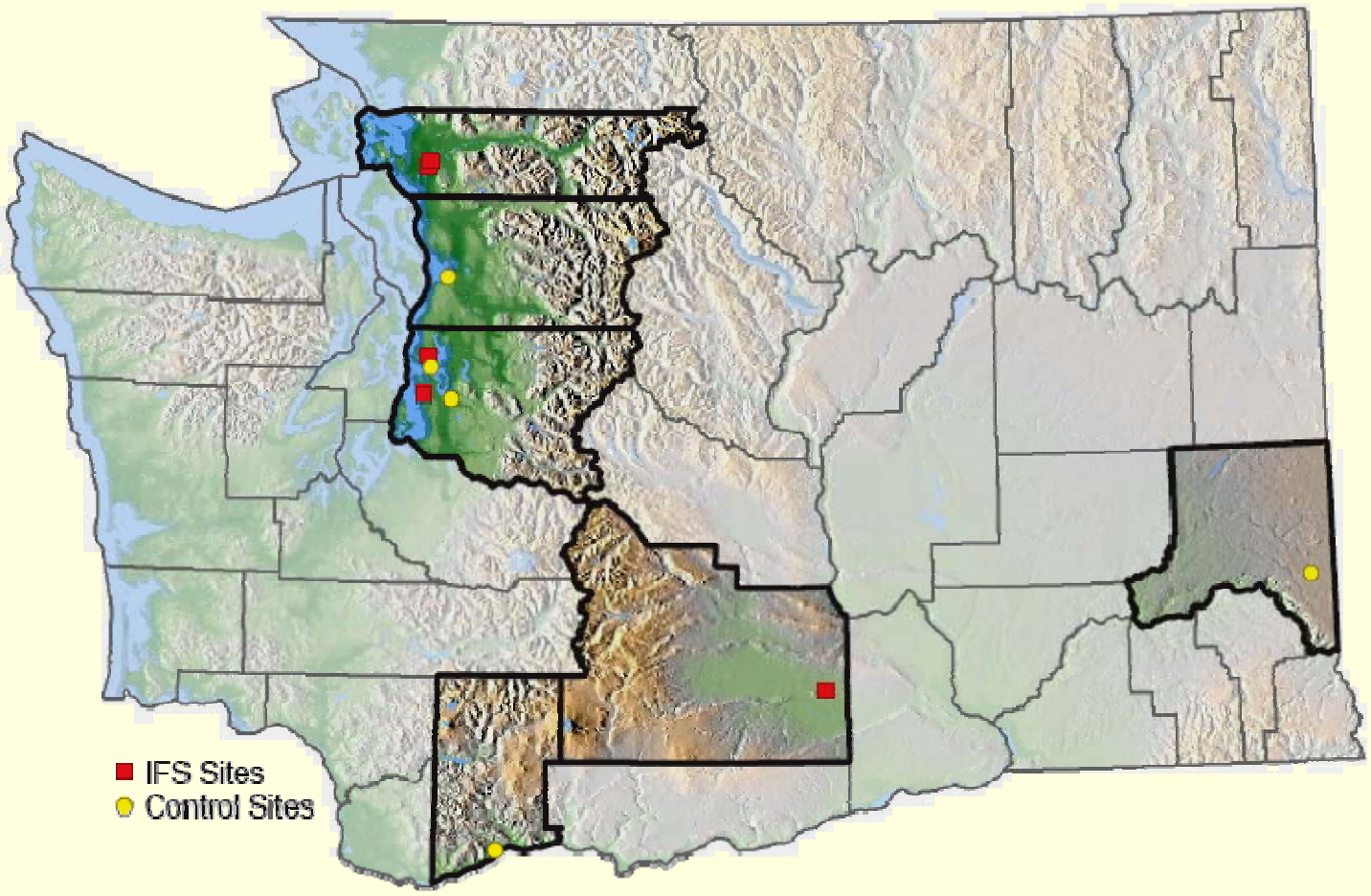
TAKE CHARGE
Interim Evaluation



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

TAKE CHARGE
Interim Evaluation

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March 2005

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REPORT 9.72

ACKNOWLEDGMENTS

This report was prepared for and funded by the Medical Assistance Administration, Department of Social and Health Services (DSHS).

We are deeply grateful to all research participants for sharing their personal information with us. We also appreciate the efforts of all of the TAKE CHARGE research providers for collecting the survey information, participating in the provider surveys and in-depth interviews, and sending us the quarterly client lists. Without their contributions this report could not have been written.

Special thanks go to the members of the First Steps Database team who contributed to this report, including the previous two project directors, Barbara Baker and Amy Ritualo, and previous research analyst, Linda Weaver. Michelle Coleman developed and maintained the client tracking database. Peter Woodcox assisted with the unduplication and matching of client records with services data and provided SAS expertise. Nora Ellsworth entered and checked survey data.

Thanks to Elizabeth Kohlenberg, Ph.D., Director of Research and Data Analysis Division, DSHS, for oversight and overall project management. Our gratitude goes to Dan Conlon of the Medical Assistance Administration, DSHS, who prepares the monthly TAKE CHARGE eligibles reports. Special thanks go to Gary Coats, also from the Medical Assistance Administration, who generates the quarterly lists of TAKE CHARGE eligible clients.

Jason Fry, Greg Kirkpatrick, and Francia Reynolds have our sincere appreciation for maintaining the Research and Data Analysis Division computer network, a system that meets the diverse demands of the agency's managers, researchers, analysts, programmers, and talented support staff.

The First Steps Database would not exist without the contributions of the Center for Health Statistics, Department of Health, which provides birth certificate files, and the Medical Assistance Administration, DSHS, which provides Medicaid claims data.

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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 at or below 200% of the federal poverty level (FPL). Program goals are to improve the health of women, children and families in Washington by reducing unintended pregnancies and lengthening intervals between births, and to reduce state and federal Medicaid expenditures for births from unintended pregnancies and their associated costs. The Medical Assistance Administration (MAA) of the Department of Social and Health Services administers this program.

This interim evaluation report describes the first three years of program implementation, from July 1, 2001, to June 30, 2004. Data sources include client surveys, Medicaid claims data and eligibility history, and birth certificates from the First Steps Database.

FINDINGS

PROGRAM PARTICIPATION

- Washington's TAKE CHARGE program enrolled more than 230,000 clients in the first three years of the demonstration. While 94% (N=218,057) of the enrolled clients were female, 13,036 were male.
- The number of newly enrolled clients (Program G) (N=143,814) was nearly twice the number of clients who were automatically enrolled in the post-pregnancy extension (Program S) (N=74,242).
- Over two-thirds (68.3%) of female clients enrolled in the first three years were between the ages of 18 and 29. The same age group accounted for 73% of Medicaid-paid births in 2003.

PROVIDER ENROLLMENT

As of October 2004, TAKE CHARGE providers offered services in 194 clinics throughout the State.

PROGRAM OBJECTIVES

Four of five program objectives described in the initial application (December 1998) have been achieved, or exceeded. The fifth objective about raising provider awareness of unintended pregnancy prevention represents a long-term goal and a number of initial steps to facilitate this objective have been completed.

- An estimated 21% of the women eligible under the waiver, who would have had an unintended pregnancy, remained pregnancy free.
- The proportion of clients using a more effective family planning method increased from 53% at enrollment to 69% one year later. The proportion that reported using abstinence in the prior two months increased slightly, from 10.8% to 11.2%.
- The number of Medicaid women who received services from family planning clinics increased from 22,850 during the baseline year to 85,607 in year one, 108,253 in year two, and 121,997 in year three.
- The number of Medicaid men receiving family planning services increased from 850 during the baseline year to 3548 in year one, 4384 in year two, and 5018 in year three.

FERTILITY RATES

Fertility rates for demonstration participants are very similar to birth rates for Washington women overall, 61 – 63 births per 1000 women 15-44. The fertility rate for each of the demonstrations years is less than half the base year fertility rate (135.2 per 1000). If the births included in computation of the fertility rate are restricted to those that occurred after enrollment in TAKE CHARGE, the fertility rates are much lower (5 – 7 per 1000), comparable to the failure rate for more effective contraceptive methods.

CHARACTERISTICS OF FEMALE CLIENTS

Women with a history of a birth were older (average age 26.1 years) than clients who did not have a prior birth (average age 22.2). Overall, half the clients with a birth (51.4%) were married at the time of their most recent birth. The proportion of women married at their most recent birth was highest for Asian women (62.2%) and women of Hispanic ethnicity (59.1%); the proportion was lowest for Native American women (28.3%). Clients who were married at their most recent birth were older (average age 24.8 years) than clients who were not married (average age 21.5 years), and the average total number of births was higher for married clients (mean 2.0) than for unmarried clients (mean 1.5).

CLIENT SERVICES

Of the total enrolled clients (N=231,093), 78% received one or more covered medical family planning service. How clients were enrolled in the program was strongly related to differences in service use. Nearly 94% of newly enrolled female clients received one or more medical family planning service, compared to 46.8% of recently pregnant women who were automatically enrolled. Among program participants, however, the proportions who used oral contraceptives and hormone injections were similar, and recently pregnant women had higher rates of use for the transdermal patch and IUDs.

CLIENT SELF-EFFICACY

Client survey questions about contraceptive self-efficacy consistently indicated modest increases in this measure one year after program enrollment; questions in other self-efficacy domains showed non-significant changes, or changes that reflected reduced self-efficacy, or perhaps more realistic expectations on the part of the clients. It had been hoped that client-centered practice would result in overall improvements in client self-efficacy; however, only contraceptive self-efficacy showed consistent modest increases.

CONCLUSION: The TAKE CHARGE program has demonstrated a very great impact on access to and provision of family planning services in Washington State. Concepts of client-centered Education, Counseling, and Risk Reduction are beginning to diffuse throughout the state and establish a new standard of care for family planning practice. Demographic profiles of female clients suggest that the program is helping younger, unmarried women avoid unintended pregnancy until they are older and hopefully married. Early results indicate a greater increase in the proportion of female clients who use more effective family planning methods at sites with Intensive Follow-up Services compared to control sites. Women with automatic extension of eligibility for family planning services in the post-pregnancy period were modest users of family planning services. How TAKE CHARGE can be more effective in reaching this group remains to be explored.

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 at or below 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. 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 first three years of the demonstration and includes program objectives, fertility rates, client characteristics, service utilization, and client self-efficacy. A process evaluation on the design, structure, organization, and implementation of the TAKE CHARGE program was published in December 2003.[2] The final evaluation report for the first five years of the TAKE CHARGE program is due in the fall of 2006.

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 2003, 45.6% 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.

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

[2] The TAKE CHARGE Process Evaluation (report 9.69) is available at the RDA website, http://www1.dshs.wa.gov/rda/research/9/69.shtm

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 for one 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.[3]

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.

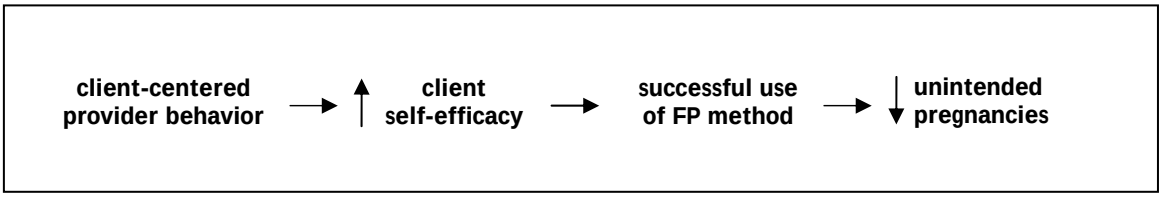
TAKE CHARGE program objectives are to:

- 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.

[3] See http://fortress.wa.gov/dshs/maa/familyplan/FP%20INTERVIEW%20GUIDE12-02..htm for a description of the Family Planning Interview Guide.

CONCEPTUAL MODEL

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



Increasing the level of client-centered practice among TAKE CHARGE providers is the first program intervention.[4] This is 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 given their particular lifestyle should lead to enhanced contraceptive self-efficacy.

When a client's contraceptive self-efficacy is achieved they 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;

[4] 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).

- 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);
- 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 confirmed 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.

Two groups of clients are eligible for TAKE CHARGE. The first group (Program G) consists of women and men who meet the criteria above and are newly eligible for family planning services under the 1115 Medicaid waiver guidelines. The second group (Program S) consists of women who were eligible for full-scope Medicaid because of pregnancy and are automatically enrolled in TAKE CHARGE after two months post-partum. All TAKE CHARGE clients must re-enroll in the program at a designated TAKE CHARGE clinic to continue their eligibility after the first year. While enrolled in the program, clients may visit any TAKE CHARGE clinic.

(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.

(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. For a more in-depth discussion of how each of the five sites has implemented IFS into their clinics regular family planning practice, refer to the TAKE CHARGE Process Evaluation Report.

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; and clinical Practice Standards; and
- Participate in MAA's specialized training for TAKE CHARGE prior to providing TAKE CHARGE services.

When the TAKE CHARGE program began, 111 clinic sites were enrolled as TAKE CHARGE providers offering services throughout the state. The 111 clinic sites included 29 local health jurisdictions (LHJ), 47 family planning clinics, 1 private physician office, 75 Title X clinics, and 14 other clinics. As of October 2004, TAKE CHARGE providers offered services in 194 clinics throughout the state.

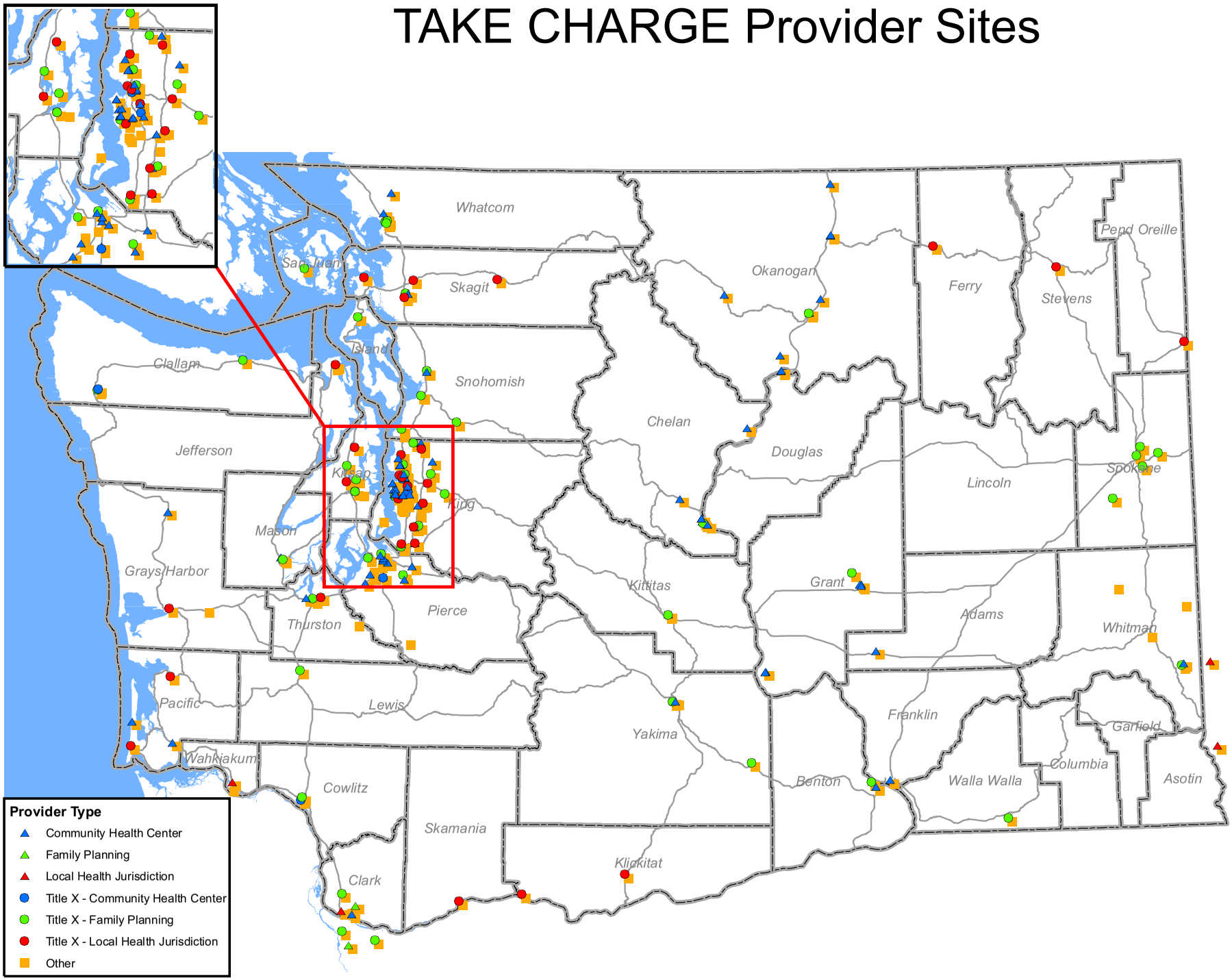
As can be seen from Map 1, almost every county has at least one TAKE CHARGE clinic, with greater concentrations occurring in more populous counties. King County has approximately fifty providers, Pierce County has twenty, and Skamania and Ferry counties each have one clinic.

Table 1. TAKE CHARGE Provider Enrollment July 1, 2001 – October 31, 2004						
Provider Category*	**First Month** July 2001			**Total to Date** July 1, 2001 - October 31, 2004		
	Number of Sites N=111	Percent	No. of Title X	Number of Sites N=194	Percent	No. of Title X
Community Health Centers	20	(18.0%)	4	77	(39.7%)	5
Local Health Jurisdictions	29	(26.1%)	26	34	(17.5%)	30
Family Planning	47	(42.3%)	45	49	(25.3%)	47
Other	15	(13.5%)	0	34	(17.5%)	0
Women's Health Clinics	5	(4.5%)		12	(6.2%)	
Hospital-Based Clinics	8	(7.2%)		12	(6.2%)	
Private Medical Doctors	1	(0.9%)		6	(3.1%)	
Primary Care Clinics	1	(0.9%)		2	(1.0%)	
Other	0	(0.0%)		2	(1.0%)	

* Provider Category definitions:

Community Health Centers: Federally Qualified Health Clinics (FQHC), Rural Health Clinics (RHC), Health Care Authority (HCA) and eligible University Clinics
Local Health Jurisdictions: regional and county health departments and districts
Family Planning: Family planning and Planned Parenthood clinics
Women's Health Clinics: sites that self-identify as women's health clinics, may also see men
Hospital-Based Clinics: Highline Medical Group, SW Washington Medical Center, and Whitman Medical Group
Private Medical Doctors: solo practice medical doctors (MD) and advanced registered nurse practitioners (ARNP)
Other: wellness centers

TAKE CHARGE Provider Sites



PROGRAM PARTICIPATION

Between July 2001 and the end of its first year, total enrollment was 98,973 unduplicated clients. By the end of the third year, TAKE CHARGE had enrolled 231,093 clients.

