

Missed Opportunities for Discussing Contraception in Adolescent Primary Care

Jennifer Leigh Woods MD, MSc, MEd, FAAP^{1,*}, Jeanelle L. Sheeder MSPH, PhD²

¹ Section of Adolescent Medicine, Children's Hospital Colorado/University of Colorado, Aurora, CO

² Division of Adolescent Medicine and Departments of Obstetrics & Gynecology and Pediatrics, University of Colorado, Aurora, CO

ABSTRACT

Background: Over half of adolescents are sexually active by age 18 years and represent half of sexually transmitted infections (STI). These individuals often do not obtain routine medical care, so discussing contraception at each visit becomes imperative. Our study objectives were to determine the frequency of visits before contraception was discussed/initiated, and to assess factors affecting primary care contraception provision.

Methods: A retrospective chart review (January 2009-June 2019) was conducted for preventive, follow-up, and sick visits; Title X confidential visits were excluded. Questions were asked about method at start and end of the visit. Nonparametric median tests for continuous variables and chi-squared tests for categorical variables assessed for differences for patient age, race, gender, insurance type, visit type, and provider gender. The institutional review board approved the study as exempt.

Results: Patients (n = 12,619; median = 15 years; 58% female) were seen in primary care clinic. Providers asked about contraception for 82% of visits, and averaged 3 visits before contraception was discussed. For patients asked about contraception, 60% were using a contraceptive method, 15% left the visit on a new method (24.9% long-acting reversible contraception [LARC]). For patients not using contraception, 39.9% left the visit on a method. Patients asked about contraception were female, older, Hispanic, had public insurance, and were seen by female providers ($P < .001$). Follow-up/sick visits represented <20% of patients asked about contraception.

Conclusions: Multiple visits occur before contraception is discussed in adolescent primary care, and factors including age, race, and gender affect these discussions. Strategies to increase contraception discussions at all visits is essential, as adolescents do not always present for yearly visits.

Key Words: Adolescent, Contraception, Primary care

Introduction

Adolescents are not seen regularly in a primary care setting, despite recommendations from the American Academy of Pediatrics (AAP) and the Society for Adolescent Health and Medicine (SAHM). Yearly preventive visits occur for only 30–40% of adolescents, and 30% of adolescents obtain 1 well visit over a 4-year span.¹ Patients who are male, low-income, and uninsured are more likely to receive no care, especially the preventive visit.^{2,3} Even when adolescent patients do come for primary care, they often have less than an ideal visit. Less than 50% of adolescents have time alone with their provider to discuss confidential issues, especially sexually transmitted infections (STI) and mental health, with Hispanic individuals and those of low socioeconomic status receiving the least time with their providers.^{3,4}

We know that adolescents participate in high-risk behaviors that may lead to significant morbidity and mortality, including unprotected sexual activity and sexual activity with multiple partners.^{5,6} Research has shown that counseling from medical professionals affects high-risk behaviors, but providers often counsel at very low rates for adolescents despite established guidelines.^{7,8} Once teens become sexually active, the need for STI screening and pregnancy prevention counseling becomes even more important; however, visits for medical care decrease in this age group. As previously mentioned, Hispanic and low-income youth have the most limited access to healthcare, and they are the groups most at risk for STI and unintended pregnancy.⁹

Addressing all the preventive issues, including sexual health, may not be feasible in a single visit, necessitating triage of important issues.¹⁰ The sheer amount of information can be overwhelming to a primary care provider, who may feel pressured to get important information into one visit. One survey showed that although most pediatricians (86%) addressed puberty/reproductive health and condoms, abstinence, and contraception (66%), only 18% addressed gender identity and sexual orientation.¹¹ The average time spent on sexual health was 36 seconds.¹²

Unfortunately, when healthcare providers miss opportunities to speak to adolescents about sexual health and contraception, pregnancy often occurs. Less than half of

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* Address correspondence to: Jennifer Leigh Woods, MD, MSc, MEd, FAAP, Section of Adolescent Medicine, Children's Hospital Colorado, University of Colorado, 13123 East 16th Avenue B025, Aurora, CO 80045; Phone: (720) 777-8054

E-mail address: jennifer.woods@childrenscolorado.org (J.L. Woods).

