Reproductive Health Needs Assessment

2014

Louisiana Department of Health and Hospitals
Office of Public Health – Bureau of Family Health
Reproductive Health Program

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2014 Reproductive Health Needs Assessment

The Office of Public Health (OPH) Bureau of Family Health (BFH) Reproductive Health Program (RHP) staff conducted a comprehensive assessment of needs and resources as part of the process of developing a strategic vision for the program. The findings of the 2014 Reproductive Health Needs Assessment are presented here and included: 1) A review of Louisiana's population, population health, and social determinants of health; 2) An evaluation of health care access and the overall capacity of the healthcare delivery system to provide the type and quality of services required by Title X; and 3) The Family Planning Community Input Assessment, a survey of current clients, potential clients, adolescents, and Title X providers to assess the population's perception of and need for reproductive health services.

State Snapshot, Population Health, and Social Determinants of Health

Louisiana is the 31st largest state in the country, covering an area of 43,204 square miles.[1] The state's 64 parishes (counties) are grouped into 9 DHH public health regions. Each of the 9 regions has an urban center, the largest of which include New Orleans as well as Baton Rouge, the state capital. However, much of the state, including 40 parishes in their entirety, can be considered rural. The population as of 2012 was approximately 4.6 million people according to the US Census Bureau.[1] Louisiana is home to a community with strong roots--nearly 4 out of every 5 individuals (78.5%) residing in Louisiana were born in-state.[2] The majority of the population in Louisiana is White (64.6%), but the state has the tenth largest Black population in the country, accounting for 32.8% of the state's population.[2,3] As of 2012, 4.3% of the population is of Hispanic or Latino ethnicity and 1.8% of residents are Asian.[2] Louisiana has a fairly young population, with a median age of 35.9 years and approximately a quarter of residents under the age of 18.[2] Poverty continues to be a pressing issue for the state, as of 2012, nearly one-fifth (18.7%) of people in Louisiana are living below the federal poverty line.2 For children under 5 that proportion rises to an astounding 30.7% living in poverty.[2]

Population Health

For nearly all health or economic indicators, Louisiana has historically been at the bottom of national rankings. In 2013, Louisiana ranked 44th in combined measures of health outcomes (i.e. rates of diabetes, infant mortality, poor mental and physical health days, premature death, cardiovascular deaths, cancer deaths, and disparities), and 48th overall in the nation for health.[4] Among the most startling rankings are the state's birth outcomes and rates of sexually transmitted infections (STI). Louisiana has much higher proportions of low birth weight and preterm births than the nation as a whole.[5] Poor preconception health, inadequate birth spacing, and lack of interconception care, particularly for women who have had a prior poor birth outcome, are key drivers of preterm birth.[6] STIs, like chlamydia and gonorrhea, have also been associated with low birth weight and preterm birth.[7]

In 2012, the state ranked 2nd in the nation for rate of gonorrhea and 4th for chlamydia.[8] Additionally, Louisiana ranked 3rd in the country for the rate of primary and secondary (P&S) syphilis and 1st in the nation for rate of congenital syphilis with 49.3 per 100,000 live births.[8] The rate of chlamydia among Blacks in Louisiana was nearly seven times higher than that for Whites, with Black women being by far the most affected. Similarly, the rate of gonorrhea in Blacks was nearly 13 times higher than in Whites.[9] The rates for HIV are just as alarming. The state was ranked 4th in the nation for diagnoses of HIV infection in 2011, with New Orleans and Baton Rouge being ranked 2nd and 3rd, respectively, amongst metropolitan areas in the country.[10]

Table 1. Rates of Sexually Transmitted Infections in Louisiana, 2012

	Chlamydia	Gonorrhea	Syphilis	
			P & S	Congenital
National Rank	4th	2nd	3rd	1st
Louisiana	594.4	192.8	7.4	49.3
Women	872.7	216.2	5.4	-
Men	304.0	168.4	9.4	-

Cases per 100,000 population. DHH-OPH STD/HIV Program Report, 2012

High overall rates and dramatic racial and ethnic disparities are also seen for teen births, which is concerning given the higher risk for adverse outcomes later in life for both teen mothers and their children. Teen pregnancy and teen motherhood have been linked to poorer mental and physical health, respectively.[11] Louisiana ranked 44th in 2012, with 43.1 births per 1,000 females aged 15-19.[12] Although this rate is an improvement since past years, it is still very high, especially when compared to a rate of 29.4 births per 1,000 teen girls for the country as a whole.[5] The majority of teen births are occurring to older teens, with a rate of birth for 15-17 year olds of 19.5 per 1,000 and for 18-19 year olds of 77.8 births per 1,000.[5] And the most recent teen birth rates by race/ethnicity show large disparities, as the teen birth rate was 34.5 per 1,000 for Whites, as compared to 50.7 for Hispanics, and 60.2 for Blacks.[12] Nearly 1 in 5 teen births are repeat births, and similar racial and ethnic disparities are seen in these rates, as well.[12]

For pregnancies overall, Louisiana data confirm national estimates that most are unplanned. According to the 2009 Louisiana Pregnancy Risk Assessment Monitoring System (LaPRAMS) Report, approximately 57% of pregnancies in Louisiana were unintended.[13] Women who are younger (18-24), low-income, cohabiting with a partner, and/or minority (particularly Black) are at higher risk of an unintended pregnancy, and subsequently unintended births and/or abortions.[14] Of the mothers surveyed in Louisiana, 67% reported that they were not trying to get pregnant at the time of conception, but over half of these women (55%) were not using contraception at that time.[13] These high rates of unintended pregnancy and low rates of contraceptive utilization prior to conception are important indicators of need for contraceptive services and education.

In addition to the dramatic effects that unintended pregnancies have on the lives of parents, there are health consequences for the children. Unintended pregnancies can lead to poor birth outcomes, including low birth weight, preterm birth, and birth defects.[6] STIs, including chlamydia and gonorrhea, have also been associated with low birth weight and preterm birth.[7] Some of the consequences of the high rates of unintended pregnancy and STIs in

Louisiana can be seen in the elevated numbers of low and very low birth weight and preterm babies. In 2012, Louisiana had higher proportions of all three of these outcomes than the nation as a whole. Dramatic racial disparities are seen here again, as Black women in Louisiana give birth to preterm and low birth weight babies at rates much higher than White, non-Hispanic and Hispanic women.[5]

Table 2. Birth Outcomes in Louisiana, 2012[5]

	Low Birth Weight (<2,500 grams)	Very Low Birth Weight (<1,500 grams)	Preterm Birth (<37 weeks gestation completed)
United States	8.0%	1.4%	11.5%
Louisiana	10.8%	2.0%	15.3%
White, non-Hispanic	8.1%	1.2%	12.6%
Black, non-Hispanic	15.1%	3.3%	19.7%
Hispanic	7.6%	1.4%	12.3%

Social Determinants of Health

Louisiana is characterized by inequality in many ways- across income categories, racial groups, and rural-urban residence. Disparities are evident not only in the state's health indicators as demonstrated above, but in the many socioeconomic factors which are known to be strongly associated with health. Educational attainment is an important predictor of a number of outcomes along the life course and is associated with many reproductive health indicators, such as fertility rates,[15] likelihood of unplanned pregnancies,[16] risk of contracting an STI,[17] and economic opportunity.[18] The Louisiana public education system is ranked in the bottom 20% in the nation.[19] The high school graduation rate for the state overall in 2012 was only 72%.[19] Stratification demonstrated dramatic racial and ethnic disparities, with 78% of White students receiving a high school diploma as compared to 71% of Hispanic and/or Latino students and 65% of Black students. Economically disadvantaged students had the lowest graduation rates of all, with only 66%.[19]

