

OREGON FPEP  
EVALUATION DESIGN REPORT  
March 15, 1999  
**(With Amendments Dated September 1999)**

TABLE OF CONTENTS

|  |    |
|--|----|
| Introduction . . . . .   | 1  |
| Background of Oregon & FPEP . . . . .  | 2  |
| Background of Evaluation . . . . .   | 3  |
| Hypotheses . . . . .   | 4  |
| Data Sources . . . . .   | 6  |
| Methodology for Testing Hypotheses . . . . .   | 8  |
| Appendices:  |    |
| A. Detailed Background of Program Design<br>and Evaluation Services Section of OHD . . . . . | 11 |
| B. Examples of Client Data . . . . .   | 13 |
| C. Population Survey Instruments:  |    |
| 1. PRAMS . . . . .   | 17 |
| 2. BRFSS . . . . .   | 18 |
| 3. YRBS . . . . .  | 23 |
| D. Examples of Vital Statistics Data . . . . .   | 26 |

INTRODUCTION

This report addresses #22 of HCFA's terms and conditions for Oregon's 1115 waiver application to extend family planning benefits to women and men up to 185% of the federal poverty level, with teens' eligibility based on their own income. We have re-formatted and expanded the description of the Project Evaluation from the original February 1998 application for Oregon's Family Planning Expansion Project (FPEP) (pages 20-25).

We provide a brief background of Oregon and FPEP and detailed background information about the high quality human and data resources available for the evaluation. Then specific hypotheses, data sources, and methodologies are described. Throughout this description, we clarify how FPEP is expected to impact both the target population and the broader population, and how and to what degree FPEP's impact can be isolated from the impact of other related

initiatives in Oregon.

## BACKGROUND OF OREGON & FPEP

Oregon became a pioneer in improving health coverage with the implementation of the Oregon Health Plan (OHP) in 1994. OHP separated medical care from welfare, increased coverage up to 100% of the federal poverty level, and pared down services covered to a list of the most preventive and effective services. Oregon's coverage for pregnant women and their children through its Poverty Level Medical Program (PLM) is still lower than many states, but did increase from the minimum required of 133% of the federal poverty level to 170% in 1998. For the privately insured population, bills are currently being proposed in Oregon's 99-01 legislature to mandate coverage of contraception.

Oregon also began focusing on preventing teen pregnancy under the auspices of the Governor's Teen Pregnancy Action Agenda in 1997. Local and statewide efforts concentrate on six strategies: (1) supporting positive community values and norms; (2) skills for life instruction; (3) responsible sex education; (4) a postponing sexual involvement program called STARS (Students Today Aren't Ready for Sex), (5) contraceptive access (including FPEP) and (6) legal issues and protections. In 1999 there will be a statewide media campaign encouraging teens to call a toll-free number to ask any questions they have about sexuality.

Oregon has also pioneered a welfare-to-work program called JOBS. Because of some of Oregon's pioneering efforts in both welfare and health reform, we have not been impacted as much by national welfare reform as some other states. JOBS was implemented before national welfare reform took effect. The fact that OHP is separate from welfare means it is not significantly impacted by national welfare reform.

The Family Planning Expansion Project (FPEP) is Oregon's newest pioneering effort. FPEP covers women and men up to 185% of the federal poverty level (with teens' eligibility based on their own income) exclusively for family planning services. It is built by a partnership between Oregon's Title X agency, the Oregon Health Division (OHD) and Oregon's Medicaid agency the Oregon Medical Assistance Program (OMAP) and FPEP advisory group.

The FPEP advisory group decided on general objectives for the project in 1997. These objectives are to increase the number of women, teens, and men with financial access to effective contraceptive methods and services in order to increase proper spacing of pregnancies and reduce unintended pregnancies for all women, especially for the Medicaid population and especially for teens.

