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Research

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Abstract
Ongoing challenges impede efforts to improve the quality of family planning services in underserved communities, which by definition lack sufficient numbers of physicians and other health professionals. Challenges to improving the quality of family planning services include financing difficulties, lack of standards, training deficiencies, as well as little understanding and attention to patient preferences. The objectives of this study were to explore female patients' preferences for family planning services in underserved areas and to develop a framework to help providers improve patient-centered care. The methodology for this paper included mixed methods research including a survey of women between the ages of 18 and 44 in 19 underserved communities (n=1868) across the United States and qualitative research involving 16 focus groups (n=103) to explore patient preferences and experiences with family planning services. Descriptive statistics of survey items and thematic analysis of transcripts were utilized to analyze study data. Triangulation of data sources and methods resulted in an overall framework for patient-centered family planning care. The results show women in underserved areas identified important aspects of family planning care as: relationship with provider, communication, confidentiality in receiving care, provider competence, service access and convenience. The conclusion suggests improving patient-centered care for family planning services could improve outcomes by increasing patient return for follow up care, patient pursuit of other primary and preventive care services, continuation rates of contraceptive method, and higher contraceptive use. Achieving patient-centered family planning care will require investments in human capital and technology, modifications in clinic operations, and an organizational culture focused on patient preferences and experience.

Keywords
Patient experience, patient-centered care, quality of care, women's health, family planning

In 2014, the United States Department of Health and Human Services (HHS) issued a report on providing quality family planning services with the goal to strengthen family planning service delivery across clinical settings.[1]The report sets forth evidence-based treatment guidelines for essential clinical functions in family planning that include counseling, diagnoses, screening, treatment, and patient management. The guidelines outline a range of services that should be delivered consisting of contraceptive care, assistance in achieving pregnancy, infertility services, pregnancy testing, preconception care, screening and treatment of sexually transmitted infections and related women's health services. Establishing guidelines on the clinical functions in family planning and recommending a standard set of complementary services is the first step in improving quality and consistency of family planning services.

Another dimension of healthcare quality drawing recent attention is the level of patient-centeredness. The HHS guidelines on quality family planning services include a discussion of the importance of providing a wide range of contraceptive methods so that "clients can make a selection based on their individual needs and preferences," invoking the concept of patient centeredness in women's reproductive health. However, there remains a need to explore a broader application of patient-centeredness in all aspects of family planning care.

The Institute of Medicine (IOM) identified patient-centeredness as one of the six domains that define quality care — the others being safety, timeliness, effectiveness, efficiency, and equity. The IOM defined patient-centered care as "providing care that is respectful of, and responsive to, individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions.".[2] The Patient Protection and Affordable Care Act (ACA, 2010) places heavy emphasis on patient-centered care, and includes enhancing patient experience as a major strategy to advance health care in the United States. [3] As a result, patient-centeredness is a central goal of numerous quality improvement efforts including the Value-Driven Health Care Initiative and Transforming Clinical Practice Initiative, major efforts by HHS to stimulate quality improvement. [4]

Patient-centered care is especially important for delivering family planning services due to the sensitive, and often times controversial, aspects of care that influences conception. Patients and clinicians are involved in making decisions on childbearing, contraception, terminations, and infertility; decisions that are based upon personal preferences and influenced by numerous medical, psychological, and social factors. [5]Previous research in family planning has found that certain elements of patient-centered care, such as provider-patient communication, patient level of trust, and the type and degree of information and counseling provided, are positively related to several beneficial outcomes. These outcomes include patient knowledge of contraceptive methods, satisfaction with both care providers and patients' chosen contraceptive method, return for follow up care, continuation rates of birth control method, and use of more effective contraceptive methods. [6-11,,,,,]

In the last several decades there have been many transformations in the delivery of health care in the United States. These changes include increased access to basic health care for underserved populations as a result of community health center (CHC) expansion and insurance reform under the ACA, new models for primary care delivery such as the Patient-Centered Medical Home, a movement on patient rights and responsibilities, and innovative efforts to improve quality of care at various levels of the health care system. Family planning has also incorporated various changes including new contraceptive devices, expanded roles for counseling and education professionals, and increased use of advanced practice clinicians such as nurse practitioners. In other ways, family planning service delivery has remained the same. Many family planning practice settings in underserved areas continue to struggle with basic operational issues such as financing, staffing, insurance coverage, and community perception, all of which influence how family planning services are delivered. For example, in conservative communities there may be less demand for specific services and/or fewer services available such as vasectomies, emergency contraceptives, and services to adolescents. [12,13,]

Previous research identified the need for studies to assess patients' preferences for family planning service delivery and the process of service-giving. [14,15,]The major objectives of this study was to explore female patients' experiences and priorities for family planning service delivery and to use this information to develop a framework for patient-centered family planning care for underserved and vulnerable populations. Defining a framework for the patient-centered nature of family planning care can help providers, administrators, and women's health advocates deliver critical programs and provide support to help patients achieve their intended reproductive health goals across their lifespan.

