1]. These domains include interpersonal connection between health care provider and patient, support in the contraceptive decision-making process, and adequate information to make such a decision. The four-item PCCC captures the three domains of quality contraceptive quality and retains validity and reliability of the original 11-item scale. Patients are asked to rate how well their individual health care provider did at each of the following, with each item presented on a 5-point Likert scale with responses ranging from 1 (“Poor”) to 5 (“Excellent”):

- Respecting me as a person
- Letting me say what matters to me about my birth control
- Taking my preferences about my birth control seriously
- Giving me enough information to make the best decision about my birth control method

The target population for the PCCC is patients age 15-45, who were assigned female at birth, and who have received contraceptive counseling as part of their recent visit. The PCCC is visit-specific, and is given to patients who have been identified as having received contraceptive counseling during their visit.

An individual provider’s score is determined by the proportion of patients who gave the highest rating for all four question on the survey. Likewise, a facility’s score is calculated as the percentage of facility patients who gave the highest rating for all four questions.

Numerator Statement: The PCCC is a visit-specific measure of patient-centeredness in contraceptive counseling. It specifically measures how many patients report a top-box (i.e., the highest possible) score of patient experience in their contraceptive counseling interaction with a health care provider during their recent visit.

Denominator Statement: The target population for the PCCC is patients age 15-45, who were assigned female at birth, who are not currently pregnant, and who received contraceptive counseling as part of their recent visit.

Exclusions: Pregnant patients are excluded from the denominator, based on two reasons. First, contraceptive counseling in the context of pregnancy is distinct from that provided to non-pregnant individuals. Specifically, perinatal contraceptive counseling often includes multiple conversations touches over the course of prenatal care and immediate postpartum care. This is appropriate as women, when pregnant, are not immediately at risk of an undesired pregnancy, and therefore there is less time sensitivity to this counseling, and is also consistent with women’s preferences for this care [1]. Given this difference in structure of counseling for pregnant women, the use of a visit-specific measure for contraceptive counseling is not appropriate.

Second, given distinct issues related to post-partum contraceptive use, including increased risk of blood clots, effect on lactation, and the health impact of birth spacing, counseling pregnant women about future contraceptive use has components distinct from that of non-pregnant women. For these conceptual reasons, the PCCC was designed for use with non-pregnant patients and has not been extensively tested with pregnant patients to determine whether it accurately captures their needs and desires for counseling.

Adjustment/Stratification: No risk adjustment or risk stratification

Level of Analysis: Facility, Clinician: Individual

Setting of Care: Outpatient Services

3543 Patient-Centered Contraceptive Counseling (PCCC) measure

Type of Measure: Outcome: PRO-PM

Data Source: Instrument-Based Data

Measure Steward: University of California, San Francisco

STANDING COMMITTEE MEETING [02/07/2020]

1. Importance to Measure and Report: <u>The measure meets the Importance criteria</u>

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **Pass-14**; **No Pass-2**; 1b. Performance Gap: **H-10**; **M-7**; **L-2**; **I-0**

<u>Rationale</u>:

- The Committee noted that evidence presented by the developer suggests a need to measure the contraceptive counseling experience of patients.
- The motivation for this measure grew from two previously endorsed measures of contraceptive provision: *2903 Contraceptive Care – Most & Moderately Effective Methods* and *2904 Contraceptive Care – Access to LARC*.
- This Committee raised concerns that these measures increase provider incentives to adopt specific contraceptive approaches. This measure aims to balance these two measures.
- The Committee agreed that the quality of patient care and experience of care is important to measure and report. It noted that this concept of patient care includes an interpersonal connection between healthcare provider and patient, support in the contraceptive decision making process, and adequate information to make the decision.
- The Committee reviewed the accessibility of the instrument for patients with different levels of literacy, especially for patients who are blind or do not speak Spanish, the only language other than English for which testing was conducted. The measure developer noted that it had reservations about live translation of the instrument due to the fact that a translator might not be specifically familiar with concepts of patient-centeredness and, therefore, the approach to translation would not be standardized. The developer indicated it would like to do additional testing for languages other than Spanish and English if this measure is endorsed.
- The developer constructed the measure so that it would reflect that patient preferences were met, rather than that certain actions were met. The purpose of this was to ensure that the instrument could be applicable to a wide variety of patients rather than being prescriptive about what constitutes a positive contraceptive counseling experience.
- One Committee member raised a concern that this measure is related to measures of contraceptive availability. The measure developer agreed that the concepts of availability of contraceptives and patient-centered counseling are tied together, but that this measure aims only to evaluate patient-centeredness and not the availability of maximal choice of contraceptives.
- The Committee agreed that the developer demonstrated a performance gap, and that it was especially distinct when examining disparities by race and ethnicity—Spanish-speaking patients on average rated their providers lower than English-speaking patients. The Committee clarified that these data came from the Spanish-language version of the survey, and the developer confirmed this was the case.

