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Perinatal and Women's Health, Spring 2022 Cycle: CDP Report

TECHNICAL REPORT
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Contents

Executive Summary

Despite spending nearly 1 in every 5 dollars in healthcare expenditures, which is more than twice that of other high-income countries (i.e., Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, and the United Kingdom), the United States (U.S.) continues to have the highest maternal morbidity and mortality rates among these countries.[1] Data also show significant disparities for marginalized women (including those with demographic, economic, and other social risks) in maternal and infant morbidity and mortality, health screenings and prevention, and the treatment of preventable conditions.

The Perinatal and Women's Health Standing Committee oversees the measure portfolio used to advance the accountability and quality of perinatal and women's health services. This portfolio includes measures for reproductive health; pregnancy/labor and delivery; high-risk pregnancy; newborn, premature, or low-birth-weight newborns; and postpartum care.

For this cycle, the Standing Committee evaluated four newly submitted measures against NQF's standard evaluation criteria. The Standing Committee initially recommended two measures for endorsement and the other two measures for trial use. During the post-comment meeting, however, the Standing Committee decided to retract its recommendation for endorsement from one of the measures (NQF #3687e). The developer then submitted a reconsideration request for this measure. The Consensus Standards Approval Committee (CSAC) decided to uphold the Standing Committee's recommendations for the three other measures and accepted the reconsideration request for NQF #3687e. This measure will be sent back to the Standing Committee for further review in a future cycle.

The following measure was endorsed:

- NQF #0471e ePC-02 Cesarean Birth (The Joint Commission)

The Standing Committee approved the following measures for trial use:

- NQF #3682e SINC-Based Contraceptive Care, Postpartum (University of California, San Francisco [UCSF])
- NQF #3699e SINC-Based Contraceptive Care, Non-Postpartum (UCSF)

The following measure will be sent back to the Standing Committee for further review:

- NQF #3687e ePC-07 Severe Obstetric Complications (The Joint Commission)

Brief summaries of the measures and their evaluations are included in the body of the report; detailed summaries of the Standing Committee's discussion and ratings of the criteria for each measure are in Appendix A.

Introduction

In the U.S., women face diverse health and wellness concerns during pregnancy and childbirth. A 2020 report published by the Commonwealth Fund found that while most maternal deaths are preventable, the U.S. rates for maternal deaths have continued to increase rather than decrease since 2000. In 2020, the U.S. maternal mortality rate was 28.3 deaths per 100,000 live births, increasing to 55.3 deaths per 100,000 live births for non-Hispanic Black populations.[2] Maternal health disparities vary across the country based on ethnicity, socioeconomic status, and access to quality healthcare. Lack of access to high quality care decreases the opportunity for the identification of risk factors and mitigation of conditions that lead to poor outcomes. Appropriate care and management of pregnancy and childbirth are essential to the health and wellness of women and their families across the nation.

The spring 2022 cycle includes a review of Perinatal and Women's Health measures that address reproductive health for both pregnant and nonpregnant women. These measures focus on severe obstetric complications, cesarean birth, and the self-identified need for contraceptive care.

Life-Threatening Obstetric Complications

The Centers for Disease Control and Prevention (CDC) reports that approximately 700 women die yearly from pregnancy or delivery complications.[3] Severe complications include, but are not limited to, hemorrhage, pulmonary embolus, sepsis, pre-eclampsia or eclampsia, and complications of abortion.[3] These complications can occur even when the mother is healthy prior to pregnancy and is more likely if the mother has poor access to regular prenatal care. Conditions such as pre-eclampsia affect 1 in 25 women, putting them at risk for stroke, placental abruption, and preterm delivery.[4] These types of life-threatening complications adversely affect a woman's health, the health of her fetus, and the well-being of her entire family. The Standing Committee evaluated a measure this cycle that assesses the number of delivery hospitalizations for women who experience a severe obstetric complication out of the total number of delivery hospitalizations during the measurement period (NQF #3687e).

Cesarean Delivery

The CDC reported an increase in cesarean delivery rates to 31.8 percent in 2020, re-approaching its 2009 peak of 32.9 percent after declining the past two years. Cesarean deliveries can be critical when the life of the mother or her fetus are at risk during delivery; yet the procedure alone has risks, and with the rates at which cesarean deliveries are performed, there is concern that mothers and their babies are facing additional unnecessary risk.[5] Complications from cesarean delivery are as much as three times higher than for vaginal deliveries, and cesarean deliveries can create increased risks during subsequent pregnancies.[6] In addition, cesarean-delivered babies face higher risks of infection, respiratory compromise, intensive care unit stays, and lower breastfeeding rates.[7] The U.S. Department of Health and Human Services' (HHS) Healthy People 2030 initiative set the reduction of cesarean births for low-risk women as a priority objective, with a goal of reducing rates to 23.6 percent by 2030.[8] The Standing Committee evaluated a measure this cycle that assesses the number of nulliparous women with a term, singleton baby in a vertex position delivered by cesarean birth (NQF #0471e).

Self-Identified Need for Contraception

When a pregnancy is unplanned, the risk of complications and adverse outcomes is higher. Unplanned or unintended pregnancies occur up to 44 percent of the time and carry increased risks of low

birthweight, premature birth, and infant mortality.[9] Unintended pregnancies are also a health equity concern, as higher rates occur among women of low socioeconomic status, Black and Hispanic women, and single women. Access to and affordability of contraception and regular health maintenance is challenging in these populations, which can further decrease the opportunity of pregnancy prevention and optimal lifestyle decisions prior to pregnancy.[10] The Standing Committee evaluated two measures related to this topic this cycle (NQF #3682e and NQF #3699e). NQF #3682e assesses the percentage of women who: (1) received or had documented use of most or moderately effective contraception during the postpartum period (primary measure) and (2) received a long-acting reversible contraceptive (LARC) method during the postpartum period (sub-measure). NQF #3699e assesses the percentage of women who: (1) received or had documented use of most or moderately effective contraception and (2) received a LARC method during the calendar year.

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

The Perinatal and Women's Health Standing Committee (Appendix C) oversees NQF's portfolio of Perinatal and Women's Health measures (Appendix B), which includes measures for life-threatening complications, cesarean delivery, and the self-identified need for contraception (SINC). This portfolio contains 13 measures: six process measures, three outcome measures, two intermediate clinical outcome measures, one patient-reported outcome performance measure (PRO-PM), and one structure measure.

Additional measures related to Perinatal and Women's Health are assigned to other project portfolios, including complications/outcomes measures (Surgery), screening and management of osteoporosis in women (Primary Care and Chronic Illness), and routine breast cancer screening (Prevention and Population Health).

Perinatal and Women's Health Measure Evaluation

On July 6, 2022, the Perinatal and Women's Health Standing Committee evaluated four new measures against NQF's standard measure evaluation criteria.

Table 1. Perinatal and Women's Health Measure Evaluation Summary

Measure	Maintenance	New	Total
Measures under review for endorsement	0	2	2
Measures endorsed	0	1	1
Measures with decisions pending future Standing Committee review	0	1	1
Measures under review for approval for trial use	0	2	2
Measures approved for trial use	0	2	2

Scientific Methods Panel Measure Evaluation

Prior to the Standing Committee's review, the Scientific Methods Panel (SMP) reviewed three complex measures in this topic area. The SMP passed one measure, did not reach consensus on both reliability and validity for one measure, and did not pass one measure on both reliability and validity during its measure evaluation. Measures that passed the SMP's review or for which the SMP did not reach consensus were reviewed by the Standing Committee. Measures that did not pass the SMP's review may or may not be eligible for a revote and full evaluation conducted by the Standing Committee. A measure is not eligible for a revote if it did not pass the SMP's review for one or more of the following reasons:

1. An inappropriate methodology or testing approach was applied to demonstrate reliability or validity.
2. Incorrect calculations or formulas were used for testing.
3. The description of specifications, testing approach, results, or data is insufficient for the SMP to apply the criteria.
4. Appropriate levels of testing were not provided or otherwise did not meet NQF's minimum evaluation requirements.

One measure was eligible for a revote; however, the measure was not pulled by the Standing Committee for a revote:

- NQF #0716e ePC-06 Unexpected Newborn Complications in Term Newborns (The Joint Commission)

A meeting summary detailing the SMP's measure evaluation for the spring 2022 cycle is available on the SMP webpage.

Evaluation of Electronic Clinical Quality Measures for Trial Use

The Standing Committee also evaluated two new electronic clinical quality measures (eCQMs) for NQF Approval for Trial Use (NQF #3682e and NQF #3699e). NQF Approval for Trial Use is intended for eCQMs that are ready for implementation but cannot yet be adequately tested to meet NQF endorsement criteria. NQF uses the multistakeholder Consensus Development Process (CDP) to evaluate and approve eCQMs for trial use that address important areas of performance measurement and quality improvement, although they may not have the requisite testing needed for NQF endorsement. These eCQMs must be assessed to be technically acceptable for implementation. The goal of approving eCQMs for trial use is to promote implementation and the ability to conduct more robust reliability and validity testing that can take advantage of clinical data in electronic health records (EHRs). NQF Approval for Trial Use carries no endorsement label but may be considered as a pathway for measures to prepare for endorsement.

Comments Received Prior to Standing 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 period during each evaluation cycle via an online tool located on the project webpage. For this evaluation cycle, the commenting period opened on May 18, 2022, and pre-meeting commenting closed on June 15, 2022. Prior to June 15, 2022,

no comments were submitted and shared with the Standing Committee prior to the measure evaluation meeting.

Comments Received After Standing Committee Evaluation

The continuous public commenting period with NQF member support closed on September 13, 2022. Following the Standing Committee's evaluation of the measures under review, NQF received 14 comments from seven organizations and individuals pertaining to the draft report and the measures under review (Appendix G). All comments for each measure under review have also been summarized in Appendix A.

NQF members had the opportunity to express their support ("support" or "do not support") for each measure submitted for endorsement consideration to inform the Standing Committee's recommendations during the commenting period. No NQF members expressed "support" for the measures under review.

Summary of Measure Evaluation

The following brief summaries of the measure evaluation highlight the major issues that the Standing Committee considered. Details of the Standing Committee's discussion and ratings of the criteria for each measure are included in Appendix A.

Life-Threatening Complications

NQF #3687e ePC-07 Severe Obstetric Complications (The Joint Commission): Decision Pending Future Standing Committee Review

Description: Hospital-level measure scores are calculated as a risk-adjusted proportion of the number of delivery hospitalizations for women who experience a severe obstetric complication, as defined by the numerator, by the total number of delivery hospitalizations in the denominator during the measurement period. The hospital-level measure score will be reported as a rate per 10,000 delivery hospitalizations; **Measure Type**: Outcome; **Level of Analysis**: Facility; **Setting of Care**: Inpatient/Hospital; **Data Source**: Electronic Health Data; Electronic Health Records

This facility-level measure was newly submitted for endorsement. It is publicly reported as part of The Joint Commission's ORYX Performance Measure Reporting: Hospital Accreditation Program (HAP) and is used in its Critical Access Hospital (CAH) Accreditation Program.

The Standing Committee agreed that the evidence shows a link between meaningful intervention on measured processes and improvements to the outcome of severe obstetric complications. It also noted that there are substantial gaps as well as disparities in severe obstetric complication rates. The Standing Committee voted to pass the measure on evidence and performance gap.

The SMP reviewed this measure in advance of the meeting and passed it on both reliability and validity. The Standing Committee raised concerns about the measure's reliability, stating that professional societies may define the same condition differently (e.g., acute renal failure), or facilities may code present on admission (POA) conditions differently, thus leading to variation in coding. The developer confirmed the POA coding to be reliable during testing and also outlined an educational outreach plan to improve coding as the measure is used more. The Standing Committee determined that both the

current specifications and the testing submitted show the measure is reliable and voted to accept the SMP's rating of moderate for reliability.

Regarding validity, some Standing Committee members raised concerns that the measure encompasses all severe obstetric complications, which could hamper quality improvement activities for specific conditions. The developer replied that the decision to combine complications into one measure improved the measure's ability to detect differences across hospitals by increasing the denominator. Patient feedback also showed a preference to see an overall score. The developer clarified that hospitals could use the value sets of this eCQM to break out their outcomes by condition for more detailed analysis. The Standing Committee also commented on a few opportunities for future improvements to the measure. First, the Standing Committee stressed that it will be important to see the measure as stratified by race and ethnicity in the future. The measure developer explained that the work of how to best stratify the measure is still being analyzed. The Standing Committee also noted that it would like to see the measure evolve in such a way that hospitals can use it to analyze whether process improvement activities were undertaken to ameliorate any outcomes that are currently viewed as unpreventable and to foster quality and process improvements to improve outcomes. Unfortunately, quorum was lost for the remainder of the meeting; therefore, the Standing Committee did not vote on whether to accept the SMP's rating of moderate for validity. Instead, the Standing Committee voted after the meeting using an online survey and passed the measure on validity.

The Standing Committee questioned the feasibility of the time-stamp data element, and the developer clarified that it was removed from the measure because it was not essential for the measure's logic. The Standing Committee then passed the measure on feasibility. The Standing Committee had no concerns with the measure's use and passed the measure on this criterion since the measure is publicly reported and is used for internal and external benchmarking. Many Standing Committee members expressed concerns with the potential unintended consequences of the measure. While the measure's design does ease the burden of reporting and aids comparability, it does not capture all morbidities and may lead to a focus on improved coding rather than improved quality of care, thereby shifting hospital resources in an inappropriate direction. Additionally, the combination of all severe obstetric complications into one measure may harm hospitals that specialize in and see a larger share of patients with certain conditions (e.g., maternal congenital cardiac conditions). The Standing Committee members noted the developer's rationale for the combination of complications and their plan for ongoing monitoring of unintended consequences and educational outreach and ultimately decided to pass the measure on usability and overall suitability for endorsement.

Following the measure evaluation meeting, a Standing Committee member, who was unable to attend the measure evaluation meeting, expressed a concern via email to NQF staff and the Standing Committee, stating that the measure was not adequately discussed by the Standing Committee. Specifically, this member commented that the Standing Committee did not address all of the member's validity concerns, which were submitted as part of the pre-evaluation Standing Committee feedback.

