Women's Health Issues 22-6 (2012) e519–e525

WOMEN'S HEALTH ISSUES
www.whijournal.com

Original article

Specialized Family Planning Clinics in the United States: Why Women Choose Them and Their Role in Meeting Women's Health Care Needs

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Article history: Received 20 April 2012; Received in revised form 30 July 2012; Accepted 6 September 2012

A B S T R A C T

Background: Publicly funded family planning clinics provide contraceptive care to millions of poor and low-income women every year. To inform the design of services that will best meet the contraceptive and reproductive health needs of women, we conducted a targeted survey of family planning clinic clients, asking women about services received in the past year and about their reasons for visiting a specialized family planning clinic.
Methods: We surveyed 2,094 women receiving services from 22 family planning clinics in 13 states; all sites included in the survey were clinics that specialize in contraceptive and reproductive health services and were located in communities with comprehensive primary care providers.
Results: Six in 10 (59%) respondents had made a health care visit to another provider in the past year, but chose the family planning clinic for contraceptive care. Four in 10 (41%) respondents relied on the family planning clinic as their only recent source for health care. The four most common reasons for choosing a specialized family planning clinic, reported by at least 80% of respondents, were respectful staff, confidential care, free or low-cost services, and staff who are knowledgeable about women's health.
Conclusions: Specialized family planning clinics play an important role as part of the health care safety net in the United States. Collaborations between such clinics and comprehensive primary care providers, such as federally qualified health centers, may be one model for ensuring women on-going access to the full range of care they need.

Background

Each year, the network of publicly funded family planning clinics provides contraceptive services to more than 7 million U.S. women (Frost, Henshaw, & Sonfield, 2010), representing one quarter of all U.S. women who receive such care (Frost, 2008). For many women, publicly funded family planning clinics serve as their regular source for medical care (Gold et al., 2009). In addition to contraceptive services, which include counseling, birth control methods, and periodic gynecological checkups, publicly funded family planning clinics provide a range of other services, such as cancer screening, sexually transmitted infection (STI) testing and treatment, pregnancy-related services, and general health screening and referrals for other conditions, such as high blood pressure and diabetes (Frost et al., 2012).

Clinics that provide publicly funded contraceptive care can be divided into those that specialize in the provision of contraceptive and reproductive health services and those that provide contraceptive services in a broader primary care context. Among specialized family planning clinics, about half are health departments and the other half includes Planned Parenthood clinics, hospital clinics, and other community women's health clinics. Among primary care–focused family planning clinics, more than half are federally qualified health centers (FQHCs); this group also includes some hospital and health department clinics that provide family planning care along with a range of different public health services.

Some of the service delivery features that distinguish specialized family planning clinics from those with a primary care focus are the number and range of contraceptive methods offered on-site; for example, 67% of all specialized family planning clinics offer at least 10 different contraceptive methods on-site compared with 41% of primary care–focused clinics that do so. Similarly, specialized family planning clinics are more likely

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http://dx.doi.org/10.1016/j.whi.2012.09.002

than primary care–focused clinics to offer clients long-acting reversible contraceptives like IUDs and implants (75% vs. 57%). Nearly 9 in 10 specialized family planning clinics provide referrals to other primary care clinics located in their communities, with three in four providing referrals to community health centers (Frost et al., 2012).

On the other hand, clinics with a primary care focus are more likely than specialized clinics to offer a wider range of nonreproductive health services, such as weight management or smoking cessation programs, diabetes screening, and mental health screening, as well as comprehensive primary care. They are also more likely to have clinicians that speak three or more languages and to have clinical staff that provides translation services for patients. Compared with specialized family planning clinics, sites with a primary care focus serve a higher proportion of Medicaid clients and are more likely to have contracts with health plans serving Medicaid enrollees (Frost et al., 2012).

Although reproductive health–focused clinics comprise about half of the publicly funded clinic network, they serve the majority of the contraceptive clients who visit this network, primarily because clinics specializing in reproductive health care serve a greater number of contraceptive clients each year. A recent survey of publicly funded family planning clinics found that 22% of specialized clinics reported serving more than 100 contraceptive clients per week compared with only 5% of primary care–focused clinics that reported serving this number of contraceptive clients. The majority of primary care–focused clinics (51%) reported serving fewer than 20 contraceptive clients per week compared with only 19% of specialized clinics that reported serving fewer than 20 clients per week (Frost et al., 2012). Based on these survey data, we estimate that specialized clinics currently serve about 70% of all contraceptive clients who receive care from the publicly funded clinic network (Frost, J. J., 2012. Survey of clinics providing contraceptive services. Unpublished raw data).