Poverty rates serve as an important indicator of need for publicly funded family planning services. They also illuminate the inequality that exists not only between the nation and the state of Louisiana, but that also exists within Louisiana amongst racial and rural-urban groups. The burden of poverty in Louisiana is not distributed equally, as demonstrated in the table below. Children under 5 years old, as well as those who are Black, live in rural areas, and/or are single mothers are disproportionately affected.[20, 21] Furthermore, while 15.5% of families in Louisiana are living in poverty, there is a dramatic gap in poverty rates among households with children under the age of 18 based on parental structure.[2] In 2011, the rate of poverty among female headed households with no husband present was more than 5 times greater than that of married couple families.[20]

Table 3. Poverty Rates in Louisiana, 2011

	Overall[20]	White[20]	Black[20]	Hispanic[20]	Rural[21]	Urban[21]
Louisiana	20.4%	11.5%	32.0%	19.9%	24.7%	19.7%
United States	15.9%	11.6%	25.8%	23.2%		

In 2010, Louisiana was ranked 6th in the nation for highest income inequality when comparing the ratio of average household income for the richest 20% of households to the poorest 20%.[22] The gaps seen amongst population groups in Louisiana are not unique, but are often on the far end of the spectrum of inequality when compared to the rest of the nation. It is important to understand that the population of Louisiana is not homogenous in having poor health, low income or a lack of education. Effects of social and economic inequities are often seen in disparities in the health indicators discussed previously: rates of unplanned pregnancy, poor birth outcomes, teen birth, and sexually transmitted infections (STI).

Scan of Access to Reproductive Health Services

Louisiana's Title X clinics are a key entry point into the health care system. For young and low-income women who are more likely to utilize family planning clinics as their main, or even sole, source of medical care, Title X services are essential.[23] Available data indicated that in 2010, there were 534,580 women in need of contraceptive services and supplies in Louisiana.[24] Of those women, 310,720 were in need of publicly funded contraceptive services and supplies, 76,040 because they were sexually active teenagers and 234,690 because their incomes fell below 250% of the federal poverty level.[24]

The family planning services provided through the OPH Title X Clinics are a vital source of care for the many uninsured individuals in the state. In 2012, 41% of clients reported having no health insurance.[25] People of color in Louisiana more often lack health insurance coverage, though, which in turn affects their ability to access health services and is reflected in a variety of health disparities like those discussed previously. Throughout Louisiana, 22% of the overall population lacks health insurance.[26] Coverage rates vary: 17% of White Louisiana residents are uninsured, 30% of Black, and 41% of Hispanic Louisiana residents lack health insurance.[26] According to the Guttmacher Institute, 27% of women aged 15-44 in Louisiana are uninsured.[27]

Louisiana has not expanded Medicaid as a part of the Affordable Care Act implementation; as such Medicaid coverage remains fairly limited. Currently, there are about 249,000 Medicaid enrollees aged 20-44 in Louisiana. Louisiana does have a family planning Medicaid waiver program called Take Charge, which provides limited benefit coverage of certain reproductive health services for women ages 19-44 and in a non-expansion state like Louisiana, serves as the only coverage option for low-income women. There are significant gaps in covered services, and men do not qualify at all. Approximately 74,000 women are currently enrolled in Take Charge, with 35% having utilized coverage benefits. The other important forms of Medicaid coverage for women of reproductive age in Louisiana are pregnancy care coverage provided through the LaMOMS program and LaCHIP. LaMOMS covers individuals with income up to 138% of the Federal Poverty Level (FPL). The coverage period includes 2 months

post-partum, after which, women are dropped from the health coverage system or have their eligibility rolled over into the Take Charge program. LaCHIP covers non-citizen women and women who do not enroll timely in a MarketPlace plan. However, there is no postpartum coverage provided.

Louisiana has also successfully pursued two novel strategies that have increased access to care in the New Orleans area. First, following Hurricane Katrina the state responded to the dearth of safety net healthcare providers by securing a Medicaid waiver that expanded coverage for primary care services for people up to 200% of the FPL living in the New Orleans region of the state. It was this expanded access to primary care coverage under the Greater New Orleans Community Health Connections (GNOCHC) waiver program that enabled the DHH Birth Outcomes Initiative to secure the aforementioned interconception care waiver, which provides support for women in New Orleans who have had a prior poor birth outcome and would otherwise lose Medicaid coverage 60 days post-partum.

Nationally, more than 6 out of 10 women who utilize family planning centers consider it their usual source of care, a number that is even higher for women in poverty, with no public insurance or no insurance, and who are non-White.[3] The importance of family planning centers' roles in helping manage women's health care needs above and beyond reproductive health, and as an entry point into the health care system cannot be overstated, especially given the shortage of primary care providers throughout the state. The U.S. Health Resources and Services Administration (HRSA) currently recognizes 206 primary care shortage areas within 61 of 64 parishes.[28] Access to essential health services is a challenge, even in some of the more populous areas of the state. The network of existing healthcare resources in Louisiana consists of a variety of public and private entities and is distinctly different in rural versus urban areas. There is at least one Federally Qualified Health Center (FQHC) operating in 44 of the 64 parishes in the state. However, the existing network of FQHCs struggle to meet quality metrics and the substantial need across the state for health services. In a recent study by the Kaiser Commission on Medicaid and the Uninsured, none of the FQHCs in Louisiana received a high performance rating.[29] Louisiana also had the largest share of low-performing sites relative to the total number of FQHCs in the state.[29]

While most community health centers are required to provide reproductive health services such as STI screening and treatment and family planning services, very few in Louisiana are currently able to do so at a caliber in accordance with Title X requirements. In the process of developing the 2014-2017 Title X Project Plan, the BFH RHP staff worked closely with the OPH Bureau of Primary Care and Rural Health, the Louisiana Primary Care Association (LPCA) and the Louisiana Public Health Institute (LPHI) to identify the needs of community based primary care entities to implement Title X reproductive health services. While each center's specific needs may vary, the preliminary assessment indicated that support is needed around reconciling Title X fee schedule requirements with the clinic's general fee policies, navigating reporting requirements, and training clinical staff on family planning services, such as counseling and procedures for long acting reversible contraception.

For decades, the historical provider of Title X services in Louisiana has been OPH. All 64 parishes in the state have at least one public Parish Health Unit (PHU). Depending on the service area, PHUs may provide WIC, Title X Family Planning, STI/HIV services, immunization, and/or tuberculosis screening and treatment. The PHUs once served as Louisiana's main provider of primary care for low-income women, children and families providing reproductive health, prenatal care, well-baby and well-child care, routine immunizations, and developmental screening at low or no cost, across generations for many families. Over the past 10-15 years, more private providers began to accept Medicaid, and many services the PHUs had provided transitioned to private providers. PHUs now primarily provide the essential public health services, with a focus on family planning, STI screening and treatment, and WIC. Currently 59 of the PHUs provide Title X family planning services (to be referred to as OPH Title X Clinics), with programmatic oversight provided by the OPH Bureau of Family Health (BFH) Reproductive Health Program (RHP). The BFH RHP also has four Title X subrecipient sites--one that specifically serves high risk adolescents, and three others in areas where the PHU closed. While the geographic reach of RHP's OPH Title X Clinics has remained largely intact, the frequency of service availability has become more limited in areas with lower demand. OPH continues to be the sole entity with statewide reach for Title X services, and is the state's largest Take Charge Medicaid family planning waiver provider.