During the post-comment meeting, the Standing Committee expanded upon concerns relating to validity, including whether codes matched the medical records and whether they represented actual severe maternal morbidity (SMM) events according to a gold standard. The developer responded, noting that the positive predictive value (PPV) for the numerator was very high overall, as well as clarified that

blood transfusion is one item that showed differing levels of agreement and was thus kept as a separate value. Regarding the gold standard issue, the developer noted that they clinically adjudicated over 200 cases in the numerator that involved SMM using the CDC's definitions. Further, secondary testing was conducted where each numerator event was adjudicated using labor and delivery summaries. The developer stressed that there is no official "gold standard" for describing SMM in the field of maternal healthcare or formal consensus on which conditions define SMM.

Following the meeting, the Standing Committee voted offline to reopen the measure discussion on validity, and then voted not to pass the measure on validity. Subsequently, the developer submitted a reconsideration request to the CSAC on the basis that NQF's measure evaluation criteria were not applied appropriately because the measure met NQF's criteria for validity and that the CDP was not followed, particularly for the public commenting process due to the measure review outcome. The CSAC voted to accept the reconsideration request and returned the measure to the Standing Committee for reconsideration in a future cycle. The CSAC noted that the review process for this measure was not as transparent as possible and that the Standing Committee should respond in detail to the issues the developer raised and stick to the evidence presented within the measure. The CSAC also noted that if other evidence is submitted for consideration, the Standing Committee should ensure that the evidence reflects the measure's specifications.

Cesarean Birth

NQF #0471e ePC-02 Cesarean Birth (The Joint Commission): Endorsed

Description: This measure assesses the number of nulliparous women with a term, singleton baby in a vertex position delivered by cesarean birth; **Measure Type**: Outcome; **Level of Analysis**: Facility; **Setting of Care**: Inpatient/Hospital; **Data Source**: Electronic Health Records; Electronic Health Data

This facility-level measure was newly submitted for endorsement. It is publicly reported as part of The Joint Commission's ORYX Performance Measure Reporting: HAP and is used in its CAH Accreditation Program.

The Standing Committee agreed that the evidence for the measure was sound and that the data showed gaps in care and variation in practice rates, thus leading to variation in outcomes. The Standing Committee ultimately passed the measure on evidence and performance gap.

The SMP reviewed this measure in advance of the Standing Committee meeting but did not reach consensus on reliability or validity. The Standing Committee noted that both the measure submission and the SMP's discussion noted an issue with the obstetrician documentation system used at one of the sites. However, the developer confirmed that after learning about the problem, the fields were made interoperable to account for the site's different documentation system so that data can be pulled from it. Other vendors having this issue will be able to use the same solution, and the developer will address it in future webinars to ensure others know about this issue. The Standing Committee had no further concerns and passed the measure on reliability.

The Standing Committee raised questions about a number of conditions that would seemingly warrant exclusion, including umbilical cord prolapse, active herpes outbreak, placenta previa, and others. The measure developer confirmed that placenta previa is now excluded from the denominator in response

to feedback; they are convening an expert panel to discuss the other exclusions mentioned. The Standing Committee ultimately passed the measure on validity.

The Standing Committee had no concerns with feasibility or use and passed the measure on both criteria. Some members noted that the measure has been shown to be highly actionable, especially from a rural and urban perspective. The Standing Committee ultimately passed the measure on usability and overall suitability for endorsement and recommended the measure for initial endorsement.

No public or member comments were received during the commenting period for this measure. The CSAC upheld the Standing Committee's decision to recommend the measure for endorsement. No appeals were received.

Self-Identified Need for Contraception

NQF #3682e SINC-Based Contraceptive Care, Postpartum (University of California, San Francisco): Approved for Trial Use

Description: Percentage of women 1) who received or had documented use of most or moderately effective contraception during the postpartum period (primary measure) and 2) received a long-acting reversible contraceptive method during the postpartum period (sub-measure). To focus the measure on the population of women interested in contraceptive services, the denominator excludes those individuals who did not receive or have documented use of a method if they indicated they did not want these services; **Measure Type**: Outcome: Intermediate Clinical Outcome; **Level of Analysis**: Facility; **Setting of Care**: Outpatient Services; **Data Source**: Electronic Health Data

This facility-level measure was newly submitted for approval for trial use. It is being tested for pilot implementation in the Innovating Contraceptive Care in Community Health Centers (ICC in CHCs) project.

The Standing Committee agreed that existing clinical guidelines support the evidence for this measure; it had no concerns and passed the measure on evidence. The Standing Committee likewise agreed that the submission showed a gap in care and passed the measure on performance gap.

NQF staff explained that as this measure seeks approval for trial use, only the specifications are assessed, and no other information will be submitted on scientific acceptability at this time. The Standing Committee asked for clarification on the specifications, specifically SINC and the clinical care context in which that determination is made. The developer explained that using SINC reduces instances of coercive contraceptive practices or choices of reproductive care that change based on a woman's evolving needs. A Standing Committee member asked about the need for the addition of a SINC code for EHRs to capture these data in differing systems. The developer explained that they have optimized the specifications to minimize data collection burden. A few Standing Committee members noted that a recent Supreme Court ruling, Dobbs v. Jackson, has created concerns that the use of long-term contraceptives, such as intrauterine devices (IUD), may be tracked and used in legal cases. The Standing Committee expressed concern that this perception may discourage honest reporting of contraceptive use but agreed it was too early to determine the impact on the validity of the measure and encouraged the developer to consider the impact as the measure is tested. The Standing Committee passed the measure on specifications.

One Standing Committee member raised a question on reporting feasibility and the inclusion of the SINC measure in standard nomenclatures within EHRs to ensure reporting is feasible. In response, the developer stated that they are engaged on multiple fronts to improve feasibility. The developer is also including standard nomenclatures in the Logical Observation Identifiers Names and Codes (LOINC) system and integrating them into the Systematically Organized Computer-Processable Collection of Medical Terms (SNOWMED) system as well. Additionally, the team is working with health center-controlled networks that support EHRs of federally qualified health centers (FQHCs) and other health systems. The developer explained that they found that SINC integration varies by EHR type.

The Standing Committee noted that the measure is not currently in use and asked whether measure users will be informed about their performance once it is in use. In response, the developer shared their plan to provide summary measure reports to participants, through which they can also obtain more information on the optimization of reporting. The Standing Committee had no further questions and passed the measure on use. The Standing Committee had no concerns regarding usability and passed the measure on this criterion and overall suitability for trial use.

During the post-evaluation commenting period, seven comments were received. All seven comments expressed support for the measure; however, one of the comments offered a suggestion for improvement, namely, the inclusion of nonprescription contraceptive methods in order to fully capture the range of potential contraceptive desires and usage by patients, as well as possibly expanding the measure to include individuals who are able to become pregnant who may also require contraceptive care who do not identify as cisgender women. The developer responded to the comment, noting that they agree with the commenter's suggestion on expanding the specifications and will continue to do so as the EHR data evolve. The CSAC upheld the Standing Committee's decision to recommend the measure for trial use. No appeals were received.

NQF #3699e SINC-Based Contraceptive Care, Non-Postpartum (University of California, San Francisco): Approved for Trial Use

Description: Percentage of women who 1) received or had documented use of most or moderately effective contraception and 2) received a long-acting reversible contraceptive method during the calendar year. To focus the measure on the population of women interested in contraceptive services, the denominator excludes those individuals who did not receive or have documented use of a method if they indicated during the year that they did not want these services, as well as those who are eligible for postpartum contraceptive services during the measurement period; **Measure Type**: Outcome: Intermediate Clinical Outcome; **Level of Analysis**: Facility; **Setting of Care**: Outpatient Services; **Data Source**: Electronic Health Records; Electronic Health Data

This facility-level measure was newly submitted for trial use. It is being tested for pilot implementation in the ICC in CHCs project.

This measure assesses the same quality of care as NQF #3682e, but in a slightly different population. NQF #3699e focuses on non-postpartum patients, who require different levels of care for assessment of the desire for contraception. The information submitted for the measures does not differ greatly across applications, and the Standing Committee focused its discussion on areas that differed or to clarify additional questions. There were no concerns about the similar evidence presented, and the Standing

Committee acknowledged evidence of a continued opportunity for improvement to address gaps in care. The Standing Committee ultimately passed the measure on evidence and performance gap. Regarding specifications, the Standing Committee recognized that the developer's efforts to build redundancies into the specifications to account for differing EHR systems is appropriate and passed the measure on specifications. Regarding feasibility, no differences were noted; therefore, the Standing Committee passed the measure on this criterion. The Standing Committee confirmed with the developer that measure users will be informed of their performance after submitting data, and while not currently in use, the measure has several planned uses. There were no additional concerns with usability; therefore, the Standing Committee passed the measure on both use and usability, as well as overall suitability for trial use.

During the post-evaluation commenting period, seven comments were received. All seven comments expressed support for the measure; however, one of the comments offered a suggestion for improvement, namely, the inclusion of nonprescription contraceptive methods in order to fully capture the range of potential contraceptive desires and usage by patients, as well possibly expanding the measure to include individuals who are able to become pregnant who may also require contraceptive care who do not identify as cisgender women. The developer responded to the comment, noting that they agree with the commenter's suggestion on expanding the specifications and will continue to do so as the EHR data evolve. The CSAC upheld the Standing Committee's decision to recommend the measure for trial use. No appeals were received.

Measures Withdrawn From Consideration

Two measures previously endorsed by NQF were withdrawn during the endorsement evaluation process. Endorsement for these measures has been removed.

Table 2. Measures Withdrawn From Consideration

Measure	Reason for Withdrawal
NQF #0483 Proportion of Infants 22 to 29 Weeks Gestation Screened for Retinopathy of Prematurity	The developer requested removal of endorsement, stating that the measure cannot meet NQF's maintenance of the Reliability, Validity, and Use requirements.
NQF #1382 Percentage of Low Birthweights	The developer requested removal of endorsement.

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Appendix A: Details of Measure Evaluation

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

NQF ensures that quorum is maintained for all live voting. Quorum is 66 percent of active Standing Committee members minus any recused Standing Committee members. Due to the exclusion of recused Standing Committee members from the quorum calculation, the required quorum for live voting may vary among measures. Quorum (14 out of 21 Standing Committee members for NQF #3687e and 15 out of 22 Standing Committee members for NQF #0471e, NQF #3682e, and NQF #3699e) was met and maintained for a portion of the review of NQF #3687e. However, quorum was lost following the reliability discussion and vote for NQF #3687e; therefore, the Standing Committee discussed all remaining criteria for measures NQF #3687e, NQF #0471e, NQF #3682e, and NQF #3699e and voted after the meeting using an online voting tool. For the post-comment call on Friday, October 19, 2022, quorum was not reached and vote totals were collected via an online voting tool. The Standing Committee received a recording of the meeting and a link to submit online votes. Voting closed after 48 hours with the minimum number of votes required for quorum. Voting results are provided below.

A measure is recommended for endorsement by the Standing Committee when greater than 60 percent of voting members select a passing vote option (i.e., Pass, High and Moderate, or Yes) on all must-pass criteria and overall suitability for endorsement. A measure is not recommended for endorsement when less than 40 percent of voting members select a passing vote option on any must-pass criterion or overall suitability for endorsement.

Measure Endorsed

NQF #0471e ePC-02 Cesarean Birth

Measure Worksheet | Specifications

Description: This measure assesses the number of nulliparous women with a term, singleton baby in a vertex position delivered by cesarean birth.

Numerator Statement: Inpatient hospitalizations for patients who deliver by cesarean section.

Denominator Statement: Inpatient hospitalizations for nulliparous patients delivered of a live term singleton newborn >= 37 weeks gestation.

Exclusions: Inpatient hospitalizations for patients with abnormal presentation or placenta previa during the encounter.

Adjustment/Stratification: N/A

Level of Analysis: Facility

Setting of Care: Inpatient/Hospital

Type of Measure: Outcome

Data Source: Electronic Health Records, Electronic Health Data

Measure Steward: The Joint Commission

STANDING COMMITTEE MEETING [July 6, 2022]

1. Importance to Measure and Report:

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

1a. Evidence: **Total votes-15**; **Pass-15; No Pass-0;** 1b. Performance Gap: **Total votes- 15; H-9**; **M-6**; **L-0**; **I-0**

Rationale:

- During the discussion on evidence, the Standing Committee noted that the developer cited research showing that roughly 30 percent of patients who had a cesarean delivery actively sought out information

on cesarean rates at their hospital; the developer also cited research to demonstrate the effect of a large-scale improvement collaborative to reduce Nulliparous, Term, Singleton, Vertex (NTSV) cesarean delivery rates in California hospitals (a total annual delivery volume of 119,000 birthing individuals). Additionally, the developer cited the American College of Obstetricians and Gynecologists (ACOG) recommendation of reduction for cesarean rates in the NTSV population and methods for reduction (increasing recommended hours of "pushing" for NTSV patients, increased training in use of forceps or manual rotation/aversion) and the benefits for reducing the repeat cesarean rate.

- The Standing Committee agreed that the evidence was strong and passed the measure on this criterion.
- The Standing Committee noted significant variation in practice rates, leading to variation in outcomes.
- Due to a small number of hospitals (n=15) participating in the pilot study, the developer reported five number statistical summaries instead of deciles, showing a mean of 27.5% (standard deviation [SD]: 20.0%), a maximum of 71.8%, a minimum of 0%, a 25th percentile of 19.5%, a 50th percentile of 23.3%, and a 75th percentile of 28.9%.
- One Standing Committee member noted that while the paper measure has been in use for years, some facilities still have a 72% cesarean section rate, which is well above the 30% goal outlined in the measure.
- The Standing Committee decided to pass the measure on performance gap.

