November 2023

National Contraceptive Quality Measures Workgroup

Contraceptive Care Performance Measures: Guidance for Health Care Providers

The goal of the National Contraceptive Quality Measures (NCQM) Workgroup is to ensure that meaningful, patient-centered quality measures and sexual and reproductive health (SRH) performance measures are endorsed, maintained, disseminated, and implemented appropriately (see the NCQM webpage for additional detail). This document provides guidance to teams at the health center and health care organization levels about how to use performance measures to assess and improve the quality of contraceptive care, with emphasis on the contraceptive care provision measures with the Person-Centered Contraceptive Counseling (PCCC) measure.

INTRODUCTION

- Performance measures, also referred to as quality measures, enable health care organizations to assess processes, outcomes, patient perceptions, and organizational systems that are associated with the ability to provide high-quality health care. These measures can help identify gaps and inequities, drive continuous improvements, and promote transparency and accountability to stakeholders and the community at large. They can be used internally to assess baseline performance and monitor progress over time and externally with stakeholders to demonstrate high-quality care provision and value.

- Measurement is a way for health care organizations to hold themselves accountable to the vision that the NCQM Workgroup has established for high-quality contraceptive care.

CECA Coalition to Expand Contraceptive Access

National Family Planning & Reproductive Health Association

NCQM Workgroup Vision for High-Quality Contraceptive Care

- All people have control over and the ability to act or not act on their contraceptive decisions, goals, and desires.
- All people who want contraception can access the contraception of their preference – when, how, and where they want it, free of barriers and bias.
- All sexual and reproductive health-related policy, programs, practice, care delivery, and research are person-centered, with a range of meaningful, values-aligned contraceptive measures at their core to holistically assess and ensure equitable access and quality.
- Patient-centered contraceptive care is embedded and valued at all levels of the U.S. health care system and contraceptive services and supplies are adequately reimbursed.
- Provider practices reflect evidence-based guidelines and best practices that uphold patient preferences and autonomy.
- Contraceptive care and the range of contraceptive measures avoid creating harms by centering people's experiences and preferences and uplifting reproductive justice, autonomy, and equity.

STANDARDIZED, NATIONAL QUALITY FORUM (NQF)-ENDORSED PERFORMANCE MEASURES

Measure	Data Source	Definition	Specifications
Contraceptive Care – Most & Moderately Effective Methods	Billing/Claims	The percentage of women aged 15-44 at risk of unintended pregnancy that is provided a most effective (i.e., sterilization, implants, IUD/IUS) or moderately effective (i.e., injectables, oral pills, patch, or ring) contraceptive method.	OPA MME
Contraceptive Care – Access to LARC	Billing/Claims	The percentage of women aged 15-44 years at risk of unintended pregnancy that is provided a long-acting reversible contraceptive (LARC) method (i.e., implants or IUD/IUS).	OPA LARC
Contraceptive Care – Postpartum Most & Moderately Effective Methods	Billing/Claims	Among women aged 15-44 years who had a live birth, the percentage that is provided a most effective (i.e., sterilization, implants, IUD/IUS) or moderately effective (i.e., injectables, oral pills, patch, or ring) contraceptive method within 3 and 60 days of delivery.	OPA Postpartum MME
Contraceptive Care – Postpartum Access to LARC	Billing/Claims	Among women aged 15-44 years who had a live birth, the percentage that is provided a LARC method (i.e., implants or IUD/IUS) within 3 and 60 days of delivery.	OPA Postpartum LARC
SINC-Based Contraceptive Care – Non-Postpartum	Electronic clinical data/EHR	Percentage of women aged 15-44 who have not indicated they do not wish to receive contraceptive services and who did not have a live birth in the measurement period who 1) received or had documented use of most or moderately effective contraception (primary measure) and 2) received a long-acting reversible contraceptive method during the calendar year (sub-measure).	UCSF eCQM
SINC-Based Contraceptive Care – Postpartum	Electronic clinical data/EHR	Percentage of women aged 15-44 who had a live birth during the measurement period and have not indicated they do not wish to receive contraceptive services 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).	UCSF eCQM
Person-Centered Contraceptive Counseling Measure (PCCC)	Patient - reported data/ survey	Percentage of patients that report a top-box (i.e., the highest possible) score of patient experience in their contraceptive counseling interaction with a health care provider during their recent visit.	UCSF PCCC

