MEETING SUMMARY REPORT

Contraceptive Care Performance Measures Expert Work Group

NOVEMBER 20, 2024

PRESENTED TO:
Office of Population Affairs
Amanda Leeson, Contracting Officer Representative (COR)
Jamie Kim, Task Lead

PRESENTED BY:
NORC at the University of Chicago
Felicia Cerbone, Project Director
Jessica Salas-Brooks, Project Manager

NORC at the University of Chicago

Introduction

Meeting Background and Purpose

On behalf of the United States Department of Health and Human Services (HHS), Office of Population Affairs (OPA), NORC at the University of Chicago (NORC) hosted an Expert Workgroup (EWG) meeting on Contraceptive Care Performance Measures (CCPM).

The purpose of this meeting was to gather expert input on current and future work related to the National Quality Forum endorsed claims-based contraceptive care performance measures, contraceptive care electronic clinical quality measures (eCQMs), and patient-reported outcome performance measures. The meeting had the following objectives:

- Provide updates on contraceptive measures development, endorsement, and implementation
- Engage workgroup members in ways to expand the use of contraceptive care performance measures to assess access, service and experience of care
- Explore measurement implementation opportunities

The virtual meeting took place on September 5, 2024, from 1:00 – 4:30 PM ET via Zoom. The panel opened with a welcome and overview led by OPA, followed by a facilitated group discussion. A detailed agenda can be found on page 3.

This report summarizes key discussion themes, highlights from the panel, and identifies recommendations for future work group meetings.

Facilitator

Lekisha Daniel-Robinson, MSPH, Senior Researcher at Mathematica facilitated the EWG meeting. Ms. Daniel-Robinson has more than twenty years of federal, state and heath policy consulting experience, with a focus on Medicaid and CHIP and expertise in maternal and child health programs and delivery, measurement, social determinants of health (SDOH), and health equity. For the CMMI VBC Learning contract, she cofacilitated the Accountable Care Organization Realizing Equity, Access, and Community Health (REACH) Model action group on identifying HRSNs among beneficiaries. She recently led Medicaid Affinity Groups to coach states and their partners in using data-driven strategies to implement postpartum care and cesarean delivery quality improvement interventions. Prior to joining Mathematica, she directed the maternal and child health services portfolio at IBM Watson Health, where she led technical assistance efforts in collaboration with Deloitte on the learning systems contract for the CMMI Maternal Opioid Misuse (MOM) Model and Integrated Care for Kids (InCK) model providing resources, including a summit for grantees to address data infrastructure, collaboration with community partners, and workforce issues. In 2021,

she cochaired the National Quality Forum's Maternal Morbidity and Mortality Committee, charged with defining frameworks to organize related measurement. Ms. Daniel-Robinson also has experience as a technical director in the CMCS Division of Quality and Health Outcomes, where she launched the child and adult quality measures program and served as a maternal and child health SME.

Expert Panelists and EWG Participants

The individuals in Table 1 below served as the expert panelists for the meeting and prepared presentations to share with the EWG participants. All expert panelists are involved in work related to the National Quality Forum (NQF) endorsed claims-based contraceptive care performance measures, contraceptive care electronic clinical quality measures (eCQMs), and/or patient-centered care measures.

Table 1. Expert Panelist Names and Organizations

Panelist	Title	Organization
Anouk Lloren	Health Researcher	Mathematica
Christine Dehlendorf	Professor, Department of Family & Community Medicine	University of California – San Francisco
Kristen Zycherman	Quality Improvement Technical Director, Division of Quality and Health Outcomes, Children and Adults Health Programs Group	CMS-Center for Medicaid and CHIP Services
Taryn Quinlan	Social Science Research Analyst, Division of Demonstration Monitoring and Evaluation, State Demonstrations Group	CMS-Center for Medicaid and CHIP Services

In addition to the panelists above, the individuals in Table 2 participated in the EWG. Like the panelists, the participants below have been involved in related work.

