CBE ID

3543

Title

Person-Centered Contraceptive Counseling [PCCC] measure: The percentage of contraceptive care patients giving “top box” scores on a PRE-PM focused on quality of contraceptive care at a specific visit

Project

Primary Prevention

Endorsement Status

Endorsed

Is Under Review

Yes

Next Maintenance Cycle

Spring 2026

Previous Endorsement Cycle

Fall 2019

Initial Endorsement

Fri, 11/20/2020 - 07:44

Steward

University of California, San Francisco

1.0 New or Maintenance

Maintenance

1.1 Measure Structure

Single Measure

1.3 Electronic Clinical Quality Measure (eCQM)

No

1.6 Measure Description

The measure is a PRE-PM that calculates the percentage of contraceptive care patients who give a “top box” score for their experience of contraceptive counseling received during their clinical encounter. The measure is a four-question survey which asks patients about key components of patient-centered counseling, including respect and adequate information. A “top box” score is defined as a response which gives the highest score for each of the four questions.

1.6a Material Specification Change(s)

Yes

1.6b Summary of Specification Changes

Due to data availability issues, we are unable to obtain recent data and are thus unable to submit updated testing required to maintain endorsement at the individual clinician level and have removed that level of analysis.

Since the time of our original endorsement, we have been made aware that our measure and the level at which it is collected, analyzed, and interpreted is more correctly categorized as clinician: group/practice than facility. We have therefore updated this specification to indicate this unit of analysis.

We have updated the age range of eligibility from 15-45 years to 15-44 years for the measure to align with other contraceptive care measures (e.g. CBE #2902, 2903, 2904, 3699, 3682)

1.7 Measure Type

Patient-reported Experience Performance Measure (PRE-PM)

1.8 Level of Analysis

Clinician: Group/Practice

1.9 Care Setting

Ambulatory Care: Clinic, Ambulatory Care: Clinician Office, Ambulatory Care: Office, Clinician Office/Clinic, Other

1.9b Other Care Setting

Community health centers

1.10 Measure Rationale

Contraception is utilized by 90% of women in their lifetimes [1], making contraceptive care a crucial and in-demand healthcare service. However, many gaps exist in access to high-quality contraceptive care. Patients also reported receiving information from their providers that was inadequate to support them in making an informed decision on contraception [2–5], and patients felt dissatisfied with the person-centeredness and adequacy of counseling overall [5–8]. Thus, when assessing quality of contraceptive care, patient experience is an important outcome to measure. Moreover, it is highly valued by patients[2] and is a critical component of patient-centeredness, a core aspect of care quality as defined by the National Academy of Medicine (previously Institute of Medicine) in its report, Crossing the Quality Chasm [9]. Additionally, patient-centeredness of contraceptive counseling has been demonstrated to be associated with contraceptive continuation at six months and use of one’s preferred method [10,11], indicating a relationship between patient experience of counseling and the ability of patients to achieve their own reproductive goals, including pregnancy prevention. Patient experience has also been linked to improved engagement with care in various contexts [12,13]; in the context of contraceptive care, this means that patients who receive patient-centered care may feel more able to continue engaging with the reproductive health care system not only for contraception but also if and when

they become pregnant and/or give birth [14] and for their other reproductive health needs. As such, positive patient experience of contraceptive counseling can support positive pregnancy and birth outcomes such as reduced maternal mortality.

Given the important implications of patient-centeredness of contraceptive counseling, both for patient experience and reproductive health outcomes, many healthcare organizations are invested in gathering information on the experiences of their patients and improving those experiences at various levels of aggregation. The Person-Centered Contraceptive Counseling measure (PCCC) (CBE #3543) is a four-item patient-reported experience performance measure (PRE-PM), informed by qualitative work with patients, the input of healthcare experts, and a patient stakeholder group that is designed to give accountable entities an opportunity to understand the quality of their patients' experience of contraceptive counseling.

The PCCC measure collects information on the quality of care at a specific encounter and is designed for use at the clinician group/practice level. Use of this measure centers the importance of positive patient experience as a measure of quality, and its use encourages providers to invest in high-quality contraceptive care practices. While the PCCC can be used as a stand-alone measure, the measure exists in an ecosystem of person-centered measures working to improve the quality of contraceptive services. This includes measures of contraceptive use and provision, as well as of screening for contraceptive need. Widespread use of validated performance measures for contraceptive care in diverse care contexts has the potential to improve patient experience and reproductive outcomes, particularly in underserved populations. As improvement in the quality of contraceptive care has been shown to improve people's ability to identify methods that they can use over time and to promote engagement with health care across the reproductive life course [15–17], this will improve people's reproductive outcomes and therefore would also be expected to have a positive impact on health care costs.

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1.11 Measure Webpage

https://pcccmeasure.ucsf.edu/

1.13 Data Dictionary

Not attached. I attest that all information will be provided where codes and/or value sets are needed (1.14a - 1.15c).

1.14 Numerator

The PCCC is a visit-specific measure of patient-centeredness in contraceptive counseling. It specifically measures how many patients 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. Identification in the numerator is determined by patient response to the PCCC.

1.14a Numerator Details

Identification in the numerator is determined by patient response to the PCCC. The numerator includes only those patients who gave a top-box score for their experience with their health care provider on the PCCC. All other conditions determining inclusion in the numerator also determine inclusion in the denominator.

1.15 Denominator

The target population for the PCCC is patients aged 15-44 years who were assigned female at birth, who are not currently pregnant, and who received contraceptive counseling as part of their recent visit.

1.15a Denominator Details

For the purposes of eligibility screening, patient age, sex, and pregnancy status are determined though patient report to their provider or clinic in the normal course of their care. As these are standard, readily available elements of patient data, entities may rely on their own data to determine eligibility, with the exception if receipt of contraceptive counseling, which is not a standard or readily available element of patient data. Eligible patients are identified through one of two pathways:

1) On the day of appointment: Patients who potentially received contraceptive counseling during their visit are identified by providers and/or staff. This assessment can either happen prospectively (prior to clinical appointment) or retrospectively (after the visit is completed).

Specifically, patients are identified through a standardized process that includes pre-emptive staff review of schedules and visit types (e.g. flagging future family planning visits for survey distribution, as contraceptive counseling is likely to take place in such visits), and/or provider or staff identification based on the exam room conversation, depending on clinic protocols and flow. The survey can then either be distributed: 1. on paper as the patient completes their visit; 2. electronically through a QR code, link or tablet provided in clinic; and/or 3. through a message sent over the patient's portal at the completion of the visit. In the latter case, the survey is considered valid if completed within a week of the appointment.

2) Weekly recruitment: On a weekly basis, all patients with a clinical encounter in the past week, who have an electronic health record (EHR)-recorded sex as female and are between the ages of 15-44 years and not receiving prenatal care receive a request through a patient portal message or text to complete the survey within a week.

In both cases, the patient will then self-identify eligibility. Specifically, at the start of the survey, patients answer the following eligibility question: "Did you talk about options for birth control during your visit?" As the PCCC is intended to measure the quality of counseling for those who did receive counseling, patients who report that they did not receive counseling are not eligible to respond to the PCCC scale, regardless of whether counseling may have been appropriate during their visit.

1.15b Denominator Exclusions

Patients are excluded if 1) they did not receive contraceptive counseling, 2) are younger than 15 years old or older than 44 years old, 3) if they are currently pregnant.

We have chosen an age range of15-44 years to be consistent with other contraceptive measures (CBE # 2902, 2903, 2904, 3682e, 3699e). This range captures the majority of women of reproductive age who will receive contraceptive counseling.