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u>

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-5**; **M-1**; **L-0**; **I-0**; 2b. Validity: **H-5**; **M-1**; **L-0**; **I-0 (votes of the Scientific Methods Panel)**

<u>Rationale</u>:

- The Committee appreciated the use of Cronbach's alpha to demonstrate reliability of the measure's data elements.
- The Committee also appreciated the use of signal-to-noise testing to demonstrate reliability of the measure score. Validity testing was done on both the paper and electronic versions of this measure. They were deemed equivalent, and Committee members agreed with this conclusion from the testing results.
- Convergent validity testing of the measure score was done at both the facility and patient levels. The PCCC was highly correlated with other measures of patient satisfaction (birth control method satisfaction and satisfaction with provider help). Committee members agreed with this conclusion from the testing results.

3543 Patient-Centered Contraceptive Counseling (PCCC) measure

- After this brief discussion, the Committee voted to accept the SMP's vote for reliability and validity.

3. Feasibility: H-5; M-10; L-4; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/ unintended consequences identified; 3d. Data collection strategy can be implemented)

Rationale:

- The developer noted that it worked to enhance this measure's feasibility by reducing the initial 11-item instrument to a four-item instrument.
- The Committee asked for clarifying information regarding the implementation of the measure within facilities. The developer responded that an implementation guidebook was provided to facilities to ensure successful use of the measure, which is developed in association with the National Family Planning & Reproductive Health Association and the National Association of Community Health Centers.
- The PCCC instrument is intended to be delivered on the same day as a visit in which contraceptive counseling takes place. The Committee agreed that the implementation of this survey on the same day might differ from implementation via mail or email several days post-visit.
- When testing feasibility, the developer collected and aggregated data for the facilities. Committee members had some concerns about the long-term feasibility of the measure regarding facility evaluation. However, the developer noted that one facility did begin to collect and aggregate the data itself. Although the developer viewed this as evidence that feasibility is high for this measure, the Committee expressed concerns about feasibility in many types of facilities where contraceptive counseling is performed.
- Committee members were also concerned about the feasibility in facilities that are dissimilar from those where testing was done. Testing was primarily done in family planning centers and federally qualified health centers, and one Committee member mentioned that her work in a large integrated health system might not be amenable to this type of measure because contraceptive counseling is embedded in other visit types. She also mentioned that the facility does not have a checkout feature, and was concerned that facilities would miss the opportunity to use the PCCC instrument without it. Other Committee members were concerned that all patients would not be captured by the measure, and the developer did acknowledge that 100% of visits would not be captured. Although Committee members had concerns about the use of this measure in larger health systems, they agreed that the measure should pass on feasibility.

4. Usability and Use:

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

4a. Use**: Pass-18; No Pass-1**; 4b. Usability: **H-7; M-12; L-0; I-0**

Rationale:

- The Committee agreed the developer presented a reasonable plan for use of this new measure and voted Pass on this criterion.
- Regarding usability, NQF staff clarified to the Committee that in order to pass, the measure does not have to be considered usable by *all* health systems; it must be usable by some or many health systems.
- Although the Committee felt that there were limited data for this measure, it also agreed that further evaluating usability during a maintenance review would be more appropriate. The measure passed usability.

5. Related and Competing Measures

- This measure is related to *2903 Contraceptive Care – Most & Moderately Effective Methods* and *2904 Contraceptive Care - Access to LARC.*
- It serves as a balancing measure to address concerns regarding provider coercion in contraceptive method selection.