The five year FPEP project is designed to meet these objectives using the following components: improved financial support, provider training, high quality services for women, men and teens, and social marketing campaign including public education and outreach. The male services program and the public education and outreach campaign will begin in the second year of the Project. The creation of a full family planning benefit for an additional population, and public

education and outreach campaign related to that benefit, are designed to cause more individuals to use effective contraception. The improved reimbursement opportunities and provider training are designed to ensure these clients receive effective services. (For more details, see the original February 1998 waiver application.)

The evaluation described in this report is designed to measure the Project's success in reaching its objectives. The extent to which these objectives might be impacted by Oregon's other initiatives is addressed in the evaluation Methodology below.

## BACKGROUND OF EVALUATION

Like the FPEP project as a whole, the evaluation will be a collaboration between OHD and OMAP, but the main resources are located in OHD. Within OHD, the evaluation will be a collaboration between two centers, the Center for Disease Prevention and Epidemiology (CDPE) and the Center for Child and Family Health (CCFH).

CDPE is administered by David Fleming, M.D., the Oregon State Epidemiologist and past president of the National Association of State and Territorial Epidemiologists. CDPE includes vital statistics and population surveys including BRFSS and YRBS, and has established relationships with other states with similar data. CDPE also has an extensive collaborative relationship with OHD's sister Department of Human Resources agency, OMAP. They are working together to make Medicaid data available to OHD for a variety of projects. CDPE is a resource for all of OHD.

Within CDPE is the Program Design and Evaluation Services (PDES). It is an interdisciplinary, inter-agency evaluation and research work group, jointly established in 1992 by the Multnomah County Health Department (MCHD) and Oregon Health Division (OHD). PDES is composed of doctoral level anthropologists, psychologists, health educators, sociologists, and medical epidemiologists. They are supported by masters' level research staff. Staff of PDES are either members of OHD or MCHD, and Dr. Stark, the Director of PDES reports to both the OHD State Epidemiologist and the MCHD Director of Planning and Development.

The PDES mission is to conduct public health research projects. This includes designing interventions, crafting and implementing evaluations, and disseminating results through technical reports and publications. Since 1992, PDES staff have studied a wide variety of public health concerns. For more detailed background information on PDES, see **Appendix A**.

Within CCFH, Kenneth Rosenberg, M.D. is OHD's Maternal and Child Health Epidemiologist. There are also specific research staff assigned to each program, including a separate staff person for the Pregnancy Risk Assessment Monitoring System (PRAMS). The Family Planning program is located in CCFH and has one full-time research analyst, Kara Stebbins, who is also working on her MPH thesis in epidemiology/ biostatistics from Oregon Health Sciences University. The Family Planning program has access to the Region X data system, operated

through a contract with Ahlers & Associates to collect family planning data, with electronic access and good relationships with other states with similar data.

Specifically for the FPEP evaluation, Michael Stark, Ph.D., Director of PDES, will provide overall leadership. The Family Planning program research analyst, Kara Stebbins, will be the lead staff working on the evaluation. Primary consultants for epidemiologic methods will be David Fleming, M.D., the Oregon State Epidemiologist, and Kenneth Rosenberg, M.D., OHD's Maternal and Child Health Epidemiologist. Additional available consultants are Joan Kapowich, Manager of OMAP's Program Evaluation Unit, and David Fine, Ph.D., Region X Title X Data Consultant.

Responsibilities for each task of the Evaluation are as follows:

- Mike Stark and Kara Stebbins worked with the FPEP advisory group to finalize the objectives of the project to make them measurable, and also wrote the Project Evaluation included in the original February 1998 waiver application (pages 20-25).
- Baseline measurements for all hypotheses will be made by Kara Stebbins, working with Mike Stark, and as needed with Joan Kapowich from OMAP.
- Yearly gathering and monitoring of data, including documentation of project and other initiative time lines, will be conducted by Kara Stebbins with input from Mike Stark, Dave Fleming, and Ken Rosenberg.
- At the end of the 5 year project, trend analyses and writing of the final report will be performed by Kara Stebbins with consultation from Dave Fleming and Ken Rosenberg, and assistance from Mike Stark and other PDES staff as needed.

