NATIONAL QUALITY FORUM
Driving measurable health improvements together

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

TECHNICAL REPORT
FEBRUARY 16, 2021

This report is funded by the Centers for Medicare & 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 (CDC) National Vital Statistics System, the 2018 maternal mortality rate was 17.4 maternal deaths per 100,000 live births and increases with age; women ages 40 and older die at a rate of 81.9 per 100,000 births.[1] Women belonging to this age group are 7.7 times more likely to die compared with women under the age of 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 (U.S.) ranked 55th, just behind Russia (17 per 100,000) and just ahead of Ukraine (19 per 100,000).[1] Access to high quality 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-birth-weight newborns; and postpartum patients. Measures related to other aspects of women's health are reviewed by other Committees (e.g., a perinatal vaccination measure is in the Prevention and Population Health Standing Committee's portfolio).

For this project, the Perinatal and Women's Health Standing Committee evaluated one newly submitted measure against NQF's standard evaluation criteria. The Consensus Standards Approval Committee (CSAC) upheld the Committee's recommendation of 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 U.S. 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 U.S., 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 also 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-birth-weight 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 14 measures: eight process measures, six outcome and resource use measures, and zero composite measures (see Table 1 below).

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

	Process	Outcome/Resource Use
Preconception	2	2
Birth	5	1
Newborns	1	3
Total	8	6

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 project), and routine breast cancer screening (Prevention and Population Health project).

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 review	0	1	1
Measures endorsed	0	1	1

Comments Received Prior to Committee Evaluation

NQF accepts 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 had 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 in which 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 reviewed 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 review, 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 review. All comments for each measure under review 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 (either *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 during the meeting held on February 7, 2020. 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. As quorum was not reached, no results were announced during the call. 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 survey was closed for all Committee members on Tuesday, February 11, 2020. Voting results are reported in Appendix A.

#3543 Patient-Centered Contraceptive Counseling (PCCC) (University of California San Francisco): Endorsed

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 PRO-PM that uses four items rated on a five-point Likert scale. In its introduction of the measure, the developer noted that it would be a "balancing measure" to three contraceptive care measures already present in NQF's portfolio (#2902 Contraceptive Care – Postpartum; #2903 Contraceptive Care – Most & Moderately Effective Methods; and #2904 Contraceptive Care – Access to LARC). 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 on 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 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 International Classification of Diseases Tenth Revision (ICD-10) or Current Procedural Terminology (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 although 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.

As of February 8, 2021 the measure title has been changed to “Person-Centered Contraceptive Counseling (PCCC)."

References

1 National Vital Statistics Reports Volume 69, Number 2 January, 2020 Maternal Mortality in the United States: 69(2):18.

2 Recommendations to Improve Preconception Health and Health Care - United States: A Report of the CDC/ATSDR Preconception Care Work Group and the Select Panel on Preconception Care. https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5506a1.htm. Last accessed February 2020.

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.

4 What Is Patient Experience? http://www.ahrq.gov/cahps/about-cahps/patient-experience/index.html. Last accessed February 2020.

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, et al. 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 Endorsed

Vote totals may differ between measure criteria and between measures as Committee members often have to join calls late or leave calls early. NQF ensures that quorum is maintained for all live voting. All voting outcomes are calculated using the number of Committee members present during the meeting for that vote as the denominator.

#3543 Patient-Centered Contraceptive Counseling (PCCC)

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 contraceptive care 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 questions 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 postpartum contraceptive use, including increased risk of blood clots, effect on lactation, and the health impact of birth spacing, counseling pregnant women about future

#3543 Patient-Centered Contraceptive Counseling (PCCC)

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

Data Source: Instrument-Based Data

Measure Steward: University of California, San Francisco

STANDING COMMITTEE MEETING [February 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: NQF #2903 *Contraceptive Care – Most & Moderately Effective Methods* and NQF #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 are 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 because a translator might not be specifically familiar with concepts of patient-centeredness; therefore, the approach to translation would not be standardized. The developer indicated it would like to perform 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 contraceptive availability and patient-centered counseling are tied together, but 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.
- At the beginning of this call, 16 members were present, but an additional Committee member joined the call after the vote on evidence; therefore, the remaining votes include 17 Committee members.

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>:

#3543 Patient-Centered Contraceptive Counseling (PCCC)

- 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 (e.g., 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 of *High* for reliability and validity. The Committee voted to accept the SMP's votes of both reliability and validity: 17 for *yes* and 0 for *no*.

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 where 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 of high feasibility 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 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.

#3543 Patient-Centered Contraceptive Counseling (PCCC)

- 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 on usability.

5. Related and Competing Measures

- This measure is related to NQF #2903 *Contraceptive Care – Most & Moderately Effective Methods* and NQF #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

- 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 that 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 the developer's response.
- Theme 2 – Capturing pregnancy intendedness: Commenters noted that the measure does not account for situations in which the patient would like to become pregnant, nor are there questions about pregnancy intendedness; therefore, the measure cannot assess the patient-centeredness of visits in which 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 (#4) 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 intended 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 the developer's response.