Methods

This study used a mixed methods research design including survey data and focus groups to explore women's experiences and preferences for family planning services in medically underserved areas in the United States. The survey was developed in 2012 based on input from patients generated through focus groups, previous frameworks for quality of family planning services, and existing survey instruments on women's health and patient experience including the Contraceptive Client Survey, [16] Kaiser Women's Health Survey, [17] Consumer Assessment of Healthcare Providers and Systems (CGCAHPS), [18] Patient Satisfaction Questionnaire (PSQ-III), [19] and the National Survey of Family Growth. [20]Survey questions focused on patient priorities for service delivery including the patient's preferred method of contraception, convenience factors, timeliness of services, communication effectiveness, continuity of care, care coordination, and privacy and confidentiality. 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 in the target population.

The paper survey was fielded in 2014 and 2015 at 19 community health center organizations in rural and urban areas across the United States. Community health centers were chosen as the setting for data collection because health centers are located in medically underserved areas and provide services to patients who live and work in these areas. Health centers recruited patients who met the following criteria: female, between the ages of 18 and 44, and not currently being seen for prenatal or obstetric care. Most sites recruited at least 100 patients to participate in the study, resulting in a total of 2,034 submitted surveys, of which 1,868 were complete and eligible for data

analysis. Because of the non-random sampling of the sites and respondents in this study, the results cannot be considered nationally representative. In order to improve the comparability of data we generated post-stratification survey weights, raking the weights to align with region, race, and Hispanic ethnicity as reported in national distributions from the 2013 Uniform Data System (UDS) for community health centers.[21] We used STATA version 13.0 to generate post-stratification survey weights and descriptive statistics.

A total of sixteen focus groups were conducted in conjunction with patient surveys to provide contextual information on women's experiences with family planning care and to generate insights from group interaction. In 2013, to inform the development of the survey, researchers conducted four focus groups with 21 women between the ages of 18 and 44. During this initial process we recognized the value of conducting additional focus groups to add depth of knowledge regarding patient preferences and experiences with family planning services. Twelve additional focus groups with a total of 82 participants were conducted in 2014 and 2015 in community health centers where the survey was being fielded. Recruitment for focus groups used the same inclusion criteria as the survey; however, response to the survey was not a requirement for focus group participation. Focus groups (n=103) were held at health center sites around the country, including California, Texas, Florida, Kentucky, New York, Oregon, Virginia, and Washington, D.C. Four of these focus group sessions were conducted in Spanish with bilingual facilitators, while

Table 1. Survey Sample Demographics (n=1868)*

	Survey% (n)	UDS (%)
Participants by Region		
Midwest	10.3 (192)	
Northeast	9.0 (168)	
South	38.8 (724)	
West	42.0 (784)	
Participant Age		
18-24	26.1 (471)	27.4
25-34	43.2 (780)	39.8
35-44	30.7 (555)	32.7
Marital or cohabitating status		
Married	34.7 (625)	-
Not married but living with a partner	24.7 (444)	-
Not married	40.6 (731)	-
Average Number of Children	1.8 ± 0.1	-
Participant Race		
White	56.7 (984)	66.0
Black	17.8(332)	23.8
Other	6.4 (120)	11.1
Not Reported	23.1 (432)	14.9
Participant Hispanic Ethnicity		
Yes	43.3 (762)	65.2
No	56.8 (1,000)	34.8
Survey Language		
English	79.8 (1,491)	-
Spanish	20.2 (377)	-
Participant Insurance Status		
Yes	74.7 (1,343)	56.3
No	25.3 (454)	43.7
Main source of current health insurance coverage		
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)	-
Received most recent family planning care at a health center	59.0(1084)	

*Not all participants answered each demographic question

the rest were conducted in English. Five facilitators were used to conduct the focus groups, who were all trained on research protocols and interview guides during special team meetings. Facilitators also met during regularly scheduled meetings to review and refine themes. QSR International's NVivo 10 Software was used to support qualitative data analysis, allowing multiple facilitators to review focus group transcripts and identify themes.

The sample included women that receive family planning services at community health centers, 59% of survey respondents and 49% of focus group participants, as well as other delivery settings. A comparison of sample demographic data to UDS data on community health centers showed that survey respondents were over sampled in the South and under sampled in the Midwest and Northeast. Race and Hispanic ethnicity were also disproportionately sampled. We corrected for these potential biases mathematically with post-stratification survey weights. Survey respondent and focus group participant ages were distributed across age groups. Insured status was higher for both survey respondents and focus group participants compared to the UDS data, which was not surprising since those without health insurance, such as undocumented persons, may be unable or unwilling to participate in research studies.

Demographic data on survey respondents is presented in Table 1 and demographic data on focus group participants is presented in Table 2.