Family Planning Community Input Assessment 2014

An in-depth Community Input Assessment Study was carried out by the Reproductive Health Program with the motivation of gaining a better understanding of how the program is viewed by communities across the state, as well as to ascertain ways in which outreach, education, and delivery of services could be improved. Although community needs assessments have been conducted by the program in past years, staff sought to greatly expand the reach of this most recent study and to provide more opportunities for community input to be given.

Methods

The statewide community input assessment study took place from October 2013 to January 2014 and included four surveys conducted with RHP clinical staff, current clients, potential clients, and adolescents. Additionally, structured interviews were conducted with staff members at a variety of community organizations in person and by phone. The components of each survey are described below:

Client Survey: A survey was developed for use with current clients which included items asking about time since last visit, barriers to care, satisfaction with services, sources of referral, and other needs. All reproductive health visit clients at all clinics across the state were asked to complete a survey for 3 weeks in November and December of 2013.

Potential Client Survey: Individuals in the community who could potentially be clients of RHP services were also surveyed to better understand awareness of services in the community, perceptions of quality, need for services, barriers to care, sources of reproductive health information accessed most frequently, and general community needs. Surveys were given to community members through WIC, MIECHV, Head Start & Early Head Start, and Volunteers of America in the New Orleans, Lafayette, Lake Charles, Alexandria, Monroe, and Shreveport areas.

Adolescent Survey: A survey was developed for use with adolescents participating in the BFH's Teen Outreach Program. Questions surveyed awareness and perception of services,

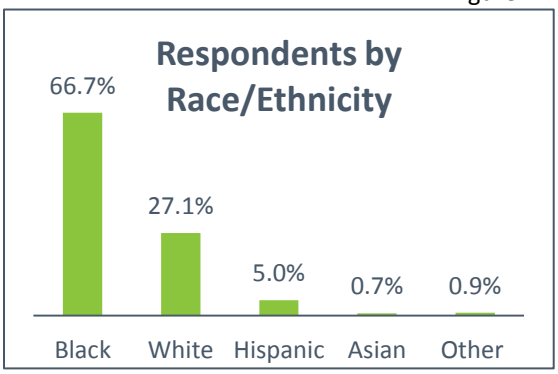
barriers to accessing care, and sources used by adolescents seeking information on sexual health issues. Agencies implementing TOP in the New Orleans, Baton Rouge, Lafayette, Lake Charles, Alexandria, and Shreveport areas were asked to have adolescents aged 14 years or older complete the survey, which was available both online and in paper form.

Clinic Staff Survey: An online survey was developed for RHP clinical staff to solicit feedback on satisfaction with the current educational and outreach materials available, how the community perceives services, barriers clients may experience in accessing services, and barriers staff experience in providing services. It was requested that at least one staff member in each position (clerical, nursing, nurse supervisors) at each clinic complete the survey, although everyone was encouraged to provide feedback.

CBO Interviews: The Community Outreach Coordinator conducted structured interviews with individuals from a variety of community-based organizations around the state working with adolescents, families, and men and women of reproductive age. The interviews provided an opportunity to inform agencies working with the community of the available services, as well as for the RHP to learn about potential new community partners and how they are involved in the community. Other topics covered in the interviews included awareness and perceptions of services, barriers to accessing care experienced by the community, general community needs, suggestions for locations and modes of conduction outreach, and suggestions of community partners. Interviews were conducted with employees of 23 organizations, including Head Start and Early Head Start agencies, Area Health Education Centers (AHEC), United Way programs, employees of other OPH programs, other community non-profits, and other health-related non-profits. Results are not presented here, but are being used internally by the program.

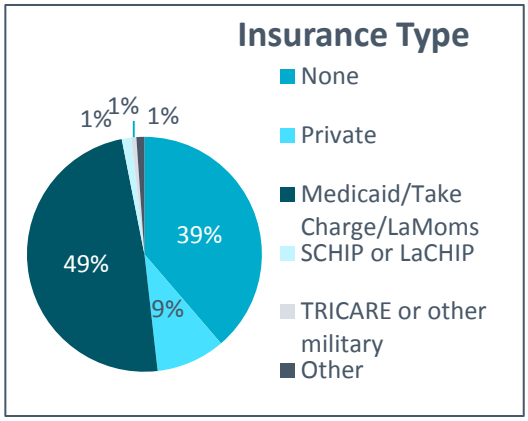
Client Survey Results

Figure 1



Surveys were received from all 9 regions from a total of 2,817 clients, the majority of whom (93.5%) were women. A total of 180 survey responses were received from men. The largest proportion of responses were received from individuals aged 20-24, but the distribution of responses across age groups was fairly normal. As shown in Figure 1, two-thirds of client survey respondents were Black.

Figure 2



Clients were asked about what kind of insurance they currently had, as well as whether they have a primary care doctor. As shown in Figure 2, the two most frequent responses for type of insurance coverage were Medicaid, Take Charge, or LaMoms 49%, or None, which for 39% of respondents indicated that they have no insurance coverage.

Approximately 6 in 10 clients reported that they do not currently have a primary care doctor, which is consistent with the findings of the Guttmacher Institute's report mentioned previously. Individuals with no insurance coverage were more likely to report not having a

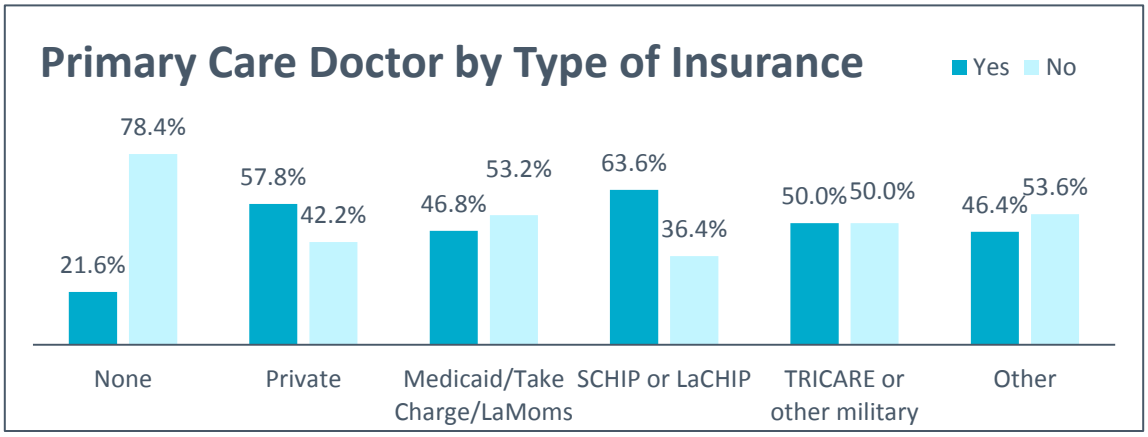


Figure 3

primary care doctor, as were those with Medicaid, Take Charge, or LaMoms, or some 'Other' kind of insurance coverage.

The reason for that day's visit to the reproductive health clinic most frequently cited was for birth control, which was reported by 65.5% of respondents, primarily women. Pap smears were the second most frequent response, cited by 17.3% of respondents, followed by STI/HIV testing and treatment, as reported by 16.4% of clients. However, among men, STI/HIV testing and treatment represented the number one reason for their visit, as reported by 67% of male respondents. Of all respondents, 12.7% cited receiving information or education on family planning and 4.7% cited receiving a pregnancy test as a main reason for that day's visit.

