The Role of Federally Qualified Health Centers in Delivering Family Planning Services to Adolescents

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ABSTRACT

Purpose: The purpose of this article was to examine the role of community health centers (CHCs) in providing comprehensive family planning services to adolescents, looking at the range of services offered and factors associated with provision of these services.

Methods: This study employed a mixed methods approach comprising a national survey of CHCs and six in-depth case studies of health centers to examine the organization and delivery of family planning services. We developed an adolescent family planning index comprising nine family planning services specifically tailored to adolescents. We analyzed the influence of state-level family planning policies, funding for adolescents, and organizational characteristics on the provision of these services in CHCs. The case studies identified barriers to the provision of family planning to adolescent patients.

Results: The survey found substantial variation in the provision of family planning services at CHCs, with a mean of 6.33 out of a maximum score of 13 on the family planning adolescent services index. Title X funding and location within a favorable state policy environment were significantly associated with higher scores on the family planning adolescent services index (p value < .001 and .002, respectively). Case studies revealed barriers to adolescent family planning, including lack of funding, lack of knowledge, and limitations on school-based clinical services.

Conclusions: CHCs have the opportunity to play a significant role in providing high-quality family planning services to low-income, medically underserved adolescents. Additional funding, resources, and a favorable policy climate would further improve CHCs’ ability to serve the family planning needs of this special patient population.

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High-quality family planning services are difficult for adolescents to obtain in many parts of the country. Adolescents report a range of barriers, including lack of knowledge, inability to use parental health insurance, out-of-pocket costs, transportation, unsatisfactory experiences with providers, and inadequate opportunities to discuss family planning needs. Studies have also found that adolescents may not access family planning services because they are unaware of the location of services and their eligibility to use them. Furthermore, lack of specialty training in adolescent care, lack of special funding for adolescent services, and inadequate guidelines for adolescent family planning services create a
delivery system that is not conducive to high-quality family planning care for adolescents [7–10]. State and local policies, such as restrictions on state funding for family planning, restrictive minor privacy and consent laws, and limitations on school-based health center services, create even more barriers for adolescents [11–16]. For low-income teens or teens living in under-resourced areas, accessing family planning care is even more challenging because of additional access and cost barriers [17].

Community health centers (CHCs) are the most widely utilized safety net provider for medically underserved patients, with approximately 1,200 organizations across the country, serving more than 2.8 million adolescents or 10% of the total U.S. adolescent population aged 12–18 years [18]. These health centers play a critical role in providing quality primary care to underserved communities; in fact, studies show CHCs provide high-quality, effective, and affordable primary care services that are typically as good as or better than those available in other primary care settings [19–22]. Moreover, health centers are mandated by both mission and legislative action to target care to vulnerable populations. They offer subsidized care and are located in low-income, medically underserved, racially diverse, urban and rural places, in an effort to reduce access barriers [23].

Given this position, health centers should serve as an important source of family planning services for underserved adolescents; however, no studies have examined the capacity of CHCs to provide high-quality family planning care to this population. The purpose of this article was to provide the first ever national examination of the role of CHCs in providing comprehensive family planning services to adolescents. We present findings on the services that health centers most frequently offer adolescents and the factors that influence health centers’ ability to provide certain adolescent family planning services. Finally, we discuss how health centers could address some of the persistent barriers to quality reproductive care for adolescents.

Methods

This article is part of a larger national study examining the organization and delivery of family planning care in CHCs for underserved women. The study employed a sequential mixed methods approach comprising a national survey of CHC organizations followed by in-depth case studies in six communities. Within the scope of the national study, we also examined services provided specifically to adolescents.

The survey of family planning services was disseminated to the chief executive officer or chief medical officer at health center organizations. Additional information on the development of the survey is published elsewhere [24,25]. The survey asked respondents to indicate typical practice at the organizations’ largest primary medical site, recognizing that CHCs often have multiple clinical sites. Selecting the largest primary care site as the unit of analysis offers an indicator of the widest range of services provided to patients of a given health center. We weighted our sample to account for size and regional distribution of health center respondents.