CONTRACEPTIVE CARE PROVISION MEASURES

- **Contraceptive Care – Most & Moderately Effective Methods**
- **Contraceptive Care – Access to LARC**
- **Contraceptive Care – Postpartum Most & Moderately Effective Methods**
- **Contraceptive Care – Postpartum Access to LARC**

Rationale

- Contraceptive care provision measures can ensure that individuals have access to the full range of contraceptive methods, with provision serving as a marker of access. Ideally, any patient that desires contraception should be able to obtain it from their health care provider. By illuminating where barriers to access may exist, and whether variations that signal inequity are present, the measures serve as an important improvement tool. These measures look at the percentage of patients who were provided with a most or moderately effective method of contraception, through a procedure (e.g., implants, IUD/IUS, sterilization), onsite dispensing, or by prescription to an offsite pharmacy.

- Contraceptive care provision measures became the first clinical performance measures for contraceptive care to gain NQF endorsement in 2016. With their endorsement, contraceptive care providers joined the broader health care field in the use of performance measures to drive improvement, inform consumers, and to influence payment strategies.

- Since 2016, there has been a consensus that a sole focus on patient uptake of most and moderately effective contraceptive methods may incentivize providers to use of directive or “tiered” counseling approaches that encourage uptake of a type of contraceptive method or category of methods with higher rates of effectiveness. This is why it is essential that a balancing measure, such as the PCCC measure, be used in tandem to ensure patient preferences, values, and experience of care are prioritized. This is essential given the history and present-day reality of reproductive oppression, contraceptive coercion, and biased counseling in the United States toward individuals who are Black, Indigenous, and People of Color (BIPOC); have low incomes; and/or are living with disabilities.

Implementation

- The measures are calculated using the claims codes that providers enter into the patient's electronic health record (EHR) or electronic practice management (EPM) system during the patient visit for billing purposes. The Office of Population Affairs (OPA) maintains a website with reporting specifications for configuration of reports. Because measure accuracy is dependent on health center staff coding encounters correctly and consistently, all health care team members must receive training and understand how the information they document will be used for reporting and quality improvement.

How should payers and state programs use the contraceptive care measures?

- **Pay-for-reporting, which rewards providers with bonus payments for reporting measure data, is a strategy that seeks to incentivize the collection of measures, thereby increasing the likelihood that data will be used to drive quality improvement.**
- **Pay-for-reporting yields several of the benefits of the value-based health care delivery model (e.g., improved patient outcomes, reduced costs, increased patient engagement) without shifting priority away from patients' needs and preferences.**

- Once the measure reports are configured, the contraceptive care provision measures can be incorporated into other measures reporting for continuous monitoring. Health center teams may want to review scores on a quarterly basis, or more frequently during a quality improvement initiative. The Reproductive Health National Training Center (RHNTC) has created a helpful measure tracker and improvement plan template to monitor trends in monthly data.

Interpretation

- Due to the personal nature of reproductive health care decision making, including contraceptive method use and choice, coupled with the long history of reproductive coercion in the US, OPA has not set a specific benchmark for the contraceptive care provision measures. The Access to LARC measure in particular is intended to identify health care providers and organizations that offer very limited or no access to LARC methods, which are more commonly inaccessible than other methods due to financial constraints and lack of provider knowledge. The Access to LARC measure should not be used to encourage high rates of use, as this could lead to coercive practices.

- The contraceptive care provision measures should never be used in a pay-for-performance context.

- Given the interpretation challenges that come with not having a benchmark, the most useful way to use the contraceptive care provision measures is as an initial data point (i.e., baseline) for monitoring changes over time and/or the effectiveness of quality improvement interventions. Stratifying by patient demographics and visit characteristics is particularly instructive and can help identify where variations in measure scores exist. Site teams should plan to monitor differences in disaggregated measure scores to determine what service delivery processes, systems, and policies may be driving suboptimal performance and inequities and where opportunities for improvement exist.