Despite extensive literature documenting the importance of publicly funded family planning clinics and describing the range of different services provided by this network (Frost, 2008; Frost et al., 2012; Gold et al., 2009), little is known about the reasons that are important to women when choosing one family planning clinic over another. Particularly in communities where women are able to choose from among several different publicly funded providers, we sought to examine why some women choose to visit a family planning clinic specializing in reproductive health when they have access to primary care–focused clinics where they would be able to receive a variety of health care services. We choose to focus on the women seeking care from specialized family planning clinics because these are the clinics that serve the majority of clients. In addition, we were interested in obtaining new data on women's perspectives that will be relevant to the ongoing policy and programmatic discussions about how to tailor women's health care services in a changing health care landscape. Understanding the perspectives of women obtaining care from specialized clinics will contribute to the evidence base needed to inform the design of services that will best meet the contraceptive and reproductive health needs of women. It will also help to inform the need for potential partnerships between specialized family planning clinics and other community-based providers, such as FQHCs.

To address these issues, we conducted a targeted study that surveyed women who were obtaining care from specialized clinics located in communities with available primary care centers, and asked them what their reasons were for choosing to seek care from the specialized clinic. Our goals in this analysis were to 1) determine for whom the specialized family planning clinic serves as their main source of medical care; 2) assess why women choose to visit a specialized family planning clinic, even when they have other choices and may have visited other providers for other types of care; and 3) compare receipt of services and reasons for clinic choice among different subgroups of women.

Methodology

Sample and Fieldwork Protocols

We surveyed 2,094 women receiving services from 22 family planning clinics in 13 states between October 2011 and January 2012. The sampled clinics were purposively selected from among the respondents to a previous nationally representative survey of family planning clinics in the United States, as well as by contacting state or regional Title X program administrators to request their advice and help in identifying sites that met our specific two-factor criteria: 1) Being a reproductive health–focused family planning clinic and 2) being located in a community with available comprehensive primary care providers. Potentially eligible clinics were identified from the prior survey based on their response to two questions. The first asked administrators to identify the clinic's 'primary service focus,' with the following response codes: Reproductive health, primary health care, or other. The second question asked administrators whether there were primary care clinics available in their community. During sample selection, we identified several sites in a state based on their responses to these questions and then contacted a Title X administrator in each state to help us to choose the sites that best met our criteria, or to identify alternative sites. Two thirds of the final sample of clinics had been part of the prior survey sample and one third of the sample was identified from administrator recommendations. The participating facilities represent a range of provider types (e.g., Planned Parenthood clinics, health department clinics, hospital clinics, and independent family planning centers) and geographic regions, and were located in Alaska, California, Colorado, Iowa, Indiana, Kentucky, Louisiana, Massachusetts, Montana, Oregon, Pennsylvania, Texas, and Utah.

During fieldwork, we contacted the clinic or agency administrator at each sampled site to request their participation in the study. In some cases, several layers of review were required before participation was granted. Survey materials and instructions were provided to clinic managers at each participating site, and clinic staff were instructed to distribute the questionnaire to every eligible patient during the fielding period. All female clients, except those coming in for pregnancy-related services, were eligible to participate. Women completed the questionnaire on-site and returned it to clinic staff in a sealed envelope to ensure anonymity and confidentiality. The fielding period lasted 1 to 4 weeks at each clinic depending on patient volume (clinics with low patient volume were in the field for longer periods). Regular follow-up was conducted with clinic managers to answer questions and guide them through the fieldwork period; a $100 gift card was offered to each clinic as an incentive. One respondent at each site was also selected to win a $100 gift card incentive. Clinic staff distributed raffle entry forms to each respondent and one winner was randomly selected from each clinic at the end of the fielding period. At the end of fieldwork, each clinic reported the total number of eligible clients seen

during the fielding period. Clinics that failed to achieve a minimum 50% response rate were excluded from analysis (only one clinic fell into this category).The four-page survey instrument consisted of mostly closed-ended questions and was available in both English and Spanish. Surveys were pretested with English-and Spanish-speaking family planning clinic patients, and changes were made after pretesting to enhance comprehensibility and respond to patient concerns. The questionnaire asked women about the reason for their visit, the desired features that led them to visit that specific facility, what medical services they had received in the prior year, and where they received those services. Demographic characteristics and information about health insurance coverage were also collected. The survey instrument and protocols were approved by our organization's institutional review board.