Table 2. EWG Participant Names and Organizations

Participant	Title	Organization
Amanda Tran	Health Researcher	Mathematica
Antoinette Nguyen	Senior Medical Officer, Division of Reproductive Health	CDC
Brittni Frederiksen	Associate Director for Women's Health Policy	Kaiser Family Foundation
Ella Puga	Public Health Research Scientist	Far Harbor
Emily Decker	Monitoring, Evaluation, and Learning Director	Upstream
Erin Wingo	Project Director	UCSF
Fei Dong	Research Statistician	Far Harbor
Ginger Grossman	Chief Operating Officer	Far Harbor
Jamie Hart	Executive Director	CECA
Julie Maslowsky	Associate Professor	U– M
Kai Tao	Principal, Impact & Innovation	ICAN!
Kim Daniels	Statistician	CDC
Kim Diaz Scott	Vice President	NFPRHA
Lindsey Gibson	Clinical Psychologist	CMS

Nancy Fang	Assistant Professor	UCSF
Phil Hastings	Principal	Far Harbor
Riley Steiner	Senior Director	Power To Decide
Samuel Simon	Senior Director	Mathematica
Sonja Goetsch-Avila	Project Coordinator	UCSF
Virginia Raney	Technical Director	CMS

Agenda

The agenda for the EWG meeting is provided in Table 3 below:

Table 3. Contraceptive Care Performance Measures (CCPM) EWG Meeting Agenda

Time	Session Focus and Presenters
1:00 pm	**Welcome and Meeting Overview** *Lynn Rosenthal, OPA; Michelle Jasczynski, OPA; Lekisha Daniel-Robinson, Mathematica; Jessica Salas-Brooks, NORC*
1:15 pm	**Goals and Workgroup Member Roles** *Lekisha Daniel-Robinson, Facilitator* • Goals and purpose of the claims-based measurement • Role of OPA as the measure steward • Purpose of the workgroup, expert workgroup roles and contributions
1:30 pm	**Measurement Use within HHS Programs** *Kristen Zycherman, CMCS; Taryn Quinlan, CMCS* • Medicaid Core Set Reporting • Medicaid 1115 Demonstration Monitoring and Evaluation • Questions and Comments
2:10 pm	**Updates and Discussion on Contraceptive Care Performance Measurement Endorsement and Implementation** *Anouk Lloren, Mathematica; Christine Dehlendorf, UCSF* • Claims-based Measures ○ Measure Testing and Endorsement ○ Questions and Comments • Electronic version (eCQM) of the contraceptive care performance measures and Person-Centered Contraceptive Counseling (PCCC) Measure ○ Learning Collaborative Outcomes ○ Questions and Comments
3:10pm	**Break**
3:20 pm	**OPA Priorities, Impact and Promotion** *Lekisha Daniel-Robinson, Mathematica* • Guidance for Usage and Interpretation, Including Additional Settings and Reporting Systems • Dissemination and Communication Strategies • Future Measurement Considerations
4:20 pm	**Closing Remarks** *Michelle Jasczynski, OPA*
4:30 pm	**Adjourn**

Meeting Highlights

In this section, we provide an overview of the meeting content and highlight key ideas that arose during the discussion, organized by agenda topic. We also provide recommendations for future EWG meetings. A link to the meeting recording, meeting notes, and copies of the slides can be found in Appendices A-C, respectively.

Session 1: Welcome and Meeting Overview

In Session one, the CCPM EWG meeting began with a brief run-through of meeting logistics by NORC and then a formal welcome by Lynn Rosenthal, Deputy Assistant Secretary for OPA and HHS Director of Sexual and Gender-based Violence, and Michelle Jasczynski, Public Health Analyst from OPA. Next, Lekisha Daniel-Robinson reviewed the meeting objectives and facilitated introductions among expert panelists and EWG participants.

Session 2: Goals and Workgroup Member Roles

In Session two, Ms. Daniel-Robinson presented the goals and purpose of the workgroup, as well as the challenges of measurement. Discussion points are summarized below:

Purpose of Contraceptive Care Performance Measurement

- The purpose of the meeting was to gather expert input on current and future activities related to claims-based CCPMs, eCQMs, and patient-reported outcome measures.
- Performance measures can assess health care delivery and can be used to increase access to contraceptive methods and quality of care and can help to provide actionable information to close gaps.

