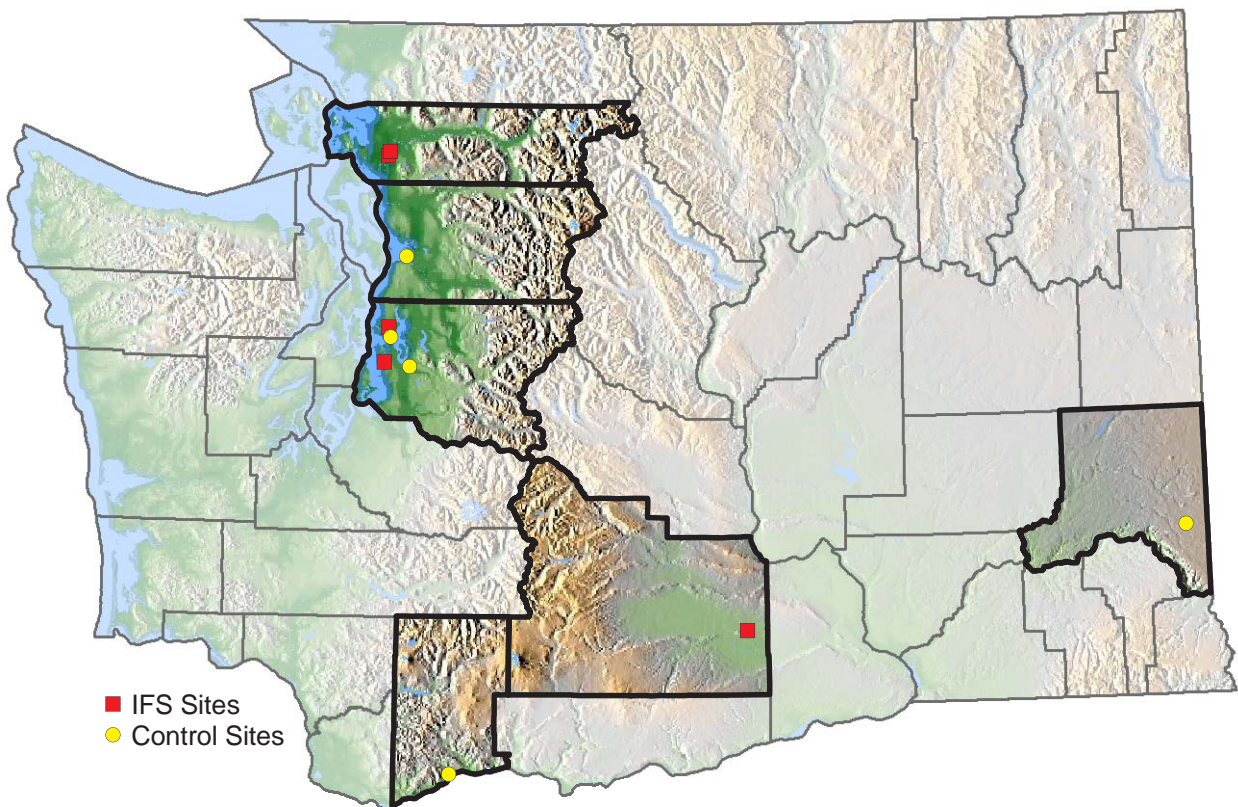


TAKE CHARGE

Final Evaluation

First Five Years: July 2001 - June 2006



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

TAKE CHARGE
Final Evaluation
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EXECUTIVE SUMMARY

Washington State's TAKE CHARGE program, which began July 2001, expands Medicaid coverage for family planning services to men and women with family incomes 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 Health and Recovery Services Administration (HRSA), formerly the Medical Assistance Administration (MAA), of the Department of Social and Health Services administers this program.

This final evaluation report describes the first five years of program implementation, from July 1, 2001, to June 30, 2006. 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 335,000 clients in the first five years of the demonstration. While 94% (N=314,626) of the enrolled clients were female, 21,131 were male.
- The number of newly enrolled clients (Program G) (N=248,669) was nearly twice the number of clients who were automatically enrolled in the post-pregnancy extension (Program S) (N=116,139).
- Over two-thirds (67.3%) of female clients enrolled in the first five years were between the ages of 18 and 29. The same age group accounted for 74% of Medicaid-paid births in 2004.

PROVIDER ENROLLMENT

As of January 2005, TAKE CHARGE providers offered services in 199 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 22% 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 53.0% at enrollment to 70.6% one year later. The proportion that reported using abstinence in the prior two months remained steady at 11.3%.
- The number of Medicaid women (including TAKE CHARGE clients) 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 (including TAKE CHARGE clients) 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

For the first three years, fertility rates for participants were very similar to birth rates for Washington women overall, 61 – 63 births per 1000 women 15-44. After the first three years, fertility rates for demonstration participants decreased, reaching a level well below the statewide fertility rate in years four and five (41 – 42 per 1000). Restricting the fertility rate computation to births occurring after enrollment in TAKE CHARGE resulted in much lower rates (5 – 7 per 1000), comparable to failure rates for more effective contraceptive methods.

CHARACTERISTICS OF FEMALE CLIENTS

Women with a history of a birth were older (mean 26.3 years) than clients without a history of a prior birth (mean 22.9 years). Overall, half the clients with a birth (50.1%) were married at their most recent birth. Asian women (62.0%) and women of Hispanic ethnicity (56.7%) demonstrated the highest proportion of those married at their most recent birth. The lowest proportion was among Native American women (27.3%). Clients married at their most recent birth were older (mean 26.9 years) than clients who were not married (mean 23.0 years). The average total number of births was higher for married clients (mean 2.4) than for unmarried clients (mean 1.7).

CLIENT SERVICES

Of the total enrolled clients in years one through four (N=289,187), 80% 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 95% of newly enrolled female clients received one or more medical family planning services, compared to 47.9% 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 indicated slight 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 slight increases.

CONCLUSION: TAKE CHARGE has demonstrated a remarkable 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 potentially married. While the proportion of female clients using more effective family planning methods increased more at Intensive Follow-up Services (IFS) sites compared to controls, the high cost of IFS precluded statewide expansion. Client-centered practice and individualized follow-up will receive greater emphasis in future program activities and trainings. 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 Health and Recovery Services Administration (HRSA), formerly 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 five 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 An interim evaluation report for the first three years of the TAKE CHARGE program, dated March 2005, was published in September 2005.³ This report provides an update to the interim evaluation report.

BACKGROUND

In Washington State, in 2002-3, approximately 55% of Medicaid deliveries represented births that 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 2004, 45.9% of all deliveries to Washington State residents were funded by Medicaid. At more than \$250 million per year, maternity care is one of HRSA'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

¹ IFS were administered in five of the ten research sites.

² The TAKE CHARGE Process Evaluation available at <http://www1.dshs.wa.gov/rda/research/9/69.shtml>.

³ The TAKE CHARGE Interim Evaluation available at <http://www1.dshs.wa.gov/rda/research/9/72.shtml>.

- Changing individual and provider behavior.

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, HRSA 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.⁴

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.

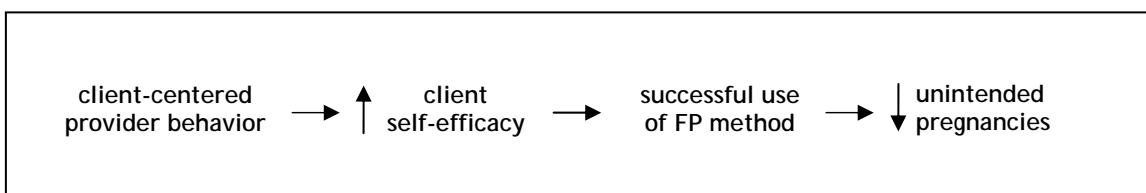
TAKE CHARGE program objectives are to:

- 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.

⁴ Provider forms to document required Maternity Support Services are available at <http://fortress.wa.gov/dshs/maa/firststeps/Provider%20Page/First%20Steps%20Documentation/Documentation.index.htm> (accessed February 14, 2007).

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.⁵ 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, she will be a more successful user 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;

⁵ 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 U.S. citizen or U.S. 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 HRSA 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 HRSA. Once eligibility has been confirmed by HRSA, the Medicaid ID card is sent to the client's home or to their provider, depending on the client's wishes. In September 2002, HRSA 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 U.S. citizen 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 (Ritualo et al. 2003).

PROGRAM ADMINISTRATION

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

- Have a current HRSA 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 HRSA'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 HRSA'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 January 2005, TAKE CHARGE providers offered services in 199 clinics throughout the state.

Almost every county has at least one TAKE CHARGE clinic, with greater concentrations occurring in more populous counties. King County has approximately fifty providers, Pierce County has twenty, and Skamania and Ferry counties each have one clinic.

Table 1. TAKE CHARGE Provider Enrollment July 1, 2001 - January 31, 2005

Provider Category*	First Month			Total		
	July 2001			July 1, 2001 - January 31, 2005		
	Number of Sites N=111	Percent	No. of Title X	Number of Sites N=199	Percent	No. of Title X
Community Health Centers	20	(18.0%)	4	77	(38.7%)	5
Local Health Jurisdictions	29	(26.1%)	26	34	(17.1%)	30
Family Planning	47	(42.3%)	45	49	(24.6%)	47
Other	15	(13.5%)	0	39	(19.6%)	0
Women's Health Clinics	5	(4.5%)		15	(7.5%)	
Hospital-Based Clinics	8	(7.2%)		13	(6.5%)	
Private Medical Doctors	1	(0.9%)		6	(3.0%)	
Primary Care Clinics	1	(0.9%)		2	(1.0%)	
Tribal Health Clinics	0	(0.0%)		1	(0.5%)	
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, Providence Everett Medical Center, Swedish Health Services, SW Washington Medical Center, and Whitman Medical Group.

Private Medical Doctors: Solo practice Doctors of Medicine (MD) and Advanced Registered Nurse Practitioners (ARNP).

Tribal Health Clinics: Indian Health Service or tribally operated clinics.

Other: Wellness centers.

PROGRAM PARTICIPATION

Between July 2001 and the end of its first year, total enrollment was 98,973 unduplicated clients. By the end of the fifth year, TAKE CHARGE had enrolled 335,757 clients.

Table 2. TAKE CHARGE July 1, 2001 - June 30, 2006

	Year 1 July 1, 2001 - June 30, 2002	Year 2 July 1, 2002 - June 30, 2003	Year 3 July 1, 2003 - June 30, 2004	Year 4 July 1, 2004 - June 30, 2005	Year 5 July 1, 2005 - June 30, 2006	Total to Date July 1, 2001 - June 30, 2006
TAKE CHARGE ¹	62,657	107,096	125,972	138,625	134,660	248,669
Pregnancy Extension ²	38,066	40,613	41,134	41,213	40,901	116,139
Total Unduplicated	98,973	145,166	164,327	177,260	173,057	335,757

¹Includes some clients who transitioned to or from Program S.

²Includes some clients who transitioned to or from Program G.

More than two-thirds, or 67.3%, of women enrolled in the first five years of TAKE CHARGE were between the ages of eighteen and twenty-nine; the same age group accounted for 73.7% of all Medicaid-paid births in 2004. TAKE CHARGE participation among teens less than eighteen years of age increased from 11,188 male and female enrollees in year one to 18,857 enrollees in year four, with a decrease in year five to 16,986.

TAKE CHARGE enrollment among men more than doubled between year one and year five, from 3,723 to 8,204, with a high in year four of 9,740. By the end of year five, TAKE CHARGE had enrolled over 21,000 males. Eighty-one 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		Year Four		Year Five		Total Enrollment ¹		
	M	F	M	F	M	F	M	F	M	F	M	F	Total
Less than 18	213	10,975	394	15,356	492	17,373	513	18,344	405	16,581	1,544	51,496	53,040
18 - 19	557	14,976	1,020	21,835	1,243	24,971	1,342	26,943	1,103	25,513	3,419	57,313	60,732
20 - 24	1,388	34,946	3,055	51,837	3,674	59,471	4,147	65,066	3,516	65,378	8,176	103,741	111,917
25 - 29	783	17,060	1,668	24,472	1,795	27,530	1,897	30,249	1,677	31,374	3,937	50,763	54,700
30 - 34	361	9,802	827	13,130	919	14,108	884	14,358	725	13,713	1,928	28,251	30,179
35 - 39	214	4,972	443	6,576	419	7,173	455	7,542	394	7,490	1,026	14,742	15,768
40 - 44	116	1,988	280	3,045	291	3,391	294	3,563	203	3,379	625	6,312	6,937
45 - 60	90	527	212	1,010	223	1,247	203	1,450	176	1,423	467	1,998	2,465
out of range ²	1	4	3	3	3	4	5	5	5	2	9	10	19
Total	3,723	95,250	7,902	137,264	9,059	155,268	9,740	167,520	8,204	164,853	21,131	314,626	335,757

¹Client age is age at first enrollment in TAKE CHARGE from Jul 1, 2001 to Jun 30, 2006.