Response

Of the 27 clinics identified for this study, three refused to participate, one was found to be ineligible, and one failed to reach a 50% response rate among clients. The remaining 22 clinics reported a total of 3,105 eligible female clients seen during the survey period and usable data were collected from 2,094 of these clients, for a response rate of 67%.

Analysis

Analyses were performed using SPSS Statistics version 18 (SPSS, Inc., Chicago, IL), using the complex samples procedures. Results are based on unweighted data, and the clustered nature of the sample has been accounted for in analysis and significance testing. Comparisons among subgroups of women have been tested for significance using independent group *t*-tests, and significance is reported for comparisons at $p < .05$.

Results

Client Characteristics

A majority of female respondents seeking services at specialized family planning clinics were under age 25–22% were teenagers and 34% were aged 20 to 24 (Table 1). Most clients had no children (58%) and most were neither married nor living with a partner (63%). Sixty-one percent of client respondents had an income below 100% of the federal poverty level, and an additional one quarter of clients had incomes between 100% and 200% of poverty. One in three respondents were on Medicaid or had some other form of public health insurance; 22% had private health insurance and 42% were uninsured. Half of respondents were non-Hispanic white (51%) and about one fifth were either non-Hispanic Black (21%) or Hispanic (23%). About 1 in 10 respondents spoke Spanish at home and a similar percentage was foreign born. Only one in five respondents indicated that this was their first visit to this clinic.

We compared the distribution of our respondents to the distribution of clients receiving care from Title X–funded clinics by key characteristics, such as age and race/ethnicity, and found them to be very similar, especially by age (Table 1). Some small variations between our sample and all Title X users can be seen in the poverty status and race/ethnicity distributions; however, the questions used to collect these data also vary between the two efforts and some variation may reflect different data collection methodologies.

Table 1
Percentage Distribution of Female Client Respondents, According to Background Characteristics, 2011 Survey of Clinic Clients and Comparison With Family Planning Program Users From the Title X Family Planning Annual Report (FPAR), 2010

Characteristics	Survey Respondents % ($n = 2094$)	FPAR 2010[†] (%)
Age (yrs)		
<18	8	10
18–19	14	12
20–24	34	31
25–29	21	21
≥30	24	26
Parity		
0 Children	58	NA
≥1 children	42	NA
Relationship status		
Married	14	NA
Living with a partner	24	NA
Not married or living with a partner	63	NA
Poverty status		
<100% FPL	61	69
100–200% FPL	25	22
≥200% FPL	15	7
Health insurance		
Medicaid or state insurance	35	NA
Private insurance	22	NA
None	42	NA
Race/ethnicity		
Non-Hispanic White	51	44
Non-Hispanic Black	21	19
Hispanic	23	28
Asian/other	6	5
Language spoken at home		
English	88	NA
Spanish	7	NA
Both English and Spanish	4	NA
Other	1	NA
Nativity		
US born	90	NA
Foreign born	10	NA
First visit to clinic		
Yes	21	NA
No	79	NA

Abbreviation: FPL, Federal poverty level; NA, not available.
[†] FPAR data (Fowler, et al., 2011) include all female family planning users for age and race/ethnicity distributions; the income distribution includes both male and female family planning users. For income, an additional 3% of users had missing data and for race/ethnicity an additional 4% of users had missing data.

Services Received

Half of respondents (48%) said that their primary reason for visiting the clinic at the time of the survey was for contraception—either to receive a new method, to continue using a method or to talk about an issue they were having with their method (Table 2). One in four respondents (27%) was at the clinic for an annual gynecological examination (which may have included receipt of a contraceptive method). Ten percent of respondents were primarily at the clinic for a pregnancy test, 8% for STI services, and 7% for some other type of service. Teens were more likely than older women to visit the clinic for contraception and less likely to be there for an annual gynecological examination.