Limitations of Measurement

- Performance measures can be considered “blunt tools” which, if used inappropriately, can exacerbate injustices, biased behaviors, and unintended consequences.

Relevance of Equity

- Sexual and reproductive health equity (SRHE) refers to systems that ensure people, across the range of age, gender, rage, and other intersectional identities, have what they need to attain their highest level of sexual and reproductive health.

OPA's Role with Contraceptive Measurement

- OPA's role is to maintain the claims-based measure specification, clearly articulate expectations of use and evaluation, support research and publish program findings, build capacity of programs, and build consensus and aligning priorities across federal agencies
- The input within the CCM workgroup provides important perspective on the success and challenges of implementation, the changes needed, and opportunities for expanded use of measures.
- There are emerging shifts in the landscape, including state developments to expand contraceptive access and remove barriers; federal actions to uphold and expand contraceptive access; innovations in contraceptive delivery (OTC birth control pills); and new forms of contraception (hormone-free barrier methods).

Session 3: Measurement Use within HHS Programs

Session three was comprised of two presentations, provided by Kristen Zycherman and Taryn Quinlan.

Medicaid, CHIP, and Adult Core Set Measures

Kristen Zycherman, Quality Improvement Technical Director at Centers for Medicare & Medicaid Services, began this session with a discussion of Medicaid, Children's Health Insurance Program (CHIP), and the Adult Core Set measures.

Ms. Zycherman shared that the 2024 Child and Adult Core Set measures include the Maternity Core Set, which is a subset of mandatory and voluntary measures focused on maternal and perinatal health. For mandatory measures, there are strategies to support reporting, including: TA resources, webinars, office hours, system features (e.g., validation), data streamlining, and TMSIS collaboration.

Ms. Zycherman also introduced the Core Set Data products, such as fact sheets, datasets and state profile pages, chart packs, and more. Ms. Zycherman also discussed 2022 contraceptive care performance measures reported at the state level via maps and charts that displayed quartiles and national medians as indicators of access (which are not designed to be tied to incentives or payments).

Medicaid 1115 Demonstration Monitoring and Evaluation

Taryn Quinlan, Social Science Research Analyst at Centers for Medicare & Medicaid Services provided a presentation on Medicaid 1115 Demonstration Monitoring and Evaluation.

Dr. Quinlan shared how there are currently ten approved 1115 family planning demonstrations, which aim to expand access to family planning and preconception care services. As all 1115 Demonstrations are considered policy experiments, monitoring

and evaluation is required. Eight of the ten demonstrations use CCPMs as their use is recommended, but not required.

Participant Questions

Participants asked the following questions after the presentations:

1. Does CMCS coverage for IUD placement include pre-medications or pain meds before IUD placement?
    - For 1115 demonstrations, this has not been typically included in the terms and conditions. States could ask for this coverage. When a demonstration is up for extension, states could continue their demonstration and add coverage during the application for extension.

2. Is the Core Set also asking states to calculate stratified measure rates for other factors than age, for example geography or race/ethnicity?
    - The final rule has stratification requirements with a ramp. Not all measures require stratification in the first year. Those that do require are within the Child and Behavioral Health mandatory measures. Measures that are not initially stratified will need to be stratified moving forward.

3. Do 1115 waivers require very defined CPT codes of what should be covered? Are there usual guidance/definitions with actual codes for each service?
    - No, there is not this level of detail in what is covered. All family planning, family planning-related, and other items within a visit should be covered. While pain medications are not historically provided, it would be interesting to see how often they are included. Additionally, if someone wanted medication for a service, it should be covered as it would help the patient receive the service. CMS will dig deeper into clarification about what exactly is being covered in the 10 demonstrations.

    - There are updated USPR recommendations for pain medications for IUD placement. Because of these updates, the CDC has gotten many questions about cost and coverage, and it seems as though it is not uniformly covered.

