



Patient Experiences With Family Planning in Community Health Centers

July 28, 2015

Susan F. Wood, Tishra Beeson, Debora Goetz Goldberg, Katherine H. Mead, Peter Shin, Aliyah Abdul-Wakil, Anna Rui, Bhakthi Sahgal, Maya Shimony, Hallie Stevens, and Sara Rosenbaum

Table of Contents

Executive Summary	4
Background	6
Methodology	8
Survey Methodology	8
Focus Group Methodology	9
Key Findings	13
Discussion and Recommendations	26

Acknowledgments

This study is a joint project of the Geiger Gibson/RCHN Community Health Foundation Research Collaborative and the Jacobs Institute of Women's Health, at the George Washington University Milken Institute School of Public Health, Department of Health Policy and Management. The authors wish to thank the community health centers that engaged with us in this project, supporting the survey research at each health center, and hosting the focus groups. Most importantly we thank the many women that responded to our survey and participated in focus groups, taking the time to answer many questions about their family planning needs and their health care.

Executive Summary

Women of childbearing age represent one of the single largest groups of community health center patients, and family planning plays a critical role in the health, economic, and social circumstances of women, their children, and families. Family planning is a required service at all health centers, and the major expansion of health centers under the Affordable Care Act means that for low-income women of reproductive age this service should be increasingly available. The Quality Family Planning (QFP) Guidelines, jointly developed by the Centers for Disease Control and Prevention (CDC) and the Office of Population Affairs (OPA) and released in 2014, provide a new opportunity to strengthen family planning service delivery for all patients of reproductive age.¹ But limited and somewhat dated information exists regarding both patients' experiences receiving primary care at health centers generally, and women's experiences with family planning care at health centers specifically.^{2,3} With patient-centeredness playing an increasingly central role in quality improvement efforts, information regarding the importance placed on family planning services by patients and their experiences receiving care becomes key.

Study Purpose

This study addresses gaps in the evidence base in order to:

- 1) *Explore patients' experiences using community health centers for their family planning and reproductive health care; and*
- 2) *Examine factors that either hinder or facilitate receipt of family planning services, from the patient's perspective, and*
- 3) *Make recommendations regarding how health centers can improve their family planning services.*

Key Findings

Our findings represent data from a national survey of 1,868 women of childbearing age who received care in 19 geographically diverse community health center sites that did not receive Title X funding; and patient focus groups with 82 women in 6 different health center sites around the country.

Only a small percentage of health center patients are actively trying to become pregnant. Nearly 7 in 10 survey respondents (69%) indicated they did not want to become pregnant in the following year, while 20% were either unsure or okay either way. Only 10% of survey respondents reported that they would like to be pregnant in the following year. This highlights the clear need for high-quality family planning services in community health centers.

¹ Gavin L, Moskosky S, Carter M, et al. (2014). Providing quality family planning services: Recommendations of the CDC and the U.S. Office of Population Affairs. *MMWR*. 63(RR04);1-29.

² Radecki SE & Bernstein GS. (1989). Use of clinic versus private family planning care by low-income women: access cost, and patient satisfaction. *AJPH*. 79(6); 692-697.

³ Becker D, Klassen AC, Koenig MA, LaVeist TA, Sonenstein FL & Tsui AO. (2009). Women's perspectives on family planning service quality: an exploration of differences by race, ethnicity, and language. *Perspectives on Sexual and Reproductive Health*. 41(3); 158-165.

Despite the low proportion of patients actively seeking to become pregnant, more than one-quarter of the women who did not want to become pregnant nonetheless are not receiving contraceptive care. Most concerning is that 28% of women respondents who expressed that they did not want to become pregnant in the next year nonetheless reported using no contraceptive method at the time of the survey. Among the women who did not express an affirmative desire to become pregnant, more than 3 in 10 were not currently using a method of contraception.

While access to effective contraception among women who do not intend to become pregnant clearly presents a key challenge, most women are using contraceptive services, suggesting patient receptivity to care. Two-thirds of women survey respondents indicated that they had received family planning care recently, with over 64% reporting that they had seen a doctor or nurse for family planning care within the last 12 months. Our analysis found that contraceptive method choice differed significantly by age and ethnicity for certain methods.

Patient satisfaction with family planning services at health centers is high, suggesting that health centers are well-positioned to increase the accessibility and quality of care. Overall, survey respondents were satisfied with their family planning and contraceptive care at community health centers, although financial issues appear to be a barrier for many women. A substantial majority of survey respondents reported that confidentiality of family planning care was extremely important to them. In particular, most women reported that “not sharing or releasing medical information without your permission,” was a critical item for maintaining family planning confidentiality. For women who obtained their family planning care through other family planning clinics, the fact that this meant separate records, separate providers, and separate contact information was more likely to be identified as important.

Conclusion

Health centers play a critical role in access to family planning services, and many of the women who receive care at health centers depend on health centers for their contraceptive care as well. Only 10% of women surveyed affirmatively desired to get pregnant in the coming year, and yet among women who were not actively seeking pregnancy, nearly one in three were not using contraceptives. Furthermore, financial barriers for women without health insurance represent an important challenge, as does the need to maintain confidentiality in treatment. With these challenges in mind, greater efforts should be made to ensure that women of childbearing age who receive care at health centers are routinely screened for their pregnancy intentions and are assured full access to the most effective forms of family planning furnished in accordance with confidentiality standards. Although many women may choose to receive all health services through their health centers rather than maintaining separate family planning providers, confidentiality of treatment should be a basic principle of all family planning services to the maximum extent feasible, regardless of whether the program is part of a health center or operated independently.

Background

Community health centers (CHCs) represent the largest primary care delivery system for medically underserved patients in the United States. In 2013, health centers operating in more than 9,000 locations in all states, the District of Columbia, and the territories served over 21 million patients.⁴ Women of childbearing age represent one of the single largest groups of health center patients, and family planning is a required service of all health centers.

Three crucial developments serve to further heighten the focus on health center family planning services. First, the Affordable Care Act (ACA) broadened Medicaid eligibility and eligibility for subsidized insurance coverage (including coverage for comprehensive family planning services) to an estimated additional 13.5 million women of childbearing age.⁵ Second, recognizing the crucial role that health centers play in enabling access to care for medically underserved communities and populations, the ACA also included a five-year health center expansion fund in order to enable the continuing development of health centers; this fund was recently expanded for an additional two years as part of the Medicaid and CHIP Reauthorization Act (Pub. L. 114-10). Third, recognizing the critical role played by high-quality family planning services in promoting the health of women, children, families, and the population as a whole, the Centers for Disease Control and Prevention (CDC) and the HHS Office of Population Affairs (OPA) have jointly issued Quality Family Planning (QFP) Guidelines in 2014. The guidelines' purpose is to strengthen family planning service delivery for all patients of reproductive age⁶ at all sites of clinical care.

Over the past several years, the Jacobs Institute of Women's Health and the Geiger Gibson/RCHN Community Health Foundation Research Collaborative, both part of the Milken Institute School of Public Health at the George Washington University, have undertaken a series of studies of health centers and family planning in recognition of both the key role they play in patient, population, and community health and of these recent developments in health care policy and practice.

Our first study, issued in 2013, reported results from the first-ever comprehensive study of health centers and family planning services.⁷ This initial study found that while virtually all health centers offer family planning services consistent with their mission and legal obligations, the depth and quality of care vary significantly. Some health centers reported activities possessing the characteristics of what the study identified as a strong family planning program: a comprehensive range of contraceptive services; active counseling; and efforts

⁴ HRSA, 2013 UDS.

⁵ Ranji U, Bair Y & Salganicoff A. (2014). Medicaid and family planning: background and implications of the ACA. Kaiser Family Foundation. Available at: <http://kff.org/womens-health-policy/issue-brief/medicaid-and-family-planning-background-and-implications-of-the-aca/>

⁶ Gavin L, Moskosky S, Carter M, et al. (2014). Providing quality family planning services: Recommendations of the CDC and the U.S. Office of Population Affairs. *MMWR*. 63(RR04);1-29.