Based on a literature review and input from an expert panel of family planning researchers, practitioners, and policy makers, the survey asked about nine services that have been shown to have implications for the provision and use of family planning among adolescents [26–32]:

- School-based education
- School-based treatment
- Staff training in adolescent family planning
- Contraceptive services tailored to and appropriate for adolescents provided on-site or off-site
- Collaboration with other entities in family planning outreach
- Drop-in centers
- Alternative entrance and/or exit
- Walk-in appointments
- Keeping family planning medical records of adolescents private

To assess the range of services delivered among respondent CHCs, we created an adolescent services index, a weighted composite index score of these nine services. We assigned one point to each of the following services: walk-in appointments; drop-in centers; alternative entrances/exits; and collaboration with other entities around adolescent family planning. School-based education and treatment, provider training for adolescent care, and offering tailored adolescent contraceptive services either on-site or off-site were assigned two points each, based on literature that suggests that they are more significantly associated with increased use of services and improved reproductive health among adolescents.

We conducted chi-square tests of proportions and a multivariate regression analysis to identify the factors that are positively correlated with higher adolescent service index scores. Our multivariate models incorporated organizational characteristics of the health center respondents and their patient populations as covariates. A full explanation of our model and definitions of our covariates are included in Appendix A.

In addition, the research team conducted case studies with six health center organizations to provide an in-depth understanding of how family planning care is organized and more specifically to identify barriers and facilitators involved in the provision of these important services. Case studies were identified after survey analysis was completed, and study sites were selected using a maximum variation sampling strategy with the following criteria:

- Patient volume as a proxy for organizational size
- Regional distribution using Census regions
- Receipt of Title X family planning funding
- The range of contraceptive methods available based on survey findings
- Variation in state Medicaid and other family planning policies

A team of two to four investigators conducted interviews with a range of clinical and administrative staff at each of the six case study sites. Interviews were audio-recorded and transcribed for accuracy. Transcripts were analyzed using thematic analysis, and emerging themes were reviewed by a team of three investigators until consensus was achieved. The George Washington University institutional review board provided approval and oversight the study protocol.

Results

We had 423 CHCs respond to our survey, reflecting a 44% response rate. More than 1.25 million adolescents received care across these CHCs in 2011, representing 13.8% of the respondents’ patient population. We found a range of adolescent family planning...
services were provided among our respondents (See Table 1). Two thirds of health centers reported staff members receive training in adolescent family planning (66%), and more than three quarters (78%) reported providing walk-in appointments for adolescents. Most health centers (82%) make efforts to protect the privacy and confidentiality of adolescent family planning information by limiting access to the patient’s medical record to the patient or a formally designated individual. A slim majority of respondents (52%) said that they collaborate with other entities in family planning outreach to adolescents.

Other services and supports proved more difficult for health centers to provide. Only 45% of respondents indicated they provide school-based family planning education, and even fewer (29%) offered school-based family planning treatment. Less than half (47%) reported providing either on-site or off-site contraceptive services specifically for adolescents. Far fewer had drop-in centers (15%) or an alternative entrance and exit for adolescents (11%). Respondent health centers had a mean score on the adolescent family planning services index of 6.33 out of a maximum score of 13.

### The role of Title X funding

Our larger study found that about 26% of health centers receive family planning funding from the federal Title X Family Planning Program [33]. This program is designed to help provide essential family planning services to low-income patients through its network of 4,400 family planning clinics in the United States. Receipt of Title X funding was associated with a number of adolescent family planning services (Figure 1). A significantly higher proportion of Title X-funded health centers provided school-based education (63% vs. 38%), school-based treatment (41% vs. 24%), received training in adolescent family planning needs (87% vs. 57%), collaborated with other agencies in outreach efforts (76% vs. 44%), and offered tailored contraceptive services for adolescents (69% vs. 38%). In addition, significantly more Title X-funded health centers had drop-in centers (26% vs. 11%) and an alternative entrance/exit for adolescents (19% vs. 8%) compared with non-Title X health centers. Title X-funded respondents scored significantly higher on the adolescent family planning services scale compared with non-Title X health centers (8.13 vs. 5.33, p value < .001).