reproductive-aged individuals, including teens, receive family planning services including contraception, despite this being considered a core competency for primary care providers.¹³ One study of adolescents with stable insurance showed that teens averaged 2.7 office visits with their primary care office in the 12 months prior to becoming pregnant; 57% of charts had no sexual activity documented; 47% had no reproductive health counseling documentation; only 35% had contraception prescribed; and only 1 contraception type was long acting.¹⁴

Provider limitations include lack of training, low comfort level, perceived lack of time, and poor knowledge, compounded by negative beliefs about contraception; providers also admit to relying on patients to initiate conversations about contraception.¹⁵ With limited confidentiality, teens may also believe that their information will not be protected in the medical record, will be shared, or will appear in billing on their parents' insurance.¹⁶

Previous studies have focused primarily on adults,¹⁵ or patient missed opportunities to discuss contraception once they are pregnant.¹⁴ This study is novel and looks directly at an adolescent primary care clinic, run by adolescent medicine fellowship trained faculty, to determine when contraception is discussed—at all visits, just preventive visits, or just acute visits. Also, this study assesses whether any differences exist in patients who are asked about contraception versus not asked in primary care based upon demographic factors.

The objectives of this study are (1) to determine the frequency of visits to a primary care clinic before discussions regarding contraception are initiated and contraception is subsequently initiated; and 2) to determine whether age, race, gender of patient, insurance (private vs public), or gender of provider significantly affect provision of care regarding contraception in a primary care clinic.

Materials and Methods

Design

This study is a retrospective chart review with data collected from visits at the Adolescent Medicine clinic at Children's Hospital Colorado (CHCO) between January 2009 and June 2019. Use of contraception is tracked for all visits in this clinic using questions integrated in the electronic health record, Epic, in association with the Adolescent Medicine section's Title X funding for its associated family planning clinic.

Participants and Setting

All patient visits for preventive, follow-up, and sick visits in the Adolescent Medicine primary care clinic at CHCO (for patients aged 12–25 years) were included in this study. Consultation visits and confidential visits for contraception were excluded, as these visits were often specifically for contraception. The clinic is run by adolescent medicine specialists with pediatrics residents and adolescent medicine fellows. There was no consent required for this study, as it is a retrospective chart review with deidentified

patient information and a waiver of consent was obtained. Due to the study nature, there were no physical risks to the subjects, and confidentiality was ensured with deidentified data.

Data Collection Procedures

A retrospective chart review was performed for patients (aged 12–25 years) seen in the Adolescent Medicine Clinic at CHCO during 2009–2019 using Web Intelligence (WebI). All visits for primary care issues (establish care/well visits, follow-ups, sick visits) were included. Follow-up visits included clinic follow-up in addition to follow-up visits from inpatient and emergency department visits. In addition to visit type, patient age, race, gender, insurance type, and gender of the visit provider were collected for each patient encounter.

Questions embedded in Epic for the Title X funding related to our family planning clinic, BC4U, are asked for each visit in Adolescent Medicine clinic and recorded in a designated contraception flowsheet. Answers to the first question “Was contraception or abstinence discussed?” (no/yes) were primarily reviewed. For patients with whom contraception was not discussed at the most recent visit to the Adolescent clinic, data were collected to determine whether the patient had had any previous visits. Although the Adolescent Medicine and BC4U clinics are separate, they do share physical space and some providers. Title X supplies are used only for the Adolescent Medicine clinic, for patients with no insurance, or in confidential situations, but the questions are mandatory for all patients per federal reporting guidelines. The study investigators reviewed whether contraception was discussed at any previous visits, and a mean number of visits was ascertained.

For patients with whom contraception was discussed at the most recent visit, the patient-reported contraception method was collected per the Epic flowsheet question “What method was the patient using before the visit?” Subsequently, the study investigators reviewed the Epic flowsheet question “What method was the patient using after the visit?” Dropdown choices included combined oral contraceptive (COC) pills, hormonal patch, Depo-Provera, implant (Implanon, Nexplanon), intrauterine device (IUD), condoms, withdrawal, abstinence, no method, and never sexually active.