⁷ Susan F. Wood et al., Health Centers and Family Planning: Results of a Nationwide Study (George Washington University, 2013) http://hsr.himmelfarb.gwu.edu/sphhs_policy_facpubs/60/

targeted at hard-to-reach populations, including adolescents, and addressing issues of confidentiality. Health centers reporting stronger programs tended to be located in certain parts of the country and were more likely to also receive funding under Title X of the Public Health Service Act, which establishes and maintains publicly funded family planning programs. Title X, in turn, is associated with strong requirements and offers additional revenues to support enhanced efforts. Researchers also found that other health centers maintained only limited family planning programs, and in some cases provided minimal contraceptive choices. Health centers offering limited family planning services tended to identify numerous barriers including, but not limited to, financial barriers and, of particular relevance to this study, concerns over patient and community perceptions regarding what might be viewed as more ambitious and comprehensive programs.

Our initial study did not attempt to directly measure the responses of health center patients themselves. Furthermore, existing quality measurement tools utilized by the Health Resources and Services Administration (HRSA), which oversees the health centers program, are not designed to specifically measure the quality of family planning services or patient experiences with family planning care. Because of the importance of family planning services, the coverage opportunities created under the Affordable Care Act, the expansion of health centers under the ACA, and the significant attention now given to the “patient centeredness” of care by HRSA and others, we concluded that a follow-on survey to measure patient experiences with family planning care at health centers was warranted. Specifically we sought to determine the level of patient satisfaction with health center family planning services and, equally as important, whether patients in fact depended on health centers for their family planning services or went elsewhere, such as an independent Title X-funded clinic or a hospital outpatient clinic.

Limited and somewhat dated information exists, on both patients’ experiences receiving general primary care from community health centers⁸ and, more specifically, on their health center family planning experiences.^{9,10} This patient perspective is critical to health centers’ efforts to improve the scope and quality of care, especially care and services deemed central to the health center mission and on which considerable quality improvement efforts have been focused (as exemplified by the CDC/OPA guidelines, which HRSA also was involved in developing). To the extent that health center perceptions about what their patients need and want in terms of family planning is at variance with the actual opinions and beliefs of their patients, understanding the existence and extent of this variation becomes critical to clinical quality improvement. Such

⁸ Roby D, Rosenbaum S, Hawkins D & Zuvekas A. (2003). Exploring healthcare quality and effectiveness at Federally-Funded Community Health Centers: results from the Patient Experience Evaluation Report System (1993-2001).

⁹ Radecki SE & Bernstein GS. (1989). Use of clinic versus private family planning care by low-income women: access cost, and patient satisfaction. *AJPH*. 79(6); 692-697.

¹⁰ Becker D, Klassen AC, Koenig MA, LaVeist TA, Sonenstein FL & Tsui AO. (2009). Women’s perspectives on family planning service quality: an exploration of differences by race, ethnicity, and language. *Perspectives on Sexual and Reproductive Health*. 41(3); 158-165.

understanding is especially important for health centers, which have long emphasized community and patient responsiveness as a hallmark of their care.

This study attempts to address gaps in the evidence base regarding patient experiences with family planning services, both generally and in relation to health centers. It had three research aims:

- (1) *To explore patients' experiences using community health centers for their family planning and reproductive health care;*
- (2) *To examine factors that either hinder or facilitate receipt of this type of care from the patient's perspective; and*
- (3) *To make recommendations regarding how health centers can improve their family planning services.*

Methodology

In an attempt to provide comprehensive findings on the patient experience with family planning care in community health centers, this study employed parallel mixed-methods, using both a national survey of 1,868 women of childbearing age in 19 community health centers and patient focus groups with 82 women in 6 different health center sites around the country.

Survey Methodology

An original survey instrument was developed in 2012 to gain information on: (1) the characteristics of patients who receive family planning and reproductive health services at CHCs, (2) patients' decision-making criteria for obtaining family planning and reproductive health services in CHCs, (3) patient experience with family planning and reproductive health services at CHCs, (4) patient barriers to family planning and reproductive health services in CHCs, (5) facilitators of receiving family planning and reproductive health services in CHCs, and (6) the reasons why women use or do not use CHCs to receive family planning and reproductive health services. Cognitive testing of this survey instrument was completed with 12 patients of the target population in order to gather feedback on clarity, readability, and survey quality as well as the time necessary to complete the survey. Both English and Spanish versions of the instrument were tested and fielded in the target population.

In 2014, a sample of 19 health center organizations was recruited to participate as research sites. These sites were purposively selected based on the following criteria:

- Patient volume (large and medium organizations).
- Non-Title X recipients.
- Located within 30 miles of a Title X grantee site.
- Geographically wide-spread across the US.

We purposively chose non-Title X health centers in relative proximity to other family planning options to ascertain the extent to which patients rely on health centers for family planning services, the reasons they may be going elsewhere for their care, and the opportunities for improving access.

Among the health center organizations for which we had current contact information, 99 health centers met our inclusion criteria, and 19 agreed to partner with us in this study. In addition, we selected our 19 research sites in order to represent maximum variation by geographic location, according to census regions and urban/rural location.

After partnering with the 19 health center organizations serving as research sites, we sent customized survey packets and instructions on enrolling eligible patients and administering the survey. Survey respondents were screened for eligibility and enrolled if they met the following criteria: (1) female; (2) ages 18 – 44; (3) not currently being seen for prenatal or obstetric care. All sites were asked to submit a minimum of 100 completed surveys during the fielding period from August 2014 through January 2015. Three sites that submitted less than 100 but more than 50 complete surveys were still included in the final study sample.

Patients who completed the survey were provided a \$20 gift card incentive in recognition of their time and effort, while health center sites that completed 100 or more surveys were awarded a \$1,000 gift card incentive for their role in screening and enrolling patients and coordinating the survey fielding process at their site.

Because of the non-random sampling of the sites and respondents in this study, the results cannot be considered nationally representative. Nonetheless, in order to improve the comparability of these data we generated post-stratification survey weights, ranking the weights to align with region, race, and Hispanic ethnicity reported in the national distributions from the 2013 Uniform Data System for community health centers. The resulting findings represent this weighted sample of respondents.

Focus Group Methodology

Focus groups were used in conjunction with patient surveys to provide contextual information on women's experiences with family planning care and to generate contextual data and insights from group interaction that cannot be captured by other data collection methods. In 2013 a team of researchers conducted four exploratory focus groups of patients to inform the development of the survey. During this initial process the research team recognized the value of conducting additional focus groups to add depth of knowledge regarding patient preferences and experiences with family planning services.

Among the 19 partnering health center organizations, six sites agreed to host focus groups with women of childbearing age. Health centers were purposefully

sampled to include geographic representation in six census regions in the United States and to represent both urban and rural areas. Participating sites were located around the country, in California, Florida, Kentucky, New York, Oregon, and Texas.

Participating health centers were asked to recruit 8-12 women of childbearing age to participate in one of two focus groups held at each site. A total of twelve patient focus groups were conducted with n=82 women between the ages of 18 and 44 who obtain health care services from a community health center. Two of these focus group sessions were conducted in Spanish with bilingual facilitators, while the rest were conducted in English. For their efforts in recruiting and hosting the focus group sessions, participating health centers were provided an additional \$250 gift card. Participants in the focus groups were given a \$30 gift card incentive to compensate for their time and offset the cost of travel involved in participating in the research. A team of two investigators facilitated the focus group meetings, which were audio recorded for later transcription and analysis. All investigators attended prior training sessions on how to conduct focus groups, which included a review and discussion of the interview guide. Focus groups were conducted at the same time as or shortly after administration of the patient survey.

Study Limitations

This study represents one of the first efforts to understand patient experiences with family planning and reproductive health care within the community health center setting. Despite the strength of the study, some limitations exist. First, we recognize that the sampling strategy employed in this study only recruited women of reproductive age in 19 health center sites and that these findings, although adjusted to align with national health center population characteristics, cannot be considered nationally representative. This sampling frame also limits the generalizability of our findings due to the fact that women were only recruited from within community health center settings – not from any other sources of family planning care, such as other family planning clinics, health departments, or private practice settings. Therefore, these findings may be skewed to overemphasize the positive aspects and experiences of care from community health centers.