4. Is CMS or OPA capturing any implementation information from states that are reporting the contraceptive measures (e.g., details about pay for reporting arrangements)? Are there other ways in which states are using measures to do QI?
    - CMS is not collecting any pay-for-reporting measures. Instead, they work on quality improvement initiatives and postpartum care measurements to drive improvements. Measurements can help determine if performance measure projects are successful. There is no written guidance from CMS on using the measures, but they provide TA as necessary.

- An EWG member has heard of states misusing measures for pay for performance and offered support from members of the National Quality Measures working group to track implementation of CCMs and catch instances of both great use and potential misuse of measures. There was a suggestion to cross-post OPA materials on measures used and interpretation to CMS sites.

- Measure specifications include measure interpretation in the technical specification manual. An EWG member suggested that the group could explore other opportunities for expanding the message.

- An EWG member advocated for less-prescriptive 1115 requirements as states follow evidence-based care.

5. Has there been any thought about presenting the LARC reports as a binary variable, suggesting access or not, as opposed to an ordinal variable that suggests "more is better?"
    - This is a question that is better suited for the measure stewards. OPA guidance does suggest using a floor measure to determine access. Measures themselves are binary and reported as an aggregate. In guidance, anything below the threshold set is considered an access issue.

6. Is it possible to separate adolescents 17 and under from those ages 18-20 in the 15-20 age band? We know that minors face specific requirements and barriers to contraceptive access versus those ages 18+.
    - The age bands are set by the measure steward and may vary across the different core sets. However, the bands can be changed. To do so, they would need to look at Medicaid claims data to understand what impact a change in the age range would have on the measure.

    - An EWG member responded that it is hard to understand minors' experiences if they are lumped in with legal adults who have different experiences accessing contraceptive care. They would like to see the age lowered to 14 and to separate minors from 18+.

Session 4: Updates and Discussion on Contraceptive Care Performance Measurement Endorsement and Implementation

Session four was comprised of two presentations from Anouk Lloren and Christine Dehlendorf. Following each presentation, panelists facilitated a group discussion.

Claims-based Contraceptive Care Performance Measures

Anouk Lloren, Health Researcher from Mathematica, began this session with an overview of claims-based contraceptive care performance measures, which she

described as an attempt to assess the provision of contraception to women in need of contraceptive services and works under the assumption that needs are not being met. Despite these limitations in the measures, they are important tools in Medicaid to improve care and evaluate programs.

Dr. Lloren then provided an overview of recent changes to the measures including the removal of diaphragm contraception from Most & Moderately Effective Methods (MMEM), the extension of the postpartum window to 90 days, and the addition of language on patient-centeredness and disparities.

Dr. Lloren presented a preliminary analysis of 2022 claims data from 10 states which were selected based on data quality, population size, and proportion of women covered by Medicaid. These charts demonstrated potential variation in the provision of MMEM and long-acting reversible contraception (LARC) for all women and for postpartum women across states and by sub-populations (e.g., age, race and ethnicity, urban/rural status).

Participant Questions

Participants made the following comments and asked the following questions after the presentation:

1. Do you have any feedback on preliminary state level results?
    - An EWG member mentioned that it is hard to interpret the results using claims-based measures, particularly as they are a “blunt tool.” The low-performing states are interesting to highlight as we can then dig into what is happening on a policy, practice, or culture level that may be causing lower rates of access.
        - Later in the discussion, an EWG member noted that it is difficult to meaningfully interpret the results presented.
        - The EWG members were reminded that Mathematica’s presentation used 2022 claims data, and CMS’ presentation used CY2021 data reported in 2022.

2. Do you think use of over-the-counter (OTC) daily contraceptive pill will affect measure performance rates?
    - An EWG member noted that it is important to track the impacts of the OTC birth control pill, although it is likely too soon to understand the impacts. There is current research on who is using the O-Pill, whether it is used as long-term contraception or as a fill-in, whether minors have access to it, and how sell-type implementation will impact access.
        - An EWG member added that her own observations are that many pharmacies keep it behind the counter, potentially limiting access. Additionally, cost may be an issue when it comes to uptake.

