NATIONAL QUALITY FORUM
Driving measurable health improvements together

Memo

June 19, 2020

To: Perinatal and Women's Health Standing Committee

From: NQF staff

Re: Post-comment web meeting to discuss public comments received and NQF member expression of support

COVID-19 Updates

Considering the recent COVID-19 global pandemic, many organizations needed to focus their attention on the public health crisis. In order to provide greater flexibility for stakeholders and continue the important work in quality measurement, the National Quality Forum (NQF) extended commenting periods and adjusted measure endorsement timelines for the Fall 2019 cycle.

Commenting periods for all measures evaluated in the Fall 2019 cycle were extended from 30 days to 60 days. Based on the comments received during this 60-day extended commenting period, measures entered one of two tracks:

Track 1: Measures Continuing in Fall 2019 Cycle
Measures that did not receive public comments or only received comments in support of the Standing Committees' recommendations will be reviewed by the CSAC on July 28 – 29.

- **Exceptions**
  Exceptions were granted to measures if non-supportive comments received during the extended post-comment period were similar to those received during the pre-evaluation meeting period and have already been adjudicated by the respective Standing Committees during the measure evaluation Fall 2019 meetings.

Track 2: Measures Deferred to Spring 2020 Cycle
Fall 2019 measures requiring further action or discussion from a Standing Committee were deferred to the Spring 2020 cycle. This includes measures where consensus was not reached or those that require a response to public comments received. Measures undergoing maintenance review will retain endorsement during that time. Track 2 measures will be reviewed during the CSAC's meeting in November.

During the Perinatal and Women's Health post-comment web meeting on June 26, 2020, the Standing Committee will be reviewing Fall 2019 measures assigned to Track 2. There were no measures that followed Track 1.

Purpose of the Call

The Perinatal and Women's Health Standing Committee will meet via web meeting on June 26, 2020 from 10:00 am to 5:30 pm ET. Member and public comments and NQF member expression of support for Fall 2019 measures will be discussed from 5:00 pm to 5:15 pm ET. The purpose of this session is to:

- Review and discuss comments received during the post-evaluation public and member comment period;
- Provide input on proposed responses to the post-evaluation comments;
- Review and discuss NQF members' expression of support of the measures under consideration; and
- Determine whether reconsideration of any measures or other courses of action are warranted.

Standing Committee Actions

1. Review this briefing memo and draft report.
2. Review and consider the full text of all comments received and the proposed responses to the post-evaluation comments (see comment table).
3. Review the NQF members' expressions of support of the submitted measures.
4. Be prepared to provide feedback and input on proposed post-evaluation comment responses.

Conference Call Information

Please use the following information to access the conference call line and webinar:

Dial-in #: 1-800-768-2983
Access Code: 600-9057
Web link: https://core.callinfo.com/callme/?ap=8007682983&ac=6009057&role=p&mode=ad

Background

According to the Centers for Disease Control and Prevention's National Vital Statistics System, the 2018 maternal mortality rate was 17.4 maternal deaths per 100,000 live births and increases with age; women aged 40 and older die at a rate of 81.9 per 100,000 births.[1] Women of this age group are 7.7 times more likely to die compared with women under age 25. Additionally, the maternal death rate for African American women was more than double that of white women, and three times the rate for Hispanic women.

Compared with other countries in the World Health Organization's latest maternal mortality ranking, the United States ranked 55th, just behind Russia (17 per 100,000) and just ahead of Ukraine (19 per 100,000).[1] Access to high quality of care for women of reproductive age before and between pregnancies—including pregnancy planning, contraception, and preconception care—can reduce the risk of pregnancy-related complications, including maternal and infant mortality.

The National Quality Forum's portfolio of measures for Perinatal and Women's Health includes measures for reproductive health; pregnancy, labor and delivery; high-risk pregnancy; newborn, premature, or low birthweight newborns; and postpartum patients. Some measures for other aspects women's health are reviewed by other Committees, e.g., a perinatal vaccination measure is in the Prevention and Population Health Standing Committee portfolio.

During the February 7, 2020 web meeting, the NQF Perinatal and Women's Health Standing Committee evaluated one new measure for endorsement consideration, *3543 Patient-Centered Contraceptive Counseling (PCCC)*.

[1] National Vital Statistics Reports Volume 69, Number 2 January, 2020 Maternal Mortality in the United States: 69(2):18.

Comments Received

NQF solicits comments on measures undergoing review in various ways and at various times throughout the evaluation process. First, NQF solicits comments on endorsed measures on an ongoing basis through the Quality Positioning System (QPS). Second, NQF solicits member and public comments during a 16-week comment period via an online tool on the project webpage.

Pre-evaluation Comments

NQF solicits comments prior to the evaluation of the measures via an online tool on the project webpage. For this evaluation cycle, the pre-evaluation comment period was open from December 5, 2019 to January 28, 2020 for the measures under review. NQF received no pre-evaluation comments.

Post-evaluation Comments

The draft report was posted on the project webpage for public and NQF member comment on March 26, 2020 for 60 calendar days. The Standing Committee's recommendations will be reviewed by the Consensus Standards Approval Committee (CSAC) on November 17-18, 2020. The CSAC will determine whether to uphold the Standing Committee's recommendation for each measure submitted for endorsement consideration. All Committee members are encouraged to attend the CSAC meeting to listen to the discussion.