- Any discussions that arise during data interpretation must keep in mind that contraception is a preference-sensitive decision, and many individual and cultural factors contribute to which contraceptive method a patient chooses – and whether a patient chooses to use a contraceptive method at all.

Data Review: Example Discussion Questions

- What percentage of patients were provided a most and/or moderately effective method of contraception in the last year?
- How do the percentages of patients provided with most and/or moderately effective contraception compare when disaggregated by visit characteristics (e.g., visit type, payer, provider)? By demographic characteristics (e.g., race, ethnicity, preferred language, age, sexual orientation and gender identity)?
- What individual (e.g., patient preference, cost), provider (e.g., bias, lack of knowledge of current guidelines), institutional (e.g., health center policies), and community-level (e.g., distrust, stigma) barriers may be contributing to lower rates of contraceptive provision among some patient groups?
- What institutional barriers may be contributing to lower rates of contraceptive provision among some visit types?
- What, if any, barriers may prevent a patient from accessing their *preferred* contraceptive method? Of a patient discontinuing their current method and initiating a new method (e.g., LARC removal)?

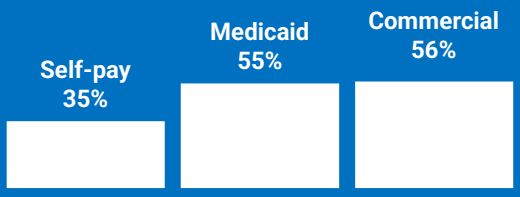
Limitations

- Provision is an imperfect proxy for access. The contraceptive care provision measures rely on a causal pathway that assumes that patients receive their preferred method, are satisfied with that method, and use and continued to use that method.

- Furthermore, because contraception is a preference-sensitive decision for individuals, patient-centered approaches are particularly important. As health care providers look to improve performance on contraceptive care provision, they need to be aware of the ways that “improving” performance may inadvertently lead to coercive practices, due to the history of reproductive oppression and coercion in the US and its ongoing legacy. A balancing measure should be used alongside the contraceptive care provision measures to ensure provision is not occurring at the expense of patient experience and autonomy.

Provision Measures Case Study Example

After reviewing contraceptive care provision measures broken out by payer type, a health center realized that self-pay patients have much lower rates in comparison to patients covered by Medicaid or commercial insurance.



In response, the quality improvement team incorporated basic financial counseling (e.g., help with insurance enrollment, verification of coverage) into all contraceptive visits and explored additional payment options (e.g., sliding fee scale, monthly payments plan) for self-pay patients.

SINC-BASED eCQMS

- **SINC-Based Contraceptive Care, Non-Postpartum**
- **SINC-Based Contraceptive Care, Postpartum**

Rationale

The electronic clinical quality measure (eCQM) of contraceptive care provision is a performance measure that looks at the percentage of patients who were provided with a most or moderately effective method of contraception using standardized data elements in the EHR in addition to claims codes. By incorporating structured fields from EHRs, the eCQM has a more accurate denominator (i.e., who self-identifies as needing contraceptive services) than the claims-based measure (i.e., percentage of women aged 15-44 at risk of unintended pregnancy). Using a standardized element that screens for a patient's interest in contraception, the eCQM excludes patients from the denominator who express that they do not want to talk about contraception as part of their health care visit. The eCQM is easier to interpret because it captures contraceptive care provision only among those patients explicitly interested in contraception.

Implementation

To assess whether a patient wants to discuss contraception during their visit, health care organizations must capture a new data element. Through engagement with Reproductive Justice Consultants and industry stakeholders, the University of California, San Francisco (UCSF) Person-Centered Reproductive Health Program (PCRHP) created a question known as the "Self-Identified Need for Contraception" or "SINC" question. This screening question asks patients for their desire for contraceptive services and serves as the primary inclusion/exclusion criteria for the eCQM's denominator:

Self-Identified Need for Contraception (SINC)
EHR standardized data element

We ask everyone about their reproductive health needs. Do you want to talk about contraception or pregnancy prevention during your visit today?