In the prior year, nearly two thirds (64%) of respondents had received an annual gynecological examination (either at the same clinic or at some other provider), 59% had received a general health examination, 47% had made a visit for an STI test

Table 2
Percentage Distribution of Clients According to Primary Purpose of Current Visit and Types and Sources of Medical Care Received During the Prior Year, by Age, Parity, Poverty Status, and Insurance Status, 2011 Survey of Clinic Clients

	Total (%)	Age, yrs (%)			Parity (%)		Poverty Status (% FPL)		Insurance Status (%)		
		<20 (ref)	20–29	30+	0 Children (ref)	>1 children	<100 (ref)	≥100	None (ref)	Medicaid†	Private
n	2094	444	1088	471	1068	759	1046	680	863	718	451
Primary purpose of today's visit											
Contraception	48	62	45*	41*	50	45	48	47	47	47	49
Annual gynecologic examination	27	14	28*	35*	26	28	26	30	28	24	30
Pregnancy test only	10	7	12	11	10	11	10	11	11	10	11
STI service only	8	10	8	4	7	8	9	6	6	11	5
Other service only	7	7	7	8	6	8	8	6	8	7	6
Care received in prior year											
Annual gynecologic examination	64	42	70*	69*	58	73*	62	68	61	67	66
General health examination	59	66	57	60	58	62	61	57	50	66*	66*
STI test or treatment	47	50	52	34*	48	47	52	41	40	59*	43
Sick visit	42	50	38*	45	45	39	40	46	35	44*	53*
Source of prior year's care											
No prior care in past year	12	16	10	11	12	12	13	11	16	10	7*
All prior care from this clinic	29	17	32*	30*	27	31	30	26	33	28	20*
Some or all prior care from another provider	59	66	57	59	61	57	57	63	50	61	72*
Total	100	100	100	100	100	100	100	100	100	100	100

Abbreviations: FPL, Federal poverty level; ref, reference group; STI, sexually transmitted infection.
* Significantly different from reference group at $p < .05$.
† Medicaid includes other public or state-sponsored insurance plans.

or treatment, and 42% made a visit to a medical provider because they were sick. Teens and women without children were less likely to have made a visit for an annual gynecological examination compared with older women or women with children. Uninsured women were less likely to have received either a general health examination or a sick visit compared with women with public or private insurance.

We combined the results from these four questions about care received in the prior year, including information about where that care was obtained, to determine the percentage of respondents who had received no medical care prior to the current visit and the percentage whose only medical care had been obtained from the specialized family planning clinic they were visiting at the time of the survey.

Overall, in the past year, one in eight (12%) respondents made no prior visit for medical care, and 29% had only received care at the specialized family planning clinic. For these 41% of respondents, the specialized family planning clinic was their only source for medical care during the year. The majority of respondents (59%) had made at least one other visit for medical care in the prior year to a different provider, but when it came to making a visit for contraceptive or reproductive health care, they chose to visit a specialized family planning provider. Teens were less likely than older women to have only received prior care from the specialized family planning clinic. Uninsured women were more likely than privately insured women to have received no prior medical care or to have received all their care at the clinic—resulting in half of all uninsured women relying on the specialized family planning clinic as their only source of medical care. In contrast, only one in four (27%) women with private health insurance was relying solely on the specialized clinic for medical care.

Insurance Status and Use

Overall, 4 in 10 (42%) respondents had neither public nor private health insurance, 35% reported having Medicaid or some other form of public insurance, and 22% had private insurance (Table 3). African-American women were more likely than non-Hispanic White women to have public insurance; women with children, women under 100% of poverty, African-American women, and Hispanic women were less likely to have private insurance, compared with comparison groups. Among women with either public or private health insurance, about two thirds (68%) planned to use their insurance to pay for the visit they were making at the time of the survey, whereas one third (32%) did not.

We asked applicable women why they were not planning to use their insurance to pay for their current visit. Some (29%) did not think their insurance covered the service they were receiving, 18% were worried that someone might find out about the visit, 13% did not think their insurance could be used at the clinic, and 6% reported some other reason for not using insurance, including that services or methods were more expensive using their insurance, that their deductible was too high, or that they had forgotten to bring their insurance card. Teenagers were significantly more likely than women in their 30s to avoid using their insurance because of confidentiality concerns (31% vs. 4%).

Reasons for Choosing the Clinic

Respondents were asked to indicate how important* each of 18 different possible reasons was to their decision to visit the specialized family planning clinic, instead of going somewhere else for their care. Table 4 presents the percentages of respondents reporting that each reason was "very important" to their clinic choice and also creates seven summary groups of reasons that were substantively related, presenting percentages of respondents who reported that any of the two or three reasons in that group was very important to their choice.

* Response categories were 'Very important,' 'Somewhat important,' 'Not so important,' and 'Not applicable or available here.'