## HYPOTHESES

Reflecting the objectives and design of FPEP, the hypotheses of the Project are that over the life of the 5 year project, we will increase the number of women, teens, and men with financial access to effective contraceptive methods and services, and thus increase proper spacing of pregnancies and reduce unintended pregnancies for all women, especially for the Medicaid population and especially for teens.

We expect the broadened reimbursement base provided through this Medicaid waiver to improve access and services for all clients seeking family planning services regardless of FPEP eligibility. We also believe that the social marketing campaign will inevitably have an impact on the broader population. Therefore we hypothesize that FPEP will impact the specific target population (defined as precisely as the data allow) and the general population. While not set up as specific hypotheses, we expect that the target population will be impacted first, and within that group, that females, teens, then males will be impacted. The specific hypotheses we will test are

for changes over the entire 5 year time period. They are listed on the next page:

## **Hypotheses for changes from before implementation to the end of the 5 year Project:**

1. *Use of Family Planning Services:*  
There will be an increase in the annual number of women, men and teens obtaining services at Title X family planning clinics. (Baseline data are not available from other providers.) This will be true for total clients and for clients between 100% and 185% of federal poverty. (AHLERS DATA)
2. *Effectiveness of Contraceptives Obtained from Family Planning Services:*
  - a. Among women and teens served at Title X family planning clinics, more will receive the most effective means of contraception (e.g., Depo-Provera, Norplant, sterilization). (Baseline data are not available from other providers.) This will be true for total clients and for clients between 100% and 185% of federal poverty.
  - b. The number of men obtaining Medicaid-funded vasectomies will increase.
3. *Financial Barriers to Not Using Contraceptives:*  
Among adult women and men who report not using contraception, fewer will report not being able to pay for it as the reason for their non-use. This will be true for the total population and for the population between approximately 100% and 185% of federal poverty.
4. *Use of Contraceptives:*
  - a. Among sexually active adult women and men, there will be an increase in contraceptive use. This will be true for both the total population and for the population between approximately 100% and 185% of federal poverty.
  - b. Among sexually active teens, there will be an increase in contraceptive use.
5. *Adult Unintended Pregnancies:*
  - a. There will be a reduction in the percent of births that are reported as unintended among Oregon women in general and among women who are eligible for Medicaid paid deliveries.
  - b. There will be a reduction in the percent of pregnancies that are reported as unintended among Oregon women in general and among women who are eligible for Medicaid paid deliveries.
  - c. Men will report a decrease in unintended pregnancies for their partners.
6. *Poorly Spaced Pregnancies:*
  - a. The proportion of inadequately spaced births (less than two years) in general and among women eligible for Medicaid paid deliveries will decline.
  - b. There will be a reduction in the proportion of births to 10 to 17 year-olds which are their second births.
7. *Teen Pregnancies:*  
There will be a reduction in the pregnancy rate for 10 to 17 year-olds.

## DATA SOURCES

Data for the evaluation will come from multiple data sets including client data, population surveys, and vital statistics. We will obtain data from similar data sources from states who have similar demographics. We will also keep records of FPEP activities and other relevant Oregon and comparison state initiatives.

### **Client Data**

The current Region X Title X data collection system is provided through Ahlers & Associates in Waco Texas. It tracks clients using Medicaid and Title X family planning services at our clinics. The information tracked includes age, gender and contraceptive method. The system also tracks income level and payment source so that we can clearly identify our target FPEP population of clients up to 185% who are not otherwise on Medicaid. Oregon's data are available electronically, and other state's data are accessible. For examples of Ahlers client data tables, see **Appendix B**.