Pregnant patients are excluded from the denominator for two reasons. First, contraceptive counseling in the context of pregnancy is distinct from that provided to non-pregnant individuals. Specifically, perinatal contraceptive counseling often includes multiple conversations touches over the course of prenatal care and immediate postpartum care. This is appropriate as women, when pregnant, are not immediately at risk of an undesired pregnancy, and therefore there is less time sensitivity to this counseling and is also consistent with women's preferences for this care [1]. Given this difference in structure of counseling for pregnant women, the use of a visit-specific measure for contraceptive counseling is not appropriate. Second, given distinct issues related to

post-partum contraceptive use, including increased risk of blood clots, effect on lactation, and the health impact of birth spacing, counseling pregnant women about future contraceptive use has components distinct from that of non-pregnant women. For these conceptual reasons, the PCCC was designed for use with non-pregnant patients and has not been extensively tested with pregnant patients to determine whether it accurately captures their needs and desires for counseling.

References

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1.15c Denominator Exclusions Details

Staff and providers are instructed not to distribute the survey to patients who have disclosed or discovered during the visit that they are pregnant or to patients outside of the designated age range or sex. When recruiting patients through the EHR, the clinician group/practice can exclude by recruitment strategy by only sending the survey only to patients identified as female, within the designated age ranges and who are not receiving prenatal care. At the start of the survey, patients answer the following eligibility question: “Did you talk about options for birth control during your visit?” Respondents who report no contraceptive counseling are excluded.

1.15d Age Group

Other

1.15e Age Range in Years

15-44 years

1.16 Type of Score

Rate/proportion

1.17 Measure Score Interpretation

Better performance = Higher score

1.18 Calculation of Measure Score

Measure users should follow these steps in order to obtain measure results:

1) Identification and data collection

Eligible patients are identified through one of two pathways:

a) On the day of appointment:

i) Providers and/or staff identify eligible, non-pregnant patients who have received contraceptive counseling before they leave the clinic following their visit

ii) A team member who is not the provider who provided counseling introduces and distributes the survey to the patient following their visit and/or sends a message through the patient's portal

iii) Patient completes the survey immediately post-visit or within a week of their appointment

(self-administered via paper or electronically, e.g. on a tablet computer)

b) Weekly recruitment:

i) On a weekly basis, all patients with a clinical encounter in the past week, who have an EMR-recorded sex as female and are between the ages of 15-44 years and not receiving prenatal care receive a request through a patient portal message or text to complete the survey.

ii) Patient completes the survey electronically within a week of receiving the survey

2) Data aggregation

a) Patient responses are aggregated for analysis, either through data entry of paper surveys or collation of responses to electronic survey

3) Measure calculation

a) Patients who indicate they did not receive contraceptive counseling are excluded

b) Incomplete PCCC responses are excluded

c) Measure responses are summed as the total of all PCCC item values (maximum value of 20)

d) PCCC value sums are dichotomized as a maximum value of 20 (top-box score) versus any value less than 20

e) Dichotomized result variable is examined at clinician group/practice level

f) Measure result is calculated as the percentage of patients responding with a top-box score, divided by the total number of patients who gave any response to the survey, on a clinician group/practice level

1.19 Measure Stratification Details

The measure is not stratified

1.20 Types of Data Sources

Patient-Reported Data and/or Survey Data

1.20c Format: Patient-Reported Data and/or Survey Data

Non-digital

1.21a Data Collection Tool URL(s)

https://pcccmeasure.ucsf.edu/document/pccc-survey-english-pdf, https://pcccmeasure.ucsf.edu/document/pccc-survey-spanish-0

1.22 Proxy Responses

No

1.23 Survey Respondent

Patient

1.24 Data Collection and Response Rate

Eligible patients for the survey are identified in two ways: 1) Patients receiving contraceptive counseling during their visit are identified by providers and/or staff, and patient identification is then communicated to the team member responsible for distributing the PCCC survey to patients. A team member who did not provide contraceptive counseling during the patient visit introduces and distributes the survey to patients, in order to mitigate the risks of social desirability bias and perceived threat to privacy affecting patient responses, as could happen if the same individual who gave counseling were to distribute the survey. 2) The survey is distributed through patient portal message and/or text post-visit and/or to all patients with female sex and documented age between 15-44 years not receiving prenatal care who had an appointment in the previous week. We have assessed whether performance scoring could be affected by recall bias between survey completion on the day of appointment and survey completion delayed by one week through examining scores from a subset of clinician group/practices that switched collection strategies, allowing for a natural experiment. In one entity, performance score was 88% among patients who completed day-of and 86% among patients who completed the survey within a week-post. For the second entity, score was 86% among patients who completed day-of and 90% among patients who completed the survey within a week. In both cases, scores were comparable assessments of performance and there was not consistent directionality in score shifts, and thus not consistent biasing in one direction.

In both verbal and written communication to patients, the anonymous nature of the survey should be emphasized, with assurance that answers to the survey will not be linked to the individual patient and would not impact care. The survey is self-administered either on paper or electronically.

The response rate is calculated as the number of patients to whom a survey is administered who return a completed survey, divided by the number of patients approached to complete a survey

1.25 Data Source Details

NA

1.26 Minimum Sample Size

The PCCC is collected using consecutive sampling for identified clinician group/practices. Based on our reliability results reported in section 5 of this application, we recommend a minimum sample size of 30 responses per clinician group/practice

2.1 Attach Logic Model

Logic-model_508.pdf

2.2 Evidence of Measure Importance

There are demonstrated gaps in the quality of contraceptive counseling. Analyses utilizing the 2017-2019 wave of National Survey of Family Growth (NSFG), which include a retrospective version of the PCCC (PCCC-RS) found that only 58% rated quality of contraceptive care received over the last year as optimal, demonstrating a gap nationally [1]. A similar national survey conducted by KFF in 2022 and 2024 demonstrates the persistence of this issue; they found only 40% and 42% of respondents reported optimal counseling respectively using the PCCC [2,3]. Use of the PCCC measure (CBE #3543) in a quality improvement context in 2022-2023 found a range of scores from 30% to 95% at the health center level in community health centers across the country, suggesting differential care at the clinician group/practice level [4]. To understand gaps in quality, studies have explored inadequacies in contraceptive counseling. In multiple studies examining patient experience of counseling, patients reported receiving information from their providers that was inadequate to support them in making an informed decision on contraception [5–8], and that patients felt dissatisfied with the patient-centeredness and adequacy of counseling overall [8–11]. Research conducted by our team at UCSF examining quality of counseling via audio recording of patient visits found that providers inconsistently elicited or engaged with patient experiences and preferences during counseling [12,13].

Gaps in quality of contraceptive care are experienced differently by different patient subgroups. Analyses using the PCCC-RS integrated into the 2017-2019 wave of the NSFG have

found lower scores among Black, Spanish-speaking Latine, low-income, and gay and bisexual patients [1,14]. Analyses of the latest wave (2022-2023) of NSFG data are nascent, however, one analysis of this same retrospective PCCC found low scores (50%) across all age groups, with adolescents ages 15-19 years having lowest odds of reporting receiving high-quality contraceptive counseling [15]. The 2024 KFF survey reported income disparities similar to those found in the 2017-2019 NSFG analyses (using a similar retrospective measure), and a multi-state longitudinal study conducted from 2018-2023 found similar differences by race/ethnicity [3,16]. Other studies have surfaced indications that poor quality of contraceptive care is differentially experienced by women of color, such as findings that low-income women of color have greater odds of being advised to limit their childbearing [17] and receive a greater emphasis on highly effective methods from providers [11,18]. A randomized controlled trial explored this dynamic explicitly by using a standardized patient approach and found that providers were more likely to recommend an intrauterine device – a provider-controlled option - to standardized patients identified as low-income Black or Latina compared to those identified as white [19]. This is further elucidated in qualitative research, where Black, Latine and low-income patients describe themes of discriminatory and/or coercive contraceptive care practices [20–24]. Scholars have highlighted that these differential practices are rooted in a longstanding history of racial and class discrimination and systemic oppression [25–28]. Thus measuring and monitoring quality of contraceptive counseling is important to address healthcare disparities and promote health equity.