If **yes**:
- *Mark yes and refer to provider for contraceptive counseling.*

If **no**:
- Clarification Prompt: "There are a lot of reasons why a person wouldn't want to talk about this, and you don't have to share anything you don't want to. Do any of these apply to you?" *(mark all that apply)*
  - **I'm here for something else**
  - **This question does not apply to me / I prefer not to answer**
  - **I am already using contraception (and what)**
  - **I am unsure or don't want to use contraception**
  - **I am hoping to become pregnant in the near future**

- The UCSF PCRHP suggests that health care organizations ask this question of each patient once a year. There may be patients that could benefit from being asked the SINC question more or less often. Health care organizations should implement clinical decision support to identify and meet these patients' needs.

- The UCSF PCRHP works with several health care organizations to implement SINC into EHRs and clinical workflows and improve data quality for capturing the necessary information. The UCSF PCRHP has more information about this initiative on its **website**.

Interpretation

- Like the claims-based contraceptive care provision measures, a specific benchmark or goal has not been set for the eCQM, as the measure score is not expected to ever reach 100%. Some patients who self-identify that they want to talk about contraception or pregnancy prevention will make informed decisions to choose methods in the lower tier of efficacy (or no method at all) even when offered the full range of methods.

- The goal of providing contraception should never be to promote any one method or class of methods over patients' individual preferences and choices.
- The Access to LARC measure is intended to identify health care providers and organizations that offer very limited or no access to LARC methods, which are more commonly inaccessible than other methods. The Access to LARC measure should not be used to encourage high rates of use, as this could lead to coercive practices.

Limitations

- While the eCQM addresses many of the data limitations of the claims-based contraceptive care provision measures, eCQMs can be challenging to implement in a standardized way, due to challenges related to data coding, categorization, and extraction. Most EHR platforms do not include all the SINC-based eCQM's values (i.e., codes), requiring health care organizations to perform custom coding or pay their EHR vendor for customizations. In addition, there is a critical lack of interoperability across EHRs. Furthermore, large networks of family planning providers still have not transitioned to EHRs.

- In addition, health centers must build new clinical workflows to support data capture for the SINC. This includes determining who on teams asks the SINC question and its clarification prompts, where in the visit this takes place, and the frequency at which patients are asked whether they want to talk about contraception.

PCCC MEASURE

Rationale

- Given the limitations of the contraceptive care provision measures, health care organizations seeking to assess and improve the quality of contraceptive care require a tool to help ensure that patients' experiences and preferences are assessed and prioritized.

- The PCCC measure is a patient-reported outcome performance measure (PRO-PM) that assesses the extent to which providers focus on patients' own needs, values, and preferences during contraceptive counseling. The PCCC measure is a 4-item, 5-point Likert scale that covers the three domains of patient experience of counseling: interpersonal connection, adequate information, and decision support. The measure indicates how patients experience contraceptive counseling at the facility and with their provider(s), which may include any clinician or non-clinician (e.g., health educator, medical assistant) who delivers any education and/or discussion that may inform or influence a patient's choice of a contraceptive method. The PCCC measure gives health care providers and organizations the opportunity to assess the person-centeredness of contraceptive counseling provided and implement quality improvement strategies to improve patient experience of care as needed.

Think about your visit. How do you think your provider did? *Please rate them on each of the following by circling a number.*

		Poor	Fair	Good	Very Good	Excellent
a.	Respecting me as a person	1	2	3	4	5
b.	Letting me say what mattered to me about my birth control method	1	2	3	4	5
c.	Taking my preferences about my birth control seriously	1	2	3	4	5
d.	Giving me enough information to make the best decision about my birth control method	1	2	3	4	5

Implementation

- PCCC measure data are collected using a survey that is administered to patients following a health care visit where discussions about contraception may have occurred. There are several processes and staff roles that need to be identified in order to successfully identify all eligible patients and ensure they have an opportunity to complete the survey.

