

Original research article

# Examining quality of contraceptive services for adolescents in Oregon's family planning program<sup>☆</sup>

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## Abstract

**Objective:** To assess the quality of care provided to adolescents (10–19 years old) compared to women (aged 20–25 years) who accessed services in Oregon's Contraceptive Care (CCare) program.

**Study Design:** We analyzed data routinely collected using the Clinic Visit Record form from women aged 25 years and younger who visited CCare clinics between January 1, 2004, and October 31, 2010. Modern methods were characterized into three tiers: Tier 1 is the intrauterine device, implant and sterilization; Tier 2, hormonal methods; and Tier 3, all barrier methods. Nonmodern methods included no method, withdrawal and natural family planning. We used multivariable logistic regression models to examine the effect of age on three indicators of quality of contraceptive care: transitioning from a nonmodern to a modern method, transitioning from Tier 3 methods to Tier 1 or Tier 2 methods, and initiation of long-acting reversible contraception (LARC). We then produced predicted probabilities to facilitate data interpretation.

**Results:** Adolescents accounted for 344,856 (41%) of the 848,221 clinic visits occurring in CCare among women under age 25. Compared with women (ages 20–25 years), young and older adolescents had decreased odds of LARC initiation [odds ratio (OR) 0.24 (95% confidence interval [CI] 0.16–0.35) and OR 0.44 (95% CI 0.38–0.52), respectively]. However, compared with women, both young and older adolescents had increased odds of leaving with any contraceptive method [OR 1.8 95% (CI 1.26–2.59) and OR 1.42 (95% CI 1.21–1.66)]. Among clients presenting with no method of contraception at the beginning of the visit, 78.7% of young adolescents (95% CI 73.84–83.03) compared with 81.44% (95% CI 77.02–85.52) of older adolescents, and 76.63% (95% CI 69.90–80.75) of young women left with a modern method, controlling for other covariates.

**Conclusion:** Although adolescents served by CCare are more likely to initiate contraception, they are less likely to receive LARC than women aged 20–25 years.

**Implication:** Efforts are needed to ensure that adolescents have access to highly effective reversible contraception.

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## 1. Introduction

Reducing adolescent unintended pregnancy remains a public health imperative; it is both a common and costly problem in the United States (US) [1–3]. Nearly half (43%)

of all unintended pregnancies result from incorrect or inconsistent contraceptive use [4]. Method failure is more common with user dependent methods (e.g., condoms, pills, patch) than long-acting reversible contraceptives (LARCs). LARCs include intrauterine devices (IUDs) and hormonal contraceptive implants. Barriers to IUD use by adolescents may include: provider attitudes and practices, adolescents knowledge and attitudes, cost, and accessibility [5,6]. For example, until recently, IUDs were assumed to only be appropriate for women who have given birth. While both the World Health Organization and the American Congress of

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Obstetricians and Gynecologists endorse the safety of LARC use in adolescents, providers' practices may not have changed [5,7–9]. Improving access to effective contraception is central to reducing unintended pregnancy.

In 2010, an estimated five million adolescents in the US were at risk of unintended pregnancy and in need of publicly funded contraceptive services [10]. Medicaid plays a critical role in access to contraception in the US; it is the single largest source of public funding for family planning nationally [11]. Publicly funded contraceptive services play a key role in averting adolescent-unintended pregnancy through the provision of quality medical and counseling services [12,13].

In 1999, Oregon implemented a family planning expansion program, Oregon Contraceptive Care (CCare), utilizing a Section 1115 Medicaid waiver [14]. Oregon's family planning waiver was introduced to facilitate access to essential family planning services by expanding eligibility to Medicaid and reducing administrative barriers to enrollment. The federal government provides a 90% match rate for family planning services, with no cost sharing for enrollees. Research has established the efficacy of family planning waiver programs in preventing unintended births and reducing Medicaid costs [15–18]. Publicly funded family planning clinics are important sources of care for adolescents and young people [5,19,20].

The efficacy of these programs is due to the leveraging of multiple strengths, including an emphasis on quality of care, and meeting the needs of adolescent clients. This includes strategies such as flexible hours, drop in visits, all contraceptive methods dispensed onsite for immediate start, ensuring confidentiality and improving provider competency with respect to adolescent health and development [5,21]. A key aspect of quality of care is provider competency in evidence-based provision of contraception, including highly effective methods of contraception, and not restricting access to LARCs based on age or nulliparity [8,22].

Multiple dimensions of quality must be considered in the evaluation of programs. Examining both the incidence and prevalence of highly effective methods of contraception, as well as the program's role in transitioning clients to more effective methods are two measures for monitoring how programs support contraceptive choice and use. The purpose of this study was to assess whether young adolescents (10–14 years) and older adolescents (15–19 years) who accessed CCare services between 2004 and 2010 received similar quality of care as women aged 20–25 years, as measured by moving to more effective methods of contraception (transitioning from no method to a modern method, changing from a barrier method to a more effective method, and LARC initiation). We hypothesized that all adolescents who accessed services would receive high-quality care, on par with that received by women.

## 2. Materials and methods

This was a retrospective cohort study using routinely collected data from the Clinic Visit Record form, required for each CCare visit, from January 1, 2004, until October 31, 2010, for women aged 25 years and under seeking care in CCare clinics. We compared adolescents with women aged 20–25 years to focus the analysis on factors specific to younger women. The data abstracted included self-reported client demographics, date of service, clinical data such the contraceptive method used at visit start and at visit end, and clinic-level variables. The Clinic Visit Record did not capture data on parity, so we were unable to control for this variable in our analysis. All data were anonymized prior to analysis. The study was approved by the ethical review boards at the Oregon Health Authority and Oregon Health and Science University.

### 2.1. Variables

Contraceptive methods were grouped by efficacy into clinically meaningful tiers (Fig. 1). Tier 3 includes all barrier methods, Tier 2 includes short-acting hormonal methods (pill, patch, ring) and injectables, and Tier 1 includes the IUD, implant and sterilization. Contraceptive methods in all three tiers are considered modern methods [23]. We categorized withdrawal and natural family planning as a nonmodern method and grouped these with individuals reporting no method use throughout our analyses [23]. We looked at changes in contraceptive use by examining the method clients reported using at the start of a CCare visit and compared it with the method they were using at the end of the visit. Our three study outcomes were moving from no method at presentation to a Tier 1, 2, or 3 method at visit end, moving from a Tier 3 method at presentation to a Tier 1 or 2 method at visit end, and initiation of LARC (among nonsterilized women not using LARC at visit start) [24]. We also examined trends in progestin injectable use. We examined progestin injectable use separately from other Tier 2 methods, because it is similar to Tier 1 methods in that it is a long-acting method, but unique in that it does not require special training for providers to offer it. Sterilization was not included in our analysis. Data on method used at visit start and at visit end allowed us to examine how clients transitioned between tiers at presentation and visit end. Our key independent variable was age (10–14, 15–19 and 20–25 years). Additional covariates included visit year, client race/ethnicity, urban/rural clinic location defined using clinic zip code, clinic county and clinic focus (primary care vs. specialized family planning).

### 2.2. Analyses

We used data visualizations, descriptive statistics and bivariate tests of association to characterize the sample by age group and depict trends in method use at visit end over time. We developed separate multivariable logistic

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