2. Scientific Acceptability of Measure Properties:
(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)
2a. Reliability: **Total votes-15**; **H-0; M-11**; **L-4**; **I-0**; 2b. Validity: **Total votes-15**; **H-0; M-13**; **L-2**; **I-0**
Rationale:

- The SMP reviewed this measure but did not reach consensus on reliability (Total votes-9; H-0, M-4, L-3, I-2) or validity (Total votes-9; H-0, M-5, L-2, I-2).
- The Standing Committee noted that the developer relied upon patient/encounter-level validity testing to demonstrate both reliability and validity.
- The Standing Committee highlighted that the SMP found the testing approach to be appropriate but had concerns with the results since the overall agreement rate was the same as the kappa-adjusted rate. It specifically noted that there is no International Classification of Diseases, 10th Revision (ICD-10) code for parity and asked the developer for more information. The developer clarified that the kappa levels are from 10 shared data elements with an excellent match rate related to the estimated gestational age, preterm and term results, and parity results. The developer was confident that the data elements could be pulled, and the Standing Committee ultimately agreed as well.
- The Standing Committee noted several concerns about coding and documentation and asked specifically about an obstetrician documentation system at one site noted in the measure submission that had reporting issues. The developer replied that after identifying this issue, the fields were made interoperable to account for the site's different documentation system and that other vendors with the same issue will receive a similar solution.
- The Standing Committee had no further concerns and passed the measure on reliability.
- The Standing Committee noted that the validity testing was conducted at the patient/encounter level, and while the specificity was high for both testing sites, the sensitivity was only high for one of the two testing sites. The Standing Committee's concerns about the testing results were ultimately assuaged by the previous discussion on reliability testing and the developer's response, considering the same testing (and therefore concerns) was utilized to show both reliability and validity.
- The Standing Committee asked about a number of conditions that seem to warrant exclusion, including umbilical cord prolapse, active herpes outbreak, placenta previa, and others. The measure developer responded by confirming that placenta previa was added as an exclusion in response to the feedback;

they will be convening an expert panel to discuss the potential appropriateness of the other exclusions mentioned as well.

- The Standing Committee asked about the threat of using such limited exclusions that might lower c-section rates below a safe level, given that some patients with a clinical indication for a c-section are still included in the denominator. The developer explained that they do not report rates that are below 30% so that hospitals do not compare or compete below that rate.
- The Standing Committee passed the measure on validity.

3. Feasibility: Total votes-15; **H-6; M-8; L-1; 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 Standing Committee noted that the data elements are generated during the provision of care and that 100% of the measure logic can be automated.
- The Standing Committee had no concerns about feasibility and passed the measure on this criterion.

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**: Total votes-15**; **Pass-15; No Pass-0**; 4b. Usability: **Total votes-15**; **H-5; M-10; L-0; I-0**

Rationale:

- The Standing Committee noted that this measure is currently used in The Joint Commission's ORYX Performance Measure Reporting: HAP and CAH Accreditation Program. These programs also provide quality improvement data with both internal and external benchmarking, and the data submitted are analyzed by The Joint Commission for trends and benchmarks and internal quality improvement purposes.
- The Standing Committee had no concerns and passed the measure on use.
- The Standing Committee noted that the paper measure has been shown to be highly actionable, especially from a rural and urban perspective, because a great deal of room for improvement still remains in those facilities. No improvement data were available for the eCQM version currently under review because the developer only has one year of data at this point in time.
- The Standing Committee had no concerns and passed the measure on usability.

5. Related and Competing Measures

- This measure was identified as related to the following measure:
    - NQF #0471 PC-02 Cesarean Birth
- The Standing Committee agreed that the measures were harmonized to the extent possible.

6. Standing Committee Recommendation for Endorsement: **Total votes- 15**; **Yes-14**; **No-1**

7. Public and Member Comment

- No public or NQF member comments were received.

8. Consensus Standards Approval Committee (CSAC) Endorsement Decision: Total votes-15; Yes-15; No-0 (December 9, 2022: Endorsed)

- The CSAC upheld the Standing Committee's decision to recommend the measure for endorsement.

9. Appeals

- No appeals were received.

Decision Pending Future Standing Committee Review

NQF #3687e PC-07 Severe Obstetric Complications

Measure Worksheet | Specifications

Description: Hospital-level measure scores are calculated as a risk-adjusted proportion of the number of delivery hospitalizations for women who experience a severe obstetric complication, as defined by the numerator, by the total number of delivery hospitalizations in the denominator during the measurement period. The hospital-level measure score will be reported as a rate per 10,000 delivery hospitalizations.

ePC07 was developed in collaboration with Yale New Haven Health Services Corporation/Center for Outcomes Research and Evaluation (CORE).

Numerator Statement: Inpatient hospitalizations for patients with severe obstetric complications including the following:

- Severe maternal morbidity diagnoses (see list below)
- Severe maternal morbidity procedures (see list below)
- Discharge disposition = expired

Severe Maternal Morbidity Diagnoses:

- Cardiac
  - Acute heart failure
  - Acute myocardial infarction
  - Aortic aneurysm
  - Cardiac arrest/ventricular fibrillation
  - Heart failure/arrest during procedure or surgery
- Hemorrhage
  - Disseminated intravascular coagulation
  - Shock
- Renal
  - Acute renal failure
- Respiratory
  - Adult respiratory distress syndrome
  - Pulmonary edema
- Sepsis
- Other OB
  - Air and thrombotic embolism
  - Amniotic fluid embolism
  - Eclampsia
  - Severe anesthesia complications
- Other Medical
  - Puerperal cerebrovascular disorder
  - Sickle cell disease with crisis

Severe Maternal Morbidity Procedures:

- Blood transfusion
- Conversion of cardiac rhythm
- Hysterectomy
- Temporary tracheostomy
- Ventilation

Denominator Statement: Initial Patient Population: Inpatient hospitalizations for patients age >= 8 years and < 65 admitted to the hospital for inpatient acute care who undergo a delivery procedure with a discharge date that ends during the measurement period

Denominator: Inpatient hospitalizations for patients delivering stillborn or live birth with >= 20 weeks, 0 days gestation completed

Exclusions: Patients with confirmed diagnosis of COVID with COVID-related respiratory condition or patients with confirmed diagnosis of COVID with COVID-related respiratory procedure.
Adjustment/Stratification: Statistical Risk Model
Level of Analysis: Facility
Setting of Care: Inpatient/Hospital
Type of Measure: Outcome
Data Source: Electronic Health Data; Electronic Health Records
Measure Steward: The Joint Commission

STANDING COMMITTEE MEETING July 6, 2022
1. Importance to Measure and Report:
(1a. Evidence, 1b. Performance Gap)
1a. Evidence: **Total votes-14**; **Pass-14; No Pass-0**; 1b. Performance Gap: **Total votes-14**; **H-9**; **M-4**; **L-1**; **I-0;**

- The Standing Committee highlighted the research the developer presented, which determined that 65.8% of obstetric maternal deaths and 40.5% of pregnancy-related deaths were both preventable.
- Some of the Standing Committee members also noted that substantial variation in care and the state of severe maternal morbidity (SMM) and maternal mortality in the U.S. also supply evidence warranting a national measure on severe obstetric complications.
- The Standing Committee agreed that the evidence submitted shows a strong link between meaningful intervention on measured processes and improvements to the outcome of severe obstetric complications.
- The Standing Committee noted that the mean risk-adjusted severe obstetric complications rate per 10,000 deliveries was 248.8, ranging from a low of 157.1 to a high of 369.5.
- The Standing Committee further highlighted that when adjusting for risk factors, Non-Hispanic African-American women, Hispanic women, and Non-Hispanic Asian/Pacific Islander women have a significantly increased risk (i.e., 18%, 41%, and 62%, respectively) of having any SMM compared to non-Hispanic White women.
- The Standing Committee agreed that there are substantial gaps and disparities in severe obstetric complication rates and applauded the developer for working to address this issue.
- The Standing Committee passed the measure on evidence and performance gap.

2. Scientific Acceptability of Measure Properties:
(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)
2a. Accept SMP's Reliability Rating of Moderate: **Total votes-14**; **Yes-14; No-0**; 2b. Validity: **Total votes-14**; **H-3**; **M-8**; **L-2**; **I-1**
Rationale:

- The SMP reviewed this measure and passed it with a rating of moderate on reliability (Total votes-10; H-4; M-5; L-1; I-0) and validity (Total votes-10; H-2; M-6; L-0; I-2).
- The Standing Committee recognized that the measure developer conducted accountable-entity level reliability testing as well as validity testing at the patient/encounter and accountable-entity levels. Patient/encounter-level validity testing was supplied to show the patient/encounter-level reliability of the measure.
- The Standing Committee highlighted that the developer showed strong reliability of the measure by conducting reliability testing at the accountable-entity level, which examined the signal-to-noise (SNR) ratio using data from eight pilot sites representing 25 individual hospitals who all had at least 25 deliveries per year over the time period of 1/1/20–12/31/20.
- The Standing Committee accepted the SMP's rating.

- The Standing Committee noted that the median reliability was 0.991 (a range of 0.982–0.997) for any severe obstetric complications and 0.955 (a range of 0.916–0.983) for severe obstetric complications excluding blood transfusion-only cases.
- The Standing Committee found the validity testing to be clear and supportive of the measure's validity.
- The Standing Committee asked the developer for clarification on the risk adjustment modeling and how it is implemented. The developer clarified that the modeling is not done by the hospital itself, and it does not rely on a sample. Instead, data for every delivery in the performance period are submitted for adjustment.
- Quorum was lost for the remainder of the meeting; therefore, the Standing Committee did not vote on whether to accept the SMP's rating of moderate for validity. Instead, it voted after the meeting using an online survey. Since voting was conducted offline, the Standing Committee was no longer given the option of whether to accept the SMP's vote on the measure and was instead asked to vote high, moderate, low, or insufficient on validity. The Standing Committee passed the measure on validity.

3. Feasibility: Total votes- 14; **H-3; M-10; L-1; 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 Standing Committee noted that the data elements for this measure are generated or collected during the provision of care, and all data are in defined fields in a combination of electronic sources.
- The Standing Committee requested clarification on the use of the time-stamp data element that was removed from the specifications. The developer replied that the draft specifications were revised to remove time stamps to better align with clinical intent, and feasibility scores based on the revised specifications subsequently increased to 98%.
- The Standing Committee passed the measure 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: Total votes- 14; **Pass-12; No Pass-2; 4b. Usability: Total votes- 14**; **H-5; M-7; L-1; I-1**

Rationale:

- The Standing Committee noted that this measure is currently used for internal and external benchmarking by The Joint Commission in its ORYX Performance Measure Reporting: HAP and CAH Accreditation Program.
- The Standing Committee discussed several concerns with unintended consequences of the measure.
- Some Standing Committee members voiced that measuring obstetric complications may cause a shift in hospital resources to support EHR data extraction rather than improving SMM rates and outcomes.
- Other members voiced that the combination of all severe obstetric complications into one measure may unfairly penalize hospitals that specialize in and see a larger share of patients with certain conditions.
- The Standing Committee also sought additional details from the measure developer on their plan for mitigating unintended consequences. The developer noted that these efforts include ongoing monitoring, webinars, and educational outreach to organizations.

5. Related and Competing Measures

- No related or competing measures were noted.

6. Standing Committee Recommendation for Endorsement: Total votes-14; Yes-9; No-5

7. Public and Member Comment

- No public comments were received.
- Following the measure evaluation meeting on July 6, a Standing Committee member, who was unable to attend the measure evaluation meeting, expressed a concern via email to NQF staff and the Standing Committee, stating that the measure was not adequately discussed by the Standing Committee. Specifically, this member commented that the Standing Committee did not address all of the member's validity concerns, which were submitted as part of the pre-evaluation Standing Committee feedback. The member's main outstanding concerns were whether the measure actually captures the construct of severe maternal morbidity (SMM), as state-level variation in SMM is inconsistent and not comparable across states. The member referenced a consensus statement from the American College of Obstetricians and Gynecologists (ACOG), which notes that "definitions of severe maternal morbidity that rely on diagnosis codes, such as the Centers for Disease Control and Prevention's (CDC) definition, may miss cases, have a relatively low positive predictive value (0.40) and, at a practical level, may be difficult for facilities to operationalize."
- During the post-comment meeting, the Standing Committee expanded upon the concerns relating to validity by explaining that the testing focused solely on verifying whether codes matched the medical record and not whether they represented actual SMM events. A Standing Committee member added that the positive predictive value (PPV) of the CDC indicators shows that the measure may be nonrepresentative of SMM events according to "gold standard" definitions.
    - The developer responded by explaining that the PPV for the numerator of the measure was very high overall and that not all of the individual data elements with lower rates of agreement were used in the final measure specifications. The developer also clarified that blood transfusion is one item that showed differing levels of agreement at different pilot sites and was thus kept as a separate value so that the measure can be stratified by "with or without blood transfusion" to help address these challenges. The developer further elaborated that in an electronic clinical quality measure (eCQM), such as this one, transfusion by units was not found to be a reliable and valid data element that could be pulled.
- A few Standing Committee members stressed that validity testing should be compared against a gold standard so that the data truly reflect hospital quality and not just coding variation in order to know whether an SMM event actually occurred.
    - The developer responded by stating that they clinically adjudicated over 200 cases in the numerator that involved SMM using the CDC's definitions. The developer added that secondary testing was conducted where each numerator event was adjudicated using labor and delivery summaries. The developer provided additional clarifications on the ACOG guidelines regarding SMM, stating that while this definition is the gold standard for reviewing cases that are considered SMM, there is no official "gold standard" for describing SMM in the field of maternal healthcare or formal consensus on which conditions define SMM.
- Another Standing Committee member added that the CDC's definition of SMM was only intended to be a surveillance tool, not to assess quality.
    - The developer explained that the current measure is likely to overestimate SMM so that instances of SMM are not missed.
- Another Standing Committee member then noted that while overpulling cases is standard for reviewing hospital quality, this is not in line with how the measure will ultimately be used, namely, as a tool to compare hospitals across populations.

- Following the meeting, the Standing Committee voted to reopen the measure discussion (Total Votes-18; Yes-11; No-7) on validity, and then voted not to pass the measure on validity (Total Votes-18; High–1; Moderate-8; Low-6; Insufficient-3).

8. Consensus Standards Approval Committee (CSAC) Endorsement Decision: Total Votes-14; Yes-13; No-1 (December 9, 2022: Reconsideration Request Granted. This measure will be sent back to the Standing Committee for reconsideration).