- Health care organizations typically administer PCCC surveys on a rolling basis, collecting a sample of surveys on a quarterly basis or perhaps more frequently during a quality improvement initiative. Some ways commonly used to administer PCCC surveys include use of a paper/tablet at the health center, follow-up email or text message with a link to the survey, or a message in the patient portal. During survey administration, patients should receive information about the purpose of the survey and how their responses will be used. To minimize positive response bias, providers of contraceptive counseling may not administer the survey to their patients. PCCC survey responses always should be collected anonymously without any identifying information.

- There may be opportunities to integrate the PCCC survey questions into existing patient experience or satisfaction surveys that already are part of a health care organization's quality improvement infrastructure. The UCSF PCRHP provides extensive **implementation resources** on their website.

Interpretation

- The PCCC measure is calculated as a top box score, which means that it represents a percentage of patients, and the numerator includes only those who selected "Excellent" on all four items of the PCCC survey. The results can be calculated at the individual provider or facility level. The recommended panel size is 50 patient responses at the facility level and 30 patient responses at the individual provider level. Panel sizes should be larger if disaggregating PCCC measure data by demographic or visit characteristics, to ensure the anonymity of survey responses.

How should payers use the PCCC measure?

The PCCC is appropriate for use in both the pay-for-reporting and pay-for-performance contexts, as there are no concerns about incentivizing coercive practices, because PRO-PMs are inherently patient-centered. In fact, PRO-PMs represent a promising practice for incorporating patient voices into value-based payment.

- The higher the PCCC score, the more patients rated their providers of contraceptive counseling highly. There is currently no minimum threshold or benchmark for the PCCC measure. The PCCC measure can be used as a stand-alone measure of patient experience for quality improvement purposes, or in tandem with the contraceptive care provision measures as a balancing measure to ensure contraceptive provision is not accompanied by bias, reproductive coercion, and/or an otherwise negative patient experience.

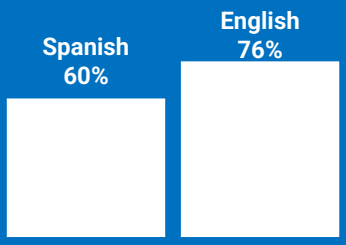
Limitations

- Patient experience is one dimension of health care quality. The PCCC measure alone will not indicate whether contraceptive counseling was offered, whether a health care organization provides the full range of contraceptive methods without barriers to access, or patient experience with other aspects of the visit.

- PMs to be sustainable for health care organizations. Health centers planning to implement the PCCC survey will need to develop workflows to support patient identification and survey administration. For health centers that utilize patient portals for survey administration, confidentiality protections should be in place to safeguard the privacy of patients who received contraceptive counseling and are eligible to complete the PCCC survey.

PCCC Case Study Example

A health center implemented the PCCC survey; baseline data indicated a top box score of 75%. The quality improvement team stratified measure data by a range of patient demographics and found a significant difference in scores between patients who completed the survey in Spanish versus English.



This variation in PCCC measure scores prompted the quality improvement team to explore how Spanish-language services were offered and strengthen translation support.

TANDEM USE

Rationale

- When used together, the PCCC measure and contraceptive care provision measures allow health care organizations to better understand how they are providing contraceptive care and where to improve. By ensuring there are no differences in access to care and patient experience by demographic and visit characteristics, tandem use represents something tangible that teams can do to advance health equity.

Implementation

- When reviewing PCCC and contraceptive care provision measure data together, use data from the same time period. The lookback period for the contraceptive care provision measures is one year; however, patient visits within any time period can be used to assess health center performance on these measures. Quarterly review of contraceptive care provision measure data is a good place to start for general monitoring. For example, health care organizations may run a report for patients who had a visit during a 3-month period and compare that data to PCCC survey data collected from visits during the same span at the same facility. During a quality improvement initiative, more frequent reviews may be helpful to determine whether changes lead to improvements.