In addition, the survey instrument was designed to gather self-report data, which may differ from actual clinical utilization data or medical records. The survey was administered in a paper format, which meant that respondents were able to view and answer all questions – even some that they were instructed to skip. Had the survey been administered electronically, a skip logic sequence could have significantly shortened the number of items requiring responses, depending on respondent's status, and reduced any potential survey fatigue. Finally, although the survey and focus group efforts reflected both English and Spanish languages, no additional language assistance or translation was offered, potentially limiting access to the study among speakers of other minority languages.

Limitations of the focus groups include the fact that they were recruited by community health center staff and may be more positively biased toward the health center. The focus groups were only conducted in English and Spanish, not in any other language.

Survey Responses & Demographics

The following section outlines the notable findings from both the national survey effort and the qualitative focus group discussions. As a part of our primary research inquiry, these results focus both on describing the survey respondents' experiences with family planning care in community health centers, and on exploring the distinction between services, utilization, and experiences across different sources of family planning care. We present findings from both quantitative and qualitative approaches to address these key research objectives.

A total of 2,034 patients completed the national survey of patient experiences with family planning in community health centers. Our final study sample includes 1,868, as a number of participants had been inadequately screened for eligibility and were excluded for the purposes of this analysis. The final sample size of survey participants represents an approximate response rate of 65.5%.¹¹

¹¹ Because each site recruited survey participants in the way that best reflected their patient population's needs, the response rate estimated here may be an overestimate. The numerator for this response rate represents the total number of complete surveys received, while the denominator represents the total number of surveys distributed.

Table 1 displays the demographic characteristics of our unweighted survey sample.

Table 1. Survey Sample Demographics	% (n)	National (%)*
<i>Number of Sites</i>	19	-
<i>Participants by Region</i>		
Midwest	10.3 (192)	18.8
Northeast	9.0 (168)	30.4
South	38.8 (724)	20.7
West	42.0 (784)	30.2
<i>Participant Age</i>		
18-24	26.1 (471)	27.4
25-34	43.2 (780)	39.8
35-44	30.7 (555)	32.7
<i>Marital or cohabitating status</i>		
Married	34.7 (625)	-
Not married but living with a partner	24.7 (444)	-
Not married	40.6 (731)	-
<i>Average Number of Children</i>	1.8 ± 0.1	-
<i>Participant Race</i>		
White	56.7 (984)	56.2
Black	17.8 (332)	20.3
Other	6.4 (120)	8.6
Not Reported	23.1 (432)	14.9
<i>Participant Hispanic Ethnicity</i>		
Yes	43.3 (762)	34.8
No	56.8 (1,000)	65.2
<i>Survey Language</i>		
English	79.8 (1,491)	-
Spanish	20.2 (377)	-
<i>Participant Insured</i>		
Yes	74.7 (1,343)	
No	25.3 (454)	34.9
<i>Main source of current health insurance coverage</i>		
Medicaid	51.6 (680)	39.8
Some other public insurance	5.1 (67)	9.2
Private insurance from employer or spouse/family	34.0 (449)	14.1
Some other health insurance	7.5 (99)	-
Multiple answers	1.8 (24)	-

*Source: 2013, HRSA Uniform Data System (UDS):
<http://bphc.hrsa.gov/uds/datacenter.aspx?q=tall&year=2013&state=>

Key Findings

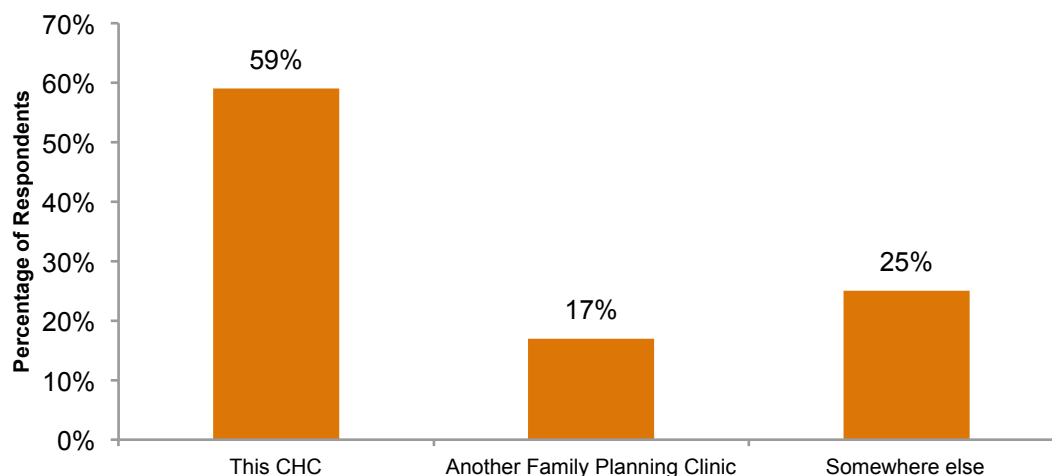
Family Planning & Contraceptive Service Use

Health centers account for the majority of family planning services received by their patients

The majority of survey respondents indicated that they had received family planning care recently, with over 64% reporting that they had seen a doctor or nurse for family planning care within the preceding 12 months. An additional 20% had received family planning between one and three years ago. Approximately 16% of survey respondents received family planning care three years ago or longer.

Among those who reported receiving family services, the majority reported that they had received their most recent family planning care at a health center (59%), while 17% had been seen in a family planning clinic. Twenty-five percent had received family planning services somewhere else (Figure 1).

Figure 1. Site of Last Family Planning Visit (n=1,838)



In an effort to better understand where patients obtain particular types of services related to family planning, we surveyed patients on various aspects of care. Table 2 shows that except for the specific services of sterilization, sterilization counseling, and emergency contraception, health centers represented the most common location for the receipt of reproductive health care. Health centers were the primary source of care for Pap smears and pelvic exams; birth control counseling; sexually transmitted disease testing, counseling, and treatment; and provision of contraceptive services.

Table 2. Have you ever received any of the following services?	Total % (n)	This CHC % (n)	Another Family Planning Clinic % (n)	Somewhere else % (n)
<i>Contraceptive visit</i>	67.99 (1176)	49.12 (519)	21.42 (227)	29.46 (312)
<i>Pregnancy test</i>	75.32 (1297)	47.41 (532)	19.64 (221)	32.95 (370)
<i>Pap smear or pelvic exam</i>	87.54 (1533)	47.92 (640)	17.08 (228)	35.00 (467)
<i>Counseling on birth control methods</i>	56.10 (941)	49.44 (386)	21.80 (170)	28.77 (225)
<i>Emergency contraception</i>	20.9 (330)	25.10 (73)	39.49 (115)	35.42 (103)
<i>Testing for a sexually transmitted disease</i>	63.51 (1055)	42.48 (381)	20.98 (188)	36.54 (328)
<i>Treatment for a sexually transmitted disease</i>	23.40 (371)	41.02 (132)	22.37 (72)	36.61 (117)
<i>Counseling on a sexually transmitted disease</i>	38.98 (634)	42.18 (220)	24.23 (126)	33.58 (175)
<i>Sterilization</i>	24.37 (386)	21.88 (65)	9.09 (27)	69.03 (204)
<i>Counseling on sterilization</i>	24.33 (390)	30.94 (101)	18.39 (60)	50.67 (166)

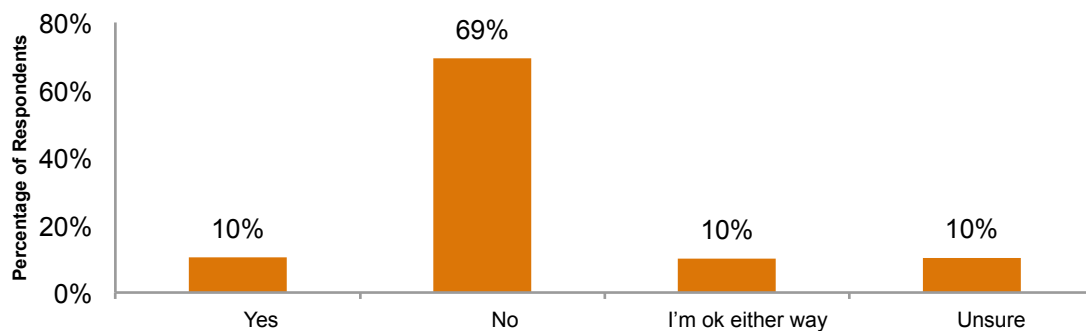
Our focus group participants echoed these survey responses, with most women indicating that they came to health centers for general primary care services along with family planning services, and at times for dental services. The most common services mentioned included Pap smears, mammograms, vaccines, counseling, and birth control. But it also became clear, at least qualitatively, that some women were receiving reproductive health services at multiple sites. For instance, they might use a health center for pelvic exams and Pap smears, while visiting a free-standing family planning clinic or the local health department for contraception, as it might be cheaper or dispensed more readily at these locations.