Results

Survey

We asked survey respondents to rate their priorities for family planning care using adapted items from the CGCAHPS. Survey respondents indicated clear preferences in answers to questions about priorities, see Table 3. To identify patient priorities, we isolated the statements to which greater than 75% of all respondents assigned a "very important" ranking on a Likert type scale. The importance of both a strong provider relationship and confidentiality was emphasized with 92.65% of women ranking "the staff treat me respectfully" as very important, followed by "the services are confidential," 92.48%, and "I feel comfortable with my provider," 90.83%.The next set of priorities involved the patient's perception of their provider's competence and communication skills with "staff knows about women's health," 89.40%, ability to communicate effectively based on "staff take time to talk to me," 86.38%, and "It is easy to talk to staff," 82.65%. Subsequent priorities had to do with respondent's ability to access healthcare, with "I can get the birth control method I want," 85.44%, "staff here can refer me for

Table 2. Focus Group Sample Demographics (n=103)*

	Focus Group % (n)	UDS (%)
Participant Age		
18-24	22(22)	27.4
25-34	34(34)	39.8
35-44	35(35)	32.7
45+	8(8)	
Combined Household Income		
< $25,000	57(54)	
Between $25,000 and $49,000	27(25)	
Between $50,000 and $74,000	6(6)	
Between $75,000 and $99,000	2(2)	
> $100,000	-	
Don't Know	7(7)	
*Participant Race***		
White	28(28)	
Black	29(29)	
Hispanic	36(35)	
American Indian or Alaska Native	3(3)	
Participant Insurance Status		
Yes	64(66)	56.3
No	36(37)	43.7
Utilized health center for family planning services	49(40)	

*Not all participants answered each demographic question
**Demographic data on race not comparable to UDS data

Table 3. Survey Results - Top Ranked Patient Preferences by Category

Category	Survey Statement	Respondents who rated statement as "very important" *n* (%)*
Provider Relationship	The staff treat me respectfully	1678 (92.65)
	I feel comfortable with my provider	1581 (90.83)
	Friends or family recommended the clinic	811 (50.36)
	Another doctor recommended the clinic	669 (46.97)
Confidentiality	The services are confidential	1653 (92.48)
	I won't see people I know	435 (28.32)
Communication	Staff take the time to talk to me	1771 (86.38)
	It is easy to talk to staff about sex and birth control	1451 (82.65)
Access	I can get the birth control method I want	1420 (85.44)
	Staff here can refer me for other healthcare I need	1467 (83.05)
	I do not have to make multiple appointments to get my care	1337 (79.16)
	I can use Medicaid	1035 (78.20)
	I can get free or low-cost care	1239 (72.98)
	I can get the birth control method, not just the prescription	1177 (72.47)
	I don't wait long for an appointment	1233 (70.41)
	Teen or young adult services available here	905 (61.35)
Convenience	I can get all my health care needs including family planning taken care of here	1392 (81.57)
	The hours fit my schedule	1377 (78.88)
	The location is convenient	1306 (74.90)

*Not all participants answered each question; percentages vary based on the number of respondents per question.

other health care I need," 83.05%, and "I can use Medicaid," 78.20%. Another group of priorities focused on convenience of services that included: "I can get all my health care needs including family planning taken care of here," 81.57%, "I do not have to take multiple appointments to get my care," 79.16%, and "The hours fit my schedule," 78.88%.

An additional set of survey questions probed respondents to select their preferred method of receiving family planning services. Patients were given two options in obtaining services to see if there was a strong preference for choice A over choice B. This set of questions, presented in Table 4, indicates which choice was preferred by the majority of women responding to each question. In regards to transfer of information, 86.25% of women surveyed preferred having their family planning questions answered during an in-person visit with a doctor or nurse over other ways, like reading pamphlets or searching the internet. The majority of women, 77.43%, preferred to see a specialist in women's health, such as an OB/GYN physician or specialized nurse practitioner, for their family planning needs instead of a general practitioner; 73.58% preferred to get counseling and information on different birth control methods from a doctor or nurse; 68.29% preferred getting family planning care in the same place where they receive general health care services; 68.01% preferred to see their own doctor or nurse, no matter the scheduling wait time for an appointment; and 48.93% preferred to schedule a same-day or next-day visit for family planning, even if required to re-arrange other activities in life.

Focus Groups

Members of the research team conducted focus groups with women in each of the six geographic U.S. Census regions. Focus groups allowed women to more thoroughly explain their expectations and difficulties with obtaining care. Focus group participants also reported a series of priorities in obtaining family planning care. Their top concerns, Table 5, crystallized categories that emerged from survey responses—provider relationship, communication, confidentiality, competence, access, and convenience.

Table 4. Survey Results - Top Ranked Patient Preferences Ranked in Order of Importance

Survey Statement	Category	Percent of women surveyed who preferred the following statements *n* (%)*
Have my family planning questions answered during an in-person visit with a doctor or nurse	Communication	1513 (86.25)
See a specialist in women's health, such as an OB/GYN for my family planning needs	Competence	1358 (77.43)
Get counseling and information on different birth control methods from a doctor or nurse	Communication	1297 (73.58)
Getting family planning care in the same place that I usually get my general health care	Convenience	1198 (68.29)
See my own doctor or nurse, no matter how long it takes to get an appointment with him or her	Provider Relationship	1193 (68.01)
Schedule a same-day or next-day visit for family planning needs, even if it means rearranging other things in my life	Access	857 (48.93)

*Not all participants answered each question; percentages vary based on the number of respondents per question.

