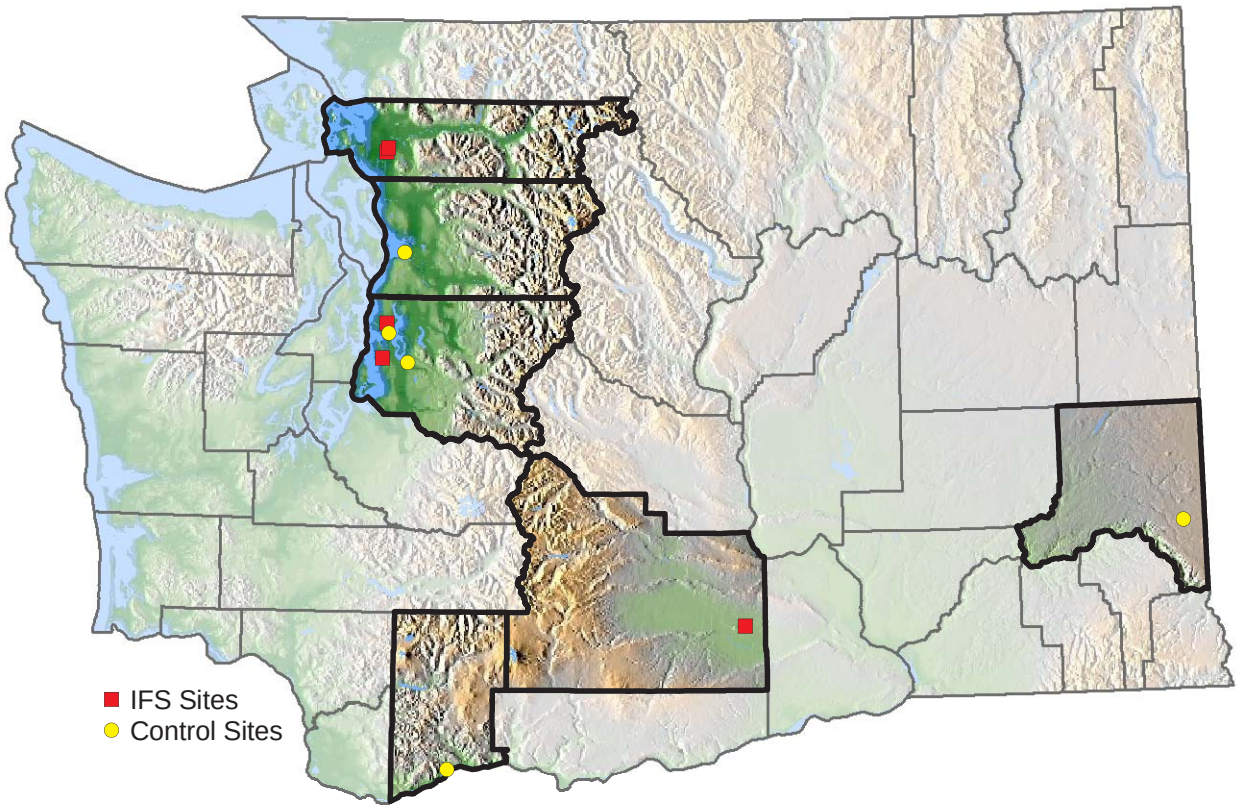
TAKE CHARGE

Process Evaluation



Washington State Department of Social and Health Services
Research and Data Analysis Division
Medical Assistance Administration

TAKE CHARGE
Process Evaluation

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EXECUTIVE SUMMARY

Washington State's TAKE CHARGE program, which began July 2001, expands Medicaid coverage for family planning services to men and women with family incomes up to and including 200% of the federal poverty level (FPL). Program goals are to improve the health of women, children and families in Washington State by reducing unintended pregnancies and lengthening intervals between births and to reduce state and federal Medicaid expenditures for unintended births and their associated costs (refer to WAC 388-532-700). TAKE CHARGE represents a change in state Medicaid policy by providing family planning services *prior* to pregnancy for low-income women not otherwise Medicaid eligible and includes low-income men in its target population. The Medical Assistance Administration (MAA) of the Department of Social and Health Services (DSHS) administers this program.

Conceptual Model

Client-centered provider behavior →↑ Client self-efficacy → Successful use of FP method →↓ Unintended pregnancies

Increasing client-centered practice among TAKE CHARGE providers is predicted to result in enhanced client contraceptive self-efficacy leading to the successful use of family planning (FP) methods. To increase providers' client-centered family planning behavior, two interventions were implemented: training in education, counseling and risk reduction (ECRR) for all sites and intensive follow-up services (IFS) for selected research sites. Both interventions represent the first time providers have been reimbursed for these services. The expected outcome for clients whose family planning services are provided by client-centered practices and whose contraceptive self-efficacy is enhanced is fewer unintended pregnancies.

FINDINGS

- **TAKE CHARGE has been reaching the target population**
  - Nearly 170,000 women and men enrolled in TAKE CHARGE in the first two years.
  - More than 94% of women who enrolled in TAKE CHARGE wanted to prevent pregnancy.
  - Over two-thirds (67.5% or 113,446) of clients enrolled in the first two years were women between eighteen and twenty-nine years of age, the same age group that accounted for 73.0% of all Medicaid-paid births in 2002.
- **Provider behavior included more client-centered practice**
  - Nearly three times as many providers felt totally confident at follow-up that they discuss clients' living situations compared to baseline.
  - While only 52.3% of providers at baseline felt mostly or totally confident that they could recognize when a client was experiencing risk factors affecting successful use of family planning, such as living in an abusive environment or relationship, by follow-up 66.67% felt that way (an increase of 27.3%).
  - Over one year after implementation, 80% of IFS providers reported always or most of the time finding out about underlying concerns, compared to roughly 60% of control site providers.

- By year two, providers at IFS sites were more likely than those at control sites to check with clients to see if their birth control plan had been put into practice: 70% of IFS providers, compared to 48% of control site providers.

- **Clients used more effective birth control methods**
  - About three-quarters of women in the first and second years of TAKE CHARGE received more effective birth control methods, such as oral contraceptives, injections, or implants.
  - Clients' reported use of a less effective method of birth control decreased from 31% at enrollment to 14% a year later; decreases were similar for IFS and control sites.
  - Of the 6.9% of women who reported using no method at their last intercourse, 34% reported that they wanted to become pregnant in the next 12 months.
- **Greater patient volumes required increases in clinic capacity**
  - Nearly 41% of providers felt their clinics were not adequately staffed to meet TAKE CHARGE clients' needs at baseline; by year two, this had decreased to 17%.
  - Significant differences existed between the providers at IFS sites and those at control sites in their perception of their ability to handle the volume of their TAKE CHARGE population. At implementation 73.2% of IFS providers felt that their clinic was adequately staffed compared to 39.3% of control site providers. At follow-up the proportion of control sites that felt adequately staffed increased by 135% to 92.3%.
  - At follow-up, the majority of providers felt mostly or totally confident that their clients were able to schedule appointments in a timely and convenient manner.

To meet the needs of the unanticipated large population of TAKE CHARGE clients, the State of Washington and provider agencies have invested in building capacity by streamlining the application and billing processes, expanding physical workspace, increasing staff, and providing extensive trainings.

Our findings support what other national health organizations are calling for in public health policy: that these family planning services continue as a regular part of the scope of Medicaid services.

INTRODUCTION

Washington State's TAKE CHARGE program, which began in July 2001, expands Medicaid coverage for family planning services to men and women with family incomes up to and including 200% of the federal poverty level (FPL). Program goals are to improve the health of women, children and families in Washington State by reducing unintended pregnancies and lengthening the interval between births, and to reduce State and Federal Medicaid expenditures for unintended births and their associated costs (refer to WAC 388-532-700). TAKE CHARGE represents a change in Medicaid policy in that TAKE CHARGE provides family planning services *prior* to pregnancy for low-income women not otherwise Medicaid eligible and includes low-income men in its target population. The Medical Assistance Administration (MAA) of the Department of Social and Health Services (DSHS) administers this program.

TAKE CHARGE is based on the concept that increasing the level of client-centered practice among providers will result in increased client contraceptive self-efficacy, leading to more successful users of family planning methods and a decrease in unintended pregnancies. In addition to expanding eligibility for Medicaid coverage for family planning services, TAKE CHARGE covers services not previously reimbursable: education, counseling, and risk reduction (ECRR) and intensive follow-up services (IFS).[1]

This report focuses on the design, structure, organization, and implementation of the TAKE CHARGE program. The process evaluation covers approximately the first two service years, July 2001 to June 2003; more recent information has been included when available. Much of the information in this report was collected from ten randomly selected research sites: five intensive follow-up services (IFS) sites, matched with five control sites. The purpose of this evaluation is to describe practices in place at clinical sites and to identify challenges faced and innovative solutions developed during program implementation. Client characteristics and behaviors, provider attitudes and behaviors, and family planning service utilization are also included.

BACKGROUND

In Washington State, in 2002, approximately 53% of all pregnancies were unintended at the time of conception. While unintended pregnancy is experienced by childbearing women of all ages, the majority occur to women in their twenties. For women age twenty to twenty-five, approximately 70% of all pregnancies are unintended.

In 2002, 43.4% of all deliveries to Washington State residents were funded by Medicaid. At more than $220 million per year, maternity care is one of MAA's largest expenses. The State Legislature and program staff recognized years ago that limiting the growth in Medicaid-paid deliveries required interventions at multiple levels:

- Increasing access to family planning services;
- Educating communities about the benefits of avoiding unintended pregnancies; and
- Changing individual and provider behavior.

[1] IFS are administered in five of the ten research sites.

- A number of programs have been initiated in Washington State over the past ten years to accomplish this. Each program has targeted a different population, and in combination, these programs have reached as broad a target population as possible.
- TANF clients and potential clients receive family planning assistance and information in Community Services Offices (CSOs) across the state. In accordance with RCW 74.12.400 and 410, MAA and the Economic Services Administration (ESA) have stationed family planning workers and nurses in most CSOs and began in the mid-1990s to co-locate clinical exam facilities in some CSOs (Campbell et al., 1999).
- Women who are Medicaid eligible solely because of pregnancy receive extended Medicaid coverage for family planning services only for a full year postpartum. For these women, full scope Medicaid coverage ends after the second postpartum month.
- All Medicaid-eligible pregnant women and new mothers receive counseling about achieving their desired family size and assistance with family planning services. Since July 2000, Maternity Support Services providers have been responsible for discussing pregnancy planning with each client and documenting the initiation of a birth control method during the postpartum period. Providers continue to be responsible for completing the Family Planning Interview Guide for each client.[2]

With the implementation of TAKE CHARGE in July 2001, women and men (who are not otherwise Medicaid eligible) with incomes up to and including 200% of the FPL became eligible for family planning services.

TAKE CHARGE program objectives are to:

- Decrease the number of unintended pregnancies;
- Increase the use of effective contraceptive methods;
- Increase the number of low-income women and men receiving family planning services;
- Raise awareness among providers regarding the importance of client-centered education, counseling, and risk reduction to increase successful use of contraceptive methods; and,
- Demonstrate through research that clients receiving intensive follow-up services (IFS) are more likely to be successful users of their chosen birth control method.

[2] See http://fortress.wa.gov/dshs/maa/familyplan/fpinterv12-99.htm for a description of the Family Planning Interview Guide.

CONCEPTUAL MODEL

The TAKE CHARGE program is based on the following conceptual model:

Client-centered provider behavior →↑ Client self-efficacy → Successful use of FP method →↓ Unintended pregnancies

Increasing the level of client-centered practice among TAKE CHARGE providers is the first program intervention.[3] This will be accomplished by training providers in the best practices related to client-centered family planning, by reimbursing providers for structured education, counseling, and risk reduction (ECRR) services and by reimbursing providers, at selected sites, for delivering intensive follow-up services (IFS) to female clients.

An expected outcome of client-centered practice is that clients will develop enhanced contraceptive self-efficacy. That is, they will be more confident that they can use their chosen family planning method successfully. Definitions of contraceptive self-efficacy vary by method type. For example, for birth control pills, self-efficacy involves remembering to take a pill every day as scheduled and not discontinuing pills if mild or temporary side effects occur. For barrier methods, self-efficacy often involves planning ahead (having the method available at the right time and place) and interrupting foreplay as required when using the method effectively. Client-centered practices that help clients critically evaluate which contraceptive method(s) are most acceptable to them and can be used most effectively should lead to enhanced contraceptive self-efficacy.

The third step in this model postulates that clients with enhanced contraceptive self-efficacy will be more successful users of family planning methods. The predicted result for clients whose family planning services are provided by client-centered practices and whose self-efficacy is enhanced is fewer unintended pregnancies.

PROGRAM COMPONENTS

The TAKE CHARGE program has three major components:

(1) Expansion of Medicaid Eligibility for Family Planning Services

Eligibility criteria for TAKE CHARGE require that a potential client:

- Need family planning services and apply for services at an approved TAKE CHARGE provider clinic/office;
- Be a US citizen or US national or a permanent legal resident for five years prior to application;
- Be a Washington State resident;
- Have a total monthly income at or below 200% of the Federal Poverty Level (FPL);

[3] Studies suggest that client-centered practice, in which providers educate women and men about the importance of choosing birth control methods that take into account their lifestyle and personal preferences, increases client contraceptive self-efficacy, confidence and continuation of their contraceptive method (Ranjit et al., 2001; Sable and Libbus, 1997; and Forrest and Frost, 1996).

- Have no other source of health care coverage for full-scope family planning services; and,
- Not be a current client of Medical Assistance programs that include Family Planning coverage.

Clients apply for TAKE CHARGE at approved TAKE CHARGE provider sites. Individual TAKE CHARGE providers are responsible for assisting potential clients with enrollment and forwarding the enrollment application to MAA. Once eligibility has been determined by MAA, the Medicaid ID card is sent to the client's home or to their provider, depending on the client's wishes. In September 2002, MAA introduced an on-line application process, which helped minimize errors and speed eligibility determinations.

(2) Client-Centered Practice: Education, Counseling, and Risk Reduction (ECRR)

The education, counseling, and risk reduction (ECRR) service is intended to increase client-centered practice among TAKE CHARGE providers. These client-centered interactive processes are based on best practices established by research studies and are intended to strengthen decision-making skills and support clients' successful use of their chosen contraceptive method.