Table 2. TAKE CHARGE July 1, 2001 – June 30, 2004				
	Year 1 July 1, 2001 – June 30, 2002	**Year 2** July 1, 2002 – June 30, 2003	**Year 3** July 1, 2003 – June 30, 2004	**Total to Date** July 1, 2001 – June 30, 2004
TAKE CHARGE[5]	62,657	107,096	125,972	152,597
Pregnancy Extension[6]	38,066	40,613	41,134	79,858
Total Unduplicated	98,973	145,166	164,327	231,093

More than two-thirds, or 68.3%, of clients enrolled in the first three years of TAKE CHARGE were women between the ages of eighteen and twenty-nine; the same age group accounted for 73% of all Medicaid-paid births in 2003. TAKE CHARGE participation among teens less than eighteen years of age increased from 11,182 male and female enrollees in year one to 17,811 enrollees by the end of year three.

TAKE CHARGE enrollment among men more than doubled between year one and year three, from 3,680 to 9,051. By the end of year three, TAKE CHARGE had enrolled over 13,000 males. Eighty percent of them were under 30 years of age.

Table 3. Annual Enrollment and Total Cumulative Enrollment by Gender and Age

Age Group	Year One		Year Two		Year Three		Total Enrollment[1]		
	M	F	M	F	M	F	M	F	Total
Less than 18	217	10,965	404	15,316	490	17,321	924	31,858	32,782
18 - 19	552	14,899	1,003	21,730	1,233	24,866	2,029	37,680	39,709
20 - 24	1,362	34,932	3,030	51,836	3,676	59,440	4,964	74,840	79,804
25 - 29	770	17,132	1,662	24,561	1,797	27,588	2,502	36,490	38,992
30 - 34	359	9,786	826	13,123	913	14,130	1,243	20,681	21,924
35 - 39	215	4,998	438	6,591	422	7,173	659	10,534	11,193
40 - 44	117	2,011	284	3,066	287	3,432	410	4,486	4,896
Over 45	85	544	208	1,036	228	1,262	297	1,398	1,695
out of range[2]	3	26	4	48	5	64	8	90	98
Total	3,680	95,293	7,859	137,307	9,051	155,276	13,036	218,057	231,093

[1]Client age is age at first enrollment in TAKE CHARGE from Jul 1, 2001 to Jun 30, 2004.

[2]Age out of range (< 8 or > 60).

Current TAKE CHARGE Enrollment by Month

The following line graph shows the monthly TAKE CHARGE enrollment for the first three years of implementation. In the first month *(July 2001)* of TAKE CHARGE implementation

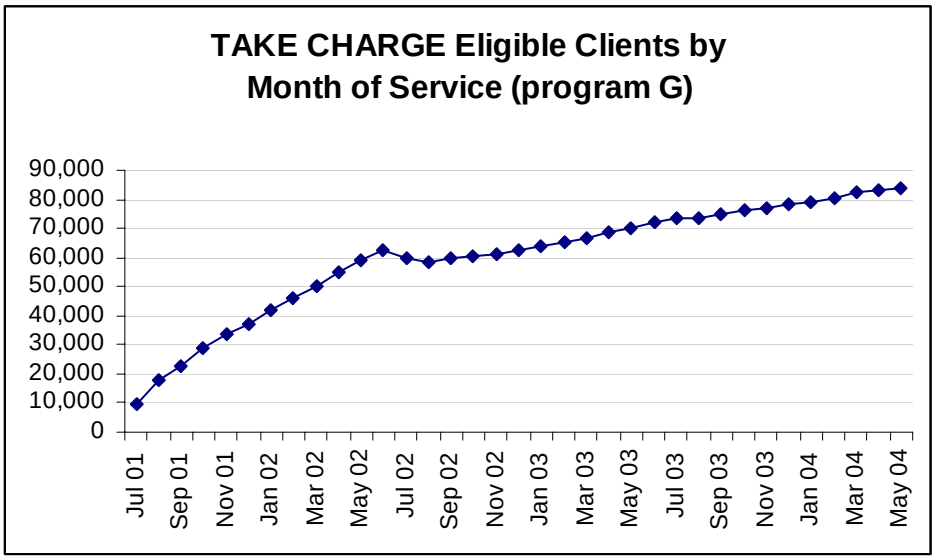
[5] Includes some clients who transitioned to or from Program S.

[6] Includes some women who transitioned to or from Program G.

9,459 clients enrolled in TAKE CHARGE. One year later *(July 2002)*, 59,875 clients were enrolled in the program. At the start of year three *(July 2003)*, 73,208 clients were enrolled and in May 2004 83,913. These figures represent current monthly enrollment and not total enrollment over time. As expected, monthly enrollment increased rapidly during year one and slowed to a consistent increase through years two and three.

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. Re-enrollment occurred almost seamlessly in year two.

Figure 1. Current enrollment by month of service



COVERED SERVICES

TAKE CHARGE covers most FDA approved birth control methods and a range of family planning-related services that help clients to prevent unwanted and mistimed pregnancies. The types of birth control methods covered include 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. Most clinics refer male and female sterilization procedures and it is not uncommon for smaller clinics to refer IUD insertions to other Medicaid participating providers. Most clinics dispense birth control methods on site and in other cases clients can have their prescriptions filled at a local pharmacy.

Family planning-related services generally include gynecological exams (when medically necessary), one initial education, counseling, and risk reduction (ECRR) session and one follow-up session ten months after the initial ECRR service and every ten months thereafter, and for clients at five research sites intensive follow-up services (IFS). STD testing and treatment are covered by TAKE CHARGE only when medically required as part of the client's selected contraceptive method.

METHODS

Multiple data sources were used to evaluate the TAKE CHARGE program. They include client surveys, provider surveys and in-depth interviews, birth certificates, eligibility history file and Medicaid claims information. The following table describes the evaluation questions that are addressed in this interim evaluation report and their related data sources. A more detailed description of each data source is provided below.

Evaluation Questions	Data Sources
Did the program achieve its objectives?	
Objective 1: 7.5 percent of the women eligible under the waiver, who would have had an unintended pregnancy, will remain pregnancy free.	Eligibility history file (OFM) and TAKE CHARGE client surveys
Objective 2: Increase the use of more effective contraceptive methods by Medicaid-eligible clients through intensive one-on-one support systems.	TAKE CHARGE client surveys
Objective 3: Increase the number of Medicaid-eligible women and teens receiving services from family planning clinics.	Eligibility history file (OFM) and Medicaid claims (MMIS)
Objective 4: Increase the number of low-income men receiving family planning services, including vasectomies.	Eligibility history file (OFM) and Medicaid claims (MMIS)
Objective 5: Raise awareness of private providers on the importance of unintended pregnancy prevention through education and training, so that more of them initiate family planning discussions with their patients.	TAKE CHARGE provider surveys and interviews
What are the fertility rates for participants and all Washington women and how do they differ and change over time?	Eligibility history file, Medicaid claims (MMIS), and First Steps Database (FSDB)
What are the characteristics of the client population (age, gender, parity, marital status, race/ethnicity)?	Eligibility history file (OFM) and First Steps Database (FSDB)
How many clients received family planning services and what types of services were delivered?	Medicaid claims (MMIS) and TAKE CHARGE client surveys
Does client self-efficacy of research participants improve one year after program entry?	TAKE CHARGE client surveys

DATA SOURCES

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 Code), for TAKE CHARGE eligible clients are extracted by MAA and provided to the evaluation team. The evaluation team maintains a

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 2003. 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) for computing fertility rates.

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 client. The MMIS extract includes 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).

TAKE CHARGE Client Surveys

One month prior to the implementation of the TAKE CHARGE program, five intervention and five control sites were selected at random from the then current pool of TAKE CHARGE-approved providers (see Table 4). The ten research sites selected are responsible for collecting client surveys and participating in provider surveys, interviews, and site visits. In addition, the five intervention sites provide intensive follow-up services (IFS) to their clients.

Table 4. Selected Evaluation Research Sites

Intensive Follow-Up Services (IFS) 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

Clients under age eighteen were not included in the research protocol; therefore, any clinic primarily serving teens was excluded from consideration as a research site. Clinic sites located in another state (though serving Washington State clients) were also excluded. The remaining clinics were stratified by geographic area (Eastern WA, Western WA, and King

County) and assigned to three categories (Local Health Jurisdiction, family planning clinic, and other). 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, with numerous follow-up trainings due to staff turnover.

Each of the ten research sites is responsible for collecting baseline client surveys, administered at program enrollment to roughly one hundred clients per site per year. Approximately one year after enrollment, a follow-up survey is mailed from RDA to the clients that completed a baseline survey. Client surveys address client family planning behavior, attitudes and perceptions, and are administered in English, Spanish and Vietnamese. At the time of this report, 1024 female clients had completed both pre- and post-surveys. Response rates for the follow-up survey are shown in Table 5. Collection of follow-up surveys is complete for year one and year two and is ongoing for year three.

In analyses using client surveys, data are presented with sample weights applied. For comparisons between IFS and control sites, clinic-specific weights were calculated based on survey respondents as a proportion of all enrolled women at each of the ten research sites. Weights reflect the number of women that an individual respondent from that site represents. Where baseline and follow-up survey responses are compared, weights were adjusted for non-response at the clinic level.

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. Clinic-specific weights are noted in Table 5.

For the analysis estimating averted pregnancies, a different weighting scheme was applied in order to consider statewide estimates rather than clinic-based behavior. Since the initial sampling design was stratified by geographic location, weights were developed to represent the population of TAKE CHARGE newly enrolled women in Eastern Washington, King County, and the rest of Western Washington. The statewide weights indicate the number of newly enrolled women in a region that a clinic respondent represents, and take into account the proportion of enrollees represented by the research clinics in that region. Specifically, these weights are the product of the weight necessary for a respondent to represent new clinic enrollees, multiplied by the weight necessary for the research clinics to represent new regional enrollment (see Table 6).

Quarterly Client Lists from Providers

Providers from research sites are required to send a quarterly list of their new TAKE CHARGE eligibles to the Research and Data Analysis Division. No other method was available to match TAKE CHARGE clients to their research clinic site.

Table 5. Clinic-Specific Sample Weights for Survey Respondents

Year One Clinic	Newly Enrolled Women	Number for Sample (Baseline Surveys)	Number of Follow-Up Surveys	Follow-Up Response Rate	Sample Weight (Baseline)	Sample Weight (Controlled for Non-Response)
White Center	898	84	39	46%	10.7	23.0
Skagit	38	16	8	50%	2.4	4.8
Mt. Baker	504	82	35	43%	6.1	14.4
Sunnyside	380	81	31	38%	4.7	12.3
Renton	327	30	15	50%	10.9	21.8
Skamania	48	8	4	50%	6.0	12.0
Everett	994	84	42	50%	11.8	23.7
Pullman	492	92	49	53%	5.3	10.0
University District/Capital Hill	5,505	119	75	63%	46.3	73.4
Total:	**9,186**	**596**	**298**	**50%**		

Year Two Clinic	Newly Enrolled Women	Number for Sample (Baseline Surveys)	Number of Follow-Up Surveys	Follow-Up Response Rate	Sample Weight (Baseline)	Sample Weight (Controlled for Non-Response)
White Center	460	113	44	39%	4.1	10.5
University District	1,928	103	69	67%	18.7	27.9
Skagit	58	22	8	36%	2.6	7.3
Mt. Baker	487	96	58	60%	5.1	8.4
Sunnyside	233	93	38	41%	2.5	6.1
Renton	345	100	35	35%	3.5	9.9
Capital Hill	2,480	104	57	55%	23.8	43.5
Skamania	11	4	2	50%	2.8	5.5
Everett	779	106	51	48%	7.3	15.3
Pullman	427	93	57	61%	4.6	7.5
Total:	**7,208**	**834**	**419**	**50%**		

Year Three (to date) Clinic	Newly Enrolled Women	Number for Sample (Baseline Surveys)	Number of Follow-Up Surveys	Follow-Up Response Rate	Sample Weight (Baseline)	Sample Weight (Controlled for Non-Response)
White Center	444	102	10	10%	4.4	44.4
University District	1,390	109	69	63%	12.8	20.1
Skagit	76	31	6	19%	2.5	12.7
Mt. Baker	512	105	27	26%	4.9	19.0
Sunnyside	181	108	43	40%	1.7	4.2
Renton	313	108	42	39%	2.9	7.5
Capital Hill	2,442	111	60	54%	22.0	40.7
Skamania	22	4	2	50%	5.5	11.0
Everett	842	100	39	39%	8.4	21.6
Pullman	476	114	9	8%	4.2	52.9
Total:	**6,698**	**892**	**307**	**34%**		

Table 6. Statewide Sample Weights for Survey Respondents

Year One Clinic	Newly Enrolled Women	Newly Enrolled Clinic Clients as Proportion of Region Total	Weight, Clinics to Region	Clinic-Specific Regional Weight for Follow-Up Surveys
King County	**24,391**	**27.59%**	**3.6**	
White Center				83.4
University District				266.0
Renton				79.0
Capital Hill				266.0
Western WA (excluding King Co)	**21,030**	**7.53%**	**13.3**	
Skagit				63.1
Mt. Baker				191.2
Skamania				159.3
Everett				314.2
Eastern WA	**11,704**	**7.45%**	**13.4**	
Sunnyside				164.5
Pullman				134.8

Year Two Clinic	Newly Enrolled Women	Newly Enrolled Clinic Clients as Proportion of Region Total	Weight, Clinics to Region	Clinic-Specific Regional Weight for Follow-Up Surveys
King County	**24,451**	**21.32%**	**4.7**	
White Center				49.0
University District				131.1
Renton				46.2
Capital Hill				204.1
Western WA (excluding King Co)	**12,987**	**10.28%**	**9.7**	
Skagit				70.5
Mt. Baker				81.7
Skamania				53.5
Everett				148.6
Eastern WA	**10,702**	**6.17%**	**16.2**	
Sunnyside				99.4
Pullman				121.5

Year Three Clinic	Newly Enrolled Women	Newly Enrolled Clinic Clients as Proportion of Region Total	Weight, Clinics to Region	Clinic-Specific Regional Weight for Follow-Up Surveys
King County	**24,673**	**18.60%**	**5.4**	
White Center				238.7
University District				108.3
Renton				40.1
Capital Hill				218.8
Western WA (excluding King Co)	**10,921**	**13.30%**	**7.5**	
Skagit				95.3
Mt. Baker				142.6
Skamania				82.7
Everett				162.4
Eastern WA	**24,673**	**18.60%**	**5.4**	
Sunnyside				64.9
Pullman				815.4

TAKE CHARGE Provider Surveys

Analyses of provider attitudes and behaviors were based on responses to the provider survey. Determination of the level of client-centered practice is based on the responses of patient care providers to questions related to their family planning practice and services and their interaction with clients. 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.

Table 7. Number of Provider Surveys

Research Sites	Baseline Survey		Follow up Survey	
	All Providers N=72	Patient Care Providers N=46	All Providers N=87	Patient Care Providers N=61
IFS	43	27	47	30
Control	29	19	40	31

ANALYSIS

Information about TAKE CHARGE enrollment, client services data, and fertility rates are based on the entire population of TAKE CHARGE enrollees. Age and gender are the only demographic characteristics available for all TAKE CHARGE clients; these data were supplemented with information from birth certificates for the subset of female clients who had a birth certificate available for analysis. Data regarding changes in client contraceptive use, client self-efficacy, future goals and aspirations, and the client's perceptions of their provider are based on the sample of clients that agreed to participate in the research protocols and completed a client survey at one of the ten randomly selected research sites.

Study Groups

TAKE CHARGE eligibles (N=231,093 years 1-3). All women and men who have been enrolled in the TAKE CHARGE program. This group contains women and men who have received family planning services and those who were enrolled but did not receive any covered family planning services through the demonstration.

TAKE CHARGE participants (N=180,564 years 1-3). All women and men who receive one or more covered medical family planning service through the demonstration as defined in the Special Terms & Conditions agreed upon by CMS and the Medical Assistance Administration. See Appendix A for a list of covered medical family planning services.

TAKE CHARGE Eligibles with Medicaid-Paid Births (n=70,813). All women enrolled in TAKE CHARGE between July 1, 2001, and June 30, 2004, who had a Medicaid-paid birth (live birth or fetal death) between July 1, 1988, and December 31, 2003, and who were residents of Washington State at the time of delivery. This group includes women enrolled in Program G and in Program S.

Survey clients (n=1024). All female TAKE CHARGE clients at least 18 years old who completed both a pre- and a post- survey. This group includes only newly enrolled TAKE CHARGE clients (Program G).

Statistical Analyses

Chi-square tests were used when comparing differences among IFS and control site clients and providers. 95% confidence limits were used to determine significant differences between pre and post survey analyses related to client self-efficacy.

Fertility Rates

The calculation of fertility rates is a required component for monitoring budget neutrality for the Washington State TAKE CHARGE family planning program and is defined in the Centers for Medicare and Medicaid Services' Special Terms and Conditions.[7] General Fertility Rates calculated for the Base Year, Year One, Year Two, and Year Three (preliminary) are presented in the *Findings* section of this report.