Figure 4 depicts the time reported since the respondents' last reproductive health clinic visit. Of the 85% of respondents who had received reproductive health services at the PHU before, the majority had been back within the last year, indicating that most RHP clients continue coming regularly once they enter care. The reasons indicated most frequently for not returning were 'I didn't feel that I needed family planning services,' recent pregnancy, or using a birth control method which does not require a yearly visit, cited by 7.5%, 4.7%, and 4.6% of clients who reported 1 or more years since their last visit, respectively.

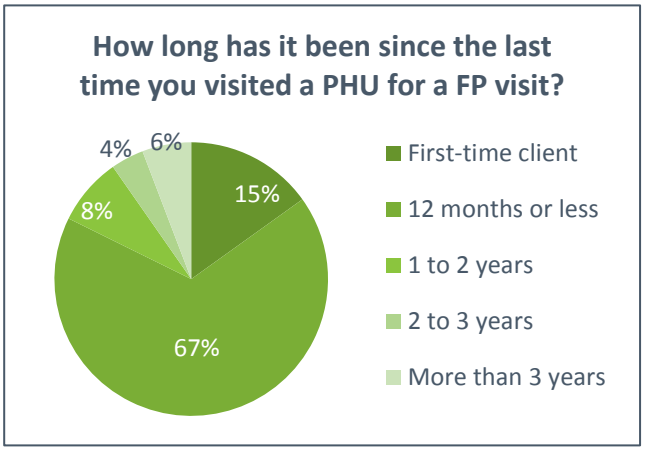


Figure 4

To gauge the relative importance of different reproductive health, and general, needs to clients, the survey included the question, 'What are you most concerned with at this time in your life?' for which respondents could select all issues that they felt applied. The top five responses were 1- Not getting an STI (39.3%) 2- Not getting pregnant yet (34.7%) 3- Not getting pregnant at any time (28.5%) 4- Getting tested or treated for STIs (20.8%) 5- Other health issues, like diabetes, blood pressure, mental health, etc (6.6%). These responses

indicate a desire among clients to take control of their reproductive health and to have the tools and knowledge to prevent and space pregnancies, and to protect themselves from STI. Response number 5 also indicates a need for additional health services, which is important to note given that 61% of respondents reported that they do not have a primary care doctor. This highlights the importance of the RHP clinics as a referral source for primary and preventive care.

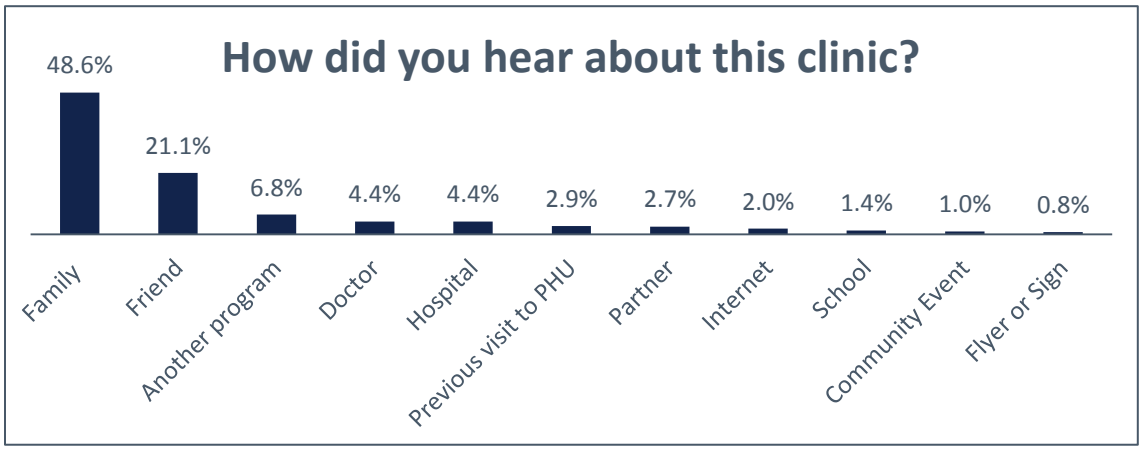
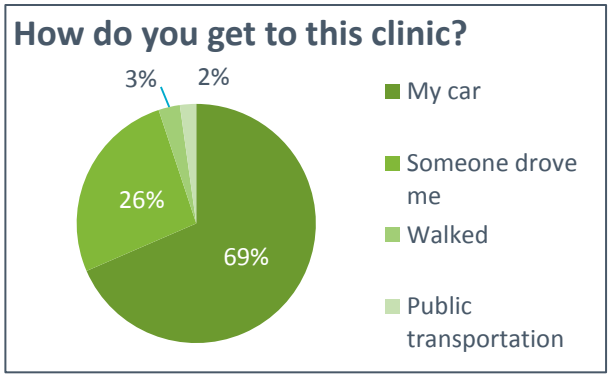


Figure 5

To better understand how clients learn about RHP services, they were asked where they heard about the clinic. The most frequent responses by far were from a family member or friend, followed by a referral from another program like WIC or Nurse-Family Partnership. All sources cited are presented in Figure 5 above.

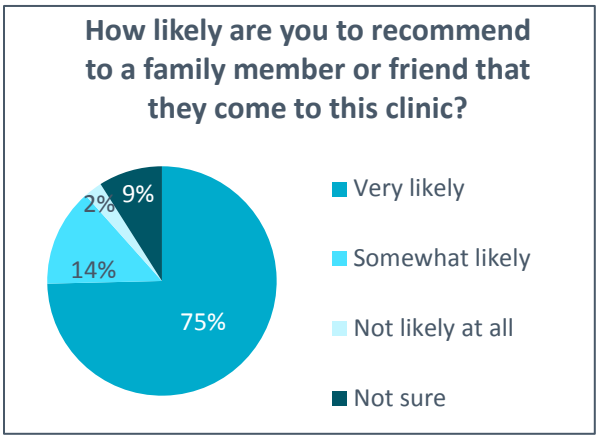
Figure 6



When asked how they got to the clinic for their appointment, 31.5% of respondents reported having to rely on someone else to drive them, using public transportation, or walking to the PHU. While this would seem to indicate a need for transportation, only 6.1% reported that they have difficulty getting to and from the PHU for appointments.

Clients were also surveyed about how likely they would be to refer a family member or friend based on their experiences. Given that the majority of clients heard about the clinic through word-of-mouth referrals from family and friends, it is very encouraging to see that 3 out of 4 clients reported being very likely to recommend the PHU reproductive health services to someone they know.

Figure 7



As part of the community input assessment client survey, a new version of the patient satisfaction survey used for ongoing performance monitoring was piloted. Response rates were very high and provided useful data for the program. Respondents were asked to choose how well they thought the clinic was doing on a number of items. Response options were: Great, Good, Ok, Fair, Poor, or Not Applicable. The percentages of respondents choosing each response are shown below with items grouped by category. The response categories Great and Good were grouped, as were Ok, Fair, and Poor to allow for more easily interpretable data. All items and responses are presented in Table 4 on the next page.

The first two categories, Making Appointments and Wait Times, present the largest opportunities for improvement based on the percentage of Ok, Fair, or Poor responses, while Staff performance, Clinic Building, and Confidentiality represent the greatest strengths. Program staff intend to perform further analyses by region on responses in order to better identify strengths and opportunities for improvement in specific areas across the state.