Most surveyed women do not intend to become pregnant in the next 12 months, underscoring the importance of effective family planning services

Our survey collected information about women's pregnancy intentions and ambivalence through a metric known as "One Key Question®," whereby a woman is asked whether or not she would like to become pregnant in the coming year. This question not only informs provider actions around contraception and pre-conception care¹² but also helps underscore – at least implicitly – the importance of effective family planning options for patients who are not actively seeking to become pregnant. Among our respondents, the majority (69%) indicated they did not want to become pregnant, while 20% were either unsure or okay either way. Only 10% of respondents reported that they would like to be pregnant in the next year (Figure 2).

¹² Bellanca HK & Hunter MS. (2013). ONE KEY QUESTION: preventive reproductive health is part of high quality primary care. *Contraception*. 88(1); 3-6.

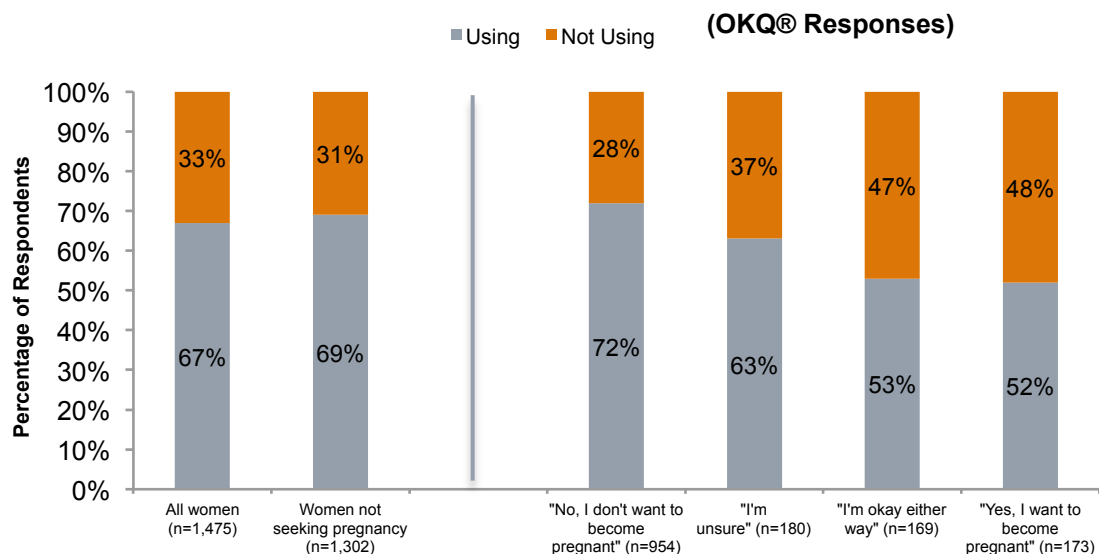
**Figure 2. Intent to Become Pregnant in the Next Year
(n=1,847)**



Many patients who do not intend to become pregnant are not using contraception

Consistent with their expressed intentions, most survey respondents are currently using contraception (67%). Figure 3 shows that over two-thirds of all respondents reported currently using contraception; however, contraceptive use differs by pregnancy intention. Among the women who reported that they do not intend to get pregnant in the next year, 28% reported using no contraceptive method at all. Among women who were unsure, 37% were not using contraception, while nearly half of those who responded that they were “okay either way” reported not using contraception (47%).

**Figure 3. Current Contraceptive Use,
by Pregnancy Intention (n=1,475)**



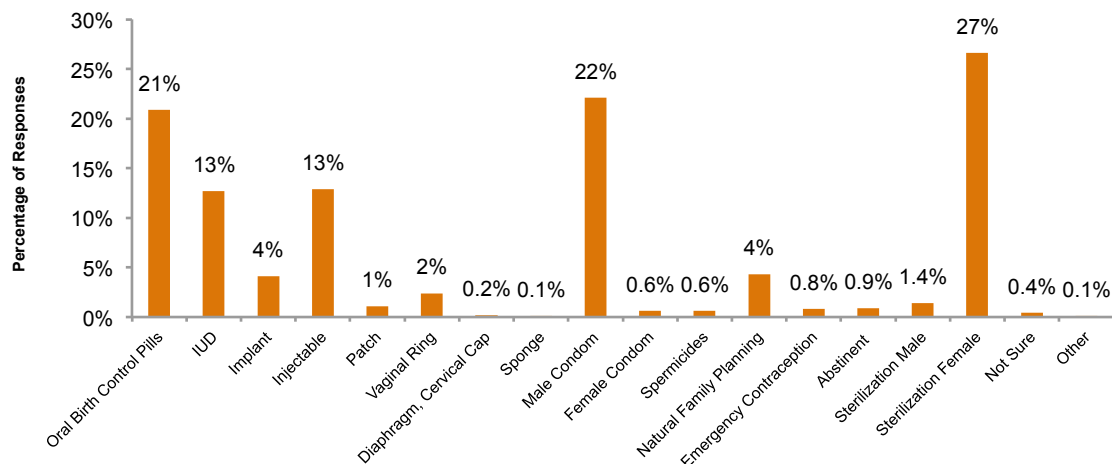
* Women not seeking pregnancy are defined as those 18-44, not sterilized, who are not pregnant, and do not want to become pregnant, are unsure or okay either way.

When assessing contraceptive use among women not seeking pregnancy, we also found significant differences based on where women report receiving their family planning care (p-value = 0.009). In fact, the highest rates of contraceptive use among these women were observed among those who reported receiving family planning services at another family planning clinic (77%) and the lowest rates among women who reported receiving family planning care somewhere else, such as a health department or private practice clinic (61%). Among women who reported receiving family planning services in community health centers, approximately 71% were using contraceptives. Still, across our total sample of women not seeking pregnancy, 31% are not using a contraceptive method.

Approaches to contraception vary, and younger women are focused on effective contraception approaches other than sterilization

Our survey respondents also reported variation in contraceptive method selection (see Figure 4). The most frequently reported contraceptive methods used by survey respondents included male condoms (22%), oral birth control pills (21%), IUDs (13%), injectable contraceptives (13%), and female sterilization (27%). Among the general population, there are similar rates of female sterilization (26%) and higher use of oral contraceptive pills (28%).¹³ However, national data show that women do not rely as heavily on male condoms compared to our survey respondents (16% vs. 22%) or on other hormonal methods, including IUDs (6% vs. 13%), although this has been increasing in recent years.¹⁴

Figure 4. Current Types of Birth Control Method Used



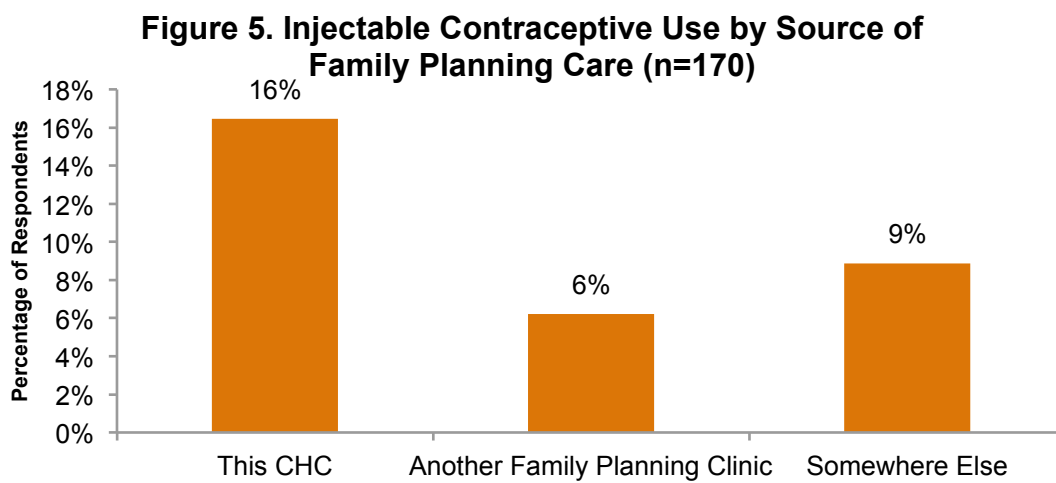
* Note: This question allowed respondents to select multiple contraceptive methods.