Standing Committee Recommendation for Endorsement: Yes-18; **No-1**

3543 Patient-Centered Contraceptive Counseling (PCCC) measure

6. Public and Member Comment

- NQF received 25 comments on the draft report from eight NQF member organizations and 17 members of the public during the extended 60-day commenting period. These comments were discussed at the June 26 post-comment meeting and addressed three themes.
- Theme 1 - Consideration of disparities during measure development – a commenter highlighted that the submission contained a limited description of the diversity within study samples and the measure was not explicit about the inclusion of marginalized communities in the development of the measure.
    - In response, the developer plans to include additional descriptions of disparity considerations during measure development in future published manuscripts about this measure.
    - The developer also acknowledged that the inclusion of researchers of color in the measure development team might have led to a different result during measure development.
    - The Committee had no concerns regarding this theme or to the developer's response.
- Theme 2 - Capturing pregnancy intendedness – commenters noted that the measure does not account for situations where the patient would like to become pregnant, nor are there questions about pregnancy intendedness, so that the measure cannot assess the patient-centeredness of visits where contraception is not desired.
    - In response, the developer explained that this measure is not meant to capture pregnancy intendedness. Rather, it is meant to focus only on visits where contraception is discussed in relation to preventing pregnancy.
    - The Committee generally agreed with this response, but also expressed interest in the development of another measure to capture pregnancy intendedness.
    - The Committee highlighted that the high rate of unintended pregnancies in the U.S. signals an opportunity to improve counseling for pregnancy intendedness, which is especially important due to its influence on pregnancy outcomes.
- Theme 3 - Utility of survey questions – commenters also noted that question four of the measure, which asks whether patients received enough information to make the best decision about their birth control method, implies that providers hold all knowledge and expertise needed for a patient to make their 'best' decision and that this perspective is not patient centered.
    - In its response, the developer reported that during testing, the final question of the survey/instrument was determined to be important for the purposes of the measure.
    - The developer demonstrated that during measure testing, participants were answering the question from their own perspective and not from an externally defined standard, multiple stakeholders signaled that the question was important to assessing patient-centeredness, and that the question captured an important aspect of measuring quality from a patient's perspective.
    - The developer highlighted that the measure is meant to assess the patient's perspective and the primary aim of the question is not focused on the content of the visit, but rather the patient's understanding of their ability to make the 'best' decision.
    - The Committee had no concerns regarding this theme or to the developer's response.

7. Consensus Standards Approval Committee (CSAC) Endorsement Decision: Yes-X; No-X (November 17-18, 2020: [Endorsed or Not Endorsed])

The CSAC upheld [or did not uphold] the Standing Committee's decision to recommend the measure for endorsement.

8. Appeals

Appendix B: Perinatal and Women's Health Portfolio—Use in Federal Programs[a]

NQF #	Title	Federal Programs: Finalized or Implemented as of February 27, 2020
0033	Chlamydia Screening in Women (CHL)	Merit-Based Incentive Payment System (MIPS) Program (Implemented); Medicaid (Implemented); Marketplace Quality Rating System (QRS) (Implemented)
0304	Late Sepsis or meningitis in Very Low Birth Weight (VLBW) neonates (risk-adjusted)	None
0469	PC-01 Elective Delivery	Hospital Compare (Implemented); Hospital Inpatient Quality Reporting (Implemented); Medicare and Medicaid Electronic Health Record Incentive Program for Hospitals and Critical Access Hospitals (Implemented); Medicaid (Implemented)
0469e	PC-01 Elective Delivery	None
0470	Incidence of Episiotomy	None
0471	PC-02 Cesarean Birth	Medicaid (Implemented)
0476	PC-03 Antenatal Steroids	None
0478	Neonatal Blood Stream Infection Rate (NQI 03)	None
0480	PC-05 Exclusive Breast Milk Feeding	Hospital Compare (Implemented); Hospital Inpatient Quality Reporting (Implemented); Medicare and Medicaid Electronic Health Record Incentive Program for Hospitals and Critical Access Hospitals (Implemented)
0480e	PC-05 Exclusive Breast Milk Feeding	Hospital Inpatient Quality Reporting (Implemented); Medicare and Medicaid Electronic Health Record Incentive Program for Hospitals and Critical Access Hospitals (Implemented)
0483	Proportion of infants 22 to 29 weeks gestation screened for retinopathy of prematurity.	None
0716	Unexpected Newborn Complications in Term Infants	Hospital Compare (Implemented)
1382	Percentage of low birthweight births	Medicaid (Implemented)