The current Medicaid data collection system, called MMIS, includes a record of services provided, including vasectomy. These data will be available through collaboration with Joan Kapowich, Manager of OMAP's Program Evaluation Unit. No data on vasectomies in the general population is readily available.

### **Population Survey Data**

We will use two statewide surveys to assess the percent of pregnancies that are unintended among Oregon women. In 1998, we began surveying a representative random sample of postpartum women in Oregon. Names and birth outcomes of postpartum women come from birth records from OHD's Center for Health Statistics. These women are asked questions about the intendedness of their pregnancies. (Most of the questions are parallel to those in the CDC PRAMS, the Pregnancy Risk Assessment Monitoring System.) For a copy of Oregon's PRAMS survey, see **Appendix C1**.

Of course a postpartum survey misses pregnant women who obtained an abortion or miscarried. So a second survey was begun in 1998 of a representative sample of women ages 18-44. It consists of the questions in the Family Planning Issues module of the CDC BRFSS (Behavioral Risk Factor Surveillance System). These questions relate to unintended pregnancy, and also include questions about the use of contraception and reasons for non-use. Oregon has also added a set of parallel questions for men 18-44. For a copy of the family planning modules of Oregon's BRFSS, see **Appendix C2**.

The specific target population for both PRAMS and BRFSS can be broken out because questions are included about broad income category and family size, and insurance coverage. Data from PRAMS surveys and BRFSS surveys from other states is accessible (except for the BRFSS

questions for men, which only Oregon asks).

Oregon's Youth Risk Behavior Survey (YRBS) includes a group of questions about sex. We will use YRBS data to assess the use of contraception among teens. The entire teen population is assumed to be our target population, since it is largely 0-185% federal poverty based on personal income. YRBS data are available from other states. For a copy of Oregon's YRBS survey questions relevant to this evaluation, see **Appendix C3**.

### **Vital Statistics Data**

OHD's Center for Health Statistics manages birth and abortion data and has good relationships with other states for sharing these data, although not all states have abortion data. Oregon is fortunate to have a long history of required abortion reporting. Both birth and abortion data are available by age. The birth certificate includes questions about birth spacing and payment source for delivery. The entire teen population is assumed to be our target population, since it is largely 0-185% federal poverty based on personal income. To identify the target group for adults, we will rely on payment source of delivery recorded on the birth certificate. Since Medicaid coverage begins at 0% of federal poverty and increased from 133% to 170% federal poverty level in March of 1998, it is recognized that pre- and post- FPEP data will overlap considerably but not be completely comparable to the target population of interest: women whose pre-pregnancy income was 100-185% of the federal poverty level. For examples of vital statistics data, see **Appendix D**.

### **Other Data**

We will keep records of FPEP activities and other relevant Oregon and comparison state initiatives, including teen pregnancy prevention and health and welfare reform activities. OHD and specifically Family Planning program staff are well-informed about these activities from intra and inter-agency meetings and communications. This information will be essential for interpretation of analysis.

## METHODOLOGY FOR TESTING HYPOTHESES

Assessing attainment of FPEP objectives will be accomplished through a series of quasi-experimental comparisons to determine if outcomes differ from what would be expected without the Project. These comparisons will include pre-post trend analyses to determine if post-implementation outcomes deviate from historical trends in Oregon.

In addition, to control for current secular trends, we will: 1) compare Oregon data relevant to this Project to the data collected in other states that have not implemented a similar family planning project; and 2) compare data from Oregon counties which have programs whose goals are related to the goals of the Family Planning Expansion Project (specifically the postponing sexual involvement curriculum STARS) to counties which do not have those programs. If additional county variations in outreach or other initiatives occur, they will be considered for analysis. The purpose of these comparisons is to determine if our findings can be reasonably attributed to the Family Planning Expansion Project, or to the effects of the other programs, or both. Interpretation of analyses will also need to occur in the context of records kept about the time lines of FPEP activities, other relevant Oregon initiatives, and initiatives in comparison states.