The most commonly discussed priority was the relationship women had with their provider. Many described trust, respect, and continuity of care as a result of a strong relationship and as the "reason I keep coming back. "Those feelings of trust in their provider and clinic staff were further augmented by their perceptions of their provider's qualifications and thoroughness. If providers took the time to talk to patients, answer questions, and refer them to community resources, women were more likely to have a positive experience with care.

The most satisfied focus group participants were those who felt as though the communication and information flow between health center systems was well executed. Many women told stories of positive provider-to-provider communication and provider-to-patient communication. Patients who received calls from providers about test results and referrals seemed to be most satisfied with their care. Others with negative communication experiences during their visits found that to be a barrier to positive care outcomes—leading to confusion and frustration.

Participants were highly concerned with the confidentiality of family planning services. While this finding was expected, we were surprised with the length of discussion and level of concern about confidentiality. They placed a high level of importance on confidentiality and were conscious when procedures were not being followed. Women described staff discussing patient information loudly, providers discussing personal patient information in open areas, and not taking into account patient preferences for communication.

Another group of priorities commonly discussed in focus groups involved access to care and convenience. In terms of accessing care, long wait times and difficulty scheduling appointments were described as barriers to care and an influence on satisfaction with care. Further, if preferred or recommended methods of birth control were not available, women were less satisfied with their experience. Insurance coverage and cost of care, a function of access, were also discussed. Women described geographic proximity, hours of operation, and the utilization of the health center by friends and family as indicators of satisfaction.

Table 5. Focus Group Themes and Examples

Theme	Example Quotes
Relationship with provider	*"I love my [nurse] and doctor [lead OBGYN]. I started out in another health center, but when the doctor moved here, I followed her. Everybody here is just wonderful. I come here because there's staff that I know and they're friendly and I trust them."* *"It's so good that my sister comes from [city name] to see the doctors here. She doesn't trust anybody in there and will drive out all the way out here so that should tell you a lot."*
Communication	*"My doctor listened to me and helped me find the right doctor to do my procedure."* *"I like this [health center] because they tell you everything. They give a lot of information. I was told about all methods of birth control and risks, and all that I needed to know."* *"I like it here because they take the time to explain everything to me. I don't feel like I am just a number here."*
Confidentiality	*"There's no judgment here and I feel comfortable. They didn't try to lecture me. At [previous source of care] the old ladies would look at my pregnant friend and glare at her. Here she's treated with respect."*
Technical Competence	*"It's important for me to see an MD. I would go to a nurse practitioner for a pediatric need if my child was running a fever or if I needed a prescription. For something like an insertion or pap, it would have to be an MD."* *"Well, it is sometimes hard to get an appointment with the doctor because she is so popular, but it's worth the wait."*
Access	*"I live really close, four blocks away, so it's logical to come here. They don't charge us much. It's affordable here."* *"They are open late, with good hours. No one else is open that late and it's helpful because of my work and childcare schedule."*
Convenience	*"I go on Saturdays for my appointment. It's convenient for me. She's [the doctor] is my women's health and regular doctor so she does everything."* *"I like that you can come here and take care of everything in one shot. It's in the neighborhood. You can get what you need done, and they will tell you "oh by the way your son has got this" and it's great. I am in and out."*

Combining survey results with focus group findings resulted in a framework for family planning service delivery. Women in the study—both survey respondents and focus group participants—identified aspects of care that were important to them, consisting of: relationship with their provider including trust, respect, and continuity of care; communication, including information flow from provider to provider, provider and office staff to patient, and care site to referral organization; confidentiality of care stemming from stigma associated with the use of contraceptives and discretion of receiving care; provider competence including qualifications and thoroughness; access to care involving availability of birth control methods, wait time, scheduling ease, and insurance coverage; and convenience such as geographic location, hours of operation, and ability to receive other types of health services in the same location.

Study Limitations

The study utilized a convenience sample of women receiving health care services (medical, dental or family planning) at community health centers in medically underserved areas, which limits the representativeness of the findings by excluding women who may be getting care in other clinical settings or who may not be getting the care they need. Our approach focused on those who currently receive or have received family planning services in the past, and did not capture individuals who desire family planning services but are unable to access these services—therefore missing an important viewpoint on service delivery. Research was also limited by only including patients who speak English and Spanish; nevertheless we recognize the importance of including perspectives of individuals that speak other languages. Future efforts to rank the dimensions and test the relationships proposed in this framework for patient-

centered family planning care are critical to further conceptualize quality family planning service delivery.