Base Year

The total base year fertility rate is calculated using the following formula:

$$\text{Base Year Fertility Rate} = \frac{B^{TC}}{P_{15-44}^{fTC}}$$

Where P_{15-44}^{fTC} is equal to the number of women ages 15-44 enrolled in TAKE CHARGE between July 1, 2001 and December 31, 2001 and who received covered medical family planning services; and B^{TC} is equal to the number of Medicaid paid live births to all TAKE CHARGE participants in calendar year 2000.

The denominator for the base-year fertility rate is our best estimate for women with family incomes up to and including 200 percent of the FPL and ineligible for Medicaid except for pregnancy. Women who are otherwise Medicaid eligible are not in the target group of TAKE CHARGE because these women receive family planning services as part of their regular Medicaid services. As previously mentioned in the report, women with incomes at or below 200 percent of the FPL who would be eligible for Medicaid only if they became pregnant is

[7] Available at: http://www.cms.hhs.gov/medicaid/1115/wafnltanc.pdf (accessed February 14, 2005)

the main target group for TAKE CHARGE. These births are births that in many cases would have likely been averted if the women had access to regular family planning services.

Receipt of covered family planning service(s) is based on the presence of a claim in the Medicaid Management Information System (MMIS). If the woman received at least one designated medical family planning service during the appropriate time period, then she is determined to be a TAKE CHARGE participant. Appendix B details the specific medical family planning codes used for the determination of the demonstration participants.

Age-specific fertility rates were also calculated for year one and year two using the base year as the standard population. The base year rate was computed for the actual enrollees so no age standardization is needed.

Demonstration Years

The *year one* fertility rate is calculated similarly to that of the base year except for the time periods covered. For demonstration year one, P_{15-44}^{fTC} is equal to the number of women ages 15-44 enrolled in TAKE CHARGE between July 1, 2001 and June 30, 2002 and who received covered medical family planning services; and B^{TC} is equal to the number of Medicaid paid live births to all TAKE CHARGE participants during the same time period.

The *year two* and *year three* fertility rates are calculated similarly to the year one fertility rate except that the time periods covered are July 1, 2002 to June 30, 2003 and July 1, 2003 to June 30, 2004, respectively. The data sources are slightly different in that the year three fertility rate uses preliminary Birth Certificate data for the last half of the year (January 1, 2004 to June 30, 2004) and therefore reflects a preliminary fertility rate.

Since the age distribution for year one and year two reflected somewhat fewer teens and more women between the ages of 20 and 24, the fertility rates for year one and year two were adjusted to the age distribution of the base year.

LIMITATIONS

Data on client race/ethnicity, parity, and marital status were limited to those with a birth certificate available in the FSDB (N=70,813). It is possible clients not matched to the FSDB differ on these characteristics which may influence their contraceptive and family planning behavior. The number of clients with history of a birth may be under-reported since information on births occurring before July 1988 or after December 2003 is not available. Finally, the survey participants in the ten research sites were not selected at random and only included women 18 years and older. The reported self-efficacy and other survey-related measures may not reflect the behavior of clients under 18. Non-random selection may result in the survey participants not being representative of TAKE CHARGE clients overall. However, we have no evidence that they are not representative and so the assumption is made that they are representative.

Table 8. Estimated Averted Unintended Pregnancies Among Newly Enrolled TAKE CHARGE G Women Clients Based on Weighted Survey Responses And Failure Rates Associated With Contraceptive Methods Used Before and After Enrollment

		Estimated Pregnancies (Per Method Failure Rates)							
		Year One		Year Two		Year Three		Combined	
	Failure	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Method	**Rate**								
Implants (Norplant)	0.0005	0.0	0.0	0.0	0.0	0.4	0.1	0.4	0.1
Male sterilization	0.0015	0.8	0.8	0.0	0.5	0.2	0.6	1.0	1.9
IUD	0.0045	1.4	6.1	2.9	4.2	0.0	1.4	4.0	10.9
Female sterilization	0.005	0.0	1.6	0.0	1.9	0.0	2.3	0.0	5.7
Injectables	0.03	170.4	139.8	83.1	140.2	59.5	87.6	313.0	367.6
Nuvaring	0.08	0.0	32.1	11.9	126.0	35.0	192.7	46.9	350.8
Orthoevra patch	0.08	0.0	42.6	10.5	175.3	107.7	346.2	118.1	564.1
Oral contraceptives	0.08	1,752.8	2,135.0	1,399.4	1,710.8	1,237.8	1,585.8	4,390.0	5,431.6
Male condoms	0.15	1,827.8	660.2	1,946.1	584.3	2,015.6	692.1	5,789.3	1,936.5
Diaphragm/cervical cap	0.16	0.0	50.3	0.0	20.9	17.3	17.3	17.3	88.5
Female condoms	0.21	55.9	106.1	25.5	0.0	65.3	13.6	146.6	119.8
Periodic abstinence	0.25	47.8	100.2	124.7	90.3	27.1	0.0	199.5	190.5
Withdrawal	0.27	254.2	157.8	342.9	207.9	184.7	59.1	781.7	424.8
Spermicide	0.29	0.0	0.0	0.0	0.0	75.1	0.0	75.1	0.0
No method (chance)	0.85	1,692.9	1,464.2	805.1	338.9	622.4	592.5	3,120.4	2,395.6
Estimated pregnancies for Take Charge G women (N):		5,804	4,897	4,752	3,401	4,448	3,591	15,003	11,888
Estimated pregnancies averted (N):			907		1,351		857		3,115
Estimated pregnancies averted (%):			15.6%		28.4%		19.3%		20.8%

Statistics are based on weighted survey responses, and exclude respondents who indicated that they wanted or kind of wanted to get pregnant. IUD use is split between Mirena and Paragard and reflects the proportions seen in overall Take Charge services billed. The use ratio varies, and IUD failure rates are adjusted accordingly by year (0.0053, 0.0046, 0.0037). The cervical cap failure rate is the nulliparous rate, since we don't know if women have previously given birth, and the nulliparous rate is the same as the rate for diaphragms, with which cervical caps are lumped in the survey. Presumably delivery history would be a factor considered in method choice. Those who indicated no sex in the last 2 months were considered abstinent, with a failure rate of 0.

Reference for Failure Rates: Trussell, James. The Essentials of Contraception: Efficacy, Safety, and Personal Considerations. In Hatcher, R.A. et al. (Eds.) Contraceptive Technology (18th Revised Edition), New York: Ardent Media, 2004.

FINDINGS

PROGRAM OBJECTIVES

In Washington's December 1998 waiver application, the goal for the TAKE CHARGE program was identified as reducing "the number of births among low-income women that are a result of an unintended pregnancy through offering family planning services to low-income men and to an expanded population of low-income women, thereby avoiding increased Medicaid-paid maternity costs." In addition, five specific program objectives were described. In this section, we present the evidence available to date that supports (or refutes) the original program objectives.

Objective 1
7.5 percent of the women eligible under the waiver, who would have had an unintended pregnancy, will remain pregnancy free.

This objective was conceptualized as the proportion of total pregnancies estimated to occur based on family planning methods prior to TAKE CHARGE, that were averted. As shown in the table on the facing page, the averted pregnancies represent the difference between the estimated pregnancies based on the pre-TAKE CHARGE methods and those based on the post-TAKE CHARGE methods. The number of pregnancies averted was estimated for newly enrolled women using the frequencies of methods used reported on the pre- and post-client surveys and established method-specific failure rates as reported by Trussell, 2004.

A recent publication about California's Family PACT Program (Foster et al., 2004) suggested this analytic strategy. These researchers relied on chart review to obtain pre-program frequencies of method use and claims data to obtain post-enrollment method use. For the TAKE CHARGE program, pre- and post-client surveys are administered to address a number of questions, including the use of specific family planning methods in the two months prior to enrollment in TAKE CHARGE and in the two months at the end of the first year of enrollment. Since the pre- and post-surveys are nearly identical in their format, this permits comparison based on a highly consistent data source. While client self-report has its limitations, we believe this method is at least as reliable as the mixed data sources used in the California study.

- Overall (all three years), the number of estimated pregnancies was reduced from 15,003 (before enrollment in TAKE CHARGE) to 11,888 (at the end of the first year of enrollment). The 3115 pregnancies averted represent a decrease of 20.8%. In other words, 21% of the women eligible under the waiver, who would have had an unintended pregnancy, remained pregnancy free.

This is a very conservative estimate because many clients continue to use their method for more than one year, client surveys under-estimate method use relative to claims data, and the actual births to participants are approximately equal to the failure rate of the more effective methods.

Objective 2
Increase the use of more effective contraceptive methods by Medicaid-eligible clients through intensive one-on-one support systems.

At the time of the December 1998 waiver application, the intensive one-on-one support system was envisioned as intensive counseling, education, follow-up, and ongoing support for clients regarding their continued and correct use of a birth control method. During program development, this intervention was named Intensive Follow-up Services (IFS), and each intervention site developed its own program for IFS to meet the unique needs of its clients and to optimize clinic operations. IFS development and implementation at the five intervention sites are described in more detail in the *TAKE CHARGE Process Evaluation* report (Ritualo et al., 2003).

Client surveys provide detailed information on family planning methods used by newly enrolled clients before they enrolled in TAKE CHARGE. The pre-TAKE CHARGE methods were compared to the methods clients reported using during the last two months of their first year of enrollment. This approach allows estimation of the change in clients' use of contraceptive methods, comparing pre- and post-TAKE CHARGE method use for IFS and control sites. Methods were categorized as "more effective" and "less effective" to simplify the comparison.

The following table shows survey responses to the question "During the last 2 months, what kinds of birth control did you or your partner use?"

Table 9. Effectiveness of Birth Control Methods Reported by Clients

Method Effectiveness	PRE-SURVEY			POST-SURVEY		
	Total (N=1,009)	IFS (N=490)	Control (N=519)	Total (N=1,009)	IFS (N=490)	Control (N=519)
Abstinent	10.8	9.9	11.3	11.2	9.7	12.1
Less Effective	33.0	36.6	31.0	14.4*	12.6	15.5
More Effective	52.8	48.7	55.2	69.3*	72.4	67.5
No Method	3.4	4.8	2.5	5.1	5.4	4.9
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."

* Differences were statistically significant at 95% confidence interval.

- The proportion of clients using a more effective method increased from 52.8% at enrollment to 69.3% one year later. At IFS sites, use of more effective methods

increased from 48.7% to 72.4% (a percentage increase of 49%), compared to an increase from 55.2% to 67.5% (a percentage increase of 22%) at control sites.

- Similarly, the proportion of clients reporting use of a less effective method decreased from 33.0% at enrollment to 14.4% one year later. At IFS sites, use of less effective methods decreased from 36.6% to 12.6% (a percentage decrease of 66%), compared to a decrease from 31.0% to 15.5% (a percentage decrease of 50%) at control sites.
- The proportion of clients that reported using abstinence in the past two months also increased slightly from 10.8% to 11.2%.
- Those using no method also increased from 3.4% to 5.1% during the one-year interval. Of the women who reported using no method, 7.9% stated that they wanted to get pregnant. At IFS sites, the proportion reporting the use of no method had increased by 12% at one year follow-up (4.8% pre and 5.4% post), while that proportion doubled at control sites (from 2.5% pre to 4.9% post).

Objective 3

Increase the number of Medicaid-eligible women and teens receiving services from family planning clinics.

The table below presents the unduplicated counts of women who received Medicaid-paid services from family planning clinics (provider type = 71) during the baseline year and during each of the first three years of TAKE CHARGE.

Table 10. Medicaid Women Receiving Services From Family Planning Clinics

Age	Baseline Year CY2000	Year One	Year Two	Year Three
All Medicaid women* excluding non-citizen women				
<18	3,998	14,747	17,661	19,137
18-19	3,731	16,150	20,314	22,806
20+	15,121	54,710	70,278	80,054
Total	**22,850**	**85,607**	**108,253**	**121,997**
All TAKE CHARGE women (S & G)*				
<18	n/a	9,530	11,895	13,330
18-19	n/a	12,538	16,154	18,893
20+	n/a	41,103	55,487	65,112
Total	**n/a**	**63,171**	**83,536**	**97,335**

*unduplicated

- The number of Medicaid women who received services from family planning clinics increased from 22,850 during the baseline year to 85,607 in year one, 108,253 in year two, and 121,997 in year three.

- The number of Medicaid women other than those enrolled in TAKE CHARGE increased slightly in years two and three—from 22,850 during the baseline year to 24,717 (108,253 – 83,536) in year two and 24,662 in year three (121,997 – 97,335).

Clients enrolled in TAKE CHARGE account for very large increases (four- to five-fold) in the number of women who received services from family planning clinics. Actual enrollment in TAKE CHARGE has far exceeded the enrollment estimates at the time of the waiver application. While such a large volume of clients seen at family planning clinics was not necessarily anticipated at the time of the waiver application, the increases are consistent with the actual enrollment numbers. In addition, the number of other (non-TAKE CHARGE) women less than 20 years old who received services from family planning clinics also increased during years two and three of the demonstration (and year one for teens less than 18 years old).

Objective 4
Increase the number of low-income men receiving family planning services, including vasectomies.

The table below shows the unduplicated counts of men who received Medicaid-paid family planning services during the baseline year and during each of the first three years of TAKE CHARGE. In this table, data are presented for TAKE CHARGE men and non-TAKE CHARGE men combined for the three years of the demonstration.

Table 11. Men Receiving Family Planning Services

	Baseline Year CY2000	Year One	Year Two	Year Three
All Medicaid men				
vasectomies	205	272	396	393
other fp services	645	3,276	3,988	4,625
Total men*	**850**	**3,548**	**4,384**	**5,018**

*unduplicated

The number of men receiving vasectomies has increased modestly. The number of men receiving other family planning services has increased greatly.

Objective 5
Raise awareness of private providers on the importance of unintended pregnancy prevention through education and training, so that more of them initiate family planning discussions with their patients.

While the December 1998 waiver application emphasized the role of private providers, as program development occurred subsequently, client-centered behaviors as practiced by all TAKE CHARGE providers received greater emphasis. This is the basis for the structured Education, Counseling, and Risk Reduction (ECRR) activity. ECRR was defined as client-centered education and counseling services designed to strengthen decision-making skills and to support clients' successful use of their chosen contraception method. Components of ECRR are described in more detail in the *TAKE CHARGE Process Evaluation* report (Ritualo et al., 2003). For many providers, this has been a new dimension to their practice, building greater rapport between provider and client, as well as helping clients consider whether their chosen method is really appropriate for their lifestyle.

From May 2001 to date, 462 clinic staff received the provider training required of all TAKE CHARGE providers. The training includes both billing and eligibility procedures and ECRR. Approximately one-third of the 462 staff were clinicians, and one-third were health educators, client advocates, and clinic assistants. The remaining participants were billing and administrative staff.

In the provider survey, providers were asked a number of questions related to their family planning practice and services, and their interaction with clients. The *TAKE CHARGE Process Evaluation* report concluded that provider behavior included more client-centered practice than at the beginning of TAKE CHARGE. Indicators of client-centered practice included providers' level of confidence that they discussed clients' living situations and that they would recognize when a client was experiencing risk factors affecting successful use of family planning. IFS providers more frequently reported finding our about underlying client concerns and checking with clients to see if their birth control plan had been put into practice.

In addition to the specific training required for TAKE CHARGE providers, ECRR concepts are beginning to diffuse throughout the State of Washington and establish a new standard of care for family planning practices. The regional training center, Region X, Center for Health Training (CHT), which developed the curriculum for the TAKE CHARGE ECRR training, expanded the scope of, and audience for, ECRR. In 2004, with funding through a cooperative agreement with the Centers for Disease Control and Prevention (#99080), the Region X Center for Health Training produced and tested a science-based Education and Counseling for Risk Reduction curriculum designed to help adolescent clients reduce their sexual risks, particularly their risk for unintended pregnancy. This curriculum (derived from the TAKE CHARGE ECRR manual) is a capacity building document, forming the basis for future on-going training of health care providers. Fifteen participants, including clinic managers, agency trainers, Title X grantee staff and other regional training center trainers, attended the training to pilot test and evaluate the curriculum, so that they can conduct training on ECRR with clinicians and counselors.

FERTILITY RATES

In the Special Terms and Conditions of Washington's TAKE CHARGE Project for Family Planning Service, the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services (CMS)) prescribed the method by which fertility rates would be calculated for monitoring budget neutrality. The details of the method are described in the Methods section of this report.

The following table compares fertility rates for all Washington women, demonstration participants according to the CMS methodology, and demonstration participants including only those births that occurred after program enrollment.

Table 12. Fertility Rates for Washington State and TAKE CHARGE Participants

Fertility Rates Per 1000 Females 15-44	CY 2000 Base Year	Year 1 7/2001 – 6/2002	Year 2 7/2002 – 6/2003	Year 3 7/2003 – 6/2004
Washington State*	62.7	61.2	60.8	62.0
Demonstration Participants	135.2	64.3	62.8	55.9†
Demonstration Participants: Births After Enrollment	n/a	7.1	5.5	6.8†

*****Washington State birth rates for calendar years from the 2003 Washington State Pregnancy & Induced Abortion Statistics annual report.
†Year 3 fertility rates are preliminary.

- Washington State's birth rate for women 15-44 years old has shown very little change in recent years.[8] During the 1980s and early 1990s birth rates for Washington women decreased slightly and since 1995, the birth rate has fluctuated between 60.8 per 1000 (in 2002) and 62.1 (in 1998).
- The base year fertility rate (135.2 per 1000) was computed for all births in calendar year 2000 to demonstration participants in the first six months of the program. For each of the first three years of the demonstration, the total number of births in each year for all demonstration participants included births that occurred before or after enrollment in the TAKE CHARGE program. The fertility rate for each of the demonstration years is less than half the base year rate.
- If the births included in computation of the fertility rate are restricted to those that occurred after enrollment in TAKE CHARGE, the fertility rates are much lower (5 to 7 per 1000)—comparable to the failure rate for more effective contraceptive methods.

[8] Birth rates for teens decreased dramatically during the 1990s. While teen birth rates continue to decline in Washington, this trend began well in advance of the implementation of the TAKE CHARGE program.