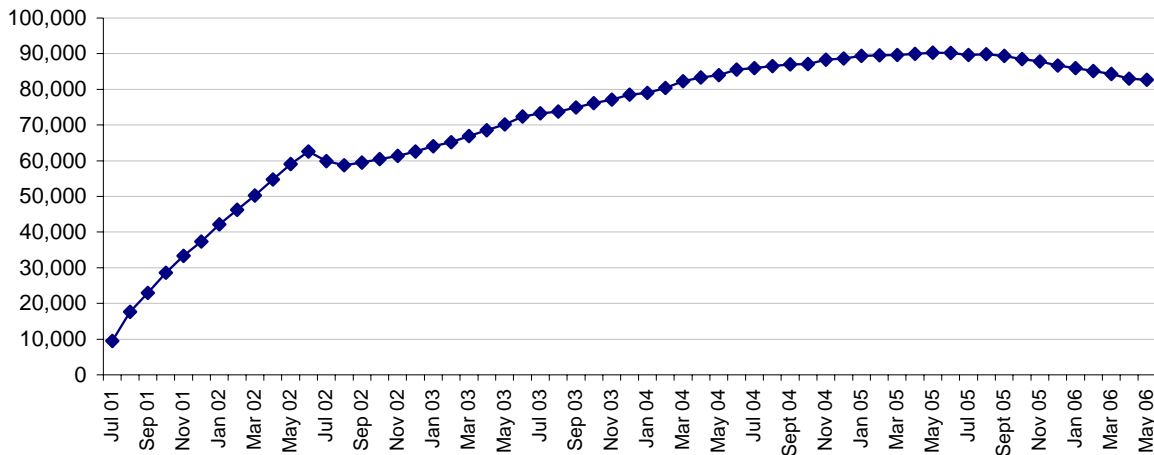
²Age out of range (< 8 or > 60).

Current TAKE CHARGE Enrollment by Month

The following line graph shows the monthly TAKE CHARGE enrollment for the first five years of implementation. In the first month (*July 2001*) of TAKE CHARGE implementation 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*), 73,254 clients were enrolled; the number enrolled increased to 85,924 at the beginning of year four (*July 2004*). In the first month of year five (*July 2005*), 89,613 clients were enrolled. Near the end of year five (*May 2006*) enrollment decreased to 82,697 clients. These figures represent current monthly enrollment and not total enrollment over time.

During the first few months of the program, client enrollment exceeded all expectations and continued to increase steadily until 2005. After reaching a plateau in 2005, enrollment decreased slightly in 2006. The slight downturn in June 2002 is likely a result of the first re-enrollment process. The first clients that enrolled in TAKE CHARGE in July 2001 had to re-enroll in the program to be eligible for another year.

Figure 1. Program G 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 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) and one initial Education, Counseling, and Risk Reduction (ECRR) session. While women may receive follow-up ECRR ten months after their initial ECRR service and every ten months thereafter, men may receive follow-up ECRR every twelve months. Additionally, women at five research sites received Intensive Follow-up Services (IFS). STD testing and treatment are covered by TAKE CHARGE only when medically necessary for the client to use his or her chosen contraceptive method.

METHODS

Multiple data sources were used to evaluate the TAKE CHARGE program. They included 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 evaluation report and their related data sources. A more detailed description of each data source is provided below.

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

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 HRSA, Medicaid identifying codes, known as PICs (Patient Identification Code), for TAKE CHARGE eligible clients are

extracted by HRSA and provided to the evaluation team. The evaluation team maintains an historical file of PICs for clients eligible for TAKE CHARGE and unduplicates these on a quarterly basis.

First Steps Database (FSDB). All Washington birth certificates are linked at the individual level to Medicaid claims and eligibility history. FSDB begins with births in July 1988 and currently contains linked birth certificates through 2004. 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). HRSA’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 HRSA 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 pool of TAKE CHARGE-approved providers (see Table 4). The ten research sites selected were responsible for collecting client surveys and participating in provider surveys, interviews, and site visits. In addition, the five intervention sites provided 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 (RDA) 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 was 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 was mailed from RDA to the clients that completed a baseline survey. Client surveys addressed client family planning behavior, attitudes and perceptions, and were administered in English, Spanish and Vietnamese (see Appendix A). Both a pre- and post-survey were completed by 1,479 female clients. Response rates for follow-up surveys collected in year one through year four are shown in Table 5.

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 clinics 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 were 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

Demonstration Year	White Center	University District	Renton	Capital Hill	Skagit	Mt. Baker	Skamania	Everett	Sunnyside	Pullman	Total
Year 1											
Newly Enrolled Women	899	*	327	5,505	38	502	49	994	382	492	9,188
Number for Sample (Baseline Surveys)	84	*	30	119	16	82	8	84	81	92	596
Number of Follow-Up Surveys	39	*	15	75	8	35	4	42	31	49	298
Follow-Up Response Rate [†]	51%	*	56%	75%	57%	49%	50%	53%	41%	60%	56%
Sample Weight (Baseline)	10.7	*	10.9	46.3	2.4	6.1	6.1	11.8	4.7	5.3	
Sample Weight (Follow-Up) [‡]	23.1	*	21.8	73.4	4.8	14.3	12.3	23.7	12.3	10.0	
Year 2											
Newly Enrolled Women	463	1,924	348	2,476	58	486	11	779	236	427	7,208
Number for Sample (Baseline Surveys)	113	103	100	104	22	96	4	106	93	93	834
Number of Follow-Up Surveys	44	69	37	57	8	58	2	51	38	57	421
Follow-Up Response Rate [†]	43%	69%	43%	69%	40%	64%	50%	59%	41%	69%	56%
Sample Weight (Baseline)	4.1	18.7	3.5	23.8	2.6	5.1	2.8	7.3	2.5	4.6	
Sample Weight (Follow-Up) [‡]	10.5	27.9	9.4	43.4	7.3	8.4	5.5	15.3	6.2	7.5	
Year 3											
Newly Enrolled Women	456	1,382	329	2,534	77	519	23	865	201	486	6,872
Number for Sample (Baseline Surveys)	101	109	104	111	31	104	4	100	106	113	883
Number of Follow-Up Surveys	43	70	52	64	15	50	2	41	50	46	433
Follow-Up Response Rate [†]	51%	69%	57%	67%	50%	55%	67%	48%	53%	48%	56%
Sample Weight (Baseline)	4.5	12.7	3.2	22.8	2.5	5.0	5.8	8.7	1.9	4.3	
Sample Weight (Follow-Up) [‡]	10.6	19.7	6.3	39.6	5.1	10.4	11.5	21.1	4.0	10.6	
Year 4											
Newly Enrolled Women	350	1,701	244	2,208	71	483	25	704	164	823	6,773
Number for Sample (Baseline Surveys)	83	113	100	114	14	102	4	108	56	98	792
Number of Follow-Up Surveys	30	69	33	56	9	35	0	38	21	36	327
Follow-Up Response Rate [†]	42%	65%	40%	59%	64%	39%	0%	42%	41%	46%	48%
Sample Weight (Baseline)	4.2	15.1	2.4	19.4	5.1	4.7	6.3	6.5	2.9	8.4	
Sample Weight (Follow-Up) [‡]	11.7	24.7	7.4	39.4	7.9	13.8	0.0	18.5	7.8	22.9	

* University District clinic surveys (n=18) combined with Capital Hill in year one.

† Follow-up response rate excludes unable to locate survey respondents.

‡ Controlled for non-response.

Table 6. Statewide Sample Weights for Survey Respondents

	Year 1	Year 2	Year 3	Year 4
King County				
Newly enrolled women in region	24,391	24,451	24,673	20,858
Proportion of region's clients enrolled at research clinic	27.6%	21.3%	19.1%	21.6%
Weight, clinics to region	3.6	4.7	5.2	4.6
Clinic-Specific Regional Weight for Follow-Up Surveys				
White Center	83.5	49.4	55.7	54.0
University District	266.0	130.8	103.6	114.2
Renton	79.0	44.1	33.2	34.2
Capital Hill	266.0	203.8	207.8	182.6
Western WA (excluding King Co.)				
Newly enrolled women in region	21,030	12,987	10,921	11,712
Proportion of region's clients enrolled at research clinic	7.5%	10.3%	13.6%	11.0%
Weight, clinics to region	13.3	9.7	7.4	9.1
Clinic-Specific Regional Weight for Follow-Up Surveys				
Skagit	63.1	70.6	37.8	72.0
Mt. Baker	190.5	81.6	76.4	126.0
Skamania	162.7	53.5	84.6	0.0
Everett	314.4	148.7	155.3	169.1
Eastern WA				
Newly enrolled women in region	11,704	10,702	10,129	9,440
Proportion of region's clients enrolled at research clinic	7.5%	6.2%	6.8%	10.5%
Weight, clinics to region	13.4	16.1	14.7	9.6
Clinic-Specific Regional Weight for Follow-Up Surveys				
Sunnyside	165.0	100.2	59.3	74.7
Pullman	134.5	120.9	155.8	218.7

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 was 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. These results are presented in the *TAKE CHARGE Process Report* (Ritualo et al. 2003).

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 was based on the entire population of TAKE CHARGE enrollees. Age and gender were 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 were 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=289,187 years 1-4). 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=231,388 years 1-4). All women and men who received one or more covered medical family planning service through the demonstration as defined in the Special Terms & Conditions agreed upon by CMS and the Health and Recovery Services Administration. See Appendix B for a list of covered medical family planning services.

TAKE CHARGE Eligibles with Medicaid-Paid Births (n=93,100). All women enrolled in TAKE CHARGE between July 1, 2001, and June 30, 2006, who had a Medicaid-paid birth (livebirth or fetal death) between July 1, 1988, and December 31, 2004, 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=1,479). 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

Two-sided two sample t tests were used to compare mean ages between programs and sites. Chi-square tests and Fisher Exact tests were used when comparing differences in service usage and participation rates among sites, programs, and genders. The relationship between age and participation rates was analyzed with the Cochran-Armitage trend test. A P value ≤ 0.05 was considered significant. 95% confidence limits were used to determine significant differences between pre- and post-survey analyses related to client self-efficacy. Large sample sizes, especially at non-research sites, increased the statistical power to detect small differences (or increased the probability of rejecting the null hypothesis). Although statistically significant, in some cases these findings may not be significant with respect to program operations.

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.⁶ General Fertility Rates calculated for the Base Year, Year One, Year Two, Year Three, Year Four, and Year Five (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 full scope Medicaid program in calendar year 2000; and B^{TC} is equal to the number of Medicaid-paid live births to these women. The base year rate was computed for the actual enrollees so no age standardization was needed.

Demonstration Years

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.

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 was

⁶ Available at: <http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/> (accessed February 14, 2007).

determined to be a TAKE CHARGE participant. Appendix C details the specific medical family planning codes used for the determination of the demonstration participants.

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. For year four (July 1, 2004, to June 30, 2005) and year five (July 1, 2005, to June 30, 2006), preliminary birth certificates were used when final birth certificates were not available.

Since the age distribution each year reflected somewhat fewer teens and more women between the ages of 20 and 24, the fertility rates for each of the first five years 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=93,100). 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 2004 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.

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 Table 8 on the next 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.

- Overall (all four years), the number of estimated pregnancies was reduced from 18,738 (before enrollment in TAKE CHARGE) to 14,587 (at the end of the first year of enrollment). The 4151 pregnancies averted represent a decrease of 22.2%. In other words, 22% 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 and client surveys under-estimate method use relative to claims data. The actual births to participants are approximately equal to the failure rate of the more effective methods.

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 were 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.