All patient identifiers were removed, and a spreadsheet using Microsoft Excel was created for safe and confidential storage of all data located on the password protected computer of the primary investigator. The study was approved by the Colorado Multiple Institutional Review Board with exempt status.

Outcome Measure(s)

The primary outcome measure is how long (ie, how many visits) it takes for patients to be asked about contraception at a primary care visit. Secondary outcomes include effects of patient age, race, gender, insurance status and provider gender on when contraception is first discussed in primary care.

Data Analysis

Data collected from the retrospective chart review were evaluated for total sample size of patients seen during the assessment period (2009–2019), patients asked/not asked about contraception, and patients with previous visits in Adolescent Medicine who were asked/not asked about contraception. The study investigators collected demographic information for each group regarding patient age, race, gender, insurance and provider gender. This information was analyzed for any significant differences using nonparametric median tests for continuous variables and chi-squared tests for (categorical variables) differences for patient age, race, gender, insurance type, visit type, and provider gender.

Results

Patients ($n = 12,619$; median = 15 years; 58% female) were seen for preventive (74.2%), follow-up (14.9%), and sick visits (10.9%) (Figure 1). Providers asked patients about contraception for 82% ($n = 10,362$) of visits, and patients ($n = 6661$) with prior visits averaged 3 visits before providers discussed contraception. For patients ($n = 2257$) not asked about birth control, 48% ($n = 1087$) had had prior visits in which they were also not asked about birth control. For patients asked about contraception at their first visit, 60% ($n = 2236$) were using a contraceptive method: 39.4% abstinence, 33.6% condoms, 9.6% LARC, 6.4% combined hormonal contraceptives (CHC), and 6% Depo. Although over 80% of patients ($n = 1820$) left on the same contraceptive method, nearly 15% ($n = 330$) chose a new method: 24.9% LARC, 19.4% condoms, 17.6% CHC, 17.6% abstinence, and 12.4% Depo. For patients ($n = 1278$) not using contraception at first visit arrival, 39.9% left on a method: 45.7% abstinence, 16.3% CHC, 16.2% condoms, 9.4% LARC, and 7.8% Depo. There were significant differences (all $P < .001$) between groups (not asked about contraception, new to clinic; not asked about contraception, prior clinic visits; asked about contraception, new to clinic; asked about contraception, prior clinic visits) (Table 1). The majority (58%) of patients were female with the overall visit sample, and this number was highest for the asked, prior clinic visits group (61%). The overall median age was 15 years, but patients were oldest in the not-asked, prior clinic visits group (median age 17 years). Patients asked about contraception (both prior clinic visits and new to clinic) were predominantly Hispanic (36% and 40%, respectively), whereas white, non-Hispanic patients were the majority for patients not asked about contraception (prior visits 34.5% and new to clinic 40%). Public insurance was higher for patients asked about contraception (63% both asked groups compared to 53, 56% in not-asked groups).

The gender of the provider was important in regard to whether contraception was discussed at clinic visits. Female providers (faculty attendings, fellows, residents) were more likely to ask about contraception and represented $\geq 75\%$ of visit providers in those visit ($P < .001$). The gender of the faculty attending provider, however, was not significant

($P = .13$). There were no differences for level of provider (trainee vs faculty).

Follow-up and sick visits represented $< 20\%$ of patients asked about contraception. For new patients and those with prior visits to clinic who were asked about contraception, 9% were at follow-up visits and 7% were sick visits for each group (84% were preventive visits). In contrast, 52% of new clinic patients not asked about contraception were preventive visits; only 5% of patients with prior clinic visits who were not asked about contraception were at a preventive visit (62% follow-up visits, 33% sick visits).

Discussion

Multiple visits typically occurred in the Adolescent Medicine clinic before providers discussed contraception, and factors including age, race, and gender appeared to affect birth control discussions. Although providers asked about contraception for over 80% of the visits in our study, the mean number of visits before contraception was brought up for any visit was 3. This in itself is concerning enough, but the implication is even stronger based upon the uneven nature of adolescents seeking medical care. As previously mentioned, studies have shown that adolescent visits are often for acute issues, and only one-third of adolescents typically obtain preventive care during a year's time.¹⁷