Discussion

Patient-centered care is an important construct of quality of care, and thus a major component of health care reform efforts in the United States. There is growing evidence that better patient care experiences are associated with higher levels of adherence to recommended prevention and treatment processes, improved patient satisfaction and clinical outcomes, increased health care system efficiency, and improvements on health-related business metrics.[22-25]

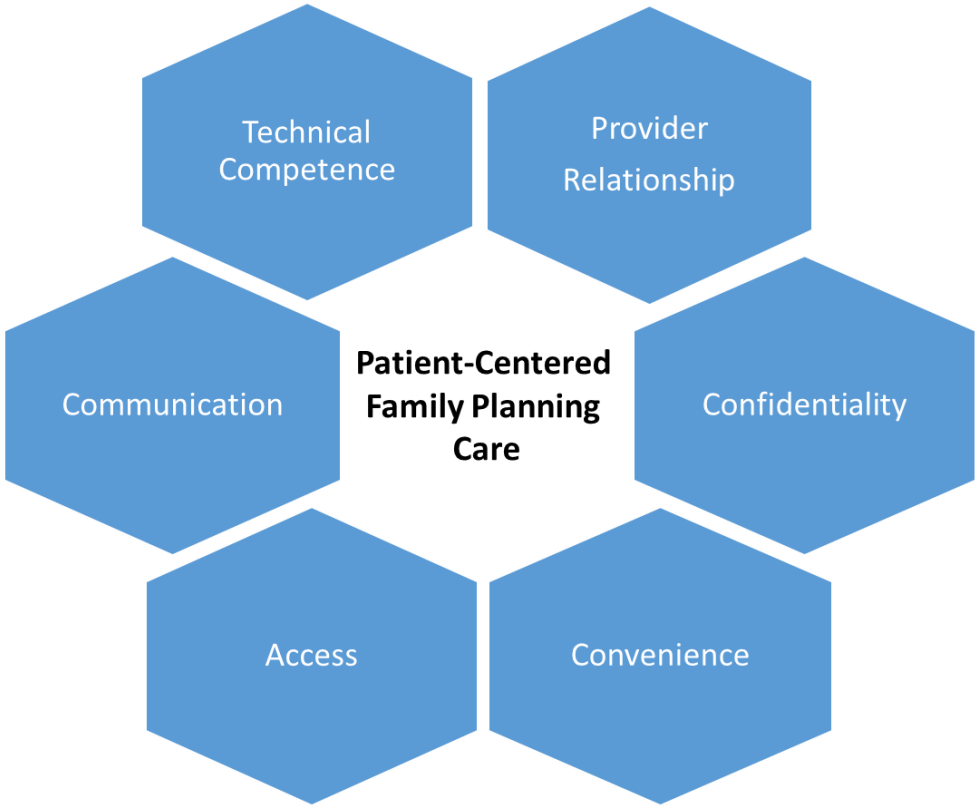
Past constructs addressing the quality of family planning services set a foundation for delivering and evaluating family planning services. In 1990, Judith Bruce proposed domains of quality family planning care based on a literature review of international studies on family planning services and personal fieldwork in developing countries. These domains include choice of method, information given to users, technical competence of providers, interpersonal relationships between client and provider, follow up services and continuity of contraceptive method, and an appropriate constellation of services.[15] A more recent literature review was conducted by Becker and colleagues on family planning services in the United States between 1985 and 2005.[14] As a result, researchers identified domains of quality in the context of care delivery in the United States that encompass access, communication, client-staff interactions, efficient and effective organization of care, technical competence, structure and facilities, contraceptive method choice and patient-centeredness.

Framework for patient-centered family planning services

Our study provides empirical evidence by asking women in underserved areas about their experiences and priorities for family planning services. The resulting framework, Figure 1, for delivering patient-centered family planning services has six dimensions: relationship with provider, communication, confidentiality and discretion in receiving care, provider competence, access to care, and convenience of services.

Relationship with provider. A caring, trusting, provider-patient relationship is the foundation for a patient-centered approach[26] for family planning services. Relationships between patients and providers, including office staff, begins at first contact and builds through continuing service and follow up care. This continuity of care involves

Figure 1. Framework for Delivering Patient-Centered Family Planning Services in Underserved Areas



not just following patients over time but establishing a reliable, trusting relationship to obtain safe and effective methods to control an individual's reproductive capacity. This approach can help providers truly know their patient, which facilitates an accurate and comprehensive assessment of a patient's situation and medical needs. Patient-provider relationships include two-way communication that offer opportunities to ask questions and obtain needed information for informed decision making, as well as the opportunity to attain guidance on family planning and other health care services. Relationships between the patient, providers, and office staff may have a strong influence on patients' satisfaction with services, confidence in treatment and contraceptive choices, and ability to use the chosen method effectively.