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

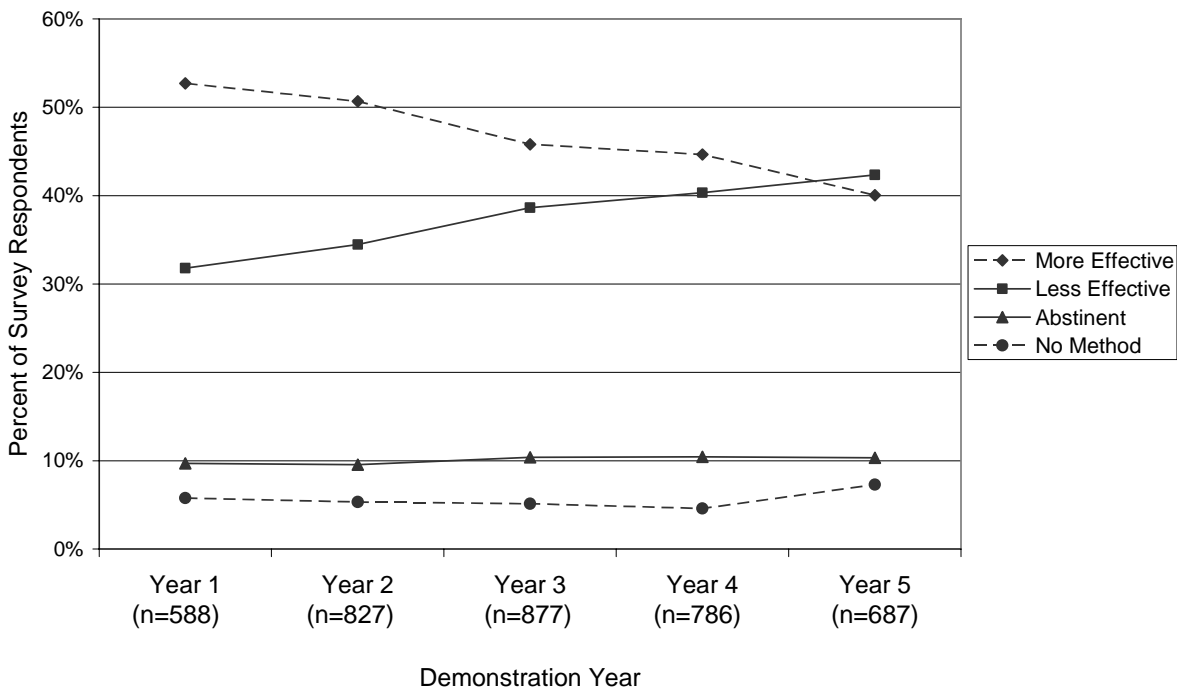
Method	Failure Rate	Estimated Pregnancies (Per Method Failure Rates)													
		Year One		Year Two		Year Three		Year Four		Combined					
		Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post				
Implants (Norplant)	0.0005	0.0	0.0	0.0	0.0	0.3	0.1	0.0	0.0	0.3	0.1	0.0	0.0	0.3	0.1
Male sterilization	0.0015	0.8	0.8	0.0	0.5	0.2	0.5	0.2	0.2	1.2	2.0	0.2	0.2	1.2	2.0
IUD	0.0044	1.4	6.1	2.9	4.2	1.0	2.6	0.5	3.6	5.7	16.1	0.0	2.1	5.7	16.1
Female sterilization	0.0005	0.0	1.6	0.0	1.9	0.0	3.6	0.0	2.1	0.0	9.1	0.0	2.1	0.0	9.1
Injectables	0.03	170.3	139.8	82.9	139.8	66.9	77.8	52.7	61.6	372.8	419.0	52.7	61.6	372.8	419.0
Nuvaring	0.08	0.0	32.0	11.9	125.8	39.3	181.1	58.9	185.8	110.1	524.8	58.9	185.8	110.1	524.8
Orthoevra patch	0.08	0.0	42.6	10.5	175.2	119.1	284.7	94.0	173.5	223.6	676.0	94.0	173.5	223.6	676.0
Oral contraceptives	0.08	1,753.2	2,135.4	1,395.7	1,710.0	1,219.7	1,589.0	1,158.7	1,581.4	5,527.4	7,015.9	1,158.7	1,581.4	5,527.4	7,015.9
Male condoms	0.15	1,827.2	660.2	1,940.7	582.0	1,907.4	726.6	1,480.7	365.6	7,155.9	2,334.5	1,480.7	365.6	7,155.9	2,334.5
Diaphragm/cervical cap	0.16	0.0	50.3	0.0	21.0	16.6	16.6	35.0	0.0	51.6	87.8	16.6	16.6	51.6	87.8
Female condoms	0.21	55.9	106.0	25.4	0.0	61.3	12.5	169.1	35.3	311.7	153.8	61.3	12.5	311.7	153.8
Periodic abstinence	0.25	47.6	100.1	124.5	90.5	25.9	0.0	45.7	60.1	243.6	250.7	45.7	60.1	243.6	250.7
Withdrawal	0.27	253.9	157.7	343.1	206.5	193.4	56.1	104.5	30.8	894.9	451.1	104.5	30.8	894.9	451.1
Spermicide	0.29	0.0	0.0	0.0	0.0	69.9	0.0	0.0	0.0	69.9	0.0	0.0	0.0	69.9	0.0
Emergency Contraceptive Pills	0.2125	0.0	0.0	0.0	0.0	0.0	0.0	11.5	0.0	11.5	0.0	11.5	0.0	11.5	0.0
No method (chance)	0.85	1,693.5	1,464.2	806.8	337.9	568.1	447.7	689.8	396.0	3,758.2	2,645.8	689.8	396.0	3,758.2	2,645.8
Estimated pregnancies for TAKE CHARGE G women (N):		5,804	4,897	4,744	3,395	4,289	3,399	3,901	2,896	18,738	14,587	3,901	2,896	18,738	14,587
Estimated pregnancies averted (N):			907	1,349	890			1,005				1,005			
Estimated pregnancies averted (%):		15.6%		28.4%		20.8%		25.8%				25.8%			

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, 0.0039, 0.0038). 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. Since ECP use within 72 hours of unprotected intercourse decreases risk of pregnancy by at least 75%, the failure rate was taken as the failure rate for no method, decreased by 75%. 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.

More recently, an Occasional Report (Frost, Sonfield, and Gold, 2006) from the Guttmacher Institute employed findings from the National Survey of Family Growth (NSFG) to describe the expected distribution of women according to contraceptive method use prior to and after implementation of a Medicaid family planning expansion. The difference in the expected number of unintended pregnancies before and after a Medicaid family planning expansion was used to estimate the number of unintended pregnancies averted. The distribution of family planning methods is compared for actual data from waiver clients in Washington State and the estimated population from the NSFG used in the Frost, Sonfield, and Gold (2006) study in Appendix D.

The distribution of method use at baseline (prior to enrollment) has changed over the five years of Washington’s waiver. Survey respondents for each year were to be recruited from women who were not previously enrolled in the family planning waiver. While weighted pre-survey data were not available at the time of this report (unweighted survey data are presented), Figure 2 shows that over time, the proportion of women reporting use of a more effective method prior to enrollment has decreased and the proportion of women reporting use of a less effective method prior to enrollment has increased. In addition, the proportion reporting use of no method prior to enrollment increased significantly from year 4 to year 5.

Figure 2. Effectiveness of Birth Control Methods Used Prior to Enrollment



These findings indicate that, even five years after program implementation, the waiver continues to reach new clients using no family planning methods prior to enrollment. The findings also predict greater reductions in the proportion of pregnancies averted in future years and underscore the conservative nature of the current estimate of pregnancies averted. On the other hand, clients who switch from no method or less effective methods to more effective methods may have special needs for client-centered practice and individualized follow-up to achieve successful and continued use of their method.

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 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=1,462)	IFS (N=726)	Control (N=736)	Total (N=1,462)	IFS (N=726)	Control (N=736)
Abstinent	11.3	9.9	12.2	11.3	9.6	12.4
More Effective	53.0	50.6	54.4	70.6*	73.7*	68.7*
Less Effective	32.7	35.7	30.9	13.4*	12.4*	14.0*
No Method	3.0	3.8	2.5	4.7*	4.3	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 Limits.

- The proportion of clients using a more effective method increased from 53.0% at enrollment to 70.6% one year later. At IFS sites, use of more effective methods increased from 50.6% to 73.7% (a percentage increase of 45.7%), compared to an increase from 54.4% to 68.7% (a percentage increase of 26.3%) at control sites.

- Similarly, the proportion of clients reporting use of a less effective method decreased from 32.7% at enrollment to 13.4% one year later. At IFS sites, use of less effective methods decreased from 35.7% to 12.4% (a percentage decrease of 65.3%), compared to a decrease from 30.9% to 14.0% (a percentage decrease of 54.7%) at control sites.
- The proportion of clients that reported using abstinence in the past two months was unchanged at 11.3%.
- Those using no method increased from 3.0% to 4.7% during the one-year interval. Of the women who reported using no method, 32.1% stated that they wanted to get pregnant, and an additional 11.7% said that they kind of wanted to get pregnant or did not care if they got pregnant. At IFS sites, the proportion reporting the use of no method increased by 13.2% at one year follow-up (3.8% pre and 4.3% 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 (including TAKE CHARGE clients) 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 from years one through three—from 22,436 (85,607 – 63,171) in year one, to 24,717 in year two, and 24,662 in year three.

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 Medicaid (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 first three years of the demonstration.

Table 11. Men Receiving Family Planning Services

All Medicaid Men	Baseline Year CY2000	Year One	Year Two	Year Three
Vasectomies	205	272	396	393
Other family planning services [†]	645	3,276	3,988	4,625
Total men*	850	3,548	4,384	5,018

*Unduplicated total.

[†]Other family planning services include: family planning office visit, ECRR, and other contraceptive methods such as condoms, spermicide, foam, and jelly.

- 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 March 2005, 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 out 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 have begun 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 7/01 – 6/02	Year 2 7/02 – 6/03	Year 3 7/03 – 6/04	Year 4 7/04 – 6/05	Year 5 7/05 – 6/06
Washington State*	62.7	61.2	60.8	62.0	62.8	n/a
Medicaid Enrollees/ Demonstration Participants	128.0	64.3	62.9	55.8	41.7 [†]	40.9 [†]
Demonstration Participants: Births After Enrollment	n/a	7.1	5.6	6.6	4.6 [†]	5.1 [†]

*Washington State birth rates for calendar years from the 2004 Washington State Pregnancy & Induced Abortion Statistics annual report. State birth rates for 2005 unavailable at this time.

[†]Year four and year five fertility rates are preliminary.

- Washington State’s birth rate for women 15-44 years old has shown very little change in recent years.⁷ 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 62.8 (in 2004).
- The base year fertility rate (128.0 per 1000) was computed for all Medicaid-paid births to full scope Medicaid clients in calendar year 2000. For each of the first five 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 demonstration year one is just over half the base year rate; for years two through five, the fertility rate is less than half the base year rate and shows a decreasing trend over the five years.
- 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.

⁷ 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, 2004. 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, 2006	Enrolled Women with a Medicaid-paid Birth ³ between July 1, 1988 - December 31, 2004	
	Number	Number	Percent of Total
G	213,402	23,871	(11.2%)
S	101,224	69,229	(68.4%)
Total	314,626	93,100	(29.6%)

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

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

³Birth certificate data from FSDB for births from Jul 1, 1988 - Dec 31, 2004.

Of the 314,626 total women enrolled in TAKE CHARGE during the first five years, nearly one-third (29.6%) had a history of a Medicaid-paid birth. Among women first enrolled in Program G, 11.2% had a history of a birth. Among women first enrolled in Program S, 68.4% had a history of a birth. This difference is consistent with program eligibility requirements: U.S. citizen women in Program S are automatically enrolled in TAKE CHARGE two months after their pregnancy ends. Birth certificates were not found for 31.6% of women on Program S; their pregnancies were assumed to have been unfulfilled (ended in miscarriage, fetal deaths before twenty weeks, or termination) or births may have taken place later than December 31, 2004, the most recent date for which birth certificates were available. Many of the 89% of Program G women who had no birth certificates may never have been pregnant.

The following analyses were based on the 93,100 TAKE CHARGE women who had a birth certificate available. Table 14 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 ($P < 0.0001$, Satterthwaite t-test). The average age of Program G clients without a birth was 22.5 years; for Program G clients with a birth, the average age was 25.4. The average age of Program S clients without a birth was 25.3 years; for Program S clients with a birth, the average age was 26.6.
- For clients with a birth and for clients without a birth, S women were older, on average, than G women ($P < 0.0001$, Satterthwaite t-test). S-women with and without a birth averaged 26.6 and 25.3 years, respectively, while G-women averaged 25.4 and 22.5 years.