Through a series of focused questions, the provider's role is to:

1. Help the client, male or female, critically evaluate which contraceptive method is the most acceptable and can be used most effectively by her/him, and clarify knowledge, assumptions, misinformation and myths about the chosen method(s). To help the client decide on a method, the provider should describe the methods and their possible side effects. Clients should be given written materials that are culturally sensitive, clear, relevant, and easy to understand. The provider should also give the client a phone number to call if she/he has any questions or concerns.
2. Facilitate the client's contingency planning regarding her/his use of contraception, including access to emergency contraception. Information about emergency contraception should relate to errors/problems with the client's chosen method.
3. Evaluate and address other client personal considerations, risk factors and behaviors that impact her/his use of a birth control method, such as a history of abuse, current substance use and abuse, current exploitation or abuse, living situation, and need for confidentiality.
4. Schedule a follow-up appointment for supporting the client's successful use of the selected contraceptive method.
5. When the client is male, (in addition to above), facilitate a discussion of the male client's role in supporting his partner's successful use of a chosen contraceptive method and prevention of unintended pregnancy.

While preconception counseling was provided in year one when a client planned no method of contraception, this was discontinued in year two.

(3) Intensive Follow-up Services (IFS)

Intensive follow-up services (IFS) are regular follow-up contacts made by providers to support the client's successful use of her chosen birth control method. IFS incorporate and expand upon the client-centered approach utilized by all TAKE CHARGE providers. Only five of the research

sites offer IFS. Only female clients eighteen years of age or older are eligible for IFS. Each intervention site developed its own program for IFS to meet the unique needs of their clients and to optimize their clinic operations.

PROGRAM ADMINISTRATION

The Department of Social and Health Services Medical Assistance Administration (MAA) administers the TAKE CHARGE program. MAA contracts with local family planning providers such as Planned Parenthood clinics, county health departments, as well as local hospitals and independent clinics. To qualify as a TAKE CHARGE provider, a clinic or agency must:

- Have a current MAA core provider agreement to provide family planning services;
- Sign the supplemental TAKE CHARGE agreement to participate in the TAKE CHARGE demonstration and research program according to MAA's TAKE CHARGE program guidelines;
- Complete and submit a TAKE CHARGE application agreeing to program
  - Administrative practices;
  - Evaluation and Research Responsibilities;
  - Clinical Practice Standards; and,
- Participate in MAA's specialized training for TAKE CHARGE prior to providing TAKE CHARGE services.

As of June 2003, seventy TAKE CHARGE providers offered services in 169 clinics throughout the state. Almost every county has at least one TAKE CHARGE clinic, with greater concentrations occurring in more populous counties; King County has approximately fifty providers; Pierce County has twenty; while Skamania and Ferry counties each have one clinic.

Provider Training. All providers were given training in the ECRR intervention component and administrative issues such as eligibility determination and billing procedures.

PROGRAM PARTICIPATION

Between July 2001 and the end of its first year, total enrollment was 98,973 unduplicated clients. By the end of the second year, total TAKE CHARGE enrollment had increased to 168,159.

Table 1: TAKE CHARGE Enrollment July 1, 2001– June 30, 2003

	Demonstration Year 1 July 1, 2001 – June 30, 2002	**Demonstration Year 2** July 1, 2002 – June 30, 2003	**Total** July 1, 2001 – June 30, 2003
TAKE CHARGE[4]	62,657	107,096	114,172
Pregnancy Extension(S)[5]	38,066	40,613	60,596
Total Unduplicated	98,973	145,166	168,159

[4] Includes some clients who transitioned to or from Program S.
[5] Includes some women who transitioned to or from Program G.

Over two-thirds or 67.5% of clients enrolled in the first two years of TAKE CHARGE were women between the ages of eighteen and twenty-nine. At the end of Demonstration year two, TAKE CHARGE had enrolled 8,152 men.

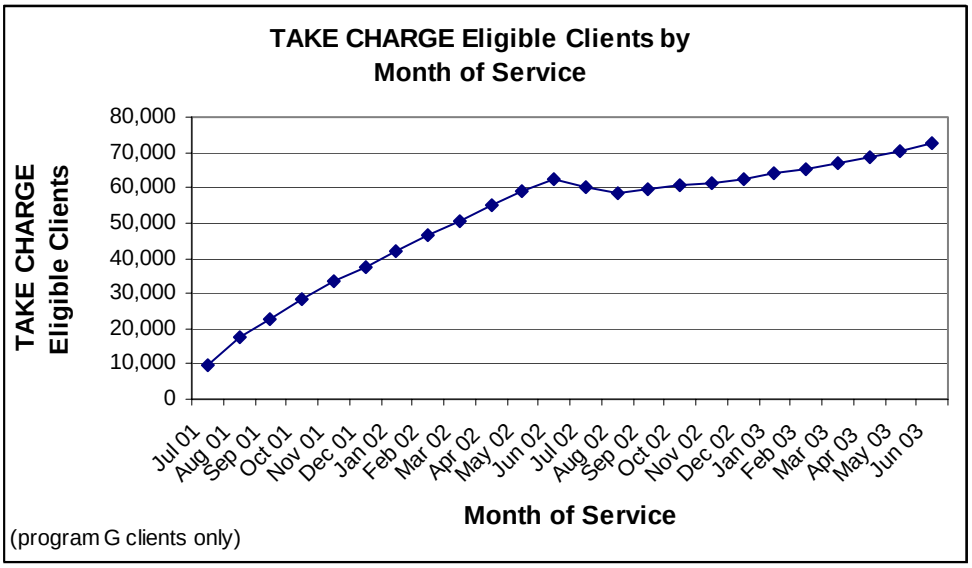
Table 2: Combined Year One and Two TAKE CHARGE Enrollees By Gender and Age

Age Group	Males	Females	Total
Less than 18	419	15,990	16,409
18-19	1,030	23,104	23,134
20-24	3,147	59,916	63,063
25-29	1,735	30,426	32,161
30-34	854	16,929	17,783
35-39	455	8,546	9,001
40-44	295	3,921	4,216
Over 45	217	1,175	1,392
Total	**8,152**	**160,007**	**168,159**

Current TAKE CHARGE Enrollment by Month

The line graph shows monthly TAKE CHARGE enrollment for the first two years of TAKE CHARGE implementation. In the first month 9,459 people enrolled in the program. One year later, 59,875 clients were enrolled. At the start of year three, 73,208 clients were enrolled. These figures represent current monthly enrollment and not total enrollment over time. The slight downturn in June 2002 is likely a result of the first re-enrollment process. The first clients that enrolled in TAKE CHARGE in July 2001 had to re-enroll in the program to be eligible for another year.

Figure 1.



METHODS

SITE SELECTION

This study employs a pre-post design, with five intervention sites selected randomly from the pool of Medicaid-approved providers to implement the IFS component of the evaluation, and five matched control sites. Clients under age eighteen were not included in the research protocol; therefore, any clinic primarily serving teens was excluded. Clinic sites located in another state (though serving Washington State clients) were also excluded. The remaining clinics were randomized by geographic area (Eastern WA, Western WA, and King County) and assigned to three categories (Local Health Jurisdiction, Planned Parenthood, Independent). IFS and control sites were chosen from the top of a randomly sorted list. The control for each IFS site was chosen by identifying the next clinic on the randomized list in the same category. Staff from DSHS Research and Data Analysis Division presented research training to the ten sites in the fall of 2001.

Table 3: Selected Evaluation Research Sites

Intensive Follow-Up Services Sites	Control Sites
Public Health Seattle & King County White Center Public Health Center	Public Health Seattle & King County Renton Public Health Center
Planned Parenthood of Western Washington University District Health Center	Planned Parenthood of Western Washington Seattle Clinic
Skagit County Health Department	Clark County Health Department Skamania Clinic
Mount Baker Planned Parenthood Mt Vernon Clinic	Planned Parenthood of Western Washington Everett Clinic
Planned Parenthood of Central Washington Sunnyside Clinic	Planned Parenthood of the Inland Northwest Whitman Clinic

DATA SOURCES

Quantitative and Qualitative Data Collection Instruments

Client Surveys. Primary data collection for clients consists of two self-administered written surveys. Baseline surveys are administered at program enrollment to roughly one hundred clients per year at each research site, and a follow-up survey is mailed to clients one year later. These client surveys describe client family planning behavior, attitudes and perceptions. Surveys are administered in English, Spanish and Vietnamese.

Clinic specific weights were calculated based on the proportion of all enrolled women at research sites that agreed to participate in the research protocol. These weights were applied in analyses of the client survey data reported in the *Findings* section. Weights were not adjusted for non-response. In year one, only eighteen clients were surveyed at the University District clinic, the second largest clinic among the ten research sites. The calculated weights based on these eighteen women were appreciably high; therefore, for year one a combined weight for the

University District and Capital Hill clinic was calculated. The following weights were calculated:

Table 4: Sample Weights for Year One Survey Respondents

Year One				
Clinic	**Frequency**	**Number for Sample**	**Percent Taken for Sample**	**Sample Weight**
White Center	1127	84	7.5	13.4
Skagit	56	16	28.6	3.5
Mt. Baker	753	82	10.9	9.2
Sunnyside	498	81	16.3	6.1
Renton	471	30	6.4	15.7
Skamania	65	8	12.3	8.1
Everett	1441	84	5.8	17.2
Whitman	569	92	16.2	6.2
Univeristy District/Capital Hill	6336	119	1.9	53.2

Table 5: Sample Weights for Year Two Survey Respondents

Year Two				
Clinic	**Frequency**	**Number for Sample**	**Percent Taken for Sample**	**Sample Weight**
White Center	511	113	22.1	4.5
University District	1884	103	5.5	18.3
Skagit	92	22	23.9	4.2
Mt. Baker	648	96	14.8	6.8
Sunnyside	298	93	31.2	3.2
Renton	349	100	28.7	3.5
Capital Hill	2803	104	3.7	27.0
Skamania	27	4	14.8	6.8
Everett	1028	105	10.2	9.8
Whitman	421	92	21.9	4.6

Provider Surveys. Analyses of provider attitudes and behaviors are based on responses to the provider survey. Evaluation staff administered a written survey to all family planning clinic staff at the research sites in the fall of 2001 (baseline) and spring of 2003 (follow-up). The initial research protocol called for administering the follow-up survey only to providers who had completed baseline surveys. A high staff-turnover rate at many of the research sites, however, required a change in protocol, in which all staff members were surveyed at follow-up, and baseline results were compared with follow-up results for all providers surveyed.

Site Visits. Evaluation staff visited the ten research sites for trainings and twice more to collect data in the first two years of TAKE CHARGE. Detailed site visit protocols were developed to insure that complete and comparable information was gathered at each site.

Key Informant Interviews. Evaluation staff interviewed three key individuals at each of the ten sites to determine the design, structure, organization, and implementation of the overall TAKE CHARGE program at each clinic. Provider surveys were also administered during these site

visits. Individuals interviewed included clinic managers/administrators, nurse practitioners (ARNPs), nurses (RNs), public health nurses (PHNs), medical assistants (MAs), patient care coordinators (PCCs), and front office staff.

IFS Site Activities. Evaluation staff coordinated training activities for IFS sites that allowed assessment of progress implementing IFS at each of the five intervention sites. These activities included five conference calls with the IFS sites, Research and Data Analysis Division, MAA, and Department of Health participating, as well as an IFS training conducted by the Center for Health Training in October 2002, with a second training scheduled for February 2004.

Agency Databases

Office of Financial Management (OFM) Medicaid Eligibility History. Spans of eligibility for specific entitlement programs are recorded with start and end dates for each Medicaid-eligible client. Specific combinations of program and match codes identify individual programs. This eligibility history file is the source of quarterly reports of clients eligible for TAKE CHARGE. While these reports are generated by MAA, Medicaid identifying codes, known as PICs (Patient Identification Codes), for TAKE CHARGE eligible clients are extracted by MAA and provided to the evaluation team. The evaluation team maintains an historical file of PICs for clients eligible for TAKE CHARGE and unduplicates these on a quarterly basis.

First Steps Database (FSDB). All Washington birth certificates are linked at the individual level to Medicaid claims and eligibility history. FSDB begins with births in July 1988 and currently contains linked birth certificates through 2002. The annual unduplicated count of individuals eligible for TAKE CHARGE is linked to the FSDB by PIC (for women with Medicaid-paid births) and by mother's name and date of birth (when births are not Medicaid-paid).

Medicaid Management Information System (MMIS). MAA's claims file contains a record for every claim submitted for reimbursement. For all TAKE CHARGE eligible clients, the FSDB staff submits the annual unduplicated PICs to MAA to obtain a service history for appropriate time periods for each PIC. The MMIS extract contains the following variables: PIC, date of service, provider ID, current procedural terminology (CPT) or other procedure codes, billed amount, and payment amount. MMIS services history data are used to describe the types of family planning services provided and to identify demonstration participants (based on receipt of one or more medical family planning services).

Program Documents

Evaluation staff reviewed program documents including provider contracts; site-specific IFS materials including the IFS description for the client and incentive materials; and other forms of written communication, such as informal notes and electronic mail messages.

Quarterly Client Lists from Providers

Providers from research sites are required to send a quarterly list of TAKE CHARGE eligibles at their clinic to Research and Data Analysis Division. No other method was available to provide site-specific data.

ANALYSIS

Study Groups

All Enrolled Women at Research Sites. This group includes all females enrolled at the research sites, identified from the quarterly client lists submitted by providers.

Research Participants. This group contains those women, eighteen years of age or older, who participated in the research protocol at one of the ten research sites. Each study participant signed a consent form and completed a pre survey with or without a post survey. Research participants were divided into two groups based on the site of enrollment, either at an intervention site (IFS site) or a control site.

Because the research protocol requires that clients be at least eighteen years of age to participate in the study, the average age of research participants is higher than that of the general TAKE CHARGE population at individual clinics. In year one, the average age of research participants was 24.7 years, while that of all TAKE CHARGE enrolled clients at the ten research sites was 22.0 years. Similarly, in year two the average age of research participants was 24.6, while the average of all TAKE CHARGE enrolled clients at the ten research sites was 21.7 years.