[a] Per CMS Measures Inventory Tool as of 02/27/2020

NQF #	Title	Federal Programs: Finalized or Implemented as of February 27, 2020
1731	PC-04 Health Care-Associated Bloodstream Infections in Newborns	None
2902	Contraceptive Care - Postpartum	None
2903	Contraceptive Care – Most & Moderately Effective Methods	None
2904	Contraceptive Care - Access to LARC	None

Appendix C: Perinatal and Women's Health Standing Committee and NQF Staff

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Appendix D: Measure Specifications

	NQF 3543 Patient-Centered Contraceptive Counseling (PCCC) measure: Specifications
Steward	University of California, San Francisco
Description	The PCCC is a four-item patient-reported outcome performance measure (PRO-PM) designed to assess the patient-centeredness of contraceptive counseling at the individual clinician/provider and facility levels of analysis. Patient-centeredness is an important component in all areas of health care, and is uniquely critical in the personal and intimate process of contraceptive decision-making. The PCCC is intended to provide health care organizations with a tool to measure the quality of interpersonal communication between clinician/provider and patient – a core aspect of patient-centeredness – in the context of contraceptive care specifically. The PCCC is specifically designed to capture three key domains of contraceptive care quality, as described as high priorities by patients themselves in previous qualitative research conducted by our team [1]. These domains include interpersonal connection between health care provider and patient, support in the contraceptive decision-making process, and adequate information to make such a decision. The four-item PCCC captures the three domains of quality contraceptive quality and retains validity and reliability of the original 11-item scale. Patients are asked to rate how well their individual health care provider did at each of the following, with each item presented on a 5-point Likert scale with responses ranging from 1 ("Poor") to 5 ("Excellent"): • Respecting me as a person • Letting me say what matters to me about my birth control • Taking my preferences about my birth control seriously • Giving me enough information to make the best decision about my birth control method The target population for the PCCC is patients age 15-45, who were assigned female at birth, and who have received contraceptive counseling as part of their recent visit. The PCCC is visit-specific, and is given to patients who have been identified as having received contraceptive counseling during their visit. An individual provider's score is determined by the proportion of patients who gave the highest rating for all four question on the survey. Likewise, a facility's score is calculated as the percentage of facility patients who gave the highest rating for all four questions.
Type	Outcome: PRO-PM
Data Source	Instrument-Based Data
Level	Facility, Clinician: Individual
Setting	Outpatient Services
Numerator Statement	The PCCC is a visit-specific measure of patient-centeredness in contraceptive counseling. It specifically measures how many patients report a top-box (i.e., the highest possible) score of patient experience in their contraceptive counseling interaction with a health care provider during their recent visit.
Numerator Details	Identification in the numerator is determined by patient response to the PCCC. The numerator for both the individual provider and facility level includes only those patients who gave a top-box score for their interaction with their health care provider on the PCCC. All other conditions determining inclusion in the numerator also determine inclusion in the denominator. As such, please see response to S.7. for additional details on inclusion.
Denominator	The target population for the PCCC is patients age 15-45, who were assigned female at birth, who are not currently pregnant, and who received contraceptive counseling as part of their