Patient experience is an outcome meaningful and important to patients and aligned with positive health outcomes. Patient experience is an important outcome to measure, in that it is highly valued by patients [5] and is a critical component of patient-centeredness, a core aspect of care quality as defined by the National Academy of Medicine (previously Institute of Medicine) in its report Crossing the Quality Chasm [29]. Further, a large body of evidence demonstrates how patient experience is associated with a range of health outcomes, structures, and processes. This includes two systematic reviews (one UK-based [30] and one US-based [31]), which both found that patient experience was positively associated with outcomes such as seeking and adhering to preventive care treatments, and positive clinical health outcomes, including self-rated health, engaging in health-promoting behavior, and primary care utilization. In addition, a 2009 meta-analysis of 127 studies documented that the quality of provider communication, which is the specific aspect of patient-centeredness measured by the PCCC, was directly associated with patient treatment adherence [32].

Patient experience of high-quality contraceptive counseling enables patients to meet their reproductive goals. In the context of contraceptive care specifically, the patient-centeredness of contraceptive counseling is associated with contraceptive continuation and satisfaction [33,34]. By working to improve patient experience, health care entities can therefore help support their patients achieve their reproductive goals, such as pregnancy prevention. Further, qualitative data suggests that patients who experience non-patient-centered contraceptive care are less likely to return to seek out care for future reproductive health needs [20,35]. This has the potential to negatively impact a range of outcomes, including pregnancy-

related morbidity and mortality.

The PCCC provides the ability to monitor contraceptive counseling alongside measures of provision and use in order to provide a more comprehensive picture of contraceptive care quality. The motivation behind the development of the PCCC originated during the Department of Health and Human Services Office of Population Affair's (OPA's) development of measures CBE #2903 and #2904, which focus on most and moderately effective contraception and long-acting reversible contraceptive (LARC) methods. The OPA team and others involved in the measure development process foresaw that use of these important measures could have the unintended consequence of incentivizing provider pressure on patients to use more effective methods and away from use of prescription methods. During the Consensus-Based Entity endorsement process, this concern was voiced by stakeholders, including the National Partnership for Women & Families (NPWF). The NPWF submitted a public comment that stated, "It is extremely important to keep in mind that reproductive coercion has a troubling history, and remains an ongoing reality for many, including low-income women, women of color, young women, immigrant women, LGBT people, and incarcerated women. We hope this measure will be paired with a woman-reported 'balancing measure' of experience of receiving contraceptive care. Such a measure can be expected to help identify and/or check inappropriate pressure from the health care system." Since this time, additional person-centered electronic clinical quality measures assessing contraceptive use have been endorsed at the facility and clinician group/practice levels (CBE# 3699e and 3682). The PCCC continues to serve as an important balancing measure to ensure that evaluation of contraceptive care quality includes consideration of how the care was delivered in addition to access to methods.

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2.4 Performance Gap

Performance data were derived from three quality improvement projects completed between 2022 and 2024. The first was a quality improvement learning collaborative with ten community health centers, with PCCC data collection from June-September 2022. The second was an implementation project conducted with the state Title X recipient and collecting data from 13 Title X subrecipient clinician group/practices in one northeastern state from March 2024-June 2025. The third source of data was an implementation project with 12 Title X agencies across the U.S., with data collected from June-September 2024. In all cases the PCCC was fielded as a standalone patient survey using the data collection methods described in section 1.18. In entirety, this includes 35 accountable entities and 2,022 patients.

Table 1. Performance Scores by Decile

	Overall	Min	Decile 1	Decile 2	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10	Max
Mean Performance Score	0.728	0.370	0.383	0.523	0.683	0.712	0.763	0.833	0.868	0.886	0.895	0.966	1.00
N of Entities	35	1	3	4	3	4	3	4	3	4	3	3	1
N of Persons / Encounters / Episodes	2022	62	162	179	142	201	152	140	250	192	206	398	40

2.6 Meaningfulness to Target Population

The choice of a contraceptive method is a highly preference-sensitive decision with multiple medically appropriate options. Each patient has unique preferences regarding key contraceptive method attributes, such as pregnancy prevention, side effects, and menstrual cycle changes. Research also shows the patient experience is influenced by historical and ongoing forceful and coercive practices of pressuring patients, particularly low-income patients and Black and Latine patients, to use contraceptive methods that they do not want [1–6]. The PCCC (CBE#3543) was specifically designed with patient and provider stakeholder input to reflect the individualized nature of contraceptive counseling and ensure that patient-centered care is prioritized, which can help safeguard against care inequities.

Specifically, the PCCC was derived from the Interpersonal Quality of Family Planning scale (IQFP) [7]. The IQFP is a validated 11-item scale of patient experience of contraceptive counseling that addresses three domains of contraceptive counseling preferences: interpersonal connection, decision support, and adequate information. These domains and items were elucidated though qualitative interviews with patients [8]. To create the PCCC, a short form of the IQFP, we conducted cognitive interviews with 33 patients (10 in English, 13 in Spanish, and 10 with bilingual participants with substantial discussion in both languages) to understand which items held the greatest relevance and importance to patients [9]. The items included in the final measure were those that held greatest importance to patients while also continuing to reflect the domains of patient importance identified in the IQFP, as well as maintaining the scientific validity and acceptability.

We tested the relevance of these qualities of the measure through iterative engagement with the Person-Centered Reproductive Health Program's Patient Stakeholder Group (PSG). The PSG, a standing group individuals assigned female at birth, provided critical feedback on survey elements, ensuring accessibility and relevance. All members of the PSG confirmed that providing feedback on their healthcare experiences with contraceptive counseling at a population level is meaningful, as it informs system-level improvements.

Overall, our patient engagement and review of the literature demonstrates that the target population values the measured outcome and finds the feedback process meaningful in enhancing contraceptive counseling experiences.

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3.1 Contributions Towards Closing Care Gaps

Evidence of Known Differences

Patient experience of quality contraceptive care is important because it enables patients to meet their reproductive goals, including through contraceptive continuation and satisfaction and continued engagement in reproductive health care [1–4]. Therefore, measuring and monitoring the quality of contraceptive counseling is important to address healthcare disparities. Professional guidelines such as from the American College of Obstetricians and Gynecologists, the Women's Preventive Services Initiative, as well as the Quality Family Planning Recommendations issued by the Office of Population Affairs have emphasized the importance of person-centered contraceptive counseling [5–7].

Differential experiences of contraceptive care have been well-documented, highlighting key care gaps. Studies have shown that poor quality of contraceptive care has differentially experienced by women of color, such as low-income women of color having greater odds of being advised to limit their childbearing [8] and that providers put greater emphasis on highly-effective methods when counseling of women of color [9,10]. A randomized controlled trial further explored this dynamic by using a standardized patient approach and found that providers were more likely to recommend an intrauterine device – a highly effective, provider-controlled method - to

standardized patients identified as low-income Black or Latina than those identified as white [11]. This is further elucidated in qualitative research, where Black, Latine and low-income patients describe themes of discriminatory and/or coercive contraceptive care practices [1,12–15]. Scholars have highlighted that these differential practices are rooted in a longstanding history of racial and class discrimination and systemic oppression [16–19].

Given this differential care, in our initial PCCC application in 2019, we explored differences in PCCC performance scores by race and ethnicity and language. Since our initial application, the Person-Centered Contraceptive Counseling measure (PCCC) has been used to surface and address these gaps in care quality, highlighting persistent differences in reported care quality and highlighting additional subgroups reporting lower rates of high-quality care. Analyses using a retrospective version of the PCCC integrated into the 2017-2019 wave of the National Survey of Family Growth found lower scores among Black and Spanish-speaking Latine individuals, consistent with our analysis in our initial application, as well as lower rates of high-quality care reported by low-income, and gay and bisexual individuals [20,21]. A multi-state longitudinal study conducted from 2018-2023 found similar differences [22]. An analysis by KFF in 2024 also noted differences in reported PCCC by income [23]. Moreover, a recent analysis from the 2022-2023 wave of NSFG data found persistently low scores by Black respondents, low English proficiency respondents and low-income respondents [24]. Another analysis of NSFG data found more specifically that English language proficiency was predictive of receiving higher quality care [25], which is consistent with data from our initial application.