3. Is this CY2022 data from Medicaid claims from the 10 states? Did they include Managed Care Organizations (MCO) and Fee-For-Service (FFS) Medicaid? Or if they have a state family planning amendment, does it include? With discussion in Value-Based Care (VBC) and amendments, what does it look like across types of coverage?
    - Since the data is Medicaid claims from the Virtual Research Data Center (VRDC), it should include waiver claims and managed care claims.
    - An EWG member suggested that the findings highlight which of the 10 states in the analysis have active demonstrations.

4. An EWG member stated that she continues to struggle with the diaphragm exclusion. While it is consistent with the most/moderate effective framing of the measure, perhaps it should be reframed as a "prescription method that requires interaction with providers."
    - EWG members discussed how changes in delivery reframe what the measure actually represents and that removal of the diaphragm from MMEM was due to studies suggesting its inefficiency based on a threshold.
    - An EWG member disagreed with diaphragm removal because it is trying to measure any access to contraception. While there are limitations to claims-based measures, there is an opportunity to reframe diaphragm use as access to any contraception.

5. An EWG presenter asked the group how to talk about findings for "all women" compared to findings for "postpartum women"
    - For the postpartum measure, the denominator is less biased than all women and maybe more straightforward to interpret.
    - Short-interval pregnancy data is variable and contested. There is a concern about paternalism towards pregnant people when they are counseled about contraception.
    - Lactational Amenorrhea Method (LAM) is hard to achieve because menses return for some people who are exclusively breastfeeding. But it is effective and can be >90% effective before menses returns.
    - The risk of coercion for LARC is very high.
    - The Mathematica presentation showed that there were disparities in MMEM and LARC provision. LARC provision is higher for minorities, which fits with literature showing coercion towards LARC among minority groups.

6. Are there any suggested changes you would like to recommend for Fiscal Year 2025 (calendar year 2024)?
    - There was a suggestion that the maps presented by CMS include a different breakdown than the existing quartiles to be meaningful.
    - It would be interesting to understand the breakdown of contraception provision by Catholic-affiliation.

    - This would require an additional data source.
- The Transforming Maternal Health (TMaH) CMMI model includes payment strategies for maternal care. It also focuses on contraceptive care for postpartum women as an area for monitoring and evaluation.
- An EWG member shared a paper with the group: Impact of the Affordable Care Act on Prescription Contraceptive Use and Costs Among Privately Insured Women, 2006-2020 - PubMed (nih.gov)
- In an Illinois MCO (MCO) (~8000 members), there are different results than the ones presented during the workgroup. The MCO has an Accountable Care Organization (ACO), so they excel in care coordination and following members. There were outliers to the pattern when the facility was religiously affiliated.

Person-Centered Contraceptive Counseling Measure (PCCC) and Electronic Clinical Quality Measures (eCQMs)

Christine Dehlendorf, Professor from the University of California, San Francisco provided an update on Person-Centered Contraceptive Counseling Measure (PCCC), and Electronic Clinical Quality Measures (eCQMs).

The Person-Centered Contraceptive Counseling Survey (PCCC) is used in a visit-specific context for Quality Improvement (QI) purposes. It is validated and endorsed on the provider- and facility-levels. The PCCC-Retrospective (RS) is used to document differences in the quality of care by race, ethnicity, and sexual orientation.

Dr. Dehlendorf discussed how eCQMs are being worked on to measure the experience of access to quality contraceptive care for those who want it. They can provide more reliable data than claims-based measures. Additionally, Self-Identified Need for Contraception (SINC) Screening eCQM is used to identify people who want contraceptive services, allowing for a refinement of the denominator of eCQMs by directly identifying interest in using contraception.

Currently, the PCCC is used in a Community Health Center learning collaborative. The next steps are to replicate the efforts of this collaborative in abortion-restricted states.