	NQF 3543 Patient-Centered Contraceptive Counseling (PCCC) measure: Specifications
Statement	recent visit.
Denominator Details	For the purposes of eligibility screening, patient age and sex are determined though patient report to their provider or clinic in the normal course of their care. As these are standard, readily available elements of patient data, clinics may rely on their own data to determine eligibility with regard to age and sex. Receipt of contraceptive counseling is not a standard or readily available element of patient data. The current application presents data collected from patients responding to the PCCC immediately following their visit. Patients receiving contraceptive counseling during their visit are identified by providers and/or staff, following instructions provided by UCSF. Patient identification is then communicated to the team member responsible for distributing the PCCC survey to patients. Patients are identified through a standardized process that included pre-emptive staff review of schedules and visit types (e.g. flagging future family planning visits for survey distribution, as contraceptive counseling is likely to take place in such visits), and/or provider or staff identification based on the exam room conversation, depending on clinic protocols and flow. In the testing attachment we describe our assessment of the degree of ascertainment bias in this process. As the PCCC is intended to measure the quality of counseling for those who did receive counseling, patients who did not receive counseling are not eligible to respond to the PCCC scale, regardless of whether counseling may have been appropriate during their visit. Whether or not people receive family planning care when appropriate is a distinct aspect of quality. This component of quality is partly captured by the existing NQF measure 2903, which assesses use of a most or moderately effective method. As all most or moderately effective methods require a prescription or a procedure from a provider, the score on this performance metric is influenced by the degree to which patients in need of family planning care receive these services. We acknowledge that future measures could be developed to more directly measure whether or not provision of contraceptive care is provided when appropriate.
Exclusions	Pregnant patients are excluded from the denominator, based on two reasons. First, contraceptive counseling in the context of pregnancy is distinct from that provided to non-pregnant individuals. Specifically, perinatal contraceptive counseling often includes multiple conversations touches over the course of prenatal care and immediate postpartum care. This is appropriate as women, when pregnant, are not immediately at risk of an undesired pregnancy, and therefore there is less time sensitivity to this counseling, and is also consistent with women's preferences for this care [1]. Given this difference in structure of counseling for pregnant women, the use of a visit-specific measure for contraceptive counseling is not appropriate. Second, given distinct issues related to post-partum contraceptive use, including increased risk of blood clots, effect on lactation, and the health impact of birth spacing, counseling pregnant women about future contraceptive use has components distinct from that of non-pregnant women. For these conceptual reasons, the PCCC was designed for use with non-pregnant patients and has not been extensively tested with pregnant patients to determine whether it accurately captures their needs and desires for counseling.
Exclusion details	Staff and providers are instructed not to distribute the survey to patients whom have disclosed or discovered during the visit that they are pregnant. In addition, the survey asks patients if they are pregnant, and these responses are excluded from the calculation of the measure.
Risk Adjustment	No risk adjustment
Stratification	No risk stratification
Type Score	Rate/proportion
Algorithm	Measure users should follow these steps in order to obtain measure results: 1) Identification and data collection a) Providers and/or staff identify eligible, non-pregnant patients who have received contraceptive counseling, before they leave the clinic following their visit

	NQF 3543 Patient-Centered Contraceptive Counseling (PCCC) measure: Specifications
	b) A team member who is not the provider who gave counseling introduces and distributes the survey to the patient following their visit, before they leave the clinic c) Patient completes the survey (self-administered via paper or electronically, e.g. on a tablet computer) d) Electronic collection of patient responses for analysis, either through data entry of paper surveys or collation of responses to electronic survey 2) Data aggregation and measure calculation a) Patients indicating they are pregnant have their responses excluded b) Measure responses are summed as the total of all PCCC item values (maximum value of 20) c) PCCC value sums are dichotomized as a maximum value of 20 (top-box score) versus any value less than 20 d) Dichotomized result variable is examined at the individual clinician/provider and facility level e) Measure result is calculated as the percentage of patients responding with a top-box score, divided by the total number of patients who gave any response to the survey, on a provider or facility level
Copyright / Disclaimer	None

Appendix E: Related and Competing Measures

Comparison of NQF #2903 and NQF #2904

2903 Contraceptive Care – Most & Moderately Effective Methods
2904 Contraceptive Care - Access to LARC

Steward

2903 Contraceptive Care – Most & Moderately Effective Methods

US Office of Population Affairs

2904 Contraceptive Care - Access to LARC

US Office of Population Affairs

Description

2903 Contraceptive Care – Most & Moderately Effective Methods

The percentage of women aged 15-44 years at risk of unintended pregnancy that is provided a most effective (i.e., sterilization, implants, intrauterine devices or systems (IUD/IUS)) or moderately effective (i.e., injectables, oral pills, patch, ring, or diaphragm) FDA-approved methods of contraception.

The proposed measure is an intermediate outcome measure because it represents a decision that is made at the end of a clinical encounter about the type of contraceptive method a woman will use, and because of the strong association between type of contraceptive method used and risk of unintended pregnancy.

2904 Contraceptive Care - Access to LARC

Percentage of women aged 15-44 years at risk of unintended pregnancy that is provided a long-acting reversible method of contraception (i.e., implants, intrauterine devices or systems (IUD/IUS).

It is an access measure because it is intended to identify situations in which women do not have access to the long-acting reversible methods of contraception (LARC), i.e., contraceptive implants and intrauterine devices.