CHARACTERISTICS OF FEMALE CLIENTS

Demographic data from birth certificates linked to Medicaid clients in the First Steps Database was used to supplement the gender and age data available for all TAKE CHARGE clients. Birth certificate data presented in this section include age, parity, marital status, and race/ethnicity and are based on any Medicaid-paid birth to a TAKE CHARGE client between July 1, 1988 and December 31, 2003. These data are presented separately for women first enrolled in Program G and those first enrolled in Program S. The following table shows the number and proportion of these women who had a history of a Medicaid-paid birth.

Table 13. Female TAKE CHARGE Clients With History of A Medicaid-Paid Birth

Program[1]	Women Enrolled in TAKE CHARGE[2] July 1, 2001 - June 30, 2004	Enrolled Women with a Medicaid-paid Birth[3] between July 1, 1988 - December 31, 2003	
	Number	Number	Percent of Total
G	143,814	15,939	(11.1%)
S	74,242	54,874	(73.9%)
Total	218,056	70,813	(32.5%)

[1]Program at first enrollment. Some clients may have transitioned to Program S or G after first enrollment.

[2]Enrolled TAKE CHARGE clients unduplicated to earliest year of enrollment.

[3]Birth certificate data from FSDB for births from Jul 1, 1988 - Dec 31, 2003.

Of the 218,056 total women enrolled in TAKE CHARGE during the first three years, nearly one-third (32.5%) had a history of a Medicaid-paid birth. Among women first enrolled in Program G, 11.1% had a history of a birth. Among women first enrolled in Program S, 73.9% had a history of a birth. This difference is consistent with program eligibility requirements: women in Program S are automatically enrolled in TAKE CHARGE two months after their pregnancy ends. Birth certificates were not found for 26% of women on Program S; their pregnancies were assumed to have been unfulfilled (ended in miscarriage, fetal deaths before twenty weeks, or termination). Many of the 90% of Program G women who had no birth certificates may never have been pregnant.

The following analyses were based on the 70,813 TAKE CHARGE women who had a birth certificate available. The first table, on the next page, shows the age distribution and average age for TAKE CHARGE clients who did and did not have a history of a Medicaid-paid birth.

- For both Program G and Program S clients, women who had a history of a birth were older than clients who did not have a prior birth. The average age of Program G clients without a birth was 21.8 years; for Program G clients with a birth, the average age was 25.3. The average age of Program S clients without a birth was 24.6 years; for Program S clients with a birth, the average age was 26.3.

- Women less than 20 years of age accounted for just 8.4% of Program S clients with a birth, compared to 22.2% of Program S clients without a birth. Women less than 20 years of age accounted for 14.7% of Program G clients with a birth and 45.6% of Program G clients without a birth.

Table 14. TAKE CHARGE Client Characteristics: Age Distribution by Program by Parity

Program G							
Age at Enrollment	Female Clients Enrolled[1]		Clients without a Birth		Clients with a Birth[2]		Percent of Client Total with a Birth
	N	(%)	N	(%)	N	(%)	
Less than 18	29,840	(20.7%)	29,225	(22.9%)	615	(3.9%)	(2.1%)
18 - 19	30,802	(21.4%)	29,081	(22.7%)	1,721	(10.8%)	(5.6%)
20 - 24	46,807	(32.5%)	40,837	(31.9%)	5,970	(37.5%)	(12.8%)
25 - 29	18,379	(12.8%)	14,140	(11.1%)	4,239	(26.6%)	(23.1%)
30 - 34	9,230	(6.4%)	7,091	(5.5%)	2,139	(13.4%)	(23.2%)
35 - 39	4,851	(3.4%)	3,918	(3.1%)	933	(5.9%)	(19.2%)
40 - 44	2,608	(1.8%)	2,338	(1.8%)	270	(1.7%)	(10.4%)
Over 45	1,228	(0.9%)	1,179	(0.9%)	49	(0.3%)	(4.0%)
out of range[3]	69	(0.0%)	66	(0.1%)	3	(0.0%)	(4.3%)
Total	143,814	(100.0%)	127,884	(100.0%)	15,939	(100.0%)	(11.1%)
Mean Age	22.2		21.8		25.3		

Program S							
Age at Enrollment	Female Clients Enrolled[1]		Clients without a Birth		Clients with a Birth[2]		Percent of Client Total with a Birth
	N	(%)	N	(%)	N	(%)	
Less than 18	2,018	(2.7%)	1,232	(6.4%)	786	(1.4%)	(38.9%)
18 - 19	6,878	(9.3%)	3,061	(15.8%)	3,817	(7.0%)	(55.5%)
20 - 24	28,032	(37.8%)	7,703	(39.8%)	20,329	(37.0%)	(72.5%)
25 - 29	18,111	(24.4%)	3,204	(16.5%)	14,907	(27.2%)	(82.3%)
30 - 34	11,451	(15.4%)	2,159	(11.1%)	9,292	(16.9%)	(81.1%)
35 - 39	5,683	(7.7%)	1,337	(6.9%)	4,346	(7.9%)	(76.5%)
40 - 44	1,878	(2.5%)	599	(3.1%)	1,279	(2.3%)	(68.1%)
Over 45	170	(0.2%)	66	(0.3%)	104	(0.2%)	(61.2%)
out of range[3]	21	(0.0%)	7	(0.0%)	14	(0.0%)	(66.7%)
Total	74,242	(100.0%)	19,368	(100.0%)	54,874	(100.0%)	(73.9%)
Mean Age	25.9		24.6		26.3		

Total							
Age at Enrollment	Female Clients Enrolled[1]		Clients without a Birth		Clients with a Birth[2]		Percent of Client Total with a Birth
	N	(%)	N	(%)	N	(%)	
Less than 18	31,858	(14.6%)	30,457	(20.7%)	1,401	(2.0%)	(4.4%)
18 - 19	37,680	(17.3%)	32,142	(21.8%)	5,538	(7.8%)	(14.7%)
20 - 24	74,839	(34.3%)	48,540	(33.0%)	26,299	(37.1%)	(35.1%)
25 - 29	36,490	(16.7%)	17,344	(11.8%)	19,146	(27.0%)	(52.5%)
30 - 34	20,681	(9.5%)	9,250	(6.3%)	11,431	(16.1%)	(55.3%)
35 - 39	10,534	(4.8%)	5,255	(3.6%)	5,279	(7.5%)	(50.1%)
40 - 44	4,486	(2.1%)	2,937	(2.0%)	1,549	(2.2%)	(34.5%)
Over 45	1,398	(0.6%)	1,245	(0.8%)	153	(0.2%)	(10.9%)
out of range[3]	90	(0.0%)	73	(0.0%)	17	(0.0%)	(18.9%)
Total	218,056	(100.0%)	147,243	(100.0%)	70,813	(100.0%)	(32.5%)
Mean Age	23.5		22.2		26.1		

[1]Client age is age at first enrollment in TAKE CHARGE from Jul 1, 2001 to Jun 30, 2004.

[2]Medicaid-paid birth data from FSBD Jul 1, 1988 - Dec 31, 2003.

[3]Age out of range (< 8 or > 60).

The next table shows the client's age at her most recent birth for the 70,813 clients who had a history of a Medicaid-paid birth.

- Thirty-eight percent (38.3%) of clients with a birth were between 20 and 24 years of age at the time of their last birth. Women age 20-to-24 years old accounted for the largest proportion of women with a history of a birth for both Program G and Program S (41.9% and 37.3%, respectively).

- Women enrolled in Program S were older on average at the time of their last birth (average age 25.7 years), compared to women enrolled in Program G (average age 22.7 years).

- For both groups, women who were married at the time of their last birth were older than women who were not married. For Program G, the average age of women who were married at their last birth was 24.8 years, compared to 21.5 years for those who were not married. For Program S, the average age of women who were married at their last birth was 27.1 years, compared to 23.7 years for those who were not married.

- More than half the women (51.4%) with a birth were married at the time they gave birth. The proportion of married women was greater among Program S women (56.3%) than among Program G women (34.7%). (data not shown)

Table 15. TAKE CHARGE Client[1] Age at Most Recent Birth[2]

Age	Program G		Program S		Total	
	N = 15,939	(100%)	N = 54,874	(100%)	N = 70,813	(100%)
Less than 18	1,670	(10.5%)	1,496	(2.7%)	3,166	(4.5%)
18 - 19	2,978	(18.7%)	5,351	(9.8%)	8,329	(11.8%)
20 - 24	6,677	(41.9%)	20,452	(37.3%)	27,129	(38.3%)
25 - 29	2,944	(18.5%)	14,163	(25.8%)	17,107	(24.2%)
30 - 34	1,229	(7.7%)	8,499	(15.5%)	9,728	(13.7%)
35 - 39	382	(2.4%)	3,851	(7.0%)	4,233	(6.0%)
40 - 44	52	(0.3%)	987	(1.8%)	1,039	(1.5%)
Over 45	1	(0.0%)	59	(0.1%)	60	(0.1%)
out of range[3]	6	(0.0%)	16	(0.0%)	22	(0.0%)
Average age[4] (most recent birth)	22.7		25.7		25.0	
Average age[4] (married)	24.8		27.1		26.8	
Average age[4] (unmarried)	21.5		23.7		23.0	

[1]Enrolled TAKE CHARGE clients unduplicated to earliest year Jul 1, 2001 - Jun 30, 2004 with a history of a birth.

[2]Medicaid-paid birth data from FSBD Jul 1, 1988 - Dec 31, 2003.

[3]Age out of range (< 8 or > 60).

[4]Out of range ages are not included in average.

The following table shows the number of births reported for these TAKE CHARGE clients with a history of a Medicaid-paid birth. This table excludes clients who had no history of a birth, nearly 90% of Program G women and 26% of Program S women.

- A large proportion of all women with a birth had only one birth (42.2%). A significantly larger proportion of clients in program G (56%) had only one birth compared to clients in Program S (38.1%).

- The average number of births was 2.1 for all program enrollees with a birth. The average number of births to Program S clients was greater (2.2 births) than the number to Program G women (1.7 births). Overall, 86.7% had 3 or fewer births, and 11.4% had 4 or more births. (The total number of births was unknown for 1.8% of these clients.)

Table 16. Number of Births[1] to TAKE CHARGE Clients[2]

Number of Births	Program G		Program S		Total	
	N = 15,939	(100%)	N = 54,874	(100%)	N = 70,813	(100%)
1	8,928	(56.0%)	20,920	(38.1%)	29,848	(42.2%)
2	4,115	(25.8%)	16,566	(30.2%)	20,681	(29.2%)
3	1,606	(10.1%)	9,228	(16.8%)	10,834	(15.3%)
4	585	(3.7%)	4,285	(7.8%)	4,870	(6.9%)
5	192	(1.2%)	1,604	(2.9%)	1,796	(2.5%)
6	60	(0.4%)	680	(1.2%)	740	(1.0%)
7	25	(0.2%)	328	(0.6%)	353	(0.5%)
8 - 10	11	(0.1%)	304	(0.6%)	315	(0.4%)
11 - 21	4	(0.0%)	75	(0.1%)	79	(0.1%)
missing	413	(2.6%)	884	(1.6%)	1,297	(1.8%)
Mean, Median[3] Number of Births	1.7, 1		2.2, 2		2.1, 2	
Mean, Median[3] Number of Births (married)	2.0, 2		2.5, 2		2.4, 2	
Mean, Median[3] Number of Births (unmarried)	1.5, 1		1.8, 1		1.7, 1	

[1]Medicaid-paid birth data from FSBD Jul 1, 1988 - Dec 31, 2003.

[2]Enrolled TAKE CHARGE clients unduplicated to earliest year Jul 1, 2001 - Jun 30, 2004 with a history of a birth.

[3]Missing data not included in average.

The next table shows the distribution of race and ethnicity for TAKE CHARGE clients who had at least one birth.

- About two thirds (65%) of all women with a birth were White, and 15.7% were Hispanic. These proportions were very similar for women in Program G and in Program S.

- The proportion of Black women was slightly higher for Program G (6.3%) than for Program S (4.5%).

- The proportion of Native American women was somewhat higher for Program S (3.0%) than for Program G (1.9%), and the proportion of Asian women was also higher for Program S (7.6%) than for Program G (4.1%).

These differences are explored in more detail in the next table (on the following page) which includes marital status.

Table 17. Race/Ethnicity of Clients[1] with a History of a Birth[2]

Race/Ethnicity	Program G		Program S		Total	
	N = 15,939	(100%)	N = 54,874	(100%)	N = 70,813	(100%)
White	10,782	(67.6%)	35,257	(64.3%)	46,039	(65.0%)
Hispanic	2,496	(15.7%)	8,646	(15.8%)	11,142	(15.7%)
Black	1,001	(6.3%)	2,470	(4.5%)	3,471	(4.9%)
Native American	308	(1.9%)	1,668	(3.0%)	1,976	(2.8%)
Asian	661	(4.1%)	4,185	(7.6%)	4,846	(6.8%)
Hawaiian/Pacific Islander	118	(0.7%)	622	(1.1%)	740	(1.0%)
more than one race	180	(1.1%)	641	(1.2%)	821	(1.2%)
other/unknown	393	(2.5%)	1,385	(2.5%)	1,778	(2.5%)

[1]Unduplicated TAKE CHARGE clients, eligible Jul 2001 - Jul 2004, with a history of a birth.

[2]Medicaid-paid live births from FSDB Jul 1988 through Dec 2003.

- On the average, about half of all women (51.4%) with a birth were married at the time of their most recent birth. The proportion of white women who were married was similar, 50.9%. Asians were found to have the highest marriage rate (62.2%), followed by Hispanics (59.1%). Native American clients had the lowest marriage rate (28.3%).

- Overall, the proportion of married women was greater among Program S women (56.3%) than among Program G women (34.7%). For each race/ethnic group as well, the proportion of married women was greater for S women than for G women.

Table 18. Race/Ethnicity of TAKE CHARGE Clients[1] by Parity and Marital Status

Program G				
Race/Ethnicity	Clients with a Birth[2]		Marital Status (married)	
	N	(%)	N	(%)
White	10,782	(67.6%)	3,681	(34.1%)
Hispanic	2,496	(15.7%)	1,132	(45.4%)
Black	1,001	(6.3%)	182	(18.2%)
Native American	308	(1.9%)	56	(18.2%)
Asian	661	(4.1%)	254	(38.4%)
Hawaiian / Pacific Islander	118	(0.7%)	36	(30.5%)
more than 1 race	180	(1.1%)	46	(25.6%)
other / unknown	393	(2.5%)	144	(36.6%)
Total	15,939	(100.0%)	5,531	(34.7%)

Program S				
Race/Ethnicity	Clients with a Birth[2]		Marital Status (married)	
	N	(%)	N	(%)
White	35,257	(64.3%)	19,739	(56.0%)
Hispanic	8,646	(15.8%)	5,457	(63.1%)
Black	2,470	(4.5%)	1,000	(40.5%)
Native American	1,668	(3.0%)	504	(30.2%)
Asian	4,185	(7.6%)	2,759	(65.9%)
Hawaiian / Pacific Islander	622	(1.1%)	300	(48.2%)
more than 1 race	641	(1.2%)	308	(48.0%)
other / unknown	1,385	(2.5%)	832	(60.1%)
Total	54,874	(100.0%)	30,899	(56.3%)

Total				
Race/Ethnicity	Clients with a Birth[2]		Marital Status (married)	
	N	(%)	N	(%)
White	46,039	(65.0%)	23,420	(50.9%)
Hispanic	11,142	(15.7%)	6,589	(59.1%)
Black	3,471	(4.9%)	1,182	(34.1%)
Native American	1,976	(2.8%)	560	(28.3%)
Asian	4,846	(6.8%)	3,013	(62.2%)
Hawaiian / Pacific Islander	740	(1.0%)	336	(45.4%)
more than 1 race	821	(1.2%)	354	(43.1%)
other / unknown	1,778	(2.5%)	976	(54.9%)
Total	70,813	(100.0%)	36,430	(51.4%)

[1]Unduplicated TAKE CHARGE clients, eligible Jul 2001 - Jul 2004, with a history of a birth.

[2]Medicaid-paid births from FSDB Jul 1988 through Dec 2003.

CLIENT SERVICES UTILIZATION AND PARTICIPATION RATES

TAKE CHARGE offers a wide range of family planning services and most FDA-approved birth control methods to help clients prevent unintended pregnancies. A detailed description of those services and family planning methods is provided on page 9 of this report. This section describes client service utilization (defined as receipt of any Medicaid-paid service) and client participation (defined as receipt of one or more covered medical family planning service, according to the Special Terms and Conditions) rates by age, gender, and program. Service use rates and participation rates for research sites (IFS and control) and non-research sites (all other provider sites) are also presented.

Table 19. Service Use: Percent of Group-Specific Totals that Received Any Medicaid-Paid Service

Year	Program[1]	All Sites			Research Sites					
					Control			IFS		
		Clients Enrolled	Received Service	Percent	Clients Enrolled	Received Service	Percent	Clients Enrolled	Received Service	Percent
1	G	61,314	58,674	(95.7%)	4,998	4,946	(99.0%)	4,246	4,163	(98.0%)
	S	37,659	17,345	(46.1%)	103	98	(95.1%)	90	87	(96.7%)
2	G	105,574	82,183	(77.8%)	5,809	5,751	(99.0%)	4,586	4,524	(98.6%)
	S	39,592	18,517	(46.8%)	96	91	(94.8%)	106	102	(96.2%)
3	G	124,205	95,225	(76.7%)	6,543	6,396	(97.8%)	4,257	4,139	(97.2%)
	S	40,122	18,594	(46.3%)	103	100	(97.1%)	99	93	(93.9%)
Total (Duplicated)		408,466	290,538	(71.1%)	17,652	17,382	(98.5%)	13,384	13,108	(97.9%)
Unduplicated Clients[2]										
	G	157,783	148,732	(94.3%)	13,006	12,847	(98.8%)	9,448	9,276	(98.2%)
	S	73,310	40,021	(54.6%)	172	167	(97.1%)	147	145	(98.6%)
Total (Unduplicated)		231,093	188,753	(81.7%)	13,178	13,014	(98.8%)	9,595	9,421	(98.2%)

[1]Program G clients were self-selected for enrollment. Program S clients were automatically enrolled in the post-pregnancy extension program.
[2]Clients are unduplicated by program in which first service was received.