Communication. Women participating in our study identified communication with providers and office staff as a top priority when receiving family planning services. Communication is defined as: accurate and complete information flow between patient and provider involving not just medical history and current medication list, but also behavioral risk factors, current issues and concerns, and review and communication of care coordination issues.[27]Core elements of communication in family planning include informing patients on: the range of methods available; advantages and disadvantages of each method, including method effectiveness; scientifically documented contraindications; correct use of the method; effect on sexual practice; non-contraceptive benefits and potential side effects; and the level of protection from STDs, including HIV. Research has shown that better provider-patient communication is associated with adherence to therapeutic regimen and self-management behavior.[28,29,]

Confidentiality. Our findings indicate that confidentiality is a critical consideration for family planning patients in community health centers. Adequate confidentiality of sensitive services is central to building a trusting relationship with providers so that patients disclose accurate information about their medical and sexual history, share preferences for treatment and/or contraceptive choices, and are fully engaged with their reproductive and medical care. Concerns about confidentiality may negatively affect patients' willingness to seek care. Patients may delay or forego treatment, or alter stories about symptoms and onset of illness to minimize public dissemination of information they consider private.[30] For example, one study of 356 female adolescent patients at a family planning clinic showed that 24% reported not trusting their primary care doctor to keep confidential conversations about sexual activity, 35% reported the same concern for STDs, and 40% for pregnancy. [31] Previous studies have found that patients' confidentiality concerns are often local and specific, with concerns that someone from their community will witness them entering or exiting a clinic or that patient medical information will be shared with relatives or others. Many family planning delivery sites face conflicts between state legal requirements for confidentiality of services and the level of confidentiality requested by patients. [32]

Several recommendations to improve confidentiality of services are reported in a recent study on confidentiality and insurance billing at specialized family planning clinics. [33] This study recommends that providers screen for confidentiality at each appointment by asking questions such as: "Can we send a bill home that would say what services you got today?" and "Do we need to keep your family planning services confidential from your partner, spouse, or parent?" Another practice to increase confidentiality of services is to document and track patients' confidentiality requests so that this information is available to other providers and staff during follow up appointments. In some instances, insurance billing and payment for services may lead to a breach of confidentiality through paper trails that cite family planning services. It is recommended that family planning providers determine if confidentiality of services is important to the patient, determine whether billing practices may lead to breaches in confidentiality and if so, determine eligibility for other sources of payment, and/or collect bills during current or follow up visits versus sending bills to the patient's home.

Provider competence. Women in our study identified provider's technical competence as a requirement for receiving family planning services, with emphasis on provider training and qualifications, thoroughness of patient care, and effective communication. The six general provider competencies recognized by the Accreditation Council for Graduate Medical Education (ACGME) and American Board of Medical Specialty (ABMS, 1999) include: patient care, medical knowledge, interpersonal and communication skills, professionalism, practice-based learning and improvement, and systems-based practice.[34] These competencies emphasize patient care that is compassionate, appropriate, and effective for treating health problems and promoting health. Interpersonal and communication skills should result in effective information exchange and teaming with patients, their families, and other health professionals. The professionalism competency is defined by a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population. In terms of family planning services, this incorporates application of standards of care, appropriate training and knowledge of a full array of contraceptive methods including dosing, patient use, and procedures such as IUD insertions, and implant insertions and removals.

Access. Women in our study reported access as an important element of family planning service delivery,

including availability of birth control methods, wait time, scheduling ease, and insurance coverage. In a recent study on patient experience at specialized family planning clinics, women (83–89%) rated access indicators as important reasons for choosing a clinic that included availability of contraceptive method, affordability and wait time.[16] Other studies of family planning services offered by community health centers[35] have clearly identified barriers to a wide range of methods and services due to institutional, financial and clinical constraints. The results of our study indicate that in order to achieve patient-centered family planning care, clinical delivery settings should address issues around access to include: expanding contraceptive choices available to women, which involves advancement in clinician training on contraceptive methods; working with women to identify affordable access to contraceptive methods and other services; and improving scheduling procedures and wait times to be seen by a provider.

Convenience. Women also identified convenience as an important consideration for where to receive family planning services. Convenience-related aspects of care reported by women include geographic location, meaning close proximity of the clinic or physician practice to their work or residence; hours of operation to include some weekend and evening hours; and the ability to receive other types of health services in the same location. Other studies support this element of patient-centeredness, including a survey of 3,611 women veterans, which identified location convenience and co-located gynecology with general healthcare as important.[36]Our study points to the need for some family planning sites to offer a broad array of health services, such as primary and preventive health care, dental and mental health services.

Transformation to Patient-Centered Care

Family planning providers can also draw upon recent efforts by primary care practices to become patient-centered.[37-39]. In a patient-centered medical home (PCMH) model the focus is on providing "whole person" care, comprehensive communication and coordination, patient support and empowerment, and ready access.[40]In a PCMH the clinician's role is that of an adviser that encourages patients to be informed and engaged partners in their care. Providers emphasize shared decision making, seek to understand patient preferences, and set mutual goals and expectations through an ongoing provider-patient relationship that involves follow-up appointments and progress feedback. This model also emphasizes care coordination with other providers and presents information to patients on the availability and quality of specialty services and community resources. A fully developed PCMH model also offers accessible and convenient care through timely appointments, ease of appointment scheduling, short waiting times in the office, timely response to e-mails and telephone calls, and service hours that include nights and weekends.