During this commenting period, NQF received 24 comments from 24 organizations/stakeholders:

Member Council	# of Member Organizations/Stakeholders Who Commented
Public/Community Health Agency	17
Provider Organization	6
Consumer	1

We have included all comments that we received (both pre- and post-evaluation) in the comment table (excel spreadsheet) posted to the Committee SharePoint site. This comment table contains the commenter's name, comment, associated measure, topic (if applicable), and—for the post-evaluation comments—draft responses (including measure steward/developer responses) for the Committee's consideration. Please review this table in advance of the meeting and consider the individual comments received and the proposed responses to each.

To facilitate discussion, the majority of the post-evaluation comments have been categorized into major topic areas or themes. Although all comments are subject to discussion, the intent is not to discuss each individual comment on the June 26, 2020 call. Instead, we will spend the majority of the time considering the three themes discussed below, and the set of comments as a whole. Please note that the organization of the comments into major topic areas is not an attempt to limit Committee discussion.

Additionally, please note measure stewards/developers were asked to respond where appropriate. Where possible, NQF staff has proposed draft responses for the Committee to consider.

Comments and Their Disposition

Themed Comments

Three major themes were identified in the post-evaluation comments, as follows:

1. Consideration of disparities during measure development;
2. Measures to support pregnancy intentions; and
3. Utility of survey questions

Theme 1 – Consideration of disparities during measure development

One commenter expressed concerns that the measure did not adequately validate disparities and that certain communities of patients and providers were not part of the development of this measure. Specifically, the commenter found it problematic that the researchers have not named their own identities and positionality with respect to the measure concept. Further, without reassurance that communities of color were part of shaping the PCCC instrument, the commenter suggests that the measure falls short of what could have been produced if people and practitioners of color had been part of the investigative team.

Measure Steward/Developer Response:

We appreciate the comments by Bold Futures and their work to hold us accountable. Below we respond to their specific concerns.

Response to Concern 1: The first question queries the person-centeredness of the fourth question in the PCCC, related to adequate information provision. We agree that we need to dismantle the power dynamic and narrative that is currently entrenched in our medical system wherein providers hold the "answers" and all the knowledge. The purpose of this measure is to highlight that patients hold knowledge about themselves, their lives, their preferences, and their experiences, and that providers must listen to these things, respect them, and center them in the conversation. In crafting the question regarding information provision, we drew from existing literature on person-centered care, and worked to ensure that the questions did not make assumptions about what patients need or want. In the context of this particular question, the language is designed to have the patient reflect, for themselves, whether they received "enough information". In responding to this question, patients can consider the extent to which they wanted information from their provider, what information they wanted from their provider, and what other sources of information they were considering. During the "think aloud" portion of our cognitive interviews with patients used to select items of inclusion in the PCCC, participants were asked to comment on the clarity/difficulty understanding each item, their understanding of its content/theme, and reasons for the score they gave their provider on that item. With respect to this item, participants responded using their own metric of what it looked like to get "enough information" for themselves. Answers ranged from having all their questions answered, getting information about the specific method they were interested in, getting information about all of the methods, having information presented clearly, and getting information that was relevant to their specific situation. This range of responses supports that this measure assesses whether the provider met the patient's information needs from the patient's perspective, without the definition of "enough information" being subject to an externally defined information standard. Similarly, the framing of the question related to whether this information was adequate to allow the respondent to make the "best decision" about their birth control method relies on patients themselves reflecting on what the "best decision" is. We consider the best decision to be the one the patient identifies, rather than anything the provider or other external entity determines. While we appreciate that individuals may interpret this question differently, the validity testing we conducted with patients as part of our measure development process indicated that this question was understandable and considered highly important.

Response to Concern 2: We agree with the need for meaningful attention to diversity of participants in all research, and consider it of the utmost importance in the context of contraceptive care, given the history of reproduction oppression of individuals of color that has occurred in family planning care contexts, such as coercive sterilization. Due to the large number of different samples and data collection strategies in our application to the NQF, we did not include participant characteristics for all phases of the formative and validity and reliability testing. As described in our application, the validity and reliability testing sample for our provider-level testing included 29% Black and 25% Latina or Hispanic participants. We also reference in the application the demographics of participants included in the initial qualitative work, with 24% Black Non-Hispanic/Latina, 24% White Non-Hispanic/Latina, and 52% Hispanic/Latina (see application for further information and other samples). We understand the desire for additional information about the demographics of other phases of the research process, and plan to include in this information in published manuscripts in the future. For the cognitive testing of the measure that informed our selection of specific items for inclusion in the measure, our sample consisted of 9% Black, 76% Hispanic or Latina, 6% American Indian/Alaska Native, 6% Asian/Pacific Islander, and 9% White participants (Note that numbers do not add to

100% as participants could indicate multiple options, and we included an oversample of participants identifying as Hispanic or Latina in order to assess for item equivalence by language).