In this maintenance application, we also report additional subgroups where differences in quality of contraceptive counseling has been reported (age category, sexual orientation) [20,26]. We also assessed scores by disability status, given evidence of barriers to high quality contraceptive care among people with disabilities, including coercion [27–29]. While there is evidence that low-income patients are less likely to report high-quality care, we were unable to explore this, as income data has not collected alongside the PCCC in the available data.

Testing Methods

To empirically test differences in performance scores across identified subpopulations:

1. We used self-reported demographic variables collected alongside the PCCC, which included patient race or ethnicity, age, disability status, and sexual orientation. For disability status, patients responded to a binary question: “Are you a person with a disability or chronic illness/condition that impacts your learning, working or living activities?” Thus responses are binary in nature. For sexual orientation, we collapsed responses of “gay or lesbian”, “bisexual”, ”queer”, “pansexual” and “asexual” into a “non-heterosexual” category. Experiences of differential care have been similar across these groups and a binary analysis gave us greater power.
2. We used chi-square tests of independence to assess the difference in measure performance across subpopulation categories.
3. We analyzed tests of independence and associated probabilities to determine whether any observed variations in performance across subpopulations were statistically significant.
4. We compared scores to those reported in the PCCC’s initial endorsement application, which

was submitted to the National Quality Forum in 2019 by age category, race/ethnicity, and language. Data on sexual orientation and disability status were not collected in the 2019 sample, and thus we are unable to complete the comparison.

Results and Interpretation

Information on clinician group/practices included in these analyses and data collected, please see section 5.1.1. Performance score results by subgroups can be found in Section 7: Supplemental materials, Table 1.

Performance scores varied significantly across racial/ethnic groups (chi-square probability = <0.0001), with White (31% of the population, with a performance rate of 86%) and Asian (3% of the population, with a performance rate of 86%) respondents reporting the highest scores and Latina/Hispanic (40% of the population, with a performance rate of 77%), Black/African American (16% of the population, with a performance rate of 70%),and Middle Eastern (<1% of the population, with a performance rate of 65%), reporting the lowest. Scores within most racial/ethnic categories were consistent (within 5 percentage points) with 2019 reporting, apart from the score from the Asian subgroup (74% in 2019 v. 86% in 2026).

Differences by language spoken were also significantly different (chi-square probability: <0.001) with English speakers more often reporting highest score (80% of the population, with a performance rate of 80%) compared to Spanish speakers (19% of the population, with a performance rate of 74%) and other language speakers (<1% of the population, with a performance rate of 44%). Rates among English speakers were comparable but slightly lower when compared to 2019 (84% in 2019 v. 80% in 2026). and higher among Spanish speakers (68% in 2019 v. 74% in 2026). Comparing these results to our testing during the initial application, there have been slight changes in the performance scores from 2019 to 2026, but none of the population scores in the subpopulations demonstrated statistically significant changes at the 0.05 level. This indicates that performance gaps persist between racial and ethnic groups and by language spoken.

No statistically significant differences in scores were found by age category, sexual orientation, or disability status.

Limitations. We note that in our data sample, there were small cell sizes across a number of subpopulation categories. Scores from within these subcategories may be unreliable. For comparison between 2019 and 2026 submissions, we note that scores are not from the same accountable entities and thus are not directly comparable and differences in scores between these two time periods should be interpreted with caution.

Anticipated impact

Results among a diverse set of health centers suggest differences in quality of care experienced by different racial and ethnic groups and different language speakers persist. We note that these data do not come from the same accountable entities as those reported in the initial endorsement application and thus are not directly comparable, however they do highlight the prevalence and

consistency of gaps in care delivery to specific groups.

Exposure to lower-quality contraceptive care may result in these groups being less supported in choosing a contraceptive method and/or pressured to utilize a contraceptive method that they do not want to use, extending a long history of reproductive oppression in healthcare as described above. Alternatively, this poor-quality care may result in these groups not using desired contraception due to negative care experiences. We know that quality of contraceptive counseling is associated with contraceptive continuation and satisfaction [3,30], suggesting that patients are less likely to have their pregnancy prevention needs met in the way they want [24]. One analysis found an association between low quality care and experiencing cost barriers to contraception [31]. Longer term, this may impact patients' overall engagement in reproductive healthcare [1,4], which may have negative impact a range of outcomes, including pregnancy-related morbidity and mortality for these groups.

Accountable entities can use these findings to identify healthcare disparities and provide resources to improve care for groups within their clinician group/ practices. This may include training providers on person-centeredness of contraceptive counseling practices using a shared-decision-making approach, as well as providing trainings to address bias and deepen understanding and practice of cultural responsiveness and humility.

Accountable entities should also tailor their approaches to contraceptive counseling to the cultural and linguistic needs of the populations they serve. This may be achieved by engaging with patient groups to identify gaps in quality of care and quality improvement targets.

In a quality improvement collaborative, the PCCC was collected before and after a health equity-informed intervention that included targeted quality improvement to improve baseline PCCC scores [32]. Five out of nine participating CHCs improved their scores, in a range of 2.1% - 26.2% after the intervention. This included an improvement of 8.8% among Black patients across all agencies. We published case studies that highlight examples from two of those clinician group/practices: one with focused on improving universal screening and training in person-centered contraceptive counseling, and the other working to improve care delivery to their Spanish-speaking patients by examining and improving the cultural responsiveness of their contraceptive counseling practices. Both of these clinician group/practices improved their overall PCCC scores and scores by racial and ethnic subgroups [33].

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4.1a Data Structure and Availability

The Person-Centered Contraceptive Counseling measure (PCCC) is a patient-reported experience performance measure (PRE-PM) collected through patient surveys; measure calculation is based solely on information provided by patients responding to the instrument and thus cannot be captured from existing electronic sources. Accountable entities identify patients who may have received contraceptive counseling, have a documented female sex, are between 15-44 years and are not currently pregnant. Survey distributors can distribute the survey to patients in clinic on the day of their appointment or utilize their patient portal to identify patients and send them the survey to complete within a week of their appointment. The survey includes an eligibility question (“Did you and your provider talk about your birth control options during your visit?") to identify patients eligible to answer the PCCC survey question. Patients’ PCCC responses may be captured using electronic or paper collection with all eligible patients who report receiving contraceptive counseling receiving the survey. There have been no changes to the measure specifications since the initial application.

We acknowledge that there is the potential for some missing data, given that procedures require administration of a patient-reported outcome measure that is not generally part of routine care. However, missing data has not exceeded 5% in all applications that we are aware of. The brevity of the survey was intentional to mitigate patient burden and facilitate high completion rates.

Additionally, we believe the PCCC has limited susceptibility to inaccuracies. The measure was developed at a 3rd grade reading level and has been well-validated in English and Spanish, with proven face and content validity. The parsimonious nature of the measure, comprised of clear, positively-worded items, suggests it unlikely to be affected by survey-fatigue-related or comprehension-related inaccuracies in self-reported data. Further, the anonymous survey collection minimizes social desirability bias. Data entry errors (from paper responses) can be minimized via double data entry or validation scripts. In electronic formats, entry errors are virtually eliminated.

4.1b Implementation Costs and Burden

The PCCC is designed to be low-burden on patients and to be administered by nonclinical staff. Thus the PCCC does not affect clinician workflow, nor does it interfere with diagnostic decisions, provider-patient interactions, or documentation processes.

Barriers and mitigation strategies

Reports from healthcare entities have identified some implementation barriers to PCCC collection.

Staff time and integration into healthcare team workflows. Agencies have reported costs in staff time dedicated to survey collection, data entry, and analysis. Since it is not appropriate for the clinical provider to administer the survey, staff must be designated with the role of data collection. Moreover, communication needed between provider and support staff about who received contraceptive counseling can be an added burden on workflow. However, multiple strategies have been leveraged to reduce this resource burden. Integrating the PCCC into existing patient experience surveys used by clinician group/practices, and/or leveraging existing infrastructure, such as posting notes in the EHR or sending the survey via post-visit patient portal messages, streamlined staff effort in administration. Collecting surveys by electronic means, such as a survey platform (e.g. Qualtrics) decreased data entry burden generated from paper survey collection.