Patient-centered practices also reach out to patients to obtain feedback and preferences. Conducting patient surveys and using data to improve family planning services is an activity that could improve patient-centered care;[41] previous research has linked patient surveys to improved quality in family planning.[42] The use of patient satisfaction surveys in clinical settings serving underserved women could provide a quick and inexpensive way of determining areas for quality improvement.

Beyond understanding the key features of patient-centeredness, it is imperative to address barriers standing in the way of achieving patient-centered family planning care. These barriers are considerable: laws that fail to protect confidentiality; inadequate insurance coverage and reimbursement for a wide range of contraceptive methods; inadequate training for cultural competency, and lack of financing for family planning services in underserved clinical settings such as community health centers. Financial barriers alone limit the availability of a full range of contraceptive methods; limits staffing patterns, which influences the availability of specialist physicians and the use of counseling staff; as well as limits clinician training on new contraceptive procedures. Taking this framework and implementing it in delivery settings will require practice modification that addresses patient preferences. Policy changes that affect financing, including reimbursement levels for the provision of contraceptive methods, and clinical training, must be addressed at the state and federal level.

Moving toward a patient-centered model for providing family planning services, particularly in settings for vulnerable patients, will take a concerted effort by providers and staff to first consider the patients' point of view and then organize delivery of services in a way that meets individual patient needs and preferences. Wide-spread adoption of patient-centered care approaches will require new tools to help providers identify patient preferences and to tailor information and services to support patients. Achieving patient-centered family planning care will require considerable investments in human capital and technology, modifications in clinic operations, and an organizational culture focused on patient preferences and experience.

References

1. Gavin L, Moskosky S, Carter M, et al. Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs. MMWR Recomm Rep. 2014 Apr 25; 63 (RR-04):1-54.
2. Institute of Medicine. Crossing the quality chasm: A new health system for the 21st century. Washington (DC): National Academies Press; 2001;6.
3. Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 (2010).

4. Department of Health and Human Services. *HHS announces $685 million to support clinicians delivering high quality, patient-centered care.* Washington, DC; 2015. Available at: http://www.hhs.gov/about/news/2015/09/29/hhs-announces-685-million-support-clinicians-delivering-high-quality-patient-centered-care.html
5. AHC Media. Good patient experiences foster positive impact on healthcare quality. *Contraceptive Technology Update*, 2015; 36, 7, 73-84. Available at: http://www.ctcfp.org/wp-content/uploads/Contraceptive-Technology-Update-7-2015.pdf
6. Wall EM. Development of a decision aid for women choosing a method of birth control. *J Fam Pract.* 1985;21(5):351-355.
7. Armstrong KA., Herceg-Baron R, Pickens G. Determinants of family planning clinic discontinuation, subsequent use of family planning services and outcomes. Philadelphia; 1985. Family Planning Council of Southeastern Pennsylvania.
8. Rosenberg MJ., Waugh MS., Burnhill MS. Compliance, counseling and satisfaction with oral contraceptives: a prospective evaluation. *Fam Plann Perspect.* 1998;30(2):89-92 & 104.
9. RamaRao S., Lacuesta M., Costello M., Pangolibay B. Jones H. The link between quality of care and contraceptive use. *Int Fam Plan Perspec.* 2003;29(2):76-83.
10. Nobili MP, Piergrossi S, Brusati V & Moja EA. (2007). The effect of patient-centered contraceptive counseling on women who undergo a voluntary termination of pregnancy. *Patient Educ Couns.* 2007;65(3):361-368.
11. Dehlendorf C, Henderson JT., Vittinghoff E, et al. Association of the quality of interpersonal care during family planning counseling with contraceptive use. *Am J Obstet Gynecol.* 2016 Jul;215(1):78.e1-9.
12. Goldberg DG, Wood S, Johnson K, et al. The Organization and Delivery of Family Planning Services in Community Health Centers. *Womens Health Iss.* 2015;25 (3):202-208.
13. Mead H., Beeson T, Wood S, et al. Adolescent Family Planning Services Delivered in Federally-Qualified Health Centers (FQHCs). *J Adolescent Health.* 2013;57(1): 87–93.
14. Becker D, Koenig MA, Kim YM, et al. The Quality of Family Planning Services in the United States: Findings from a Literature Review. *Perspect Sex Reprod Health.* 2007;39(4):206–215.
15. Bruce J. Fundamental Elements of the Quality of Care: A Simple Framework. *Stud Fam Plann.* 1990;21(2):61-91.
16. Frost JJ, Lindberg LD. Reasons for using contraception: perspectives of U.S. women seeking care at specialized family planning clinics. *Contraception.* 2013;87(4):465-472. Available at: http://www.guttmacher.org/pubs/journals/j.contraception.2012.08.012.pdf
17. Kaiser Family Foundation. Women's Health Care Chartbook: Key Findings From the Kaiser Women's Health Survey, 2011. Available at: https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8164.pdf
18. Agency for Healthcare Research and Quality. Consumer Assessment of Healthcare Providers and Systems (CAHPS). CAHPS -Adult Primary Care Questionnaire 1.0 – Core Items and CAHPS PCMH Set. 2011. Available at: https://www.cahps.ahrq.gov/
19. Rand Corporation. Patient Satisfaction Questionnaire (PSQ-III). 1987 Available at: http://www.rand.org/content/dam/rand/www/external/health/surveys_tools/psq/psq3_survey.pdf
20. Centers for Disease Control and Prevention. National Survey of Family Growth, Cycle 6: Sample Design, Weighting, Imputation, and Variance Estimation. 2006; Series 2, Number 142. Available at: http://www.cdc.gov/nchs/data/series/sr_02/sr02_142.pdf
21. Wood SF, Beeson T, Goldberg DG, et al. Patient Experiences With Family Planning in Community Health Centers. Washington, D.C.: Geiger Gibson Program in Community Health Policy/RCHN Community Health Foundation. 2015.
22. Manary M, Boulding W, Staelin R, et al, The Patient Experience and Health Outcomes. New Engl J Med. 2013 January 17;368:201-203. Available at: http://www.nejm.org/doi/full/10.1056/NEJMp1211775
23. Price RE, Elliot MN, Zaslavsky AM, et al. Examining the Role of Patient Experience Surveys in Measuring Health Care Quality. *Med Care Res Rev.* 2014 October;71(5):522-554.
24. Charmel P, Frampton S. Building the Business Case for Patient Centered Care. *Health Financ Manage.* 2008 March;62:80 – 85. Available at: http://planetree.org/wp-content/uploads/2012/12/2.-Planetrees-Business-Case.pd
25. Browne K, Roseman D, Shaller D, et al. Measuring patient experience as a strategy for improving primary care. *Health Affair.* 2010;29(5):921–5.
26. Singleton J, DiGregorio RV. Primary Care: An Interprofessional Perspective, 2nd Edition. Springer Publishing Company: 2015;5.
27. Patient-Centered Primary Care Collaborative. Patient/Family Engagement Framework, 2014. Available at: https://www.pcpcc.org/resource/state-patient-engagement-and-health-it
28. Liu Y, Malin JL, Diamant AL, et al. Adherence to adjuvant hormone therapy in low-income women with breast cancer: The role of provider-patient communication. *Breast Cancer Res Tr.* 2013;137:829-836.