Table 3
Percentage of Clients by Insurance Status and Among Those With Public or Private Insurance, Plans to Use Insurance for Visit Payment and Reasons Why Not, by Age, Parity, Poverty Status, and Race/Ethnicity, 2011 Survey of Clinic Clients

Insurance Status and Reasons for Not Using Insurance	Total (%)	Age, yrs (%)			Parity (%)		Poverty Status (% FPL)		Race/ethnicity (%)			
		<20 (ref)	20–29	≥30	0 Children (ref)	≥1 children	<100 (ref)	≥100	White (ref)	Black	Hispanic	Asian/Other
Insurance status ($n = 2{,}064$)												
No insurance	42	32	43	52	41	45	44	42	46	23	50	51
Medicaid or state insurance	35	43	35	31	28	45	41	24	21	68*	40	24
Private insurance	22	25	23	17	30	10*	14	34*	33	9*	10*	25
Among those with public or private insurance, plans to use insurance to pay for visit ($n = 1{,}169$)												
Yes	68	63	69	74	62	78	73	62	63	79	70	55
No	32	37	31	26	38	22	27	38	37	21	30	45
Among those with insurance, but not using it, reasons why not ($n = 359$)												
Service not covered	29	30	26	35	31	21	25	34	39	8*	23	17
Someone might find out	18	31	15	4*	24	2*	17	19	22	5	14	38
Can't use insurance here	13	10	17	7	13	13	11	14	13	10	14	17
Other reason	6	6	8	4	7	6	9	5	8	5	3	4
Not specified	34	23	34	51	24	58*	38	28	19	73*	45	25
Total	100	100	100	100	100	100	100	100	100	100	100	100

Abbreviations: FPL, Federal poverty level; ref, reference group.
* Significantly different from reference group at $p < .05$.

The four individual reasons reported as very important by at least 80% of respondents were: "The staff here treat me respectfully" (84%), "Services here are confidential" (82%), "I can get free or low-cost services here" (80%), and "The staff here know about women's health"(80%). For teens, "Services here are confidential" was the top individual reason (86%), and for uninsured women, "I can get free or low-cost services" was the top reason (90%).

When reasons were combined into summary groups, six of the seven groups were reported as very important by more than 8 in 10 respondents (83%–89%). Accessibility was ranked at the top, with 89% of respondents reporting that at least one of three access-related reasons (location, hours, or wait time) was very important to their clinic choice. A similarly high percentage of respondents (88%) reported that the way they were treated by clinic staff (respectfully, or that staff take time to talk to me) was very important to their decision to visit the clinic. Affordability (either free or low-cost services or ability to use Medicaid) was very important to 85% of respondents; the same percentage reported that the clinic's focus on women's health (staff knowledge about women's health or easy to talk to staff about sex and birth control) was very important. Contraceptive method availability (can get the method I want or can get supplies, not just a prescription) was very important to 84% of respondents, and confidentiality (services are confidential or I won't see people I know) was very important to 83% of respondents. Just over half (56%) of respondents reported that having been referred to the clinic (either by friends, family, or another doctor or clinic) was very important to their choice to visit this clinic. For two thirds of respondents, the fact that staff at the clinic can refer them to other providers was very important to their choice; half of respondents said that the availability of teen or young adult services was important; and 17% reported that the availability of childcare was important.

Overall, there was relatively little variation among respondents in terms of what they valued and why they chose to visit the specialized family planning clinic. Accessible, affordable, confidential care delivered by respectful staff who are knowledgeable about contraceptive and reproductive health was considered very important by the vast majority of respondents from all major demographic subgroups. There were a few unsurprising variations: 92% of uninsured respondents reported that affordability was very important compared with 73% of respondents with private insurance. Method availability and confidentiality were relatively more important for teenagers compared with women in their 30s (88% vs. 76% for method availability and 88% vs. 81% for confidentiality), as was the availability of teen or young adult services. Women with children were more likely than those without to report that the availability of childcare was important to their clinic choice. There was also little variation in women's reasons for coming to the clinic by whether the respondent had received care from other providers during the year, had only visited this clinic, or had received no prior health care (data not shown).

Discussion

This study illustrates the role that family planning clinics that specialize in provision of reproductive health services play within the U.S. health care safety net. The women surveyed chose to seek care at a specialized family planning clinic, even though they had other choices in their communities. Although women typically gave multiple reasons for their choice, they most frequently said that they chose the specialized clinic because they felt that they would be treated with respect. The desire to be accorded respect was important to women regardless of age, income, insurance status, or whether they already had children.

