Addendum to CBE# 3682 application

<u>Section 2.2: Evidence of importance</u>

Extant intervention science evidence highlights strategies for improving contraceptive provision that could be leveraged for measure improvement. Primary strategies include provide training on counseling and technical skill-building, improving screening for contraceptive need, improving clinical capacity for same-day provision of methods, and removing financial barriers, as detailed in the examples below. Data used in the CU-SINC, Non-Postpartum (CBE#3699), a companion application to this one, was produced in the context of a quality improvement learning collaborative. Participating community health centers utilized staff training in contraceptive method and counseling competencies alongside integrating and standardizing screening for contraceptive need (through use of SINC). Within a nine-month period CHCs realized a median relative increase in CU-SINC, Non-Postpartum scores of 4.9% (IQR [3.7% - 22.3%) (1). Other learning collaboratives and statewide initiatives point toward strategies that may be leveraged to improvements in provision. For example, twelve Title X grantee service sites participated in an eight-month learning collaborative, utilizing the claims-based measures of contraceptive provision (CBE#2902, 2903, 2904). Ten sites saw improvement in scores using a mix of strategies, including improving contraceptive counseling practices, developing systems for same-day provision of all methods, and utilizing diverse payment options to reduce cost (2). Another recent initiative in Utah focused on increasing capacity to support Medicaid-eligible individuals through provider training in primary care settings, alongside financial coverage of contraceptive methods. Sites engaging in the intervention provided 1.76 times the contraceptive services per month compared to control sites (3). In New York, another group sought to improve access through a learning collaborative model and focused on method stocking, routine screening for contraceptive need, same-visit provision, and leveraging diverse payment options. They found an increase of 22%-38% of patients in primary care setting and 0%-17% in the immediate postpartum period receiving a most or moderately effective method, respectively (4). Another effort, the Increasing Access to Contraception Learning Community, run by the Association of State and Territorial Health Officials, worked with 27 jurisdictions across the U.S. They identified nine focus areas for improvement: provider awareness and training; reimbursement and financial sustainability; informed consent and ethical considerations; logistical, stocking, and administrative barriers; consumer awareness; stakeholder partnerships; service locations; data, monitoring, and evaluation; and specific populations. While pre-post provision data are not provided, updated reports show ongoing dedication by participating sites to goals under these strategies (5).

As this measure intends to measure contraceptive use and not just provision, another focus area is increased documentation of patient-reported contraceptive use, which is particularly an issue in the primary care setting. One study of care provided to over 27,000 patients in a Federally Qualified Health Center found that 45% of family planning services were not documented, with substantial improvement in this documentation with implementation of clinical decision support (6). In addition to improving documentation, consistent use of SINC will ensure that patients are being screened for contraceptive need, which also serves to optimize measure denominator to better capture the population of interest and facilitates contraceptive counseling where desired.

REFERENCES

1. Dehlendorf C, Wingo E, Gibson L, Goetsch-Avila S, Kriz R. Advancing equitable, person-centered contraceptive care using data-driven quality improvement. Journal of the American Board of Family Medicine. 2025;(In press).

2. Loyola Briceno AC, Kawatu J, Saul K, DeAngelis K, Frederiksen B, Moskosky SB, et al. From theory to application: using performance measures for contraceptive care in the Title X family planning program. Contraception. 2017 Sep;96(3):166–74.

3. Simmons RG, Gero A, Carter G, Sanders JN, Quade C, Baayd J, et al. Changes in Contraceptive Services During Utah's Family Planning Elevated Contraceptive Access Initiative: A Prospective Assessment of Intervention and Control Sites. Am J Public Health. 2025 Mar;115(3):387–96.

4. Kawatu J, Clark M, Saul K, Quimby KD, Whitten A, Nelson S, et al. Increasing access to single-visit contraception in urban health care settings: Findings from a multi-site learning collaborative. Contraception. 2022 Apr;108:25–31.

5. Estrich C, DeSisto CL, Uesugi K, Akbarali S, Pliska ES, Romero L, et al. Use of a Learning Community to Expand Access to Contraception. Am J Public Health. 2022 Jun;112(S5):S523–7.

6. Srinivasulu S, Shah SD, Schechter CB, Prine L, Rubin SE. Effectiveness of clinical decision support to enhance delivery of family planning services in primary care settings. Contraception. 2020 Mar;101(3):199–204.