¹³ Jones J, Mosher W & Daniels K. (2012). Current contraceptive use in the United States 2006 – 2010, and changes in patterns of use since 1995. National Health Statistics Report no. 60, October 18, 2012.

¹⁴ Inferences about contraceptive use in health center populations compared the general population should use a fair degree of caution, given that measurement and methodologies differ substantially across these two data sources.

Our analysis found that contraceptive method choice differed significantly by age for certain methods. For example, more women under age 25 reported using oral birth control pills (p-value < 0.001), implants (p-value = 0.001), injectable contraceptives (p-value = 0.025), and male condoms (p-value < 0.001) compared to women over age 25. Women over age 35 reported female sterilization significantly more than younger women (p-value < 0.001).

Finally, we found that variation in contraceptive method utilization was not explained by source or location of care, with the exception of injectable contraceptives, which were used significantly more among patients of community health centers than patients of family planning clinics or other sources of care. Figure 5 shows women who rely on health centers as their usual source of care are more likely to use a contraceptive injection compared to women who use other sources of care.



* differences by source of care are significant at p-value <0.05

Other differences in contraceptive method choice exist across Hispanic ethnicity. Hispanic/Latina women reported more utilization of male condoms (29%) compared to non-Hispanic women (19%, p-value<0.001) but far lower rates of female sterilization (21% vs. 30%; p-value =0.014).

Most women report using their preferred birth control method, but many seek information about additional options

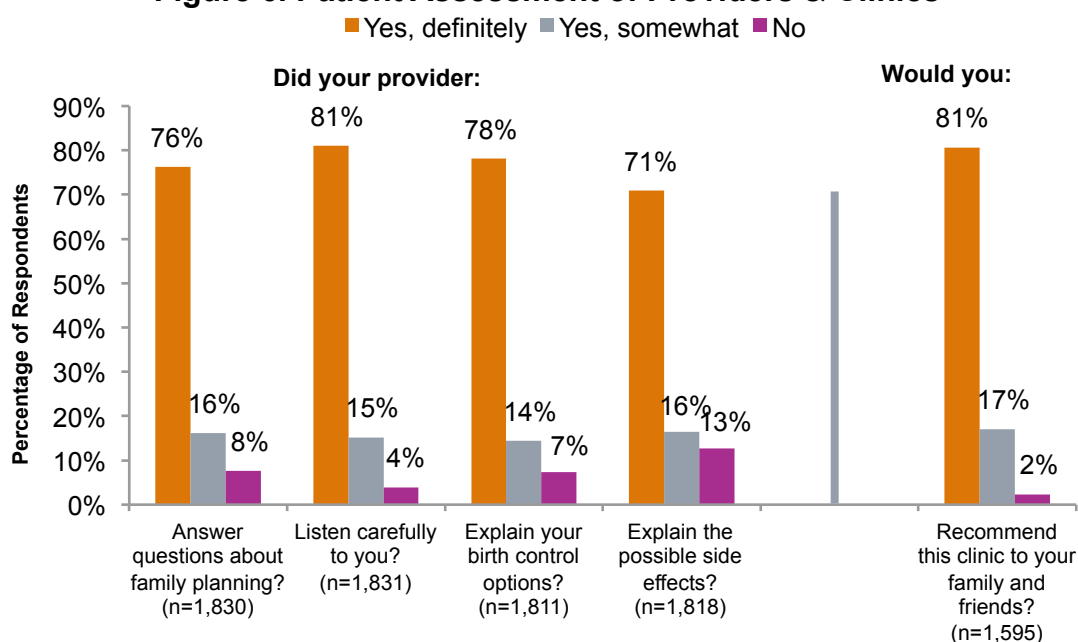
In addition, we found that among the women reporting contraceptive use at the time of the survey, over 85% reported using their preferred method, while 13% reported wanting to use a different method, and very few women indicated they were unsure. Of the women currently using their preferred method, the top three reasons for using their selected method were “it’s affordable,” “my insurance covers it,” and “my provider recommended it to me.” Among the women who reported not currently using their preferred method, nearly one in four reported that they experienced complications or side effects with their first-choice method. Another 15% reported affordability as a barrier, and 13% reported not having adequate insurance to cover the method. This finding of perceived inadequate insurance coverage is especially important given recent reports suggesting deficiencies in family planning coverage among plans sold in state insurance marketplaces, as well as potential coverage limitations under state Medicaid programs. These results did not significantly differ by respondent’s source of care.

Experiences with Family Planning Care at Health Centers

Women reported a high level of satisfaction with their family planning services

We asked survey respondents to rate their overall satisfaction of and experience with family planning care using adapted items from the Clinician-Group Consumer Assessment of Healthcare Providers and Systems survey (CG-CAHPS).¹⁵ Regardless of the source of care, survey respondents reported a high degree of satisfaction with their care. Over three-quarters reported that their providers answered their family planning questions. Over 80% reported that their providers listened fully, and nearly that many reported that their providers explained their options. A smaller proportion reported that their providers explained possible side effects. Over 80% reported that they would recommend their source of family planning care to family and friends.

Figure 6. Patient Assessment of Providers & Clinics



We compared measures of patient experience and satisfaction across three sources of care (community health centers, family planning clinics, and other sources of care). For nearly all measures of patient experience, respondents receiving care at health centers reported generally high satisfaction compared to respondents who reported receiving care in other locations. For example, 81% of those receiving family planning care at health centers felt like their provider definitely answered questions about family planning care to their satisfaction, compared to 71% each at family planning clinics and other sources of care (p-

¹⁵ Agency for Healthcare Research and Quality (AHRQ). CAHPS Clinician & Group Visit Survey. Available at: <https://cahps.ahrq.gov/surveys-guidance/cg/visit/index.html>

value = 0.002). Overall according to our survey respondents, satisfaction was consistently higher at health centers compared to other sources of family planning care, even as satisfaction was high at all places women received care.

Women identify important priorities when selecting health centers as their source of family planning care

We also asked survey respondents to indicate their most important reasons for choosing a particular source of family planning care, and results are shown in Table 3. Among those receiving care at community health centers, the top two priorities for selecting a health center for family planning care were “the staff treat me respectfully” and “the services are confidential” (91% of respondents). In addition, 87% of respondents reported “I feel comfortable with my provider” and “staff know about women’s health” as priorities for family planning care.

Table 3. Top 5 Patient Priorities in Family Planning by Source of Care			
	<i>This CHC</i>	<i>Another Family Planning Clinic</i>	<i>Somewhere else</i>
1	The staff treat me respectfully	Staff know about women’s health	The services are confidential
2	The services are confidential	The services are confidential	I feel comfortable with my provider
3	I feel comfortable with my provider	The staff treat me respectfully	The staff treat me respectfully
4	Staff know about women’s health	I feel comfortable with my provider	Staff know about women’s health
5	Staff take time to talk to me	Staff take time to talk to me	Staff take time to talk to me

Focus group participants echoed these priorities as important components of family planning care. The rich nature of our qualitative data allowed us to explore additional priorities for care in more depth with focus group participants. In particular, they offered many reasons for choosing their particular source of care: convenience; the availability of multiple services on site; a consistent provider relationship; and affordability. At multiple sites, women reported that convenience and strong provider relationships made them feel satisfied with care. Positive relationships with providers and staff and the availability of counseling services helped women feel satisfied with referrals and care coordination.