Although questions about ever/current sexual activity and contraception were specifically included in the well visit template for our Adolescent clinic, similar questions were not part of the standard follow-up or same day sick visit templates. As previously mentioned, less than 40% of teens obtain a preventive yearly visit, so we are missing the opportunity to discuss contraception with acute visits. It is also important to acknowledge that providers seeing patients coming to clinic as new patients for acute issues used acute templates that did not capture contraception use versus nonuse. Given the study's findings that asking teens about contraception is not universal and that multiple visits are required for such a discussion, it is imperative that providers understand the importance of discussing contraception at all adolescent medical visits (not just preventive visits or visits specific for contraception) to ensure that teens receive the necessary knowledge and education regarding contraception. Therefore, questions regarding sexuality should be included in all visit templates, not just those for well visits. In a group that accounts for 25% of all sexually transmitted infections in the United States and the highest teen birth-rate among all developed countries, missing opportunities to discuss contraception is unconscionable.^{18,19}

Asking about contraception also appears to be inconsistent based upon both patient and provider characteristics. Female providers were more likely to ask about contraception for all patients. Prior studies have shown that female providers tend to have communication that is considered more patient-centered, with longer visits, than male colleagues.²⁰ Other studies have shown that younger, female pediatricians are more likely to counsel about LARC options.²¹