7. Consensus Standards Approval Committee (CSAC) Endorsement Decision: Yes-11; No-0 (November 17-18, 2020: Endorsed)

#3543 Patient-Centered Contraceptive Counseling (PCCC)
• The CSAC upheld the Standing Committee's decision to recommend the measure for endorsement.
8. Appeals • **No appeals were received.**

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

NQF #	Title	Federal Programs: Finalized or Implemented as of June 22, 2020
0033	Chlamydia Screening in Women (CHL)	Medicaid (Implemented); Marketplace Quality Rating System (Implemented)
0469	PC-01 Elective Delivery	Hospital Inpatient Quality Reporting (Implemented); Medicaid (Implemented)
0469e	PC-01 Elective Delivery	None
0470	Incidence of Episiotomy	None
0471	PC-02 Cesarean Birth	Medicaid (Implemented)
0478	Neonatal Bloodstream Infection Rate (NQI 03)	None
0480	PC-05 Exclusive Breast Milk Feeding	None
0480e	PC-05 Exclusive Breast Milk Feeding	Hospital Inpatient Quality Reporting (Implemented); Medicare and Medicaid Promoting Interoperability Program for Eligible 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	None
1382	Percentage of Low-Birth-Weight Births	Medicaid (Implemented)
2902	Contraceptive Care - Postpartum	Medicaid (Implemented)
2903	Contraceptive Care – Most & Moderately Effective Methods	Medicaid (Implemented)
2904	Contraceptive Care - Access to LARC	Medicaid (Implemented)

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

STANDING COMMITTEE

Kimberly Gregory, MD, MPH (Co-Chair)
Women's Healthcare Quality & Performance Improvement, Cedars Sinai Medical Center
Los Angeles, California

Carol Sakala, PhD, MSPH (Co-Chair)
National Partnership for Women & Families
Washington, DC

Jill Arnold
Maternal Safety Foundation
Bentonville, Arkansas

J. Matthew Austin, PhD
Faculty, Johns Hopkins School of Medicine
Baltimore, Maryland

Jennifer Bailit, MD, MPH
MetroHealth Medical Center
Cleveland, Ohio

Amy Bell, DNP, RNC-OB, NEA-BC, CPHQ
Women's and Children's Services and Levine Cancer Institute, Atrium Health
Charlotte, North Carolina

Martha Carter, DHSc, MBA, APRN, CNM
WomenCare, Inc.
Scott Depot, West Virginia

Tasha Cooper, RN
CIGNA HealthCare
Minot, Maine

Tracy Flanagan, MD
Kaiser Permanente
Oakland, California

Lisa Holtzclaw, RN, BS, MHA, MSN
HCA Healthcare
Brentwood, Tennessee

Mambarambath Jaleel, MD
Parkland NICU, University of Texas Southwestern Medical Center
Dallas, Texas

Diana Jolles, CNM, MS, PhD
American College of Nurse-Midwives
Tucson, Arizona

Deborah Kilday, MSN
Premier, Inc.
Woodstock, Georgia

Sarah McNeil, MD
Contra Costa Medical Center
Martinez, California

Jennifer Moore, PhD, RN
Executive Director, Institute for Medicaid Innovation
Washington, DC

Sarah Nathan, MSN, RN, FNP
Department of Family Health Care Nursing, UCSF
San Francisco, California

Kristi Nelson, MBA, BSN
Intermountain Healthcare
Salt Lake City, Utah

Sheila Owens-Collins, MD, MPH, MBA
Johns Hopkins Healthcare, LLC
Glen Burnie, Maryland

Diana E. Ramos, MD, MPH, FACOG
Los Angeles County Public Health Department
Laguna Beach, California

Sindhu Srinivas, MD, MSCE
University of Pennsylvania Health System and Perelman School of Medicine
Philadelphia, Pennsylvania

Nan Strauss, JD
Every Mother Counts
New York, New York

Angeline Ti, MD, MPH
Emory University School of Medicine, Division of Reproductive Health at the Centers for Disease Control and Prevention
Atlanta, Georgia

Rajan Wadhawan, MD, MMM, CPE, FAAP
Florida Hospital for Children
Orlando, Florida

NQF STAFF

Sheri Winsper, RN, MSN, MSHA
Senior Vice President, Quality Measurement

Michael Katherine Haynie
Senior Managing Director, Quality Measurement

Kathleen Giblin, RN
Acting Senior Vice President, Quality Measurement

Apryl Clark, MHSA
Acting Vice President, Quality Measurement

Matthew Pickering, PharmD
Senior Director

Chelsea Lynch, MPH, MSN, RN, CIC
Director

Yemsrach Kidane, PMP
Project Manager

Erin Buchanan, MPH
Manager

Hannah Ingber, MPH
Senior Analyst

Robyn Y. Nishimi, PhD
Senior Consultant

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 questions 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 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.

	NQF 3543 Patient-Centered Contraceptive Counseling (PCCC) measure: Specifications
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 postpartum 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

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

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

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

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.

National Quality Forum
1099 14th Street NW, Suite 500
Washington, DC 20005
http://www.qualityforum.org