Type

2903 Contraceptive Care – Most & Moderately Effective Methods

Intermediate Clinical Outcome

2904 Contraceptive Care - Access to LARC

Structure

Data Source

2903 Contraceptive Care – Most & Moderately Effective Methods

Claims

2904 Contraceptive Care - Access to LARC

Claims

Level

2903 Contraceptive Care – Most & Moderately Effective Methods

Facility, Health Plan, Population: Regional and State

2904 Contraceptive Care - Access to LARC

Facility, Health Plan, Population: Regional and State

Setting

2903 Contraceptive Care – Most & Moderately Effective Methods

Other primary care and reproductive health settings

2904 Contraceptive Care - Access to LARC

Other primary care and reproductive health settings

Numerator Statement

2903 Contraceptive Care – Most & Moderately Effective Methods

Women aged 15-44 years of age at risk of unintended pregnancy who are provided a most (sterilization, intrauterine device, implant) or moderately (pill, patch, ring, injectable, diaphragm) effective method of contraception

2904 Contraceptive Care - Access to LARC

Women aged 15-44 years of age at risk of unintended pregnancy who were provided a long-acting reversible method of contraception (LARC), i.e., intrauterine device or implant.

Numerator Details

2903 Contraceptive Care – Most & Moderately Effective Methods

The target population is eligible women 15-44 years of age who are provided a most or moderately effective method of contraception. To identify the numerator, follow these steps:

Step 1 Define the numerator by identifying women who used a most (sterilization, IUD, implant) or moderately (injection, oral pills, patch, ring, or diaphragm) effective method of contraception in the measurement year. To do this, use the codes in Table UCM-E.

Step 2 Adjust for LARC removals and re-insertions. The LARC methods can be removed at the woman's request so adjustments must be made to reflect this. Use the codes in Table UCM-F to identify women who had their IUD or implant removed at any point during the measurement year. Check to see if they had an IUD or implant reinserted on the same or a subsequent date. If there is no code indicating reinsertion, use the codes in Table UCM-E to determine whether a woman was provided another most or moderately effective method. Do so by looking back over the 30 days prior to the removal (since a

woman may receive a prescription for another method prior to the removal) as well as the period after the LARC removal (i.e., through the end of the measurement year). If there is no code for reinsertion or provision of another most or moderately effective method, consider them as a non-user.

Step 3 Calculate the rates by dividing the number of women who used a most or moderately effective method of contraception by the number of women in the denominator. Calculate the rates separately for adolescents and adults.

2904 Contraceptive Care - Access to LARC

The target population is eligible women 15-44 years of age who were provided a long-acting reversible method of contraception (LARC). To identify the numerator, follow these steps:

Step 1 Define the numerator by identifying women who used a long-acting reversible method of contraception (LARC) in the measurement year. To do this, use the codes in Table UCM-E.

Step 2 Adjust for LARC removals and re-insertions. The LARC methods can be removed at the woman's request so adjustments must be made to reflect this. Use the codes in Table UCM-F to identify women who had their IUD or implant removed at any point during the measurement year. Check to see if they had an IUD or implant reinserted on the same or a subsequent date through the end of the measurement year. If there is no code for reinsertion or provision of another most or moderately effective method, consider them as a non-user of LARC.

Step 3 Calculate the rates by dividing the number of women who used a most or moderately effective method of contraception by the number of women in the denominator. Calculate the rates separately for adolescents and adults.

Denominator Statement

2903 Contraceptive Care – Most & Moderately Effective Methods

Women aged 15-44 years of age who are at risk of unintended pregnancy.

2904 Contraceptive Care - Access to LARC

All women aged 15-44 years of age who are at risk of unintended pregnancy

Denominator Details

2903 Contraceptive Care – Most & Moderately Effective Methods

The target population is women of reproductive age (i.e., ages 15–44 years). In a Medicaid population, this includes:

Women in the general Medicaid program who were continuously enrolled during the measurement year, i.e., had no more than one gap in enrollment of up to 45 days. To determine continuous enrollment for a Medicaid enrollee for whom enrollment is verified monthly, the enrollee may not have more than a 1-month gap in coverage (i.e., an enrollee whose coverage lapses for 2 months is not considered continuously enrolled)

All women participating in a state-sponsored family planning-specific Section 1115 waiver or in a family–planning specific state plan amendment (SPA) program, even if they were not continuously enrolled. This is because the primary intent of these waiver and/or SPA programs is to provide family planning services, including contraception.