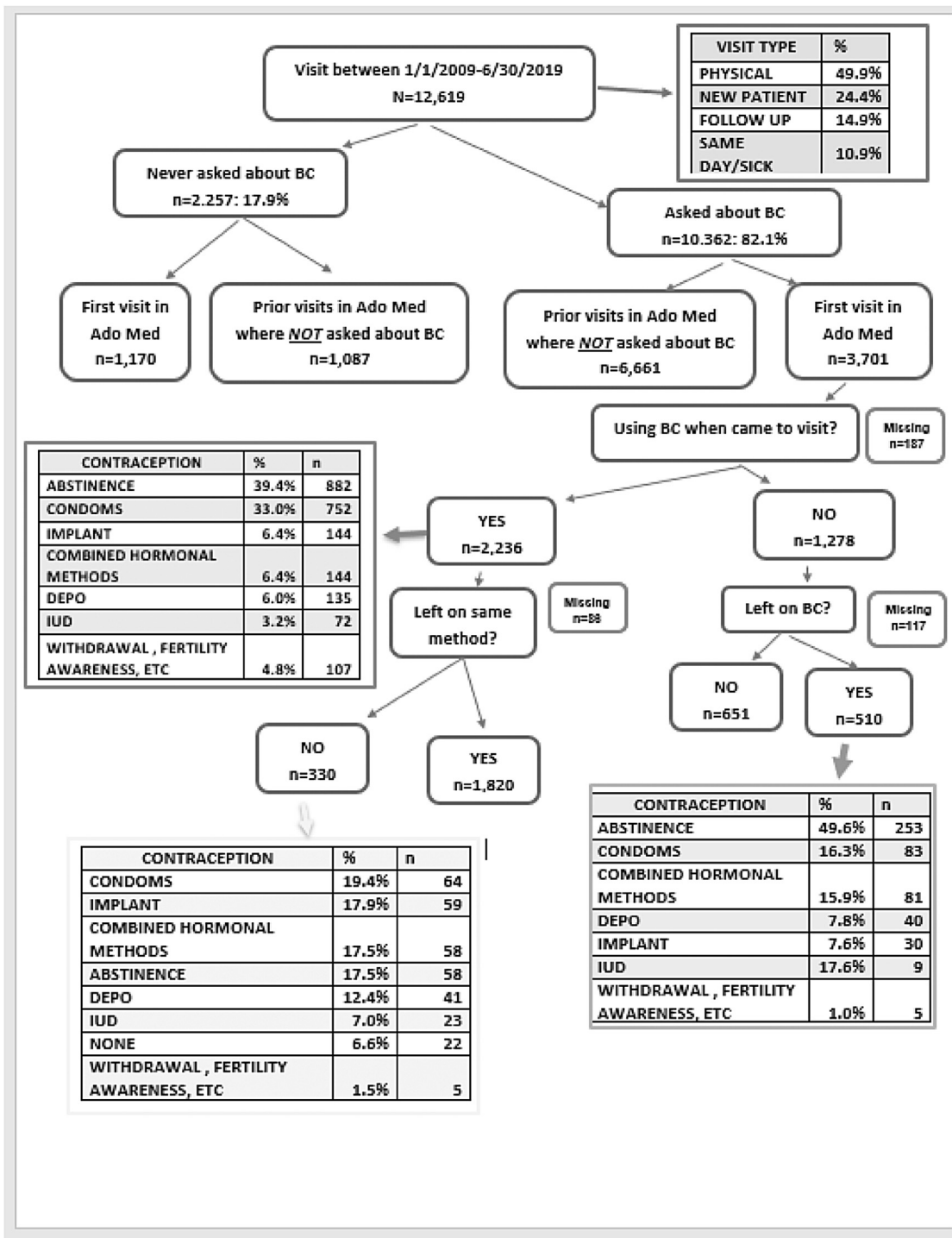


Fig. 1. Adolescents seen in primary care asked and not asked about contraception.

Interestingly, the providers in our clinic are adolescent medicine fellowship trained, but opportunities for discussing contraception were still missed, similar to previous study findings with general pediatricians working with adolescents.^{10–12} Despite 60-minute visits for new patients and 30 minutes (faculty and fellows)/45 minutes (residents) for follow-up/sick visits, there is still often not enough time to address all necessary medical issues in 1 visit. Time limitations are exacerbated with residents, often first-year

interns, exposed to adolescent medicine for the first time. As previously mentioned, adding specific sexuality questions to every template type could improve documentation and serve as a reminder for providers to discuss contraception at each visit.

Patient characteristics also affected whether contraception was discussed. Patients who were older, female, Hispanic, and had public insurance were more likely to be asked about contraception. A major factor in provision of

Table 1
Factors Affecting Discussion of Contraception in Adolescent Primary Care

Factors Affecting Care	Not Asked, New to Clinic	Not Asked, Prior Visits	Asked, Prior Visits	Asked, New to Clinic	P Value
Female	52.8%	56.1%	54.7%	61.4%	<.001
Age, median (range)	15 (11–24)	17 (11–24)	16 (11–24)	15 (11–24)	<.001
Race/Ethnicity					<.001
White, non-Hispanic	40.4%	34.6%	33.7%	27.3%	
Black	16.2%	24.9%	19.8%	24%	
Hispanic	33%	31.6%	36%	40.1%	
Other	10.4%	8.9%	10.5%	8.6%	
Attending provider female	48.3%	43.6%	47%	45.9%	.13
Visit provider female	70.5%	68.4%	74.6%	76.5%	<.001
Payor group					<.001
Public	56.5%	53.7%	62.6%	63.4%	
Private	37.2%	39.9%	32.1%	29.6%	
Military	2.5%	2.2%	1.6%	1.4%	
None	3.9%	4.2%	3.6%	5.4%	
Other	0%	0.1%	0.1%	0.1%	
Visit type					<.001
Follow-up	23.1%	62.1%	9.1%	9%	
New/physical	52.6%	5.2%	83.9%	84%	
Sick	24.3%	32.7%	7.1%	7%	

contraception, especially LARC methods, is knowledge and comfort level of medical providers, who may erroneously feel certain methods are inappropriate for younger teens.²² Prevention of pregnancy, and therefore contraception, is often attributed solely to women, as men cannot become pregnant and effective contraception for males is limited to condoms. This can contribute to subsequent inequalities in contraception discussions among males and females.²³ Pediatricians, on average, take sexual health histories 3 times more often in female teens compared to male teens, and discuss barrier methods with females twice as often as with males.^{24,25}

When it does occur, male contraceptive counseling focuses on condoms compared to hormonal methods, despite willingness of male teens to be discuss all options that their partner may (or may not) also be using.²⁶ Providers should also be counseling male patients about safe sex and obtaining consent from sexual partners. Similarly, providers recommend the human papillomavirus (HPV) vaccine more for female teens compared to male teens, despite health benefits for all patients.²⁷ Our study appeared to emphasize this bias, as more female patients were asked about contraception, despite male patients not having a preferred provider gender but rather wanting providers that “know what they are doing and act like they respect you.”²⁸