Patient engagement. The PCCC requires patient participation in the completion of the brief survey. Some agencies have reported challenges with patient engagement. Strategies employed to improve patient responsiveness include: sending follow-up texts to patients post-visit, leveraging multimodal data collection strategies, posting QR codes with a link to the survey in the exam room, and encouraging completion at the time of visit.

No barriers have been reported related to PCCC interpretation. The measure is simple to

calculate and has a clear higher-is-better interpretation. Actions to improve scores are described in section 6.

4.1c Confidentiality

PCCC is designed to be administered as an anonymous survey in order to minimize social acceptability bias. Implementation guidance highlights that the survey should not be collected by the same person who conducted the contraceptive counseling and that survey should never be connected to the patient's electronic health record. Thus, PCCC data collection presents no confidentiality concerns.

For data reporting, the recommended panel size of 30 is sufficient to protect unintentional identification of specific patients. If, for quality improvement purposes, clinician group/practices choose to report PCCC scores disaggregated by patient demographics, we advise that scores are not reported for subgroups with fewer than 5 observations in order to both protect patient confidentiality and to increase reliability of subgroup scores.

4.3 Feasibility Informed Final Measure

Since its initial application, we made changes to the levels of analysis, specifically removing individual: clinician level and replacing facility level with clinician group/practice level. The former was due to the steward's limited ability to gain recent data with which to conduct updated testing and the latter was as a correction to our prior application, as we recognized that our testing and attribution was in fact more appropriately described as clinician group/practice. We also adjusted the eligible age range from 15-45 to 15-44 years to align with other contraceptive care measures. None of these updates were made due to feasibility issues or feedback.

Feasibility strengths of the measure include its short length (4-items), use of plain language, flexibility in terms of collection modality, and simple scoring.

Based on feedback received from the field, we continue to assess the feasibility of the measure and adjust implementation guidance as needed. To support fidelity in and ease of implementation, we provide templates and tutorials on data collection, analysis, and interpretation.

4.4 Proprietary Information

Not a proprietary measure and no proprietary components

5.1.1 Data Used for Testing

Data used for reliability testing as well as performance gap and closing the care gap analyses (section 2.4 and 3) were derived from three quality improvement projects completed between 2022 and 2024. The first was a quality improvement learning collaborative with ten community health centers, with PCCC data collection from June-September 2022. The second was an implementation project conducted with the state Title X recipient and collecting data from 13 Title X subrecipient clinician group/practices in one northeastern state from March 2024-June 2025. The third source of data was an implementation project with 12 Title X agencies across the U.S., with data collected from June-September 2024. In all cases the PCCC was fielded as a standalone patient survey using the data collection methods described in section 1.18.

Data for validity testing were collected as part of a statewide evaluation of a contraceptive access initiative and were embedded in a broader survey, which was fielded to patients at 24 clinician group/practices in two states ending in Winter 2021. Patients were invited to complete the survey by a staff member from clinic waiting rooms/check in areas prior to their appointment, then completed a survey that included the PCCC post-visit electronically on a tablet.

5.1.1a Dates of Testing Data

Project 1: June-September 2022

Project 2: March 2024-June 2025

Project 3: June-September 2024

Statewide evaluation: October 2018- December 2021

5.1.2 Differences in Data

We used the composite dataset derived from three quality improvement projects for reliability testing, for performance gap analysis in section 2, and for the closing care gaps analysis in section 3.

The PCCC is commonly fielded as a standalone measure. As a result, available data does not routinely include the additional items needed for accountable-entity validity testing. We were able to use data from a statewide evaluation for validity testing. However, this source used a variation of the response options for the PCCC. Specifically, the questions stems were phrased as declarative statements instead of questions and the standard response options for the currently endorsed PCCC are “Poor”, ”Fair”, “Good”, “Very good”, and “Excellent”, whereas in this survey, it used a Likert response option array of “Disagree” “Slightly disagree”, “Moderately agree”, "Very much agree”, and “Completely agree."

5.1.3 Characteristics of Measured Entities

Our sample for reliability testing included 35 clinician group/practices. Clinician group/practices were from 18 states distributed across all regions of the U.S., with the majority in the Northeast: 56% Northeast, 19% Midwest, 12% Southwest, 9% Northwest, and 3% Southeast. Seventeen clinician group/practices were primarily sexual and reproductive health-focused clinician group/practices, 15 were primary care health centers, and 2 were school-based health centers. Clinician group/practices ranged in size and volume, serving between approximately 2,600 and 62,000 patients annually.

Our sample for validity testing included 24 clinician group/practices, including 10 located in South Carolina and 12 in Alabama. Seven were Federally Qualified Health Centers and 17 were Health Department practices. Clinician group/practices ranged in size and volume, serving between approximately 1,900 and 6,500 annually.

5.1.4 Characteristics of Units of the Eligible Population

The characteristics of the patient respondents by clinician group/practice are provided in Section 7, Supplemental Tables 2a and 2b.

Overall, across the sample used for validity testing, the average age was 28 years. By race and ethnicity, 16% identified as Black or African American, 40% identified as Latina or Hispanic, 31% identified as White, 3% identified as Asian, 7% identified as Multi-racial, less than 1% identified as Native Hawaiian/Pacific Islander, Native American or Alaska Native, or Middle Eastern or Arab, and 2% identified as some other race. Eighty percent completed the survey in English, 19% completed the survey in Spanish, and 1% completed in some other language. Seven percent identified as a person with a disability and 26% identified as gay, lesbian, bisexual, or some other queer identity.

Across the sample used for validity testing, the average age was 26 years. By race and ethnicity, 50% identified as Black or African American, 41% identified as Latina or Hispanic, 31% identified as White, 12% identified as Asian, 1% identified respectively as Native American or Alaska Native or with some other race/ethnicity, and less than 1% identified as Pacific Islander. Twelve percent identified as gay, lesbian, bisexual, or some other queer identity. Data on survey language completion was unavailable and disability status was not collected.

5.2.1 Level(s) of Reliability Testing Conducted

Accountable entity level (i.e., measure score) (e.g., signal-to-noise analysis)

5.2.2 Method(s) of Reliability Testing

Accountable entity reliability

For both conceptual and analytic reasons, our calculation of the performance score used a dichotomous scoring system, in which all surveys reporting the highest rating (20/20) was given for all four questions are considered a positive score, whereas any survey in which a less-than-optimal rating on any of the four questions is considered a negative score. To assess accountable entity reliability, we used the signal-to-noise method suggested by Nieser and Harris [1]. Signal-to-noise is used to estimate how much of the variation in performance scores is due to actual difference between entity performance (signal) and random variation or measurement error (noise). This signal-to-noise ratio ranges between 0 when all of the variability can be attributed to non-performance sources of variation (e.g., measurement error) and 1 when all the variability is due to true differences in quality of care across clinician group/practices. The Nieser and Harris approach is calculated as a function of sample size and beta-binomial parameter estimates and is appropriate for assessing the reliability of the PCCC, as each respondent represents a binary opportunity for a clinician group/practice to achieve a top-box overall rating of highest rating. This approach is aligned with the Partnership for Quality Measurement's recommendations [2]. To calculate the maximum likelihood estimates of the alpha and beta parameters, we utilized the R code *CalcBetaBin*, as developed by Nieser and Harris. Sample size was then inserted into the formula to generate reliability estimates for each clinician group/practice.

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5.2.3 Reliability Testing Results

Table 2 displays the estimates of signal-to-noise reliability by decile of clinician group/practice. Reliability ranged from 0.737 (panel n=16) to 0.979 (panel n=294), with an average reliability of 0.876.

5.2.4 Interpretation of Reliability Results

Our results indicate high reliability across our clinician group/practice-level sample (0.727 – 0.979) and exceed the CBE-recommended guidance for endorsement of "greater than or equal to 0.6 for 70% or more of the accountable entities"[1].