Table 6: Average Age of Research Participants and All TAKE CHARGE Clients by Site

Clinic Site	Year One		Year Two	
	Research Participants N=596	All TAKE CHARGE Clients N=8,359	Research Participants N=833	All TAKE CHARGE clients N=8,151
White Center	25.9	23.1	26.5	23.3
University District	21.7	21.8	22.6	22.0
Skagit County	23.9	20.7	24.1	20.1
Mount Vernon	23.9	21.5	26.4	21.5
Sunnyside	26.3	24.3	25.0	23.1
Renton	24.1	22.7	25.6	24.3
Capital Hill	25.8	22.9	25.0	22.9
Skamania	29.0	22.0	24.6	19.9
Everett	24.2	21.1	24.2	20.0
Pullman	21.7	19.6	21.7	19.7
Total	**24.7**	**22.0**	**24.6**	**21.7**

Statistical Analyses

Two different measures of association were used to detect differences among binary variables. Chi-square tests were used when comparing differences among IFS and control site clients and providers. McNemar's test was used to detect significant differences between the pre and post analyses. The McNemar test is appropriate for pre and post comparisons of two dichotomous nominal variables in a dependent sample (Lutz, 1983).

LIMITATIONS

Implementation of IFS did not start until the end of year one for some sites. This delay may mask effects when comparing IFS and control sites during the first year. Client survey data is limited to women eighteen and older and may not reflect the behavior of clients under age eighteen.

At the Sunnyside clinic, IFS were only provided to the 100 survey clients during the first two years of the program, instead of to all TAKE CHARGE enrolled women. Because Sunnyside is a high volume site and only one-fifth to one-quarter of their clients received the intervention, our ability to detect an effect of IFS may be reduced. This misunderstanding was corrected in year three and the clinic added staff to handle these additional IFS responsibilities.

Quarterly data for TAKE CHARGE eligibles were not received for the last quarter of year two (April – June 2002) from the Skamania Clinic; therefore, results related to services in the *Findings* section do not include all TAKE CHARGE clients from the Skamania Clinic. Since Skamania is a very small clinic, the results for control sites should not be appreciably affected.

RESEARCH SITES

SITE DESCRIPTIONS

Individual site descriptions follow this general information.

Services. In addition to providing most current FDA-approved birth control methods, TAKE CHARGE clinics also provide ECRR, pregnancy tests, referrals for maternity or adoption services, annual exams, breast exams, STD checks and HIV/AIDS tests. Clients can usually receive hormonal birth control methods with a delayed pelvic exam, when a careful medical history is taken. This removes a barrier to contraception for many women.[6]

Finding providers to refer clients to for sterilizations presented difficulties for some clinics, but others reported increases in available Medicaid providers since TAKE CHARGE began.

Patient Flow. The number of patients that can be seen each hour varies by how many providers are available and type of services provided. Clinicians see three to four patients per hour for most services, fewer for annual exams; as few as one per hour when ECRR is provided. At urban clinics two or more clinicians are available daily; rural clinics often only have one clinician who is not on-site daily. Clinicians often provide ECRR, but patient care coordinators (PCCs) provide ECRR at some sites. Registered nurses, where available, generally administer DepoProvera® shots and provide pill refills. Injections are sometimes provided by a medical assistant, when a nurse practitioner is on-site.

Telephone Protocols. Most clinics triage incoming calls. At some, front desk staff answers questions from a fact sheet, and questions not covered are referred to the clinician. All health department family planning clinics have direct lines to family planning reception. Medical questions are sent to the public health nurses for triage. Clients are given business cards with the direct phone number for the clinician.

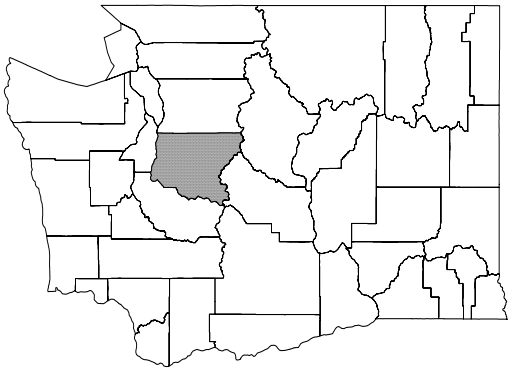
Lunches are staggered at most clinics so telephones are always answered, but two rural clinics in this study are completely closed for lunch; clients with urgent concerns are referred to other clinics. With the increase in call volume since TAKE CHARGE began, some clinics report hiring additional staff and/or revamping their phone systems to triage calls more effectively.

Walk-In Clients. All clinics in this study accept walk-in clients with urgent needs, such as pelvic inflammatory disease (PID), STD symptoms, and pregnancy testing. Most clinics fit walk-in clients in between appointments, wherever possible, but try to make appointments for those who want to start a new birth control method or need an annual exam. Walk-in clients can often be seen the same day; non-emergency walk-in clients are encouraged to make an appointment to limit their wait time. In many cases, clients are scheduled within a few days; however, at some clinics, clients may have to wait as long as three weeks for an appointment.

[6] In the demonstration project First Stop, which provided hormonal contraception without pelvic exams to low-income women in California, 76% of clients interviewed said that it was important to be able to receive pills or injections without a pelvic examination (Harper et al., 2001).

Public Health—Seattle & King County, White Center Public Health Center

"The Mission of Public Health - Seattle & King County is to achieve and sustain healthy people and healthy communities throughout King County, Washington, by providing public health services which promote health and prevent disease."



White Center is a district of south Seattle. Seattle's population is approximately 571,900, and King County's population is estimated to be 1,779,300.[7] White Center's population is diverse; 48% of clinic clients report that they are Latina or Hispanic. The clinic also serves many Vietnamese speakers, as well as members of other language groups.

White Center Public Health Center (WCPHC), an IFS site, is one of ten Public Health—Seattle & King County (PHSKC) clinics that offer family planning services.[8]

The clinic has four exam rooms and a counseling room. Family planning staff includes two nurse practitioners, one public health nurse (PHN), one health program assistant, one to two front desk clerks and a health educator. Clinic staff members, including clinicians, stagger their lunches to provide continuous service throughout the clinic's business hours. WCPHC has a direct line for family planning, a direct line for the public health nurse who provides IFS, direct lines for interpreters, and one for the clinician. Family planning calls go to the main switchboard, then to the nurse who triages calls.

WCPHC has a high volume of walk-in business and provides numerous opportunities for these clients to obtain their desired services. Established clients are encouraged to walk-in on Wednesdays, Thursdays and Fridays for pill refills.

Intensive Follow-Up Services (IFS)

WCPHC provides IFS for all of its family planning clients; *"One of the important successes is that follow-up is incorporated in daily practice for all our clients."* Each family planning client starting a new birth control method receives a form where she can indicate how she wishes to be supported in her continued use of her chosen method, whether she needs an interpreter, and, if so, the language required. Clients indicate how they would like to be contacted; if by phone, they are asked whether a detailed message may be left. The form includes a place for the nurse to write the date a new birth control method is started and a checklist of methods, as well as space

[7] Washington State Office of Financial Management, Official April 1, 2003 Population Estimates.
[8] In addition to family planning and reproductive health services, White Center Public Health Center (WCPHC) provides general health services to the community.

for the date the client should return to the clinic and a checklist for the purpose of that follow-up visit, such as pill refill or annual exam.

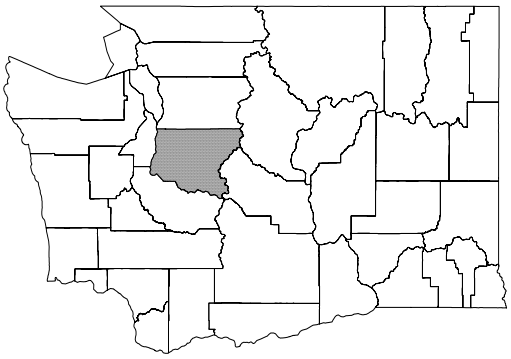
WCPHC provides between thirty-five and forty IFS calls per week. The majority of IFS is performed by the public health nurse, who leaves her direct phone number so clients can return her calls without going through the clinic's main switchboard. Interpreters provide IFS follow-up calls for non-English speakers in their native languages; these clients also receive cards with their interpreter's direct phone number. WCPHC has worked to improve literature and outreach for speakers of Vietnamese. Clinic staff is currently working on translating birth control methods information into Spanish. WCPHC used to have a large number of family planning clients who did not show up for their appointments; now the health program assistant makes reminder calls for all family planning appointments, which has helped reduce the number of no-shows. WCPHC IFS are described in more detail in the box below.

INTENSIVE FOLLOW-UP SERVICES COMPONENTS AT WCPHC

- **IFS Dedicated Staff:** Public health nurse (PHN), health program assistant (HPA), and part-time interpreter
- **Access to medical staff for questions about their birth control method or reproductive health concerns:**
  - Direct family planning phone line to IFS staff and interpreters
  - Direct phone line to the nurse practitioner
- **Best Practices:** WCPHC has identified best practices for its IFS to provide "*better engagement in ongoing care*."
- **Client-Specified Plan** for IFS staff to:
  - Check in with clients who have recently started a new birth control method
  - Remind client of follow-up appointments
  - Help clients make appointments before they leave
  - Remind client of need to re-order birth control supplies
  - Provide services in the client's native language, as needed
  - Use an agreed upon best way to keep in contact (phone, e-mail, or letter)
  - Self-addressed reminder cards for annuals, as confidentiality allows
  - Follow-up calls or cards for missed appointments
- **Method-Specific Follow-Up Protocols:** A protocol has been defined for each birth control method and put in a grid for easy reference.
- **Targeted Follow-Up:** Clients with the following indications receive follow-up specific to their needs: pregnancy test, a failed birth control method, emergency contraception, two or more method changes in six months, pregnancy termination, non-English speakers.
- **Ongoing Clerical Staff Training** keeps staff prepared to appropriately screen and schedule clients.

Planned Parenthood of Western Washington, University District Health Center

Planned Parenthood Western Washington has "*provided high-quality, affordable birth control since 1935. Many of our patients have no other health care available to them.*"



Seattle's population is approximately 571,900, while King County's population is estimated to be 1,779,300.[9] University District Health Center primarily serves students from the University of Washington (UW). The UW Seattle Campus has a student population of approximately 36,700.[10]

University District Health Center, a Planned Parenthood of Western Washington (PPWW) health center, is an IFS site. PPWW, the largest reproductive health care provider in the Northwest, has nineteen health centers in eight counties.[11]

The clinic has four exam rooms and two counseling rooms, and is open six days and two evenings per week. The clinic employs three nurse practitioners, one of whom was hired after TAKE CHARGE began. The addition of a nurse practitioner allows clinicians to rotate their workdays so that there are two clinicians on-site during all hours of clinic operation. Additional family planning staff includes a nurse's station team leader and seven patient care coordinators, as well as two IFS staff hired for TAKE CHARGE: an IFS coordinator and an IFS educator.

Intensive Follow-Up Services (IFS)

University District Health Center began its implementation of IFS in June 2002. IFS staff keeps detailed records of their contacts with patients, about three pages per patient, which allow them to review the development of their contact with individual patients and see whether their contacts have made a difference. The recall list for IFS is currently about ninety-five patients per week, a challenge for the two staff members, and this number does not include calls to patients who have missed appointments. As students move frequently, IFS staff requests cell phone numbers, whenever possible. IFS staff also encourage other clinic staff to ask patients to keep their contact information current at each visit. University District Health Center IFS are described in more detail in the box below.

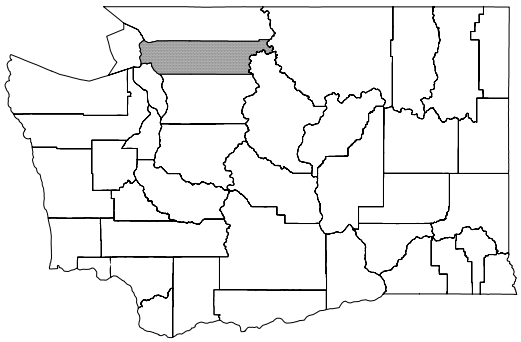
[9] Washington State Office of Financial Management, Official April 1, 2003 Population Estimates.
[10] University of Washington webpage, Student Headcount by Campus and Term, http://magma.opb.washington.edu:7778/pls/portal30/PARTY.RPT_ST_HCOUNTS_BY_CAMPUS_TERM.show, accessed 11/12/2003.
[11] Planned Parenthood of Western Washington web page: http://www.ppww.org/, accessed 11/10/2003.

INTENSIVE FOLLOW-UP SERVICES COMPONENTS AT UNIVERSITY DISTRICT HEALTH CENTER

- **Dedicated Staff:** IFS coordinator and IFS educator
- **Direct IFS Phone Line**
- **Tracking Program (QSI):** IFS staff uses QSI, a computer program, to enter and track IFS patient information, according to birth control type. This allows IFS staff to query the database for patients who need follow-up calls each week.
- **Chart Stickers and Alert System:** Each IFS client has a green IFS sticker affixed to their chart. When IFS clients come in and their charts are pulled by the front desk staff, they can see that the IFS staff needs to be notified. An IFS alert system is programmed in the computers used by the front desk staff for scheduling appointments. This system flags a client so front desk staff knows to alert the IFS staff of the patient's needs.
- **Client-Specified Plan** for IFS staff to:
  - Check in with clients who have recently started a new birth control method
  - Remind client of follow-up appointments
  - Remind client of need to re-order birth control supplies
  - Use an agreed upon best way to keep in contact (phone, e-mail, or letter)
  - Self-addressed reminder cards for annuals, as confidentiality allows
  - Follow-up calls or cards for missed appointments
- **Method-Specific Follow-Up Protocols:** A protocol has been defined for each birth control method and put into a grid for easy reference. This information is entered into the QSI program so that clients will get follow-up calls on schedule as appropriate for their chosen method of birth control. These protocols outline procedures for positive and negative responses from clients about new birth control methods. For example, if a client is happy with her birth control method and experiencing no problems, the recall code will be changed to a reminder for her annual exam; if the patient does not like her method, but wishes to try it for a little longer, the recall is changed to four weeks; or if she wants to change her method, the clinician is notified and takes over, and the recall date is changed to six weeks from the start of the new method.
- **Ongoing Clerical Staff Training:** At each staff meeting, IFS staff reminds clinic staff to notify them each time an IFS patient calls the clinic or comes in. Currently front desk staff members are consistent about letting IFS staff know when their patients come into the clinic, helped by the chart stickers and alert system (see above), but IFS staff report that they do not always know when an IFS client has called the clinic.
- **Weekly Task Management:** In addition to follow-up protocols, the clinic has established a Weekly Task Management list that provides a schedule of IFS tasks for each day.

Skagit County Health Department

"Always working for a safer, healthier Skagit County."



Skagit County is located between Seattle, Washington and Vancouver, B.C., Canada. Mount Vernon's population is 27,060, 25% of whom are Hispanic (compared to fewer than 9% for the state). Skagit County's economy is based on agriculture, fishing, wood products, tourism, international trade, and specialized manufacturing.