Hispanic patients represented the largest percentage of patients asked about contraception; Hispanic patients also comprise the largest patient population for our clinic and its surrounding community. Younger Hispanic women are half as likely to use contraceptive methods compared to non-Hispanic women of the same age, and young Hispanic women with higher levels of acculturation actually have higher LARC use rates, whereas women who are bicultural or low in acculturation are more likely to use no method or condoms.²⁹ Latina women, compared to white women, also have a more favorable attitude toward pregnancy and childbearing.³⁰

An important issue that cannot be ignored is the justified distrust of many minority patients in contraception due to systemic racism. Therefore, many Latina and black

Americans believe that the government encourages contraception to limit minority populations.³⁰ Additionally, past studies have emphasized the idea of reproductive justice and shown that minorities are more likely to have LARC recommended than white patients, particularly poor women of color compared to poor white women.^{31,32} Historically, minority adolescents also average more confidential time with providers than white adolescents; however, time is also greater for those with private insurance compared to Medicaid, so ethnic or racial background alone is not the sole factor in contraception discussions.³³ Therefore, it is important that adolescent patients are asked whether they have any concerns about contraception, both generally and in regard to specific methods. Asking what they have heard from friends or family is also essential in providing best care for all patients.

A concern for patient confidentiality may also be responsible for some of the disparity between patients with public and private insurance being asked about contraception. In our state (Colorado), provision of contraception and screening for STI does not appear on the explanation of benefits (EOB) when billing occurs with public insurance. Therefore, providers feel comfortable providing contraception for patients with public insurance without fear of breaching the teen's confidentiality. With private insurance, providers must create a separate confidential encounter that is billed to our Title X grant; this step may be onerous to some providers, decreasing the numbers even asked about contraception. Prior studies have confirmed that concern for potential loss of confidentiality is higher for patients with private insurance compared to those with Medicaid coverage.³³

This study does have limitations, including the focus on 1 clinical setting. Although not fully generalizable to other populations, many of the concepts relating to provision of best care are translatable. The study was also a retrospective chart review, which did not allow for direct patient interaction or patient-specific data.

In conclusion, adolescent patients are inconsistent in receiving any medical care, so providers must be prepared

to discuss contraception at every visit, not just acute visits. Keys to improving healthcare include addressing provider bias, empowering patients with patient-centered care, and assessing healthcare systems for provision of equal care regardless of race, ethnicity, gender, or insurance coverage. Further attention should be paid to opportunities for including sexual and reproductive health in nonpreventive visits, in which there may be more time for discussion compared to preventive visits, especially as well care is sporadic in teens. Educating providers regarding the importance of contraception discussions at all visits is also important, and surveying providers about specific barriers and improvements is also essential to improved care.