Table 4. Client Satisfaction Survey Responses		
	Great or Good	Ok, Fair, or Poor
Making Appointments		
Phones answered promptly	75.0	16.2
Messages are returned quickly	69.0	17.9
Able to get an appointment when you need one	75.6	15.5
Hours when the clinic is open	81.5	9.7
Wait Times		
Time in waiting room	52.7	39.4
Time in exam room	68.2	19.5
Time waiting for tests to be performed	67.5	20.4
Time waiting for test results	66.9	20.5
Staff		
Nurses (Pre & Post-counseling)		
Listens carefully to you	84.4	6.1
Spends enough time with you	83.3	6.5
Explains things in a way you can understand	84.4	5.6
Gives you good advice and treatment	84.3	5.1
Shows respect for what you have to say	84.1	5.8
Nurse Practitioner/Doctor (Exam)		
Listens carefully to you	84.7	5.1
Spends enough time with you	83.4	5.5
Explains things in a way you can understand	83.9	4.9
Gives you good advice and treatment	83.6	5.1
Shows respect for what you have to say	83.6	5.2
Other staff (Receptionists, Assistants, etc.)		
Being friendly and helpful	83.9	7.1
Answer your questions	84.2	6.2
Treat you with courtesy	84.2	6.3
Payment		
Explaining your bill and charges clearly	71.5	7.2
Amount we are asking you to pay	69.0	8.0
Paying is quick and easy	69.0	7.8
Clinic Building		
Neat and clean	86.2	5.5
Easy to find where to go	86.8	4.7
Comfort and Safety while waiting	85.1	6.1
Privacy	83.9	7.0
Confidentiality		
Keeping your information private	85.2	4.1

Community Member Survey Results

A total of 1,217 community member surveys were collected from Regions 1, 4, 5, 6, 7, and 8 from potential clients. Region 4 was somewhat overrepresented, with 40% of the surveys. The majority (77%) of survey responses were obtained through WIC, with Head Start being the second largest source of responses (14%). The remaining surveys came from Parents As Teachers, Nurse-Family Partnership, and Volunteers of America.

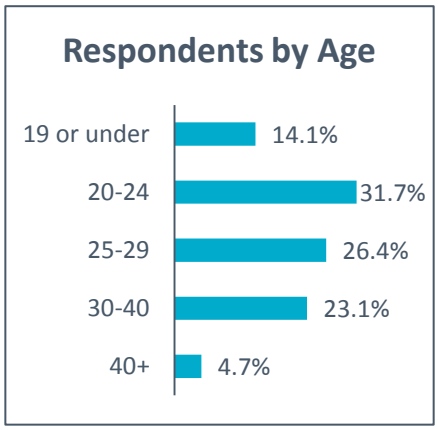


Figure 8

The majority (95.2%) of respondents were female and as shown in Figure 8 were under the age of 30. A total of 58 responses were received from men. Over half, 54.9% of the respondents reported their race as Black or African American. White respondents accounted for 39.5% of responses, and 3.5% of surveys came from Hispanic respondents.

When asked about the kind of insurance that they currently have, as well as whether they have a primary care doctor, the most frequent response was Medicaid, Take Charge, or LaMoms, as reported by 62% of respondents. The second most common response was None, which for 21% of respondents indicated that they currently have no health insurance coverage. Figure 9 presents all responses.

Figure 9

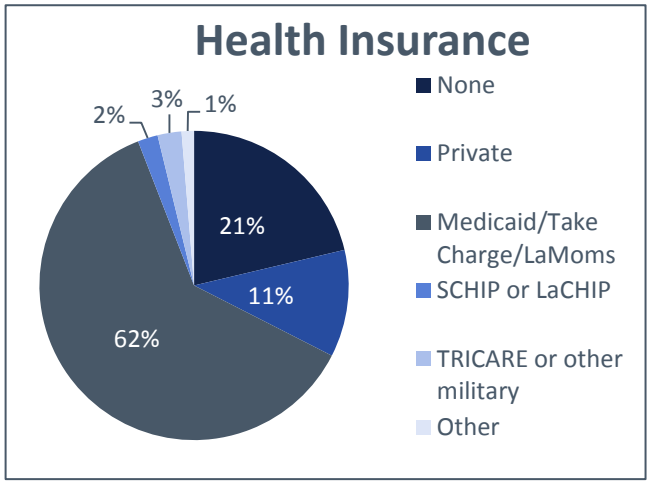
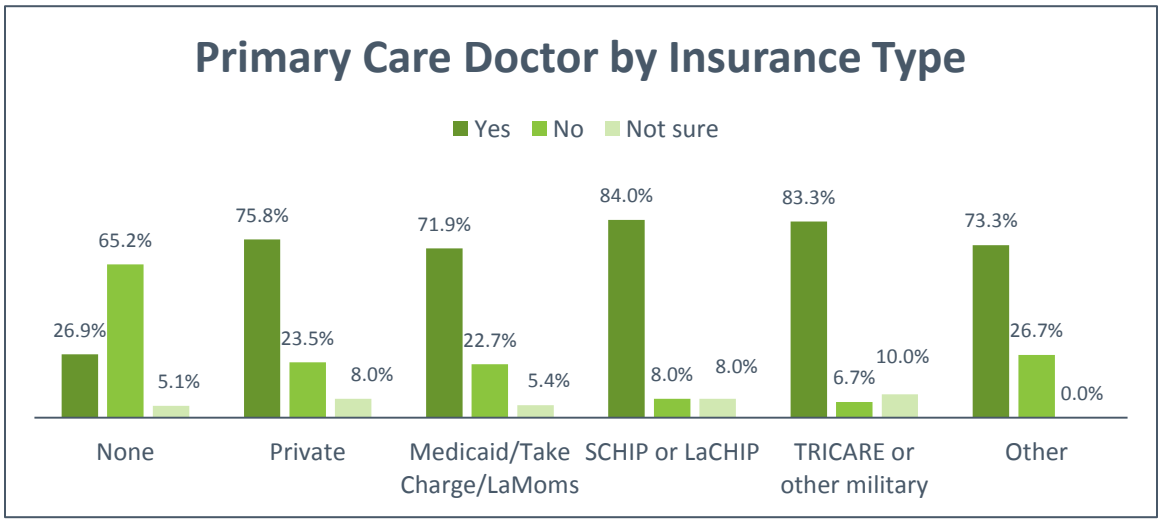


Figure 10



A much greater proportion of community member survey respondents than client survey respondents reported having a primary care doctor. 64% of community respondents have a primary care doctor, as compared to 39% of clients. A similar trend was seen amongst community members as clients in that individuals with no insurance were more likely to report not having a primary care doctor, while a much larger percentage of individuals with some kind of public or private health insurance do report having a primary care doctor.