2904 Contraceptive Care - Access to LARC

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Women in the general Medicaid program who were continuously enrolled during the measurement year, i.e., had no more than one gap in enrollment of up to 45 days. To determine continuous enrollment for a Medicaid enrollee for whom enrollment is verified monthly, the enrollee may not have more than a 1-month gap in coverage (i.e., an enrollee whose coverage lapses for 2 months is not considered continuously enrolled)

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Exclusions

2903 Contraceptive Care – Most & Moderately Effective Methods

The following categories of women are excluded from the denominator: (1) those who are infecund for non-contraceptive reasons; (2) those who had a live birth in the last 2 months of the measurement year; or (3) those who were still pregnant or their pregnancy outcome was unknown at the end of the year.

2904 Contraceptive Care - Access to LARC

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Exclusion Details

2903 Contraceptive Care – Most & Moderately Effective Methods

Follow the steps below to identify the denominator. The tables that are referenced are found in the attached Excel files (one file is for 2014 and the second is for 2015).

Step 1 Identify and exclude women who were infecund due to non-contraceptive reasons such as natural menopause or oophorectomy. To do this, use the codes listed in Table UCM-A.

Step 2 Identify women who were pregnant at any point in the measurement year by using the codes listed in Table UCM-B. We obtained this list of codes by reviewing the following documents, and including all pregnancy-related codes:

CMS & NCHS (2011). ICD-9-CM Official Guidelines for Coding and Reporting, effective October 1, 2011. Available online at: http://www.cdc.gov/nchs/icd/icd9cm_addenda_guidelines.htm.

CMS & NCHS (2016). ICD-10-CM Official Guidelines for Coding and Reporting FY 2016 Available online at: http://www.cdc.gov/nchs/icd/icd10cm.htm.

Step 3 Among women who were pregnant at any point in the measurement year, exclude those who:

Had a live birth in the last 2 months of the measurement year because there may not have been an opportunity to provide them with contraception. A two-month period was selected because the American College of Obstetricians and Gynecologists (ACOG) recommends having a postpartum visit by 6 weeks, and an additional 2 weeks was added to allow for reasonable delays in attending the postpartum visit. To identify live births, use the codes listed in Table UCM-D. This list of codes is drawn from the HEDIS measure of Prenatal and Postnatal care.

Were still pregnant at the end of the year because they did not have a pregnancy outcome code indicating a non-live birth (Table UCM-C) or a live birth (Table UCM-D). Codes for non-live births were also drawn from the HEDIS measure of Prenatal and Postnatal Care.

Once the exclusions are applied, the denominator includes women who:

Were not pregnant at any point in the measurement year,

Were pregnant during the measurement year but whose pregnancy ended in the first 10 months of the measurement year, since there was adequate time to provide contraception in the postpartum period.

Were pregnant during the measurement year but whose pregnancy ended in an ectopic pregnancy, stillbirth, miscarriage, or induced abortion.

2904 Contraceptive Care - Access to LARC

Follow the steps below to identify the denominator. The tables that are referenced are found in the attached Excel files (one file is for 2014 and the second is for 2015).

Step 1 Identify and exclude women who were infecund due to non-contraceptive reasons such as natural menopause or oophorectomy. To do this, use the codes listed in Table UCM-A.

Step 2 Identify women who were pregnant at any point in the measurement year by using the codes listed in Table UCM-B. We obtained this list of codes by reviewing the following documents, and including all pregnancy-related codes:

CMS & NCHS (2011). ICD-9-CM Official Guidelines for Coding and Reporting, effective October 1, 2011. Available online at: http://www.cdc.gov/nchs/icd/icd9cm_addenda_guidelines.htm.

CMS & NCHS (2016). ICD-10-CM Official Guidelines for Coding and Reporting FY 2016 Available online at: http://www.cdc.gov/nchs/icd/icd10cm.htm.

Step 3 Among women who were pregnant at any point in the measurement year, exclude those who:

Had a live birth in the last 2 months of the measurement year because there may not have been an opportunity to provide them with contraception. A two-month period was selected because the American College of Obstetricians and Gynecologists (ACOG) recommends having a postpartum visit by 6 weeks, and an additional 2 weeks was added to allow for reasonable delays in attending the postpartum visit. To identify live births, use the codes listed in Table UCM-D. This list of codes is drawn from the HEDIS measure of Prenatal and Postnatal care.