References

- Rand CM, Auinger P, Klein JD, Weitzman M: Preventive counseling at adolescent ambulatory visits. *J Adolesc Health* 2005; 37:87
- Mulye TP, Park MJ, Nelson CD, et al: Trends in adolescent and young adult health in the United States. *J Adolesc Health* 2009; 45:8
- Irwin CE, Adams SH, Park MJ, et al: Preventive care for adolescents: few get visits and fewer get services. *Pediatrics* 2009; 123:e565
- Fortuna RJ, Robbins BW, Halterman JS: Ambulatory care among young adults in the United States. *Ann Intern Med* 2009; 151:379
- Kann L, Kinchen S, Shanklin SL, et al: Centers for Disease Control and Prevention (CDC). Youth risk behavior surveillance—United States, 2013. *MMWR Suppl* 2014; 63:1–168
- Centers for Disease Control and Prevention: Sexually transmitted disease surveillance 2018. Available at: www.cdc.gov/std/stats18/adolescents.htm. Accessed March 6, 2020.
- Rand CM, Goldstein NP: Patterns of primary care physician visits for US adolescents in 2014: implications for vaccination. *Acad Pediatr* 2018; 18:S72
- American Academy of Pediatrics: Bright futures: guidelines for health supervision of infants, children, and adolescents. Elk Grove Village, IL, National Center for Education in Maternal and Child Health and Georgetown University, 2008
- Coker TR, Sareen HG, Chung PJ, et al: Improving access to and utilization of adolescent preventive health care: the perspectives of adolescents and parents. *J Adolesc Health* 2010; 47:133
- Song X, Klein JD, Yan H, et al: Parent and adolescent attitudes towards preventive care and confidentiality. *J Adolesc Health* 2019; 64:235
- Henry-Reid LM, O'Connor KG, Klein JD, et al: Current pediatrician practices in identifying high-risk behaviors of adolescents. *Pediatrics* 2010; 125:e741
- Alexander SC, Fortenberry JD, Pollak KI, et al: Sexuality talk during adolescent health maintenance visits. *JAMA Pediatr* 2014; 168:163
- Cappiello J, Levi A, Nothnagle M: Core competencies in sexual and reproductive health for the interprofessional primary care team. *Contraception* 2016; 93:438
- Kharbanda EO, Stuck L, Molitor B, et al: Missed opportunities for pregnancy prevention among insured adolescents. *JAMA Pediatrics* 2014; 168:e142809
- Akers AY, Gold MA, Borrero S, et al: Providers' perspectives on challenges to contraceptive counseling in primary care settings. *J Womens Health* 2010; 19:1163
- Ott MA, Sucato GS: Contraception for adolescents. *Pediatrics* 2014; 134:e1257
- Nordin JD, Solberg LI, Parker ED: Adolescent primary care visit patterns. *Ann Family Med* 2010; 8:511
- Centers for Disease Control and Prevention: Teen Pregnancy 2017. Available at: <https://www.cdc.gov/teenpregnancy/about/index.htm>. Accessed March 5, 2020.
- Kearney MS, Levine PB: Why is the teen birth rate in the United States so high and why does it matter? *J Econ Perspect* 2012; 26:141
- Roter DL, Hall JA, Aoki Y: Physician gender effects in medical communication: a meta-analytic review. *JAMA* 2002; 288:756
- Wilson SF, Strohsnitter W, Baecher-Lind L: Practices and perceptions among pediatricians regarding adolescent contraception with emphasis on intrauterine contraception. *J Pediatr Adolesc Gynecol* 2013; 26:281
- Pritt NM, Norris AH, Berlan ED: Barriers and facilitators to adolescents' use of long-acting reversible contraceptives. *J Pediatr Adolesc Gynecol* 2017; 30:18
- Kimport K: Talking about male body-based contraceptives: the counseling visit and the feminization of contraception. *Soc Sci Medicine* 2018; 201:44
- Marcell AV, Burstein GR: Sexual and reproductive health care services in the pediatric setting. *Pediatrics* 2017;140
- Marcell AV, Gibbs SE, Pilgrim NA, et al: Sexual and reproductive health care receipt among young males aged 15–24. *J Adolesc Health* 2018; 62:382
- Richards MJ, Peters M, Sheeder J, Kaul P: Contraception and adolescent males: an opportunity for providers. *J Adolesc Health* 2016; 58:366
- Johnson KL, Lin MY, Cabral H, et al: Variation in human papillomavirus vaccine uptake and acceptability between female and male adolescents and their caregivers. *J Community Health* 2017; 42:522
- Lindberg C, Lewis-Spruill C, Crownover R: Barriers to sexual and reproductive health care: urban male adolescents speak out. *Issues Comprehensive Pediatr Nurs* 2006; 29:73
- Roncancio AM, Ward KK, Berenson AB: The use of effective contraception among young Hispanic women: the role of acculturation. *J Pediatr Adolesc Gynecol* 2012; 25:35
- Rocca CH, Harper CC: Do racial and ethnic differences in contraceptive attitudes and knowledge explain disparities in method use? *Perspectives Sex Reprod Health* 2012; 44:150
- Dehlendorf C, Ruskin R, Grumbach K, et al: Recommendations for intrauterine contraception: a randomized trial of the effects of patients' race/ethnicity and socioeconomic status. *Am J Obstet Gynecol* 2010; 203:319
- Higgins JA, Kramer RD, Ryder KM: Provider bias in long-acting reversible contraception (LARC) promotion and removal: perceptions of young adult women. *Am J Public Health* 2016; 106:1932
- Fuentes L, Ingerick M, Jones R, et al: Adolescents' and young adults' reports of barriers to confidential health care and receipt of contraceptive services. *J Adolesc Health* 2018; 62:36