Large majorities of women also said that they chose the family planning clinic because the staff is knowledgeable about—or easy to talk to about—sexual and reproductive issues or because the clinic makes it easy for them to get the contraceptive method they want, and to do so directly, without having to make a separate trip to a pharmacy to have a prescription filled. Provision of a broad package of contraceptive and related sexual and reproductive health (SRH) care services is a central feature of the specialized family planning clinic network that continues to be important to women. In fact, compared with primary care–focused family planning clinics, specialized clinics have been shown to provide a greater range of contraceptive methods, are more likely to have implemented streamlined method dispensing protocols, including dispensing methods on

Table 4
Percentage of Clients Reporting That Each Reason or Any of the Reasons Within a Summary Group Was Very Important to Their Choice to Visit the Clinic Instead of Going Somewhere Else, by Age, Parity, Poverty Status, and Insurance Status, 2011 Survey of Clinic Clients

Reasons for Deciding to Visit the Clinic Instead of Going Somewhere Else	Total		Age, yrs (%)			Parity (%)		Poverty Status (% FPL)		Insurance Status (%)		
	%	*n* (Unweighted)	<20 (ref)	20–29	≥30	0 Children (ref)	≥1 children	<100 (ref)	≥100	None (ref)	Medicaid†	Private
Top four individual reasons												
Staff treat me respectfully	84	1760	81	86	85	82	88	86	84	86	86	79
Services are confidential	82	1714	86	82	80	81	84	84	80	82	86	77
Can get free or low-cost services	80	1675	78	83	78	80	81	83	79	91	74*	72*
Staff know about women's health	80	1657	75	81	83	78	82	81	80	81	81	75
Summary groups												
Accessibility	89	1864	90	89	89	88	91	90	90	88	92	88
Location is convenient	72	1497	71	73	70	70	74	74	69	70	77	66
Hours fit my schedule	73	1528	68	73	79*	69	78*	74	73	74	76	69
Don't wait long for appointment	66	1379	65	65	69	62	70	67	64	67	68	62
Interaction with staff	88	1842	85	89	89	86	91	89	89	90	89	84
Staff treat me respectfully	84	1760	81	86	85	82	88	86	84	86	86	79
Staff take time to talk to me	77	1603	75	77	79	75	81	79	77	78	80	71
Affordability	85	1781	84	87	84	83	89	89	82	92	87	73*
Can get free or low-cost services	80	1675	78	83	78	80	81	83	79	91	74*	72*
Can use Medicaid	35	719	32	34	34	25	46*	40	26	22	64*	12*
Women's health focus	85	1779	85	86	86	84	87	87	85	86	88	81
Staff know about women's health	80	1657	75	81	83	78	82	81	80	81	81	75
Easy to talk to staff about sex and birth control	71	1485	72	73	66	70	73	75	66	72	76	63
Method availability	84	1750	88	86	76*	85	83	86	82	84	87	79
Can get the method I want	77	1597	78	78	71	77	76	79	76	77	78	73
Can get birth control, not just prescription	74	1536	76	78	64*	73	75	77	71	74	78	68
Confidentiality	83	1739	88	83	81*	82	85	85	81	83	88	78
Services are confidential	82	1714	86	82	80	81	84	84	80	82	86	77
Won't see people I know	26	548	33	26	20*	27	24	27	24	25	30	24
Referrals	56	1162	65	55*	47*	54	56	59	49*	57	60	48
Friends or family recommended clinic	50	1032	62	48*	39*	50	48	53	42*	51	53	43
Other doctor recommended clinic	26	544	19	29*	26	21	32*	28	23	25	31	20
Other												
Staff can refer me for other health care	67	1399	67	67	68	63	73*	71	64	68	71	61
Teen or young adult services	52	1081	74	50*	36*	53	48	55	44*	49	56	49
Childcare available	17	355	10	20*	15	7	32*	19	14	16	23*	8*

Abbreviations: FPL, Federal poverty level; ref, reference group.
* Significantly different from reference group at $p < .05$.
† Medicaid includes other public or state-sponsored insurance plans.

site, and to spend more time with clients during initial contraceptive examinations (Frost et al., 2012).