Testing submitted with our initial application suggested that a panel size of 50 was necessary to

achieve high reliability (we used a conservative threshold of >0.80). However, testing conducting as part of this maintenance submission demonstrates that high reliability can be achieved with a smaller panel size. Based on these testing results and applying the Neiser and Harris formula to a range of panel sizes, we recommend accountable entities utilize a minimum panel size of 30 respondents to achieve the same level of reliability (>0.80).

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Table 2a. Accountable Entity Level Reliability Testing Results by Denominator, Target Population Size

	Overall	Min	Decile 1	Decile 2	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10	Max
Reliability	0.876	0.727	0.741	0.826	0.857	0.873	0.891	0.897	0.900	0.914	0.917	0.958	0.979
Mean Performance Score	0.728	0.91	0.890	0.705	0.827	0.866	0.725	0.555	0.755	0.681	0.681	0.620	0.989
N of Entities	35	2	3	4	3	4	3	4	3	4	3	4	1
N of Persons / Encounters / Episodes	2022	32	52	116	108	166	136	196	157	218	192	681	294

Table 2b. Accountable Entity Level Reliability Testing Results by Reliability Score

	Overall	Min	Decile 1	Decile 2	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10	Max
Reliability	0.876	0.727	0.741	0.826	0.857	0.873	0.891	0.897	0.900	0.914	0.917	0.958	0.979
Mean Performance Score	0.728	0.91	0.890	0.705	0.827	0.866	0.725	0.555	0.755	0.681	0.681	0.620	0.989
N of Entities	35	2	3	4	3	4	3	4	3	4	3	4	1
N of Persons / Encounters / Episodes	2022	32	52	116	108	166	136	196	157	218	192	681	294

5.3.1 Level(s) of Validity Testing Conducted

Accountable entity level (i.e., measure score) (e.g., criterion validity)

5.3.2 Type of Accountable Entity Level Validity Testing Conducted

Empirical validity testing at the accountable entity-level (e.g., criterion validity, construct validity, known groups analysis)

5.3.3 Method(s) of Validity Testing

Construct validity

Convergent validity was assessed by examining associations between the PCCC and 1) a measure of patient overall satisfaction with the clinical visit and 2) a measure of contraceptive method satisfaction that were collected in the same modality within the same survey as the PCCC.

Overall satisfaction. Patients were asked "Overall, how satisfied are you with the talk you had today with your provider about birth control methods?" with 5-point Likert-type response options ranging from "Very dissatisfied" to "Very satisfied." The choice of this measure as a comparator was based on the fact that measures of satisfaction often correlate with measures of patient-centered processes of care but are considered distinct. We conceptualized the PCCC as being more specific than measures of satisfaction, as satisfaction measures tend to be informed by expectation disconfirmation theory (i.e., the extent to which an experience exceeded or fell below expectations [1,2]) and have additional limitations of lack of differentiation and lack of specificity of measured behaviors [3]. In contrast, the items in the PCCC assess the extent to which the patient experienced or perceived specific types of communication and exchanges consistent with patient-centered care. Given their conceptual relationship, we hypothesize these measures to be highly and positively correlated.

Method choice: Patients were given the following statement: "The birth control method I will use after today's visit is the best method of birth control for me." With 4-point Likert-type response options ranging from "disagree" to "Very much agree." The choice of this measure as a comparator was based on the hypothesis that positive experience with contraceptive counseling would correlate with positive feelings toward contraceptive method choice. However, feelings about the material result from the contraceptive counseling (i.e. the birth control method) are distinct from the experience of care provided. We hypothesize a weak to moderate positive correlation.

To align with PCCC scoring, for each of the comparator variables, we created a binary variable, comparing responses in the highest or most positive rating category ("Very satisfied"/ "Very much agree") to all other responses.

Aligned with guidance for PRO-PMs [4], we first tested the constructs at the individual (Patient Reported Experience Measure [PREM]) level, and then conducted testing at the clinician group/practice 9Patient Reported Experience Performance Measure [PRE-PM]) level, both using the South Carolina dataset (see 5.1.1).

For the PREM level, we conducted two simple univariate logistic regression models with PCCC as the outcome and overall satisfaction with counseling and method satisfaction as predictors respectively.

For the PRE-PM level, we averaged PCCC scores, overall satisfaction, and method satisfaction scores at the unit of analysis (clinician group/practice). We estimated Pearson's correlation coefficient (*r*) to assess strength and direction of the linear relationship between the mean PCCC score by clinician group/practice and the mean scores of each of the comparator variables. We then conducted two univariate Ordinary Least Squares regression models with PCCC score (outcome) and overall appointment satisfaction as predictors averaged at the clinician group/practice level.

Analysis of missing data

We identified the extent and distribution of missing items among respondents. Missingness did not exceed 1% for any of the PCCC questions, with overall missingness across the scale of 1.5%. The best birth control variable had a missingness of 4.6% and the overall satisfaction variable had missingness of 7.1%. Given low level of missingness, we conducted a complete case analysis, aligned with best practice of handling item-level missingness [5].

Assessment of Non-Response Bias

This PRE-PM is collected through an anonymous survey and, by design, not connected to other sources of patient information, such as electronic health records. This practice serves to protect data quality and improve response rates, as patients may be concerned about care consequences if they report lower scores and, as a result, choose to either record higher scores that do not reflect quality of care or refuse to respond to the survey if they know or suspect it will be linked to their patient records. Thus, we do not have demographic information on nonrespondents and cannot assess differences between groups. Moreover, the survey is distributed to patients identified as likely having received contraceptive counseling in their clinical visit. This is verified when respondents answer the survey screening question, confirming that they did, in fact, receive counseling. Without confirmation of eligibility of nonrespondents, we do not know the true population of those who received contraceptive counseling among those who were contacted, and thus, cannot directly assess differences between that population of interest and the sample who completed the survey.

To approximate how well the responders accurately reflect the demographics of the target patient population, we compared the demographics of the overall female patient population in the desired age range to PCCC respondents within a subsample of 9 of our testing entities (see Tables 2.a-i in section 5.3.4a). Specifically, we used electronic health data to identify the age and, race and

ethnicity among female patients ages 15-44 years from the same time period as PCCC collection at those entities. In addition, eight of the nine sites also provided us the percentage of patients by preferred language.

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5.3.4 Validity Testing Results

At the clinician group practice level, the PCCC was strongly correlated with the measure of overall visit satisfaction (r = 0.738) and weakly correlated with the measure of method satisfaction (r = 0.214), See tables in 5.3.4a for full results.

5.3.4a Attach Additional Validity Testing Results

5.3.4a-validity-tables_508.pdf

5.3.5 Interpretation of Validity Results

Our construct validity results are largely consistent with our hypotheses, demonstrating validity. First, we found a strong positive association with PCCC and the measure of overall satisfaction (the more conceptually related measure), as hypothesized. Between the PCCC and the best birth control we found a strong correlation at the individual level that was attenuated at the clinician group/practice level, with a weak, positive linear relationship (r=0.21) that was not statistically significant in regression results. This is not inconsistent with our hypothesis of a weak to moderate positive correlation, as feelings about contraceptive methods may be influenced by factors beyond the quality of counseling, such as limitations with the conceptive method options available on the market, resulting in patients having to choose between options that may not align with their preferences, e.g. comparing side effect potential, modality and preference for frequency of dosing, and so forth. Moreover, with a hypothesized small effect size and the results showing

the significant relationship at the individual level and lack of statistical significance at the clinician group/practice level suggests the lack of correlation may also be affected by limited sample size (n=24) at the clinician group/practice level. A larger sample would increase precision, stability, and possibly, statistical significance of the correlation.