The hypotheses and methodology to test them are listed below, grouped by the type of data used:

### **Methodology for Testing Hypotheses using Client Data**

- Hypothesis 1 :**        **There will be an increase in the annual number of women, teens, and men obtaining services at Title X family planning clinics following the implementation of the Expansion Project. This will be true for total clients and for clients between 100% and 185% of federal poverty.**
- Hypothesis 2a:**     **Among women and teens served at Title X family planning clinics, more will receive effective means of contraception (e.g., Depo-Provera, Norplant, sterilization) after implementation of the Expansion Project. This will be true for total clients and for clients between 100% and 185% of federal poverty.**

Methodology: We will use Ahlers data to determine the number, age, gender, contraceptive method, income level, and payment source of clients using Medicaid and Title X family planning services at our clinics. Trend analyses will be used to compare the number of people in each subgroup before and during the Expansion Project. Title X Family Planning Program data will be available from other states for comparison purposes.

- Hypothesis 2b:**        **The number of men obtaining Medicaid-funded vasectomies will increase following the implementation of the Expansion Project.**

Methodology: OMAP data will be used to assess the numbers of Medicaid-funded vasectomies performed before and during the Expansion Project. Trend analyses will be used to determine if there is an increase in the number of Medicaid-funded vasectomies during the life of the Project.

## **Methodology for Testing Hypotheses using Population Survey Data**

**Hypothesis 3: Among adult women and men who report not using contraception, fewer will report not being able to pay for it as the reason for their non-use.**

**This will be true for the total population and for the population between approximately 100% and 185% of federal poverty.**

**Hypothesis 4a: Among sexually active adult men and women there will be an increase in contraceptive use over the course of the Expansion Project. This will be true for both the total population and for the population between approximately 100% and 185% of federal poverty.**

Methodology: Responses from BRFSS questions about current use of contraception and reasons for not using contraception will be compared at baseline vs post-baseline annual waves to determine changes in the prevalence of those reporting not being able to pay as the reason for not using contraception. Data from BRFSS surveys from other states using this module will be used to control for secular trends, except in the case of the data on men, which is not available from any other states.

**Hypothesis 4b: More sexually active teens will report using a birth control method following implementation of the Expansion Project.**

Methodology: We will use Oregon's YRBS data to assess the use of contraception among teens. We will compare the percent of sexually active teens reporting contraceptive use at baseline to subsequent years after the Expansion Project has been implemented. Data from YRBS surveys from other states will be used to compare to Oregon to control for secular trends.

**Hypothesis 5a: There will be a reduction in the percent of births that are unintended among Oregon women in general and among women who are eligible for Medicaid paid deliveries following the implementation of the Expansion Project.**

Methodology: We will compare baseline and post-baseline PRAMS results to determine changes in the percent of births that are unintended in general and specifically in the population of women eligible for Medicaid paid deliveries. Data from PRAMS surveys from other states will be used to compare with Oregon's results as a way to control for secular trends.

**Hypothesis 5b:** There will be a reduction in the percent of pregnancies that are unintended among Oregon women in general and among women who are eligible for Medicaid paid deliveries following the implementation of the Expansion Project.

**Hypothesis 5c:** Men will report a decrease in unintended pregnancies for their partners over the course of the Expansion Project.

Methodology: We will compare baseline and post-baseline BRFSS responses to determine changes in the percent of pregnancies that are unintended in general and for women eligible for Medicaid paid deliveries. Data from BRFSS surveys from other states will be used to compare with Oregon's results as a way to control for secular trends, except in the case of data on men, which is not available from any other states.

#### **Methodology for Testing Hypotheses using Vital Statistics Data**

**Hypothesis 6a:** The proportion of inadequately spaced births (less than two years) in general and among women eligible for Medicaid paid deliveries will decline following the implementation of the Expansion Project.

**Hypothesis 6b:** There will be a reduction in the proportion of births to teens 10 to 17 years old which are their second births.