Participant Questions

Participants made the following comments and asked the following questions after the presentation:

1. Power to Decide has included the PCCC-RS in their new online panel survey (Youth Reproductive Health Access Survey).

2. Is there any discussion ongoing that may consider SINC as a part of the emerging maternity CAPs activity?
    - There are in discussions about the use of SINC in the peripartum context. It is very rare for someone to go through pregnancy without contraceptive

counseling, and SINC measures whether the conversations are held in a person-centered way.

3. Do you have initial percentages for SINC provision via eCQMs? Is there a recommended percentage of people being asked SINC to calculate the measure?
    - There is about 30-40% in the field right now. For the recommended percentage, it is more of a QI opportunity. While they have not considered a threshold yet, they would be incentivized to ask more people. Asking more patients would exclude the individuals who do not want contraception from the denominator, resulting in a greater access measurement.

4. On another measures project, CMS is interested in claims data because it can reach populations that don't have EHR. Do results from these other measures miss this population that should be counted?
    - There are fewer people now that are not on eHRs, and there are new regulations that may help eHRs reach a broader number of people.
    - It is also important to ask when can we use eCQMs to capture the population and their experiences in a reliable and valid way? At what point do we reach adequate saturation or data interoperability?
    - Data interoperability is at the forefront of many discussions. While eCQMs are a viable QI tool at the facility-level, it will take more work to become workable at higher levels.

Session 5: OPA Priorities, Impact and Promotion

During Session Five, Ms. Daniel-Robinson facilitated this session, which was an open discussion that focused on the following questions:

1. What can measurement help us understand? What might measurement help us demonstrate, now and in the future? Where are there gaps? What aspects of contraceptive care performance measurement need to evolve?
2. Who are other partners or potential users of contraceptive care performance measures and measure results?
3. What might help other partners or potential users understand the importance of contraceptive measurement? How can it be socialized?
4. Based on previous discussion section, identify any additional guidance needed for existing users(s)/settings
5. Where/how might OPA have the greatest impact?
6. What should OPA prioritize?
7. What alignment may be useful across measurement approaches?
8. What would be helpful to enhance the usage of measures?

9. Are there organizations or agencies through which we should channel additional guidance?
10. What is helpful for different audiences?
11. How should we think about emerging technologies in contraception?

NORC staff shared their screen, documenting the following on-screen notes.

What can measurement help us understand? What might measurement help us demonstrate, now and in the future? Where are there gaps? What aspects of contraceptive care performance measurement need to evolve?

- State-level findings show minimal variation across sub-groups. It is currently difficult to find differences, but the findings may be useful to identify where individuals have lower access or access issues.
- Excited for facility-level endorsement of measures. Historically, using measures at the facility level has been difficult.
- There is a need to ensure measures are validated among young people. It is likely that some measures would look different among younger people. Their data should be separated out when reporting.

Who are other partners or potential users of contraceptive care performance measures and measure results?

- Private payers/private health plans
- Pharmacists: providing self-administered hormonal contraception. Safeguards around coercion, provision practices. Varying objectives around prescribing/providing. An opportunity to implement measures; now is the time to begin these conversations at the federal level.
- Reimbursement
- Telehealth/asynchronous visits use in Medicaid: new access point.
- Pediatricians and other pediatric providers

What might help other partners or potential users understand the importance of contraceptive measurement? How can it be socialized?

- External Quality Review Organization (EQRO): Medicaid requirement for quality review organizations. Would like these organizations to understand the specifics of the measures they are looking at.
- Use and interpretation guides per audience/user: setting matters (e.g., primary care vs family planning clinics). Documents regarding socializing/culture shift/goal aligning and implementation in service sites
  https://www.contraceptionaccess.org/measures
  https://www.manatt.com/Manatt/media/Media/Images/People/PPFA-Manatt-Measuring-Quality-Contraceptive-Care.pdf
- Considerations: difficulty to involve stakeholders in development of specific guides. Existing materials on how to align larger concepts within guidance.
- Family Planning Annual Report (FPAR) 2.0 Data

As it relates to guidance for usage and interpretation, what should OPA prioritize?