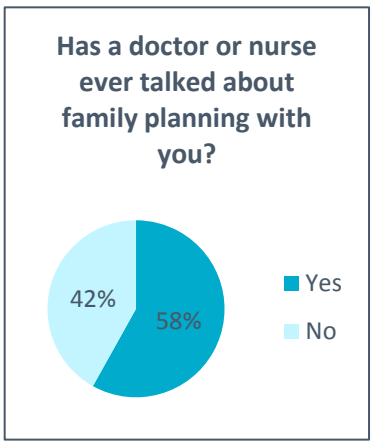


Figure 11

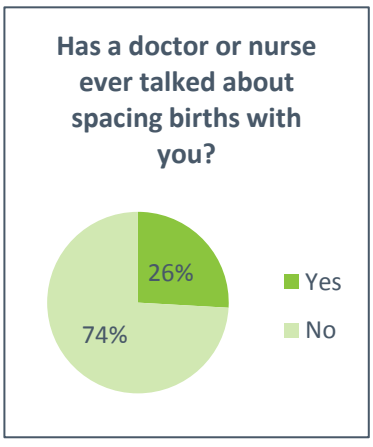


Figure 12

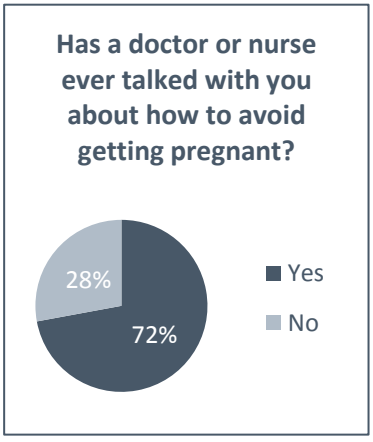


Figure 13

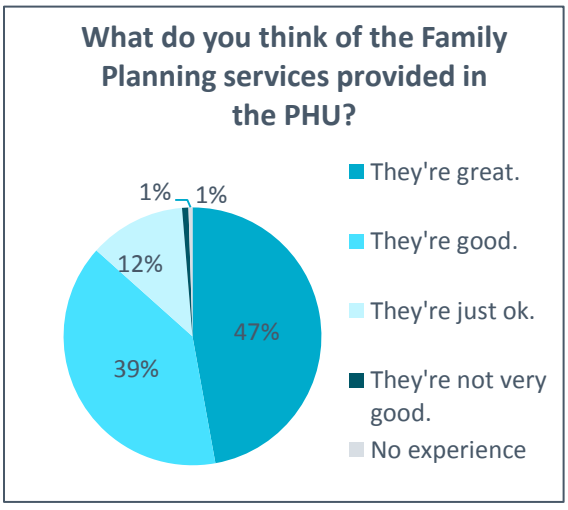
Three questions were included in the community member survey to gauge knowledge of family planning topics. The questions probed whether a health care professional had ever discussed family planning, birth spacing, or how to avoid getting pregnant with the

respondent. Responses are shown in Figures 11, 12, and 13. Responses demonstrated a need for education on family planning topics amongst individuals of reproductive age in the community. While 72% of respondents reported that they had discussed how to avoid pregnancy with a doctor or nurse, for many it was not in the context of family planning, as only 58% of community members reported having talked about family planning with a health care professional. It is important to note that this number represents a self-reported measure, meaning that some respondents may have discussed topics related to family planning, such as contraceptives, with a doctor or nurse but that the connection between those topics and their larger reproductive life plans was not clear. In particular, there is a great need for education about the importance of birth spacing, as only 1 in 4 community members reported having received education from a provider on this topic.

In response to the question, 'Do you know where you can get family planning care in your area? (Meaning someplace you can get birth control, pelvic exams & pap smears, advice about how to prevent pregnancy, or testing and treatment for sexually transmitted infections)' 1 out of every 5 respondents reported that they did not know where to go for services. This represents an opportunity to use outreach to increase awareness of services in the community. Many of the survey respondents were familiar with the PHU, though, as 4 out of 5 had been there before for some kind of service. And 44.2% of community member survey respondents were currently receiving or had previously received reproductive health services at the PHU.

To gauge the community's perception of the quality of services available at the PHU, respondents were asked to rate the services based on their own experiences or what they might have heard from others. The vast majority of responses were positive with 86% of community members finding the services to be good or great, as shown in Figure 14.

Figure 14



The following question asked survey respondents how likely they would be to go to the PHU for reproductive health care. The majority of respondents, 54%, reported that they would be very likely to go, and an additional 27% reported that they would possibly go.

When asked what barriers prevented or would prevent them from going to the PHU for care, the most frequent response was having a different doctor, as reported by 37.8% of respondents. The second most common response, reported by 15.6% of respondents, was long wait times at the clinic. Not having transportation was the third most common barrier reported, cited by 6.7%.

As on the client survey, community members were asked what, at this time in their life, most concerned them, in order to gauge the relative importance of reproductive health issues to potential clients. When asked outside of a healthcare setting, respondents were much more likely to respond that their main concern was some other issue, not related to their health. With 21.9% of community respondents choosing this option, it was the number one response. Of those who specified what the issue that most concerned them was, employment, education, and the well-being of their family were the top three topics. The second most frequent response was not getting an STI, reported by 16.2%, followed by not getting pregnant at any time, reported by 12.9%, other health issues, reported by 11.3%, and not getting pregnant yet, reported by 9.6% of respondents. All of these concerns represent a need for family planning education and reproductive health care.

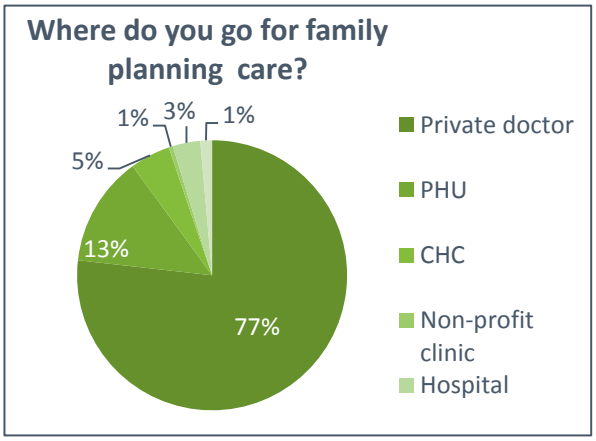


Figure 15

Of the community member survey respondents, 70% reported that they currently have somewhere to go to receive reproductive health care. Of those who do not currently have a source of care, approximately half reported that they want to receive reproductive health care. The majority of individuals reported receiving care from a private doctor, with the PHU

representing the second most frequently cited source of care. The breakdown of all responses is shown in Figure 15.

As a way to gauge need for contraceptive services or education, a series of two questions was included in the survey asking first whether they currently wish to become pregnant and then whether they are currently doing anything to prevent pregnancy. Answers are shown in Figures 16 and 17 to the left and demonstrate a need for contraceptive services and education. Although 91% of survey respondents indicated that they do not currently wish to become pregnant, only 68% were currently doing anything to keep from getting pregnant.