Methodology: We will use birth records from the Oregon Health Division's Vital Statistics Section. Trend analyses will be used to compare the spacing of all deliveries for each subgroup during the Expansion Project to spacing in previous years. Vital statistics data from other states will be used to compare to Oregon to control for secular trends.

**Hypothesis 7:** There will be a reduction in the pregnancy rate for 10 to 17 year-olds following the implementation of the Expansion Project.

Methodology: We will use birth and abortion records from OHD's Center for Health Statistics. We will compare the teen pregnancy rate at baseline to subsequent years after the Expansion Project has been implemented. Teen birth data but not abortion data from other states can be obtained for comparison purposes.

Data about which counties have the STARS program will allow comparisons between counties who have it vs. those which do not. The comparisons will allow a determination of the Family Planning Expansion Project's impact independent of the STARS program.

## APPENDIX A:

### Detailed Background of the Program Design and Evaluation Services Section of the Oregon Health Division

The Program Design and Evaluation Services (PDES) is an interdisciplinary, inter-agency evaluation and research work group, jointly established in 1992 by the Multnomah County Health Department (MCHD) and Oregon Health Division (OHD). PDES is composed of doctoral level anthropologists, psychologists, health educators, sociologists, and medical epidemiologists. They are supported by masters' level research staff. Staff of PDES are either members of OHD or MCHD, and Dr. Stark, the Director of PDES reports to both the OHD State Epidemiologist and the MCHD Director of Planning and Development..

PDES mission is to conduct public health research projects. This includes designing interventions, crafting and implementing evaluations, and disseminating results through technical reports and publications.. Since 1992, PDES staff have studied a wide variety of public health concerns. Prevention projects include an Edward Byrne Memorial Grant Program funded study of nineteen programs to prevent juvenile violence in Oregon. We are also one of the sites under the Byrne grant, with a project to prevent truancy among 4-6 grade and beginning high school students in the Portland School District. In addition, PDES is evaluating a U.S. Department of Education funded Portland Public School District truancy prevention project. Another prevention project conducted in the Portland Public Schools by PDES staff is aimed at preventing teen pregnancy. This project employs a curriculum-based, peer-mediated postponement of sexual initiation strategy delivered to sixth grade students. The STARS (Students Today Aren't Ready for Sex) model developed from this program has been implemented widely in school districts throughout Oregon.

In addition to the aforementioned studies, PDES staff are currently evaluating a Robert Wood Johnson funded Smoke Free Families Project. The purpose of this study is to prevent relapse to cigarette smoking among post partum women who quit smoking during their pregnancy. We are also part of the evaluation team examining OHD's Statewide Tobacco Prevention Project. This project is funded by a recent tobacco tax in Oregon, and will consist of a mass media campaign, comprehensive school-based and local (county-level) anti-tobacco activities.

In the area of HIV prevention, PDES staff conducted the following research projects: 1. NIDA funded HIV Cooperative Agreement for AIDS Community-Based Outreach/Intervention Program. The purpose of this project was to prevent HIV in out-of-treatment injection drug and crack users; 2) CDC funded Prevention of HIV in Women and Infants Demonstration Project. This community-based program's goals were to reduce HIV/STD risk and to enhance decision-making regarding childbearing among 14-34 year old women in high-risk communities; 3) CSAT funded Prevention and Outreach for High-Risk Homeless Substance Abusers and Their Sexual Partners. This project was targeted to homeless substance users and consisted of outreach, education, HIV prevention interventions, and referral for HIV, STD's, TB, and the myriad of other health and social problems endemic in this population. Other projects evaluated by PDES staff include: 1) MCHD's Seropositive Wellness Program, a

project designed to ensure that newly diagnosed HIV-positive individuals are connected to medical services, and to provide them with skills necessary to reduce the spread of HIV; b) Population Services International Social Marketing of Condoms Project, a study of the social marketing of condoms intervention targeted to sexually active adolescents in the Portland area; c) CSAT funded project Linking Health, Mental Health and Substance Abuse Treatment, a study to determine if providing comprehensive health and mental health services for high risk substance abusers and their family/sexual partners leads to better drug treatment outcomes, and d) HRSA funded Special Programs of National Significance (SPNS) program to provide integrated health, mental health and substance abuse treatment for HIV-positive clients.