The main clinic of the Skagit County Health Department, an IFS site, is located in the county administration building in downtown Mount Vernon. Skagit County Health Department also operates walk-in clinics located in Anacortes, Concrete and Sedro Woolley offering family planning, STD and HIV services.[12]

Skagit County Health Department's main family planning clinic operates Tuesdays and Thursdays on a walk-in basis. A nurse practitioner provides services three Thursdays per month.[13] The recent hire of a Spanish-speaking physician assistant, who works on Tuesdays, allows clinical services to be offered on both days of clinic operation. Now Spanish speakers who come in on Tuesdays can speak to the clinician without the need for an interpreter. The public health nurse is available on clinic days, with additional unscheduled availability to meet clients' needs. Getting backup help for family planning staff is an ongoing challenge for the clinic. On days when a clinician is not available, clients can come in for pregnancy testing and pill refills, as well as ECRR (this last service is only available when the public health nurse is on-site). IUD insertions are referred to the Anacortes clinic. Family planning clinic staff noted that TAKE CHARGE has made main clinic staff more aware of the family planning services that are available at Skagit County Health Department.

When a clinician provides ECRR, counseling takes place in the clinic's one exam room. The counseling office, used by the public health nurse for ECRR, was designed as a hearing test room. This tiny space causes some patients to feel claustrophobic; in those cases, the door must be left open, which can compromise the client's confidentiality. This nurse's own office space is a shared open cubicle.

[12] Skagit County Health Department webpage: http://www.skagitcounty.net, accessed 11/18/2003.
[13] She is also on-site every other Monday for two to four hours.

Intensive Follow-Up Services (IFS)

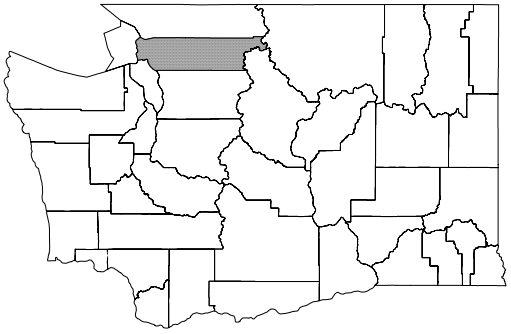
The public health nurse provides IFS for health department clients. Because she has responsibilities as the public health nurse to the county population as a whole, in addition to her TAKE CHARGE responsibilities, this nurse does not have enough time to make all of the necessary client contacts for IFS; so an additional part-time nurse is scheduled to make some of the IFS contacts. Skagit County Health Department IFS are described in more detail in the box below.

INTENSIVE FOLLOW-UP SERVICES COMPONENTS AT SKAGIT COUNTY HEALTH DEPARTMENT

- **IFS Staff:** One part-time public health nurse (PHN) who is the IFS coordinator working with the clinician to handle medical aspects of follow-up; a part-time nurse (RN) assists with follow-up calls.
- **Direct Phone Line:** Clients who have questions or need help can call the public health nurse directly.
- **Client-Specified Plan** for IFS staff to:
  - Remind clients when additional birth control supplies need to be reordered or when injections are due and remind clients of follow-up appointments
  - Agreed-upon phone consultations regarding new birth control methods or method changes
  - Client access to medical staff for questions
  - Establishment of a best method of contact (phone, e-mail, letter or card)
  - Contact new patients two weeks after initial visit
- **Confidential Consultation Services:** The public health nurse provides needs assessment and help with problem-solving and makes referrals to appropriate community resources, such as domestic violence and counseling assistance.
- **Outreach Care:** Skagit County's public health nurse makes house calls to those clients who are housebound or do not have transportation to the clinic. She has longstanding relationships with many members of the community, especially those needing multiple interventions by community services; so she is in a unique position to help high-risk clients address family planning concerns.
- **Outreach Education:** The public health nurse provides family planning outreach and education to nurses throughout the county. The health department also pays a college student to provide outreach education at the local community college for a few hours each week in the lunch room. Her boyfriend, who provides outreach to male students, often joins her. Clinic staff is currently considering training her to provide urine testing for *Chlamydia* and gonorrhea; the hope is that, if male students come to the student educator for testing, she or her boyfriend may get the opportunity to talk to them about birth control options and partner responsibility for preventing unintended pregnancies.

Mt. Baker Planned Parenthood
Mount Vernon Clinic

Mount Baker Planned Parenthood's mission is to "provide family planning information, education and quality clinical services, according to the ability to pay, and to promote understanding and acceptance of responsible parenthood by choice."



Skagit County is located between Seattle, Washington and Vancouver, B.C., Canada. Mount Vernon's population is 27,060, 25% of whom are Hispanic (compared to fewer than 9% for the state). Skagit County's economy is based on agriculture, fishing, wood products, tourism, international trade, and specialized manufacturing.

Mount. Vernon Clinic, an IFS site, is a Mt. Baker Planned Parenthood (MBPP) clinic. MBPP has three family planning clinics and one full primary care clinic in Bellingham, Washington. This is the first clinic of its kind administered by a Planned Parenthood affiliate.[14] Mount. Vernon Clinic is attached to the Mount Vernon DSHS Community Services Office and was built as part of a program to co-locate family planning services with DSHS services throughout Washington State.

When TAKE CHARGE began, clinic staff included a nurse practitioner, on-site three days a week; a medical assistant; and two patient care coordinators at the front desk. An additional medical assistant and an IFS coordinator were hired to handle the growth in clinic business due to TAKE CHARGE. An additional clinician is also being added to the staff. On days when the clinician is not at the clinic, clients can come in for pregnancy testing, and pill refills; a medical assistant can provide DepoProvera® injections only when a clinician is on-site. The clinic includes a small lobby, three exam rooms, and an office, allocated to the IFS coordinator that is also used as a counseling room as needed. Staff reported that the current clinic space is barely adequate for their increased patient volume.

In spring 2003, a bilingual outreach specialist was hired to conduct outreach in Skagit County through the summer. Outreach activities included networking with Spanish lay advocates, as well as presentations and Spanish language materials for Spanish-speaking populations in Skagit County arranged through Spanish radio shows and organizations serving Spanish-speaking and migrant populations, including shelters. Additional outreach was targeted toward health care providers and pharmacists throughout the county, to let them know what services and products TAKE CHARGE covers. More recently, outreach efforts have been aimed at people who work with marginalized young adults, such as Job Corps and probation officers.

[14] Mount Baker Planned Parenthood website: http://www.mbpp.org/aboutus.htm, accessed 11/10/03.

Intensive Follow-Up Services (IFS)

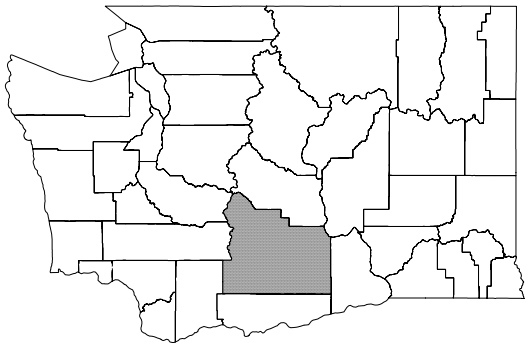
All Mount Vernon Clinic TAKE CHARGE clients receive intensive follow-up services. Mount Vernon's IFS program, entitled "TC Benefits" and coordinated by the IFS coordinator, promotes an attitude that empowers clients to follow through with their birth control methods and eliminates any stigma associated with publicly-funded services. The IFS coordinator spends about 25% of her time following up with clients, referring those with medical concerns to the medical assistant or clinician as appropriate. Mt. Vernon's IFS program is described below.

INTENSIVE FOLLOW-UP SERVICES COMPONENTS AT MOUNT VERNON PLANNED PARENTHOOD

- **IFS Staff:** TAKE CHARGE IFS coordinator provides non-medical follow-up; medical questions are handled by the medical assistant or nurse practitioner; and part-time bilingual outreach worker.
- **Direct Phone Line:** Clients can call the IFS coordinator directly.
- **Client-Specified Plan** for IFS staff to:
  - Remind clients when additional birth control supplies need to be reordered or when injections are due and remind clients of follow-up appointments
  - Agreed-upon phone consultations regarding new birth control methods or method changes
  - Client access to medical staff for questions
  - Establishment of a best method of contact (phone, e-mail, pager, letter or card)
  - Provide phone consultations five to six weeks after the start of a new birth control method or following a change in contraceptive methods
- **TAKE CHARGE Benefits Card** includes the phone number of the clinic
- **TAKE CHARGE Benefits Membership Rewards**
  - Special calendar with reminder stickers for the Ring, Patch, and DepoProvera®
  - "Once-a-Day" birth control reminder system
  - Bonuses for six-months' successful use of chosen birth control method, such as Starbucks Gift Certificates and Blockbuster Video gift cards
  - Raffles with monthly drawing winners
- **Confidential Consultation Services:** The IFS coordinator provides needs assessment and problem solving assistance and makes referrals to appropriate resources such as parenting resources, domestic violence help, shelters and transitional housing programs, and provides bus passes and/or taxi vouchers for clients with transportation needs.
- **Outreach Care:** The IFS coordinator works with medical providers at sites such as in-patient treatment facilities and residential centers to provide continuous care for clients' family planning needs.
- **Outreach Education:** A part-time outreach specialist provides outreach education throughout Skagit County.

Planned Parenthood of Central Washington
Sunnyside Clinic

"Planned Parenthood of Central Washington (PPCW) exists to assure that all people are empowered to make reproductive health choices and have access to the quality health care and sexuality education required to exercise those choices."



Sunnyside's population is estimated at 13,905, 63.5% of those over five speak Spanish; 35% were Spanish speakers who reported that they did not speak English well in the 2000 U.S. Census. Clinic staff reports that outlying agricultural areas have significantly higher numbers of Spanish speakers with limited English proficiency.

Sunnyside Planned Parenthood clinic, an IFS site, is one of five regular clinics operated by Planned Parenthood of Central Washington (PPCW). Headquartered in Yakima, PPCW also operates six clinics in DSHS Community Services Offices.[15]

Sunnyside is about an hour southeast of Yakima, near the Yakama Indian Reservation. The Sunnyside Planned Parenthood clinic is situated in a shopping center in downtown Sunnyside. The clinic is open four days a week, usually until 6:30. While the clinic closes for staff lunch (12:30-1:30), it is open during the peak hours of client volume, offering family planning services on a walk-in basis. During the staff lunch break, the clinic phone goes to voicemail, which directs people with urgent concerns to call the Yakima clinic for immediate assistance.

Two of the clinic's four exam rooms are used for exams and two are used for counseling. All but one member of the clinic staff members are bilingual. Staff consists of a nurse practitioner, three part-time health care assistants (2.5 FTE), a site supervisor, a registered nurse and two IFS/outreach specialists with casework experience. The IFS/outreach staff was hired at the outset of year three and works part-time in the clinic and will also work part-time in the mobile clinic van, purchased prior to TAKE CHARGE, which is soon to be operational.

Sunnyside initially had problems with some patients enrolling in TAKE CHARGE more than once, but the clinic has since implemented a protocol to check enrollment status prior to starting new patients on TAKE CHARGE. Some patients were denied TAKE CHARGE coverage due to lack of legal residence documentation; so now, when a new patient first applies for TAKE CHARGE, staff ask if the client has been in the country for five years or more, requests her/his residency card, and sends a photocopy of the card with the TAKE CHARGE application. This has helped speed the approval process. PPCW is updating the frequently asked questions (FAQ) section of its webpage to include questions commonly asked by TAKE CHARGE clients.

[15] Planned Parenthood of Central Washington webpage: http://www.ppcentwa.org/, accessed 11/18/20023.

Intensive Follow-Up Services

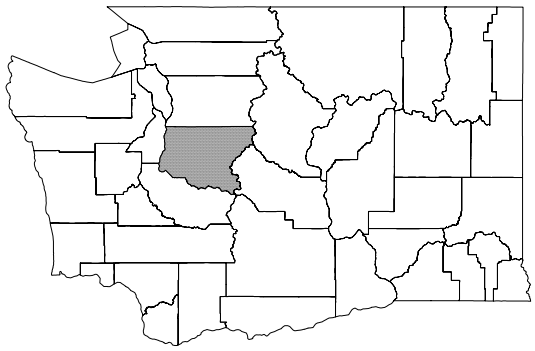
IFS were inadvertently provided only to the one hundred survey clients during the first two years of TAKE CHARGE, instead of to all women enrolled in TAKE CHARGE. This was corrected in year three, when the clinic added three IFS staff members, two former First Steps caseworkers and a registered nurse, to provide sufficient staff resources to handle the large volume of calls that will be required to meet the clinic's model of IFS. Sunnyside's IFS program is described in more detail in the box below.

INTENSIVE FOLLOW-UP SERVICES COMPONENTS AT PLANNED PARENTHOOD CENTRAL WASHINGTON SUNNYSIDE CLINIC`

- **Dedicated Staff:** Two full-time IFS/outreach workers, a part-time health care assistant and a registered nurse.
- **Follow-up Telephone Calls:** The IFS staff calls each patient after they start a new birth control method. Staff assesses the client's need for further follow-up by her satisfaction with her chosen method: whether she is reporting any difficulties with her method, whether she is determined to stay with that method and needs additional help, or whether she needs to consider another method. Clients who are fully satisfied and not experiencing any problems will receive fewer follow-up calls; while those who are having problems or seem to be in danger of giving up on their birth control will receive as much support as necessary to help them find appropriate methods and achieve contraceptive self-efficacy.
- **Drop-In Services:** IFS staff provides a regularly scheduled time for drop-in clients to ask questions related to birth control, sexually transmitted diseases and other issues.
- **Clients' work schedules are in their chart:** IFS staff keeps abreast of their clients' work schedules so they know when they can be reached.
- **Outreach:** Staff works with community partners, such as food banks, to locate and access hard to reach rural populations. Staff is currently networking with a variety of agencies to establish further partnerships throughout their community to improve access for clients. It is also planned that IFS staff will participate in community events to improve the clinic's visibility.
- **Outreach Care:** The IFS staff will provide IFS through home visits where needed. In addition to this, it is planned that they will provide ECRR, TAKE CHARGE and IFS enrollment, and dispense birth control methods to clients who live in remote areas. The staff will also encourage patients to visit the clinic for continued family planning services.