Utilization of any Medicaid-paid Services

The table above shows the number and percent of TAKE CHARGE clients who received any Medicaid-paid service during the first three years of the demonstration.

1) Total enrollment and services received by program (all sites)

- During the first three years of TAKE CHARGE, the program enrolled a total of 231,093 clients (unduplicated by person). Of those, 157,783 (68.3%) were in Program G and 73,310 (31.7%) were in Program S.

Table 20. Participation Rates for Men and Women Years 1 - 3

Males					
Age	Clients Enrolled		Participants[1]		Participation Rate
	N = 13,036	(100%)	N = 11,087	(100%)	(85.0%)
Less than 18	926	(7.1%)	764	(6.9%)	(82.5%)
18 - 19	2,041	(15.7%)	1699	(15.3%)	(83.2%)
20 - 24	4,962	(38.1%)	4289	(38.7%)	(86.4%)
25 - 29	2,494	(19.1%)	2155	(19.4%)	(86.4%)
30 - 34	1,238	(9.5%)	1048	(9.5%)	(84.7%)
35 - 39	660	(5.1%)	544	(4.9%)	(82.4%)
40 - 44	408	(3.1%)	347	(3.1%)	(85.0%)
Over 45	293	(2.2%)	238	(2.1%)	(81.2%)
out of range[2]	14	(0.1%)	3	(0.0%)	(21.4%)

Females					
Age	Clients Enrolled		Participants[1]		Participation Rate
	N =218,057	(100.0%)	N = 169,477	(100%)	(77.7%)
Less than 18	31,756	(14.6%)	28,323	(16.7%)	(89.2%)
18 - 19	37,780	(17.3%)	32,711	(19.3%)	(86.6%)
20 - 24	74,741	(34.3%)	60,130	(35.5%)	(80.5%)
25 - 29	36,350	(16.7%)	25,437	(15.0%)	(70.0%)
30 - 34	20,688	(9.5%)	12,794	(7.5%)	(61.8%)
35 - 39	10,490	(4.8%)	6,138	(3.6%)	(58.5%)
40 - 44	4,431	(2.0%)	2,794	(1.6%)	(63.1%)
Over 45	1,369	(0.6%)	1,080	(0.6%)	(78.9%)
out of range[2]	452	(0.2%)	70	(0.0%)	(15.5%)

Total					
Age	Clients Enrolled		Participants[1]		Participation Rate
	N = 231,093	(100%)	N = 180,564	(100%)	(78.1%)
Less than 18	32,682	(14.1%)	29,087	(16.1%)	(89.0%)
18 - 19	39,821	(17.2%)	34,410	(19.1%)	(86.4%)
20 - 24	79,703	(34.5%)	64,419	(35.7%)	(80.8%)
25 - 29	38,844	(16.8%)	27,592	(15.3%)	(71.0%)
30 - 34	21,926	(9.5%)	13,842	(7.7%)	(63.1%)
35 - 39	11,150	(4.8%)	6,682	(3.7%)	(59.9%)
40 - 44	4,839	(2.1%)	3,141	(1.7%)	(64.9%)
Over 45	1,662	(0.7%)	1,318	(0.7%)	(79.3%)
out of range[2]	466	(0.2%)	73	(0.0%)	(15.7%)

[1]Participants received medical covered family planning services

[2]Age out of range (< 8 or > 60).

- Of all clients enrolled in the program, 188,753 (81.7%) received Medicaid-paid services. The proportion receiving services differed between Programs G and S. While 94.3% of clients in Program G received services, only 54.6% of their counterparts in Program S received any Medicaid-paid service.

2) Enrollment and services for clients at IFS and control sites

- A larger number of clients were enrolled at the control sites (N=13,178) than at the IFS sites (N=9,595). Clients in Program S accounted for less than two percent of total enrollment at the research sites. The total number of clients enrolled at research sites (13,178 + 9,595) represented 9.9% of the total clients enrolled in TAKE CHARGE.

- Both control and IFS sites had a very high rate of service use (98.8% and 98.2%, respectively). This pattern held true for both Program G and Program S clients.

3) Service utilization rates for research and non-research sites

- Compared to the research sites, the non-research sites had a lower service utilization rate. While more than 98% of clients at the research sites received a Medicaid-paid service, 80% in the non-research sites fell into that category. This is consistent with the low enrollment rate of Program S clients at research sites. Although Program S clients enrolled at research sites had high rates of service use, only 54.6% of Program S clients at all sites received a Medicaid-paid service.

- For both Program G clients and Program S clients, service use rates were higher at research sites than at non-research sites (data not shown). While the difference was small for Program G clients (93.6% at non-research sites and 98.5% at research sites), the difference was much larger for Program S clients (54.4% at non-research sites and 97.8% at research sites). This difference is not surprising since clients in Program G were self-selected for enrollment in TAKE CHARGE, and clients in Program S were automatically enrolled two months after their pregnancy ended and may not have sought any Medicaid services.

Utilization of covered medical family planning (FP) services by gender and age

This section summarizes findings about clients' use of covered medical family planning services. According to the Special Terms and Conditions agreed upon by CMS and the Medical Assistance Administration, program participants are defined as those clients who received one or more covered medical family planning service. (A list of covered medical family planning services is provided in Appendix A.) Table 20 shows the age and gender distribution of all the clients who received any medical covered family planning service in the first three years of the demonstration.

- Overall, 78% of all program enrollees met the definition of a participant, i.e., received one or more covered medical family planning service. The participation rate was highest for

Table 21. Participation [1] Rates: Women in Program G and Program S Receiving Medical Covered Family Planning Services

Non-Research Sites										
Age	Program G					Program S				
	Enrolled		Participants[1]		Participation Rate	Enrolled		Participants[1]		Participation Rate
	N = 122,942	(100.0%)	N = 114,302	(100.0%)	(93.0%)	N = 74,003	(100.0%)	N = 34,500	(100.0%)	(46.6%)
Less than 18	27,227	(22.1%)	24,922	(21.8%)	(91.5%)	1,970	(2.7%)	945	(2.7%)	(48.0%)
18 to 19	26,867	(21.9%)	25,284	(22.1%)	(94.1%)	6,911	(9.3%)	3,497	(10.1%)	(50.6%)
20 to 24	38,568	(31.4%)	36,572	(32.0%)	(94.8%)	27,948	(37.8%)	15,434	(44.7%)	(55.2%)
25 to 29	14,734	(12.0%)	13,692	(12.0%)	(92.9%)	18,027	(24.4%)	8,225	(23.8%)	(45.6%)
30 to 34	7,642	(6.2%)	7,006	(6.1%)	(91.7%)	11,437	(15.5%)	4,209	(12.2%)	(36.8%)
35 to 39	4,208	(3.4%)	3,827	(3.3%)	(90.9%)	5,656	(7.6%)	1,702	(4.9%)	(30.1%)
40 to 44	2,278	(1.9%)	2,041	(1.8%)	(89.6%)	1,835	(2.5%)	448	(1.3%)	(24.4%)
Over 45	1,056	(0.9%)	901	(0.8%)	(85.3%)	160	(0.2%)	33	(0.1%)	(20.6%)
out of range[2]	362	(0.3%)	57	(0.0%)	(15.7%)	59	(0.1%)	7	(0.0%)	(11.9%)
Control Sites										
Age	Program G					Program S				
	Enrolled		Participants[1]		Participation Rate	Enrolled		Participants[1]		Participation Rate
	N = 12,081	(100.0%)	N = 11,845	(100.0%)	(98.0%)	N = 124	(100.0%)	N = 119	(100.0%)	(96.0%)
Less than 18	1,528	(12.6%)	1,480	(12.5%)	(96.9%)	10	(8.1%)	10	(8.4%)	(100.0%)
18 to 19	2,306	(19.1%)	2,263	(19.1%)	(98.0%)	15	(12.1%)	15	(12.6%)	(100.0%)
20 to 24	4,585	(38.0%)	4,523	(38.2%)	(98.0%)	63	(50.8%)	58	(48.7%)	(92.1%)
25 to 29	2,111	(17.5%)	2,073	(17.5%)	(97.5%)	26	(21.0%)	26	(21.8%)	(100.0%)
30 to 34	925	(7.7%)	909	(7.7%)	(97.9%)	6	(4.8%)	6	(5.0%)	(100.0%)
35 to 39	358	(3.0%)	348	(2.9%)	(96.7%)	3	(2.4%)	3	(2.5%)	(100.0%)
40 to 44	184	(1.5%)	176	(1.5%)	(95.4%)	1	(0.8%)	1	(0.8%)	(100.0%)
Over 45	71	(0.6%)	68	(0.6%)	(95.2%)	0	(0.0%)	0	(0.0%)	
out of range[2]	13	(0.1%)	5	(0.0%)		0	(0.0%)	0	(0.0%)	
IFS Sites										
Age	Program G					Program S				
	Enrolled		Participants[1]		Participation Rate	Enrolled		Participants		Participation Rate
	N = 8,792	(100.0%)	N = 8,599	(100.0%)	(97.8%)	N = 115	(100.0%)	N = 112	(100.0%)	(97.4%)
Less than 18	1,015	(11.5%)	960	(11.2%)	(94.6%)	6	(5.2%)	6	(5.4%)	(100.0%)
18 to 19	1,670	(19.0%)	1,641	(19.1%)	(98.3%)	11	(9.6%)	11	(9.8%)	(100.0%)
20 to 24	3,520	(40.0%)	3,487	(40.6%)	(99.1%)	57	(49.6%)	56	(50.0%)	(98.2%)
25 to 29	1,430	(16.3%)	1,400	(16.3%)	(97.9%)	22	(19.1%)	21	(18.8%)	(95.5%)
30 to 34	664	(7.6%)	651	(7.6%)	(98.0%)	14	(12.2%)	13	(11.6%)	(92.9%)
35 to 39	262	(3.0%)	255	(3.0%)	(97.3%)	3	(2.6%)	3	(2.7%)	(100.0%)
40 to 44	131	(1.5%)	126	(1.5%)	(96.2%)	2	(1.7%)	2	(1.8%)	(100.0%)
Over 45	82	(0.9%)	78	(0.9%)	(95.1%)	0	(0.0%)	0	(0.0%)	
out of range[2]	18	(0.2%)	1	(0.0%)	(5.6%)	0	(0.0%)	0	(0.0%)	

[1]Participants received medical covered family planning services

[2]Age out of range (< 8 or > 60)

clients less than 20 years old (87.6%). Clients 25 and older had a much lower participation rate (67%).

- The participation rate was higher for men (85%) than for women (77.7%). The distribution of participants by age was very similar for men and women and corresponded to the age distribution of all enrollees. More than two-thirds of all participants were between the ages of 18 and 29 (69.8% for women; 73.4% for men).

- For women, the highest participation rate was among clients less than 18 years old (89.2%); for men, participation was highest for 20 – 29 year olds (86.4%).

Participation rates for women by program and age

The table on the facing page compares female clients' utilization of covered medical family planning services by program, and between research and non-research sites.

- Overall, the research sites demonstrated a significantly higher participation rate than the non-research sites, regardless of program type. About 98% of all women in the research sites received one or more covered medical family planning service. Only 75.6% of women in the non-research sites received such services.

- At the research sites, participation rates were very similar for Program G and Program S clients (97.9% for G women versus 96.6% for S women). In the non-research sites, the participation rate for women in Program G (93%) was more than double that for women in Program S (46.6%). This difference in participation rates is consistent with the differing rates of receipt of any Medicaid-paid service between these two groups. Women in Program S who sought out TAKE CHARGE providers at research sites had a participation rate similar to that for other women at those sites, while just over half (54.4%) the Program S women at non-research sites received any Medicaid-paid service.

- Among Program G women less than 18 years old, the participation rate was higher at the research sites (95.9%) than at the non-research sites (91.5%). At the non-research sites, participation rates for Program G tended to decrease with increasing age. This trend was less pronounced at the research sites.

- The age distribution of participants revealed very similar patterns for the IFS and the control sites. For women in both programs at IFS and control sites, clients between the ages of 18 and 29 accounted for more than three-fourths of all participants.

Table 22. Participation[1] Rates
Men Receiving Medical Covered Family Planning Services

Non-Research Sites					
Age	Enrolled		Participants[1]		Participation Rate
	N = 11,590	(100.0%)	N = 9,717	(100.0%)	(83.8%)
Less than 18	863	(7.4%)	704	(7.2%)	(81.6%)
18 - 19	1,842	(15.9%)	1,516	(15.6%)	(82.3%)
20 - 24	4,333	(37.4%)	3,687	(37.9%)	(85.1%)
25 - 29	2,191	(18.9%)	1,867	(19.2%)	(85.2%)
30 - 34	1,110	(9.6%)	924	(9.5%)	(83.2%)
35 - 39	589	(5.1%)	477	(4.9%)	(81.0%)
40 - 44	376	(3.2%)	318	(3.3%)	(84.6%)
Over 45	272	(2.3%)	221	(2.3%)	(81.3%)
out of range[2]	14	(0.1%)	3	(0.0%)	(21.4%)

Control Sites					
Age	Enrolled		Participants[1]		Participation Rate
	N = 832	(100.0%)	N = 807	(100.0%)	(97.0%)
Less than 18	36	(4.3%)	36	(4.5%)	(100.0%)
18 - 19	109	(13.1%)	106	(13.1%)	(97.2%)
20 - 24	343	(41.2%)	337	(41.8%)	(98.3%)
25- 29	204	(24.5%)	195	(24.2%)	(95.6%)
30 - 34	76	(9.1%)	74	(9.2%)	(97.4%)
35 - 39	35	(4.2%)	34	(4.2%)	(97.1%)
40 - 44	18	(2.2%)	16	(2.0%)	(88.9%)
Over 45	11	(1.3%)	9	(1.1%)	(81.8%)
out of range[2]					

IFS Sites					
Age	Enrolled		Participants[1]		Participation Rate
	N = 614	(100.0%)	N = 563	(100.0%)	(91.7%)
Less than 18	27	(4.4%)	24	(4.3%)	(88.9%)
18 - 19	90	(14.7%)	77	(13.7%)	(85.6%)
20 - 24	286	(46.6%)	265	(47.1%)	(92.7%)
25- 29	99	(16.1%)	93	(16.5%)	(93.9%)
30 - 34	52	(8.5%)	50	(8.9%)	(96.2%)
35 - 39	36	(5.9%)	33	(5.9%)	(91.7%)
40 - 44	14	(2.3%)	13	(2.3%)	(92.9%)
Over 45	10	(1.6%)	8	(1.4%)	(80.0%)
out of range[2]					

[1]Participants received medical covered family planning services

[2]Age out of range (< 8 or > 60)

Participation rates for men

The table on the facing page compares male clients' utilization of covered medical family planning services by program and between the research and the non-research sites. The analysis revealed very similar patterns of utilization of covered medical family planning services by men and by women.

- Like women clients, men in the research sites had a significantly higher participation rate than those in the non-research sites. About 95% of all men in the research sites received one or more covered medical family planning service. More than 80% (83.9%) of men in the non-research sites received such services. This was true across all age groups.
- Men between the ages of 20 and 24 accounted for 38 – 47% of all male participants in both the research and the non-research sites.
- As shown for women clients, the participation rate for men was very high in both the IFS and control sites. While the participation rate for women varied little between the two types of research sites, the participation rate for men in the control sites (97%) was higher than for those in the IFS sites (91.7%).

Participation rates for men and women in Program G

The table on the following page displays participation rates for men and women in Program G by age and site. Since Program S clients are restricted to women, it is more appropriate to compare participation for men and women by examining Program G clients only.

- At the non-research sites, the participation rate for women (93%) was much higher than for men (83.8%). At the IFS sites, the participation rate was slightly higher for women (97.8%) than for men (91.7%). Only marginal differences were found in the participation rates for men and women at the control sites (98% for women; 97% for men).
- Compared with clients in other age categories, clients between the ages of 20 and 24 accounted for the largest proportion of participants (32 – 47%). This pattern held true for both gender groups and at all sites and was consistent with the age distribution of Program G enrollees.
- Across all sites, the participation rate for women under 20 years of age (93.3%) was much higher than that for men of the same ages (83%) across all sites. The proportion of women less than 20 years old who were participants was lower at the non-research sites (92.8%) compared to the research sites (97.6% at control sites and 96.9% at IFS sites). Participation rates tended to decrease with increasing client age.