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	32,517	(15.2%)	31,522	(16.6%)	995	(4.2%)	(3.1%)
18 - 19	42,898	(20.1%)	40,422	(21.3%)	2,476	(10.4%)	(5.8%)
20 - 24	78,974	(37.0%)	70,205	(37.0%)	8,770	(36.7%)	(11.1%)
25 - 29	31,186	(14.6%)	24,811	(13.1%)	6,376	(26.7%)	(20.4%)
30 - 34	13,780	(6.5%)	10,610	(5.6%)	3,171	(13.3%)	(23.0%)
35 - 39	7,497	(3.5%)	6,032	(3.2%)	1,465	(6.1%)	(19.5%)
40 - 44	4,238	(2.0%)	3,747	(2.0%)	491	(2.1%)	(11.6%)
Over 45	2,247	(1.1%)	2,123	(1.1%)	124	(0.5%)	(5.5%)
out of range ³	65	(0.0%)	62	(0.0%)	3	(0.0%)	(4.6%)
Total	213,402	(100.0%)	189,534	(100.0%)	23,871	(100.0%)	(11.2%)
Mean Age	22.8		22.5		25.4		

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	2,420	(2.4%)	1,526	(4.8%)	894	(1.3%)	(36.9%)
18 - 19	7,966	(7.9%)	4,046	(12.6%)	3,920	(5.7%)	(49.2%)
20 - 24	37,301	(36.8%)	12,304	(38.5%)	24,997	(36.1%)	(67.0%)
25 - 29	25,600	(25.3%)	6,316	(19.7%)	19,284	(27.9%)	(75.3%)
30 - 34	16,228	(16.0%)	4,041	(12.6%)	12,187	(17.6%)	(75.1%)
35 - 39	8,413	(8.3%)	2,494	(7.8%)	5,919	(8.5%)	(70.4%)
40 - 44	2,945	(2.9%)	1,117	(3.5%)	1,828	(2.6%)	(62.1%)
Over 45	322	(0.3%)	142	(0.4%)	180	(0.3%)	(55.9%)
out of range ³	29	(0.0%)	9	(0.0%)	20	(0.0%)	(69.0%)
Total	101,224	(100.0%)	31,995	(100.0%)	69,229	(100.0%)	(68.4%)
Mean Age	26.2		25.3		26.6		

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	34,937	(11.1%)	33,048	(14.9%)	1,889	(2.0%)	(5.4%)
18 - 19	50,864	(16.2%)	44,468	(20.1%)	6,396	(6.9%)	(12.6%)
20 - 24	116,275	(37.0%)	82,509	(37.2%)	33,767	(36.3%)	(29.0%)
25 - 29	56,786	(18.0%)	31,127	(14.1%)	25,660	(27.6%)	(45.2%)
30 - 34	30,008	(9.5%)	14,651	(6.6%)	15,358	(16.5%)	(51.2%)
35 - 39	15,910	(5.1%)	8,526	(3.8%)	7,384	(7.9%)	(46.4%)
40 - 44	7,183	(2.3%)	4,864	(2.2%)	2,319	(2.5%)	(32.3%)
Over 45	2,569	(0.8%)	2,265	(1.0%)	304	(0.3%)	(11.8%)
out of range ³	94	(0.0%)	71	(0.0%)	23	(0.0%)	(24.5%)
Total	314,626	(100.0%)	221,529	(100.0%)	93,100	(100.0%)	(29.6%)
Mean Age	23.9		22.9		26.3		

¹Client age is age at first enrollment in TAKE CHARGE from Jul 1, 2001 to Jun 30, 2006.

²Medicaid-paid birth data from FSBID Jul 1, 1988 - Dec 31, 2004.

³Age out of range (< 8 or > 60).

Table 15 shows the client's age at her most recent birth for the 93,100 clients who had a history of a Medicaid-paid birth.

- Thirty-eight percent (38.4%) 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 (43.2% and 36.8%, 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 24.9 years, compared to 21.6 years for those who were not married. For Program S, the average age of women who were married at their last birth was 27.3 years, compared to 23.8 years for those who were not married.

Table 15. TAKE CHARGE Client¹ Age at Most Recent Birth²

Age	Program G		Program S		Total	
	N = 23,871	(100%)	N = 69,229	(100%)	N = 93,100	(100%)
Less than 18	2,269	(9.5%)	2,035	(2.9%)	4,304	(4.6%)
18 - 19	4,316	(18.1%)	6,439	(9.3%)	10,755	(11.6%)
20 - 24	10,305	(43.2%)	25,484	(36.8%)	35,789	(38.4%)
25 - 29	4,514	(18.9%)	18,194	(26.3%)	22,708	(24.4%)
30 - 34	1,800	(7.5%)	10,768	(15.6%)	12,568	(13.5%)
35 - 39	572	(2.4%)	4,937	(7.1%)	5,509	(5.9%)
40 - 44	90	(0.4%)	1,272	(1.8%)	1,362	(1.5%)
Over 45	1	(0.0%)	76	(0.1%)	77	(0.1%)
out of range ³	4	(0.0%)	24	(0.0%)	28	(0.0%)
Average age ⁴ (most recent birth)	22.7		25.7		25.0	
Average age ⁴ (married)	24.9		27.3		26.9	
Average age ⁴ (unmarried)	21.6		23.8		23.0	

¹Enrolled TAKE CHARGE clients unduplicated to earliest year Jul 1, 2001 - Jun 30, 2006 with a history of a birth.

²Medicaid-paid birth data from FSBD Jul 1, 1988 - Dec 31, 2004.

³Age out of range (< 8 or > 60).

⁴Out of range ages are not included in average.

Table 16 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 32% of Program S women.

Table 16. Number of Births¹ to TAKE CHARGE Clients²

Number of Births	Program G		Program S		Total	
	N = 23,871 (100%)		N = 69,229 (100%)		N = 93,100 (100%)	
1	13,755	(57.6%)	25,520	(36.9%)	39,275	(42.2%)
2	5,863	(24.6%)	21,183	(30.6%)	27,046	(29.1%)
3	2,379	(10.0%)	11,818	(17.1%)	14,197	(15.2%)
4	826	(3.5%)	5,530	(8.0%)	6,356	(6.8%)
5	276	(1.2%)	2,116	(3.1%)	2,392	(2.6%)
6	87	(0.4%)	878	(1.3%)	965	(1.0%)
7	42	(0.2%)	414	(0.6%)	456	(0.5%)
8 - 10	19	(0.1%)	393	(0.6%)	412	(0.4%)
11 - 21	5	(0.0%)	103	(0.1%)	108	(0.1%)
missing	619	(2.6%)	1,274	(1.8%)	1,893	(2.0%)
Mean, Median ³	1.6	1	2.2	2	2.1	2
Mean, Median ³ (married)	2.0	2	2.5	2	2.4	2
Mean, Median ³ (unmarried)	1.5	1	1.8	1	1.7	1

¹Medicaid-paid birth data from FSBD Jul 1, 1988 - Dec 31, 2004. Most recent birth plus reported prior live births.

²Enrolled TAKE CHARGE clients unduplicated to earliest year Jul 1, 2001 - Jun 30, 2006 with a history of a birth.

³Missing data not included in average.

- A large proportion of all women with a birth had only one birth (42.2%). A significantly larger proportion of clients in program G (57.6%) had only one birth compared to clients in Program S (36.9%).
- 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 (1.6 births). Overall, 86.5% had 3 or fewer births, and 11.5% had 4 or more births. (The total number of births was unknown for 2.0% of these clients.)
- On average, married clients had more births than unmarried clients. At most recent birth, married clients averaged 2.4 births compared to 1.7 births for unmarried clients.

Table 17 shows the distribution of race and ethnicity for TAKE CHARGE clients who had at least one birth.

- About two thirds (64.7%) of all women with a birth were White, and 15.8% were Hispanic. These proportions were very similar for women in Program G and in Program S.
- The proportion of African American women was slightly higher for Program G (6.1%) than for Program S (4.6%).
- The proportion of Native American women was somewhat higher for Program S (3.1%) than for Program G (1.9%), and the proportion of Asian women was also higher for Program S (7.6%) than for Program G (3.8%).

Table 17. Race/Ethnicity of Clients¹ with a History of a Birth²

Race/Ethnicity	Program G		Program S		Total	
	N = 23,871	(100%)	N = 69,229	(100%)	N = 93,100	(100%)
White	16,241	(68.0%)	44,020	(63.6%)	60,261	(64.7%)
Hispanic	3,668	(15.4%)	11,038	(15.9%)	14,706	(15.8%)
African American	1,456	(6.1%)	3,200	(4.6%)	4,656	(5.0%)
Native American	465	(1.9%)	2,123	(3.1%)	2,588	(2.8%)
Asian	896	(3.8%)	5,278	(7.6%)	6,174	(6.6%)
Hawaiian/Pacific Islander	176	(0.7%)	808	(1.2%)	984	(1.1%)
more than one race	450	(1.9%)	1,168	(1.7%)	1,618	(1.7%)
other/unknown	519	(2.2%)	1,594	(2.3%)	2,113	(2.3%)

¹Unduplicated TAKE CHARGE clients, eligible Jul 2001 - Jun 2006, with a history of a birth.

²Medicaid-paid births from FSDB Jul 1988 through Dec 2004.

These differences are explored in more detail in Table 18 which includes marital status.

- On the average, about half of all women (50.1%) with a birth were married at the time of their most recent birth. The proportion of white women who were married was similar (50.0%). Asians were found to have the highest marriage rate (62.0%), followed by Hispanics (56.7%). Native American clients had the lowest marriage rate (27.3%).
- Overall, the proportion of married women was greater among Program S women (55.6%) than among Program G women (34.2%). For each race/ethnic group as well, the proportion of married women was greater for S women than for G women.
- Differences in the proportion of married clients for each race/ethnicity existed between programs. Asian clients had the greatest difference (28.1%) in the proportion married between programs (Program S: 66.0% married; Program G: 37.9% married). The smallest difference was 9.4% for Native American clients (Program S: 29.0% married; Program G: 19.6% married).

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

Program G				
Race/Ethnicity	Clients with a Birth²		Marital Status (married)	
	N	(%)	N	(%)
White	16,241	(68.0%)	5,589	(34.4%)
Hispanic	3,668	(15.4%)	1,560	(42.5%)
African American	1,456	(6.1%)	246	(16.9%)
Native American	465	(1.9%)	91	(19.6%)
Asian	896	(3.8%)	340	(37.9%)
Hawaiian/Pacific Islander	176	(0.7%)	54	(30.7%)
more than 1 race	450	(1.9%)	118	(26.2%)
other/unknown	519	(2.2%)	175	(33.7%)
Total	23,871	(100.0%)	8,173	(34.2%)
Program S				
Race/Ethnicity	Clients with a Birth²		Marital Status (married)	
	N	(%)	N	(%)
White	44,020	(63.6%)	24,550	(55.8%)
Hispanic	11,038	(15.9%)	6,778	(61.4%)
African American	3,200	(4.6%)	1,239	(38.7%)
Native American	2,123	(3.1%)	616	(29.0%)
Asian	5,278	(7.6%)	3,486	(66.0%)
Hawaiian/Pacific Islander	808	(1.2%)	391	(48.4%)
more than 1 race	1,168	(1.7%)	507	(43.4%)
other/unknown	1,594	(2.3%)	936	(58.7%)
Total	69,229	(100.0%)	38,503	(55.6%)
Total				
Race/Ethnicity	Clients with a Birth²		Marital Status (married)	
	N	(%)	N	(%)
White	60,261	(64.7%)	30,139	(50.0%)
Hispanic	14,706	(15.8%)	8,338	(56.7%)
African American	4,656	(5.0%)	1,485	(31.9%)
Native American	2,588	(2.8%)	707	(27.3%)
Asian	6,174	(6.6%)	3,826	(62.0%)
Hawaiian/Pacific Islander	984	(1.1%)	445	(45.2%)
more than 1 race	1,618	(1.7%)	625	(38.6%)
other/unknown	2,113	(2.3%)	1,111	(52.6%)
Total	93,100	(100.0%)	46,676	(50.1%)

¹Unduplicated TAKE CHARGE clients, eligible Jul 2001 - Jun 2006, with a history of a birth.

²Medicaid-paid births from FSDB Jul 1988 through Dec 2004.

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

Year	Program ¹	All Sites			Non-Research Sites			Control			Research Sites			IFS		
		Clients Enrolled	Received Service	Percent Served	Clients Enrolled	Received Service	Percent Served	Clients Enrolled	Received Service	Percent Served	Clients Enrolled	Received Service	Percent Served	Clients Enrolled	Received Service	Percent Served
1	G	61,314	58,024	(94.6%)	51,572	48,542	(94.1%)	5,217	5,104	(97.8%)	4,525	4,378	(96.8%)			
	S	37,659	16,794	(44.6%)	37,391	16,541	(44.2%)	126	118	(93.7%)	142	135	(95.1%)			
2	G	105,574	82,006	(77.7%)	94,459	71,046	(75.2%)	6,173	6,091	(98.7%)	4,942	4,869	(98.5%)			
	S	39,592	18,404	(46.5%)	39,341	18,167	(46.2%)	120	113	(94.2%)	131	124	(94.7%)			
3	G	124,205	98,773	(79.5%)	112,672	87,374	(77.5%)	6,965	6,893	(99.0%)	4,568	4,506	(98.6%)			
	S	40,122	18,946	(47.2%)	39,867	18,698	(46.9%)	126	124	(98.4%)	129	124	(96.1%)			
4	G	137,182	105,213	(76.7%)	125,848	94,008	(74.7%)	6,487	6,406	(98.8%)	4,847	4,799	(99.0%)			
	S	40,078	17,992	(44.9%)	39,891	17,824	(44.7%)	94	81	(86.2%)	93	87	(93.5%)			
	Total ²	585,726	416,152	(71.0%)	541,041	372,200	(68.8%)	25,308	24,930	(98.5%)	19,377	19,022	(98.2%)			
	Unduplicated Clients³															
	G	200,527	191,082	(95.3%)	171,550	162,507	(94.7%)	16,810	16,610	(98.8%)	12,167	11,965	(98.3%)			
	S	88,660	49,829	(56.2%)	88,310	49,492	(56.0%)	161	153	(95.0%)	189	184	(97.4%)			
	Total	289,187	240,911	(83.3%)	259,860	211,999	(81.6%)	16,971	16,763	(98.8%)	12,356	12,149	(98.3%)			

¹Program G clients self-selected enrollment. Program S clients enrolled automatically in post-pregnancy extension program.

