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National Contraceptive Quality Measures Workgroup

Promoting Patient-Centered, Equity-Focused Contraceptive Measures

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 Appendix A for additional detail). This document is intended to help clarify and highlight the value these measures contribute within SRH care and their relationship to equity, justice, patient-centeredness[1], and other quality measures.

WHY IS IT IMPORTANT TO IMPROVE OUR ABILITY TO MEASURE THE PROVISION AND IMPACT OF CONTRACEPTIVE SERVICES?

- The measures used to track and evaluate public health programming and clinical services allow the identification of gaps in access, quality of care, and patient experience, allowing us to determine the impacts of interventions. The availability of measures that reflect what we care about, including experience of care and people's lived experience, is particularly important in contraception due to the personal nature of decisions related to reproduction and the well-documented inequities in care by race/ethnicity. Of note, individual measures focus on the health outcomes of a single person, while population measures look at health across and within groups of individuals.

- Contraceptive care entails providing quality, patient-centered counseling and ensuring that patients have unrestricted access to a broad range of contraceptive methods. By improving and implementing existing measures and developing new measures, we can better capture whether people are having their contraceptive needs met, moving the needle toward quality and equity in reproductive health care. This shift requires a fundamental and holistic change in measurement toward person-centered metrics that center patients' values and preferences.

Existing Clinical Performance Measures for Contraceptive Care

- Measures used for assessing performance in health care settings specifically (performance measures or quality improvement metrics) are an important way to examine population health-level outcomes. Use of nationally recognized and validated health care quality measures is critical to service improvement and the advancement of public health. They not only allow for effective quality monitoring at many levels but can also be used to demonstrate performance to both consumers and payers. Available and consistently implemented performance measures influence which health services receive priority overall. Patient-centered and equity-focused measures for contraceptive care are a critical means of ensuring attention to quality improvement in health care.

What can we measure now?

- **CONTRACEPTIVE PROVISION MEASURES to help ensure providers meet patients' contraceptive needs by providing them with methods to control their fertility as desired, including those – long-acting reversible contraceptive methods – that have the most barriers to provision.**
- **PATIENT-REPORTED OUTCOME MEASURES to help ensure that patients have the support to make informed choices concerning their contraceptive options and that they can do so freely and without being coerced to choose a particular method or none at all. They play an important role in addressing fears that the provision measures may incentivize providers to inappropriately promote the more effective methods of contraception.**

- Patient-centeredness in SRH care is essential because of the history and ongoing legacy of reproductive oppression and coercion in the US (see **Appendix B** for more detail). Performance measures must assess patient-centered, equity-focused contraceptive care, be available, and have consistent implementation.

Future Suite of SRH Measures

What might we measure in the future?

- **A person's need for services, determining whether they accessed the care they desired**
- **Contraceptive provision and patient satisfaction with services**
- **Patients' SRH outcomes, such as pregnancy, fertility, and the ultimate outcome of sexual and reproductive wellbeing (SRWB)**

Rather than continuing to rely solely on current measures, we can expand the existing "suite" to better reflect the broad experiences, desires, and needs of diverse people (see the NCQM webpage for more detail). Developing diverse measures, at both the population- and individual-level, could help transform how we think about and understand the goals and outcomes of SRH services and policies. This can also provide tools to create programs and policies that advance person-centeredness and reproductive autonomy and help ensure that SRH services align with individuals' goals, values, and desires.

WHAT SHOULD WE KNOW ABOUT THE EXISTING CONTRACEPTIVE PERFORMANCE MEASURES?

Critical work has been completed, with additional work in process, to develop validated, standardized clinical performance measures for assessing the quality of contraceptive care. The following measures have been endorsed by the National Quality Forum (NQF). The federal government and many private sector entities depend on NQF-endorsed measures because of the rigor and consensus process behind them.

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 Measures

The Office of Population Affairs (OPA) developed contraceptive care measures that assess provision to all women in need of contraceptive services. The claims-based version of the measures was endorsed by the National Quality Forum (NQF) in 2016, signaling the value and rigor of the measures; the electronic clinical quality (eCQM) version has been endorsed for trial use and is currently undergoing testing.

How can states use contraceptive measures?

The provision measures are in the Office of Population Affair (OPA) Family Planning Annual Report (FPAR 2.0) and the Centers for Medicare and Medicaid Services (CMS) core sets of health quality measures for adults (voluntary reporting) and children (mandatory). The Person-Centered Contraceptive Counseling Measure (PCCC) is in the process of being added to FPAR 2.0.

- **Claims-Based Measures (NQF endorsed).** The work on provision measures began with claims-based versions. This approach was an important first step, because the data are commonly available and relatively inexpensive to analyze. Data are available for a large population, and coding accuracy has improved over the past 20 years. Medicaid used these measures in the Maternal and Infant Health Initiative, and they are currently in Medicaid's Adult and Child Core Measure Set. It is inappropriate to use claims-based measures for benchmarking or value-based payment, as these practices may incentivize coercive or directive contraceptive counseling. Pay-for-reporting, which rewards providers with bonus payments for reporting on measures, is an alternative 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 but does so without shifting priority away from patients' needs and preferences.