Table 23. Participation[1] Rates: Clients Enrolled in Program G Receiving Medical Covered Family Planning Services

Non-Research Sites

Age	Males					Females				
	Enrolled		Participants[1]		Participation Rate	Enrolled		Participants[1]		Participation Rate
	N = 11,590	(100.0%)	N = 9,717	(100.0%)	(83.8%)	N = 122,942	(100.0%)	N = 114,302	(100.0%)	(93.0%)
Less than 18	863	(7.4%)	704	(7.2%)	(81.6%)	27,227	(22.1%)	24,922	(21.8%)	(91.5%)
18 - 19	1,842	(15.9%)	1,516	(15.6%)	(82.3%)	26,867	(21.9%)	25,284	(22.1%)	(94.1%)
20 - 24	4,333	(37.4%)	3,687	(37.9%)	(85.1%)	38,568	(31.4%)	36,572	(32.0%)	(94.8%)
25 - 29	2,191	(18.9%)	1,867	(19.2%)	(85.2%)	14,734	(12.0%)	13,692	(12.0%)	(92.9%)
30 - 34	1,110	(9.6%)	924	(9.5%)	(83.2%)	7,642	(6.2%)	7,006	(6.1%)	(91.7%)
35 - 39	589	(5.1%)	477	(4.9%)	(81.0%)	4,208	(3.4%)	3,827	(3.3%)	(90.9%)
40 - 44	376	(3.2%)	318	(3.3%)	(84.6%)	2,278	(1.9%)	2,041	(1.8%)	(89.6%)
Over 45	272	(2.3%)	221	(2.3%)	(81.3%)	1,056	(0.9%)	901	(0.8%)	(85.3%)
out of range[2]	14	(0.1%)	3	(0.0%)	(21.4%)	362	(0.3%)	57	(0.0%)	(15.7%)

Control Sites

Age	Males					Females				
	Enrolled		Participants[1]		Participation Rate	Enrolled		Participants[1]		Participation Rate
	N = 832	(100.0%)	N = 807	(100.0%)	(97.0%)	N = 12,081	(100.0%)	N = 11,845	(100.0%)	(98.0%)
Less than 18	36	(4.3%)	36	(4.5%)	(100.0%)	1,528	(12.6%)	1,480	(12.5%)	(96.9%)
18 - 19	109	(13.1%)	106	(13.1%)	(97.2%)	2,306	(19.1%)	2,263	(19.1%)	(98.0%)
20 - 24	343	(41.2%)	337	(41.8%)	(98.3%)	4,585	(38.0%)	4,523	(38.2%)	(98.0%)
25 - 29	204	(24.5%)	195	(24.2%)	(95.6%)	2,111	(17.5%)	2,073	(17.5%)	(97.5%)
30 - 34	76	(9.1%)	74	(9.2%)	(97.4%)	925	(7.7%)	909	(7.7%)	(97.9%)
35 - 39	35	(4.2%)	34	(4.2%)	(97.1%)	358	(3.0%)	348	(2.9%)	(96.7%)
40 - 44	18	(2.2%)	16	(2.0%)	(88.9%)	184	(1.5%)	176	(1.5%)	(95.4%)
Over 45	11	(1.3%)	9	(1.1%)	(81.8%)	71	(0.6%)	68	(0.6%)	(95.2%)
out of range[2]						13	(0.1%)	5	(0.0%)	

IFS Sites

Age	Males					Females				
	Enrolled		Participants[1]		Participation Rate	Enrolled		Participants[1]		Participation Rate
	N = 614	(100.0%)	N = 563	(100.0%)	(91.7%)	N = 8,792	(100.0%)	N = 8,599	(100.0%)	(97.8%)
Less than 18	27	(4.4%)	24	(4.3%)	(88.9%)	1,015	(11.5%)	960	(11.2%)	(94.6%)
18 - 19	90	(14.7%)	77	(13.7%)	(85.6%)	1,670	(19.0%)	1,641	(19.1%)	(98.3%)
20 - 24	286	(46.6%)	265	(47.1%)	(92.7%)	3,520	(40.0%)	3,487	(40.6%)	(99.1%)
25 - 29	99	(16.1%)	93	(16.5%)	(93.9%)	1,430	(16.3%)	1,400	(16.3%)	(97.9%)
30 - 34	52	(8.5%)	50	(8.9%)	(96.2%)	664	(7.6%)	651	(7.6%)	(98.0%)
35 - 39	36	(5.9%)	33	(5.9%)	(91.7%)	262	(3.0%)	255	(3.0%)	(97.3%)
40 - 44	14	(2.3%)	13	(2.3%)	(92.9%)	131	(1.5%)	126	(1.5%)	(96.2%)
Over 45	10	(1.6%)	8	(1.4%)	(80.0%)	82	(0.9%)	78	(0.9%)	(95.1%)
out of range[2]						18	(0.2%)	1	(0.0%)	(5.6%)

[1]Participants received medical covered family planning services.

[2]Age out of range (< 8 or > 60)

Summary: How clients were enrolled in the demonstration was strongly related to differences in service utilization and participation. Both male and female clients who were self-selected for enrollment (Program G clients) had higher rates of service use and correspondingly higher rates of participation than female clients who were automatically enrolled post-pregnancy (Program S clients).

In many ways, the research sites demonstrated very similar patterns of service utilization and participation compared to non-research sites. This supports the generalizability of findings from the client surveys conducted only at the ten research sites. However, to some extent, patterns at the control sites appear more similar to those at the IFS sites than at the non-research sites. For example, the service use rates of clients in Program S who enrolled at research sites were much higher than for those at non-research sites. Service use rates of Program G clients at research sites were also higher than at non-research sites. A similar pattern was observed for participation rates. Such findings suggest the possibility that differences in program services between the control sites and the IFS sites may be less distinct than planned and with smaller differences in program services at the research sites, it may be more difficult to identify differences in outcomes of interest.

Table 24. Distribution of Contraceptive Methods and Services to Women in Programs G and S

Total (Year 1-3)													
Family Planning Method or Service[1]	**Program G**						**Program S**						**Program G and S**
	Non-Research		Control		IFS		Non-Research		Control		IFS		All Sites
	No. of Events	% of Total	No. of Events	% of Total	No. of Events	% of Total	No. of Events	% of Total	No. of Events	% of Total	No. of Events	% of Total	No. of Events	% of Total
Family Planning Visit	175,649	(30.0%)	15,475	(30.3%)	11,731	(31.5%)	22,092	(28.4%)	273	(31.0%)	263	(32.8%)	225,483	(29.9%)
Education, Counseling, and Risk Reduction	131,593	(22.5%)	13,357	(26.2%)	10,243	(27.5%)	3,112	(4.0%)	186	(21.1%)	177	(22.0%)	158,668	(21.1%)
Oral Contraceptives	120,154	(20.5%)	10,601	(20.8%)	8,389	(22.5%)	23,917	(30.8%)	168	(19.1%)	144	(17.9%)	163,373	(21.7%)
Hormone Injection[2]	35,783	(6.1%)	2,005	(3.9%)	1,970	(5.3%)	9,074	(11.7%)	71	(8.1%)	86	(10.7%)	48,989	(6.5%)
Unlisted drug[3]	29,642	(5.1%)	2,598	(5.1%)	1,381	(3.7%)	2,195	(2.8%)	43	(4.9%)	41	(5.1%)	35,900	(4.8%)
Condoms	27,629	(4.7%)	2,042	(4.0%)	591	(1.6%)	4,370	(5.6%)	23	(2.6%)	11	(1.4%)	34,666	(4.6%)
Emergency Contraception Pills	26,821	(4.6%)	2,613	(5.1%)	1,520	(4.1%)	2,128	(2.7%)	54	(6.1%)	36	(4.5%)	33,172	(4.4%)
Other contraceptives[4]	21,657	(3.7%)	1,286	(2.5%)	448	(1.2%)	1,920	(2.5%)	27	(3.1%)	5	(0.6%)	25,343	(3.4%)
Transdermal Patch	7,674	(1.3%)	392	(0.8%)	359	(1.0%)	4,692	(6.0%)	13	(1.5%)	20	(2.5%)	13,150	(1.7%)
Vaginal Ring	5,904	(1.0%)	384	(0.8%)	338	(0.9%)	929	(1.2%)	12	(1.4%)	14	(1.7%)	7,581	(1.0%)
Intrauterine Device	1,918	(0.3%)	146	(0.3%)	127	(0.3%)	2,301	(3.0%)	9	(1.0%)	5	(0.6%)	4,506	(0.6%)
Bilateral Tubal Ligation	677	(0.1%)	23	(0.0%)	24	(0.1%)	703	(0.9%)			1	(0.1%)	1,428	(0.2%)
Diaphragm and Cervical Cap	711	(0.1%)	113	(0.2%)	84	(0.2%)	263	(0.3%)					1,171	(0.2%)
Implantable System[5]	109	(0.0%)	24	(0.0%)	13	(0.0%)	16	(0.0%)	1	(0.1%)			163	(0.0%)
Total Number of Events	585,921	(100.0%)	51,059	(100.0%)	37,218	(100.0%)	77,712	(100.0%)	880	(100.0%)	803	(100.0%)	753,593	(100.0%)

[1]Clients may receive more than one family planning method or service, but are only counted once for each method or service. For example, four oral contraception refills in one year equals one oral contraception event.

[2]Includes Lunelle™, a once a month injectible, which was removed from the market in October 2002

[3]Healthcare Common Procedure Coding System (HCPCS) unlisted drug code J3490.

[4]Other Contraceptives include spermicide (e.g. foam, gel, jelly, cream).

[5]Norplant® , an implantable system effective for up to 5 years, was removed from the market in July 2002.

FAMILY PLANNING SERVICES AND METHODS

TAKE CHARGE covers most FDA-approved birth control methods and family planning services to help clients prevent unintended pregnancies. For female clients, a wide range of birth control methods are available, from abstinence and natural family planning to oral contraceptives and IUDs. For male clients, five major methods and services including vasectomy were identified. In this section, the distribution of family planning methods and services delivered to the clients are described for women and men separately. Distributions by program and by site (research and non-research sites) are compared where applicable.

Distribution of family planning methods and services to female clients

Table 24 shows the distribution of encounters for family planning services and birth control methods provided to female clients during the first three years of TAKE CHARGE. The encounters are not unduplicated by person: if one woman received condoms and birth control pills (different methods), each method is counted as an encounter; multiple events of each method for one person are only counted once (e.g. 4 birth control pill prescription refills for 1 woman in 1 year = 1 birth control pill encounter for the year). This analysis describes the practice patterns in terms of the overall services provided for research and non-research providers, and for female clients in Program S compared to clients in Program G.

Statewide distribution

- A wide range and large volume of family planning methods and services were provided to women statewide. Of the 753,593 total encounters, family planning visits (29.9% of total), Education, Counseling, and Risk Reduction (ECRR) (21.1%), and oral contraceptives (21.7%) in combination accounted for two-thirds of the encounters. Emergency contraception pills accounted for 4.4% of the encounters.

Distribution by program and by site

- The distribution of family planning encounters by program and by site generally follows the same patterns as the statewide distribution. For Program G clients and for Program S clients at research sites (IFS and control), the three most frequently provided services were Family Planning Visits, ECRR, and Oral Contraceptives. For Program S clients at non-research sites, the distribution of services differed: the most frequent services were Oral Contraceptives (30.8%), followed by Family Planning Visits (28.4%). Hormone Injection ranked the third (11.7%). ECRR accounted for only 4.0% of all encounters. Program S clients were permitted to obtain family planning services at any Medicaid-approved provider, not restricted to TAKE CHARGE providers, so it is not surprising that the frequency of ECRR was so much lower for this group.

- Family planning visits and ECRR accounted for a slightly larger proportion of services in the research sites than in the non-research sites. The difference was pronounced for ECRR. ECRR accounted for more than 20% of encounters for women in Program S at the

research sites, compared to only 4% at the non-research sites. For Program G clients at the research sites, ECRR accounted for about 27% of encounters.

- The proportion of encounters for some of the more effective birth control methods was higher for services provided to Program S clients. At non-research sites, hormone injections accounted for 11.7% of encounters for Program S clients, compared to 6.1% for Program G. The transdermal patch accounted for 6% of encounters for Program S clients, compared to 1.3% for Program G. IUDs accounted for 3% of encounters for Program S clients, compared to 0.3% for Program G.

- The distribution of family planning services and birth control methods for each year of the program (data not shown) demonstrates that the number of encounters increased each year—from 197,569 encounters in year one, to 248,916 in year two and 339,217 in year 3. This is consistent with the increased number of women enrolled in the program each year.

Distribution of contraceptive methods and services to male clients

The five types of family planning services and birth control methods identified for male clients included family planning visits, ECRR, condoms, vasectomy, and other contraceptives, such as spermicidal gel, jelly, and cream. Table 25 on the facing page shows the distribution of birth control methods and family planning services provided to male clients.

- A total of 25,363 contraceptive encounters were provided to male clients. Family planning visits and ECRR accounted for nearly 86% of encounters for men.

- The distribution of contraceptive methods and services at the research sites (IFS and control combined) was very similar to that for the non-research sites. Family planning visits and ECRR were the most frequently provided services for men at all sites. However, at the research sites, these two services, especially ECRR, were provided somewhat more frequently than in the non-research sites. In the research sites, ECRR accounted for 43.9% of encounters for men, compared to 39.2% at non-research sites.

- At the IFS and control sites, the distribution of contraceptive encounters by service type was nearly identical. The number of encounters was greater at control sites (N=1,778) than at IFS sites (N=1,190). This is consistent with the larger number of males enrolled at control sites (N=832) compared to IFS sites (N=614).

The distribution of family planning services and birth control methods for each year of the program (data not shown) demonstrates that the number of encounters increased each year—from 6,616 in year one, to 8,817 in year two, and to 9,930 in year three. This is consistent with the increased number of men enrolled in the program each year.

<u>Men receiving family planning services in the first three years</u>

Table 26 presents the number and proportion of male clients who were provided family planning services. The number of clients presented in the table is not unduplicated by method

Table 25. Methods and Services Distributed to Men Paticipating in Program G

Family Planning Method or Service[1]	Total (Year 1 - 3)							
	Non-Research		Control		IFS		All Sites	
	No. of Events	% of Total	No. of Events	% of Total	No. of Events	% of Total	No. of Events	% of Total
Family Planning Visit	10,172	(45.4%)	836	(47.0%)	575	(48.3%)	11,583	(45.7%)
Education, Counseling, and Risk Reduction	8,778	(39.2%)	792	(44.5%)	514	(43.2%)	10,084	(39.8%)
Condoms	1,567	(7.0%)	76	(4.3%)	48	(4.0%)	1,691	(6.7%)
Other contraceptives[2]	935	(4.2%)	52	(2.9%)	29	(2.4%)	1,016	(4.0%)
Vasectomy	943	(4.2%)	22	(1.2%)	24	(2.0%)	989	(3.9%)
Total Number of Events	22,395	(100.0%)	1,778	(100.0%)	1,190	(100.0%)	25,363	(100.0%)

[1]Clients may receive more than one method or service.

[2]Other Contraceptives: spermicide (e.g. foam, gel, jelly, cream)

or service. For example, if a client received two types of services, one family planning visit and one ECRR, he is counted twice, once for each service.

- Of the total 11,063 male participants with family planning services during the first three years, 97.4% received family planning visits, and 87.5% received ECRR. More than 10% had a vasectomy.

- The proportion of men at research sites who received family planning visits (99%) was slightly higher than at non-research sites (97.2%). Similarly, the proportion of men at research sites who received ECRR (92%) was higher than at non-research sites (86.9%). However, at the non-research sites, the proportion of men who had a vasectomy (10.4%) was nearly three times that at the research sites (3.6%).

- Comparing the IFS and the control sites, the proportions of men receiving each service were nearly identical. The only marked difference was found in ECRR. The proportion of men at control sites who received ECRR (94%) was greater than at IFS sites (88.6%).

<u>Men receiving family planning services by year (data not shown)</u>

- Statewide, the number of male participants grew steadily each year—from 3,261 in year one, to 4,174 in year two and 4,634 in year three.

- No significant differences were observed in the proportion of men receiving family planning visits and ECRR over these three years. However, changes were noted for condoms and other contraceptives. First, the proportion of men receiving condoms each year grew rapidly from 2.1% in year one to 14.3% in year two and 22.2% in year three. Additionally, the proportion of men receiving other contraceptives declined sharply in year three (4.8%), compared to year one (10%) and year two (11.2%).

Table 26. Family Planning Methods and Services Received by Male Participants

Family Planning Method or Service[1]	Years 1 - 3							
	Non-Research Sites		Control Sites		IFS Sites		All Sites	
	No. of Clients	% of Clients	No. of Clients	% of Clients	No. of Clients	% of Clients	No. of Clients	% of Clients
Family Planning Visit	9,479	(97.2%)	772	(99.2%)	528	(99.1%)	10,779	(97.4%)
Education, Counseling, and Risk Reduction	8,474	(86.9%)	734	(94.3%)	472	(88.6%)	9,680	(87.5%)
Condoms	1,487	(15.2%)	73	(9.4%)	46	(8.6%)	1,606	(14.5%)
Vasectomy	**1,100**	**(11.3%)**	**24**	**(3.1%)**	**27**	**(5.1%)**	1,151	**(10.4%)**
Other Contraceptives[2]	906	(9.3%)	48	(6.2%)	25	(4.7%)	979	(8.8%)
Total number of clients who received at least one family planning method or service[3]	9,752		778		533		11,063	

[1]A client may receive more than one method or service. More effective methods are highlighted in bold.

[2]Other Contraceptives include spermicide (e.g. foam, gel, jelly, cream).

[3]Unduplicated number of clients who received at least one family planning method or service.

Women receiving family planning services during the first three years

Of the 169,394 total female participants with family planning services during the first three years, 89% received family planning visits, 70.5% percent received ECRR, and 64.3% received oral contraceptives. Emergency contraception was provided to 17.8%.

- The patterns of services and methods received were very different for female participants in Program G compared to Program S. The proportions of Program G women at non-research sites who received family planning visits and ECRR (97% and 83.8%, respectively) were much greater than those for Program S women (53.9% and 10.5%, respectively). The proportions receiving oral contraceptives and hormone injections were similar: 66.4% of female Program G participants at non-research sites received oral contraceptives, compared to 55.2% of Program S participants; and 20.2% of Program G participants received hormone injections, compared to 20.1% of Program S participants. For some very effective methods (transdermal patch and IUD), the proportion of Program S clients who received these methods was much higher than for Program G clients: 11.9% of Program S participants received the transdermal patch, and 5.8% received an IUD, compared to 5.4% and 1.3% of Program G participants.

- In the research sites, the two programs also differed, but less so than at the non-research sites. The proportions of Program G clients who received ECRR and oral contraception (88.6% and 67.1%, respectively) were greater at research sites compared to Program S clients (64.5% with ECRR and 58.9% with oral contraceptives). On the other hand, at research sites, the proportion of women who had hormone injections was greater for Program S (25.9%) compared to Program G (13.7%).