- Formal integration of PCCC into evaluation and review processes for grantees
- Hearing from users on how they use the measures and interpret the results. Find ways to promote how people use the measures.
- Conferences.
- Managing user implementation subcommittee: opportunities to hear directly. Opportunities for OPA and CMS to collaborate on a webinar/conference to discuss importance of measures from the Federal perspective and have users discuss on-the-ground meaning, opportunities, challenges. Particularly important for appropriate use in pay-for-performance.
- Break down measures by method type: a method to socialize the measures.
- Fear around coercion/paternalism via measures: how to capture that access is the goal (not coercion) and lack of access is violation of choice. Find ways to communicate these themes in reporting.

What alignment may be useful across measurement approaches?

- HRSA and OPA: engage with HRSA and interpret results. No contraceptive measures in Uniform Data System (UDS+) yet (opportunity to collaborate).
- Aligning age groups across data sets.

What would be helpful to enhance the usage of measures?

- Conference attendance for dissemination: National Academy for State Health Policy (NASHP)

Are there organizations or agencies through which we should channel additional guidance?

- Providers in the perinatal space (Title V)
- Early education space working with people of reproductive age (MIECHV)
- HRSA Ryan White STI Groups: stay aligned with each other's work
- State Perinatal Quality Care Collaboratives

What is helpful for different audiences?

- Consideration for delivery based on setting: pharmacy, primary care, family planning
- Additional specific guidance about pain, coverage during IUD placement and removal
- Implementation documents for facilities/networks implementing CCMs for QI

How should we think about emerging technologies in contraception?

- Role of telehealth in contraceptive counseling and provision
- Incorporating male partners' contraceptive care into measurements (potential eHR activity).

After the meeting participants were sent a thank you note.

Recommendations for OPA

Measurement Recommendations

Throughout the discussion, panelists raised important points for OPA's consideration as they move various contraceptive care performance measures forward. NORC has identified the following key recommendations for OPA:

- **Develop implementation guidance:** Participants suggested providing guidance on how to use measures so they can be interpreted correctly. Participants also inquired about the specifics of interpretation on the OPA webpage and suggested including language around the description for Most Moderately Effective methods.

- **Increase accessibility and transparency of measures:** Participants were interested in transparency with interpreting measurement data, including how information is displayed in and across settings and age groups to inform targeted efforts.

- **Increase involvement from other partners, potential users of contraceptive care performance measures and measure results:** This can include providers in the perinatal space (Title V), the early education space (MIECHV), HRSA Ryan White STI Groups, and State Perinatal Quality Care Collaboratives. Participants also suggested engaging private payers/private health plans, pharmacists, pediatricians, and other pediatric providers.

Meeting Logistics Recommendations

In addition, as discussed during the OPA-NORC-Mathematica debrief, it may be beneficial to restructure the CCPM EWG next year. As the work group meets regularly and the meeting shifts more toward measurement updates, two 2-hour meetings may elicit more conversation rather than one 4-hour meeting.

Supplying materials in advance (such as the slide deck) may benefit participants and allow them to come to the meeting prepared with questions for the presenters.

Appendices

Appendix A – Meeting Recording Link

Topic: Contraceptive Care Performance Measures Panel

Start Time: September 5, 2024, 1:00 PM

Meeting Recording:

https://norc.zoom.us/rec/play/vbWF6BPrgG2aKyivowtXzdBqLDzfUz0DieSG2825Yx-xsYNSbRRGehyt2ru1faotmGzSJ6ErACXJNHvy.RlOGudjEDcRi3g_2?canPlayFromShare=true&from=share_recording_detail&continueMode=true&componentName=rec-play&originRequestUrl=https%3A%2F%2Fnorc.zoom.us%2Frec%2Fshare%2F8EbMvTktAA9eTghvgvHC9Qp1g2YSgd2lCE6qW-uQiR6qHzpxeBA7kBlfZLfrd3Hc.PMdk3klXlhBW_f3h&autoplay=true&startTime=1725555769000

Appendix B – Meeting Notes

Please see attachment Appendix B_CCM EWG Meeting Notes.pdf.

Appendix C – PowerPoint Slides

Please see attachment Appendix C_CCM EWG Slide Deck.pdf