### Size and location of health center organizations

The size and location of the CHC also appeared to play a role in the range of adolescents services offered (Table 2). A significantly higher proportion of medium/large health centers offered school-based treatment (35% vs. 21%), provided tailored contraceptive services for adolescents (54% vs. 38%), and collaborated with other agencies in outreach efforts to adolescents (57% vs. 47%) than did small health centers. Medium/large centers also had significantly higher average index scores than did small centers (6.55 vs. 5.58, p value = .001). Furthermore, a significantly higher proportion of rural health centers offered a drop-in center for adolescents,
compared with health centers in urban/suburban settings (27% vs. 13%), and 95% of rural health centers employed policies to limit access to adolescents’ family planning records compared with 83% of urban/suburban health centers (p value = .002).

**Policy climate for family planning care delivery to adolescents**

Health centers located in favorable/neutral policy climates, as identified by existing state family planning policies, exhibited higher rates of collaborating with other entities in adolescent family planning delivery (57% vs. 42%; Table 2). These health centers also had more facility supports for adolescent services such as having a drop-in center (18% vs. 7%) and offering walk-in appointments (81% vs. 73%) when compared with health centers in unfavorable policy climates. On the whole, health centers located in favorable/neutral states scored significantly higher on the adolescent services index (6.33 vs. 5.48, p value = .013).

**Factors associated with high provision of adolescent services**

In our multivariate analysis, we found that receipt of Title X funding (p value < .001), the number of health center sites that provide family planning services per health center organization (p value = .038), the presence of a family planning educator on staff (p value < .001), and being located in a favorable policy state (p value = .002) were associated with a higher adolescent family planning services index score. Our analysis also demonstrated a positive correlation between the proportion of adolescents among the total patient population and higher index scores (p value = .001; Table 3).

**Barriers to the provision of adolescent family planning: Qualitative results**

The case studies found that providing accessible and confidential family planning services to adolescents is a priority, but that study sites faced challenges doing so. Barriers included inadequate funding, underutilization due to lack of knowledge of services, access barriers due to restrictive school policies, and the absence of confidentiality protocols for adolescents who seek family planning services (see Table 4 for representative quotes).

Lack of funding was the most substantial challenge to the provision of adolescent family planning care cited in our case studies. All the CHC study sites reported the reduction of funding for some aspect of their family planning services for teens. Because of cuts, some case study sites had been forced to eliminate entire programs for teens, whereas others had to reduce outreach efforts to adolescents. One health center reported funding cuts for a subsidy program that allowed teens to get free care without using their parents insurance or providing proof of income, which is often needed to prove eligibility for a health center’s sliding fee scale.

Study sites also reported that a lack of knowledge about the availability and confidentiality of services may lead to underutilization among teens. Without adequate education and outreach about the confidentiality and availability of their services, health centers in our study said they struggle to get teens into their clinics. The director of the teen clinic at one of our study sites said the lack of knowledge among teens around the confidentiality of services is one of the biggest barriers to care among the teen population in that community. Another study site reported they offered a weekly teen clinic, but that the...
services were “not well utilized” because they did not have the funds to staff outreach and education for the clinic. This provider explained that the underutilization of teen-targeted programs feeds into the cycle of funding cuts. If the services are not being used, then the center cannot justify funding them.

