The Electronic Clinical Quality Measure of Contraceptive Provision

What is the electronic clinical quality measure of contraceptive provision?

The electronic clinical quality measure (eCQM) of contraceptive provision is a performance measure derived from standardized data elements in electronic health records to calculate the percentage of women in need of contraceptive services in a given facility or plan who are using contraception.

Why do we need an eCQM of contraceptive provision?

Many people – and especially women of color and women of low socioeconomic status – experience barriers accessing family planning care. Disparities in reproductive health outcomes could be mitigated by innovative approaches that expand options for receiving contraceptive care. Providing contraceptive care in Community Health Centers (CHCs) – which are primary care, safety net clinics – is one approach to expanding care. The eCQMs assess access to contraception services in a given facility or plan, and provides an opportunity to have public reporting and Quality Improvement around meeting people's contraceptive needs.

How is this better than the existing performance measure for contraceptive provision that is based on claims data?

Claims data is limited by the fact that it does not always accurately identify which contraceptive method a woman is using following a visit (particularly LARC methods and sterilization, which are not captured in claims if provided during a previous measurement period). Claims-based measures are also imperfect in that the population of interest for the measure is not well defined, as they cannot accurately parse out which women are in need of contraceptive services. Electronic measures address these issues with both the numerator and the denominator by 1) more accurately documenting contraceptive use, and 2) more accurately defining the denominator of who is in need of contraceptive services. Additionally, claims-based measures can only be used in systems with a fee-for-services model. Electronic measures can be used in a wider array of settings, including systems using prospective payment systems under Medicaid policy, such as CHCs.

What changes to the electronic health records are needed to calculate the eCQMs of contraceptive provision?

For calculation of eCQMs, standardized data elements for both the numerator and the denominator need to be in the EHR, interpretable across EHR systems, and consistently completed in the course of clinical care. For the numerator, existing standardized coding systems are in place for specific contraceptive methods. Therefore, the only barrier to reporting of this aspect of the eCQM is ensuring that clinical care providers are accurately and consistently documenting specific contraceptives using these standardized codes. For the denominator, it is necessary to determine which patients should be receiving contraceptive care. While the initial conceptualization of the denominator relied on excluding women based on the use of data elements regarding sexual activity, fecundity, and pregnancy intention, initial data exploration from two Health Center Controlled Networks, OCHIN and Alliance Chicago, revealed that these data elements were not consistently available or completed. In addition, consideration of how measurement of the eCQM can and should align with the provision of patient-centered care pointed to the need to reconsider the definition of the denominator to allow for patients themselves to identify whether they are in need of contraceptive care. Defining the denominator in this way guards against the possibility of directive or coercive counseling towards contraception that may be an unintentional result of the measure, which is particularly important given the (ongoing) history of reproductive oppression, contraceptive coercion and biased counseling in the United States directed at women of color and low income women. In addition to guarding against the harm that could result from implementing an inappropriately defined measure, defining a standardized measure of self-identified contraceptive need also provides an opportunity to hardwire patient-centered workflows into the EHR that can facilitate patients getting their needs met. As there is not currently a measure of patient desire for contraceptive services that has been defined and implemented in a standardized way in EHRs, it has been necessary to generate a novel data element to capture this construct.

How will the denominator be defined?

Through engagement with Reproductive Justice Consultants and industry stakeholders, UCSF has created a standardized data element that will serve as the primary inclusion/exclusion criteria for the denominator. This screening question asks patients for their desire for contraceptive services.

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**

How is this different than One Key Question and other measures of pregnancy intention?

One Key Question is designed to assess a person's pregnancy intention over the next year. In contrast, SINC assesses a person's need for specific services on the day of their visit. While a person may hope to become pregnant in the next year, they may also want contraception today, and this need would be missed if they were only asked One Key Question. Data from several statewide surveys have in fact documented that asking people about desire to prevent pregnancy identifies more people interested in contraceptive care than does One Key Question.

What are the next steps in implementation?

UCSF is working with NACHC, OCHIN and Alliance Chicago, as well as three other data partners, to implement SINC into EHRs and clinical workflows and improve data quality for capturing the numerator. Once the SINC data element has been in used for one year, UCSF and Far Harbor will use data extracts from these partners to calculate validity and reliability of the measure and submit for NQF endorsement.

How does the PCCC relate to other performance measures for contraceptive care?

It is important to pair measures of contraceptive provision, such as the eCQMs, with the Person-Centered Contraceptive Counseling measure (PCCC), a patient-reported outcome performance measure (PRO-PM) of patient experience of contraceptive counseling. Given the focus of the provision measures on highly/moderately effective methods, there is a risk of ignoring people's preferences for other methods. The PCCC acts as a balancing measure to ensure patient preferences are respected in contraceptive counseling.

What is the benefit of having the eCQM of contraceptive provision NQF endorsed and disseminated?

NQF endorsement is an important step in signaling the value and rigor of the eCQMs. The eCQMs mark improved measurement of whether patient's needs are being met, without the pitfalls of the current claims-based measures of contraceptive provision. By defining the denominator as those who self-identify as needing contraceptive services, the eCQMs are part of a necessary narrative shift to focus on people's needs, as they define them. This will allow for QI processes to better meet people's needs by increasing access to contraception in a wider range of settings *in a patient-centered manner*, a step towards the goal of reproductive autonomy and well-being for all.

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