Confidentiality, yet another hallmark of the family planning clinic system, also featured prominently in the decision-making process, especially for teens. Importantly, confidentiality played a role not only in where the women chose to go for care but also in how they paid for their care. Nearly one in five insured women who indicated they were not planning to use their insurance to pay for their care said that they were not doing so because of confidentiality concerns. Not surprisingly, teens were the most likely to say confidentiality was the reason for not using their coverage. Teens are almost always insured as dependents on someone else's insurance policy. Widely used claims processing procedures, most notably the practice of sending explanation-of-benefit forms to the policyholder (who is often a parent or a spouse) make it virtually impossible for someone insured as a dependent to access confidential care (English et al., 2012).

Almost 6 in 10 of the women surveyed said they had received at least some health care from a different provider in their community over the course of the last year, but still chose to obtain their contraceptive care from a separate provider with specialized expertise in family planning service provision. For the remaining 4 in 10 clients, the family planning clinic was their only source of health care during the year. For many of these women, the family planning clinic serves as an entry point to the health care system, a role that presents family planning clinics with a vital obligation. If this is the first stop in the health care system for many of their clients, family planning clinics need to be prepared to connect them to both insurance coverage for which they may be eligible and to other health care that they may need. Family planning clinics have taken important steps in both these directions, providing application assistance that facilitates Medicaid enrollment and establishing linkages and referral mechanisms to meet clients' needs—96% of specialized family planning clinics reported regularly referring their clients to primary care clinics in their community (Frost et al., 2012).

One of this study's strengths—targeting data collection to women attending specialized family planning clinics in communities with comprehensive care centers—also presents some limitations. The data are not nationally representative of all women going to family planning clinics and some of the indicators reported here, especially those related to what and where services were received in the prior year, will be influenced by the fact that we were targeting communities known to have multiple safety-net providers available. For example, the percentage of clients who made a visit to a provider other than the family

planning clinic during the year is potentially higher in this sample than in the general population owing to greater access to multiple providers in the communities of sampled clinics. Therefore, our results likely underestimate the percentage of women who rely on family planning clinics as their only source of medical care. The fact that there was little variation in women's reasons for going to the specialized clinic, either according to demographic subgroups or prior use of services suggests that these reasons are relatively universal and are less likely to be biased owing to our targeted sampling strategy. However, because we did not survey women who were obtaining contraceptive care from comprehensive primary care clinics, we do not know how their reasons for choosing a clinic differ from those of women going to specialty family planning clinics.

These data complement prior studies suggesting that, for some women, specialized family planning clinics provide necessary care that is less often available at primary care–focused clinics, and point to possible strategies for restructuring family planning clinic services in the new health care environment. For example, it may be important to develop collaborations between specialized family planning clinics and comprehensive service providers, such as FQHCs (Gold et al., 2011; Shin, Rosenbaum, & Paradise, 2012). Given the potential capacity limitations of FQHCs to absorb all of the anticipated increase in demand for care arising, at least in part, from the implementation of the Affordable Care Act (Shin & Sharac, 2012a, 2012b), coupled with the fact that many women prefer to obtain contraceptive care from specialized providers, it makes sense to capitalize on the strengths of both systems. FQHCs are skilled at providing a broad range of primary care services, whereas family planning clinics have a particular expertise in providing confidential contraceptive and other closely related preventive care.

Partnerships between FQHCs and family planning clinics could make it easy for women to obtain their contraceptive care at a family planning clinic and the rest of their care at an FQHC, while allowing for integrated electronic health records when confidentiality concerns are not prohibitive. They could also permit women who use a family planning clinic as their entry point to the system to be easily referred to the FQHC for needed health care beyond the scope of that provided by the family planning clinic, again with integrated health records. These collaborations could leverage the unique strengths of both of these important safety-net providers while benefiting the communities they serve.

Acknowledgments

Jennifer J. Frost is senior research associate, Rachel Benson Gold is director of policy analysis, and Amelia Bucek is research assistant, all with the Guttmacher Institute, in New York and Washington, DC.

The authors thank the following Guttmacher colleagues: Lawrence Finer, Laura Lindberg and Cory Richards for guidance and helpful comments on survey design and article drafts; Lori Frohwirth for fieldwork management; Carolyn Cox, Michelle Eilers, Allison Grossman, and Jesse Philbin for research assistance; and Fatima Juarez for translation services. The authors extend special gratitude to the Title X program administrators who assisted with clinic recruitment, to clinic administrators and staff who facilitated survey fieldwork, and to the women who participated in this study.

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