Public Health—Seattle & King County, Renton Public Health Center

"The Mission of Public Health - Seattle & King County is to achieve and sustain healthy people and healthy communities throughout King County, Washington, by providing public health services which promote health and prevent disease."



Renton is located southeast of Seattle; its population is about 50,900, with King County's population estimated at 1,779,300.[16] Approximately 22.6% of Renton's population over age five speaks a language other than English at home; staff reports that the percentage is higher among Renton Public Health Center clients.

Renton Public Health Center, a control site, is one of ten Public Health—Seattle & King County (PHSKC) clinics that offer family planning services.

The clinic is open Monday through Friday, and is open late on Mondays, from 10:00 a.m. to 7:00 p.m. Before TAKE CHARGE began, the clinic closed during the lunch hour; now, however, staff staggers their lunch breaks to keep the clinic open throughout the day. Family planning staff includes two nurse practitioners, one full-time and one part-time; a public health nurse; a health care assistant, who also functions as a Spanish interpreter; a front office clerk, and a full-time health educator, who provides outreach at colleges and other locations throughout the community. On Tuesday afternoons there is not a clinician on site, so only nurse visits are scheduled.

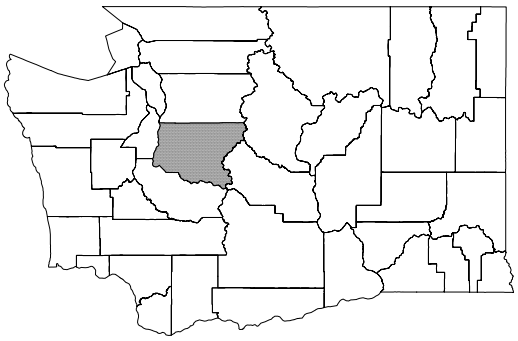
Clients starting a new birth control method are asked to return to the clinic in two to four weeks; clients needing to reorder birth control supplies, or have a reinsertion, are given a card with the appropriate date to return to the clinic. Patients missing appointments for annual exams are called three times and then sent a letter.

The clinic's high number of Spanish speakers overwhelms the clinic's one Spanish-speaking staff member; respondents reported that the clinic needs additional Spanish-speaking staff. The clinic serves a large number of undocumented clients. The health department is not reimbursed by Medicaid for family planning services to those clients.

[16] Washington State Office of Financial Management, Official April 1, 2003 Population Estimates.

Planned Parenthood of Western Washington, Seattle Health Center

Planned Parenthood Western Washington has "*provided high-quality, affordable birth control since 1935. Many of our patients have no other health care available to them.*"



Seattle's population is approximately 571,900, while King County's population is estimated to be 1,779,300.[17] Seattle Health Center is located in the Central Area of Seattle, an area known for its economically and ethnically diverse population.

Seattle Health Center (SHC), a Planned Parenthood of Western Washington (PPWW) health center, is a control site. PPWW, the largest reproductive health care provider in the Northwest, has nineteen health centers in eight counties.[18]

Seattle Health Center is open six days a week, with evening hours two days a week, and operates half days on Saturdays. The clinic remains open during the lunch hour for scheduling, pill refills, information, walk-in pregnancy tests, and HIV results.

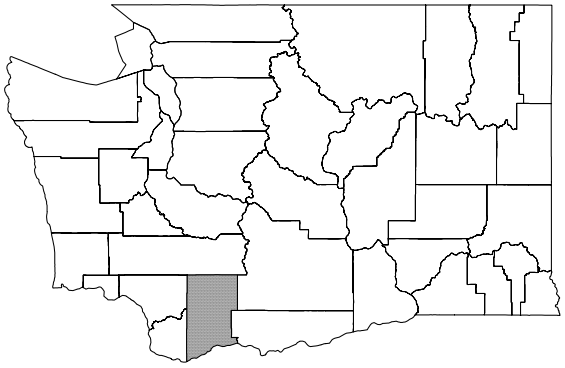
At the outset of TAKE CHARGE, the clinic had two clinicians, a nurse practitioner and a physician assistant, six patient care coordinators, a health educator, and the clinic manager. TAKE CHARGE increased clinic volume dramatically; clinic staff estimates that they serve approximately fifty TAKE CHARGE patients daily. An additional ARNP, who works four days per week, and three additional patient care coordinators have been hired to handle the increased caseload. A new computer program has improved client tracking. Respondents reported that the additional clinic staffing is still not adequate to meet the demand for services. Before TAKE CHARGE, clients could get an annual exam the day they called for an appointment or came in to the clinic, but now they must wait a week and a half. The clinic also accepts fewer walk-in patients; patients with urgent medical concerns are accepted as walk-ins.

ECRR is provided and documented by the clinicians during a patient's first visit. The clinician reviews the first half of the ECRR prior to the pelvic exam and completes the ECRR following the exam. Staff members report that the extra clinician time spent with the client results in greater collaboration between client and provider. Some respondents at Seattle Health Center reported that their clinic's upscale architecture, clients' ease in talking to the staff and assurance of confidentiality, along with the clinic's elevated standards for service, create a high level of client satisfaction with SHC as their family planning clinic. "*We go the extra mile and do more than a private practice would.*"

[17] Washington State Office of Financial Management, Official April 1, 2003 Population Estimates.
[18] Planned Parenthood of Western Washington web page: http://www.ppww.org/, accessed 11/10/2003.

Clark County Health Department—Skamania County Office

"Our services are low cost, confidential, welcome medical cards and private insurance, and are administered by female providers."



Stevenson, population 1,210, is the county seat of Skamania County (population 9,900 with 8,075 of its residents living in the unincorporated county).[19] To save resources, Skamania and Clark County Health Departments are jointly administered by the Clark County Health Department in Vancouver, some fifty miles from Stevenson.

The Skamania County Office, a control site, is located in downtown Stevenson and is one of two clinics operated by the Clark County Health Department. The clinic, which has one exam room and one counseling room, is open five days per week. In addition to providing family planning services, the clinic provides general health services for men, women and children.

Clinic staff consists of one nurse practitioner who works in the clinic twice a month, one public health nurse (PHN) who works four days per week in the clinic, and one to two program assistants at the front desk. The clinic manager is at the Clark County office. On the two days per month when the clinician is in the office, clients can schedule appointments between 9:00 a.m. and 4:30 p.m. A four-week wait for clinician appointments is typical, but some walk-in clients can be accommodated. Although the clinic has a delayed pelvic exam protocol, the clinician's schedule can create a long wait for those clients with negative pregnancy tests who need to start a birth control method. IUD insertions are referred to the Clark County office.

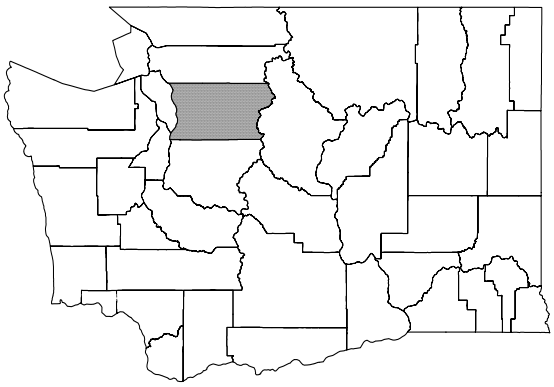
The public health nurse typically provides ECRR, allowing the clinician to see more patients; if a patient has not been given ECRR by the nurse, the clinician will provide it. Clients starting new birth control methods are encouraged to make a follow-up appointment to discuss their method in three month's time. The public health nurse and the nurse practitioner are never in the office at the same time due to limited exam room space—they cannot both see patients at the same time.

Because Stevenson is a small town, confidentiality is extremely important to their clients. One staff member noted that the clients appreciate that the parking lot is located discretely behind the clinic.

[19] Washington State Office of Financial Management, Official April 1, 2003 Population Estimates.

Planned Parenthood of Western Washington, Everett Health Center

"Planned Parenthood of Western Washington is the largest reproductive health care provider in the Northwest. We've provided high-quality, affordable birth control since 1935. Many of our patients have no other health care available to them."



Everett, the main city of Snohomish County, is twenty-eight miles north of Seattle on Puget Sound. Everett's population is currently estimated at 95,000.[20] The population of Snohomish County is roughly 637,500, with nearly half of its residents living in the unincorporated county. An estimated one-third of Everett's population commutes to Seattle to work.[21]

The Everett Health Center, located in Snohomish County, is one of eighteen health centers operated by Planned Parenthood of Western Washington, which has its headquarters in Seattle. The clinic, a control site, is located in downtown Everett.

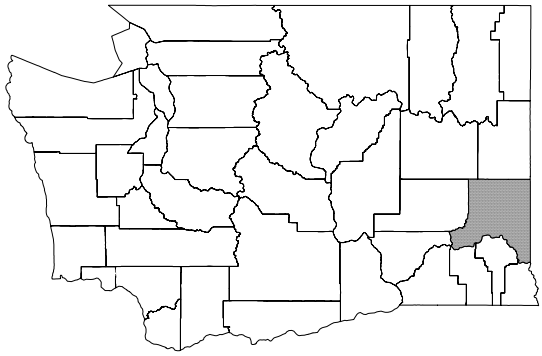
Everett Health Center is open six days a week. Prior to TAKE CHARGE, the Everett Planned Parenthood clinic had been open five days with one evening per week, but, after TAKE CHARGE began, they dropped the evening hours and added Saturdays to their schedule. Everett Health Center has six patient care coordinators (two added since TAKE CHARGE began); two nurse practitioners; a registered nurse, who joined the staff during TAKE CHARGE year two; and three medical assistants. The medical assistants provide ECRR and may give DepoProvera® reinjections. The nurse handles medical questions that come into the clinic by phone, referring calls to the clinicians as needed. Everett Health Center refers patients who want tubal ligations or vasectomies to providers in King County, as no providers for sterilizations are available in Snohomish County.

The Everett Health Center has faced some serious challenges, including a complete turnover of its staff, as it began implementation of TAKE CHARGE. In the process of training all new front desk staff with clinic operations and TAKE CHARGE paperwork, patients sometimes experienced longer wait times for appointments. The clinic hired a staff member dedicated to TAKE CHARGE who handles collecting all TAKE CHARGE paperwork, and this has helped things run more smoothly.

[20] Washington State Office of Financial Management, Official April 1, 2003 Population Estimates.
[21] Snohomish County Profile. Labor Market and Economic Analysis Branch, Washington State Employment Security Department, April 2001.

Planned Parenthood of the Inland Northwest, Whitman County Clinic

"Planned Parenthood believes in everyone's right to choose when or whether to have a child, that every child should be wanted and loved, and that women should be in charge of their own destinies."



Pullman, population 25,300, is located in remote southeastern Washington, some seventy-five miles from Spokane, Washington.[22] Whitman county clinic is within easy walking distance of the Washington State University (WSU), which has over 18,000 students on campus.[23]

The Whitman County Clinic, a control site, is a Planned Parenthood of the Inland Northwest (PPINW) clinic. PPINW operates a total of seven clinics. At the outset of TAKE CHARGE, the clinic was closed during lunch; now the clinic opens later in the mornings, and stays open during lunch for pill refills, and pregnancy testing. The clinic has four exam rooms, two used for exams and two for education and counseling. Staff includes one nurse practitioner, one clinic manager, and one medical assistant.

College interns periodically do outreach for the clinic at both WSU and the nearby University of Idaho, where many students are Washington residents. While WSU has its own women's clinic, providers reported that many students prefer the confidentiality of the Whitman County Clinic, as it is off-campus and downtown. Clinic staff provides ECRR to walk-ins, when they will accept it, and try to capitalize on the opportunity to get clients to think about choosing a birth control method that will work for them. Clients are referred to local gynecologists for tubal ligations; vasectomies are performed in Spokane.

Respondents reported that, prior to TAKE CHARGE, clinic business fluctuated greatly with the seasons, being very busy during the college school year and fairly quiet during summer months. With TAKE CHARGE, more permanent community members visit the clinic, so the clinic stays busier during the summer. Clinic staff reported that, previously, their clients had to go to different providers when they were out of town during summer term. This entailed transferring clients' medical records. With TAKE CHARGE, however, clients are given a three-month supply of their birth control method prior to the start of summer term. This has proved to be more convenient for clients and saves on paperwork for clinic staff.

[22] Washington State Office of Financial Management, *April 1 Population of Cities, Towns, and Counties* http://www.ofm.wa.gov/pop/april1/finalpop2003.xls
[23] WSU Overview web page: http://www.wsu.edu/NIS/WSUOverview.html

INTENSIVE FOLLOW-UP SERVICES DEVELOPMENT AND IMPLEMENTATION

Five intervention sites implemented intensive follow-up services (IFS). Before the implementation of IFS, intervention sites used a routine follow-up protocol that is standard clinical practice for reproductive health clinics. Follow-up ranged from sending reminder postcards or letters for annual exams to contacts for abnormal Pap smears. One clinic had started calling clients a day ahead to remind them of appointments due to the large number of no-shows at their clinic. Clinics had varying follow-up protocols for injectible contraceptives, DepoProvera® and Lunelle™, ranging from giving clients a reminder card with the date when the client should make the next appointment to scheduling the appointment before the client left the clinic.

During initial visits to IFS sites, evaluation staff presented the goals of intensive follow-up services (IFS). Staff brainstormed ideas for the IFS methods to implement at their clinics. This sharing process during the development of each site's model continued through IFS conference calls during year one. Each intervention site developed its own program for IFS to meet the unique needs of their clients and to optimize clinic operations. Table 7 lists the components of IFS models implemented by the clinics; it includes those components funded through a contract with MAA.

While billing for TAKE CHARGE services began July 1, 2001, most intervention sites experienced significant delays initiating their IFS activities in year one due to the time needed to develop research contracts and hire the additional personnel needed to provide these intensive services. Start times for IFS implementation ranged between November 2001 and June 2002.

IFS Components

IFS Staff. All four high-volume intervention sites have a full-time IFS coordinator. Four sites have hired outreach workers, who visit a variety of places, ranging from college campuses to organizations of Spanish-speaking populations and remote rural areas.

Follow-up Contact. Each clinic has developed its own follow-up protocols. In general, the specific follow-up activities that clients receive are method specific, i.e., depend on their chosen birth control method. Clients choose the method of contact that works best for them: reminder card, phone call, e-mail, cell phone, pager, home visit or scheduled follow-up visit.

All five clinics do follow-up ***phone consultations*** with clients who are beginning or changing their birth control method to see how the client is doing with her new method and to identify any barriers to successful use. At two IFS clinics, these initial follow-up calls are made by a PHN, while at the other three IFS clinics an IFS coordinator or patient educator calls the client.