We note that the response options utilized in the version of the PCCC used for validity testing vary from those used in the endorsed version of the measure, however we do not believe this affects the applicability of the findings. The scale consistently uses five response categories, providing for similar symmetry, and assesses the same construct. Moreover, the use of topbox scoring means any impact of interpretation issues between middle and low values are less relevant and would not affect performance scoring. Also, the distribution of PCCC score across the sample (range: 43.6% - 74.3%) is consistent with the range and distribution of scores of the endorsed version of the measure, such as presented in Section 2.4, suggesting it was interpreted similarly to the endorsed version of the measure. External evidence also supports limited impact of response format. One study looked at the effect of a change from Likert type response options to Item-Specific Response Options, which presents individuals with a direct question (rather than a statement to which they are asked to agree or disagree) and a set of tailored response categories that match its content. While there were some differences in the distribution of responses by response option type, the magnitude was negligible [1].

Moreover, analysis of this data is consistent with peer-reviewed evidence demonstrating that the PCCC has the ability to distinguish between groups who have different experiences of care as depicted by different scores. These findings are supplemented with independent testing conducted externally. Specifically, an independent organization, Upstream USA, conducted validity testing at the individual level with data collected from partner clinics in 2021-2022 [2]. They used a similar measure about experience of care delivered compared to PCCC to assess construct validity and found high levels of correlation (aOR = 1.13, 95% CI: 1.05, 1.22). They used the version of the PCCC endorsed by the CBE. While this analysis was not conducted as part of this application and is not at the clinician group/practice level of analysis, it does illustrate useful correlations that support the interpretation that PCCC continues to be a valid measure.

Nonresponse bias assessment

Demographic distributions of PCCC respondents compared to the target patient population by age and primary language were comparable in most clinician group/practices, Exceptions by age include no capture of 15-20 year olds (5% of target population) by clinician group/practice 3, and underrepresentation of 15-20 year olds by clinician group/practice 5 (2% v. 21%), clinician group/practice 8 (6% v. 17%), and clinician group/practice 9 (8% v. 35%). Exceptions by language are underrepresentation of Spanish-speakers by clinician group/practice 3 (74% v. 94%) and clinician group/practice 6 (2% v. 11%).

Assessment of race/ethnicity was complicated by data quality issues, namely, high levels of missingness in the EHRs for these variables. Race and ethnicity are typically categorized separately in EHRs. However, because Latine/Hispanic identity is a racialized ethnicity [3], the variable used alongside the PCCC is a combined race/ethnicity variable. We attempted to make a comparable variable from cross-referencing race and ethnicity data in the EHR datasets. However, five out of nine sites did not have recorded ethnicity data for more than 50% of observations and three out of nine did not have recorded race data for more than 30% of observations. Thus, we were unable to accurately distinguish a Latine/Hispanic population and build a meaningful comparison variable to the PCCC race/ethnicity variable. Likely, results for those clinician group/practices overestimate the White populations served and underestimate the Latine/Hispanic population. Distributions across other racial categories were fairly comparable, with the exception of Clinician group/practice 7 and 9, each with a 10-point difference is distribution of Black patients, the former underrepresenting and the latter overrepresenting Black patients among PCCC respondents.

With these challenges taken into account, we believe this investigation suggests that PCCC sampling produces a reasonable comparable sample to the demographic profile of patients served.

We interpret these findings alongside our analyses from our initial application, in which we were able to capture survey nonresponse from nine accountable entities. In order to test what effect biased non-response would have on performance scores, we imputed missing data by provider and facility under the conservative assumptions that all individuals with missing data were either 25% more or less likely to give a top-box score than were respondents. Ultimately, we found that survey nonresponse in that sample did not meaningfully under or over-estimates of provider performance.

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5.4.1 Methods Used to Address Risk Factors

No risk adjustment or stratification

5.4.1b Rationale For No Adjustment or Stratification

We do not believe that risk adjustment is justified. While it is possible that different demographic groups may report different results on the PCCC measure, this would likely represent true differences in patient-centeredness due to the manner in which the questions are framed and the fact that the concepts of respect and attention to preferences and adequate provision of information are generally desirable. This interpretation is supported by prior work demonstrating broad alignment in women's preferences for contraceptive counseling across race and ethnicity, particularly with respect to respect, attention to preferences, and provision of adequate information [1,2].

With respect to language, we note that our development of the measure included a rigorous process of developing the Spanish language version alongside the English language version [3]. This process included ensuring equivalence of items across languages through cognitive interviews, collecting data on item importance from Spanish and English speakers, and using these data to determine the items included in our measure. We also conducted face validity testing with both Spanish and English speakers. While in our initial testing of the PCCC measure submitted to the National Quality Forum (NQF), some differences by language were observed, these were not consistent across sites. Notably, in at least one site that demonstrated strong attention to language-concordant and culturally responsive care, Spanish-speaking patients reported higher PCCC scores than English-speaking patients.

Combined with our attention to equivalence by language in the development process, this pattern indicates that differences by language are not driven by bias in how the measure captures patient-centeredness, but rather reflect true differences in the quality of care delivered. This interpretation is consistent with our broader analytic framework, in which variation in scores across demographic groups is understood to represent meaningful differences in patient experience rather than limitations of the measure itself.

With respect to the question of stratification, studies suggest that women of color receive poorer quality contraceptive counseling than their white counterparts [4]. These disparities are rooted in the long history in the United States of coercion on the part of the reproductive health care system towards women of color, including forced sterilization and pressure to use long-acting contraceptive methods [5,6]. While this suggests that stratification by race/ethnicity may be desirable to assess differences in care, we currently lack sufficient data to conduct necessary reliability and validity testing on stratified measures. We plan to evaluate stratification by

race/ethnicity and language in future applications.

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6.1.1 Current Status

In use

6.1.2 Current or Planned Use(s)

Quality Improvement (Internal to the specific organization)

6.1.3 Program Details

Name of the program and sponsor
Planned Parenthood Federation of America (PPFA)
URL of the program
https://www.plannedparenthood.org/
Purpose of the program

PPFA is a national network of affiliates that provide sexual and reproductive healthcare. PPFA utilizes PCCC within their ongoing patient engagement survey fielded by Press Ganey and that is compiled quarterly and used for internal quality improvement.

Geographic area and percentage of accountable entities and patients included

PPFA affiliates cover all 50 states and Washington, D.C., serving millions of patients annually. In 2024, PPFA collected PCCC surveys from 27,136 patients across affiliates.

Applicable level of analysis and care setting

clinician group/practice, ambulatory care: clinic

,
Name of the program and sponsor
Illinois Contraceptive Access Now (ICAN!)
URL of the program
https://ican4all.org/
Purpose of the program

ICAN! Provides workforce development and training to FQHCs with the goal of expanding high-quality contraceptive access in Illinois. They use PCCC as a quality improvement tool as part of their health center workforce development and training program.

Geographic area and percentage of accountable entities and patients included

ICAN!'s Quality Hub Network includes 24 community health centers serving over 321,000 female patients of reproductive age annually through more than 200 individual health center locations throughout Illinois (Chicago/Cook County, Northwest, Central, and Southern Illinois). 57% of Quality Hub Network patients are on Medicaid, and 18% are uninsured or self-pay. 51% of patients identify as Black, 29% as Hispanic/Latino, 25% as White, and 4% as AAPI. Since 2021, they have collected 900 PCCC surveys across 15 of their 24 partner clinics.

Applicable level of analysis and care setting

clinician group/practice, ambulatory care: clinic

,
Name of the program and sponsor
Upstream USA
URL of the program
https://upstream.org/
Purpose of the program

Upstream USA is a nonprofit that works with healthcare organizations to expand access to patient-centered contraceptive care. They provide training and technical assistance to health centers and use PCCC as a measure within their pre- and post-training/quality improvement efforts with health centers.

Geographic area and percentage of accountable entities and patients included

Since 2021, Upstream has fielded the PCCC with 155 healthcare organizations across 34 states. As of March 13, 2026, they have received 66,835 patient responses to the PCCC from the above

155 healthcare organizational partners.

Applicable level of analysis and care setting

clinician group/practice, ambulatory care: clinic

6.1.4 Attributes for Accountability Use

This measure would be appropriate for use in reporting and/or pay for performance accountability programs for ambulatory clinic sites serving female patients aged 15-44 years, measured at the clinician group/practice level, focused on primary care and reproductive health sites.