- Following the Standing Committee's post-comment revote on validity, which was no pass, the developer submitted a reconsideration request ahead of the CSAC meeting citing two areas of concern:
    - NQF's measure evaluation criteria were not appropriately applied because this measure (NQF #3687e) met NQF's criteria for validity. Specifically, the revote taken by the Standing Committee was based in part on the lack of empiric measure score validity, which is not required for new measures. Further, the Standing committee members inaccurately generalized data element validity results from the literature rather than the testing submitted. Lastly, the Standing Committee's revote was based on an error regarding the measure's PPV validity testing results.
    - NQF's CDP was not followed because the Standing Committee did not follow the public comment process. Specifically, the Standing Committee reopened the vote for the measure during the post-comment meeting in violation of the process, which states that the Standing Committee will not re-vote on the measure unless the decision is based on submitted comments or a formal request from the developer. Additionally, the *Measure Developer Guidebook* states that during the post-comment web meeting, the Standing Committee will review relevant submitted comments, while the conversation at the post-comment meeting was focused on a concern that was not submitted as a comment.
- The CSAC voted to grant the reconsideration request and sent the measure back to the Standing Committee for reconsideration. The CSAC stated that the review process for this measure was less than transparent and noted that the Standing Committee should respond in detail to the issues the developer raised and only evaluate that information when reviewing the submission. Furthermore, if outside information is considered, the Standing Committee should ensure that the evidence reflects the measure's specifications. The CSAC also suggested that an eCQM expert should be present when this measure is sent back to the Standing Committee and that the Standing Committee should not necessarily be beholden to the SMP's vote for validity concerns.

Measures Approved for Trial Use

NQF #3682e SINC-Based Contraceptive Care, Postpartum

Measure Worksheet | Specifications

Description: Percentage of women 1) who received or had documented use of most or moderately effective contraception during the postpartum period (primary measure) and 2) received a long-acting reversible contraceptive method during the postpartum period (sub-measure). To focus the measure on the population of women interested in contraceptive services, the denominator excludes those individuals who did not receive or have documented use of a method if they indicated they did not want these services.

Numerator Statement: Primary measure: All eligible patients who received a most or moderately effective method in the postpartum period

Sub-measure: Of eligible patients, those who received a long-acting reversible contraceptive method (intrauterine device or implant) during the postpartum period.

Denominator Statement: All women between ages 15-44 with a prenatal care visit between 1/1/XX-1 and 12/31/XX with a live birth date, if documented, or a documented EDD between 10/1/XX-1 and 9/30/XX.

Exclusions: Those who indicated they did not want contraceptive services and did not receive or were documented to be using a most or moderately effective method in the postpartum period

1. Those who experienced a non-live birth between 10/1/XX-1 and 9/30/XX (e.g., still birth, miscarriage, ectopic pregnancy, or induced abortion)

Adjustment/Stratification: N/A

Level of Analysis: Facility

Setting of Care: Outpatient Services

Type of Measure: Outcome: Intermediate Clinical Outcome /Trial Use

Data Source: Electronic Health Data

Measure Steward: University of California, San Francisco

STANDING COMMITTEE MEETING July 6, 2022

1. Importance to Measure and Report:

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

1a. Evidence: **Total votes- 15**; **H-6**; **M-9**; **L-0**; **I-0**; 1b. Performance Gap: **Total votes- 15; H-5**; **M-10**; **L-0**; **I-0**;

Rationale:

- The Standing Committee noted that the developer provided both a Clinical Practice Guideline recommendation from the Morbidity and Mortality Weekly Report (MMWR) as well as graded systematic reviews as evidence for the measure.
- The Standing Committee had no concerns with the guideline, which states that "providers should work with the client interactively to select an effective and appropriate contraceptive method."
- The Standing Committee noted that the developer links the systematic reviews published by the Centers for Disease Control and Prevention (CDC) in the *American Journal of Preventive Medicine*, describing the evidence and their grading. The review contains 132 studies from nine systematic reviews that are graded according to the United States Preventive Services Task Force (USPSTF) criteria, from "A" (good evidence to consider inclusion) to "F" (good evidence to support exclusion). The systematic reviews include 41 randomized controlled trials, as well as other types of research studies and national survey data.
- The Standing Committee noted that the evidence mirrors evidence reviewed in NQF #2902 *Contraceptive Care-Postpartum*, which was previously endorsed by the Standing Committee. The Standing Committee agreed that the evidence was strong and passed the measure on evidence.
- The Standing Committee noted that while no performance sores were included in the submission, the developer did provide data from the Pregnancy Risk Assessment Monitoring System (PRAMS), which found that approximately 67% of women overall are using reversible contraception two to six months after giving birth, demonstrating overall room for improvement. The Standing Committee also noted that Iowa Medicaid data were included, which showed differences across Clinician Group/Practices, with a mean of 33% for most and moderately effective methods but 40%of practices having a score of 10% or less. Texas Medicaid data showed a mean by group/practice of 39%, although only 1% of practices had a score below 10.
- The Standing Committee agreed that there was a gap in care and asked about variation in the performance of contraceptive use across practices. The developer replied that the data gathered during the trial use period can be stratified to examine women within different subgroups across practices. The Standing Committee passed the measure on performance gap.

2. Scientific Acceptability of Measure Properties:

Specifications: **Total Votes-15; H-4; M-11; L-0; I-0**

Rationale:

- The scientific acceptability of measure properties is not discussed or voted on for measures under consideration for approval for trial use; a vote was taken on the measure specifications to ensure the specifications were clear and unambiguous and could be used to guide the implementation of the measure during the trial use period.
- The Standing Committee asked for clarification about the clinical care context in which SINC is determined. The developer replied that using SINC reduces coercive contraceptive practices and allows for choices of reproductive care that change based on a woman's evolving needs and reproductive histories.
- A few Standing Committee members noted that a recent Supreme Court ruling, Dobbs v. Jackson, has created concerns that the use of long-term contraceptives, such as IUDs, may be tracked and used in legal cases. The Standing Committee expressed concern that this perception may discourage honest reporting of contraceptive use but agreed it was too early to determine the impact on the validity of the measure and encouraged the developer to consider the impact as the measure is tested.
- The developer stated that they envision the trial use period as a time during which they can gather information about self-reporting to determine how this measure best fits within different policy contexts.
- A Standing Committee member asked whether a SINC code is needed in EHRs to capture these data in differing systems. The developer explained that the specifications were optimized to minimize the data collection burden.
- The Standing Committee passed the measure on specifications.

3. Feasibility: Total votes- 15; **H-2; M-11; L-1; I-1**

(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:

- A Standing Committee member raised a question on reporting feasibility and the inclusion of the SINC measure in standard nomenclatures within EHRs to ensure reporting is feasible. In response, the developer stated that they have found that SINC integration varies by EHR type. The developer also stated that they have included standard nomenclatures in the LOINC system and are working to integrate it into the SNOWMED system as well.
- The Standing Committee had no further concerns and passed the measure 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**: Total votes- 15**; **Pass-14; No Pass-1**; 4b. Usability: **Total votes- 15**; **H-3; M-10; L-2; I-0**

Rationale:

- The Standing Committee noted that the measure is not currently in use in any accountability programs; however, the developer stated that they are testing the measure for pilot implementation in the Innovating Contraceptive Care in Community Health Centers (ICC in CHCs) project.
- The Standing Committee also noted that the measure is being used in 20 FQHCs.
- The Standing Committee had no concerns about use or usability and passed the measure on both criteria.

5. Related and Competing Measures

- This measure was identified as related to the following measure:
    - NQF #2902 Contraceptive Care – Postpartum
- The Standing Committee agreed that the measures were harmonized to the extent possible.

6. Standing Committee Approval for Trial Use: Total votes- 15; **Yes-14**; **No-1**

7. Public and Member Comment

- Seven post-evaluation comments were submitted. All seven comments expressed support for the measure; however, one of the comments did offer a suggestion for improvement, namely, the inclusion of nonprescription contraceptive methods in order to fully capture the range of potential contraceptive desires and usage by patients, as well possibly expanding the measure to include individuals who are able to become pregnant who may also require contraceptive care who do not identify as cisgender women.
    - The developer responded to the comment, noting that they agree with the commenter's suggestion on expanding the specifications and will continue to do so as the EHR data evolve.

8. Consensus Standards Approval Committee (CSAC) Endorsement Decision: Total votes-15; Yes-15; No-0 (December 9, 2022: Approved for Trial Use)

- The CSAC upheld the Standing Committee's decision to approve the measure for trial use.

NQF #3699e SINC-Based Contraceptive Care, Non-Postpartum

Measure Worksheet | Specifications

Description: Percentage of women who 1) received or had documented use of most or moderately effective contraception and 2) received a long-acting reversible contraceptive method during the calendar year.

To focus the measure on the population of women interested in contraceptive services, the denominator excludes those individuals who did not receive or have documented use of a method if they indicated during the year that they did not want these services, as well as those who are eligible for postpartum contraceptive services during the measurement period.

Numerator Statement: Primary measure: Eligible women who received or were documented to be using a most (i.e., sterilization, implants, intrauterine devices or systems [IUD/IUS]) or moderately effective (i.e., injectables, oral pills, patch, or ring) contraceptive method.

Sub-measure: Eligible women provided a long-acting reversible contraceptive method (IUD or implant).

Denominator Statement: All women, aged 15-44, with a qualifying encounter in the calendar year.

Exclusions:

1. Documentation of anatomical infecundity due to removal of uterus and/or bilateral ovaries, and
2. Among those who did not receive or be documented to use a most or moderately effective method in the measurement period, those who indicated they did not want contraceptive services, and
3. Those who had prenatal visit between 1/1/XX-1 (year prior to the measurement year) and 9/30/XX (the measurement year) with a live birth date, if documented, or a documented estimated delivery date between 10/1/XX-1 and 9/30/XX, provided they did not have a documented ectopic pregnancy intrauterine fetal demise, early pregnancy loss, or abortion. The inclusion in this measure of those who were documented to have a non-live birth ensures that whether the contraceptive needs of these individuals are met is measured, as the peripartum measure excludes these individuals to focus on the peripartum care pathway.

Adjustment/Stratification: N/A

Level of Analysis: Facility

Setting of Care: Outpatient Services

Type of Measure: Outcome: Intermediate Clinical Outcome/Trial Use

Data Source: Electronic Health Records; Electronic Health Data

Measure Steward: University of California, San Francisco

STANDING COMMITTEE MEETING July 6, 2022

1. Importance to Measure and Report:

(1a. Evidence, 1b. Performance Gap)
1a. Evidence: **Total votes- 15**; **H-8**; **M-7**; **L-0**; **I-0**; 1b. Performance Gap: **Total votes- 15; H-4**; **M-11**; **L-0**; **I-0**
Rationale:

- The Standing Committee noted that the developer links the systematic reviews published by the CDC in the *American Journal of Preventive Medicine*, describing the evidence and their grading. The review contains 132 studies from nine systematic reviews that are graded according to USPSTF criteria, from "A" (good evidence to consider inclusion) to "F" (good evidence to support exclusion). The systematic reviews include 41 randomized controlled trials, as well as other types of research studies and national survey data. The Standing Committee also noted that the evidence for this measure is appropriate and very similar to the evidence for the previous measure, #3682e, but in a non-postpartum population. The Standing Committee passed the measure on evidence.
- The Standing Committee noted that the evidence of a gap included 2019 Family Planning Annual Report (FPAR) results, which showed that overall, 15.9 percent of clients ages 15–19 and 17.2 percent of clients ages 20–44 were provided a LARC method.
- The Standing Committee noted that a gap existed and passed the measure on performance gap.

2. Scientific Acceptability of Measure Properties:
—Specifications: **Total Votes-15; H-2; M-12; L-1; I-0**
Rationale:

- The scientific acceptability of measure properties is not discussed or voted on for measures under consideration for approval for trial use; a vote was taken on the measure specifications to ensure they were clear and unambiguous and could be used to guide implementation of the measure during the trial use period.
- The Standing Committee recognized the developer's efforts to build redundancies into the specifications to account for differing EHR systems and had no other concerns.
- The Standing Committee passed the measure on specifications.

3. Feasibility: Total votes-15; **H-2; M-12; L-1; 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 Standing Committee noted that the developer identified feasibility issues for several data elements and provided additional context for the issues as well as a plan for addressing the issues.
- The Standing Committee noted that the same feasibility discussion from #3862e would apply to this measure and that the developer had already expressed their work to integrate with both LOINC and SNOWMED systems.
- The Standing Committee had no concerns and passed the measure 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**: Total votes- 15**; **Pass-14; No Pass-1**; 4b. Usability: **Total votes- 15**; **H-2; M-12; L-1; I-0**
Rationale:

- The Standing Committee noted that the measure is not currently used in any accountability programs.
- The developer stated that the measure is planned for pilot implementation in the ICC in CHCs project and is being used in 20 FQHCs.

- The Standing Committee asked about feedback opportunities, and the developer confirmed that measure users will be informed of their performance after the data are submitted.
- The Standing Committee had no concerns about use and usability and passed the measure on both criteria.

5. Related and Competing Measures

- This measure was identified as related to the following measures:
    - NQF #2903 Contraceptive Care – Most & Moderately Effective Methods
    - NQF #2904 Contraceptive Care – Access to LARC
    - NQF #3543 Person-Centered Contraceptive Counseling (PCCC) Measure
- The Standing Committee agreed that the measures were harmonized to the extent possible.

6. Standing Committee Recommendation to Approve for Trial use: Total votes-15; Yes-14; No-1

7. Public and Member Comment

- Seven post-evaluation comments were submitted. All seven comments expressed support for the measure; however, one of the comments did offer a suggestion for improvement, namely, the inclusion of nonprescription contraceptive methods in order to fully capture the range of potential contraceptive desires and usage by patients, as well possibly expanding the measure to include individuals who are able to become pregnant who may also require contraceptive care who do not identify as cisgender women.
    - The developer responded to the comment, noting that they agree with the commenter's suggestion on expanding the specifications and will continue to do so as the EHR data evolve.

8. Consensus Standards Approval Committee (CSAC) Endorsement Decision: Total votes-15; Yes-15; No-0 (December 9, 2022: Approved for Trial Use)

- The CSAC upheld the Standing Committee's decision to approve the measure for trial use.