²Total includes duplicated count of clients enrolled more than one year.

³Individual clients assigned to first program and first site enrolled.

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 in page 8 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.

Utilization of any Medicaid-paid Services

Table 19 shows the number and percent of TAKE CHARGE clients who received any Medicaid-paid service during the first four years of the demonstration.

- 1) Total enrollment and services received by program (all sites)
 - During the first four years of TAKE CHARGE, the program enrolled a total of 289,187 clients (unduplicated by person). Of those, 200,527 (69.3%) were in Program G and 88,660 (30.7%) were in Program S.
 - Of all clients enrolled in the program, 240,911 (83.3%) received Medicaid-paid services. The proportion of clients receiving services differed significantly between Programs G and S. While 95.3% of clients in Program G received services, only 56.2% of their counterparts in Program S received any Medicaid-paid service ($P < 0.0001$, chi-square test).
- 2) Enrollment and services for clients at IFS and control sites
 - A larger number of clients enrolled at the control sites ($N=16,971$) than at the IFS sites ($N=12,356$). Clients in Program S accounted for one percent of total enrollment at the research sites. The total number of clients enrolled at research sites ($16,971 + 12,356$) represented 10.1% of the total clients enrolled in TAKE CHARGE.
 - Both control and IFS sites had very high rates of service use (98.8% and 98.3%, respectively). At IFS sites, clients enrolled in Program G and S had similar rates of service use. At control sites, Program G clients had a significantly higher rate of service use than Program S clients (G vs. S at IFS sites: $P = 0.25$, G vs. S at control sites: $P < 0.0001$, Fisher's exact test).
- 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, 81.6% 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

Table 20. Participation Rates for Men and Women, Demonstration Years 1 - 4

Men					
Age	Clients Enrolled		Participants ¹		Participation Rate
	N = 17,861	(100.0%)	N = 15,495	(100.0%)	(86.8%)
Less than 18	1,293	(7.2%)	1,076	(6.9%)	(83.2%)
18 - 19	2,858	(16.0%)	2,477	(16.0%)	(86.7%)
20 - 24	6,918	(38.7%)	6,067	(39.2%)	(87.7%)
25 - 29	3,306	(18.5%)	2,915	(18.8%)	(88.2%)
30 - 34	1,660	(9.3%)	1,420	(9.2%)	(85.5%)
35 - 39	880	(4.9%)	744	(4.8%)	(84.5%)
40 - 44	546	(3.1%)	464	(3.0%)	(85.0%)
45 - 60	394	(2.2%)	328	(2.1%)	(83.2%)
out of range ²	6	(0.0%)	4	(0.0%)	(66.7%)
Women					
Age	Clients Enrolled		Participants ¹		Participation Rate
	N = 271,326	(100.0%)	N = 215,893	(100.0%)	(79.6%)
Less than 18	42,679	(15.7%)	39,401	(18.3%)	(92.3%)
18 - 19	48,555	(17.9%)	43,396	(20.1%)	(89.4%)
20 - 24	90,868	(33.5%)	74,025	(34.3%)	(81.5%)
25 - 29	44,219	(16.3%)	31,163	(14.4%)	(70.5%)
30 - 34	24,935	(9.2%)	15,503	(7.2%)	(62.2%)
35 - 39	12,821	(4.7%)	7,553	(3.5%)	(58.9%)
40 - 44	5,497	(2.0%)	3,443	(1.6%)	(62.6%)
45 - 60	1,742	(0.6%)	1,404	(0.7%)	(80.6%)
out of range ²	10	(0.0%)	5	(0.0%)	(50.0%)
Total					
Age	Clients Enrolled		Participants ¹		Participation Rate
	N = 289,187	(100.0%)	N = 231,388	(100.0%)	(80.0%)
Less than 18	43,972	(15.2%)	40,477	(17.5%)	(92.1%)
18 - 19	51,413	(17.8%)	45,873	(19.8%)	(89.2%)
20 - 24	97,786	(33.8%)	80,092	(34.6%)	(81.9%)
25 - 29	47,525	(16.4%)	34,078	(14.7%)	(71.7%)
30 - 34	26,595	(9.2%)	16,923	(7.3%)	(63.6%)
35 - 39	13,701	(4.7%)	8,297	(3.6%)	(60.6%)
40 - 44	6,043	(2.1%)	3,907	(1.7%)	(64.7%)
45 - 60	2,136	(0.7%)	1,732	(0.7%)	(81.1%)
out of range ²	16	(0.0%)	9	(0.0%)	(56.3%)

¹Participants received medical covered family planning services.

²Age out of range (< 8 or > 60).

clients enrolled at research sites had high rates of service use, only 56.2% 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. While the difference was small for Program G clients (94.7% at non-research sites and 98.6% at research sites), the difference was much larger for Program S clients (56.0% at non-research sites and 96.3% 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 Health and Recovery Services 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 B.) Table 20 shows the age and gender distribution of all the clients who received any covered medical family planning service in the first four years of the demonstration.

- Overall, 80% 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 clients less than 20 years old (90.5%). Clients 25 and older had a lower participation rate (67.6%).
- The participation rate was significantly higher for men (86.8%) than for women (79.6%) ($P < 0.0001$, chi-square test). 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 (68.8% for women; 74.0% for men).
- For women, the highest participation rate was among clients less than 18 years old (92.3%); for men, participation was highest for 25 – 29 year olds (88.2%).

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

Age	Non-Research Sites					
	Program G			Program S		
	Enrolled	Participants ¹	Participation Rate	Enrolled	Participants ¹	Participation Rate
Less than 18	N = 155,756	N = 147,001	(100.0%) (94.4%)	N = 88,310	N = 42,124	(100.0%) (47.7%)
18 - 19	36,743	34,597	(23.6%) (94.2%)	2,531	1,500	(2.9%) (59.3%)
20 - 24	34,765	33,136	(22.3%) (95.3%)	8,389	4,945	(9.5%) (58.9%)
25 - 29	47,600	45,330	(30.6%) (95.2%)	32,763	18,328	(37.1%) (45.5%)
30 - 34	18,124	17,012	(11.6%) (93.9%)	21,565	9,702	(24.4%) (45.0%)
35 - 39	9,216	8,527	(5.9%) (92.5%)	13,743	5,036	(15.6%) (36.6%)
40 - 44	5,132	4,686	(3.3%) (91.3%)	6,868	2,070	(7.8%) (30.1%)
45 - 60	2,822	2,539	(1.8%) (90.0%)	2,252	503	(2.6%) (22.3%)
out of range ²	1,346	1,169	(0.9%) (86.8%)	197	40	(0.2%) (20.3%)
	8	5	(0.0%) (62.5%)	2	0	(0.0%) (0.0%)
	Control Sites					
	Program G			Program S		
Age	Enrolled	Participants ¹	Participation Rate	Enrolled	Participants ¹	Participation Rate
Less than 18	N = 15,655	N = 15,388	(100.0%) (98.3%)	N = 161	N = 153	(100.0%) (95.0%)
18 - 19	2,025	1,973	(12.9%) (97.4%)	11	11	(6.8%) (100.0%)
20 - 24	3,115	3,064	(19.9%) (98.4%)	19	18	(11.8%) (94.7%)
25 - 29	5,893	5,813	(37.6%) (98.6%)	85	81	(52.8%) (95.3%)
30 - 34	2,689	2,650	(17.2%) (98.5%)	34	31	(21.1%) (91.2%)
35 - 39	1,132	1,113	(7.2%) (98.3%)	8	8	(5.0%) (100.0%)
40 - 44	459	443	(2.9%) (96.5%)	3	3	(1.9%) (100.0%)
45 - 60	243	235	(1.6%) (96.7%)	1	1	(0.7%) (100.0%)
out of range ²	99	97	(0.6%) (98.0%)	0	0	(0.0%) (0.0%)
	0	0	(0.0%) (0.0%)	0	0	(0.0%) (0.0%)
	IFS Sites					
	Program G			Program S		
Age	Enrolled	Participants ¹	Participation Rate	Enrolled	Participants	Participation Rate
Less than 18	N = 11,255	N = 11,045	(100.0%) (98.1%)	N = 189	N = 182	(100.0%) (96.3%)
18 - 19	1,360	1,311	(12.1%) (96.4%)	9	9	(4.8%) (100.0%)
20 - 24	2,244	2,212	(19.9%) (98.6%)	23	21	(12.2%) (91.3%)
25 - 29	4,437	4,387	(39.4%) (98.9%)	90	86	(47.6%) (95.6%)
30 - 34	1,769	1,731	(15.7%) (97.9%)	38	37	(20.1%) (97.4%)
35 - 39	814	797	(7.2%) (97.9%)	22	22	(11.6%) (100.0%)
40 - 44	355	347	(3.2%) (97.7%)	4	4	(2.1%) (100.0%)
45 - 60	176	162	(1.6%) (92.0%)	3	3	(1.6%) (100.0%)
out of range ²	100	98	(0.9%) (98.0%)	0	0	(0.0%) (0.0%)
	0	0	(0.0%) (0.0%)	0	0	(0.0%) (0.0%)

¹Participants received medical covered family planning services.

²Age out of range (< 8 or > 60).

Participation rates for women by program and age

Table 21 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 ($P < 0.0001$, chi-square test). About 98% of all women at research sites received one or more covered medical family planning service. Only 77.5% of women at non-research sites received such services.
- At research sites, participation rates were similar for Program G and Program S clients (98.2% for G women versus 95.7% for S women). At non-research sites, the participation rate for women in Program G (94.4%) was almost double that for women in Program S (47.7%). 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 (56.0%) of 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 research sites (97.0%) than at non-research sites (94.2%). For Program G women ages 18 or older, participation rates at all sites decreased with increasing age at first enrollment (Control sites: $P = 0.01$, IFS sites: $P < 0.0001$, non-research sites: $P < 0.0001$, Cochran-Armitage trend test).
- 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 three-fourths of all participants.

**Table 22. Participation Rates:
Men Receiving Medical Covered Family Planning Services**

Non-Research Sites					
Age	Enrolled		Participants ¹		Participation Rate
	N = 15,794	(100.0%)	N = 13,511	(100.0%)	(85.5%)
Less than 18	1,208	(7.6%)	996	(7.4%)	(82.5%)
18 - 19	2,586	(16.4%)	2,216	(16.4%)	(85.7%)
20 - 24	6,014	(38.1%)	5,202	(38.5%)	(86.5%)
25 - 29	2,867	(18.2%)	2,493	(18.5%)	(87.0%)
30 - 34	1,476	(9.3%)	1,240	(9.2%)	(84.0%)
35 - 39	777	(4.9%)	644	(4.8%)	(82.9%)
40 - 44	494	(3.1%)	413	(3.1%)	(83.6%)
45 - 60	367	(2.3%)	304	(2.3%)	(82.8%)
out of range ²	5	(0.0%)	3	(0.0%)	(60.0%)
Control Sites					
Age	Enrolled		Participants ¹		Participation Rate
	N = 1,155	(100.0%)	N = 1,120	(100.0%)	(97.0%)
Less than 18	47	(4.1%)	45	(4.0%)	(95.7%)
18 - 19	151	(13.1%)	149	(13.3%)	(98.7%)
20 - 24	468	(40.5%)	452	(40.4%)	(96.6%)
25 - 29	278	(24.1%)	269	(24.0%)	(96.8%)
30 - 34	110	(9.5%)	108	(9.6%)	(98.2%)
35 - 39	56	(4.8%)	54	(4.8%)	(96.4%)
40 - 44	31	(2.7%)	30	(2.7%)	(96.8%)
45 - 60	13	(1.1%)	12	(1.1%)	(92.3%)
out of range ²	1	(0.1%)	1	(0.1%)	(100.0%)
IFS Sites					
Age	Enrolled		Participants ¹		Participation Rate
	N = 912	(100.0%)	N = 864	(100.0%)	(94.7%)
Less than 18	38	(4.2%)	35	(4.1%)	(92.1%)
18 - 19	121	(13.3%)	112	(13.0%)	(92.6%)
20 - 24	436	(47.8%)	413	(47.8%)	(94.7%)
25 - 29	161	(17.7%)	153	(17.7%)	(95.0%)
30 - 34	74	(8.1%)	72	(8.3%)	(97.3%)
35 - 39	47	(5.2%)	46	(5.3%)	(97.9%)
40 - 44	21	(2.3%)	21	(2.4%)	(100.0%)
45 - 60	14	(1.5%)	12	(1.4%)	(85.7%)
out of range ²	0	(0.0%)	0	(0.0%)	(0.0%)

¹Participants received medical covered family planning services.