6.2.1 Actions of Measured Entities to Improve Performance

The PCCC is measure focused on the quality of contraceptive care delivery. Entities can engage in a diversity of quality improvement activities to improve performance. Quality improvement actions may vary in amount of effort needed to achieve favorable results, in accordance with what scores indicate about performance (e.g. how much improvement is needed) and the size and structure of the accountable entity.

Broadly, entities seeking to improve scores can provide provider training on person-centered contraceptive counseling skills, either provided internally within the agencies or through leveraging existing training materials, such as the e-learning course provided by Partners in Contraceptive Choice and Knowledge (PICCK). For more targeted training, entities can examine PCCC scores by item to identify if patients are reported in a particular deficit in care delivery needs, (e.g. delivering enough information to make a decision about their contraception). An evaluation of a contraceptive access initiative in South Carolina (from which our validity data were drawn), which provided trainings on reproductive autonomy and person-centered contraceptive care, found that post-intervention, patients had higher odds of reporting topbox PCCC scores compared to patients at comparison clinics [1]. Difficulties of this approach include provider time and buy-in; however training can make scaled to meet provider time demands.

For more targeted quality improvement efforts, entities can examine PCCC scores by patient subgroups. If differences in scores are noted by patient subgroup, such as by Spanish-speaking patients, younger patients, or a particular racial or ethnic group, entities should focus quality improvement efforts on improving care within those patient groups. To do so, entities can leverage expertise within staff and engage patient advisory boards to identify what may be contributing to the subpar scores, from which entities can build a quality improvement plan, such as improving language services or providing cultural humility training. In a 2025 publication, we provide an example of an FQHC who utilized engaged staff and patients to develop a quality improvement strategy to improve the score among Spanish-speaking patients [2]. How difficult quality improvement activities are is dependent on the findings of the needs assessment and extent of quality improvement infrastructure.

Lastly, entities may utilize a contraceptive need screening tool such as the Self-Identified Need for Contraception (CBE#4655e) as a means of targeting contraceptive counseling only to those patients who seek want to discuss pregnancy prevention. Since contraception is a preference sensitive decision, patients who do not want to discuss contraception but are engaged in counseling by the provider may report low quality care, as counseling is misaligned with their preferences for their care appointment. Targeting the self-determined appropriate patient population will improve contraceptive care delivery and performance scores. There may be some initial difficulties integrating SINC into the EHR and clinical workflows, however feedback from users suggest the addition into workflows is minor because it's one question that can be asked during rooming procedures and implementation of SINC may increase provider time and efficiency by focusing on contraceptive counseling only among patients who are interested.

Following the implementation of these interventions, we recommend re-measurement of the PCCC to track change and reevaluate quality. When used in combination other currently endorsed contraceptive access measures, such as the Contraceptive Use electronic clinical quality measures (CU-SINC, CBE #3699e & 3682e), PCCC can also serve as a tool for identifying whether attention to method provision is leading to a decrease in attention to patient-centeredness and allow for intervention if such an effect is observed. In a quality improvement learning collaborative that we ran in 2022-2023 and that included a pre-post assessment of PCCC scores alongside CU-SINC, after nine months, PCCC scores improved from 2% to 26% among healthcare entities that engaged in dedicated training and accountability practices around contraceptive care delivery [3].

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6.2.2 Feedback on Measure Performance

We have obtained feedback on PCCC through multiple means. First, with clinician group/practices that we worked with on PCCC-focused implementation and quality improvement (n=35, across three project cohorts), we solicited group feedback at the end of the projects, as well as conducted individual interviews with clinic representatives about their experience with the measure.

To obtain feedback from entities independently using PCCC, we fielded a survey to entities known to have used the PCCC over the past 5 years. The survey asked about feasibility of measure implementation, use and usability. We conducted individual follow-up calls with a subset of respondents for clarification and further information as needed.

Little concern was raised about the validity of the measure itself or about its specifications. Many entities reflected that the PCCC is a valuable tool that enables meaningful assessment and quality improvement on contraceptive care delivery. Many organizations, including Planned Parenthood Federation of America, the Illinois Contraceptive Access Now (a state-based non-profit contraceptive access initiative), and Upstream (a national non-profit contraceptive access organization that works with federally qualified health centers), integrate PCCC into broader patient experience surveys and track PCCC scores before and after quality improvement interventions, feeling that the PCCC is a valid and reliable instrument for assessing patient experience of contraceptive counseling.

In 2024, some federally qualified health centers in the Massachusetts Department of Health network noted some interpretability concerns with the PCCC among Haitian Creole immigrant patient populations. The FQHCs created and were using their own translation of the PCCC, which has not been validated, to field the survey to this population.

Overall, feedback received primarily focused not on measure specifications, but instead on implementation and sustainability challenges, in the following categories (also described in section 4):

- **Challenges in sustained staff engagement necessary to collect PCCC surveys**. This was expressed as a concern for the sustainability of collection over time. Depending on the workflow used, healthcare staff are often responsible for identifying potentially eligible patients and providing them with the paper survey or a link to an electronic version of the survey. These staff have many competing priorities, making it sometimes challenging to incorporate the survey into their workflows, particularly if collection is sustained over long periods of time, such as ongoing collection.
- **Challenges in patient engagement in completing the survey.** Some also report challenges in motivating response from patients to complete the survey.
- **Panel size.** Minimum of 50 surveys (previously recommended panel size) has been hard to achieve in low-volume clinics.

6.2.3 Consideration of Measure Feedback

We did not receive any feedback that called for any changes to measure specifications and have made no changes to the specifications in response to measure feedback. We plan on developing

and validating a low-literacy version of the scale to improve capture of accurate data from low-literacy populations and will present that in future maintenance applications. Currently, we recommend clinician group/practices with sizeable low-literacy populations utilize screen reader technology for electronic surveys.

We continuously engage entities using the PCCC and update our implementation guidance in response to feedback to include data collection strategies to meet the needs of different healthcare settings and patient populations. For the challenges raised above, we recommend the following:

Staff engagement: For all clinician group/practices initiating data collection, we recommend: early engagement with staff when incorporating data collection protocols; providing information on the motivation and use of the data to be collected; using accountability milestones and internal communication touchpoints to stay on target, as well as staff incentives to increase motivation. We permit diverse data collection strategies that can rely on staff to a varying degree in order to meet the data collection needs of different clinics and patient populations. For contexts where staff capacity may compromise collection, we recommend low-burden collection strategies, such as incorporating the PCCC into existing patient engagement surveys (if applicable) or utilizing post-visit patient portal messages. To decrease survey burden, guidelines suggest collecting PCCC surveys once or twice a year for monitoring, as opposed to ongoing collection. This serves to capture change over time while limiting potential of collection fatigue that could result from continuous collection.

Patient engagement: In our guidelines, we suggest that clinician group/practices try alternative collection strategies. Feedback has suggested that suitability of collection strategies (paper versus electronic collection) varies by setting (see section 4.1b). Clinics can also offer monetary incentives for completion. We also provide talking points to use with patients that explicate the important role of patient feedback and prompt clinician group/practices to communicate how the data will be used.

Low-volume settings: As a result of our renewed reliability analyses, we now recommend a lower threshold for a high-reliability panel, decreasing the recommended panel size from 50 to 30. This new guideline is more in line with what has been attainable for low volume clinician group/practices.

6.2.4 Progress on Improvement

Across the Planned Parenthood Federation of America affiliates using the Press Ganey survey, between quarter one of 2022 and quarter one of 2026, overall performance scores increased from 71.7% to 76.9%, however significant variation remains by practice. In the same time period,

performance scores increased within racial and ethnic subgroups: from 65.8% to 73.0% among Black patients, from 68.3% to 73.1% among Latine patients, and from 77.0% to 83.1% among White patients. However gaps between scores by racial and ethnic group persist, aligned with findings presented in section 3.

6.2.5 Unexpected Findings

We have had no unexpected findings.

7.1 Supplemental Attachment

Section-7_508.pdf

Developer POC email

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Measure Developer POC

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The measure developer is different from the measure steward

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