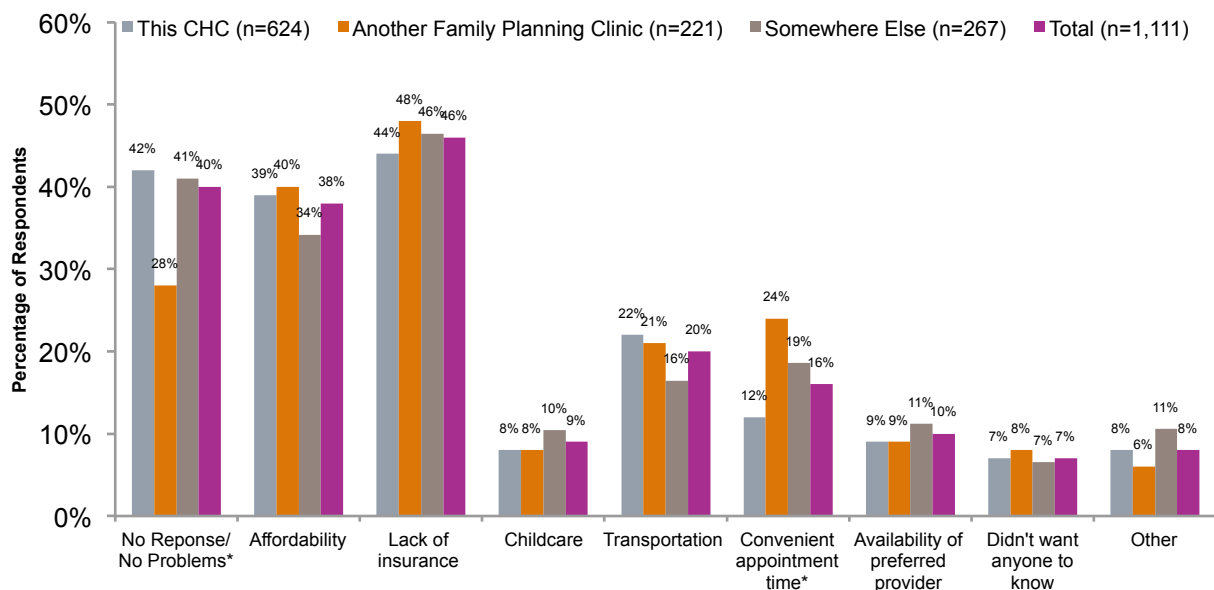
Focus group participants reported that they had left other care sites as a result of poor counseling, education, and overall atmosphere. Younger women tended to be content with multiple, sometimes inconsistent, sources of care, while older women preferred staying with a single provider at the health center. Health centers with school-based sites had more satisfied younger women. Additionally, because most women had been uninsured at one time or another, the ability to get free or low-cost care at health centers drove their decisions regarding care. The majority of focus group participants had children, and felt that being able to

take care of family planning along with a well-child visit improved their ability to access care and was convenient. Participants who did not avail themselves of family planning services at the health center either already had a family planning service provider somewhere else or preferred to keep their services separate. A smaller group indicated that they followed past providers from previous sources of care to the health center. Younger women who were both parents and new patients at the health centers felt that their needs had been previously met at other family planning clinics or the local health department, but that these providers were no longer adequate once they had given birth and were seeking care for their children as well.

Women also reported barriers to care

While most survey respondents reported being fairly satisfied with their care, they also reported barriers across all sources of care. The most frequently cited barriers were unaffordability of care (38%) and lack of health insurance (46%). Other notable reasons for not receiving needed family planning care included transportation barriers (20%) and not being able to get a convenient appointment time (16%). Figure 7 shows that women who received family planning care at community health centers were significantly less likely to report access barriers than were those who used other family planning clinics (p-value = 0.009). Comparing across sources of care, nearly one in four women obtaining care at a family planning clinic reported not being able to get a convenient appointment time, compared to only 19% of women who get their care somewhere else, and 12% of health center respondents (p-value = 0.003).

Figure 7. Barriers to Access to Family Planning by Source of Family Planning Care (n=1,111)



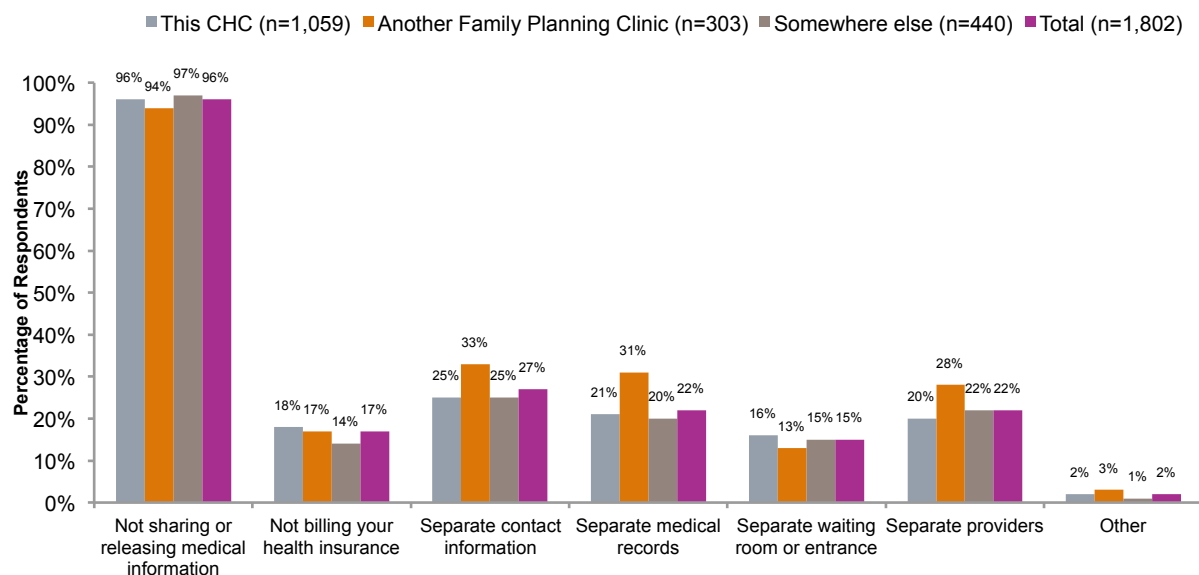
*difference is significant at p-value <0.01

Focus group participants often reported similar barriers to those reported by survey respondents. Concerns arose at all focus group sites around wait times and provider consistency. Women expressed discontent with having to wait for appointment times and needing to get an internal referral prior to receiving care or when moving from one part of the health center to another (in the case of health centers that maintained separate women's health departments). Women placed great importance on a consistent provider relationship; however, newly insured women or women without insurance were less concerned with consistency compared to access to care. Women overwhelmingly reported an ease of getting birth control on-site at other family planning clinics compared to health centers. They reported that while health centers required regular renewal of birth control prescriptions, family planning clinics often dispensed a long-term supply immediately.

Privacy and confidentiality are extremely important to all women

Over 80% of survey respondents reported that confidentiality of family planning care was extremely important to them, with 15% indicating confidentiality to be very important. In particular, most women reported that “not sharing or releasing medical information without your permission,” was a critical item for maintaining family planning confidentiality. Other confidentiality practices that were important to women appeared to differ by source of care; this was primarily reflected in the subgroup of survey respondents who also reported receiving family planning care from a family planning clinic, of which a larger proportion viewed “maintaining separate medical records for family planning services” to be a key element of confidentiality (Figure 8).

Figure 8. Important Measures to Maintain Confidential Services by Source of Family Planning Care (n=1,802)



In light of patients' priorities for family planning confidentiality, our survey asked respondents if they had ever paid for a family planning visit out-of-pocket rather than bill their insurance because they didn't want someone else to know. Approximately 15% of survey respondents reported that they had avoided billing insurance for family planning services out of confidentiality concerns. Significantly fewer women getting family planning care at health centers reported this practice (13%) compared with survey respondents receiving care at family planning clinics (22%) or other sources of care (15%; $p\text{-value} = 0.022$).

When asked about what was important to their care experience, focus group participants indicated that privacy, communication, and trust were the most important to them in the realm of family planning. Women wanted to have all their questions answered by their provider without judgment or feeling stigmatized.

Focus group participants also were often concerned about confidentiality. Some found that health centers offered services that were sufficiently confidential, while others did not. Some women felt that getting care from a community provider whose staff knows them undermined confidentiality, suggesting that health center staff did not sufficiently prioritize the confidentiality of patient care. At the same time however, women valued the anonymity that comes from receiving health care at a community health center, because their visit could be for one of an array of purposes and not necessarily for family planning. In this respect, health centers were perceived as offering a level of privacy not available at single-purpose providers.