29. Heisler MI., Bouknight RR., Hayward RA., Smith DM., Kerr EA. The relative importance of physician communication, participatory decision making, and patient understanding in diabetes self-management. *J Gen Intern Med.* April 2002; 17(4):243-52.
30. Sankar P, Mora S, Merz, J. et al. Patient Perspectives of Medical Confidentiality: A Review of the Literature. *J Gen Intern Med.* August 2003;18(8):659–669.
31. Sugerman S, Halfon N, Fink A, Anderson M, Valle L, Brook RH. Family planning clinic patients: their usual health care providers, insurance status, and implications for managed care. *J Adolesc Health.* 2000;27:25–33.
32. Beeson T, Mead K, Wood SF, et al. Privacy and Confidentiality Practices Supporting Adolescent Family Planning Care in Federally Qualified Health Centers. *Perspect Sex Reprod Health.* 2016 Mar 17;48(1):17-24.
33. Masselink L., Lewis J, Morales M, et al. Title X Network Perspectives on Confidentiality and Insurance Billing. National Family Planning and Reproductive Health Association, 2016.
34. American Board of Medical Specialties. Board Certification – Based on Core Competencies, 1999. Available at: http://www.abms.org/board-certification/a-trusted-credential/based-on-core-competencies/
35. Wood SF, Beeson T, Bruen B, et al. Scope of family planning services available in Federally-Qualified Health Centers. *Contraception.* 2014;89(2):85-90.
36. Washington DL, Bean-Mayberry B, Hamilton AB, et al. Women veterans' healthcare delivery preferences and use by military service era: findings from the National Survey of Women Veterans. *J Gen Intern Med.* 2013;28 Suppl 2:S571-6.
37. Davis K, Schoenbaum SC, Audet AM. A 2020 Vision of Patient-Centered Primary Care. *J Gen Intern Med.* 2005 October; 20(10):953–957.
38. Agency for Healthcare Research and Quality. The Patient Centered Medical Home Model. Available at: https://pcmh.ahrq.gov/
39. Epstein R, Street RL. The Values and Value of Patient-Centered Care. *Ann Fam Med.* 2011 March;9(2):100–103.
40. Bechtel C, Ness D, If You Build It Will They Come? *Health Affair.*, 2010;29(5): 914-920. Available at: http://content.healthaffairs.org/content/29/5/914.full
41. Clancy CM. How Patient-Centered Healthcare Can Improve Quality AHRQ. 2008. Available at: http://www.psqh.com/marapr08/ahrq.html
42. Williams T, Schutt-Aine J, Cuca, Y. Measuring Family Planning Service Quality Through Client Satisfaction Exit Interviews. *Int Fam Plan Perspect.* 2000;26(2):63-71.