Table 27. Family Planning Methods and Services Received by Female TAKE CHARGE Participants

Family Planning Method or Service[1]	Years 1 - 3													
	Program G						Program S						Program G and S	
	Non-Research Sites		Control Sites		IFS Sites		Non-Research Sites		Control Sites		IFS Sites		All Sites	
	No. of Clients	% of Clients	No. of Clients	% of Clients	No. of Clients	% of Clients	No. of Clients	% of Clients	No. of Clients	% of Clients	No. of Clients	% of Clients	No. of Clients	% of Clients
Family Planning Visit	117,484	97.0%	9,511	98.1%	6,393	98.3%	17,115	53.9%	137	97.2%	130	92.2%	150,770	89.0%
Education, Counseling, and Risk Reduction	101,475	83.8%	8,555	88.2%	5,802	89.2%	3,351	10.5%	91	64.5%	91	64.5%	119,365	70.5%
Oral Contraceptives	**80,380**	**66.4%**	**6,386**	**65.9%**	**4,491**	**69.0%**	**17,549**	**55.2%**	**86**	**61.0%**	**83**	**58.9%**	**108,975**	**64.3%**
Unclassified drug code[3]	29,464	24.3%	2,562	26.4%	1,358	20.9%	2,153	6.8%	43	30.5%	39	27.7%	35,619	21.0%
Hormone Injection[2]	**24,432**	**20.2%**	**1,188**	**12.3%**	**1,040**	**16.0%**	**6,382**	**20.1%**	**33**	**23.4%**	**40**	**28.4%**	**33,115**	**19.5%**
Condoms	24,786	20.5%	1,584	16.3%	483	7.4%	3,647	11.5%	21	14.9%	8	5.7%	30,529	18.0%
Emergency Contraception Pills	25,299	20.9%	1,671	17.2%	1,041	16.0%	2,075	6.5%	32	22.7%	24	17.0%	30,142	17.8%
Other Contraceptives[4]	19,635	16.2%	860	8.9%	361	5.5%	1,855	5.8%	16	11.3%	4	2.8%	22,731	13.4%
Transdermal Patch	**6,545**	**5.4%**	**261**	**2.7%**	**211**	**3.2%**	**3,797**	**11.9%**	**13**	**9.2%**	**17**	**12.1%**	**10,844**	**6.4%**
Vaginal Ring	**5,232**	**4.3%**	**324**	**3.3%**	**245**	**3.8%**	**811**	**2.6%**	**8**	**5.7%**	**8**	**5.7%**	6,628	3.9%
IUD	**1,612**	**1.3%**	**113**	**1.2%**	**82**	**1.3%**	**1,828**	**5.8%**	**8**	**5.7%**	**3**	**2.1%**	**3,646**	**2.2%**
Bilateral Tubal Ligation	**884**	**0.7%**	**34**	**0.4%**	**30**	**0.5%**	**784**	**2.5%**	**0**	**0.0%**	**2**	**1.4%**	**1,734**	**1.0%**
Diaphram/Cervical Cap	722	0.6%	92	0.9%	70	1.1%	255	0.8%	0	0.0%	0	0.0%	1,139	0.7%
Implantable System[5]	**7**	**0.0%**	**0**	**0.0%**	**4**	**0.1%**	**9**	**0.0%**	**1**	**0.7%**	**0**	**0.0%**	**21**	**0.0%**
Total number of clients who received at least one family planning method or service[6]	121,132		9,697		6,506		31,777		141		141		169,394	

[1]A client may receive more than one method or service. More effective methods are highlighted in **bold**.

[2]Includes Lunelle™, a once a month injectible, which was removed from the market in October 2002

[3]Healthcare Common Procedure Coding System (HCPCS) unlisted drug code J3490.

[4]Other Contraceptives include spermicide (e.g. foam, gel, jelly, cream).

[5]Norplant® , an implantable system effective for up to 5 years, was removed from the market in July 2002.

[6]Unduplicated number of clients who received at least one family planning method or service.

Women receiving family planning services by program year (data not shown)

Statewide, the proportions of women receiving family planning services increased in several areas. Many of these changes were directly related to the availability of new products or methods and the difficulties in obtaining definitive billing codes in a short time frame. Before a new drug or device receives a definitive billing code, providers may submit claims using the HCPCS code for an unlisted drug (J3490). Since clients are often eager to obtain newly available methods, the use of the J3490 code facilitates their receipt of these new methods. However, the J3490 code may be used for a wide range of unlisted drugs and in many cases, it is not possible to ascertain which specific drug was provided.

Method use by year reflects the recent availability and rapid growth in use of the transdermal contraceptive patch (Ortho Evra®), introduced in May 2002 (near the end of the first year of the demonstration).[9] In year one, this method was practically nonexistent. Only 47 of the 69,017 female participants in that year received a transdermal patch. In year two, nearly 8% of women (N=7,302) received a patch. In year three, the proportion of women receiving transdermal patches (5.6%) declined slightly.

Coding problems for Emergency Contraception (EC) resulted in variability in the identified rates of providing EC. The proportion of women receiving EC decreased from 21.7% in year two to 1.2% in year three because the billing code changed to J3490 and with that code, EC cannot be distinguished from other unlisted drugs.

Summary: Overall, the service delivery patterns were very similar at research sites and non-research sites. Just 2.2% of Program S clients received services at research sites. When Program S clients enrolled at research sites, they were more likely to receive ECRR, a special TAKE CHARGE service. Otherwise, Program S clients were permitted to obtain family planning services from any approved Medicaid provider, not restricted to TAKE CHARGE providers. Presumably, many of them received services from non-TAKE CHARGE providers who were not routinely providing ECRR.

While a substantially smaller proportion of Program S women were identified as receiving family planning services (approx. 46.8% of Program S women were identified as participants, compared to 93.7% of Program G women), among those who were participants, the proportions receiving oral contraceptives and hormone injections were similar: 66.4% of female Program G participants at non-research sites received oral contraceptives, compared to 55.3% of Program S participants, and 19.4% of Program G participants received hormone injections, compared to 20.1% of Program S participants. For some very effective methods (transdermal patch and IUD), the proportion of Program S clients who received these methods was much higher than for Program G clients. These differences presumably reflect different priorities and decisions among these clients. Women who have recently given birth (women in Program S) may be more highly motivated to select more effective methods, if they are going to use a family planning method.

[9] A press release at http://www.orthoevra.com/newsroom/press-release-07312003.html describes the popularity of Ortho Evra® during the first year of its availability.

CLIENT SELF-EFFICACY

The TAKE CHARGE program is based on the conceptual model that increased level of client-centered practice by providers will lead to enhanced self-efficacy among clients. Developed by Albert Bandura, the self-efficacy concept relates to one's belief in her abilities to perform a specific task and her expectation that a specific behavior will result in a specific outcome. Research in various domains has found that increasing one's self efficacy can improve the behavior which in turn can lead to improved outcomes. In family planning settings, enhanced self-efficacy expectation was found to contribute significantly to female's contraceptive use and contraceptive self-efficacy was found to be a strong predictor of contraceptive use among college female students (Levinson, 1982; Heinrich, 1993). For this evaluation, we examine client self-efficacy in several domains, including contraceptive self-efficacy which addresses the client's use of birth control and perceived abilities to control the family size; clinical self-efficacy which addresses the client's perceived abilities to communicate with her health care providers about her family planning needs and problems; self-efficacy to obtain social support; and self-efficacy about changing life circumstances which describes the client's perceived control over changes in her life.

One of the evaluation questions is whether client self-efficacy improved one year after enrollment in the TAKE CHARGE program. This question was addressed by comparing client responses to a series of questions in the baseline and the follow-up surveys. The surveys analyzed here (n=1024) cover program year one through year three. Overall, few significant changes between the baseline and the follow-up responses were found. However, several important changes deserve mention. (Because the pre-post differences are generally fairly small in magnitude, comparisons between the control sites and IFS sites are not presented.)

Contraceptive Self-Efficacy

Several survey questions related to client contraceptive self-efficacy, including whether she used birth control, whether the partner supported her goals for having or not having children, how confident she was in using the birth control correctly, how confident she was in talking about birth control use with her partner/spouse and in controlling the number of children she wanted.

- After one year in the program, more clients (84.5%) reported the use of birth control the last time they had sex than at program entry (80.5%).

- The vast majority of clients at the research sites were confident that they could control the number of children they will have in the future, as reported in both the baseline and the follow-up surveys. Furthermore, we see an increase at the one year follow-up as compared to at enrollment. At enrollment, 92.4% reported being mostly or totally confident that they could control the number of children they would have. At follow-up, that proportion increased to 94.6%.

Self-efficacy: Response Frequencies from 1024 Client Surveys at Research Sites

C.	**Answer the following questions either Yes, No, or Not Applicable (N/A).**		**Yes**	**No**	**N/A**
1.	Did you use birth control the last time you had sex?	*pre*	80.5%	16.3%	3.1%
		post	84.5%*	12.3%*	3.2%
2.	Do you feel your partner supports your goals for having (or not having) children?	*pre*	86.8%	2.6%	10.6%
		post	84.1%	3.0%	12.9%
3.	Do you have a supportive group of family and friends?	*pre*	97.3%	2.0%	0.7%
		post	95.7%	2.7%	1.6%
4.	Do you have friends or family members who you can talk to about birth control?	*pre*	95.1%	4.1%	0.7%
		post	93.2%	4.7%	2.1%
5.	Are you confident that your provider and her/his staff will protect your privacy?	*pre*	97.2%	1.5%	1.3%
		post	96.4%	2.9%	0.7%
6.	Do you expect a change in your marital status over the next two years?	*pre*	20.8%	68.2%	11.0%
		post	24.9%*	66.0%	9.1%
7.	If yes, do you think this change will be for the better?	*pre*	98.4%	0.6%	1.0%
		post	95.6%*	1.5%	2.9%
8.	Do you think your living situation (housing, number of roommates) will change over the next two years?	*pre*	70.2%	26.2%	3.7%
		post	68.7%	28.4%	2.9%
9.	If yes, do you think this change will be for the better?	*pre*	83.3%	1.3%	15.4%
		post	89.4%*	1.9%	8.7%*
10.	Is it difficult for you to arrange transportation to this clinic?	*pre*	3.6%	96.2%	0.2%
		post	6.6%*	91.4%*	2.1%*
11.	Do you usually bring a list of questions when you see your health care provider?	*pre*	31.1%	67.8%	1.2%
		post	37.4%*	61.7%*	0.9%

* Significant change in response frequency based on 95% Confidence Limits for percent.

- Clients' confidence in talking about birth control use with their partners/spouses also increased at follow-up. At enrollment, 93.7% said they were mostly or totally confident as compared to 95.1% one year later, although this increase was not statistically significant.

These findings suggest that contraceptive self-efficacy has increased slightly. Changes from baseline to follow-up on other related questions were not significant.

Clinical Self-Efficacy

The survey asked a number of questions about the client's perceived abilities to communicate with her health care provider regarding her family planning needs and issues. On the positive note, more clients were communicating with their providers at follow-up by bringing a list of questions when they went to see their providers. However, on other related questions, the overall picture seems to suggest that clients' confidence level diminished from baseline to follow-up. Results for questions where the changes between baseline and follow-up were statistically significant are summarized as follows:

- At follow up, more clients reported bringing a list of questions when they went to see their health care providers (37.4% at follow-up versus 31.1% at baseline).

- When asked whether the client was confident that she could identify and resolve any problems she might have with her providers, the proportion reporting mostly or totally confident decreased at follow-up, from 88.8% at baseline to 80.9%. The same patterns were observed for clients' confidence level in accessing their providers to get more family planning services if needed and in asking the provider uncomfortable questions without being judged. At follow-up, a smaller proportion of clients (88.5%, 86.2% respectively) reported being mostly or totally confident than at enrollment (93.8%, 89.2%).

Self-Efficacy about changing life circumstances

In the baseline and follow-up surveys, the client was asked whether she expected a change in her marital status and living situation and whether she thought the change was for the better. The analysis shows mixed results.

- Of those who reported a possible change in their living situation in the next two years, more clients said the change would be for the better one year after program entry (89.4 % at follow-up versus 83.3% at baseline). On the other hand, of those who reported a possible change in their marital status, fewer clients thought the change would be for the better one year later.

Summary: While questions about contraceptive self-efficacy consistently indicated modest increases in this measure, other questions showed non-significant changes, or changes that reflected reduced self-efficacy, or perhaps more realistic expectations on the part of the clients. It had been hoped that client-centered practice would result in overall improvements in client self-efficacy; however, only contraceptive self-efficacy showed consistent modest increases.

Self-efficacy: Response Frequencies from 1024 Client Surveys at Research Sites

D.	How *confident* are you that you can:		Mostly / Totally	Somewhat	Not at all / A little
1.	Ask your provider about things (now or in the future) that worry you.	*pre*	91.3%	6.0%	2.7%
		post	89.3%	8.2%	2.5%
2.	Talk openly with your provider about any problems related to your choice of birth control.	*pre*	95.5%	2.0%	2.5%
		post	93.7%	4.4%*	2.0%
3.	Identify and resolve any problems you may have with your provider.	*pre*	88.8%	8.8%	2.4%
		post	80.9%*	15.6%*	3.5%
4.	Trust the skills and competence of your provider.	*pre*	93.1%	4.5%	2.4%
		post	91.3%	7.3%*	1.3%
5.	Use your birth control correctly.	*pre*	94.3%	3.9%	1.8%
		post	94.6%	4.3%	1.1%
6.	Talk about birth control use with your partner/spouse.	*pre*	93.7%	3.5%	2.8%
		post	95.1%	3.0%	1.9%
7.	Access your provider to get more family planning services if needed.	*pre*	93.8%	4.6%	1.5%
		post	88.5%*	7.7%*	3.8%*
8.	Control the number of children you will have in the future, including not having any (or any more) children.	*pre*	92.4%	6.0%	1.6%
		post	94.6%*	4.0%	1.4%
9.	Reach your educational and employment goals in the future.	*pre*	88.0%	9.9%	2.2%
		post	85.2%	12.1%	2.7%
10.	Remain non-pregnant, if that is your goal.	*pre*	94.5%	4.0%	1.6%
		post	95.0%	3.5%	1.5%
11.	Ask your provider uncomfortable questions without being judged by him or her.	*pre*	89.2%	7.4%	3.4%
		post	86.2%*	9.4%	4.4%

* Significant change in response frequency based on 95% Confidence Limits for percent.

DISCUSSION

A large number of Washingtonians lack health insurance or have health insurance that does not include full coverage for family planning services. In 2000, 7.7% of Washington residents did not have health insurance (Washington State Population Survey). In 2004, the uninsured rate increased to 9.5% (N=587,145). For those in poverty, the rate was much higher. In 2000, about 16% of Washington residents with an income below 200% of federal poverty level (FPL) did not have health insurance. In 2004, the uninsured rate was 18.2% (N=361,968). Many of these uninsured were women at risk of pregnancy. Further, 55% of all births to Washington women at this income level were unintended at the time of conception.

Washington State's TAKE CHARGE program 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 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. To meet these goals, the program not only expands eligibility for Medicaid coverage for family planning services, it also covers services not previously reimbursable: education, counseling, and risk reduction (ECRR) and intensive follow-up services (IFS).

The first three years of enrollment demonstrated great demand for family planning services among the TAKE CHARGE target population. In the first three years of demonstration, the program enrolled more than 230,000 clients (unduplicated count). About two-thirds were newly eligible clients who were otherwise not eligible for Medicaid and had no other source of coverage for family planning services (Program G). About one-third were women automatically enrolled into the program two months postpartum (Program S). Overall, women represented about 94% of the total enrollment, and men represented 6%. Enrollment increased each year from 98,973 in year one to 145,166 in year two, and to 164,327 in year three. Similar increases were seen for both men and women. More than two-thirds of the clients were between 18 and 29 years old, with the same age group accounting for 73 percent of all Medicaid-paid births in 2003.

By expanding Medicaid coverage for family planning services to men and women with family incomes at or below 200% of the FPL, the TAKE CHARGE program has provided Medicaid services to more than 148,000 newly enrolled clients in its first three years of demonstration. The demand for these services increased each year as enrollment increased. The number of Program G men and women receiving any Medicaid-paid services increased from 58,674 in year one to 82,183 in year two and to 95,225 in year three. Additionally, about 80% of all enrollees received medical covered family planning services (i.e., met CMS's definition of participants).

According to birth certificate data available in the First Steps Database, newly enrolled women (Program G) differed from women automatically enrolled into the program (Program S) in several areas: age, marital status, and parity. In general, the newly eligible women were

younger, and more likely to be unmarried and to have had fewer prior births. These differences are consistent with program eligibility requirements: women in Program S are automatically enrolled in TAKE CHARGE two months after their pregnancy ends.

Eligibility requirements were also related to differences in clients' service utilization and participation between the two programs. Both men and women who self-selected themselves into the program had higher service utilization and participation rates than their counterparts who were automatically enrolled into the program. These differences, however, were much less distinct in the research sites (IFS and control) than in the non-research sites. For example, the proportions receiving any Medicaid-paid services were highly comparable between the two programs at the research sites (98.5% for Program G; 97.8% for Program S). At non-research sites, the proportion receiving any Medicaid-paid services for Program S clients (54.4%) was significantly lower than that of clients in Program G (93.6%). This pattern held true for participation rates as well. The lower participation and service utilization rates for clients in Program S may be attributable to the fact that women in this program could go to any Medicaid provider for services, and were not limited to those specifically authorized to provide TAKE CHARGE services. (Program G clients were required to enroll in the program at an approved TAKE CHARGE provider.) These findings suggest that program services between the IFS and the control sites may not be as different as it was originally anticipated and this may reduce our ability to detect differences in the outcome measures between the IFS and control sites.

TAKE CHARGE implemented client-centered practices aimed at enhancing client contraceptive self-efficacy, thus leading to more successful users of family planning methods and a decrease in unintended pregnancies. During the first three years of demonstration, TAKE CHARGE achieved remarkable progress in reducing unintended pregnancies. An estimated 21 percent of the women eligible under the waiver, who would have had an unintended pregnancy, remained pregnancy free. This reduction was directly attributable to clients' use of more effective contraceptive methods after enrollment in the program, as shown in the client baseline and the follow-up surveys.

TAKE CHARGE provides most FDA-approved birth control methods and family planning services to help clients prevent unintended pregnancies. During the first three years of demonstration, a wide range and large volume of family planning services were provided to female clients, from family planning visits to ECRR, and from oral contraceptives to transdermal patches. The number of family planning services provided increased each year as well. Of the 753,593 three-year total encounters for female clients, Family Planning Visits accounted for nearly 30% of all encounters, and ECRR accounted for 21%. ECRR provided counseling and education to strengthen clients' decision-making skills and support the successful use of their chosen contraceptive methods.