Each PDES' work station is equipped with a Pentium or Pentium Pro computer with high speed Internet access. Computers have access to literature databases(e.g., MEDLINE, PsychINFO) and are equipped with Windows software, including: data analysis (SPSS), power analysis (PASS), presentation (Harvard Graphics), and relational database (Access, Paradox) software. As part of MCHD and OHD, PDES staff have access to county and statewide health encounter and vital statistics records.

**AMENDMENT TO EVALUATION DESIGN REPORT**  
**SEPTEMBER, 1999**

Subsequent to the delivery of the Evaluation Design Report, the State Epidemiologist and the Health Division's MCH Epidemiologist reviewed all the Demonstration Project objectives to be tested as hypotheses in the formal evaluation along with the baseline data now available. The evaluation of the planned measures and recommendations for alterations in the evaluation process which resulted from this meeting are as follows:

1. The group classified the objectives in the following manner:  
*(all objectives are numbered as they appear in the evaluation proposal)*

Process or "Clients Served" Objectives:

1. Increase the number of people using Title X/FPEP services

Intermediate or "Contraceptives Used" Objectives:

2. Increase the percent of women and men obtaining the most effective contraceptives through Title X/FPEP providers.
3. Decrease the percentage of adults not using contraceptives because of financial barriers.
- 4a. Increase the percentage of all adults using contraceptives.
- 4b. Increase the percentage of all sexually-active teens using contraceptives.

Outcome or "Unintended Pregnancies Averted" Objectives:

5. Decrease unintended births and pregnancies.
6. Decrease inadequately spaced births for adults and teens.
7. Decrease the teen pregnancy rate.

2. The required budget neutrality monitoring serves to focus on the process and outcome objectives. Therefore it is critical that the formal evaluation focus on the intermediate objectives. This is appropriate, as the intermediate objectives related to the amount, kind, and reasons for “contraceptive use” can serve as the “missing link” between a fairly plausible causal connection between contraceptive use and averting unintended pregnancy and the still-to-be-demonstrated connection between clients served by FPEP and improving contraceptive use.
3. An analysis of baseline data now available makes it clear that the BRFSS data base available to us does not surface a meaningful number of adults who report not using contraceptives and even fewer reporting that their reason for not using is a financial barrier. Analysis on the basis of this small sample is not recommended. The recommendation is that intermediate objective 3 be dropped from the analysis.
4. Baseline data also shows that the vast majority of adults responding to our BRFSS already report using some form of contraceptive. As a result, the intermediate objective measured by Hypothesis 4a is not a sensitive enough measure of contraceptive use. The recommendation is that this Hypothesis be modified as follows
  - 4a. Increase the percent of adults using the most “effective” contraceptive methods. (“Effective” is defined as a method failure rate of <100 pregnancy per 1,000 persons per year with typical use. Thus the category includes sterilizations, IUD and hormonal methods.)

This modification makes the Hypothesis more sensitive, as well providing a parallel to Hypothesis 2. The underlying concern of Hypothesis 3, namely the cost barrier of more effective contraceptive methods, can also be partially addressed by this modification.

5. An evaluation of data availability from other states and the widespread initiation of family planning waivers in potential comparison states resulted in the recommendation that instead of choosing two comparison states for all possible hypotheses, the project should compare in the aggregate as many possible non-waiver states as are available for each hypothesis.
6. As a further aid in making data comparable across states teen pregnancy analysis should be limited to the 15-19 year-olds age group.