Many of our study sites identified partnerships with schools as critical to serving the adolescent population and increasing use of services at the health center among this target group. One study site noted its work with the local school was a critical strategy to reach out to their patient population, which is largely comprised hard-to-reach immigrants. It is “a way to feed back to the adolescent clinic.” The school is “focused on refugees and immigrants, [which] is a good fit to serve [the health center’s] patient population.” However, the case studies also revealed that there are substantial barriers to fully leveraging school partnerships, including funding and push back from the community and parents. One study site reported that it operated a school-based clinic but was prohibited from furnishing on-site contraceptives at the location because of community backlash. Although students who attend the school clinic are referred to the health center for contraception, the provider noted that they have a high no-show rate. Participants at this CHC felt strongly that their inability to dispense birth control at the school clinic dramatically impeded their ability to provide needed care. Another site that provided care in schools said the inability to provide contraceptives was a huge “missed opportunity.” This site explained that students at schools are a captive audience, and it is very difficult to get adolescents to come into the health center itself.

Case study participants also reported that the lack of protocols or enforcement of protocols to protect adolescents’ privacy and confidentiality was also a concern. One study site participant said that providers at their health center often defer to the parents’ wishes on confidentiality, allowing them to stay during confidential discussions of family planning services. Health centers also reported the absence of policies related to separate billing for adolescent family planning services is an issue when trying to provide confidential care. Most of the health centers said that they try to accommodate teenagers’ requests not to use their parents’ insurance by waiving fees, but that there are no protocols to make this automatic for teens.

Discussion

Recent guidance by the Centers for Disease Control and Prevention (CDC) and the Office of Population Affairs (OPA) discusses key elements of providing quality family planning care and emphasizes the importance of offering services that are tailored to the unique needs of adolescent patients [34].

### Table 3

<table>
<thead>
<tr>
<th>Factors associated with adolescent services index (n = 365)</th>
<th>Coefficient</th>
<th>Standard Error</th>
<th>t</th>
<th>p value</th>
<th>95% Confidence interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title X</td>
<td>1.887</td>
<td>.289</td>
<td>6.520</td>
<td>&lt;.001*</td>
<td>1.318–2.456</td>
</tr>
<tr>
<td>Medium/large size</td>
<td>−.140</td>
<td>.294</td>
<td>−.480</td>
<td>.634</td>
<td>−.719 to .438</td>
</tr>
<tr>
<td>Small Size</td>
<td>−</td>
<td>−</td>
<td>−</td>
<td>−</td>
<td>−</td>
</tr>
<tr>
<td>Urban or suburban</td>
<td>.519</td>
<td>.369</td>
<td>1.410</td>
<td>.161</td>
<td>−.207 to 1.244</td>
</tr>
<tr>
<td>Rural</td>
<td>−</td>
<td>−</td>
<td>−</td>
<td>−</td>
<td>−</td>
</tr>
<tr>
<td>Percent adolescent</td>
<td>.116</td>
<td>.035</td>
<td>3.350</td>
<td>.001*</td>
<td>.048–1.85</td>
</tr>
<tr>
<td>Family planning sites</td>
<td>.097</td>
<td>.041</td>
<td>2.350</td>
<td>.019*</td>
<td>.016–1.78</td>
</tr>
<tr>
<td>Family planning educator</td>
<td>1.907</td>
<td>.303</td>
<td>6.290</td>
<td>&lt;.001*</td>
<td>1.311–2.503</td>
</tr>
<tr>
<td>OBGYN</td>
<td>.024</td>
<td>.076</td>
<td>.310</td>
<td>.753</td>
<td>−.126 to 1.174</td>
</tr>
<tr>
<td>Certified nurse midwife</td>
<td>.089</td>
<td>.070</td>
<td>1.260</td>
<td>.207</td>
<td>−.049 to .227</td>
</tr>
<tr>
<td>Favorable Adolescent Policies</td>
<td>.895</td>
<td>.286</td>
<td>3.130</td>
<td>.002*</td>
<td>.333–1.457</td>
</tr>
<tr>
<td>Neutral adolescent policies</td>
<td>.018</td>
<td>.044</td>
<td>−.050</td>
<td>.959</td>
<td>−.695 to .659</td>
</tr>
<tr>
<td>Unfavorable adolescent policies</td>
<td>−</td>
<td>−</td>
<td>−</td>
<td>−</td>
<td>−</td>
</tr>
<tr>
<td>Constant</td>
<td>2.425</td>
<td>.637</td>
<td>3.810</td>
<td>&lt;.001*</td>
<td>1.173–3.678</td>
</tr>
</tbody>
</table>

**OBGYN — Obstetrician/Gynecologist.**

* Italics signify the reference group.