Figure 16

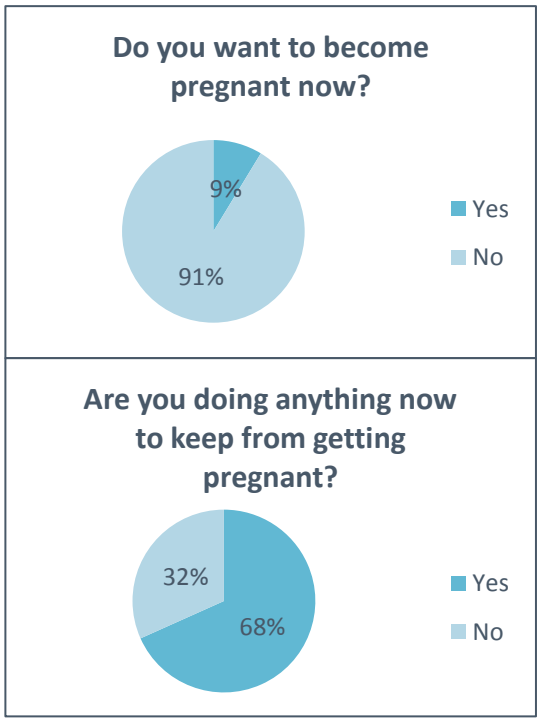
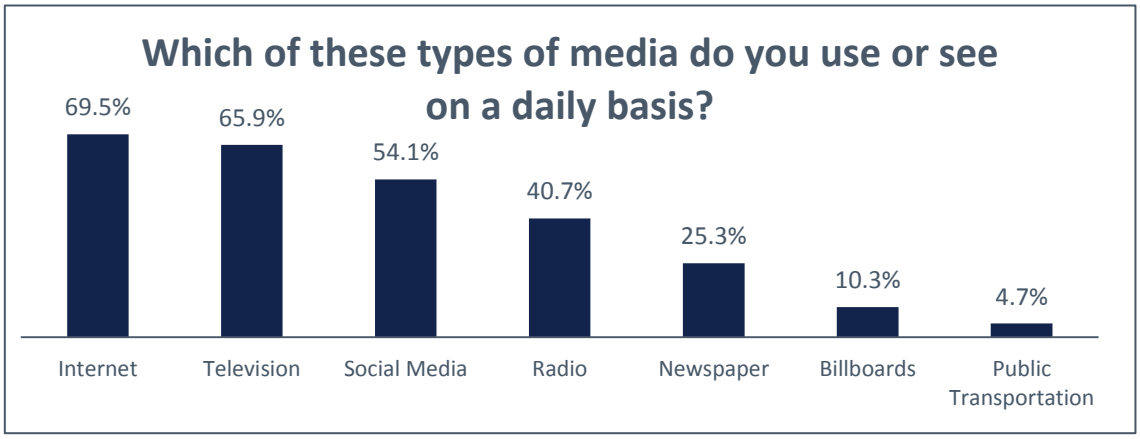


Figure 17

Figure 18



To better understand where community members are currently going to seek information about family planning and reproductive health issues, a question concerning this was included in the survey. The most common sources of information cited were: 1- Doctor or nurse (64.6%) 2- Family (22.1%) 3- Internet (18.1%) 4- Friend (11.9%). Along the same line,

respondents were asked to indicate which types of media they use or see on a daily basis for the purpose of informing outreach and marketing strategies. As shown in Figure 18, the vast majority of respondents chose internet, television, and social media as parts of their daily media habits.

Adolescent Survey Results

A total of 110 Adolescent Surveys were received from Regions 1, 2, 4, 5, and 6. The majority (64%) of respondents were female and all were between the ages of 14 and 18. Adolescents represent an important population served by the RHP both in terms of providing reproductive health services and in terms of providing education.

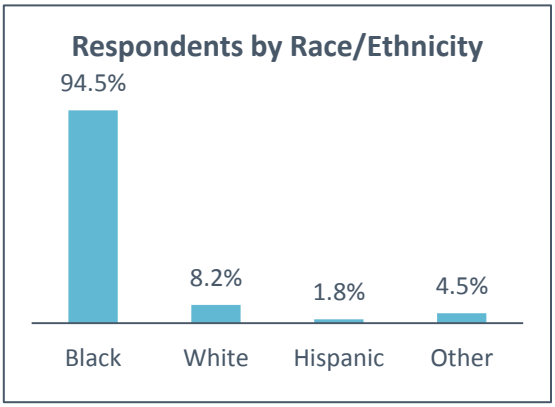
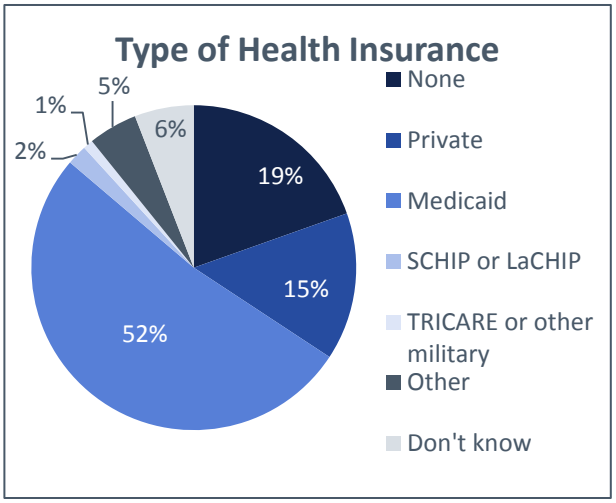


Figure 19

Figure 20



The survey asked teens what kind of health insurance they had, the responses to which are displayed in Figure 20. The most common response was Medicaid, which 52% of adolescents chose, followed by None, as reported by 19% and Private, as reported by 15%. When asked if they have a primary care doctor, only 65% responded yes while 35% responded no or that they were not sure.

Adolescents were also asked whether a health care professional had ever discussed safe sex, STDs, birth control, or general sexual health with them. Overall, 42% of adolescents reported that they had never discussed any of these topics with a doctor or nurse. However, females were more likely than males to report that a provider had provided them with education on these topics. While only 46% of males

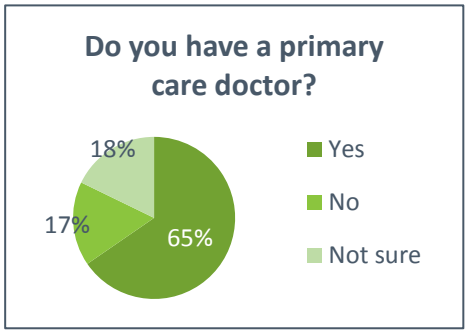
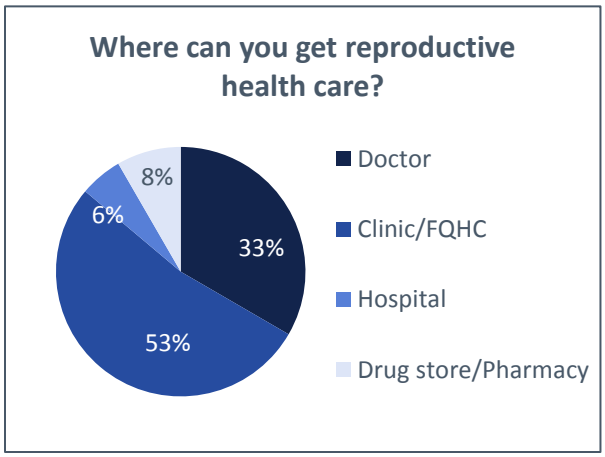


Figure 21

responded yes to this question, 65% of their female peers responded yes. This indicates that providers need to be educated on the importance of counseling adolescents on these topics, as well as the fact that males and females in equal measure need to receive this counseling.

Figure 22



When asked if they knew where to get reproductive health care, only 36.4% of respondents reported that they did know somewhere that they could go. Of those who responded yes, the vast majority did cite a doctor, clinic, or FQHC, but 8% specified a pharmacy or drug store and 6% specified a hospital. The latter answers indicate a need for further education and outreach.

The survey also included the following passage, informing teens of their right to reproductive health care: 'The health department's reproductive health clinics must provide teens with quality, confidential care. That means you do not need anyone's permission to get care at the parish health unit. And no one has to know if you come to the clinic. It is strongly encouraged that teens talk about their relationships and sexual health decisions with their families or another trusted adult, though.' After the passage, adolescents were asked whether they had known previously that they could receive services without parental consent. The majority, 66.4%, reported that they had not known. This represents an important opportunity for using outreach and education to increase awareness of the available adolescent-friendly services.