Response to Concern 3: We agree that recognizing the influence of positionality is critical. The Person-Centered Reproductive Health Program, which led this work, is an academic program directed by Dr. Christine Dehlendorf, a white woman. While we worked to include a range of perspectives in the measure development work, including through collaboration with a patient advisory group, we recognize that having researchers of color lead this work could have resulted in a different result. As a white woman-led program, we are committed to continue to strive to collaborate, step up, and step back, with the goal of lending our voices and effort to the broader effort to advance person-centered, equitable care, and racial justice more broadly.

Proposed Committee Response:

Thank you for your comments. The Committee will review these comments during its deliberations on the Post-Comment Call scheduled on June 26, 2020.

Action Item:

The Committee should review the comments and the developer's response and be prepared to discuss any recommendations for the developer to consider.

Theme 2 – Measure to support pregnancy intentions

Several commenters expressed the need for a measure that captures information regarding women's pregnancy intentions. Specifically, commenters underscored that it is important that there be information provided in the situation where a woman does not wish to have a family planning method but would rather become pregnant.

Measure Steward/Developer Response:

We appreciate the call for attention to the experience of women who desire pregnancy. This current measure is designed to evaluate the experience of women who receive contraceptive counseling during a specified visit, and is focused on that component of care. We agree that many patients, including some patients who receive contraceptive counseling, would want to receive information about achieving healthy pregnancies as well, and the resources suggested are highly valuable. We also agree that future work could focus on additional performance measures that would provide standardized approaches to evaluating the provision of care focused on healthy pregnancies as another component of the experience of reproductive health care.

Proposed Committee Response:

Thank you for your comments. The Committee will review these comments during its deliberations on the Post-Comment Call scheduled on June 26, 2020.

Action Item:

The Committee should review the comments and the developer's response and be prepared to discuss and recommendations to the developer.

Theme 3 – Utility and framing of survey questions

Two commenters expressed concerns regarding the questions used within the measure. Specifically, one commenter stated that the questions were not helpful and that the questions do not include any information related to whether the provider inquired about history of family planning or any previous unintended pregnancy. The commenter further mentioned that the questions do not ask patients about

their sources of information for contraception. Additionally, another commenter had concerns that the framing of certain questions implies that the provider holds the information needed for the patient to make decisions, and this contrary to the patient-centered dynamic.

Measure Steward/Developer Response:

We appreciate this comment, and agree that person-centered reproductive health care requires respect for and attention to the full range of preferences and desires related to reproduction. This particular measure is designed to focus on the experience of those individuals who receive contraceptive counseling, and the extent to which this care is person-centered, including being respectful and responsive to their preferences (which would include preferences related to how to prioritize method effectiveness in relationship to other method characteristics). We agree that an additional consideration for person-centered reproductive health care is how patients' desire for contraceptive counseling is assessed prior to providing this counseling, which is related to the commenter's point about respect for pregnancy intentions, including ambivalent intentions. We encourage additional work to develop measures to assess person-centeredness across the spectrum of engagement with reproductive health care.

The goal of this measure is to capture patients' perspectives on what is important to them about contraceptive counseling, as determined by an extensive process of formative research, stakeholder engagement, and face validity testing. Consistent with other measures evaluating provider behaviors and communication, the intent is to provide a standardized metric of performance providing the opportunity for quality improvement, and not to in any way produce a sense of the provider and the patient being in conflict. The appropriateness of this approach is further supported by face validity testing we conducted with providers, using a modified Delphi process, as described in the NQF application. This process demonstrated consensus that this measure was meaningful and appropriate for use as a performance metric from the perspective of providers.

This comment also references a range of considerations that can contribute to contraceptive counseling and decision making, including sources of information, previous history of contraceptive use, and previous reproductive experiences. While these are important to consider, the current measure is designed to be appropriate for patients to answer regardless of these individual factors. As an example, the measure includes an item assessing whether the provider gave them enough information to make the best decision about birth control. The amount of information that is necessary and appropriate to score highly on this item is determined by the patient, taking into account their history and other sources of information. Similarly, questions about demonstrating respect for the patient, allowing the patient to indicate their preferences, and taking those preferences seriously are all applicable to patients across the range of preferences, experiences, and information sources.

Proposed Committee Response:

Thank you for your comments. The Committee will review these comments during its deliberations on the Post-Comment Call scheduled on June 26, 2020.

Action Item:

The Committee should review the comments and the developer's response and be prepared to discuss whether it wishes to reconsider the recommendation for the measure.

NQF Member Expression of Support

Throughout the 16-week continuous public commenting period, NQF members had the opportunity to express their support ("support" or "do not support") for each measure submitted for endorsement consideration to inform the Committee's recommendations. Several NQF members provided their expressions of support or non-support: See Appendix A.

Appendix A: NQF Member Expression of Support Results

Several NQF members provided their expressions of support/nonsupport. One measure under consideration received support from NQF members. Results for each measure are provided below.

3543 Patient-Centered Contraceptive Counseling (PCCC) (University of California, San Francisco)

Member Council	Support	Do Not Support	Total
Public/Community Health Agency	14	3	17
Provider Organization	5	1	6
Consumer	1	0	1