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

NQF Number	Title	Federal Programs (Finalized or Implemented)
0033	Chlamydia Screening in Women (CHL)	Merit-Based Incentive Payment System Program Marketplace Quality Rating System Medicaid: Child Core Set
0469	PC-01 Elective Delivery	Hospital Compare Hospital Inpatient Quality Reporting Hospital Value-Based Purchasing Medicare and Medicaid Electronic Health Record Incentive Program for Hospital and Critical Access Hospitals
0469e	PC-01 Elective Delivery	None
0470	Incidence of Episiotomy	None
0471	PC-02 Cesarean Birth	None
0471e	ePC-02 Cesarean Birth	Hospital Inpatient Quality Reporting Medicare and Medicaid Electronic Health Record Incentive Program for Hospital and Critical Access Hospitals Medicare Promoting Interoperability Program for Eligible Hospitals and CAHs
0480	PC-05 Exclusive Breast Milk Feeding	None
0480e	PC-05 Exclusive Breast Milk Feeding	None
0716	Unexpected Complications in Term Newborns	None
2902	Contraceptive Care – Postpartum	Medicaid: Adult Core Set Medicaid: Child Core Set
2903	Contraceptive Care – Most & Moderately Effective Methods	None
2904	Contraceptive Care – Access to LARC	None
3543	Patient-Centered Contraceptive Counseling (PCCC) Measure	None

*Adapted from CMS Measures Inventory Tool. Last Accessed on January 23, 2023.

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

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Appendix D: Measure Specifications

NQF #0471e ePC-02 Cesarean Birth

STEWARD

The Joint Commission

DESCRIPTION

This measure assesses the number of nulliparous women with a term, singleton baby in a vertex position delivered by cesarean birth.

TYPE

Outcome

DATA SOURCE

Electronic Health Records, Electronic Health Data

Hospitals report EHR data using Certified Electronic Health Record Technology (CEHRT), and by submitting Quality Reporting Document Architecture Category 1 (QRDA-1).

LEVEL

Facility

SETTING

Inpatient/Hospital

NUMERATOR STATEMENT

Inpatient hospitalizations for patients who deliver by cesarean section.

NUMERATOR DETAILS

1. Cesarean birth is represented with the QDM datatype and value set of “Procedure, Performed: Cesarean Birth (OID:2.16.840.1.113883.3.117.1.7.1.282). The delivery procedure must be performed during the encounter.
2. The measure looks to see if the Cesarean birth was performed during the inpatient encounter.
3. To access the value sets for the measure, please visit the Value Set Authority Center (VSAC), sponsored by the National Library of Medicine, at https://vsac.nlm.nih.gov/. A list of value sets for the measure is attached in the Excel workbook provided for question sp.11.

DENOMINATOR STATEMENT

Inpatient hospitalizations for nulliparous patients delivered of a live term singleton newborn >= 37 weeks gestation.

DENOMINATOR DETAILS

1. Nulliparous patients are represented by the following QDM datatypes and value sets

Assessment, Performed: Parity (Result = 0) using Parity LOINC Direct Reference Code 11977-6

OR

Assessment, Performed: Gravida (Result =1) using Gravida (# Pregnancies) LOINC Direct Reference Code 11996-6)

OR

Assessment, Performed: Preterm (result = 0) AND Assessment, Performed: Term Newborn (result = 0) using Preterm LOINC Code 11637-6AND Term Newborn LOINC Direct Reference Code 11639-2

The nulliparous conditions must be resulted <= 42 weeks before the time of delivery. The relevant date/time (when the assessment was actually performed) of the nulliparous condition is used. Time of Delivery is represented by the QDM datatype of Assessment, Performed: Date and time of obstetric delivery using Date and time of obstetric delivery LOINC Direct Reference Code 93857-1.

2. The logic determines gestational age as follows:

1. For the Estimated Due Date (EDD), the QDM datatype and value set of Assessment, Performed: Delivery date Estimated using Delivery date Estimated LOINC Direct Reference Code 11778-8 is used. To assure the most up to date EDD is used, the logic looks for the last EDD one day or less before or on the delivery date/time.
2. For the Date of Delivery, the QDM datatype Assessment, Performed: Date and time of obstetric delivery using Date and time of obstetric delivery LOINC Direct Reference Code 93857-1 is used. To assure the most accurate date/time of delivery, the logic looks for the last assessment of date/time of delivery during the encounter.
3. The logic includes a function which calculates the gestational age. This function reflects the ACOG ReVITALize Guidelines for Calculated Gestational Age (CGA):

Gestational Age = (280-(EDD minus Reference Date)) /7

Reference Date is the date on which you are trying to determine gestational age. For purposes of this eCQM, Reference Date would be the Date of Delivery.

3. If the necessary data elements are not available to calculate CGA, CGA will be null. Then the estimated gestational age which is derived from the QDM datatype and value set of Assessment, Performed:

Estimated Gestational Age at Delivery using SNOMEDCT Value Set (2.16.840.1.113762.1.4.1045.26 is used.

4. Live singleton newborns are represented by the QDM datatype Encounter Performed, Diagnosis: Delivery of Singleton using ICD10 and SNOMED codes (2.16.840.1.113762.1.4.1045.99)

To access the value sets for the measure, please visit the Value Set Authority Center (VSAC), sponsored by the National Library of Medicine, at https://vsac.nlm.nih.gov/. A list of value sets for the measure is attached in the Excel workbook provided for question sp.11.

EXCLUSIONS

Inpatient hospitalizations for patients with abnormal presentation or placenta previa during the encounter.

EXCLUSION DETAILS

1. Encounter Performed, Diagnosis: Abnormal Presentation (2.16.840.1.113762.1.4.1045.105) and Assessment Performed: Abnormal Presentation (2.16.840.1.113762.1.4.1045.105) are used to identify patients with Abnormal Presentation for exclusion from the denominator.
2. Encounter Performed, Diagnosis: Placenta Previa (2.16.840.1.113762.1.4.1110.37) is used to identify patients with Placenta Previa for exclusion from the denominator.

RISK ADJUSTMENT

No risk adjustment or stratification

STRATIFICATION

Not applicable; this measure is not stratified.

TYPE SCORE

Rate/proportion

Better quality = Lower score

ALGORITHM

Please see the attached HQMF specifications for the complete measure logic. Additionally, a flow diagram of the denominator, denominator exclusions, and numerator logic is attached to the NQF submission form as a supplemental document in response to question sp.10.

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Measure specifications are in the Public Domain.

These performance measures are not clinical guidelines and do not establish a standard of medical care and have not been tested for all potential applications. The measures and specifications are provided without warranty.

NQF #3682e SINC-Based Contraceptive Care, Postpartum

STEWARD

University of California, San Francisco

DESCRIPTION

Percentage of women 1) who received or had documented use of most or moderately effective contraception during the postpartum period (primary measure) and 2) received a long-acting reversible contraceptive method during the postpartum period (sub-measure). To focus the measure on the population of women interested in contraceptive services, the denominator excludes those individuals who did not receive or have documented use of a method if they indicated they did not want these services.

TYPE

Outcome: Intermediate Clinical Outcome

DATA SOURCE

Electronic Health Data, Electronic Health Records

This measure uses data from the Electronic Health Record, as documented using standardized coding languages, collected during clinical encounters and exported for analysis.

LEVEL

Facility

SETTING

Outpatient Services

NUMERATOR STATEMENT

Primary measure: All eligible patients who received a most or moderately effective method in the postpartum period

Sub-measure: Of eligible patients, those who received a long-acting reversible contraceptive method (intrauterine device or implant) during the postpartum period.

NUMERATOR DETAILS

Receipt or documented use of a most or moderately effective method (primary measure) or receipt of a contraceptive implant or intrauterine device (sub-measure) is documented using HCPCS, RXNORM, ICD10, CPT, LOINC and SNOMED codes (OIDs contained in following tabs from Value Set excel document, provided in sp.11: Contraceptive Patch, Contraceptive Implant, Contraceptive Ring, Injectable Contraceptive, IUD, and OCP)

1. These codes must be documented within 90 days of a live birth date, if available, or 90 days of the estimated delivery date (EDD) if a live birth date is not available.
2. For those without a live birth date, these codes must be documented after 24 weeks of pregnancy, as determined by 16 weeks prior to the EDD. This will allow inclusion of contraceptive provision in the case of preterm birth for patients without the actual date of delivery documented while minimizing the likelihood of capturing contraceptive provision that occurred prior to the pregnancy.

DENOMINATOR STATEMENT

All women between ages 15-44 with a prenatal care visit between 1/1/XX-1 and 12/31/XX with a live birth date, if documented, or a documented EDD between 10/1/XX-1 and 9/30/XX

DENOMINATOR DETAILS

1. Definition of a qualifying encounter during the calendar year (from 1/1/XX to 12/31/XX) as per CPT, HCPCs and SNOMED codes, using the following:

    1. Office visits (OID 2.16.840.1.113883.3.464.1003.101.12.1001)
    2. Home health (OID 2.16.840.1.113883.3.464.1003.101.12.1016)
    3. Preventative visits initial and established for 0-17, respectively (OID 2.16.840.1.113883.3.464.1003.101.12.1022, OID 2.16.840.1.113883.3.464.1003.101.12.1024)
    4. Preventative visits initial and established for 18+, respectively: (OID 2.16.840.1.113883.3.464.1003.101.12.1023; OID 2.16.840.1.113883.3.464.1003.101.12.1025)

2. Definition of a prenatal care visit 1/1/XX-1 and 12/31/XX as per CPT, HPs and SNOMED codes – Prenatal care bundle visits (OID 2.16.840.1.113762.1.4.1166.205); Prenatal care specific visits (OID 2.16.840.1.113762.1.4.1166.114)

3. Documentation of a live birth date between 10/1/XX-1 and 9/30/XX as per CPT, SNOMED and ICD10 codes – Delivery of Live Birth (OID 2.16.840.1.113883.3.464.1003.111.12.1015)

4. Documentation of an EDD between 10/1/XX-1 and 9/30/XX, as per LOINC codes – Estimated Delivery Date (OID 2.16.840.1.113762.1.4.1221.131)

EXCLUSIONS

1. Those who indicated they did not want contraceptive services and did not receive or were documented to be using a most or moderately effective method in the postpartum period
2. Those who experienced a non-live birth between 10/1/XX-1 and 9/30/XX (e.g. still birth, miscarriage, ectopic pregnancy, or induced abortion)

EXCLUSION DETAILS

1. Documentation of "No" responses to the self-identified need for contraception (SINC) question as per LOINC code in the measurement period – SINC (OID 2.16.840.1.113762.1.4.1166.115)
2. Documentation of a non-live birth between 10/1/XX-1 and 9/30/XX as per CPT, SNOMED and ICD10 codes – Nonlive Births and Procedures and Diagnoses, respectively (OID 2.16.840.1.113762.1.4.1166.137, OID 2.16.840.1.113762.1.4.1166.136)

RISK ADJUSTMENT

NO RISK ADJUSTMENT OR RISK STRATIFICATION

STRATIFICATION

No stratification

TYPE SCORE

Rate/proportion

Better quality = Higher score

ALGORITHM

Step 1: Identify all women aged 15-44 years who had a qualifying encounter during the measurement period at the specified facility and had a prenatal care visit during the year prior to the measurement year (i.e., 1/1/XX-1) and the measurement year (i.e., through 12/31/XX) with a live birth delivery date, if documented, or a documented estimated delivery date (EDD) between the 3 months prior to the start of the measurement year (i.e., 10/1/XX-1) and the first nine months of the measurement year (i.e., 1/1/XX through 9/30/XX)

Step 2: Define the denominator by excluding women who:

- Had a non-live birth during the measurement period (e.g. still birth, miscarriage ectopic pregnancy, or induced abortion)
- Indicated they did not wish to discuss contraception and did not receive or have documented use of a most or moderately effective contraceptive method during the postpartum period

Step 3a: Define numerator 1 by using codes to identify women in the denominator who were provided or documented to use of a most or moderately effective method within 90 days of either their live birth delivery date, if available, or their EDD (primary measure)

Step 3b: Define numerator 2 by using codes to identify women in the denominator who have a long-acting reversible method of contraception (LARC), i.e., IUD or implant provided within 90 days of either their live delivery date or their EDD (sub-measure)

If a live birth delivery date is documented, provision or documentation of method use must occur in a visit following this date and prior to 90 days after this date. If no live birth delivery date is documented, then the visit in which contraception was provided or documented must occur after 24 weeks of pregnancy as determined by the EDD, and prior to 90 days from the EDD.

Step 4a: Calculate the primary measure rates by dividing numerator 1 by the denominator

Step 4b: Calculate the sub-measure by diving numerator 2 by the denominator

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N/A

NQF #3687e ePC-07 Severe Obstetric Complications

STEWARD

The Joint Commission

DESCRIPTION

Hospital-level measure scores are calculated as a risk-adjusted proportion of the number of delivery hospitalizations for women who experience a severe obstetric complication, as defined by the numerator, by the total number of delivery hospitalizations in the denominator during the measurement period. The hospital-level measure score will be reported as a rate per 10,000 delivery hospitalizations.

ePC07 was developed in collaboration with Yale New Haven Health Services Corporation/Center for Outcomes Research and Evaluation (CORE).

TYPE

Outcome

DATA SOURCE

Electronic Health Records, Electronic Health Data

Not applicable.

LEVEL

Facility

SETTING

Inpatient/Hospital

NUMERATOR STATEMENT

Inpatient hospitalizations for patients with severe obstetric complications including the following:

- Severe maternal morbidity diagnoses (see list below)
- Severe maternal morbidity procedures (see list below)
- Discharge disposition = expired

Severe Maternal Morbidity Diagnoses:

- Cardiac
  - Acute heart failure
  - Acute myocardial infarction
  - Aortic aneurysm
  - Cardiac arrest/ventricular fibrillation
  - Heart failure/arrest during procedure or surgery
- Hemorrhage
  - Disseminated intravascular coagulation
  - Shock
- Renal
  - Acute renal failure
- Respiratory
  - Adult respiratory distress syndrome
  - Pulmonary edema
- Sepsis
- Other OB
  - Air and thrombotic embolism

  - Amniotic fluid embolism
  - Eclampsia
  - Severe anesthesia complications
- Other Medical
  - Puerperal cerebrovascular disorder
  - Sickle cell disease with crisis

Severe Maternal Morbidity Procedures:

- Blood transfusion
- Conversion of cardiac rhythm
- Hysterectomy
- Temporary tracheostomy
- Ventilation

For further details on changes made to the numerator specifications during pilot testing, please see Changes Made to ePC07 Specifications During Pilot Testing in additional attachments.