Newly enrolled women in general were more likely to receive family planning services such as ECRR and family planning visits, compared to women automatically enrolled in the program two months postpartum. However, for some very effective contraceptive methods (transdermal patch and IUDs), the reverse was true. Among those clients who used family planning services, the proportion of Program S clients who received these methods was much

higher than for Program G clients. These differences presumably reflect different priorities and decisions among these clients. Women who have recently given birth (women in Program S) may be more highly motivated to select more effective methods, if they are going to use a family planning method.

While women were the primary recipients of the TAKE CHARGE services, as evidenced by the volume of female enrollees, men were an integral part of the program as well. It has been well accepted that men who are educated about reproductive health issues are more likely to support their partners in decisions about contraception and family planning. One of the program objectives was to increase the number of men receiving family planning services. TAKE CHARGE offered five types of family planning services to male clients including office visits about family planning, ECRR, vasectomy, condoms, and other contraceptives. For the first three years of demonstration, the number of men receiving these services increased steadily each year, from 3,261 in year one to 4,634 in year three. This is consistent with the steady increase in the number of men enrolled in the program each year. Like female clients, a large majority of men had family planning visits and ECRR. Nearly 10% had vasectomy.

A key component of the TAKE CHARGE program is client-centered practice, including education, counseling, and risk reduction services intended to enhance clients' contraceptive self-efficacy and support clients' successful use of their chosen contraceptive method. Measures of client self-efficacy for this evaluation included contraceptive self-efficacy which addressed the client's birth control and her ability to control the family size, clinical self-efficacy which addressed the client's perceived abilities to communicate with her provider about the family planning needs, self-efficacy to obtain social support, and self-efficacy about perceived control over changes in her life. Survey questions about contraceptive self-efficacy consistently indicated modest increases in this measure. Given the research showing an association between contraceptive self-efficacy and women's contraceptive use, it is highly likely that this increase is related to clients' reports about using a more effective contraceptive method at follow-up. On the other hand, other self-efficacy questions showed no changes, or changes that reflected reduced self-efficacy, or perhaps more realistic expectations on the part of the clients. It had been hoped that client-centered practice would result in overall improvements in client self-efficacy; however, only contraceptive self-efficacy showed consistent modest increases.

CONCLUSION

The TAKE CHARGE program has demonstrated a very great impact on access to and provision of family planning services in Washington State. During the first few months of the program, client enrollment exceeded all expectations and has continued to increase steadily. With such a large demand for program services, the Medical Assistance Administration has invested in building capacity by streamlining application and billing processes and providing extensive trainings. Individual provider agencies have correspondingly increased staffing and expanded physical workspace. Furthermore, the concepts of Education, Counseling, and Risk Reduction (ECRR) are beginning to diffuse throughout the State of Washington and establish a new standard of care for family planning practice.

TAKE CHARGE incorporates both of the main programmatic strategies to reduce unintended pregnancies. The first approach is to extend post-pregnancy coverage for family planning services. The second is to expand eligibility for family planning services for men and women with incomes at or below 200% of the FPL. These two groups of clients enrolled in the program by different methods. Female clients who were Medicaid-eligible because of pregnancy were automatically enrolled in the post-pregnancy extension, while other clients, both male and female (not recently pregnant) sought enrollment on their own initiative. The demographic differences in these groups (age, marital status, and parity of female clients) suggest that by expanding eligibility to all clients with incomes at or below 200% of the FPL, the program is reaching younger, unmarried women who have not previously given birth, enabling them to avoid unintended pregnancy more effectively until they are older and, hopefully, married. While such a shift in the demographic profile of women giving birth may not be demonstrable for a number of years, this would represent a significant accomplishment.

On the other hand, while female users of family planning services in the post-pregnancy extension were more likely to receive certain more effective birth control methods, overall, women with automatic enrollment in the post-pregnancy family planning extension were modest users of Medicaid services during the extension of their eligibility. How TAKE CHARGE can be more effective in reaching this group remains to be explored. We propose to study this question for the evaluation activities to be conducted during the three-year renewal period.

At this stage of the evaluation, it is difficult to assess fully the impact of Intensive Follow-up Services (IFS). At IFS sites, the proportion of clients using a more effective method at one-year follow-up compared to baseline increased by 49%, more than twice the increase observed at control sites (22%). This suggests that greater emphasis on client-centered practice and intensive follow-up may be a worthwhile strategy to incorporate into family planning programs like TAKE CHARGE.

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APPENDICES

APPENDIX A

TAKE CHARGE Services

[Refer to WAC 388-532-740]

Only family planning services and services delivered in conjunction with family planning are covered under TAKE CHARGE.

Services for Women

- Gynecological exam (as medically necessary);
- One session of application assistance per client, per year;
- One initial education, counseling, and risk reduction (ECRR) service;
- One follow-up ECRR service ten months after the initial ECRR service and one every ten months thereafter;
- Food and Drug Administration (FDA) approved contraceptives as provided in Chapter 388-530 WAC, including, but not limited to, the following:
    - Birth control pills;
    - Cervical cap;
    - Injectable contraceptives (Depo-Provera and Lunelle);
    - Diaphragm;
    - Emergency contraception;
    - Intrauterine devices (IUDs);
    - Birth control patch;
    - Birth control ring;
    - Birth control implant;
    - Spermicides (foam, gel, suppositories, and cream); and
    - Male and female condoms;
- Natural family planning and abstinence;
- Surgical sterilization service that meets the requirements found in MAA's Family Planning Services and Family Planning Only Program Billing Instructions, if the service is:
    - Requested by the TAKE CHARGE client; and
    - Performed in an ambulatory surgery center or hospital outpatient setting only;
- Testing for sexually transmitted diseases/infections (STD-I) when performed in conjunction with a principle purpose diagnosis of family planning;

- Treatment of STD-I when medically required as part of the client's selected Contraceptive method(s);

Services for Men

- One session of application assistance per client, per year;
- One initial education, counseling, and risk reduction (ECRR) service;
- One follow-up ECRR service per calendar year after the initial ECRR service;
- FDA-approved contraceptives as provided in Chapter 388-530 WAC;
- Natural family planning and abstinence;
- Surgical sterilization service that meets the requirements found in MAA's Family Planning Services Billing Instructions, if the service is:
    - Requested by the TAKE CHARGE client; and
    - Performed in an appropriate setting for the procedure;
- Testing for sexually transmitted diseases/infections (STD-I) when performed in conjunction with a principal purpose diagnosis of family planning;
- Treatment of STD-I when medically required as part of the client's selected contraceptive method(s).

Family Planning Education, Counseling, and Risk Reduction (ECRR) Services

- Description

  Client-centered education and counseling services designed to strengthen decision making skills and support clients' successful use of their chosen contraception method.

- Service Delivery Parameters

  Must be provided by professional staff using client-centered practices/techniques and be available only to TAKE CHARGE clients.

- Required components for the basic Education, Counseling, and Risk Reduction (ECRR) Services

  These client-centered interactive processes are founded on research-based best practices for increasing clients' contraception efficacy. Through a series of focused questions, the provider's role is to:

- Help the client (female and male) evaluate which contraception method(s) are most acceptable to him/her and can be used most effectively by him/her. This discussion should focus on each client's choice of method(s) and clarify knowledge, assumptions, misinformation, and myths about the chosen method(s).
- Facilitate contingency planning regarding the client's use of contraception, including emergency contraception.
- Evaluate and address the client's other personal considerations, risk factors and behaviors that impact successful use of contraception (e.g., history of abuse, current substance use and abuse, current exploitation or abuse, living situation, need for confidentiality, etc.).
- Schedule a follow-up appointment for supporting the client's successful use of the chosen contraception.
- When the client is male, facilitate a discussion of his role in supporting the successful use of contraception method(s).

- <u>ECRR documentation is necessary to receive payment. You must keep the following documentation in the client's chart:</u>

  a) Did you help the client (female or male) evaluate which contraception method was most acceptable and could be used most effectively by her/him? □ **Yes** □ **No**

  b) Did you discuss backup methods with the client and provide ECP access? □ **Yes** □ **No**

  c) Did you evaluate and address the client's personal considerations that could impact the use of contraception method(s)? □ **Yes** □ **No**

  d) Did you make a follow-up appointment, as appropriate to the method? □ **Yes** □ **No**

  e) For a male client, (in addition to above), did you discuss his role in supporting the successful use of contraception and prevention of unintended pregnancy? □ **Yes** □ **No**

<u>Ancillary Services for TAKE CHARGE [Refer to WAC 388-532-730 (2)]</u>

MAA providers (e.g., pharmacies, independent labs, radiologists, anesthesiologists, ambulatory surgery centers, and outpatient hospitals) may furnish family planning ancillary services to TAKE CHARGE clients without enrolling as TAKE CHARGE providers.

Approved TAKE CHARGE providers should develop a team relationship with the providers of the ancillary services to assure that the clients get necessary services. The partnership with pharmacists is especially critical since they provide immediate access to methods not in stock at the TAKE CHARGE agency/clinic.

What services are not covered? [WAC 388-532-750]

MAA does not cover certain services under TAKE CHARGE. These services include, but are not limited to, the following:

- Pregnancy services, with the exception of an initial pregnancy test performed by a TAKE CHARGE provider to rule out an existing pregnancy. Excluded pregnancy services include:

    - Services that are ancillary to an existing pregnancy; or
    - Abortions, services related to pregnancy termination, or services required due to complications from pregnancy termination;

- Reproductive health services not performed in relation to a principal purpose diagnosis of family planning, such as:

    - Fertility assessments, treatments, or drugs;
    - Hysterectomies;
    - Colposcopies;
    - Loop Electrosurgical Excision Procedures (LEEP's);
    - Mammograms;
    - Treatments for menopause; or
    - Cancer screenings (other than pap smears) or cancer treatments;

- Testing or treatment for sexually transmitted diseases/infections (STD-I), AIDS, or HIV unless the testing and/or treatment is:

    - Done in conjunction with a principal purpose diagnosis of family planning; and
    - Required as an essential component of the family planning services being delivered to the client;

- Genetic counseling; and

- Hospital inpatient services.

    Exception: Inpatient charges may be incurred as a result of complications arising directly from a covered TAKE CHARGE service. To bill MAA for these services, providers must submit to MAA a complete report of the circumstances and conditions that caused the need for inpatient services. After reviewing the report, MAA will consider reimbursement based on an evaluation of the extenuating circumstances and other potential payment sources. **[Refer to WAC 388-532-780 (8)]**

APPENDIX B

MEDICAL FAMILY PLANNING CODES*

Procedure Code	Description
99201-99205	OFFICE or OTHER OP VISIT-EVAL/MGMT NEW PATIENT (family planning diagnosis code)
99211-99215	OFFICE or OTHER OP VISIT-EVAL/MGMT ESTABLISHED PATIENT (family planning diagnosis code)
4805A	COUNSELING FEE FOR ECP
0392M	EDUCATION, COUNSELING, AND RISK REDUCTION SESSION — FEMALE
0393M	EDUCATION, COUNSELING, AND RISK REDUCTION SESSION — MALE
5911M	ANESTHESIA FOR VASECTOMIES
5912M	ANESTHESIA FOR STERILIZATIONS (TUBAL)
5913M	ANESTHESIA FOR HYSTERECTOMY BASE OF 4
5914M	ANESTHESIA FOR HYSTERECTOMY BASE OF 8
11975 (old value: 1797M)	INSERTION, IMPLANTABLE CONTRACEPTIVE CAPSULES
11976 (old value: 1798M)	REMOVAL, IMPLANTABLE CONTRACEPTIVE CAPSULES
11977	REMOVAL, WITH REINSERTION, IMPLANTABLE CONTRACEPTIVE CAPSULES
55250	VASECTOMY — UNILATERAL OR BILATERAL REMOVAL OF SPERM DUCT (SEPARATE PROCEDURE), INCLUDING POSTOPERATIVE SEMEN EXAMINATION(S)
55450	VASECTOMY — LIGATION OF SPERM DUCT
57170	DIAPHRAGM OR CERVICAL CAP FITTING WITH INSTRUCTIONS
58300	INSERTION OF INTRAUTERINE DEVICE (IUD)
58301	REMOVAL OF INTRAUTERINE DEVICE (IUD)
58600	LIGATION OR TRANSECTION OF FALLOPIAN TUBE(S), ABDOMINAL OR VAGINAL APPROACH, UNILATERAL OR BILATERAL

*Covered services also include miscellaneous surgical procedures, radiology, and laboratory services.

Procedure Code	Description
58605	LIGATION OR TRANSECTION OF FALLOPIAN TUBE(S), ABDOMINAL OR VAGINAL APPROACH, POSTPARTUM , UNILATERAL OR BILATERAL, DURING SAME HOSPITALIZATION (SEPARATE PROCEDURE)
58611	LIGATION OR TRANSECTION OF FALLOPIAN TUBE(S) WHEN DONE AT THE TIME OF CESAREAN DELIVERY OR INTRA-ABDOMINAL SURGERY (NOT A SEPARATE PROCEDURE)
58615	OCCLUSION OF FALLOPIAN TUBE(S) BY DEVICE (EG, BAND, CLIP, FALOPE RING) VAGINAL OR SUPRAPUBIC APPROACH
58670	LAPAROSCOPY, SURGICAL, WITH FULGURATION OF OVIDUCTS (WITH OR WITHOUT TRANSECTION)
58671	LAPAROSCOPY, SURGICAL, WITH OCCLUSION OF OVIDUCTS BY DEVICE (EG, BAND, CLIP, OR FALOPE RING)
58700	REMOVAL OF FALLOPIAN TUBE(S)
58720	REMOVAL OF OVARY/TUBE(S)
90782	INJECTION (SC)/(M) — (Depo Provera, Lunelle, Progesterone) (must include dx V25)
99401	HIV COUNSELING (must include dx V65.44)
A4260	LEVONORGESTREL IMPLANT SYSTEM (NORPLANT)
A4261 (old value: 9912M)	CERVICAL CAP
A4266 (old value: 9912M)	DIAPHRAGM
A4267	CONDOM, MALE
A4268	CONDOM, FEMALE
A4269 (old value: 0391M)	OTHER CONTRACEPTIVES (SPERMICIDE — FOAM, GEL)
J1051	MEDROXYPROGESTERONE ACETATE INJECTION, 50 MG
J1055	MEDROXYPROGESTERONE ACETATE INJECTION, 150 MG (DEPO PROVERA)
J1056 (old value: 1111J)	MA/EC INJECTION (LUNELLE)
J2675	PROGESTERONE INJECTION
1112J	EMERGENCY CONTRACEPTION PILLS

Procedure Code	Description
1113J	ORTHO-EVRA CONTRACEPTIVE PATCH
J3490	UNCLASSIFIED DRUGS
J7303 (old value: 1114J)	NUVARING CONTRACEPTIVE RING
J7300	COPPER IUD (PARAGARD)
J7302 (old value: 9913M)	MIRENA IUD (LEVONORGESTREL-RELEASING)
S4981	INSERTION OF IUD (LEVONORGESTREL-RELEASING)
S4989 (old value: 9911M)	NON-COPPER + NOT MIRENA IUD (PROGESTACERT)
S4993 (old value: 0390M)	ORAL CONTRACEPTIVES
S9445	PATIENT EDUCATION, NOT OTHERWISE CLASSIFIED, INDIVIDUAL
69.70	INSERTION OF IUD
66.20	BILATERAL ENDOSCOPIC DESTRUCTION OR OCCLUSION OF FALLOPIAN TUBES
66.21	BILATERAL ENDOSCOPIC LIGATION AND CRUSHING OF FALLOPIAN TUBES
66.22	BILATERAL ENDOSCOPIC LIGATION AND DIVISION OF FALLOPIAN TUBES
66.30	OTHER BILATERAL DESTRUCTION OR OCCLUSION OF FALLOPIAN TUBES
66.32	OTHER BILATERAL LIGATION AND DIVISION OF FALLOPIAN TUBES (POMEROY OPERATION)
66.39	OTHER BILATERAL DESTRUCTION OR OCCLUSION OF FALLOPIAN TUBES (FEMALE STERILIZATION OPERATION NOS)
66.29	OTHER BILATERAL ENDOSCOPIC DESTRUCTION OR OCCLUSION OF FALLOPIAN TUBES
66.50	TOTAL BILATERAL SALPINGECTOMY
66.51	REMOVAL OF BOTH FALLOPIAN TUBES AT SAME OPERATIVE EPISODE
66.52	REMOVAL OF SOLITARY FALLOPIAN TUBE

Diagnosis Code	Description
V25	ENCOUNTER FOR CONTRACEPTIVE MANAGEMENT
V25.2	STERILIZATION – ADMISSION FOR INTERRUPTION OF FALLOPIAN TUBES OR VAS DEFERENS

Drug Class	Description
G1A	ESTROGENIC AGENTS
G2A	PROGESTATIONAL AGENTS
G1B	ESTROGEN/ANDROGEN COMBINATION
G2B	PROGESTATIONAL AGENTS, (CONT – 1)
G8A	CONTRACEPTIVES, ORAL
G8B	CONTRACEPTIVES, IMPLANTABLE
G8C	CONTRACEPTIVES, INJECTABLE
G8F	CONTRACEPTIVE, TRANSDERMAL (PATCH)
G9A	CONTRACEPTIVES, INTRAVAGINAL
G9B	CONTRACEPTIVE, INTRAVAGINAL SYSTEMIC (RING)
X1A	CONDOMS (MALE + FEMALE)
X1B	DIAPHRAGMS/CERVICAL CAPS
X1C	IUD

Drug Code	Description
6219-20-01	ORTHO EVRA PATCHES TRANSDERMAL SYSTEM, 1 PATCH
6219-20-15	ORTHO EVRA PATCHES TRANSDERMAL SYSTEM, 3 PATCHES
6219-20-24	ORTHO EVRA PATCHES TRANSDERMAL SYSTEM, 3 PATCHES
6219-20-25	ORTHO EVRA PATCHES TRANSDERMAL SYSTEM, 1 PATCH
6219-20-29	ORTHO EVRA PATCHES TRANSDERMAL SYSTEM, 3 PATCHES
12860-0273-1	NUVARING VAGINAL RING
12860-0273-2	NUVARING VAGINAL RING
12860-0273-3	NUVARING VAGINAL RING

Washington State
Department of Social
& Health Services

Research and Data Analysis Division
Report Number 9.72