

Original research article

IUD services among primary care practices in New York City

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Abstract

Objective: Intrauterine devices (IUDs) are one of the most effective forms of reversible contraception and can reduce unintended pregnancy rates. We explored practice characteristics associated with IUD services across a network of primary care practices in New York City during 2010–2013.

Study Design: Data were extracted from electronic health records (EHRs) for 253 primary care practices participating in an EHR quality improvement program in New York City. We used diagnostic and procedure codes to count IUD insertions and removals among females aged 10–49 years during 2010–2013. Logistic regression models predicted the likelihood of IUD insertion, removal or no activity for 2013, based on practice characteristics. We stratified trends in IUD services over time by practice type and specialty.

Results: From 2010 to 2013, the proportion of practices that inserted IUDs increased slightly from 4.7% to 6.3% ($p=0.17$), and the proportion removing IUDs increased from 8.3% to 12.3% ($p<0.01$). More than 60% of obstetricians/gynecologists and midwives performed insertions or removals each year; fewer than 10% of internal medicine and pediatric providers did so. Community health centers had higher odds of performing removals than independent practices (adjusted odds ratio=10.24, 95% confidence interval: 3.37–31.17). Practices seeing >66% female patients had higher odds of performing both insertions and removals.

Conclusions: From 2010 to 2013, IUD services increased but remained low among primary care practices in this network. Provider training and system readiness programs should include independent primary care practices, which rarely provide IUDs, to ensure that women can receive IUDs or IUD service referrals in the primary care setting.

Implications: Much of primary care in the United States takes place in independent practices with one or two providers. Our study of a major urban area found that these types of practices are much less likely to offer IUD services than community health centers. Ensuring that small practices know where to refer women for IUD insertion and removal services is warranted to ensure women's access to IUDs.

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1. Introduction

Intrauterine devices (IUDs), along with contraceptive implants, are the most effective forms of reversible contraception available in the United States [1]. Numerous professional

and public health organizations, including the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics and the World Health Organization, have endorsed IUDs as first-line contraceptive methods for most women and adolescents [2–4]. Given their safety, efficacy and ease of use, IUDs have great potential to reduce the high national rates of unintended pregnancy [5].

Use of IUDs among US women is increasing. Estimates from the National Survey of Family Growth, a survey by the National Center for Health Statistics, indicate that the percentage of contracepting women using an IUD increased from 2% in 2002 to 10.3% in 2012 [6,7]. Similarly, Xu et al.

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conducted a retrospective insurance claims-based analysis and found that, from 2002 to 2008, IUD insertion rates increased from 1.6 to 9.8 per 1000 women of reproductive age [8].

At the same time, a growing body of research has focused on provider training, knowledge and attitudes associated with IUD provision. Greenberg, Makino and Coles found that about one third of Society for Adolescent Health and Medicine members reported currently providing IUDs, with physicians trained in obstetrics/gynecology and family medicine more likely to do so [9]. Rubin et al. surveyed family physicians and found that 24% had inserted an IUD in the past 12 months; providers who had inserted IUDs had greater knowledge and comfort discussing the method [10]. Numerous provider education interventions have been implemented to address provider-level barriers and improve clinician comfort with provision, especially for adolescents and nulliparous women (e.g., Secura et al. [11]; Ricketts, Klingler, Schwalberg [12]; Biggs et al. [13]). Despite such efforts, barriers to obtaining IUDs in the United States persist, leading to unmet demand among women at risk of unintended pregnancy [13,14].

Beyond recent studies that focused on the availability of IUDs as a barrier to provision [15–17], little attention has been paid to other practice-level factors that might affect actual delivery of IUD services. This is especially true for primary care practices, which are not typically viewed as reproductive health care providers but can play a critical role in addressing unmet need for contraceptive care. With the implementation of the Patient Protection and Affordable Care Act (ACA), which has increased the number of insured women and mandated coverage of all Food and Drug Administration-approved contraceptive methods [18], more women might seek contraception from their primary care providers. It is important to understand not only whether primary care practices offer IUD services but also whether women are actually receiving such services from these providers and whether trends in primary care practices mirror those of other types of practices. More than half of pregnancies in New York City are unintended [19], yet IUD use in New York City remains much lower than in Colorado, where a well-funded statewide initiative in Title X-funded clinics removed many barriers to IUD use and where uptake among women aged 15–24 was 10.4% [12,20]. The purposes of this study were to assess recent trends in IUD insertions and removals and ascertain practice-level factors associated with IUD services using data from electronic health records (EHRs) among a large, diverse network of primary care practices in New York City.

2. Materials and methods

Data were collected using the Hub Population Health System (Hub), described by Buck et al. [21], a partnership between the eClinicalWorks EHR vendor and the New York City Department of Health and Mental Hygiene's Primary Care Information Project (PCIP). This data network consists of

more than 700 New York City practices that joined PCIP to receive EHR implementation and quality improvement support. For each provider and each year 2010–2013, the Hub returned aggregate counts of females aged 10–49 years who had a visit where a billing code, blood pressure or body mass index were recorded, as well as the subset of those women who had an IUD inserted or removed, according either to International Classification of Diseases, Ninth Revision (ICD-9) diagnosis code or Current Procedural Terminology (CPT) procedure code. No patient-level or protected health information was obtained. This project was determined exempt by the Public Health Solutions Institutional Review Board.

Because EHR use and data quality vary widely [22], practices were only included in the study if they had at least one provider actively using the EHR. *Active EHR use* was defined as (a) at least 25 patients with a documented CPT code and (b) 80% or more of the patient panel with a documented ICD-9 code for each study year. In addition, practices were only included in this analysis if they had at least one provider who (a) had 25 or more female patients aged 10–49 years each year and (b) fell under a primary care specialty that provides IUD services as part of its scope of practice [family medicine, internal medicine, midwifery, nurse practitioner (NP), obstetrician/gynecologist (OB/GYN), pediatrics, physician assistant or unknown specialty]. The NPs studied all specialized in women's health, and so they were grouped with OB/GYN and midwife. Only data from providers who met these criteria were included in the study.

Practice characteristics came from PCIP practice documentation and provider medical specialty came from SK&A Information Services in Irvine, CA. We categorized practices as community health centers (CHCs) [including Federally Qualified Health Centers (FQHCs) and similar facilities and one hospital outpatient department] or as independent practices. Title X status was not included as only two of the practices in this cohort received Title X family planning funding. For purposes of modeling, practices were also grouped by patient panel demographics: sex, neighborhood poverty, race/ethnicity and overall volume from 2013. The cut point for percentage female was set at two thirds ($\leq 66\%$ female patients; most practices had $>50\%$ female patients so the next meaningful cut point was chosen), and other cut points were set according to rounded cut points near the median: ≤ 2000 total patients; $\leq 50\%$ of patients residing in high-poverty neighborhoods (defined as $>20\%$ of the population living below the federal poverty threshold (FPT) [23]); and $\leq 50\%$ Black and/or Hispanic patients.

Three dichotomous outcome variables were coded reflecting whether practices had documented any IUD insertions, removals or neither during a given year. Simple logistic regression models were run to examine associations between each practice characteristic and the three IUD service-delivery outcomes for 2013. We then constructed multivariable logistic regression models for these outcomes in 2013, retaining practice-level characteristics found to be significant ($p=0.05$) in the bivariate model. Multicollinearity

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