- **Self-Identified Need for Contraception (SINC)-Based Electronic Clinical Quality Measures (eCQM) (NQF endorsed for trial use and currently undergoing testing).** As a critical next step, the measures are evolving into an eCQM version to better align with the changing health care context and reduce the burden of manual abstraction and reporting. The eCQMs of contraceptive use are performance measures derived from standardized data elements in electronic health records to calculate the percentage of those in need of contraceptive services in a given facility or those who plan to use contraception. Electronic measures are an improvement over the claims-based measures as they can be used in a wider array of settings, including systems using prospective payment systems under Medicaid policy, such as community health centers. They also allow for capturing use of long-acting methods over time, rather than just in the year the method is provided, allowing for a more accurate measure of those using contraception. An additional advance is the ability to refine the denominator to better capture the population of interest – those in need of contraceptive services. Current claims measures by necessity use the entire population of women aged 15-44 as the denominator, as there is no means to exclude those not interested in contraceptive care using claims data. Through engagement with reproductive justice

consultants and industry stakeholders, the Person-Centered Reproductive Health Program (PCRHP) at the University of California, San Francisco (UCSF) has created a standardized data element that serves as the primary inclusion/exclusion criteria for the denominator (see **Appendix C**: The SINC Screening Question). This screening question asks patients about their desire for contraceptive services at the time of their appointment and allows for exclusion those who are not interested in contraceptive services during the measurement year.

Person-Centered Contraceptive Counseling Measure (PCCC) (NQF Endorsed)

- Endorsed by NQF in 2020, the PCCC is a patient-reported outcome performance measure (PRO-PM) assessing the extent to which providers are focusing on patients' own needs, values, and preferences during contraceptive counseling. Developed by the PCRHP at UCSF, the team conducted interviews and focus groups with patients to understand what person-centeredness looks like in contraceptive counseling. The development of the survey items used for the PCCC was guided by this research, and the final four questions cover three patient-identified domains: interpersonal connection, adequate information, and decision support. The PCCC assesses how patients experience contraceptive counseling, and the results can be used in quality improvement efforts. The measure can be used by itself as an indicator of patient experience or in tandem. For example, the PCCC can help ensure that patient preferences are prioritized while a facility expands its contraceptive services to offer a broader range of methods. The PCCC is appropriate to use in both pay-for-reporting and pay-for-performance contexts since there are no concerns about incentivizing person-centered experience of counseling. Due in part to the burdens of data collection, this measure has not yet been widely implemented.

Tandem Use

- Both measures – provision measures like the eCQMs and PCCC – are needed to balance each other. Traditionally, health systems and clinicians have focused on measuring concrete clinical outcomes for ease, but this can come at the expense of understanding patients' health and experience of care. Clinical and patient experience outcomes need to be considered in tandem to capture a more holistic picture of the quality of care, which means pairing measures of contraceptive provision, such as the eCQMs, that assess if patients are having their needs met, with the PCCC, that assesses if patient preferences are respected in counseling. To support successful tandem use, work is underway to develop and evaluate

Why is tandem use important?

Given the focus on highly/moderately effective methods, measures of contraceptive provision must be used in tandem with measures of patient experience of contraceptive counseling to ensure patient preferences are respected.

tools and processes that can be used to facilitate the appropriate use. Piloting and evaluating tandem use of the measures includes developing quality improvement (QI)-related materials to help improve care and help us learn how to interpret the results of the measures.

HOW CAN WE PROMOTE AND ENHANCE PATIENT-CENTERED, EQUITY-FOCUSED MEASURES OF CONTRACEPTIVE CARE, AND SRH CARE MORE BROADLY?

The overarching goal is to facilitate contraceptive services – and all SRH services– that center the person and value individual sexual and reproductive experiences and health, needs, and desires. To achieve this goal, the innovative and evolving measurement work described above provides the opportunity to embed principles of equity, person-centeredness, autonomy, reproductive justice[2] into how contraceptive access, quality, and outcomes are understood and measured.

- **Continue development and testing of contraceptive care performance measures and support integration into federal reporting systems.** This includes dedicating time and resources to enhance existing technology and technical assistance systems to support widespread adoption of tandem use of the measures. Performance measurement is a central component of health care reform. Validated tools will help ensure that contraception is included in large-scale health care transformations that are underway.

- **Promote contraceptive measure implementation in value-based programs.** This includes use of pay-for-reporting for the contraceptive care provision measures to incentivize the collection of measures, thereby increasing the likelihood that data will be used to drive quality improvement. This also includes use of pay-for-reporting or pay-for-performance for the PCCC measure to encourage providers to strengthen patient-centered contraceptive counseling.

- **Ensure contraceptive measures are used appropriately for action and to inform relevant policy, programs, practice, and research.** This includes disseminating findings to promote implementation, sharing data with audiences to help ensure measures are being interpreted in a meaningful way, and helping systems address challenges to access and person-centeredness without perpetuating existing injustices.