NUMERATOR DETAILS

1. The QDM datatype of Encounter Performed, Diagnosis evaluates the Severe Maternal Morbidity Diagnoses value set (2.16.840.1.113762.1.4.1029.255) to see if a code is present on the encounter. If so, the Encounter, Performed, PresentOnAdmission Indicator datatype evaluates the Present on Admission = No or Unable to Determine value set (2.16.840.1.113762.1.4.1029.370) and the numerator will be met if the code has a POA code of “No” or “Unable to Determine”.
2. The QDM datatype of Procedure, Performed evaluates the Severe Maternal Morbidity Procedures value set (2.16.840.1.113762.1.4.1029.256) and the Blood Transfusion value set (2.16.840.1.113762.1.4.1029.213) to see if a code is present with a corresponding procedure date anytime during the hospitalization encounter. The Blood Transfusion value set is kept separate from the other procedures so that the rates can be stratified with and without blood transfusion.
3. The QDM datatype of Encounter, Performed, Discharge Disposition evaluates the Patient Expired value set (2.16.840.1.113883.3.117.1.7.1.309) to determine if the patient expired during the encounter.

If any one of the 3 conditions above are met, the patient will be in the numerator. To access the value sets for the measure, please visit the Value Set Authority Center, sponsored by the National Library of Medicine, at https://vsac.nlm.nih.gov/. A list of value sets for the measure is attached in the Excel workbook provided for question sp.11.

For further details on changes made to the numerator specifications during pilot testing, please see Changes Made to ePC07 Specifications During Pilot Testing in additional attachments.

DENOMINATOR STATEMENT

Initial Patient Population: Inpatient hospitalizations for patients age >= 8 years and < 65 admitted to the hospital for inpatient acute care who undergo a delivery procedure with a discharge date that ends during the measurement period

Denominator: Inpatient hospitalizations for patients delivering stillborn or live birth with >= 20 weeks, 0 days gestation completed

DENOMINATOR DETAILS

For patients meeting the initial patient population:

1. The logic determines calculated gestational age (CGA) as follows:

1. For the Estimated Due Date (EDD), the QDM datatype Assessment, Performed: Delivery date Estimated using Delivery date Estimated LOINC Direct Reference Code 11778-8 is used. To assure the most up to date EDD is used the logic looks for the last EDD 42 weeks or less before or on delivery.
2. For the Date of Delivery, the QDM datatype Assessment, Performed: Date and time of obstetric delivery using Date and time of obstetric delivery LOINC Direct Reference Code 93857-1 is used. To assure the most accurate date/time of delivery the logic looks for the last assessment of date/time of delivery during the encounter. To account for deliveries that may occur outside of the inpatient encounter, the logic looks at the expanded encounter including any Emergency Department, Observation or OB Triage visits within one hour of the inpatient admission.
3. The logic includes a function which calculates the gestational age. This function reflects the ACOG (American College of Obstetrics and Gynecology) ReVITALize Guidelines for Calculating Gestational Age (CGA):

Gestational Age = (280-(EDD minus Reference Date))/7

Reference Date is the date on which you are trying to determine gestational age. For purposes of this eCQM, Reference Date would be the Date of Delivery.

1. If the necessary elements are not available to calculate CGA, CGA will be null. Then the estimated gestational age, which is derived from the QDM datatype Assessment, Performed: Estimated Gestational Age at Delivery using SNOMEDCT Value Set (2.16.840.1.113762.1.4.1045.26) is used.
2. Gestational age >= 20 weeks, 0 days will meet the logic.
3. Lastly, the QDM datatype of Procedure, Performed evaluates Procedure, Performed: Delivery Procedures (2.16.840.1.113762.1.4.1045.59) to determine if a delivery code is present. The delivery procedure codes do not distinguish live from stillborn deliveries.

EXCLUSIONS

Patients with confirmed diagnosis of COVID with COVID-related respiratory condition or patients with confirmed diagnosis of COVID with COVID-related respiratory procedure.

For further details on changes made to the denominator exclusion specifications during pilot testing please see Changes Made to ePC07 Specifications During Pilot Testing in additional attachments.

EXCLUSION DETAILS

A denominator exclusion for COVID plus respiratory conditions was added post pilot due to the growing evidence of perinatal complications in women who have COVID infection with respiratory conditions.

Patients with confirmed diagnosis of COVID with COVID-related respiratory condition or patients with confirmed diagnosis of COVID with COVID-related respiratory procedure are excluded.

1. The QDM datatype of Encounter Performed, Diagnosis evaluates the COVID 19 Confirmed value set (2.16.840.1.113762.1.4.1029.373) to see if a code is present on the encounter

AND

2. The QDM datatype of Encounter Performed, Diagnosis evaluates the COVID 19 Related Respiratory Conditions value set (2.16.840.1.113762.1.4.1029.376) to see if a code is present on the encounter OR the QDM datatype of Procedure Performed evaluates COVID 19 Related Respiratory Procedures (2.16.840.1.113762.1.4.1029.379) and that the procedure starts during the encounter.

For further details on changes made to the denominator exclusion specifications during pilot testing please see Changes Made to ePC07 Specifications During Pilot Testing in additional attachments.

RISK ADJUSTMENT

Statistical risk model with risk factors (specify number of risk factors)

STRATIFICATION

A subset of the numerator population will be reported in Stratification as Stratum 1: Nontransfusion only severe obstetric complications (excluding cases where transfusion was the only severe obstetric complication)

Calculation:

(Risk-standardized number of encounters with nontransfusion only severe obstetric complications (excluding cases where transfusion was the only severe obstetric complication) / Number of encounters in Denominator) * 10,000

The logic includes a definition entitled: "Delivery Encounter Greater Than Or Equal To 20 Weeks Gestation Completed With Severe Obstetric Complications (Excluding Blood Transfusions)". This definition unions the following 2 definitions:

- "Delivery Encounter Greater Than Or Equal To 20 Weeks Gestation Completed With Severe Obstetric Complications Diagnosis or Procedure (Excluding Blood Transfusion)"
- Union "Delivery Encounter Greater Than Or Equal To 20 Weeks Gestation Completed With Expiration"

The first definition includes patients with a Severe Obstetric Complication Diagnosis or a procedure indicative of severe obstetric complication (other than blood transfusion) as described in the numerator. Cases with blood transfusions are not excluded from this definition if they have another SOC. Thereby, patients who only had a SOC of blood transfusion would not qualify for Stratum 1.

TYPE SCORE

Rate/proportion

Better quality = Lower score

ALGORITHM

Please see the attached HQMF specifications for the complete measure logic. Additionally, a flow diagram of the denominator, denominator exclusions, and numerator logic is attached to the NQF submission form as a supplemental document in response to question sp.10.

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NQF #3699e SINC-Based Contraceptive Care, Non-Postpartum

STEWARD

University of California, San Francisco

DESCRIPTION

Percentage of women who 1) received or had documented use of most or moderately effective contraception and 2) received a long-acting reversible contraceptive method during the calendar year.

To focus the measure on the population of women interested in contraceptive services, the denominator excludes those individuals who did not receive or have documented use of a method if they indicated during the year that they did not want these services, as well as those who are eligible for postpartum contraceptive services during the measurement period.

TYPE

Outcome: Intermediate Clinical Outcome

DATA SOURCE

Electronic Health Records, Electronic Health Data

This measure uses data from the Electronic Health Record, as documented using standardized coding languages, collected during clinical encounters and exported for analysis.

LEVEL

Facility

SETTING

Outpatient Services

NUMERATOR STATEMENT

Primary measure: Eligible women who received or were documented to be using a most (i.e., sterilization, implants, intrauterine devices or systems (IUD/IUS) or moderately effective (i.e., injectables, oral pills, patch, or ring) contraceptive method.

Sub-measure: Eligible women provided a long-acting reversible contraceptive method (IUD or implant).

NUMERATOR DETAILS

Receipt or documented use of a most or moderately effective method (primary measure) or receipt of a contraceptive implant or intrauterine device (sub-measure) is documented using HCPCS, RXNORM,

ICD10, CPT, LOINC and SNOMED codes (OIDs contained in following tabs from Value Set excel document, provided in sp.11: Contraceptive Patch, Contraceptive Implant, Contraceptive Ring, Injectable Contraceptive, IUD, and OCP)

DENOMINATOR STATEMENT

All women, aged 15-44, with a qualifying encounter in the calendar year

DENOMINATOR DETAILS

Definition of a qualifying encounter during the calendar year (from 1/1/XX to 12/31/XX) as per CPT, HCPCs and SNOMED codes, using the following:

1. Office visits (OID 2.16.840.1.113883.3.464.1003.101.12.1001)
2. Home health (OID 2.16.840.1.113883.3.464.1003.101.12.1016)
3. Preventative visits initial and established for 0-17, respectively (OID 2.16.840.1.113883.3.464.1003.101.12.1022, OID 2.16.840.1.113883.3.464.1003.101.12.1024)
4. Preventative visits initial and established for 18+, respectively: (OID 2.16.840.1.113883.3.464.1003.101.12.1023; OID 2.16.840.1.113883.3.464.1003.101.12.1025)

EXCLUSIONS

1. Documentation of anatomical infecundity due to removal of uterus and/or bilateral ovaries, and
2. Among those who did not receive or be documented to use a most or moderately effective method in the measurement period, those who indicated they did not want contraceptive services, and
3. Those who had prenatal visit between 1/1/XX-1 (year prior to the measurement year) and 9/30/XX (the measurement year) with a live birth date, if documented, or a documented estimated delivery date between 10/1/XX-1 and 9/30/XX, provided they did not have a documented ectopic pregnancy intrauterine fetal demise, early pregnancy loss, or abortion. The inclusion in this measure of those who were documented to have a non-live birth ensures that whether or not the contraceptive needs of these individuals are met is measured, as the peripartum measure excludes these individuals in order to focus on the peripartum care pathway.

EXCLUSION DETAILS

1. Infecundity

1. Infecund Not for Contraceptive Reasons ICD10 CM (OID 2.16.840.1.113762.1.4.1166.97)
2. Infecund Not for Contraceptive Reasons, Procedures CPT (OID 2.16.840.1.113762.1.4.1166.15)

2. Documentation of “No” responses to the self-identified need for contraception (SINC) question in the measurement period

1. SINC LOINC (OID 2.16.840.1.113762.1.4.1166.115)

3. Eligible for postpartum contraception

1. Definition of a prenatal care visit 1/1/XX-1 and 12/31/XX as per CPT, HPs and SNOMED codes – Prenatal care bundle visits (OID 2.16.840.1.113762.1.4.1166.205); Prenatal care specific visits (OID 2.16.840.1.113762.1.4.1166.114)
2. Documentation of a live birth date between 10/1/XX-1 and 9/30/XX as per CPT, SNOMED and ICD10 codes – Delivery of Live Birth (OID 2.16.840.1.113883.3.464.1003.111.12.1015)
3. Documentation of an EDD between 10/1/XX-1 and 9/30/XX, as per LOINC codes – Estimated Delivery Date (OID 2.16.840.1.113762.1.4.1221.131)
4. With the exception of, if they had documentation of a non-live birth between 10/1/XX-1 and 9/30/XX as per CPT, SNOMED and ICD10 codes – Nonlive Births and Procedures and Diagnoses, respectively (OID 2.16.840.1.113762.1.4.1166.137, OID 2.16.840.1.113762.1.4.1166.136). These cases are to be added back in.

RISK ADJUSTMENT

No risk adjustment or risk stratification

STRATIFICATION

N/a - no stratification

TYPE SCORE

Rate/proportion

Better quality = Higher score

ALGORITHM

Step 1. Identify all women aged 15-44 years of age who had a qualifying encounter at the specified facility

Step 2. Define the denominator by excluding women who:

- Are not at risk for pregnancy due to removal of uterus and/or bilateral ovaries;
- Indicated that they did not wish to discuss contraception and did not receive or have documented use of a most or moderately effective contraceptive method during the calendar year
- Had a prenatal visit with a documented delivery/live birth data between 3 months prior and 9 months into the measurement period, or if no delivery/live birth data documented, had an EDD between 3 months prior and 9 months into the measurement period and did not have documentation of a non-live birth (e.g. still birth, miscarriage, or ectopic)

Step 3. Define the numerator by using codes to identify women in the denominator who were provided or continued use of a 1) provision or use of a most or moderately effective method (primary measure) and 2) provision of a long-acting reversible method of contraception (LARC), i.e., IUD or implant (sub-measure).

Step 4a: Calculate the primary measure rates by dividing numerator 1 by the denominator

Step 4b:Calculate the sub-measure by dividing numerator 2 by the denominator

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N/A

Appendix E: Related and Competing Measures

Comparison of NQF #0471e and NQF #0471

Steward/Developer

NQF #0471E EPC-02 CESAREAN BIRTH

The Joint Commission

NQF #0471 PC-02 CESAREAN BIRTH

The Joint Commission

Description

NQF #0471E EPC-02 CESAREAN BIRTH

This measure assesses the number of nulliparous women with a term, singleton baby in a vertex position delivered by cesarean birth.

NQF #0471 PC-02 CESAREAN BIRTH

This measure assesses the rate of nulliparous women with a term, singleton baby in a vertex position delivered by cesarean birth. This measure is part of a set of four nationally implemented measures that address perinatal care (PC-01: Elective Delivery, ePC-01: Elective Delivery; PC-02: Cesarean Birth, ePC-02: Cesarean Birth will be added as an eCQM 1/1/2020; PC-05: Exclusive Breast Milk Feeding, ePC-05: Exclusive Breast Milk Feeding; PC-06 Unexpected Complications in Term Newborns was added 1/1/2019). PC-02: Cesarean Birth is one of three measures in this set that have been re-engineered as eCQMs (ePC-01 Elective Delivery, ePC-02 Cesarean Birth and ePC-05 Exclusive Breast Milk Feeding). A reduction in the number of nulliparous patients with live term singleton newborns in vertex position (NTSV) delivering by cesarean birth will result in increased patient safety, a substantial decrease in maternal and neonatal morbidity and substantial savings in health care costs, Main et al. (2011).