* Signifies p value < .05.

### Table 4

<table>
<thead>
<tr>
<th>Barriers to adolescent family planning care with representative quotes: themes emerging from the qualitative case studies</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inadequate funding for adolescent family planning programs</strong></td>
</tr>
<tr>
<td>• “[Health Center] had a young adult clinic that used to have a specific time and specific provider once a week. They do not have that specific time and provider anymore.”</td>
</tr>
<tr>
<td>• “Funding and staff is a barrier to starting the male outreach again.”</td>
</tr>
<tr>
<td>• “Young adults can access care without proof of income. [We] used to have waivers for co-pays... but it got cut.”</td>
</tr>
<tr>
<td><strong>Lack of knowledge about services leads to underutilization by adolescents</strong></td>
</tr>
<tr>
<td>• “I think they’re just not getting [family planning care]. They probably do not know they can come in without their parents’ knowing and get it.”</td>
</tr>
<tr>
<td>• “The number of adolescents coming to... request birth control is next to zero. They might be getting it at a school-based center, but not here.”</td>
</tr>
<tr>
<td>• “[Services] are not well utilized because of marketing and staff changes—less staff for outreach.”</td>
</tr>
<tr>
<td><strong>Access issues due to funding, restrictive school policies limiting services</strong></td>
</tr>
<tr>
<td>• “They do not dispense on site [at the school], so they get referred to the family planning department for contraceptives. They tracked who got referred and who completed referral and it was somewhere around 30 percent. They are teenagers and once they’re gone, they’re gone.”</td>
</tr>
<tr>
<td>• “[Health center] used to have a relationship with the teen health center at the school twice a week and it fed the young adult clinic. The funding ended and [we] withdrew from the school center.”</td>
</tr>
<tr>
<td><strong>Lack of confidentiality protocols</strong></td>
</tr>
<tr>
<td>• “I know that usually we are supposed to ask them to leave, it depends on the parents. There are some parents that are comfortable with it, but there are some that would think that anything you have to tell my kids you have to tell me.”</td>
</tr>
<tr>
<td>• “Confidential visits would happen separately—charting for family planning, sexual health is separate and confidential. They have special hours [for adolescents], but I’m not certain as to the utilization... it’s not well utilized.”</td>
</tr>
</tbody>
</table>
Our study examines whether and how CHCs provide quality family planning to teens. Survey results found substantial variation in both the range and type of family planning services provided to adolescents in CHC settings, and the case studies suggest that there are substantial funding and organizational barriers that make provision and utilization of family planning for teens challenging.

Many health centers incorporate key elements of quality adolescent family planning care as outlined by the CDC/OPA guidance, such as confidential care and youth-friendly services. The survey found that most health centers protect adolescents’ privacy by limiting access to family planning/medical records and have walk-in appointments for adolescents in an effort to increase accessibility. A majority of health centers also train their staff on adolescent needs and collaborate with other organizations to target teen family planning needs. In these ways, health centers are filling a critical gap—they address many of the access barriers that impede teens’ use of preventive services generally, and family planning care in particular, and provide services recommended by the CDC/OPA guidance [3,35–37].

Despite these important inroads, however, CHCs still face substantial challenges in providing care to this population. For example, few health centers have special access points for adolescents, such as drop-in centers or a separate entrance, both of which have been shown to facilitate use of family planning services [30]. Less than half offer family planning education or treatment through school-based health centers, another factor that has been shown to improve utilization of reproductive health care among teens [26,27].