- Since the PCCC survey items are collected anonymously, the PCCC and contraceptive care provision measures should only be used at the facility level, and individual PCCC survey responses should never be linked to the EHR or to patients' contraceptive care provision measure data.

Interpretation

- As a first step, it is helpful for health care organizations to look at their overall facility-level scores for the contraceptive care provision and PCCC measures for the same time period. The findings should be examined by multidisciplinary health center teams using a discussion-based approach to guide interpretation.

Example table for performance measure comparison during the same time period

	Most/Moderate Contraception Provision – Low	Most/Moderate Contraceptive Provision – High
PCCC Below 80%	Patients could have a better counseling experience, and there may be barriers to providing contraception.	Contraceptive methods are provided to patients, but patients could have a better counseling experience.
PCCC Above 80%	Patients report a positive counseling experience, but it is possible that the full range of contraceptive methods are not being provided.	Scores indicate that contraceptive methods are provided and patients report a positive counseling experience. The next step is to ensure there is no variation by demographic or visit characteristics.

- Next, health center teams should stratify the measures and compare scores by different demographic and visit characteristics. This allows teams to determine whether their system performs differently for select groups of patients. Performance measures should be stratified by patient demographics such race, ethnicity, preferred language for services, age, sexual orientation and gender identity, payment used for visit, federal poverty level, and/or other socioeconomic indicators. Measures should also be stratified by visit characters such as visit type and provider. These additional details will help teams interpret the measures and identify processes or policies that may contribute to variation in performance.

- As part of the interpretation process, health center teams – preferably with representation from different levels of staff and disciplines – should plan to review and discuss whether there are differences in measure scores, whether those differences are meaningful, what may be driving those differences, whether the differences indicate inequities, and what strategies to implement to close gaps in access and quality.

Example table for performance measure comparison

	Most/Mod Contraceptive Method %	PCCC %
Overall		
Race/Ethnicity *Black/African American* *White* *Latiné/Hispanic* *American Indian/Alaska Native* *Asian/Pacific Islander*		
Age *15-19* *20-44*		
Primary Language *English* *Spanish*		
Payer Type *Commercial Insurance* *Medicaid* *Title X* *Self-pay*		
Facility Designation *Title X* *Non-Title X*		

- Health care organizations do not need to complete rigorous statistical analyses to identify significant differences. Instead, they can identify measurable differences by benchmarking current data against historical data from their own organization or against comparison data from other comparable organizations. There are several reference points that can be used for comparing scores across categories to identify differences that warrant further investigation:
  - **Highest-scoring group:** Health care organizations can use the health center or department with the highest measure scores for comparison, since this high-scoring group may indicate what level of performance is currently possible within that system. However, when looking at health centers with higher scores, it is necessary to learn more about counseling practices and

method availability to ensure higher measure scores are not the result of any coercive practices.

- **Historical data:** Health care organizations can compare current and past measure scores using historical data. For example, a health center may look at performance measure data for the same quarter one year earlier, both overall and disaggregated by demographic and visit characteristics.

- **Local or national data:** Health care organizations may look to peers for a source of comparison. For example, similar data points in regional quality reports, health plan reports, or national surveys (e.g., KFF Women's Health Survey) may shed light on relative and overall performance (i.e., whether and the extent to which the quality of contraceptive services delivered is on par with that provided outside the system).