²Age out of range (< 8 or > 60).

Participation rates for men

Table 22 compares male clients' utilization of covered medical family planning services by program and between research and non-research sites. The analysis revealed very similar patterns of utilization of covered medical family planning services by men and by women.

- Like female clients, men at research sites had a significantly higher participation rate than those at non-research sites. About 96% of all men at research sites received one or more covered medical family planning service. More than 85% of men at non-research sites received such services. This was true across all age groups.
- Men between the ages of 20 and 24 accounted for 38 – 48% of all male participants at both research and non-research sites.
- As shown for women clients, the participation rate for men was very high at both IFS and control sites. While participation rates for women between the two types of research sites were similar, the participation rate for men at control sites (97.0%) was significantly higher than for those at IFS sites (94.7%; $P = 0.01$, chi-square test).

Participation rates for men and women in Program G

Table 23 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 non-research sites, the participation rate for women (94.4%) was much higher than for men (85.5%). At IFS sites, the participation rate was slightly higher for women (98.1%) than for men (94.7%). Lesser differences were found in participation rates between women (98.3%) and men (97.0%) at control sites ($P = 0.001$, chi-square test).
- Compared with clients in other age categories, clients between the ages of 20 and 24 accounted for the largest proportion of participants (30.8 – 47.8%). 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 (95.1%) was much higher than that for men of the same ages (85.6%) across all sites. The proportion of women less than 20 years old who were participants was lower at the non-research sites (94.7%) compared to the research sites (98.0% at control sites and 97.8% at IFS sites). For clients 20 years or older, participation rates tended to decrease with increasing client age (non-research: $P < 0.0001$, control $P = 0.006$, IFS: $P < 0.0001$, Cochran-Armitage trend test).

Table 23. Participation 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
Less than 18	N = 15,794	N = 13,511 (100.0%)	(85.5%)	N = 155,756	N = 147,001 (100.0%)	(94.4%)
18 - 19	1,208	996 (7.4%)	(82.5%)	36,743	34,597 (23.5%)	(94.2%)
20 - 24	2,586	2,216 (16.4%)	(85.7%)	34,765	33,136 (22.5%)	(95.3%)
25 - 29	6,014	5,202 (38.1%)	(86.5%)	47,600	45,330 (30.8%)	(95.2%)
30 - 34	2,867	2,493 (18.2%)	(87.0%)	18,124	17,012 (11.6%)	(93.9%)
35 - 39	1,476	1,240 (9.3%)	(84.0%)	9,216	8,527 (5.8%)	(92.5%)
40 - 44	777	644 (4.9%)	(82.9%)	5,132	4,686 (3.2%)	(91.3%)
45 - 60	494	413 (3.1%)	(83.6%)	2,822	2,539 (1.7%)	(90.0%)
out of range ²	367	304 (2.3%)	(82.8%)	1,346	1,169 (0.8%)	(86.8%)
	5	3 (0.0%)	(60.0%)	8	5 (0.0%)	(62.5%)
Control Sites						
Age	Males			Females		
	Enrolled	Participants ¹	Participation Rate	Enrolled	Participants ¹	Participation Rate
Less than 18	N = 1,155	N = 1,120 (100.0%)	(97.0%)	N = 15,655	N = 15,388 (100.0%)	(98.3%)
18 - 19	47	45 (4.1%)	(95.7%)	2,025	1,973 (12.8%)	(97.4%)
20 - 24	151	149 (13.1%)	(98.7%)	3,115	3,064 (19.9%)	(98.4%)
25 - 29	468	452 (40.4%)	(96.6%)	5,893	5,813 (37.8%)	(98.6%)
30 - 34	278	269 (24.1%)	(96.8%)	2,689	2,650 (17.2%)	(98.5%)
35 - 39	110	108 (9.5%)	(98.2%)	1,132	1,113 (7.2%)	(98.3%)
40 - 44	56	54 (4.8%)	(96.4%)	459	443 (2.9%)	(96.5%)
45 - 60	31	30 (2.7%)	(96.8%)	243	235 (1.5%)	(96.7%)
out of range ²	13	12 (1.1%)	(92.3%)	99	97 (0.6%)	(98.0%)
	1	1 (0.1%)	(100.0%)	0	0 (0.0%)	(0.0%)
IFS Sites						
Age	Males			Females		
	Enrolled	Participants ¹	Participation Rate	Enrolled	Participants ¹	Participation Rate
Less than 18	N = 912	N = 864 (100.0%)	(94.7%)	N = 11,255	N = 11,045 (100.0%)	(98.1%)
18 - 19	38	35 (4.2%)	(92.1%)	1,360	1,311 (11.9%)	(96.4%)
20 - 24	121	112 (13.3%)	(92.6%)	2,244	2,212 (20.0%)	(98.6%)
25 - 29	436	413 (47.8%)	(94.7%)	4,437	4,387 (39.7%)	(98.9%)
30 - 34	161	153 (17.7%)	(95.0%)	1,769	1,731 (15.7%)	(97.9%)
35 - 39	74	72 (8.1%)	(97.3%)	814	797 (7.2%)	(97.9%)
40 - 44	47	46 (5.2%)	(97.9%)	355	347 (3.1%)	(97.7%)
45 - 60	21	21 (2.3%)	(100.0%)	176	162 (1.5%)	(92.0%)
out of range ²	14	12 (1.4%)	(85.7%)	100	98 (0.9%)	(98.0%)
	0	0 (0.0%)	(0.0%)	0	0 (0.0%)	(0.0%)

¹Participants received medical covered family planning services.

²Age 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, Years 1-4

Family Planning Method or Service ¹	Program G				Program S				Program G and S					
	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 Office Visit	250,731	(28.4%)	22,017	(28.7%)	16,742	(30.5%)	29,112	(27.8%)	410	(30.5%)	431	(31.2%)	319,443	(28.4%)
Oral Contraceptives	171,850	(19.4%)	14,914	(19.5%)	11,818	(21.5%)	30,795	(29.4%)	237	(17.6%)	239	(17.3%)	229,853	(20.5%)
Education, Counseling, and Risk Reduction	190,798	(21.6%)	19,191	(25.1%)	14,748	(26.8%)	4,099	(3.9%)	281	(20.9%)	306	(22.1%)	229,423	(20.4%)
Emergency Contraception Pills	60,858	(6.9%)	6,062	(7.9%)	3,000	(5.5%)	4,252	(4.1%)	96	(7.1%)	64	(4.6%)	74,332	(6.6%)
Condoms	54,764	(6.2%)	4,377	(5.7%)	1,304	(2.4%)	6,391	(6.1%)	48	(3.6%)	25	(1.8%)	66,909	(6.0%)
Hormone Injection ²	47,971	(5.4%)	2,680	(3.5%)	2,719	(4.9%)	10,773	(10.3%)	103	(7.7%)	138	(10.0%)	64,384	(5.7%)
Unlisted drug ³	41,755	(4.7%)	3,329	(4.3%)	1,986	(3.6%)	2,955	(2.8%)	68	(5.1%)	64	(4.6%)	50,157	(4.5%)
Other contraceptives ⁴	31,702	(3.6%)	1,723	(2.2%)	689	(1.3%)	2,494	(2.4%)	40	(3.0%)	13	(0.9%)	36,661	(3.3%)
Transdermal Patch	14,396	(1.6%)	903	(1.2%)	747	(1.4%)	7,230	(6.9%)	27	(2.0%)	44	(3.2%)	23,347	(2.1%)
Vaginal Ring	14,208	(1.6%)	947	(1.2%)	848	(1.5%)	1,834	(1.8%)	19	(1.4%)	36	(2.6%)	17,892	(1.6%)
Intrauterine Device	2,940	(0.3%)	228	(0.3%)	194	(0.4%)	3,257	(3.1%)	15	(1.1%)	18	(1.3%)	6,652	(0.6%)
Bilateral Tubal Ligation	1,333	(0.2%)	56	(0.1%)	55	(0.1%)	1,107	(1.1%)	0	(0.0%)	4	(0.3%)	2,555	(0.2%)
Diaphragm and Cervical Cap	923	(0.1%)	147	(0.2%)	104	(0.2%)	350	(0.3%)	0	(0.0%)	0	(0.0%)	1,524	(0.1%)
Implantable System ⁵	128	(0.0%)	31	(0.0%)	18	(0.0%)	24	(0.0%)	1	(0.1%)	0	(0.0%)	202	(0.0%)
Natural Family Planning	3	(0.0%)	0	(0.0%)	0	(0.0%)	0	(0.0%)	0	(0.0%)	0	(0.0%)	3	(0.0%)
Total Events	884,360	(100.0%)	76,605	(100.0%)	54,972	(100.0%)	104,673	(100.0%)	1,345	(100.0%)	1,382	(100.0%)	1,123,337	(100.0%)

¹Clients 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.

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

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

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

⁵Norplant®, 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 four 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 1,123,337 total encounters, family planning office visits (28.4%), oral contraceptives (20.5%), and Education, Counseling, and Risk Reduction (ECRR) (20.4%) in combination accounted for more than two-thirds of all encounters.
- The number of overall encounters for emergency contraception pills is underreported. Variability in annual data (not shown) demonstrates EC identification problems. In years one and two, EC accounted for 6.6% and 7.8% of total encounters. In year three, the EC billing code changed to J3490, making it difficult to distinguish EC from other unlisted drugs. Consequently, the proportion of EC dropped to 0.6% of total encounters. Code revisions in year four improved EC identification, and EC provision increased to 11.4% of total encounters.

Distribution by program and by site

The distribution of family planning encounters by program and site generally follows the same patterns as the statewide distribution. For Program G and Program S clients at research sites (IFS and control), the three most frequently provided services were family planning office 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 (29.4%), followed by family planning office visits (27.8%). Hormone injection ranked third (10.3%). ECRR accounted for only 3.9% of all encounters. The low frequency of ECRR for this group is not surprising because Program S clients may receive family planning services from any Medicaid-approved provider, not only TAKE CHARGE providers.

- Family planning office 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 3.9% at the non-research sites. For Program G clients at the research sites, ECRR accounted for about 26% 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 10.3% of encounters for Program S clients, compared to 5.4% for Program G. The transdermal patch accounted for 6.9% of encounters for Program S clients, compared to 1.6% for Program G. IUDs accounted for 3.1% 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 181,714 encounters in year one, to 262,896 in year two, 321,025 in year 3, and 357,702 in year 4. This is consistent with the increased number of women enrolled in the program each year.

Table 25. Methods and Services Distributed to Men Participating in Program G, Years 1-4

Family Planning Method or Service ¹	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 Office Visit	13,198	(41.6%)	1,080	(43.7%)	816	(45.2%)	15,094	(41.9%)
Education, Counseling, and Risk Reduction	12,641	(39.9%)	1,109	(44.8%)	796	(44.1%)	14,546	(40.4%)
Condoms	2,907	(9.2%)	173	(7.0%)	104	(5.8%)	3,184	(8.8%)
Other contraceptives ²	1,395	(4.4%)	67	(2.7%)	34	(1.9%)	1,496	(4.2%)
Vasectomy	1,570	(5.0%)	45	(1.8%)	55	(3.0%)	1,670	(4.6%)
Total Events	31,711	(100.0%)	2,474	(100.0%)	1,805	(100.0%)	35,990	(100.0%)

¹Clients may receive more than one method or service.

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

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 office visits; ECRR; condoms; vasectomy; and other contraceptives, such as spermicidal gel, jelly, and cream. Table 25 shows the distribution of birth control methods and family planning services provided to male clients.

- A total of 35,990 contraceptive encounters were provided to male clients. Family planning office visits and ECRR accounted for 82.3% 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 office 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 44.5% of encounters for men, compared to 39.9% 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=2,474) than at IFS sites (N=1,805). This is consistent with the larger number of males enrolled at control sites (N=1,155) compared to IFS sites (N=912).
- 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 until year three—from 6,404 in year one to 8,606 in year two, and to 10,543 in year three—then decreased slightly to 10,437 in year four.

Table 26. Family Planning Methods and Services Received by Male Participants, Years 1-4

Family Planning Method or Service ¹	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 Office Visit	12,071	(88.6%)	962	(89.9%)	733	(90.7%)	13,766	(88.8%)
Education, Counseling, and Risk Reduction	12,031	(88.4%)	986	(92.2%)	722	(89.4%)	13,739	(88.7%)
Condoms	2,710	(19.9%)	163	(15.2%)	94	(11.6%)	2,967	(19.1%)
Vasectomy	1,514	(11.1%)	44	(4.1%)	56	(6.9%)	1,614	(10.4%)
Other Contraceptives ²	1,339	(9.8%)	62	(5.8%)	29	(3.6%)	1,430	(9.2%)
Total number of clients who received at least one family planning method or service ³	13,617		1,070		808		15,495	

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

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

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

Men receiving family planning services in the first four years

Table 26 presents the number and proportion of male clients who received family planning services. The number of clients presented in the table is not unduplicated by method or service. For example, if a client received two types of services, one family planning office visit and one ECRR, he is counted twice, once for each service.