Successful quality improvement efforts incorporate audit and feedback strategies combined with provider and nurse education, guidelines and peer review. The measure will assist health care organizations (HCOs) to track nulliparous patients with live term singleton newborns in vertex position delivering by cesarean birth to reduce the occurrence. Nulliparous women have 4-6 times the cesarean birth rate than multiparous women; thus, the NTSV population is the largest driver of primary cesarean birth rate. Furthermore, nulliparity varies greatly among hospitals (20% to 60%) making it the most important risk factor for stratification or adjustment, Main et al. (2006). NTSV has the large variation among facilities, thus identifying an important population on which to focus quality improvement efforts. In addition, a reduction in primary cesarean births will reduce the number of women having repeat cesarean births (currently >90% of mothers who have a primary cesarean birth will have a Cesarean

for all her subsequent births). Thus, improvement in the rates of cesarean birth for the first birth will reduce the morbidity of all future births and avoid all the controversies with trial of labor after cesarean/elective repeat cesareans. Main, E.K., Moore, D., Farrell, B., Schimmel, L.D., Altman, R.J., Abrahams, C., et al., (2006). Is there a useful cesarean birth measure? Assessment of the nulliparous term singleton vertex cesarean birth rate as a tool for obstetric quality improvement. Am J Obstet Gynecol.

194:1644-51. Main, E.K., Morton, C.H., Hopkins, D., Giuliani, G., Melsop, K. and Gould, J.B. (2011). Cesarean Deliveries, Outcomes, and Opportunities for Change in California: Toward a Public Agenda for Maternity Care Safety and Quality. Palo Alto, CA: CMQCC.

Numerator

NQF #0471E EPC-02 CESAREAN BIRTH

Inpatient hospitalizations for patients who deliver by cesarean section.

NQF #0471 PC-02 CESAREAN BIRTH

Patients with cesarean births with ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes for cesarean birth as defined in Appendix A, Table 11.06.

Denominator

NQF #0471E EPC-02 CESAREAN BIRTH

Inpatient hospitalizations for nulliparous patients delivered of a live term singleton newborn = 37 weeks gestation.

NQF #0471 PC-02 CESAREAN BIRTH

The outcome target population being measured is: Nulliparous patients with an ICD-10-CM Principal or Other Diagnosis Code for outcome of delivery as defined in Appendix A, Table 11.08 and with a delivery of a newborn with 37 weeks or more gestation completed or with an ICD-10-PCS Principal or Other Procedure Codes for delivery as defined in Appendix A, Tables 11.01.1.

Measure Type

NQF #0471E EPC-02 CESAREAN BIRTH

Outcome

NQF #0471 PC-02 CESAREAN BIRTH

Outcome

Data Source

NQF #0471E EPC-02 CESAREAN BIRTH

Electronic Health Records, Electronic Health Data

NQF #0471 PC-02 CESAREAN BIRTH

Electronic Health Records: Electronic Health Records, Paper Medical Records, Other

Target Population

NQF #0471E EPC-02 CESAREAN BIRTH

Women

NQF #0471 PC-02 CESAREAN BIRTH

Women

Care Setting

NQF #0471E EPC-02 CESAREAN BIRTH

Inpatient/Hospital

NQF #0471 PC-02 CESAREAN BIRTH

Inpatient/Hospital

Level of Analysis

NQF #0471E EPC-02 CESAREAN BIRTH

Facility

NQF #0471 PC-02 CESAREAN BIRTH

Other, Facility

Appendix F: Pre-Evaluation Comments

Comments received as of June 15, 2022.

No public or member comments were received during the pre-evaluation public commenting period.

Appendix G: Post-Evaluation Comments

Comments received as of September 13, 2022.

NQF #3682e SINC-Based Contraceptive Care, Postpartum (Approved for Trial Use)

Dr. Ellie Smith

Comment ID#: 8223 (Submitted: 09/13/2022)

Council / Public: Public

Level of Support: N/A

Comment

The SINC-Based Contraceptive Performance measures, developed by the Person-Centered Reproductive Health Program (PCRHP) at UCSF, is a critically important tool in order to improve the quality of contraceptive provision while advancing person-centered contraceptive counseling. Utilizing electronic Clinical Quality Measures (eCQM) in performance metrics is an innovative approach to capturing more accurate and comprehensive information regarding contraceptive provision, particularly by capturing and accounting for individuals who self-report a need for contraception. This is a necessary step forward from currently endorsed claims-based measures that do not account for patient-reported contraceptive need and holds the potential to avoid directive or coercive counseling practices and support autonomous contraceptive choice. The measure would provide key quality improvement information on screening for contraceptive need and fulfilling those needs, particularly for Title X clinics who often serve individuals experiencing barriers in accessing contraceptive care. An area for potential improvement would be the inclusion of non-prescription contraceptive methods (e.g., withdrawal, fertility awareness, condoms) in order to fully capture the range of potential contraceptive desires and usage by patients, as currently the measure only includes moderately/most effective methods. Additionally, some attention should be given to expanding the measure to include individuals who are able to become pregnant who may also require contraceptive care that do not identify as a cisgender woman.

Developer Response

We concur with Dr. Smith's comments regarding the potential for further optimization of this measure in the future, with respect to documenting non-prescription contraceptive methods and expanding gender inclusivity. Our current measure specifications are limited by the availability of data within standardized nomenclatures within Electronic Health Records, including non-universal use of sexual orientation and gender identity (SOGI) data, which records sex documented at birth. Standardized collection of this data would allow for inclusion of all people with the potential for pregnancy in the denominator. In addition, non-prescription methods are not routinely and reliably documented in the EHR. As EHRs improve their documentation in the future, we will ensure we evolve our measure specifications to take advantage of these developments. This will also require system change to prioritize documentation of non-prescription method use, which implementation of the SINC screening question can help facilitate.

NQF Response

Thank you for your comment. It has been shared with the Standing Committee and measure developer.

NQF Committee Response

N/A

Emily Decker

Comment ID#: 8240 (Submitted: 09/13/2022)

Council / Public: Public

Level of Support: N/A

Comment

Upstream USA welcomes the opportunity to comment in support of fully approving NQF# 3699e and NQF#3682e. These eCQMs will be tremendously helpful for all levels of stakeholders involved in the field of contraceptive access and quality improvement, and they are particularly important at this moment in time when we are working to measure the impact of federal and state policy changes on contraceptive use. Upstream USA is a technical assistance and training nonprofit that partners with healthcare-providing organizations across the U.S. to improve patient access to person-centered contraceptive care. Our transformative approach involves whole care teams in providing patients with the information and resources they need to decide if and when they want to become pregnant, a critical step towards improving maternal health, as well as positive outcomes for parents and children. The endorsement of these measures will enable organizations that have access to EHR-based data to calculate person-centered contraceptive access in a standardized way. This will be an important advancement for programs like Upstream and any organization seeking to leverage EHR data in quality improvement initiatives for contraceptive care. Until now, Upstream has been translating the specifications from claims-based measures NQF #2902, #2903, and #2904 into ad hoc eCQMs, and having these new endorsed specifications will provide uniformity and standardization, ultimately improving our ability to analyze and interpret results in more valid and reliable ways. Endorsed eCQM specifications will open the door for us to collaborate and learn from different health systems also implementing the measures, including large federal programs that we hope will adopt these measures into annual reporting requirements. These measures are a critical indicator of access to contraceptive care, and Upstream anticipates adopting the specifications as soon as they are approved. If there is any further information we can provide, please reach out to Emily Decker at edecker@upstream.org.

Developer Response

N/A

NQF Response

Thank you for your comment. It has been shared with the Standing Committee and measure developer.

NQF Committee Response

N/A

Jacquelyn S. Witt

Comment ID#: 8242 (Submitted: 09/13/2022)

Council / Public: Public

Level of Support: N/A

Comment

Negative experiences with contraceptive counseling and provision can negatively affect uptake and utilization. There is no more vulnerable time for messaging and patient perceptions, including recognition of the right to personal autonomy, than the first few days, weeks and months following the end of a pregnancy. Building the self-identified need for contraception measure into the outpatient and inpatient EMR for reproductive age people is an innovative strategy for aligning contraceptive performance measurement with the ethical and patient-centered provision of contraception.

Developer Response

N/A

NQF Response

Thank you for your comment. It has been shared with the Standing Committee and measure developer.

NQF Committee Response

N/A

Jamie Hart

Comment ID#: 8244 (Submitted: 09/13/2022)

Council / Public: Public

Level of Support: N/A

Comment

Dear NQF Colleagues, We, at The Coalition to Expand Contraceptive Access (CECA), are writing to express our deep support of the full endorsement of NQF measures #3699e: SINC-Based Contraceptive Care, Non-Postpartum and #3682e SINC-Based Contraceptive Care, Postpartum. Thank you for eliciting comments on the endorsement of these novel measures of contraceptive care use. CECA is a group of stakeholders committed to ensuring access to quality contraception as part of the broader vision of achieving sexual and reproductive health equity, wellbeing, and quality of life for all individuals. The comments below are informed by our extensive work with diverse stakeholders and technical experts in the field of sexual and reproductive health measurement and quality improvement to learn of the current state of clinical quality and performance measurement for contraceptive care, identify successes and needs, and support the field in developing a path forward for enhanced contraceptive care measurement. The studied benefits of contraception are wide-ranging and substantial. Equally beneficial is the ability to collect and track meaningful contraceptive care outcomes that measure quality in accordance with current clinical guidelines, leverage the most specific data sources and elements available, and – particularly important for contraception – center patient-specific factors that help improve access, quality, and greater equity. The SINC-based contraceptive care measures, derived from standardized data elements in electronic health records (EHRs), offer an improved and more precise approach to calculate the percentage of contraceptives use according to individuals' self-identified need for contraceptive services. Use of EHR data is innovative for contraceptive care measurement and leverages the more nuanced information available, which aligns with the next generation of performance measurement. Using data derived from the SINC questionnaire, the denominator more accurately defines, in a person-centered manner, which patients should be receiving contraceptive care. This critical step to exclude patients who do not wish to receive contraceptive care minimizes the potential for harm and risk of incentivizing directive contraceptive counseling. Currently, there is not another existing standard measure of patient desire for contraceptive services. Additionally, the SINC-based contraceptive care measures capture both provision and use of contraception across a broad range of settings, including those that do not have a fee-for-service or claims-based structure, such as Federally Qualified Health Centers (FQHCs). The development and use of these electronic Clinical Quality Measures for contraceptive care in FQHCs is especially important to improve equitable access as many individuals who experience barriers to contraceptive access receive their contraceptive care from FQHCs. Endorsement of the SINC-based contraceptive care measures by NQF will offer strong support of the need to establish eCQMs for contraceptive provision in clinical settings, validate the extensive evidence-based process through which they were developed, and underscore the gaps addressed by their implementation. To garner a more holistic understanding of quality in the context of contraceptive care, NQF endorsement of the SINC-based contraceptive care measures will also better position them to be used in combination with the NQF-endorsed Person-Centered Contraceptive Counseling (PCCC) measure. These measures serve as a critical tool for promoting patient-centered contraceptive access, which is particularly important in today's environment given the increased threats to sexual and reproductive autonomy. Please contact us at CECA@contraceptionaccess.org if you have any questions or need further information.

Developer Response

N/A

NQF Response

Thank you for your comment. It has been shared with the Standing Committee and measure developer.

NQF Committee Response

N/A

Kate Satterfield

Comment ID#: 8255 (Submitted: 09/13/2022)

Council / Public: Public

Level of Support: N/A

Comment

I am writing to support NQF's endorsement eCQMs 3682e and 3699e for trial use. I applaud UCSF's Person-Centered Reproductive Health Program for creating and supporting contraceptive care measures that a) can be calculated without claims data and b) better account for patient desires than existing eCQMs 2902, 2903, and 2904. This endeavor is necessary to better direct quality improvement efforts toward patient-led decision-making. One of the strongest aspects of the proposed measures is that, with its standardized denominator, it may have the potential to offer comparable insights across multiple settings (including primary care, Title X, and more traditional OB/GYN clinics), and they undoubtedly will be an asset for quality improvement at a small-scale (specific facilities, small health systems, etc.). However, because the proposed measures are contingent on clinics implementing a specific workflow in order to successfully calculate the eCQM, I am concerned about both their feasibility and validity. More specifically, I wonder if the new SINC data element will face challenges in widespread uptake and adoption and, subsequently, if those systems that choose to adopt the data element and commit to using it in their workflow will generate a selection bias that negatively impacts the ability to use the measures as tools for understanding access. I hope the developer will look more deeply into these questions during the trial period and also explore how to include patients who choose contraceptive methods and behaviors that are not deemed "most or moderately effective". I also hope to read more, after the trial use period, about patient-acceptability of the questions in SINC data element and how these proposed measures relate to the existing contraceptive care eCQMs (since they are being tested in many of the same populations) and the PCCC PRO-PM. It would be a best-case scenario if these new measures help strengthen our understanding of 2902, 2903, and 2904. Despite the flaws of these existing measures, they are remarkable for how they remind us of the breadth, fluidity, and ambiguity in reproductive desires and contraceptive use. Although we ultimately cannot box every person's desire into a standardized concept or fully embrace ambiguity and uncertainty, we can find ways to measure the quality and accessibility of care that is not dependent on whether a specific (contraceptive) service is rendered. I look forward to the next steps in creating a more just reproductive health care practice.

Developer Response

N/A

NQF Response

Thank you for your comment. It has been shared with the Standing Committee and measure developer.

NQF Committee Response

N/A

Krishna Upadhya, Planned Parenthood Federation of America; Submitted by Monika Grzeniewski

Comment ID#: 8238 (Submitted: 09/13/2022)

Council / Public: Public

Level of Support: N/A

Comment

Planned Parenthood Federation of America enthusiastically submits comments in support of the Self-Identified Need for Contraception (SINC)-Based Contraceptive Care electronic clinical quality measures (eCQM) submitted by the University of California, San Francisco for endorsement from the National Quality Forum (NQF). Planned Parenthood is the nation's leading sexual and reproductive health care provider and advocate and a trusted, nonprofit source of primary and preventive care for communities across the United States. Planned Parenthood is dedicated to improving access to quality health care throughout the country, and we strongly support initiatives that align with that mission. A performance measure of contraceptive care that centers patient choice and autonomy will advance positive perinatal and reproductive health care outcomes. The SINC-based contraceptive care measure takes a patient-centered approach in how it defines the eligibility criteria thus creating an actionable data point for health care providers to use when trying to increase access to contraceptive care and improve quality of service delivery. It incentivizes providers to assess the contraceptive needs of their patients while decreasing the risk of directive or coercive counseling. Additionally, this innovative approach leverages the availability of more nuanced information in the electronic health record and aligns contraceptive quality measurement with the next generation of performance measurement. We look forward to utilizing this more precise data point in tandem with the NQF-endorsed Person-Centered Contraceptive Counseling measure to take a more holistic view of contraceptive access and experience of care that can be used for quality improvement efforts. We applaud the UCSF's Person-Centered Reproductive Health Program for their thoughtful, deliberate, and collaborative approach to the development of this measure. Planned Parenthood strongly supports NQF's endorsement of the SINC-based contraceptive care eCQM.