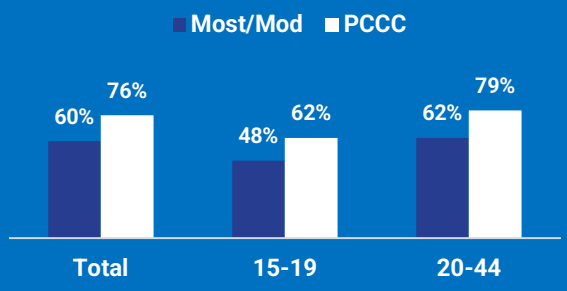
Case Study Example

- What is your first impression when reviewing the contraceptive care provision and PCCC measure scores together? What, if anything, surprised you?
- To what extent are all contraceptive methods available onsite? How might method availability differ by demographic and visit characteristics?
- How is contraceptive counseling delivered? How might the person-centeredness of contraceptive counseling vary by demographic and visit characteristics?
- When data are broken into groups, to what extent do you observe meaningful differences in measure scores? Where do you see the largest differences among groups? To what extent are such differences similar across the contraceptive care provision and PCCC measure scores?
- To what extent might contraceptive care provision and PCCC measure scores be correlated? What are some possible explanations for what you observe?
- What are some strategies your health care organization might implement to increase access overall?
- What additional barriers might need to be removed for certain groups of patients? What strategies should be considered to support more equitable care?
- What are some ways to solicit patient and community input on strategies for improvement?

Case Study Example

One health center reviewed their contraceptive care provision measures in tandem with PCCC measure scores. Data collected during the same quarter indicated that 60% of all patients were provided with a most or moderately effective method of contraception, and 76% rated their providers as "Excellent" on all PCCC survey items.

The quality improvement team stratified both measures by age and found that patients aged 15-19 had lower rates of contraceptive care provision (48%) and lower PCCC scores (62%).



They decided to explore when and how services were being offered to their younger patients and focus quality improvement efforts there. They also made plans to collect a large enough panel of PCCC surveys to analyze scores at the provider level.

DATA SHARING AND IMPROVEMENT

- Performance measure data should be shared widely with all health center staff. As part of this process, organizations should offer opportunities for staff at all levels to provide feedback about performance and potential strategies for improvement. Ideas for data sharing may include:
  - Adding contraceptive care provision and PCCC measures scores to existing quality reports or dashboards
  - Reporting out on scores during staff meetings or team huddles
  - Sharing dashboards and tables with all staff via email
  - Posting dashboards and charts in staff areas, such as health center breakrooms.
- Once a health care organization has successfully incorporated the contraceptive care provision and PCCC measures into their data review process, teams can begin to identify opportunities for improving performance. There likely will be several change ideas that health center teams identify to potentially improve scores. When selecting which intervention(s) to prioritize, health center teams should solicit meaningful participation from internal stakeholders about feasibility and potential impact. The broader the group of stakeholders, the greater the likelihood the team will uncover experiential knowledge that can complement or inform improvement activities. The added opportunity for teams to communicate with a broader audience about their vision for high-quality contraceptive care, and for others to collaborate and present ideas, will foster buy-in.

Improvement Resources

The RHNTC has several resources available to support performance improvement on the contraceptive care provision measures:

- **A change package that includes rationale, improvement strategies, and Title X success stories.**
- **A toolkit to support health care organizations in ensuring access to the full range of contraceptive methods for patients who could become pregnant but wish to avoid pregnancy at this time.**
- **A Birth Control Method Options Job Aid that includes information about a range of characteristics about their contraception that might be important to patients.**

- When health center teams observe measurable differences in contraceptive care provision and/or PCCC measure scores between different groups, they should strive to engage with patients and community members that are representative of the group(s) experiencing potentially inequitable care and outcomes. Patients are the experts of their own lives and are best positioned to provide meaningful feedback on their experiences of care, what barriers they perceive, and what interventions and supports might help alleviate these barriers. Patient or community advisory boards may be helpful to engage for such input. Monetary compensation is particularly important when patients and community stakeholders allocate their time to participate in quality improvement initiatives.

PRIVACY, CONFIDENTIALITY, AND SECURITY CONSIDERATIONS

- It is essential that health care teams consult with their organization's information technology and security teams when working with data containing any patient's personal health information, or protected health information (PHI). The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") **Privacy Rule** outlines standards for how patient information is stored and shared. Additionally, health care organizations may want to consider added precautions given the sensitive nature of sexual and reproductive health care, specifically the heightened need to safeguard patient information and outcomes in the post-Dobbs era.

Suggested citation:

National Contraceptive Quality Measures Workgroup, *Contraceptive Care Performance Measures: Guidance for Health Care Providers* (Washington, DC: Coalition to Expand Contraceptive Access; Washington, DC: National Family Planning & Reproductive Health Association, 2023).