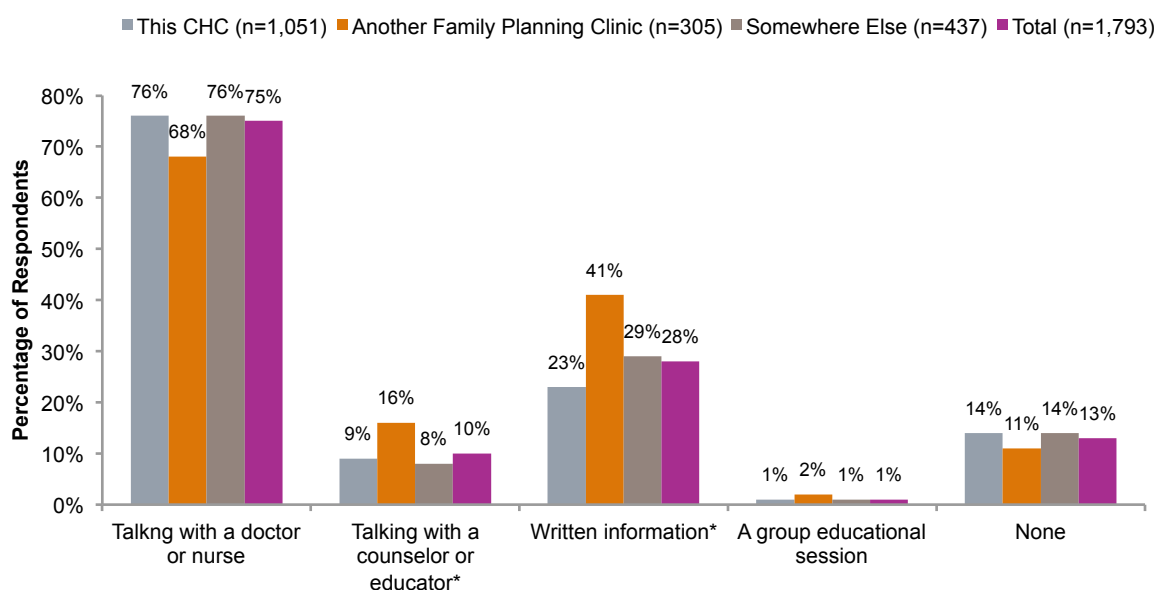
Concerns about privacy and ease of access may be causing health center patients to seek family planning services elsewhere

If they did not receive family planning care at the health center, focus group participants were likely to have visited a family planning clinic, a local health department, or an office-based health care professional. Respondents who used other sites most often indicated that they were receiving STD and pregnancy testing at these other locations, suggesting that privacy might be a consideration. Those women who went consistently to other family planning clinics reported doing so because of the greater ease with which they could obtain birth control pills and because of lower costs. Many women who visited local health departments reported experiencing difficulty in obtaining family planning care from the health center or finding the atmospheres to be uninviting and stigmatizing, which in turn caused them to seek out alternative sources of care.

Women reported only limited counseling

Our survey asked women about the type of information they received during their most recent family planning visit (Figure 9). A large majority of survey respondents reported receiving family planning information directly from their provider (75%). But far fewer (28%) reported receiving written information, and only 10% reported receiving information from a women's health counselor or family planning educator. Thirteen percent of survey respondents indicated that they did not receive any information at all. Women were more likely to get written information or talk with a counselor at other family planning clinics.

Figure 9. Sources of Family Planning Information by Source of Family Planning Care (n=1,793)



* significant differences in source of family planning information, by source of care (p-value < 0.05)

The importance of comprehensive access to information and counseling, along with timely care, was echoed among focus group participants who valued these resources as key components of family planning care.

Care coordination emerged as an important issue

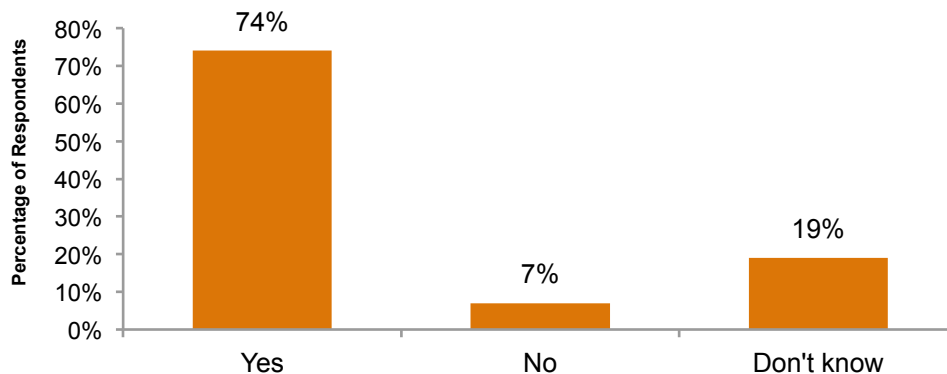
While many survey respondents reported that they received most family planning services within their regular source of family planning care, 49% reported receiving a referral to another source of care for certain family planning services. Among those who had received a referral, the most frequently reported reasons were because “my doctor or nurse didn’t provide the service” (27%) and “it was free or low-cost at another place” (22%). Thirty-two percent of respondents who used health centers for family planning reported receiving referrals because “my doctor or nurse didn’t provide the service,” which was significantly higher than those receiving care at family planning clinics (26%) or somewhere else (15%, p-

value = 0.024). No other reasons for referrals appeared to differ by source of care.

For most survey respondents who were referred, regardless of their original source of family planning care, the referred services were accessed with no identified problems. However, nearly 13% of survey respondents who originally got their care from somewhere else reported that they were not able to get the family planning services for which they were referred. Only 4% of women receiving family planning care at a health center and 6% of those receiving care at a family planning clinic reported that they could not get the family planning service for which they were referred.

Finally, we asked women insured at the time of the survey to report whether or not their health insurance covered the cost of family planning care. Three-quarters of survey respondents (74%) indicated that their health insurance coverage was adequate in covering the cost of family planning care; however, 7% of respondents did not find their coverage adequate and even more (19%) did not know whether their insurance provided adequate coverage for family planning (Figure 10).

Figure 10. Adequate Insurance Coverage for Family Planning (n=1,443)



Discussion and Recommendations

These findings yield several important conclusions and a series of recommendations.

1. *Ninety percent of women patients at health centers are not actively seeking pregnancy, and over 3 in 10 of these women are not using contraception. This signals a high unmet need for family planning.*

Family planning is a core health center activity, and as we found in our earlier research, health centers recognize its importance. Virtually all community health centers reported providing family planning services and offering at least one contraceptive method on-site.¹⁶ In our current study, we asked women who obtain their primary care at participating health centers if they wanted to become pregnant in the next year, the One Key Question®, and nearly 70% responded that they did not. Only 10% of respondents were actively considering pregnancy during the next year. This makes access to high-quality family planning counseling and services essential at all health centers, especially because the majority of patients look to health centers for their family planning care.

Women hold a positive view of the family planning care they receive at health centers, and yet this study also revealed serious challenges. Of particular concern is our finding that among patients not actively considering pregnancy (the vast majority of patients surveyed) three in ten women at risk of unintended pregnancy nonetheless were not using contraception at the time of the survey. Furthermore, some women who depended on health centers for family planning services reported lapses in the effectiveness and quality of care, including a lack of counseling, insufficient care management, and limited access to onsite contraceptives such as birth control pills.

These findings underscore the importance of clearly identifying women's pregnancy intentions as part of routine primary health care. Our findings also reveal the importance to women and their families of health center capacity where accessible, high-quality family planning services are concerned. Routine screening for unmet family planning need, along with rapid access to comprehensive family planning services as outlined in the 2014 CDC/OPA Guidelines, is essential to performance improvement efforts at health centers.

