JOGNN

RESEARCH

Adherence to the Women's Preventive Services Guidelines in the Affordable Care Act

Mindy B. Tinkle, Beth B. Tigges, Blake Boursaw, and Deborah R. McFarlane Q10

Correspondence
Mindy B. Tinkle, PhD, RN, WHNP-BC, FAAN, 13424 Sunset Canyon Dr. NE, Albuquerque, NM 87111.
mtinkle@salud.unm.edu

Keywords
adherence
clinical practice guidelines
implementation
women's health

ABSTRACT

Objective: To assess the adherence of women's health providers in New Mexico to the Women's Preventive Services Guidelines and to examine how providers' knowledge, attitudes, and external barriers are associated with adherence.

Design: Cross-sectional, descriptive survey.

Setting: New Mexico.

Participants: Women's health providers in New Mexico, including nurse practitioners, certified nurse-midwives, and family practice and obstetrician-gynecologist physicians.

Methods: Participants completed a self-administered survey to measure knowledge, attitudes, external barriers, and adherence to each of the eight guidelines. Adherence was defined as following a guideline more than 90% of the time.

Results: The response rate was 22% (399/1,798). Among the eight guidelines, participant adherence ranged from 17.2% to 88.4%. Only 39.7% of participants indicated adherence to most of the guidelines (four or more). Overall, provider adherence was directly associated with familiarity with the guidelines (odds ratio = 3.69; 95% confidence interval [1.96, 6.96]), self-efficacy to implement them (odds ratio = 4.25; 95% confidence interval [2.21, 8.20]), and younger age (odds ratio = 0.97; 95% confidence interval [0.94, 1.00]).

Conclusion: Adherence to the Women's Preventive Services Guidelines by providers in New Mexico is variable and, for many recommended practices, less than optimal. New targeted implementation strategies are needed to address barriers to adherence.

JOGNN, ■, ■–■; 2016. http://dx.doi.org/10.1016/j.jogn.2016.07.005

Accepted July 2016

Mindy B. Tinkle, PhD, RN, WHNP-BC, FAAN, is an associate professor in the College of Nursing, University of New Mexico, Albuquerque, NM.

Beth B. Tigges, PhD, RN, PNP-BC, is an associate professor in the College of Nursing, University of New Mexico, Albuquerque, NM.

Blake Boursaw, MS, is an instructor in the College of Nursing, University of New Mexico, Albuquerque, NM.

(Continued)

The authors report no conflict of interest or relevant financial relationships.

In the Affordable Care Act (ACA), signed into law on March 23, 2010, it is stipulated that new health insurance plans must cover preventive health services without cost sharing, including copayment, coinsurance, or deductible charges (Patient Protection and Affordable Care Act, 2010). Women's preventive health services are specifically included under the law and include many preventive services already recommended by the U.S. Preventive Services Task Force, such as cancer screenings. To identify what additional preventive health services should be included, the U.S. Department of Health and Human Services (USDHHS) directed the Institute of Medicine (IOM, 2011) to convene a panel of experts to review the evidence and recommend needed clinical preventive services for women ages 16 to 65 years beyond those already covered by the ACA. On July 19, 2011, the IOM issued a set of eight new recommendations on what should be included in these guidelines. The USDHHS quickly adopted these recommendations as clinical guidelines for providers and made them a part of the required set of covered services for new health plans under the ACA as of August 1, 2012 (USDHHS, n.d.; Table 1).

Although the ACA mandates the coverage of these services (with some limited exceptions), how these guidelines are adopted and delivered by clinicians is an essential piece of their implementation. Evidence suggests that clinical practice guidelines that have promise to improve health move very slowly into clinical practice, and many of these evidence-based interventions never reach those who could benefit (Balas & Boren, 2000; Green, Ottoson, Garcia, & Hiatt, 2009). In general, researchers who examined the processes associated with how providers incorporate clinical guidelines into their practice

FLA 5.4.0 DTD ■ JOGN109_proof ■ 9 September 2016 ■ 2:59 am ■ ce

Table 1: Health Resources and Services Administration's Women's Preventive Services Guidelines Q5

Type of Preventive Service	HHS Guideline for Health Insurance Coverage	Frequency
Well-woman visits	Well-woman preventive care visit annually for adlt women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception care and many services necessary for prenatal care. This well-woman visit should, when appropriate, include other preventive services listed in this set of guidelines, as well as others referenced in section 2713.	Annual, although HHS recognizes that several visits may be needed to obtain all necessary recommended preventive services, depending on a woman's health status, health needs, and other risk factors.[a]
Screening for gestational diabetes	Screening for gestational diabetes.	In pregnant women between 24 and 28 weeks of gestation and at the first prenatal visit for pregnant women identified to be at high risk for diabetes.
Human papillomavirus testing	High-risk human papillomavirus DNA testing in women with normal cytology testing results.	Screening should begin at 30 years of age and should occur no more frequently than every 3 years.
Counseling for sexually transmitted infections	Counseling on sexually transmitted infections for all sexually active women.	Annual
Counseling and screening for HIV	Counseling and screening for HIV infection for all sexually active women.	Annual
Contraceptive methods and counseling[b]	All U.S. Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity.	As prescribed
Breastfeeding support, supplies, and counseling	Comprehensive lactation support and counseling, by a trained provider during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment.	In conjunction with each birth
Screening and counseling for interpersonal and domestic violence	Screening and counseling for interpersonal and domestic violence.	

Note. HHS = U.S. Department of Health and Human Services.
[a]Refer to Center for Consumer Information and Insurance Oversight (n.d.), question 10. [b]Guidelines concerning contraceptive methods and counseling do not apply to women who are participants or beneficiaries in group health plans sponsored by religious employers. From U.S. Department of Health and Human Services, Health Resources and Services Administration. (n.d.). *Women's Preventive Services Guidelines*. Retrieved from http://www.hrsa.gov/womensguidelines. Q8

behaviors found that uptake of guidelines and practice behavior change are complex phenomena influenced by many factors (Ament et al., 2015). Understanding the factors that may promote or impede providers' adherence to clinical guidelines is a critical first step in the development of strategies to increase the implementation of best-evidence recommendations and improve care and patient outcomes.

Cabana et al. (1999) proposed an evidence-based framework to examine factors associated with the adoption of and adherence to clinical practice guidelines by providers (Figure 1). The

Deborah R. McFarlane, DrPH, MPA, is a professor in the Department of Political Science, University of New Mexico, Albuquerque, NM.

FLA 5.4.0 DTD ■ JOGN109_proof ■ 9 September 2016 ■ 2:59 am ■ ce