- Of the total 15,495 male participants with family planning services during the first four years, 88.8% received family planning office visits, and 88.7% received ECRR. More than 10% had a vasectomy.

- The proportion of men at research sites who received family planning office visits (90.3%) was slightly higher than at non-research sites (88.6%). Similarly, the proportion of men at research sites who received ECRR (90.9%) was higher than at non-research sites (88.4%). However, at the non-research sites, the proportion of men who had a vasectomy (11.1%) was two times that at the research sites (5.3%).
- Comparing IFS and control sites, the proportions of men receiving ECRR, condoms, and other contraception were significantly higher at the control sites ($P = 0.04$, $P = 0.02$, and $P = 0.03$ respectively, chi-square test). However, the proportion of men receiving vasectomies was significantly greater at the IFS sites ($P = 0.007$, chi-square test).

Men receiving family planning services by year (data not shown)

- Statewide, the number of male participants grew steadily from 3,248 in year one to 5,027 in year three, and then slightly decreased to 4,787 in year four.
- The greatest changes across years 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 14.1% in year two, to 22.2% in year three, and 29.4% in year four. Although, the proportion of men receiving other contraceptives declined sharply in year three (4.7%), compared to year one (10.2%) and year two (11.2%), it increased about two-fold to 9.5% in year four.

Women receiving family planning services during the first four years

Of the 215,893 total female participants with family planning services during the first four years, 88.7% received family planning office visits, 72.9% percent received ECRR, and 64.5% received oral contraceptives. Emergency contraception was provided to 30.3%.

- 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 office visits and ECRR (95.7% and 85.4%, respectively) were much greater than those for Program S women (55.8% and 13.6%, respectively). The proportions receiving oral contraceptives and hormone injections were similar: 66.5% of female Program G participants at non-research sites received oral contraceptives, compared to 55.5% of Program S participants; and 19.2% of Program G participants received hormone injections, compared to 19.0% 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: 14.3% of Program S participants received the transdermal patch, and 6.6% received an IUD, compared to 7.8% and 1.6% 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, oral contraception, EC,

Table 27. Family Planning Methods and Services Received by Female TAKE CHARGE Participants, Demonstration Years 1-4

Family Planning Method or Service ¹	Program G				Program S				Program G and S			
	Non-Research Sites No. of Clients	% of Clients	Control Sites No. of Clients	IFS Sites No. of Clients	Non-Research Sites No. of Clients	% of Clients	Control Sites No. of Clients	IFS Sites No. of Clients	No. of Clients	% of Clients		
Family Planning Office Visit	150,077	95.7%	11,389	97.2%	21,565	55.8%	162	97.6%	179	97.6%	191,467	88.7%
Education, Counseling, and Risk Reduction	133,984	85.4%	10,478	89.4%	5,260	13.6%	114	68.7%	137	72.1%	157,476	72.9%
Oral Contraceptives	104,336	66.5%	7,569	64.6%	21,463	55.5%	98	59.0%	109	57.4%	139,354	64.5%
Emergency Contraception Pills	54,142	34.5%	4,612	39.4%	4,226	10.9%	48	28.9%	52	27.4%	65,348	30.3%
Condoms	45,155	28.8%	3,090	26.4%	5,196	13.4%	31	18.7%	19	10.0%	54,550	25.3%
Unclassified drug code ²	38,486	24.5%	2,243	19.1%	2,636	6.8%	33	19.9%	42	22.1%	45,058	20.9%
Hormone Injection³	30,088	19.2%	1,331	11.4%	7,332	19.0%	41	24.7%	56	29.5%	40,077	18.6%
Other Contraceptives ⁴	27,785	17.7%	1,137	9.7%	2,496	6.5%	19	11.4%	9	4.7%	31,994	14.8%
Transdermal Patch	12,168	7.8%	667	5.7%	5,524	14.3%	17	10.2%	32	16.8%	18,931	8.8%
Vaginal Ring	11,041	7.0%	678	5.8%	1,458	3.8%	8	4.8%	22	11.6%	13,780	6.4%
IUD	2,489	1.6%	180	1.5%	2,533	6.6%	9	5.4%	11	5.8%	5,347	2.5%
Bilateral Tubal Ligation	1,272	0.8%	47	0.4%	1,079	2.8%	0	0.0%	4	2.1%	2,448	1.1%
Diaphragm/Cervical Cap	920	0.6%	123	1.0%	352	0.9%	0	0.0%	1	0.5%	1,473	0.7%
Implantable System⁵	7	0.0%	0	0.0%	16	0.0%	1	0.6%	0	0.0%	28	0.0%
Natural Family Planning	3	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	3	0.0%
Total number of clients who received at least one family planning method or service ⁶	156,824		11,715		38,664		166		190		215,893	

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

²Healthcare Common Procedure Coding System (HCPCS) unlisted drug code J3490.

³Includes Lunelle™, a once a month injectable, which was removed from the market in October 2002

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

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

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

and condoms (89.7%, 66.6%, 34.3%, and 20.7% respectively) were significantly greater ($P \leq 0.05$, Chi-square and Fisher's exact test) at research sites compared to Program S clients (70.5% with ECRR, 58.1% with oral contraceptives, 28.1% with EC, and 14.0% with condoms). On the other hand, at research sites, the proportion of women who had hormone injections, transdermal patch, and IUD was significantly greater for Program S (27.2%, 13.8%, and 5.6%) compared to Program G (12.8%, 5.9%, and 1.5%).

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).⁸ In year one, this method was practically nonexistent. Only 47 of the 67,953 female participants in that year received a transdermal patch. In year two, nearly 8% of women (N=7,303) received a patch. In year three, the proportion of women receiving transdermal patches (5.4%) declined slightly. In year four, 8.9% of women received the patch.

Coding problems for Emergency Contraception (EC) resulted in variability in the identified rates of providing EC. The proportion of women receiving EC decreased from 22.4% in year two to 1.7% in year three because the billing code changed to J3490 and with that code, EC cannot be distinguished from other unlisted drugs. In year four, a procedure modifier for EC was added to the J3490 billing code and a billing code for EC counseling was also added. These coding modifications increased identification of EC methods. As a result, the proportion of women receiving EC in year four increased to 35.2%.

⁸A 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.

Summary

Overall, the service delivery patterns were very similar at research sites and non-research sites. Less than 1% 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.

A substantially smaller proportion of Program S women were identified as receiving family planning services (approx. 47.9% of Program S women were identified as participants, compared to 94.9% of Program G women). Among participants at non-research sites, hormone injection was the only method without a significantly different distribution between Program G and Program S women: 19.2% of Program G participants at non-research sites received hormone injections, compared to 19.0% of Program S participants ($P = 0.32$, chi-square test). For some very effective methods (transdermal patch, IUD, and bilateral tubal ligation), 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.

Table 28. Self-efficacy: Response Frequencies from 1479 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?	<i>pre</i> 80.0%	16.7%	3.3%
		<i>post</i> 85.2%*	11.8%*	3.0%
2.	Do you feel your partner supports your goals for having (or not having) children?	<i>pre</i> 87.3%	2.6%	10.2%
		<i>post</i> 85.6%	2.7%	11.7%
3.	Do you have a supportive group of family and friends?	<i>pre</i> 97.3%	1.9%	0.8%
		<i>post</i> 95.9%*	2.7%	1.4%
4.	Do you have friends or family members who you can talk to about birth control?	<i>pre</i> 95.2%	3.9%	0.9%
		<i>post</i> 93.2%*	4.7%	2.2%*
5.	Are you confident that your provider and her/his staff will protect your privacy?	<i>pre</i> 97.3%	1.2%	1.5%
		<i>post</i> 96.5%	2.5%*	1.0%
6.	Do you expect a change in your marital status over the next two years?	<i>pre</i> 22.5%	65.2%	12.3%
		<i>post</i> 26.6%*	64.8%	8.6%*
7.	If yes, do you think this change will be for the better?	<i>pre</i> 96.8%	0.6%	2.6%
		<i>post</i> 96.3%	1.0%	2.7%
8.	Do you think your living situation (housing, number of roommates) will change over the next two years?	<i>pre</i> 69.7%	26.5%	3.8%
		<i>post</i> 68.8%	28.4%	2.8%
9.	If yes, do you think this change will be for the better?	<i>pre</i> 84.3%	2.1%	13.7%
		<i>post</i> 88.8%*	1.8%	9.3%*
10.	Is it difficult for you to arrange transportation to this clinic?	<i>pre</i> 3.5%	96.1%	0.4%
		<i>post</i> 6.4%*	91.0%*	2.6%*
11.	Do you usually bring a list of questions when you see your health care provider?	<i>pre</i> 31.4%	67.4%	1.2%
		<i>post</i> 37.7%*	61.2%*	1.2%

*Significant change in pre- and post-response frequency based on 95% Confidence Limits for percent.

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 one's abilities to perform a specific task and one's 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 addressed the client's use of birth control and perceived abilities to control the family size; clinical self-efficacy which addressed 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 was 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 (n=1479) cover program year one through year four. Several significant changes between the baseline and the follow-up responses were found. Because the pre-post differences were fairly small in magnitude, comparisons between the control sites and IFS sites are not presented.

Contraceptive Self-Efficacy

Survey questions related to client contraceptive self-efficacy addressed 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 (85.2%) reported the use of birth control the last time they had sex than at program entry (80.0%).
- The vast majority of clients at the research sites were confident that they could control the number of children they would 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, 92.2% reported being mostly or totally confident that they could control the number of children they would have. At follow-up, that proportion increased to 94.1%.

These findings suggest that contraceptive self-efficacy has increased slightly.

Table 29. Self-efficacy: Response Frequencies from 1479 Client Surveys at Research Sites

D. How <i>confident</i> 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.	<i>pre</i>	91.0%	6.4%	2.6%
	<i>post</i>	89.8%	8.2%*	2.0%
2. Talk openly with your provider about any problems related to your choice of birth control.	<i>pre</i>	95.5%	2.5%	2.0%
	<i>post</i>	94.1%	4.5%*	1.4%
3. Identify and resolve any problems you may have with your provider.	<i>pre</i>	89.1%	8.5%	2.5%
	<i>post</i>	80.4%	16.1%*	3.5%
4. Trust the skills and competence of your provider.	<i>pre</i>	93.3%	4.5%	2.2%
	<i>post</i>	90.5%*	8.0%*	1.5%
5. Use your birth control correctly.	<i>pre</i>	94.7%	4.0%	1.3%
	<i>post</i>	94.4%	4.4%	1.2%
6. Talk about birth control use with your partner/spouse.	<i>pre</i>	94.2%	3.8%	2.0%
	<i>post</i>	94.5%	3.4%	2.2%
7. Access your provider to get more family planning services if needed.	<i>pre</i>	94.0%	4.6%	1.4%
	<i>post</i>	88.5%*	8.0%*	3.4%*
8. Control the number of children you will have in the future, including not having any (or any more) children.	<i>pre</i>	92.2%	6.1%	1.7%
	<i>post</i>	94.1%*	4.5%	1.4%
9. Reach your educational and employment goals in the future.	<i>pre</i>	88.5%	9.3%	2.2%
	<i>post</i>	85.1%*	12.0%*	2.9%
10. Remain non-pregnant, if that is your goal.	<i>pre</i>	94.5%	3.9%	1.6%
	<i>post</i>	94.7%	3.9%	1.5%
11. Ask your provider uncomfortable questions without being judged by him or her.	<i>pre</i>	89.3%	7.8%	2.8%
	<i>post</i>	85.8%*	10.4%*	3.8%

*Significant change in pre- and post-response frequency based on 95% Confidence Limits for percent.

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 (37.7% at follow-up versus 31.4% 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 89.1% at baseline to 80.4%. The same patterns were observed for clients' confidence level in accessing their providers to get more family planning services if needed, in asking the provider uncomfortable questions without being judged, and trusting the skills and competence of their provider. At follow-up, a smaller proportion of clients (88.5%, 85.8%, and 90.5% respectively) reported being mostly or totally confident than at enrollment (94.0%, 89.3%, and 93.3%).

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 (88.8 % at follow-up versus 84.3% 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, although this difference was not significant.

Summary: While questions about contraceptive self-efficacy indicated slight 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 slight increases.

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 five years of enrollment demonstrated great demand for family planning services among the TAKE CHARGE target population. The program enrolled more than 335,000 individual 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 steadily in the first four years from 98,973 in year one to 145,166 in year two, 164,327 in year three, and 177,260 in year four, until settling at 173,057 in year five. Similar patterns were seen for both men and women. More than two-thirds of the clients were between 18 and 29 years old. This age group accounted for 74 percent of all Medicaid-paid births in 2004.