Were still pregnant at the end of the year because they did not have a pregnancy outcome code indicating a non-live birth (Table UCM-C) or a live birth (Table UCM-D). Codes for non-live births were also drawn from the HEDIS measure of Prenatal and Postnatal Care.

Once the exclusions are applied, the denominator includes women who: were not pregnant at any point in the measurement year; were pregnant during the measurement year but whose pregnancy ended in the first 10 months of the measurement year, since there was adequate time to provide contraception in the postpartum period; or were pregnant during the measurement year but whose pregnancy ended in an ectopic pregnancy, stillbirth, miscarriage, or induced abortion.

Risk Adjustment

2903 Contraceptive Care – Most & Moderately Effective Methods

No risk adjustment or risk stratification

2904 Contraceptive Care - Access to LARC

No risk adjustment or risk stratification

Stratification

2903 Contraceptive Care – Most & Moderately Effective Methods

No risk adjustment or risk stratification

2904 Contraceptive Care - Access to LARC

No risk adjustment or risk stratification

Type Score

2903 Contraceptive Care – Most & Moderately Effective Methods

Rate/proportion better quality = higher score

2904 Contraceptive Care - Access to LARC

Rate/proportion better quality = score within a defined interval

Algorithm

2903 Contraceptive Care – Most & Moderately Effective Methods

Step 1 Identify all women aged 15-44 years of age who were enrolled in the health plan or program. In the case of general Medicaid, include women who were continuously enrolled (i.e., had no more than one gap in enrollment of up to 45 days). In the case of women enrolled in a family planning-specific expansion program (1115 waiver or state plan amendment), include all women even if they do not meet the continuous enrollment criteria because the reason for their visit is related to pregnancy prevention.

Step 2 Define the denominator by excluding women who: (a) are infecund for non-contraceptive reasons; (b) had a live birth in the last 2 months of the measurement year; or (c) were still pregnant or their pregnancy outcome was unknown at the end of the year. Once exclusions are applied, the following groups of women will be included in the denominator: (a) those who were not pregnant at any point in the measurement year; (b) those who had a live birth in the first 10 months of the measurement year; and (c) those who had a known miscarriage, stillbirth, ectopic pregnancy, or induced abortion during the measurement year.

Step 3 Define the numerator by using claims codes to identify women who adopted or continued use of one of the following methods of contraception in the measurement year: sterilization, IUD, implant, contraceptive injection, contraceptive pills, patch, ring, or diaphragm. Adjust for LARC removals, in the manner specified above.

Step 4 Calculate the rates by dividing the number who used a most or moderately effective method of contraception by the number of women in the denominator. Calculate the rates separately for adolescents and adults. Available in attached appendix at A.1

2904 Contraceptive Care - Access to LARC

Step 1 Identify all women aged 15-44 years of age who were enrolled in the health plan or program. In the case of general Medicaid, include women who were continuously enrolled (i.e., had no more than one gap in enrollment of up to 45 days). In the case of women enrolled in a family planning-specific expansion program (1115 waiver or state plan amendment), include all women even if they do not meet the continuous enrollment criteria because the reason for their visit is related to pregnancy prevention.

Step 2 Define the denominator by excluding women who: (a) are infecund for non-contraceptive reasons; (b) had a live birth in the last 2 months of the measurement year; or (c) were still pregnant or their pregnancy outcome was unknown at the end of the year. Once exclusions are applied, the following groups of women will be included in the denominator: (a) those who were not pregnant at any point in the measurement year; (b) those who had a live birth in the first 10 months of the measurement year; and (c) those who had a known miscarriage, stillbirth, ectopic pregnancy, or induced abortion during the measurement year.

Step 3 Define the numerator by using claims codes to identify women who adopted or continued use of a long-acting reversible method of contraception (LARC), i.e., IUD or implant. Adjust for LARC removals, in the manner specified above.

Step 4 Calculate the rates by dividing the number who used a long-acting reversible method of contraception (LARC) by the number of women in the denominator. Calculate the rates separately for adolescents and adults. Available in attached appendix at A.1

Submission items

2903 Contraceptive Care – Most & Moderately Effective Methods

2904 Contraceptive Care - Access to LARC

Appendix F: Pre-Evaluation Comments

No comments were received prior to the February 7, 2020 measure evaluation meeting.

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