The qualitative case studies provide further insight into why these gaps are so prevalent. Lack of funding impedes health centers ability to provide targeted programs, to effectively partner with schools and other organizations providing outreach to teens, and to build infrastructure that could protect privacy and provide adolescent-specific services. Importantly, health centers suggested that teens might not be aware of the availability of low-cost, confidential family planning services at CHCs. In contrast, providers such as Planned Parenthood, are more familiar to teens and perhaps better positioned to meet their unique needs [15,37].

In the multivariate analysis, we found that Title X-funded CHCs and those in a state with favorable adolescent policies rank significantly higher on the adolescent services index, controlling for other factors. In addition, health centers with multiple sites that provide family planning services and with family planning educators on staff also rank significantly higher on the adolescent services index, controlling for other factors. These findings suggest there are mutable factors that influence the provision of a greater number of adolescent family planning services and ways in which health centers can better leverage their services for adolescent family planning care.

Although this study offers important information about how well CHCs provide family planning care to adolescents, there are some important limitations to our findings. First, our analysis is limited to our respondents’ largest practice site, which may be more likely to have the resources and staff capacity to deliver specialized adolescent care. Thus, we cannot conclude that our findings represent the average health center site, nor can we infer the availability of these services at smaller sites, which may face more barriers. In addition, the cross-sectional nature of the study means our models cannot determine directionality in the positive correlations found. For example, it is unclear whether

the proportion of adolescent patients at a given health center site drives the presence of adolescent-friendly family planning services or whether the presence of these services encourages access to more adolescent patients. Finally, we recognize that our findings represent only one segment of family planning providers serving low-income adolescents and do not offer findings on the role of CHCs within the broader context of other types of family planning clinics that may be more teen-friendly.

Based on our research findings, CHCs have the opportunity to play a significant role in providing quality family planning care to adolescents who are disproportionately low-income, from racial and ethnic backgrounds, and medically underserved. Many health centers offer a range of family planning services specifically targeting adolescents, which means an expansive network of high-quality providers is in place to address their needs. However, gaps exist and much can be done to improve care for this special population.

With implementation of the Affordable Care Act (ACA), CHCs’ role in providing high-quality reproductive health care is expected to grow as a result of both health insurance expansions and the $9.5 billion Health Center Growth Fund. The additional funding in the ACA may provide health centers with the infrastructure and capital needed to expand both the scope and reach of family planning services for adolescents. CHCs should explore using this new funding to support services targeted to family planning for teens, especially when Title X funding is not available.

In addition, although health centers have little control over state-level policies related to family planning care, the ACA should address some policy issues that impact CHCs’ provision of family planning to adolescent. For example, insurance expansions through both Medicaid and the health insurance exchanges will increase adolescents’ access to preventive care, including family planning services, with no cost sharing, thereby reducing a significant barrier to family planning care [38]. Support in the ACA for delivery system reform may also spur innovative programs that target teens’ family planning needs, such as specific clinics for adolescents or team-based approaches that include professionals (e.g., nurses or social workers) with expertise in adolescent health [39].

The infusion of resources associated with the ACA and the release of the OPA/CDC guidelines for quality family planning care may also serve to stimulate outreach and education efforts focused on adolescents. This could include targeted educational programs within CHCs, and additional collaborations with schools. School and CHC partnerships can be further leveraged, especially in states with favorable policy environments, to provide family planning education, referrals to partner CHCs, and even family planning services.

Finally, additional research examining the relationships and referral networks between CHCs and other family planning providers within a community should be undertaken. Health centers play a unique role in reducing many of the substantial access barriers keeping teenagers from getting high-quality care. However, there are no studies that effectively examine their role for providing family planning care to teens when other family planning clinics, such as Planned Parenthood, are located in their communities. This is an important research question that should be further explored.

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Supplementary data

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References