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 190,000 newly enrolled clients in its first four 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 service increased from 58,024 in year one to 82,006 in year two, 98,773 in year three, and 105,213 in year four. Additionally, about 80% of all enrollees received covered medical family planning services (i.e., met CMS's definition of participant).

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, more likely to be unmarried, and have 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 comparable between the two programs at the research sites (98.6% for Program G; 96.3% for Program S). At non-research sites, the proportion receiving any Medicaid-paid services for Program S clients (56.0%) was much lower than that of clients in Program G (94.7%). This pattern held true for participation rates as well. These findings suggest that program services between IFS and control sites may not be as different as originally anticipated, therefore reducing our ability to detect differences in outcome measures between IFS and control sites.

TAKE CHARGE implemented client-centered practices to enhance client contraceptive self-efficacy to achieve more successful use of family planning methods and to decrease unintended pregnancies. During the first five years of demonstration, TAKE CHARGE achieved remarkable progress in reducing unintended pregnancies. An estimated 22 percent of 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 four years of demonstration, a wide range and large volume of family planning services were provided to female clients, from family planning office visits to ECRR, and from oral contraceptives to transdermal patches. The number of family planning services provided increased each year as well. In the first four years, female clients received 1.1 million encounters. Family planning office visits accounted for nearly 30% of all family planning services, and ECRR accounted for 20%. ECRR provided counseling and education to strengthen clients' decision-making skills and support the successful use of their chosen contraceptive methods.

Newly enrolled women were more likely to receive family planning services such as ECRR and family planning office 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 family planning office visits, ECRR, vasectomy, condoms, and other contraceptives. For the first three years of demonstration, the number of men receiving these services increased steadily—from 3,248 in year one to 5,027 in year three. In year four, this number decreased slightly to 4,787. Like female clients, a large majority of men had family planning office visits and ECRR. Over 10% had a 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 remarkable 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 continued to increase steadily until 2005. After reaching a plateau in 2005, enrollment decreased slightly in 2006. With such a large demand for program services, the Health and Recovery Services 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, potentially, 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, although 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 during the three-year renewal period.

While the impact of Intensive Follow-up Services (IFS) has been impressive, the cost to provide these services has also been high, and IFS services as a distinct service will not be continued in the renewal period. At IFS sites, the proportion of clients using a more effective method at one-year follow-up compared to baseline increased by 46%, nearly twice the increase observed at control sites (26%). This suggests that greater emphasis on client-centered practice and individualized follow-up are worthwhile strategies to incorporate into family planning programs like TAKE CHARGE. Future program activities in Washington will include more focused provider training based on best practices identified during the first five years by:

- Training providers to recognize high-risk clients who need intensive ECRR services to assist them in the successful use of their family planning method;

- Including staff from IFS sites as presenters at provider trainings to highlight best practices; and
- Incorporating information about best practices into regular trainings for community-based TAKE CHARGE providers.

These strategies parallel current thinking that meaningfully reducing unintended pregnancy is a goal that will not be achieved merely by increasing the availability of contraceptives (Gold, 2006). The success of IFS in increasing the proportion of clients using a more effective family planning method emphasizes the importance of client-centered practice and individualized follow-up. Incorporating best practices in these areas will hopefully address the needs of clients who have access to family planning services yet nevertheless have difficulties in using contraceptives properly and consistently (Gold, 2006).

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APPENDICES



APPENDIX A

TAKE CHARGE Client Survey

Your comments on this program are important to us, please help us by answering the following questions.

A. Which of the following statements best describes what you want to happen during the next 12 months (check one).

- I *want* to get pregnant during the next 12 months.
- I kind of want to get pregnant and I kind of don't want to get pregnant.
- I don't care one way or the other if I get pregnant.
- I do not want to get pregnant.
- I *really do not* want to get pregnant during the next 12 months.

B. During the last 2 months, what kinds of birth control did you or your partner(s) use when you had sex? (Check all that apply):

- No sex last 2 months (abstinent)
- ECPs (Emergency Contraception Pills)
- Ring—NuvaRing[®]
- We did not use any method
- Foam, jelly, cream
- Shot—Depo Provera[®] or Lunelle[®]
- Birth control pills
- IUD (intrauterine device)
- Sterilization, female (tubes tied)
- Condoms, female
- Norplant[®] implant
- Sterilization, male (vasectomy)
- Condoms, male
- Patch—Ortho Evra[®]
- Withdrawal
- Diaphragm, cervical cap
- Rhythm (natural family planning)

C. Answer the following questions either Yes, No, or Not Applicable (N/A).

1. Did you use birth control the last time you had sex? Yes No N/A
2. Do you feel your partner supports your goals for having (or not having) children? Yes No N/A
3. Do you have a supportive group of family and friends? Yes No N/A
4. Do you have friends or family members who you can talk to about birth control? Yes No N/A
5. Are you confident that your provider and her/his staff will protect your privacy? Yes No N/A
6. Do you expect a change in your marital status over the next two years? Yes No N/A
Do you think this change will be for the better? Yes No N/A
7. Do you think your living situation (housing, number of roommates) will change over the next two years? Yes No N/A
Do you think this change will be for the better? Yes No N/A
8. Is it difficult for you to arrange transportation to this clinic? Yes No N/A
9. Do you usually bring a list of questions when you see your health care provider? Yes No N/A

D. We would like to know **how confident** (or sure) you are about certain activities and behaviors.

For each of the following questions, please circle the number that corresponds to your confidence that you can do these things at the present time.

- 1 = Not at all Confident
- 2 = A Little Confident
- 3 = Somewhat Confident
- 4 = Mostly Confident
- 5 = Totally Confident

How **confident** are you that you can:

- | | | | | | | |
|-----|--|---|---|---|---|---|
| 1. | Ask your provider about things (now or in the future) that worry you. | 1 | 2 | 3 | 4 | 5 |
| 2. | Talk openly with your provider about any problems related to your choice of birth control. | 1 | 2 | 3 | 4 | 5 |
| 3. | Identify and resolve any problems you may have with your provider. | 1 | 2 | 3 | 4 | 5 |
| 4. | Trust the skills and competence of your provider. | 1 | 2 | 3 | 4 | 5 |
| 5. | Use your birth control correctly. | 1 | 2 | 3 | 4 | 5 |
| 6. | Talk about birth control use with your partner/spouse. | 1 | 2 | 3 | 4 | 5 |
| 7. | Access your provider to get more family planning services if needed. | 1 | 2 | 3 | 4 | 5 |
| 8. | Control the number of children you will have in the future, including not having any (or any more) children. | 1 | 2 | 3 | 4 | 5 |
| 9. | Reach your educational and employment goals in the future. | 1 | 2 | 3 | 4 | 5 |
| 10. | Remain non-pregnant, if that is your goal. | 1 | 2 | 3 | 4 | 5 |
| 11. | Ask your provider uncomfortable questions without being judged by him or her. | 1 | 2 | 3 | 4 | 5 |

Thank you for completing this survey, your comments are important to us. Now that the survey is done, put it in the attached envelope. Seal the envelope and drop it in the survey box.

APPENDIX B

TAKE CHARGE Services

(In effect until January 2006)

[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).
- ECRR documentation is necessary to receive payment. You must keep the following documentation in the client's chart:
 - 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**

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

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 C

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
0395M	FAMILY PLANNING ANNUAL SERVICES PACKAGE
0396M	PROGESTASERT IUD INCLUDING INSERTION
0397M	PARAGARD INTRAUTERINE DEVICE INCLUDING INSERTION
0398M	CERVICAL CAP INCLUDING INSERTION
1197M	REMOVAL AND REIMPLANT OF NORPLANT
1799M	REMOVAL AND REIMPLANTATION OF NORPLANT
5911M	ANESTHESIA FOR VASECTOMIES
5912M	ANESTHESIA FOR STERILIZATIONS (TUBAL)
9910M	NORPLANT PACKAGE
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

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

Procedure Code	Description
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
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	NATURAL FAMILY PLANNING COUSELING
99701	NATURAL FAMILY PLANNING BOOKLET
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)

Procedure Code	Description
A4931	ORAL THERMOMETER
J1055	MEDROXYPROGESTERONE ACETATE INJECTION, 150 MG (DEPO PROVERA)
J1056 (old value: 1111J)	MA/EC INJECTION (LUNELLE)
J2675	PROGESTERONE INJECTION
1112J	EMERGENCY CONTRACEPTION PILLS
1113J	ORTHO-EVRA CONTRACEPTIVE PATCH
J3490	UNCLASSIFIED DRUGS
J3490 and 'FP'	EMERGENCY CONTRACEPTION PILLS, must include proc. modifier 'FP'
J7300	COPPER IUD (PARAGARD)
J7302 (old value: 9913M)	MIRENA IUD (LEVONORGESTREL-RELEASING)
J7303 (old value: 1114J)	NUVARING CONTRACEPTIVE RING
J7304	CONTRACEPTIVE SUPPLY, HORMONE CONTAINING PATCH, EACH
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, must include procedure modifier 'FP'
T5999	CYCLE BEADS, must include procedure modifier 'FP'
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

Procedure Code	Description
66.29	OTHER BILATERAL ENDOSCOPIC DESTRUCTION OR OCCLUSION OF FALLOPIAN TUBES
66.30	OTHER BILATERAL DESTRUCTION OR OCCLUSION OF FALLOPIAN TUBES
66.31	OTHER BILATERAL LIGATION AND CRUSHING 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)
66.50	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
V25.03	EMERGENCY CONTRACEPTION COUNSELING
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)

Drug Class	Description
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

APPENDIX D

Distribution of Methods and Effectiveness Across Studies

In Table D1, the distribution of methods is presented for actual data from waiver clients in Washington State and the estimated population from the National Survey of Family Growth (NSFG) used in the Frost, Sonfield, and Gold (2006) study (Table A9, p 55).

Table D1. Comparison of Individual Methods and Effectiveness Across Studies

Birth Control Method	Before Enrollment		After Enrollment	
	WA State Demonstration Findings*	AGI Estimate†	WA State Demonstration Findings*	AGI Estimate†
More Effective Total	52.9%	46.8%	72.9%	68.7%
Birth control pills	41.3%	25.9%	52.5%	39.2%
Hormonal injection	7.4%	13.7%	8.4%	23.5%
Transdermal patch	1.7%		5.1%	
NuvaRing®	0.8%		3.9%	
IUD	0.8%	5.4%	2.2%	5.5%
Male sterilization	0.5%		0.8%	
Implantable system	0.4%	1.8%	0.1%	0.5%
Less Effective Total	32.4%	31.8%	12.8%	30.5%
Male condom	28.5%	21.5%	9.3%	17.3%
Withdrawal	2.0%	7.1%	1.0%	5.7%
Diaphragm/cap	0.2%	0.3%	0.3%	0.1%
Spermicide	0.1%	0.1%	1.1%	6.8%
Periodic abstinence	0.6%	2.8%	0.6%	0.6%
Female Condom	0.9%		0.4%	
Emergency Contraception	0.0%			
Abstinence Total	12.1%	0.0%	12.4%	0.0%
No sex	12.1%		12.4%	
No method Total	2.6%	21.5%	1.9%	0.0%

*Statewide sample weights for survey respondents applied to WA State data.

†AGI estimate derived from AGI Occasional Report No. 26 table A9 (Frost, Sonfield, and Gold, 2006).

Comparison of individual methods across studies has numerous limitations including changing availability of methods over time, potential geographical differences in the distribution of methods, and the structure of survey questions. The summary data (more versus less effective methods) more readily explain the differences. The estimation of averted pregnancies according to Frost, Sonfield, and Gold is based largely on reducing the proportion of women reporting “no method” (from 21.5% before to 0.0% after) and assuming those women became users of “more effective” methods (increased from 46.8% before to 68.7% after). In the Frost, Sonfield, and Gold model, the proportion of women using “less effective” methods decreased very slightly, from 31.8% before to 30.5% after.

In Washington State, the actual experience has been quite different. Only a small proportion of women reported “no method” prior to enrollment in the waiver, and a similar small proportion continued to report “no method” after one year’s enrollment. The proportion of women in Washington’s waiver program who reported using “more effective” methods was, in fact, slightly higher (72.9%) than that estimated by Frost, Sonfield, and Gold (68.7%). The users of more effective methods were not, however, recruited from the non-users, but instead from the users of “less effective” methods. This difference, whether at baseline (prior to waiver enrollment) women were using no method or a less effective method, is critical to the estimate of unintended pregnancies averted. Although less effective methods are by definition less effective, they have some effectiveness compared to no method.

It is very tempting to assume that women who were using no family planning method prior to a waiver will enroll once the waiver is implemented. This is likely if the reason for the woman’s non-use of a family planning method is absence of health insurance or lack of financial access to family planning services. However, other factors, including personal preference, ambivalence about pregnancy, and lack of perceived risk of pregnancy, may account for non-use of family planning. In such cases the assumption that a woman who previously used no family planning method will enroll in a family planning waiver program may be overly optimistic and unwarranted.