All of the clinics provide ***reminder contacts*** for appointments, Depo shots or birth control supply refills and annual exams. All five clinics follow a protocol for missed appointments requiring a call to the client and an attempt to reschedule.

All intervention clinics have a ***direct IFS phone line***, where clients with questions or concerns can speak directly with staff or leave a message on voicemail. As most IFS coordinators are non-medical staff, any medical questions or problems are triaged to a nurse or clinician.

Incentive Program. Planned Parenthood of Mount Vernon (MBPP) offers clients a benefits program, called TAKE CHARGE Benefits, to increase the likelihood of clients' adherence to their birth control method. The benefits program includes the "Once-A-Day" birth control pill reminder dial; a special pocket calendar with reminder stickers for the ring, patch and Depo; and bonuses such as monthly raffles; Blockbuster gift cards, and Starbucks gift certificates after six months' successful use of their chosen birth control method. Sunnyside Clinic (PPCW) plans a raffle to give away gift certificates to a local department store each quarter to IFS participants.

Outreach. The IFS models of four of the five clinics include outreach as a funded component. Outreach education, conducted to increase both community awareness and client utilization of TAKE CHARGE, includes written materials and informational presentations to social service and health care providers, educators, nurses and counselors, colleges, Job Corps and parent's groups. Outreach education for the University District Clinic is done by Planned Parenthood of Western Washington at their administrative office. Many control sites also do outreach (see individual site descriptions, above).

Outreach care refers to medical care provided off-site. Outreach care includes procedures to coordinate family planning services at facilities where medical providers are available: at in-patient treatment facilities and residential centers. Sunnyside Clinic plans to expand its program in year three to have outreach workers visit remote areas in a van to provide birth control methods.

Referrals to Community Resources. Staff felt that since the implementation of TAKE CHARGE and IFS, the level of resources to help clients has increased. After needs assessment and problem solving with clients, IFS coordinators help establish plans, including solutions ranging from referrals to shelters and transitional housing programs, to resources for sexual assault or domestic violence, or to parenting classes. For clients who have problems with transportation, IFS staff provides bus passes and/or cab vouchers. IFS staff follows up client referrals to services in conjunction with follow-up visits or other follow-up contacts.

Training for IFS Sites

The Center for Health Training (CHT) conducted training in October 2002 for IFS sites on family planning case management, using the Stages of Change model (Prochaska et al., 1992). IFS staff also participates in conference calls with TAKE CHARGE evaluation staff, MAA staff, and DOH staff roughly three times per year to share information about their activities, challenges, and solutions. A second IFS training by the Center for Health Training is scheduled for February of 2004.

Table 7: IFS Funded Components by Research Site

IFS Funded Components	White Center	University	Skagit County	Mt Vernon	Sunnyside
Dedicated IFS Coordinator	•	•	+	•	•
ARNP, PHN	•		+	+	
Patient Educator		•			+
CMA				+	
HCA, HPA or PCC	•				+
Interpreter/Bilingual Staff	+			+	•
Outreach Worker				+	•
Office Support			+	+	
Phone Consultation-New BC Method	*	*	*	*	*
Reminder Contact for Appointment	*	*	*	*	*
Reminder Contact for Depo shot or refill	*	*	*	*	*
Reminder Contact for Annual Exam	*	*	*	*	*
Contact for Missed Appointment	*	*	*	*	*
Contact by Phone, e-mail, Beeper	*	*	*	*	*
Contact by Home Visit			*		*
Direct IFS Phone Line	*	*	*	*	*
Client Calls triaged through front office	*	*		*	*
Business Card with Contact Number	*	*	*	*	*
Incentive Program				*	*
Outreach Care			*	*	*
Outreach Education	*		*	*	*
Referrals to Community Resources	*	*	*	*	*
IFS Client Contacts per Week	35-40	95	4-5	21	80
Total IFS Clients	1,200	510	53	159	300

ARNP = Advanced Registered Nurse Practitioner; PHN = Public Health Nurse; CMA = Certified Medical Assistant; HCA = Health Care Assistant; HPA = Health Program Assistant; PCC = Patient Care Coordinator

- = FTE; + = part-time for IFS staff

Challenges Providing IFS[24]

At IFS sites, clinic staff members are responsible for follow-up with each TAKE CHARGE patient. Medical personnel must provide follow-up for problems with birth control methods and other medical issues. Non-medical personnel may provide follow-up for other issues, such as contacting patients who have missed an appointment. Some patients who miss appointments need extra help, such as bus passes or having transportation to the clinic arranged for them. In some rural areas, patients who do not have telephones receive home visits from the public health nurse. Most IFS sites have hired additional staff to handle the workload; however, providers have reported that this is often insufficient to manage the number of IFS calls needed. Providers report that it is challenging to fit IFS in with all of their other responsibilities.

Keeping track of clients is a major challenge for IFS staff. Several respondents noted that their clients move frequently. This seems to be especially true for college populations, but it is a challenge at all IFS sites. Most IFS providers allow clients to select e-mail or cell phone as their main method of contact since they are more likely to keep them for a longer period of time than a home address. Another suggestion was to ask clients to update their contact information at each office visit.

Some clients, for various reasons, cannot be contacted at their homes; providers suggested that those clients be given the IFS provider's phone number and urged to call or come to the clinic if they have any problems or questions, or to provide a safe contact: using a friend's phone number as a message phone or providing a work phone number. Providers also stressed that it was important to find out whether they could leave a detailed message or not when they called and, when they could not, to leave messages that "*sound like roommates*."

Several providers reported that documenting follow-up services in clients' charts or in a database is a challenge. One provider created her own system for following up with patients. She would like to see IFS sites provided with a computer program that could flag dates for follow-up services, as this varies greatly between birth control methods.

Among successes for IFS, providers noted that IFS clients generally either maintain their birth control methods or change methods as needed. Providers reported that, through the IFS interaction, clients have the chance to really learn new information and understand their birth control options. Some providers noted that IFS provided a liaison point between clinicians and that teamwork among clinic staff had increased through the process of providing IFS.

[24] Some of these challenges and suggestions were identified in an in-person training conducted by the Center for Health Training on October 31, 2002 for all IFS sites.

FINDINGS

REACHING THE TARGET POPULATION

The TAKE CHARGE program, which targets low-income women who want to prevent an unintended pregnancy, is reaching its target population. Table 8 below shows that at the time of enrollment in both years one and two, the majority of women reported they did not want to get pregnant or that they really did not want to get pregnant. In addition, the age distributions of TAKE CHARGE enrollees and pregnant Medicaid women are similar. Over two-thirds (67.5%, or 113,446) of clients enrolled in the first two years of TAKE CHARGE were women between eighteen and twenty-nine years of age, the target age group (Table 2 in *Methods*). In Washington State, 73.0% of all Medicaid-paid births in 2002 were to women in this age group.

Table 8: Client Reported Pregnancy Intention Statements

In both years one and two, more than 94% of clients did not want to get pregnant or really did not want to get pregnant.

Which of the following statements best describes what you want to happen during the next 12 months?	YEAR 1			YEAR 2		
	% Total (n=596)	% IFS (n=281)	% Control (n=315)	% Total (n=833)	% IFS (n=427)	% Control (n=406)
I want to get pregnant during the next 12 months.	1.4	1.0	1.5	1.1	1.4	0.8
I kind of want to get pregnant and I kind of don't want to get pregnant.	3.4	4.6	2.9	3.1	3.0	3.2
I don't care one way or the other if I get pregnant.	0.9	0.7	1.0	0.7	1.3	0.2
I do not want to get pregnant.	24.1	28.6	22.1	20.8	22.5	19.6
I really do not want to get pregnant during the next 12 months.	70.3	65.1	72.6	74.3	71.7	76.2

- The results of survey respondents' statements as to what they want to happen in the next twelve months regarding pregnancy remained consistent over the two year period and few differences existed among the IFS and control sites. In year one, 94.4% of survey respondents reported that they "do not want to get pregnant" or "really do not want to get pregnant" during the next 12 months. In year two, the same figure was 95.1%.
- In year one, 5.3% of the IFS respondents reported that they "kind of want to get pregnant and kind of don't want to get pregnant" or that they "don't care one way or the other about getting pregnant." Comparatively, 3.9% of the control site respondents reported one of these statements. In year two, 4.3% of IFS respondents and 3.4% of control site respondents reported these statements.
- A small number of clients reported they "want to get pregnant" in the next twelve months.

INCREASING CLINIC CAPACITY

Clinic capacity reflects a clinic's ability to provide adequate family planning services for its volume of patients. Staffing, access to providers, and clinic facilities such as the number of exam and counseling rooms are three factors in determining capacity.

Do providers feel that their clinics are adequately staffed?

Clinics at the five research sites that provided IFS received additional funding for providing IFS. Funding was used for additional staff, outreach, phone lines, computer hardware, incentives, and informational materials.

Table 9: Provider Reported Clinic Capacity Statements

At implementation, 41% of providers surveyed felt that their clinics were not adequately staffed to meet the needs of their TAKE CHARGE clients.

In your opinion…		Baseline			Follow-Up		
		% Total	% IFS	% Control	% Total	% IFS	% Control
The clinic is adequately staffed to meet the needs of **Take Charge** clients	yes	59.4	73.2	39.3	88.3	75.6	92.3
	no	40.6	26.8	60.7	16.7	24.4	7.7
The clinic is able to handle the volume of your client population	yes	72.9	82.9	58.6	88.4	87.0	90.0
	no	27.1	17.1	41.4	11.6	13.0	10.0

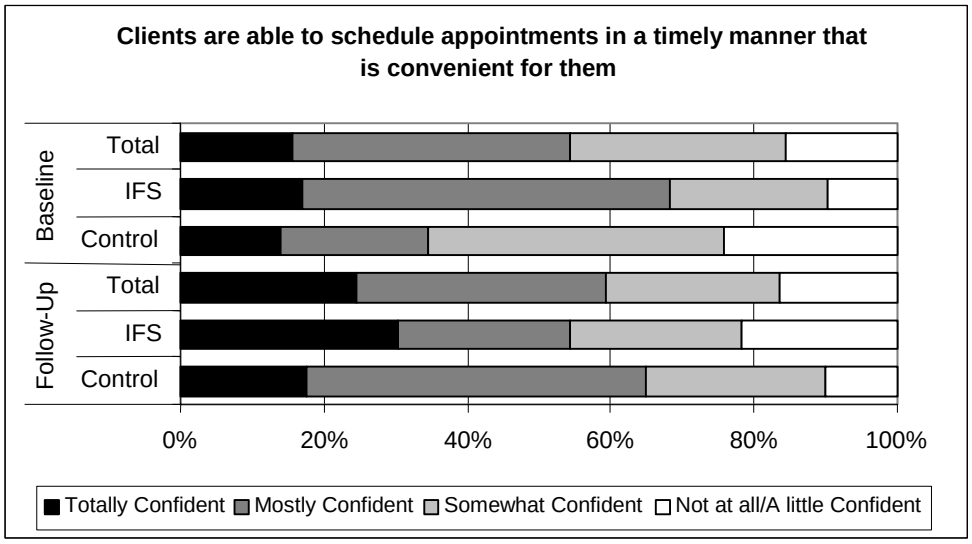
- At baseline, provider's responses to adequacy of staffing vastly differed at IFS and control sites. While 73.2% of IFS providers felt that their clinic was adequately staffed to meet the needs of TAKE CHARGE clients, only 39.3% of control site providers agreed.
- At follow-up, still about three quarters of IFS providers felt that their clinic was adequately staffed to meet the needs of TAKE CHARGE clients, while the percent of providers at control sites that felt adequately staffed increased by 135% to 92.3%.
- When asked about their ability to handle the volume of their client population, providers were more positive. At baseline, 82.9% of IFS providers agreed, while 58.6% of control site providers agreed. At follow-up the gap between IFS and control site providers' responses narrowed: there was no difference between the responses of IFS and control site providers.

Can clients access a provider when they need services?

Providers were asked whether clients could make appointments in a timely manner that was convenient for them, and whether clients with urgent needs could access clinic staff without an appointment. Similarly, clients were asked whether they could access their provider for additional family planning services if needed.

Figure 2.

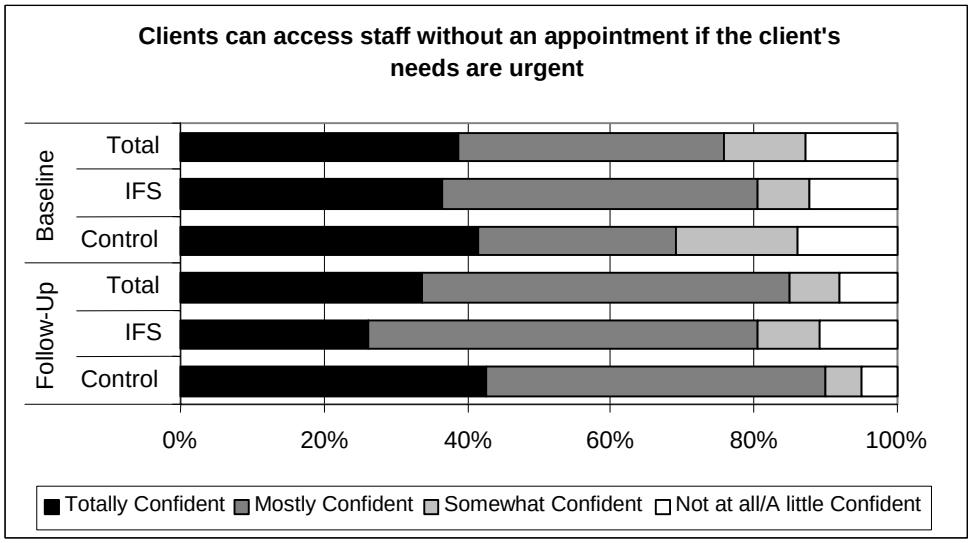
The majority of providers felt mostly or totally confident that their clients were able to schedule appointments in a timely and convenient manner.



- While over two-thirds of IFS providers, at baseline, felt mostly or totally confident that their clients were able to schedule appointments in a timely manner that was convenient for them, at control sites just a little over a third of the providers felt this way.
- At follow-up, control site providers felt slightly more confident than IFS staff about timely appointments, and 60% of providers at all sites felt mostly or totally confident.

Figure 3.

About three-quarters of providers felt mostly or totally confident that clients could access staff without an appointment if the client's needs were urgent.