- **Develop, pilot, and test new measures for contraceptive care, and SRH more broadly.** This includes work to transform our understanding of the need for, goals of, and outputs of SRH services and to ensure that values-aligned, holistic, and person-centered metrics are at the core of policy, programs, practice, and research.

APPENDIX A: OVERVIEW OF THE NATIONAL CONTRACEPTIVE QUALITY MEASURES WORKGROUP

Background: Prior to 2016, there were no validated quality measures for contraception. To address this gap, stakeholders developed measures to assess provision to all people in need of and client experience with contraceptive services. Between 2013-2019, the NCQM Workgroup brought together experts from the SRH field to help develop and disseminate nationally recognized quality measures related to contraceptive services. Re-imagined in 2022, the NCQM now focuses on sharing information and lessons learned from the multitude of past and current activities, with an explicit focus on implementation and policy.

Vision: The NCQM Workgroup envisions a future state where:

- 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.

Goal and Objectives: To this end, the overarching goal of the NCQM Workgroup is to ensure that meaningful, patient-centered quality measures and sexual and reproductive health performance measures are endorsed, maintained, disseminated, and implemented appropriately. The NCQM Workgroup's objectives are to:

- **Foster Culture Shift and Goal Alignment:** Support consensus building and goal alignment across different audiences to implement and improve the measurement ecosystem.
- **Support Measure Use and Interpretation:** Expand the use of the existing contraceptive measures within the field and support the field to understand and interpret the data and goals for contraceptive measures.
- **Enhance National Tracking and Reporting:** Advocate for and collaborate with federal agencies and other entities as they integrate contraceptive measures into national systems and programs, promote and incentivize use of contraceptive measures at sites of care, and monitor and evaluate the uptake and impact of measures.

APPENDIX B: ACKNOWLEDGING HISTORICAL AND CONTEMPORARY REPRODUCTIVE COERCION

Defining Sexual and Reproductive Health Equity (SRHE)

SRHE means that systems ensure that all people, across the range of age, gender, race, and other intersectional identities, have what they need to attain their highest level of SRH. This includes self-determining and achieving their reproductive goals. Government policy, health care systems, and other structures must value and support everyone fairly and justly.[3]

To shape this definition, CECA first conducted a comparative analysis of the foundational constructs that currently shape SRH care and policy. CECA reviewed relevant literature and compiled a crosswalk of key terms and frameworks (including health disparities, health equity, person-centeredness, and reproductive justice) and described definitions of these constructs, how they were developed, and the context in which they are currently used. CECA then convened an interdisciplinary technical expert panel in spring 2020. Twenty-seven experts with relevant, diverse expertise—including SRH, reproductive justice, health equity, disability rights, LGBTQ+ (lesbian, gay, bisexual, transgender, queer, plus) health, public health, and familiarity with federal executive branch processes to expand contraceptive access—were selected to participate. Technical expert panel participants analyzed the relevance of various frameworks to federal policy, explored past and present federal actions to advance equity, and worked to develop a common framework for integrating reproductive health equity into government processes.

Acknowledging Historical and Contemporary Reproductive Coercion

In SRH care, patient-centeredness is particularly important because of the history of reproductive oppression and coercion in the US and its ongoing legacy. This history influences contemporary policies restricting sexual and reproductive health and wellbeing, including contraceptive access. Reproductive coercion, starting with sexual violence against Indigenous people during colonization and the forced breeding of enslaved African people, has been used as a tool of racial and gender oppression since before the US was founded.

Twentieth-century examples of reproductive coercion include testing of the oral contraceptive pill on Puerto Rican women without informed consent and state-sanctioned mass eugenic sterilization of people with physical and intellectual disabilities. Coercive sterilization practices continue into the twenty-first century in carceral settings. The federal government has contributed to these injustices, including coerced or forced sterilization of Native American women through the Indian Health Service and of women living in poverty through 1960s War on Poverty initiatives.

This history manifests in numerous ways today, including:

- Interpersonal, structural, systemic racism in health care settings.
- Overt and subtle contraceptive coercion directed at specific communities.
- Failing to address racial inequities in health care access and patient outcomes.
- Policies restricting sexual and reproductive health and wellbeing.

References for this section and resources for additional information

Online Resources

If/When/How, *Issue Brief: Women of Color and the Struggle for Reproductive Justice* (Oakland, CA: If/When/How, 2016).

Books

Killing the Black Body by Dorothy Roberts
Undivided Rights by Jael Silliman, Marlene Gerber Fried, Loretta Ross, and Elena R. Gutiérrez
Eugenic Nation by Alexandra Minna Stern

Endnotes:

1 Person- or patient-centeredness means prioritizing the needs, preferences, and values of people during their health care visits. This contrasts with prioritizing population-based public health outcomes during a visit or making assumptions about patients do or should want.
2 Reproductive justice can be defined as the human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities.
3 Jamie Hart, Joia Crear-Perry, and Lisa Stern, US Sexual and Reproductive Health Policy: Which Frameworks Are Needed Now, and Next Steps Forward**,** *American Journal of Public Health* 112, S518_S522 (2022), https://doi.org/10.2105/AJPH.2022.306929.

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