Developer Response

N/A

NQF Response

Thank you for your comment. It has been shared with the Standing Committee and measure developer.

NQF Committee Response

N/A

Loretta Gavin

Comment ID#: 8251 (Submitted: 09/13/2022)

Council / Public: Public

Level of Support: N/A

Comment

As one of the original developers of the NQF-endorsed claim-based performance measure for contraceptive care, I wholeheartedly endorse this measure! It solves most of the problems of the original claims-based measure in that the denominator only includes people seeking care, it is conceptually more advanced since it is client-centered and relies on the person's determination of the need for care, and the results can be more readily interpreted to identify where improvements in care are needed. Together with the NQF-endorsed Person-Centered Contraceptive Counseling measure, the SINC measure has fulfilled earlier NQF expert recommendations to develop a set of measures that balance each other by focusing on two key aspects of contraceptive care, i.e., access to care that is client-centered. Given the recent SCOTUS decision to overturn Roe v Wade, the need for measures to monitor contraceptive care has never been greater.

Developer Response

N/A

NQF Response

Thank you for your comment. It has been shared with the Standing Committee and measure developer.

NQF Committee Response

N/A

NQF #3699e SINC-Based Contraceptive Care, Non-Postpartum (Approved for Trial Use)

Dr. Ellie Smith

Comment ID#: 8222 (Submitted: 09/13/2022)

Council / Public: Public

Level of Support: N/A

Comment

The SINC-Based Contraceptive Performance measures, developed by the Person-Centered Reproductive Health Program (PCRHP) at UCSF, is a critically important tool in order to improve the quality of contraceptive provision while advancing person-centered contraceptive counseling. Utilizing electronic Clinical Quality Measures (eCQM) in performance metrics is an innovative approach to capturing more accurate and comprehensive information regarding contraceptive provision, particularly by capturing and accounting for individuals who self-report a need for contraception. This is a necessary step forward from currently endorsed claims-based measures that do not account for patient-reported contraceptive need and holds the potential to avoid directive or coercive counseling practices and support autonomous contraceptive choice. The measure would provide key quality improvement information on screening for contraceptive need and fulfilling those needs, particularly for Title X clinics who often serve individuals experiencing barriers in accessing contraceptive care. An area for potential improvement would be the inclusion of non-prescription contraceptive methods (e.g., withdrawal, fertility awareness, condoms) in order to fully capture the range of potential contraceptive desires and usage by patients, as currently the measure only includes moderately/most effective methods. Additionally, some attention should be given to expanding the measure to include individuals who are able to become pregnant who may also require contraceptive care that do not identify as a cisgender woman.

Developer Response

We concur with Dr. Smith's comments regarding the potential for further optimization of this measure in the future, with respect to documenting non-prescription contraceptive methods and expanding gender inclusivity. Our current measure specifications are limited by the availability of data within standardized nomenclatures within Electronic Health Records, including non-universal use of sexual orientation and gender identity (SOGI) data, which records sex documented at birth. Standardized collection of this data would allow for inclusion of all people with the potential for pregnancy in the denominator. In addition, non-prescription methods are not routinely and reliably documented in the EHR. As EHRs improve their documentation in the future, we will ensure we evolve our measure specifications to take advantage of these developments. This will also require system change to prioritize documentation of non-prescription method use, which implementation of the SINC screening question can help facilitate.

NQF Response

Thank you for your comment. It has been shared with the Standing Committee and measure developer.

NQF Committee Response

N/A

Emily Decker

Comment ID#: 8239 (Submitted: 09/13/2022)

Council / Public: Public

Level of Support: N/A

Comment

Upstream USA welcomes the opportunity to comment in support of fully approving NQF# 3699e and NQF#3682e. These eCQMs will be tremendously helpful for all levels of stakeholders involved in the field of contraceptive access and quality improvement, and they are particularly important at this moment in time when we are working to measure the impact of federal and state policy changes on contraceptive use. Upstream USA is a technical assistance and training nonprofit that partners with healthcare-providing organizations across the U.S. to improve patient access to person-centered contraceptive care. Our transformative approach involves whole care teams in providing patients with the information and resources they need to decide if and when they want to become pregnant, a critical step towards improving maternal health, as well as positive outcomes for parents and children. The endorsement of these measures will enable organizations that have access to EHR-based data to calculate person-centered contraceptive access in a standardized way. This will be an important advancement for programs like Upstream and any organization seeking to leverage EHR data in quality improvement initiatives for contraceptive care. Until now, Upstream has been translating the specifications from claims-based measures NQF #2902, #2903, and #2904 into ad hoc eCQMs, and having these new, endorsed specifications will provide uniformity and standardization, ultimately improving our ability to analyze and interpret results in more valid and reliable ways. Endorsed eCQM specifications will open the door for us to collaborate and learn from different health systems also implementing the measures, including large federal programs that we hope will adopt these measures into annual reporting requirements. These measures are a critical indicator of access to contraceptive care, and Upstream anticipates adopting the specifications as soon as they are approved. If there is any further information we can provide, please reach out to Emily Decker at edecker@upstream.org.

Developer Response

N/A

NQF Response

Thank you for your comment. It has been shared with the Standing Committee and measure developer.

NQF Committee Response

N/A

Jacquelyn S. Witt

Comment ID#: 8241 (Submitted: 09/13/2022)

Council / Public: Public

Level of Support: N/A

Comment

Patient-centered reproductive autonomy is increasingly being threatened in the U.S. Performance measures are a critical component to ensure ethical access to a wide range of contraceptive options. The self-identified need for contraception measure is an innovative step towards addressing people's needs as they see them, while excluding those who do not desire contraception or contraception information, thereby decreasing the potential risk of incentivizing providers for directive counseling regarding birth control.

Developer Response

N/A

NQF Response

Thank you for your comment. It has been shared with the Standing Committee and measure developer.

NQF Committee Response

N/A

Jamie Hart

Comment ID#: 8243 (Submitted: 09/13/2022)

Council / Public: Public

Level of Support: N/A

Comment

Dear NQF Colleagues, We, at The Coalition to Expand Contraceptive Access (CECA), are writing to express our deep support of the full endorsement of NQF measures #3699e: SINC-Based Contraceptive Care, Non-Postpartum and #3682e SINC-Based Contraceptive Care, Postpartum. Thank you for eliciting comments on the endorsement of these novel measures of contraceptive care use. CECA is a group of stakeholders committed to ensuring access to quality contraception as part of the broader vision of achieving sexual and reproductive health equity, wellbeing, and quality of life for all individuals. The comments below are informed by our extensive work with diverse stakeholders and technical experts in the field of sexual and reproductive health measurement and quality improvement to learn of the current state of clinical quality and performance measurement for contraceptive care, identify successes and needs, and support the field in developing a path forward for enhanced contraceptive care measurement. The studied benefits of contraception are wide-ranging and substantial. Equally beneficial is the ability to collect and track meaningful contraceptive care outcomes that measure quality in accordance with current clinical guidelines, leverage the most specific data sources and elements available, and – particularly important for contraception – center patient-specific factors that help improve access, quality, and greater equity. The SINC-based contraceptive care measures, derived from standardized data elements in electronic health records (EHRs), offer an improved and more precise approach to calculate the percentage of contraceptives use according to individuals' self-identified need for contraceptive services. Use of EHR data is innovative for contraceptive care measurement and leverages the more nuanced information available, which aligns with the next generation of performance measurement. Using data derived from the SINC questionnaire, the denominator more accurately defines, in a person-centered manner, which patients should be receiving contraceptive care. This critical step to exclude patients who do not wish to receive contraceptive care minimizes the potential for harm and risk of incentivizing directive contraceptive counseling. Currently, there is not another existing standard measure of patient desire for contraceptive services. Additionally, the SINC-based contraceptive care measures capture both provision and use of contraception across a broad range of settings, including those that do not have a fee-for-service or claims-based structure, such as Federally Qualified Health Centers (FQHCs). The development and use of these electronic Clinical Quality Measures for contraceptive care in FQHCs is especially important to improve equitable access as many individuals who experience barriers to contraceptive access receive their contraceptive care from FQHCs. Endorsement of the SINC-based contraceptive care measures by NQF will offer strong support of the need to establish eCQMs for contraceptive provision in clinical settings, validate the extensive evidence-based process through which they were developed, and underscore the gaps addressed by their implementation. To garner a more holistic understanding of quality in the context of contraceptive care, NQF endorsement of the SINC-based contraceptive care measures will also better position them to be used in combination with the NQF-endorsed Person-Centered Contraceptive Counseling (PCCC) measure. These measures serve as a critical tool for promoting patient-centered contraceptive access, which is particularly important in today's environment given the increased threats to sexual and reproductive autonomy. Please contact us at CECA@contraceptionaccess.org if you have any questions or need further information.

Developer Response

N/A

NQF Response

Thank you for your comment. It has been shared with the Standing Committee and measure developer.

NQF Committee Response

N/A

Kate Satterfield

Comment ID#: 8254 (Submitted: 09/13/2022)

Council / Public: Public

Level of Support: N/A

Comment

I am writing to support NQF's endorsement eCQMs 3682e and 3699e for trial use. I applaud UCSF's Person-Centered Reproductive Health Program for creating and supporting contraceptive care measures that a) can be calculated without claims data and b) better account for patient desires than existing eCQMs 2902, 2903, and 2904. This endeavor is necessary to better direct quality improvement efforts toward patient-led decision-making. One of the strongest aspects of the proposed measures is that, with its standardized denominator, it may have the potential to offer comparable insights across multiple settings (including primary care, Title X, and more traditional OB/GYN clinics), and they undoubtedly will be an asset for quality improvement at a small-scale (specific facilities, small health systems, etc.). However, because the proposed measures are contingent on clinics implementing a specific workflow in order to successfully calculate the eCQM, I am concerned about both their feasibility and validity. More specifically, I wonder if the new SINC data element will face challenges in widespread uptake and adoption and, subsequently, if those systems that choose to adopt the data element and commit to using it in their workflow will generate a selection bias that negatively impacts the ability to use the measures as tools for understanding access. I hope the developer will look more deeply into these questions during the trial period and also explore how to include patients who choose contraceptive methods and behaviors that are not deemed "most or moderately effective". I also hope to read more, after the trial use period, about patient-acceptability of the questions in SINC data element and how these proposed measures relate to the existing contraceptive care eCQMs (since they are being tested in many of the same populations) and the PCCC PRO-PM. It would be a best-case scenario if these new measures help strengthen our understanding of 2902, 2903, and 2904. Despite the flaws of these existing measures, they are remarkable for how they remind us of the breadth, fluidity, and ambiguity in reproductive desires and contraceptive use. Although we ultimately cannot box every person's desire into a standardized concept or fully embrace ambiguity and uncertainty, we can

find ways to measure the quality and accessibility of care that is not dependent on whether a specific (contraceptive) service is rendered. I look forward to the next steps in creating a more just reproductive health care practice.

Developer Response

N/A

NQF Response

Thank you for your comment. It has been shared with the Standing Committee and measure developer.

NQF Committee Response

N/A

Krishna Upadhya, Planned Parenthood Federation of America ; Submitted by Monika Grzeniewski

Comment ID#: 8237 (Submitted: 09/13/2022)

Council / Public: Public

Level of Support: N/A

Comment

Planned Parenthood Federation of America enthusiastically submits comments in support of the Self-Identified Need for Contraception (SINC)-Based Contraceptive Care electronic clinical quality measures (eCQM) submitted by the University of California, San Francisco for endorsement from the National Quality Forum (NQF). Planned Parenthood is the nation's leading sexual and reproductive health care provider and advocate and a trusted, nonprofit source of primary and preventive care for communities across the United States. Planned Parenthood is dedicated to improving access to quality health care throughout the country, and we strongly support initiatives that align with that mission. A performance measure of contraceptive care that centers patient choice and autonomy will advance positive perinatal and reproductive health care outcomes. The SINC-based contraceptive care measure takes a patient-centered approach in how it defines the eligibility criteria thus creating an actionable data point for health care providers to use when trying to increase access to contraceptive care and improve quality of service delivery. It incentivizes providers to assess the contraceptive needs of their patients while decreasing the risk of directive or coercive counseling. Additionally, this innovative approach leverages the availability of more nuanced information in the electronic health record and aligns contraceptive quality measurement with the next generation of performance measurement. We look forward to utilizing this more precise data point in tandem with the NQF-endorsed Person-Centered Contraceptive Counseling measure to take a more holistic view of contraceptive access and experience of care that can be used for quality improvement efforts. We applaud the UCSF's Person-Centered Reproductive Health Program for their thoughtful, deliberate, and collaborative approach to the

development of this measure. Planned Parenthood strongly supports NQF's endorsement of the SINC-based contraceptive care eCQM.

Developer Response

N/A

NQF Response

Thank you for your comment. It has been shared with the Standing Committee and measure developer.

NQF Committee Response

N/A

Loretta Gavin

Comment ID#: 8250 (Submitted: 09/13/2022)

Council / Public: Public

Level of Support: N/A

Comment

As one of the original developers of the NQF-endorsed claim-based performance measure for contraceptive care, I wholeheartedly endorse this measure! It solves most of the problems of the original claims-based measure in that the denominator only includes people seeking care, it is conceptually more advanced since it is client-centered and relies on the person's determination of the need for care, and the results can be more readily interpreted to identify where improvements in care are needed. Together with the NQF-endorsed Person-Centered Contraceptive Counseling measure, the SINC measure has fulfilled earlier NQF expert recommendations to develop a set of measures that balance each other by focusing on two key aspects of contraceptive care, i.e., access to care that is client-centered. Given the recent SCOTUS decision to overturn Roe v Wade, the need for measures to monitor contraceptive care has never been greater.

Developer Response

N/A

NQF Response

Thank you for your comment. It has been shared with the Standing Committee and measure developer.

NQF Committee Response

N/A

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