Providers were more positive about clients with urgent needs accessing staff:

- The proportion of providers that were mostly or totally confident that their clients could access staff if their needs were urgent increased by about 10 percentage points between baseline and follow-up.
- At baseline and follow-up, 80.5% of IFS staff reported being mostly or totally confident that their clients could access staff without an appointment if the need was urgent. Comparatively, 69.0% of control site staff felt mostly or totally confident at baseline, and at follow-up 90.0% of control site staff felt mostly or totally confident. These differences were not statistically significant.

Clients were also asked whether they could access their provider to get more family planning services if needed. Clients that reported being "not at all," "a little" or "somewhat" confident were categorized as being less confident. Overall clients were very positive in their report on accessing their providers.

- At intake, 95.0% of clients reported that they were mostly or totally confident that they could access their provider and at follow-up 88.8% of clients reported feeling mostly or totally confident ($p = 0.12$).
- At intake, 5.4% of IFS clients and 4.9% ($p = 0.07$) of control site clients reported being less confident in their ability to access their provider to get more family planning services if needed.
- At follow-up, twice as many control site clients (13.5%) reported being less confident in their ability to access services compared to IFS site clients (6.1%, $p = 0.12$) and almost three times as many compared to control site clients at intake. (4.9%, $p < 0.01$).

FEELING AT EASE AT CLINICS

Through provider and client survey responses, two perspectives were gained on clients' perceptions of their clinic and provider. Providers were asked about clients' sense of ease with the general clinic atmosphere and their treatment by the clinic staff as a whole; clients were asked about their ability to openly discuss things of a personal nature related to contraception with their provider.

Do providers feel that clients are comfortable at their family planning clinics?

Providers, who were surveyed at implementation and again over one year later, rated their clients' comfort-level at their clinic very highly. In many cases, their confidence levels increased during the period between baseline and follow-up.

Table 10: Provider Reported Client Sense of Ease

At baseline, over 90% of providers felt mostly or totally confident that their clients were treated with respect; by year two 100% of providers felt this confident.

How confident are you that…	Baseline			Follow-Up		
	% Total	% IFS	% Control	% Total	% IFS	% Control
Clients feel safe and comfortable at this location						
Not at all/A little Confident	1.4	0.0	3.5	0.0	0.0	0.0
Somewhat Confident	5.7	2.4	10.3	4.7	4.4	5.0
Mostly Confident	50.0	46.3	55.2	46.5	54.4	37.5
Totally Confident	42.9	51.2	31.0	48.8	41.3	57.5
Male clients feel comfortable at this location						
Not at all/A little Confident	2.9	2.4	3.6	1.2	0.0	2.6
Somewhat Confident	15.9	22.0	7.1	21.2	28.3	12.8
Mostly Confident	58.0	53.7	64.3	45.9	47.8	43.6
Totally Confident	23.2	22.0	25.0	31.8	23.9	41.0
Clients are treated with respect						
Not at all/A little Confident	1.4	0.0	3.5	0.0	0.0	0.0
Somewhat Confident	5.7	4.9	6.9	0.0	0.0	0.0
Mostly Confident	12.9	14.6	10.3	22.1	23.9	20.0
Totally Confident	80.0	80.5	79.3	77.9	76.1	80.0
Clinic staff can effectively work with a culturally and ethnically diverse clientele						
Not at all/A little Confident	5.9	0.0	14.3	0.0	0.0	0.0
Somewhat Confident	7.4	12.5	0.0	12.8	10.9	15.0
Mostly Confident	36.8	45.0	25.0	34.9	41.3	27.5
Totally Confident	50.0	42.5	60.7	52.3	47.8	57.5

- At baseline, 92.9% of providers surveyed were mostly or totally confident that their clients felt safe and comfortable at their clinics; 95.3% felt this way by year two.
- Providers were less certain of male clients' ease in their clinic; only about one-quarter of providers felt totally confident that males were comfortable in their clinic at implementation and 31.8% felt this way at follow-up. An additional 58.0% at baseline and 45.9% at follow-up felt mostly confident that their male clients felt comfortable.
- At both baseline and follow-up, about half of providers felt totally confident that their staff could work effectively with a culturally and ethnically diverse population, and another one-third of providers reported that they were mostly confident of this. Control site staff (60.7%) tended to be slightly more confident of this compared to IFS staff (42.5%) although differences are not statistically significant (p=0.14).

Are clients at ease talking to their providers?

In year one and year two TAKE CHARGE clients were asked several questions about their feeling of ease working with their providers, before and after a year of service. Overall, the clients' responses confirmed providers' perceptions about their clients' feeling of ease at their clinic.

Table 11: Client Reported Feeling at Ease with their Provider

Over 93% of clients felt mostly or totally confident that they could talk openly with their provider about any problems related to their birth control method.

How confident are you that…	Year One %				Year Two %			
	Not at all/A little confident	Somewhat confident	Mostly confident	Totally confident	Not at all/A little confident	Somewhat confident	Mostly confident	Totally confident
Talk openly with your provider about any problems related to your choice of birth control.	1.7	3.3	17.2	77.8	2.4	4.2	16.7	76.8
Identify and resolve any problems you may have with your provider.	2.9	10.2	30.2	56.8	3.3	9.8	22.4	64.5
Ask your provider uncomfortable questions without being judged by him or her.	3.4	9.9	24.1	62.7	2.5	8.4	22.3	66.8

- Of clients surveyed, about 87% felt mostly or totally confident that they could identify any problems that they might have with their providers; about 10% felt somewhat confident, and 3% did not feel confident about this.
- Most clients felt that they could ask their provider uncomfortable questions without being judged by her/him; less than 4% felt that they could not.

PROVIDING MORE CLIENT-CENTERED PRACTICE

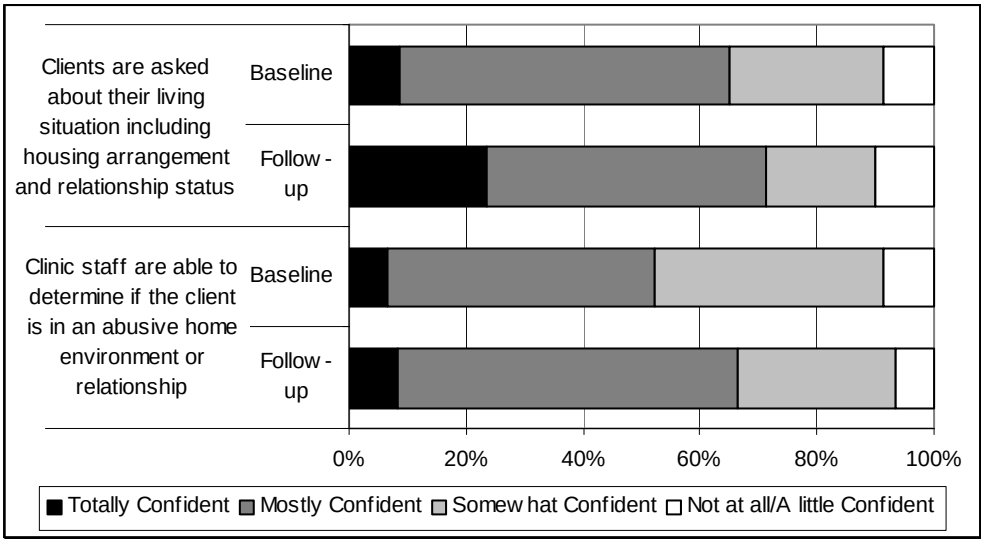
The two interventions that were designed to increase the level of client-centered practice among providers are ECRR and IFS. With ECRR, providers discuss lifestyle with the client. For many providers this is a new dimension in education, building greater rapport between providers and clients, as well as helping clients really consider whether their chosen method is appropriate for their way of life. Talking about clients' partners is an important part of this discussion.

Intensive follow-up services are an enhancement of ECRR. Each of the five intervention sites developed its own model for implementation of IFS. Detailed descriptions of the different IFS options implemented can be found in the individual site descriptions and on pages 29-32.

Providers were asked a number of questions related to their family planning practice and services and their interaction with clients. All figures and tables presented here are based on the responses of patient care providers.

Figure 4.

Providers discussed their clients' living situations more often.



- At implementation, less than 8.7% of providers reported that they were totally confident that their clients were asked about their living situation including their housing arrangement and relationship status. However, at follow-up the percentage of providers that reported being totally confident increased almost three-fold to 23.7%.
- At baseline, only 52.3% of clinic staff surveyed felt mostly or totally confident that clinic staff could detect if a client was living in an abusive environment or relationship; 47.8% were only somewhat confident or a little confident. In the follow-up survey, 66.6% felt mostly or totally confident that they could determine this (an increase of 27.3%).

Table 12: Provider Reported Client Interaction

IFS providers reported an increase in client-centered behavior.

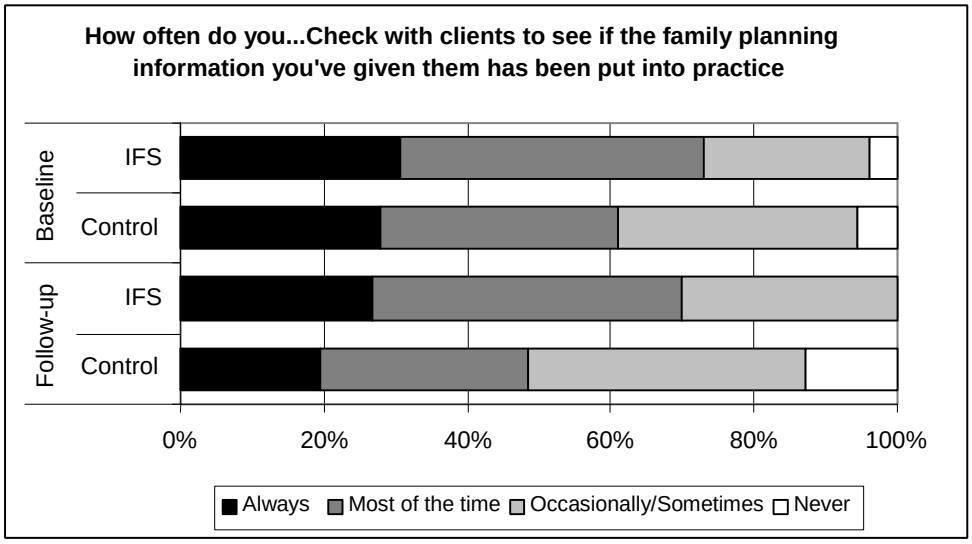
How often do you…	Baseline			Follow-up		
	% Total	% IFS	% Control	% Total	% IFS	% Control
Reach aggreement with clients on their short-term family planning goals						
Never	0.0	0.0	0.0	5.0	3.3	6.7
Occasionally/Sometimes	27.3	26.9	27.8	30.0	16.7	43.3
Most of the time	45.5	50.0	38.9	30.0	36.7	23.3
Always	27.3	23.1	33.3	35.0	43.3	26.7
Find out a client's underlying worries/concerns about family planning						
Never	2.3	3.9	0.0	0.0	0.0	0.0
Occasionally/Sometimes	22.7	19.2	27.8	30.0	20.0	40.0
Most of the time	45.5	46.2	44.4	40.0	53.3	26.7
Always	29.6	30.8	27.8	30.0	26.7	33.3

Limited to patient care providers.

- The proportion of IFS providers that said they always reached agreement with their clients on their short-term family planning goals increased from 23.1% to 43.3%. About one-quarter of control site providers reported always reaching agreement.
- Only about 30% of providers in year one and year two said that they *always* find out their clients' underlying worries/concerns about family planning. In year one, there was no statistically significant difference between the IFS and control site providers who said that always or most of the time they find out their clients' underlying worries/concerns about family planning; at follow-up there were greater differences. At follow-up, 80.0% of the IFS site providers reported that they do so always or most of the time, compared to about 60.0% of control site providers (p =0.09).

Figure 5.

More IFS providers reported following-up with clients on utilization of family planning information compared to control site providers.



- In year one, about 73.1% of IFS providers and 61.1% of control site providers said that they always or most of the time check with clients to see if the family planning information they have given them has been put into practice. In year two, however, the gap was greater such that 70.0% of IFS providers compared to 48.4% of control site providers reported doing so (p = 0.09).

UTILIZING FAMILY PLANNING METHODS AND SERVICES

The TAKE CHARGE program covers most FDA-approved family planning methods, family planning-related services, and two new services, education, counseling, and risk reduction (ECRR) and intensive follow-up services (IFS). This section describes what family planning methods providers offer, what family planning services are provided, and what clients report about their use of methods.

What family planning methods do providers offer?

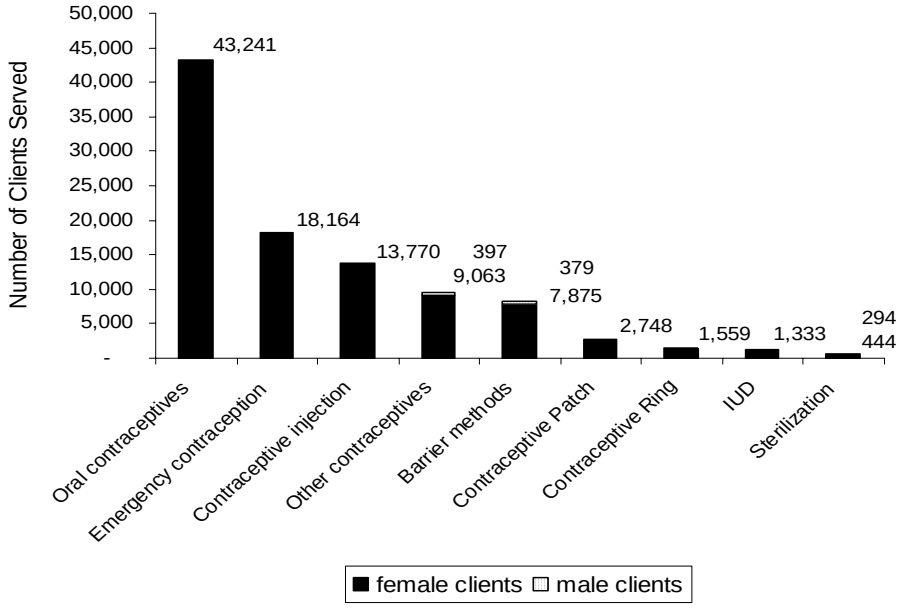
Interviews with nurse practitioners at the ten research sites confirmed that all clinics provide access to most birth control methods including abstinence counseling; birth control pills; male and female condoms; diaphragm and cervical cap; emergency contraception; foam, jelly, and cream; IUD; natural family planning; contraceptive injections; contraceptive ring and patch; and male and female sterilization. Two clinics (Skagit County Health Department and Skamania) refer IUD insertion to other practitioners, and all clinics refer male and female sterilization procedures. Other methods are available on-site at the clinics. [25]

What family planning services are provided to TAKE CHARGE clients?