The high proportion of women not affirmatively seeking to become pregnant and yet not using contraception should be of especial concern, as should the access problems identified in this study. Overall, contraceptive use rates among health center patients appear similar to national rates.¹⁷ But 28% of women who

¹⁶ Susan F. Wood et al., Health Centers and Family Planning: Results of a Nationwide Study (George Washington University, 2013) http://hsr.himmelfarb.gwu.edu/sphhs_policy_facpubs/60/

¹⁷ According to the CDC's most recent estimates, approximately 62% of women age 15 – 44 were currently using contraception in 2011-2013. However, this data includes adolescents age 15-18, who were not eligible for our study. Daniels K, Daugherty J & Jones J. (2014). Current contraceptive status among women aged 15-44: United States 2011 – 2013.

express no desire to become pregnant in the next year nonetheless are not using any form of contraception. Still higher rates of non-contraceptive use are present among women who express ambivalence toward pregnancy (47%). This finding supports other studies that have shown the strong association between ambivalence and contraceptive non-use or gap in use of contraceptive methods.¹⁸

2. Confidentiality of Family Planning Remains a Key Component of Patient-Centered Care

As expected, a considerable number of women responding to our survey and focus group discussion believe that confidentiality and privacy are key components of high-quality family planning care. In fact, 96% of survey respondents reported that confidentiality of personal information was extremely or very important to them. However, confidentiality of services was expressed in different ways, according to the survey responses. Nearly all survey respondents agreed that not sharing or releasing medical information without permission was important for maintaining confidential services, but far fewer consider other practices critical for maintaining confidentiality. These included not billing insurance for family planning, and maintaining separate contact information, separate medical records, separate providers, or separate waiting rooms specifically for family planning and reproductive health care.

Women who reported getting their care at a family planning clinic were more likely to value “separate” care. This includes having a separate medical record for family planning care as a critical component of confidentiality of care, as well as separate providers and separate contact information. Due to the comprehensive nature of most CHC clinical settings and primary care delivery models, it is not surprising that many women receiving care at health centers would not view separate medical records, providers, or waiting rooms for family planning as key mechanisms of maintaining confidentiality. In fact, according to our focus group participants, women feel like their care is confidential because they are able to seek services at a CHC without an obvious indication that the care they are seeking is necessarily related to reproductive health. In this respect, health centers seem to meet their patients’ expectations with regard to confidentiality and privacy of family planning services.

3. Experiences at Community Health Centers Differ Compared to other Sources of Care

Overall, patients report very high satisfaction with family planning and reproductive health care across multiple sources of care. However, we found that respondents receiving family planning care at health centers reported higher rates of satisfaction on several indicators than did respondents who received family planning care in other settings, including family planning clinics. Some of

¹⁸ Frost JJ, Singh S & Finer LB. (2007). Factors associated with contraceptive use and nonuse, United States, 2004. *Perspect Sex Repro Health.* 39(2); 90-99.

the reasons women getting family planning care at health centers reported being satisfied often had to do with being able to receive multiple services in one site – regardless of family planning needs – and because they had strong relationships with clinical providers, as well as the ability to access health center sites in convenient locations. The fact that women value and depend on health centers for family planning care serves to further emphasize the importance of engaging in quality improvement efforts in order to further strengthen the patient experience.

While women who received family planning care at health centers had no significant difference in accessing contraceptive methods compared to women receiving their care in other settings, one important difference was noted. Survey respondents receiving family planning care in community health centers reported significantly higher use of injectable contraceptives than women in other sources of care. This appears to align with the findings of our previous study on availability of contraceptive services from the perspective of the health center organization. This study found that health centers' typical family planning service package included STI testing and treatment as well as provision of oral contraceptives plus one additional contraceptive method, usually injectable contraception.¹⁹ This is reflected in health center patients' utilization of contraceptive methods, quite possibly because it is the most available method on-site at health centers.

Another key difference in survey respondents' experiences with family planning care across different sources of care was in the delivery of information and counseling. According to our previous organizational survey, fewer health centers employed a women's health counselor or educator compared to those health centers that had Title X funding. We found this to be true, even from the patient perspective, as those patients who received care in family planning clinics (which generally receive Title X funding) reported receiving information from a women's health counselor or through written materials more frequently than did survey respondents getting their family planning services at community health centers. However, overall women reported general satisfaction with the information they received, regardless of the source of information or the source of care.

4. Major Barriers to Family Planning Care Persist, Regardless of Source of Care

Even though survey respondents reported high satisfaction in health centers and in other sources of care, they also consistently reported affordability-related barriers to family planning care. With respect to both family planning and contraceptive use, the two most frequently reported concerns were cost of care and insurance coverage. For example, women reported that the predominant reasons they chose a particular contraceptive method was because it was affordable and because it was covered by their health insurance. We found this

¹⁹ Susan F. Wood et al., *Health Centers and Family Planning: Results of a Nationwide Study* (George Washington University, 2013) http://hsrc.himmelfarb.gwu.edu/sphhs_policy_facpubs/60/

to be echoed strongly in our focus group discussions. Similarly, women indicated that if they had to avoid, forgo, or delay family planning care, it was often because it was either unaffordable or because they were uninsured. These barriers were reported by a significant proportion of the women in our survey, regardless of where they sought family planning services. Importantly, and troubling, is the fact that among the women who reported having insurance coverage, nearly one in five did not know if their coverage was sufficient to cover the cost of family planning and contraceptive care. Because family planning is covered by both Medicaid and private insurance without cost sharing, this level of confusion is troubling.

Based on our findings, we make the following recommendations:

1. Given the high degree to which women depend on health centers for family planning services, health centers should examine and strengthen their family planning programs. HRSA should prioritize helping health centers achieve this, through clear guidance on how to utilize the CDC/OPA guidelines, technical support, and the resources needed to upgrade services. Key investments would, as we have noted in previous studies, include the recruitment and training of clinical staff and family planning counselors, investment in a broader array of onsite contraceptive methods, and expansion of service locations. Given the fact that virtually all women with public or private health insurance will have coverage for family planning services – including all FDA-approved methods – insurers and Medicaid programs should be covering ongoing costs after initial investment is made.
2. Health centers should move rapidly toward assessing women's pregnancy intention by adopting a screening protocol such as the One Key Question®. Women readily answered the question in our survey, and use of the question helps ensure identification of all women of reproductive age who do not affirmatively intend to become pregnant, so that such women can receive immediate follow-up counseling, contraceptive care, or referral for family planning services.
3. Working with health centers and state primary care associations, HRSA should develop recommended best practice approaches to patient privacy and confidentiality. Some health center patients may prefer to use a separate health care provider for their family planning services for many reasons. But there should be no doubt about the privacy of health information or the confidentiality of care for those patients who depend on health centers for sensitive services such as family planning. For health centers that receive Title X funding, federal law effectively supersedes state laws that limit the confidentiality of treatment. But health centers should not assume that state law permits a lower level of confidentiality than it does. To the fullest extent possible, health centers should ensure that their protocols maximize the confidential nature of services.

About the Geiger Gibson/RCHN Community Health Foundation Research Collaborative:

The Geiger Gibson Program in Community Health Policy, established in 2003 and named after human rights and health center pioneers Drs. H. Jack Geiger and Count Gibson, is part of the Milken Institute School of Public Health at The George Washington University. It focuses on the history and contributions of health centers and the major policy issues that affect health centers, their communities, and the patients that they serve.

The RCHN Community Health Foundation is a not-for-profit foundation established to support community health centers through strategic investment, outreach, education, and cutting-edge health policy research. The only foundation in the U.S. dedicated solely to community health centers, RCHN CHF builds on a long-standing commitment to providing accessible, high-quality, community-based healthcare services for underserved and medically vulnerable populations. The Foundation's gift to the Geiger Gibson program supports health center research and scholarship. Additional information about the Research Collaborative can be found online at [Geiger Gibson Program in Community Health Policy](#) or at [RCHN CHF - GEIGER GIBSON](#)

About the Jacobs Institute of Women's Health

The Jacobs Institute of Women's Health (JIWH) is a nonprofit organization working to improve health care for women through research, dialogue, and information dissemination. Our mission is to:

- Identify and study women's health care issues involving the interaction of medical and social systems
- Facilitate informed dialogue and foster awareness among consumers and providers alike
- Promote problem resolution, interdisciplinary coordination and information dissemination at the regional, national and international levels

The Jacobs Institute works to continuously improve the health care of women across their lifespan and in all populations. The Jacobs Institute promotes environments where an interdisciplinary audience, including health care professionals, researchers, policymakers, consumers, and advocates come together to discuss ways to advance women's health. Information can be found online at www.jiwh.org