In addition to birth control methods and family planning-related services, TAKE CHARGE offers two new services to enrolled clients, education, counseling, and risk reduction (ECRR) for all clients, both male and female, and intensive follow-up services (IFS) for female clients at five research sites.

Figure 6: Family Planning Methods Provided for TAKE CHARGE Clients July 2002 – June 2003

The most frequent birth control method was oral contraceptives, provided to 56% of female clients in year one and 54% in year two.



Note: Other contraceptives include spermicides, foam, and jelly.

In general, the distribution of birth control methods was similar in year one and year two, with the following exceptions: (1) the contraceptive patch (Ortho Evra®) and the contraceptive ring (NuvaRing®) were newly available in year two (no women received these methods in year one.);

[25] Lunelle™, a popular once a month injectible birth control product was voluntarily removed from the market in October 2002, due to a production error.

(2) The implantable contraceptive Norplant® was no longer available for distribution; providers used their existing stocks for a limited number of clients (60 in year one and 45 in year two).

Overall, in year one, 74.6% of women received a more effective birth control method such as oral contraceptives, injections, or implants, and in year two, 71.9%.

- In year two, 11.0% of male clients received other contraceptives (spermicides, creams, or jellies). Barrier methods were the next most frequent method provided to men, with 10.5% of male clients receiving a barrier method.
- Sterilizations were the least common birth control method in general use. In year two, 444 women (0.5%) had a tubal ligation, and 294 men (8.2%) had a vasectomy.
- The distribution of birth control methods was similar in the research sites. In year one and year two the most frequent birth control method provided to women in the IFS and control sites was oral contraceptives followed by injections such as Depo Provera® and Lunelle™, excluding emergency contraception. Comparing the distribution of the less frequent methods at the research sites was difficult because of small numbers.

Emergency contraception (EC). One of the provider roles in the education counseling and risk reduction services is to facilitate the client's contingency planning, including planning for emergency contraception (EC). In the provider survey, 98% of patient care providers were mostly or totally confident that clients are informed of the availability of emergency contraception, and 97% were totally or mostly confident that clients are informed about how to access emergency contraception. Many clinics routinely provide emergency contraception as a back-up birth control method to clients seeking family planning services so that the client will have ready access to emergency contraception in the event of method failure.

- In year one, 10,809 female clients (17.6%) received emergency contraception, and in year two, 18,164 (22.5%) received emergency contraception.
- Control sites tended to provide emergency contraception more frequently than IFS sites; from year one to year two, emergency contraception provision increased from 21.8% to 27.1% among women at control sites and from 14.7% to 19.5% among women at IFS sites.

Education, Counseling, and Risk Reduction (ECRR). TAKE CHARGE reimburses providers for performing education, counseling, and risk reduction services (ECRR), intended to increase the level of client-centered practice and to support clients' successful use of their chosen contraceptive method. Prior to TAKE CHARGE, some family planning providers offered similar counseling that was less standardized and less thorough. Because providers previously were not reimbursed for this counseling, it was likely to be overlooked.

- Nearly two-thirds of female clients (61% in year one and 59% in year two) received ECRR services compared to over 80% of men (85% in year one and 82% in year two).

What family planning methods do clients report using?

The client survey asks “During the last 2 months, what kinds of birth control did you or your partner use?” Clients complete a survey at the time of enrollment in TAKE CHARGE and a second survey one year later. For combined years one and two, at the time this report was written, 432 clients completed both surveys.

Table 10: Effectiveness of Birth Control Methods Reported by Clients

One year after enrollment in TAKE CHARGE, half as many survey respondents reported using a less effective birth control method.

Method Effectiveness	PRE-SURVEY			POST-SURVEY		
	% Total	% IFS	% Control	% Total	% IFS	% Control
Abstinent	10.2	4.6	12.9	12.7	9.8	14.2
Less Effective	30.5	32.9	29.3	13.5	9.4	15.3
More Effective	54.6	53.8	55.0	66.9	73.7	63.7
No Method	4.7	8.8	2.8	6.9	7.1	6.8
Total	100.0	100.0	100.0	100.0	100.0	100.0

More Effective Methods include: Birth Control Pills, IUD, Norplant, Shot-Depo or Lunelle™, Sterilization (Male and Female), Ortho Evra® Patch and NuvaRing®.

Less Effective Methods include: Condoms (Male and Female), Diaphragm, Cervical Cap, ECPs, Foam, Jelly, Cream, Rhythm, and Withdrawal

Any woman that reported a less effective method in combination with a more effective method was coded as using a "more effective method."

- The proportion of clients reporting use of a less effective method decreased from 30.5% at enrollment to 13.5% one year later. Both the IFS and control sites demonstrated similar decreases.
- The proportion of clients using a more effective method increased from 54.6% at enrollment to 66.9% one year later.
- The proportion of clients that reported using abstinence in the past two months also increased slightly from 10.2% to 12.7%.
- Those using no method also increased from 4.7% to 6.9% during the one-year interval. Of the women who reported using no method, 33.9% stated that they wanted to get pregnant.

DISCUSSION

Washington State's TAKE CHARGE program is a Federal Medicaid waiver that expands Medicaid coverage for family planning services to men and women with family incomes up to and including 200% of the federal poverty level. Program goals are to improve the health of women and children in Washington State by reducing unintended pregnancies and lengthening the interval between births, and to reduce State and Federal Medicaid expenditures for unintended births and their associated costs (refer to WAC 388-532-700). To meet these goals the program not only expands eligibility for Medicaid coverage for family planning services, it also covers services not reimbursable previously: education, counseling, and risk reduction (ECRR) and intensive follow-up services (IFS).

Providing no-cost birth control methods with comprehensive client-centered family planning services and information and, in some cases, targeted follow-up services is the foundation of the TAKE CHARGE program. In the first two years of TAKE CHARGE, these services have been well received by its target population and by the providers who deliver the services. The program has made great strides in reaching the target population, reducing barriers and changing the dimensions of family planning education to a more holistic approach that asks clients to consider their lifestyle as an important factor when choosing a birth control plan.

In the first two years of TAKE CHARGE almost 170,000 women and men enrolled in the program. Over two-thirds of the clients enrolled in the first two years of TAKE CHARGE were women between eighteen and twenty-nine years of age, the same age group that accounted for 73.0% of all Medicaid-paid births in 2002. In addition, 8,152 men were enrolled in TAKE CHARGE in its first two years.

One administrator has estimated that, *"Throughout Western Washington, there has been about a 60% increase in the number of patients we're seeing"* (Michael, 2003).

While more clients are receiving family planning services, many providers expressed concern over their clinics' capacity to meet the needs of their TAKE CHARGE clients. Staffing concerns varied greatly between IFS and control site staff. While 73% of IFS providers felt that they were adequately staffed to meet the needs of their TAKE CHARGE population at implementation, only 39% of control site providers agreed. Similarly, at baseline, there was concern, particularly among control site providers, over whether clients could schedule appointments in a timely manner that was convenient for them. Over a year later, however, staffing and scheduling concerns lessened, especially among control site staff.

The dramatic change at control sites may reflect staffing increases allowed by greater revenues from an increased volume of clients. While IFS sites also experienced greater volume and therefore greater revenues, they found that providing IFS to clients took more time than anticipated. The workload of IFS providers has compounded with the addition of new IFS clients in each year of the program. Sufficient staff hours are, therefore, still a challenge for IFS sites.

Staff at all clinics that participated in the in-depth interviews reported a significant increase in workload. Some staff reported an increase in answering phone inquiries, scheduling, and intake

paperwork. Other staff reported spending more time with clients discussing ECRR and providing intensive follow-up services. Not only did providers report concerns with staffing, they also expressed concerns over a lack of physical clinic space, such as competition for limited work areas and the need for larger storage areas for birth control products and patients' charts. One provider stated, *"TAKE CHARGE made people more aware of our services and it has quintupled our business. We had charts in a cubby hole; now it's taking up an exam room, floor to ceiling."*

One population in Washington State not covered by TAKE CHARGE is undocumented women and men. When providers were asked if there was anything they would like to see changed about TAKE CHARGE, the majority responded that they would like TAKE CHARGE to cover undocumented clients. In many cases, clinics still provide services to undocumented clients, on a sliding scale at reduced cost or no cost, but clinics have no way to recover those expenses. One provider stated, *"so many clients want sterilizations—but they're undocumented—they can't get them."* Prior research (Cawthon 2001) has shown that undocumented women who were eligible for postpartum family planning services were more likely to receive these services compared to other women with similar eligibility.

Allowing clients to sign up for TAKE CHARGE at the point of service, rather than at Department of Social and Health Services Community Services Offices, has had a positive influence on enrollment. Providers reported, through in-depth interviews and surveys, that their clients choose to come to their clinic because they trust their providers and can receive high-quality and confidential services. After over one year of TAKE CHARGE implementation, all providers surveyed felt mostly or totally confident that their clients were treated with respect. They also felt confident that their clients felt safe and comfortable at their clinics and that their staff could work effectively with a culturally and ethnically diverse clientele. More importantly, their clients reported these feelings too. Over three-quarters of the clients surveyed felt totally confident that they could talk openly with their provider and two-thirds felt totally confident that they could ask their provider uncomfortable questions without being judged by him or her.

TAKE CHARGE's education component includes two primary interventions: education, counseling and risk reduction (ECRR) and intensive follow-up services (IFS). These two interventions were designed to increase client-centered practice among providers. These practices are expected to increase clients' contraceptive self-efficacy resulting in fewer unintended pregnancies. While it is still too early in the evaluation data collection process to determine if this model has been successful among the TAKE CHARGE population, provider surveys appear to demonstrate provider use of more client-centered practices.

Through surveys and interviews, many providers reported discussing clients' lifestyles more often, while IFS providers reported increases in other client-centered practices. For example, a little over a year after implementation, three-times as many providers reported that they were totally confident that they inquire about their clients' living situations. At the same time, 29% more providers reported feeling mostly or totally confident that they could determine if their client was in an abusive home or relationship.

Some providers suggested that, after ECRR not only do clients understand how their birth control method works, but also they have thought about how their method fits their lifestyle and

they know that they can return to the clinic or call their provider if they have problems or concerns with their method. In the provider interviews, one provider stated, *"It allows clinicians to ask the questions that help clients decide what's best for them. It also forces the clients to ask the questions that help determine their best methods and their family planning goals."* Another provider stated with respect to ECRR, *"It shows the patient that we are interested in their family planning decisions and we get more cooperation from patients as a result."*

Nearly two-thirds of female clients received ECRR services compared to over 80% of men. As men are primarily a new population receiving family planning services, the proportion of men receiving the education component is greater. Women who have been using a contraceptive method consistently for years may not need ECRR services.

According to services data, over 70% of women receiving medical family planning services received an effective birth control method such as oral contraceptives, injections or implants. Not surprisingly, the most frequent birth control method provided to women was oral contraceptives followed by injections such as Depo Provera® and Lunelle™, excluding emergency contraception.

According to client surveys, 55% of women reported using a more effective method of birth control at enrollment, while a year later, the figure increased to 67%. Figures for both years, based on client surveys, are slightly lower than those based on services data. Services data represent methods that were given to clients, whereas client surveys represent methods that clients reported using within the two months prior to the survey.

One year after enrollment in TAKE CHARGE, the number of survey respondents who reported using a less effective birth control method had decreased by half. Of the women reporting using a less effective birth control method at enrollment, 53% were using a more effective method of birth control one year later.

As part of ECRR, providers facilitate the client's contingency planning including planning for emergency contraception. According to provider surveys, almost 100% of providers felt mostly or totally confident that their clients had information about the availability of emergency contraception and how to access it. Some staff also reported that they always give EC to women who are using condoms as their primary method of birth control and to clients who report having unprotected sex. According to services data, 18% of women in year one and 23% of women in year two received emergency contraception. Less than two percent of women who participated in the client survey, however, reported using emergency contraception as a method of birth control the two previous months.

When asked during in-depth interviews about the impact of TAKE CHARGE on their clients, providers were unanimous in their highly positive responses, citing increased client education and TAKE CHARGE making family planning affordable to more people. One provider stated, *"Being able to access birth control gives people a sense of empowerment because they can take family planning into their own hands and not worry about payment.*" Another provider stated, *"Now their birth control method truly is there; access is there, ease of use, and education. They have all the tools to control their fertility."*

Clients who wrote messages on their surveys had this to say about the program:

“I am incredibly thankful that this is provided. I feel much more confident in myself knowing that I am protected against pregnancy.”

“Due to financial hardship, without the TAKE CHARGE program, I would not have been able to go to the doctor when needed. This program has been wonderful and so has the staff.”

CONCLUSION

With nearly 170,000 women and men enrolled in the first two years of the TAKE CHARGE program, demands were much greater than anticipated. In order to meet the needs of the TAKE CHARGE population, the State of Washington and individual provider agencies have made numerous investments in building capacity through extensive provider trainings, streamlining the application and billing process, expanding physical workspace, and increasing staffing. Positive responses from both providers and clients participating in the program suggest that TAKE CHARGE has successfully met a clear need.

The data from this report show that TAKE CHARGE is reaching the targeted age population and that women receiving services are using more effective methods of birth control, such as oral contraceptives and injections. In addition, over 80% of the men that received services under the program were exposed to targeted family planning education and counseling.

Washington TAKE CHARGE providers have made substantial progress toward reaching the TAKE CHARGE implementation goals for client-centered practice. These goals are intended to increase client contraceptive efficacy by actively involving clients in their choice of birth control method. In addition to talking to clients about their family planning goals, providers and clients discuss elements of the client's lifestyle that may affect her/his use of contraception. At selected research sites, staff also follows-up with each female client to address any concerns or problems that might prevent her from continuing her birth control, facilitating changes and method refills as needed.

By reducing unintended pregnancies, particularly to those women who are Medicaid eligible because of pregnancy, women and men will be better able to plan their families and space their children, having children only when they are prepared to support and nurture them. This ensures that families and children in Washington State have healthier outcomes.

These findings support what other national health organizations (Gold, 2003) are calling for in public health policy: that these family planning services continue as a regular part of the scope of Medicaid services.

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