Having been informed of the services available to them at the PHU, adolescents were then asked how likely they would be to

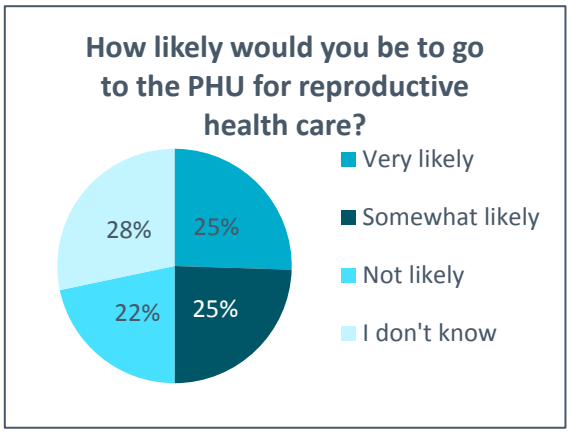


Figure 23

go to the PHU for care. Responses were fairly split, as shown in Figure 23, with 25% answering very likely, 25% answering somewhat likely, 22% answering not likely, and the remainder responding 'I don't know.'

Adolescents were then given three examples of services that they could receive at the PHU and asked to indicate which, if any, they would be interested in receiving. The most popular option was health education, selected by 67% of respondents. Birth control was selected by 59% of females (43% overall), and STI testing and treatment was selected by 41% of respondents. These responses indicate a high level of interest among adolescent respondents in receiving reproductive health counseling and services.

As stated above, while the RHP provides services to adolescents without parental consent, it is our practice to provide counseling in a manner that encourages teens to involve their parents in their reproductive health choices and to discuss these matters with them. In an effort to gauge (albeit in a very small sample) how frequently adolescents inform their parents that they have received services at the PHU, the survey provided respondents with the option to report whether they had been to the PHU for services, and if so, whether they had disclosed that information to their parents. Of the respondents, 15.2% reported having received reproductive health services at the PHU and the majority (86.7%) had also discussed it with their parents.

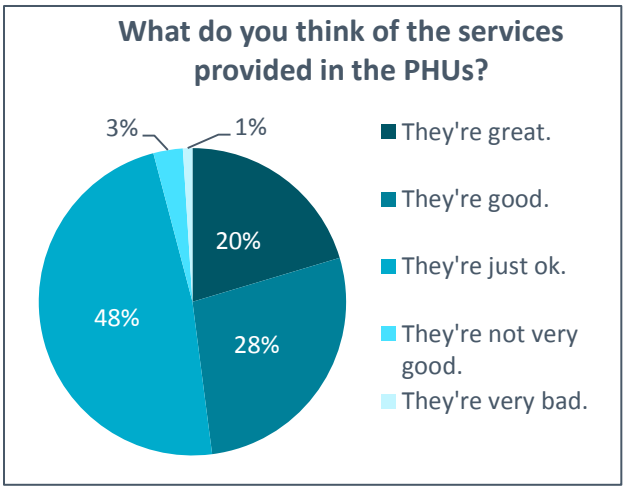


Figure 24

Adolescents' perceptions of the quality of services available were also surveyed. The most common response was that services are just ok, but a combined 48% reported that they think services are good or great.

When questioned about what kind of barriers prevent them from accessing services, adolescents most frequently reported concerns about confidentiality "I don't want people I know to see me going there" (22.7%). This finding is similar to those of national studies. Other commonly cited barriers included: having a different doctor (20.0%), not having transportation (20.0%), long wait times at clinics (18.2%), not wanting their parents to find out (16.4%), cost (15.5%), clinic hours (11.8%), and poor quality of services (11.8%).

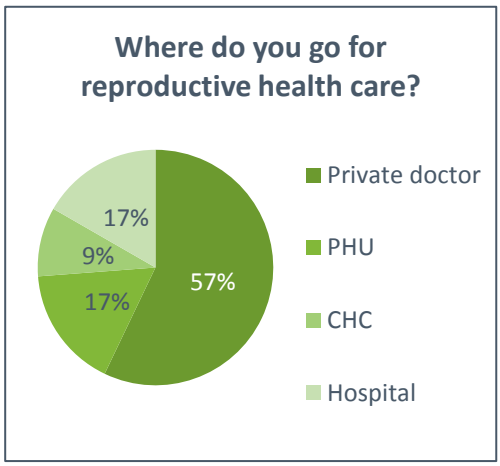
As with the client and community member surveys, adolescents were asked to specify what they are most concerned with at this time in their life. Table 5 presents the responses in ranked order of how frequently they were chosen. The most common issues cited for concern 6: other concerns- not health related, were school, employment, and housing. These responses indicate a great deal of interest in reproductive health issues amongst adolescents and a need for adequate education and care.

Table 5. Adolescent Concerns

Rank	Concern	% Reporting
1	Not getting an STI	46.4
2	Learning how to deal with relationships	44.5
3	Not getting pregnant.	40.0
4	Learning how to talk to my partner (boyfriend/girlfriend) about our relationship and healthy sexual choices.	38.2
5	Learning how to talk to my parents about healthy relationships and sexual choices.	30.0
6	Other concerns -not health related	25.5
7	Getting testing or treatment for STIs	20.0
8	Other health issues (such as asthma, weight, mental health, etc)	20.0

When asked if they have somewhere that they currently go to receive reproductive health care, 56.7% of adolescent respondents said no. Of those who responded no, 44.2% indicated that they do want reproductive health care. Of the adolescents who responded yes, the majority reported that they see a private doctor for reproductive health care. The PHU was the second most common response, followed by community health clinics. The hospital was specified by 17% of respondents, which may indicate that they did not understand the question or that they visit a clinic co-located with a hospital.

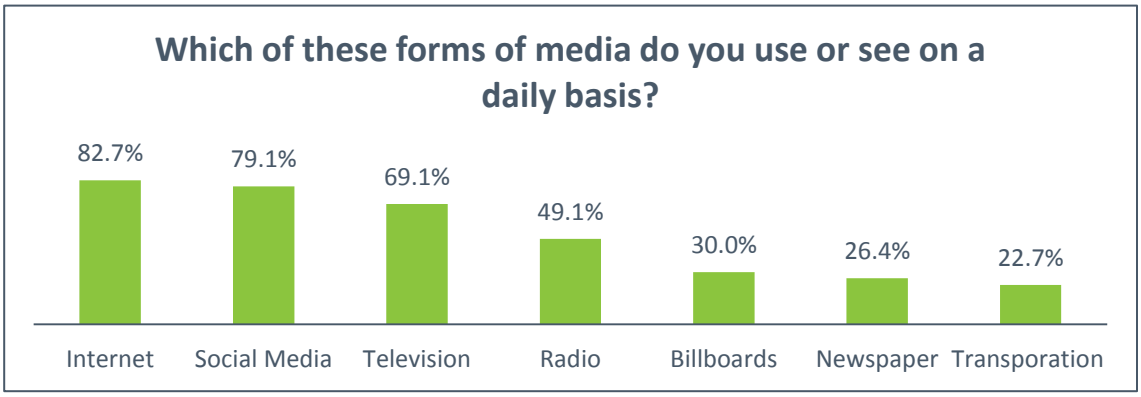
Figure 25



Adolescents were asked where they go when they need information about relationships, sexual health issues, or birth control, in order to better understand how outreach and education can be effectively conducted. Respondents most frequently reported family (42.7%) and friends (41.8%), followed by health care professionals (36.4%) and online (22.7%). Additionally, 10.9% of adolescents reported that they are not sure where to go for information.

Lastly, adolescents were asked to indicate which forms of media they use or encounter on a daily basis for outreach purposes. As shown in Figure 28, internet and social media were selected by almost all adolescents. Television and radio were also popular responses.

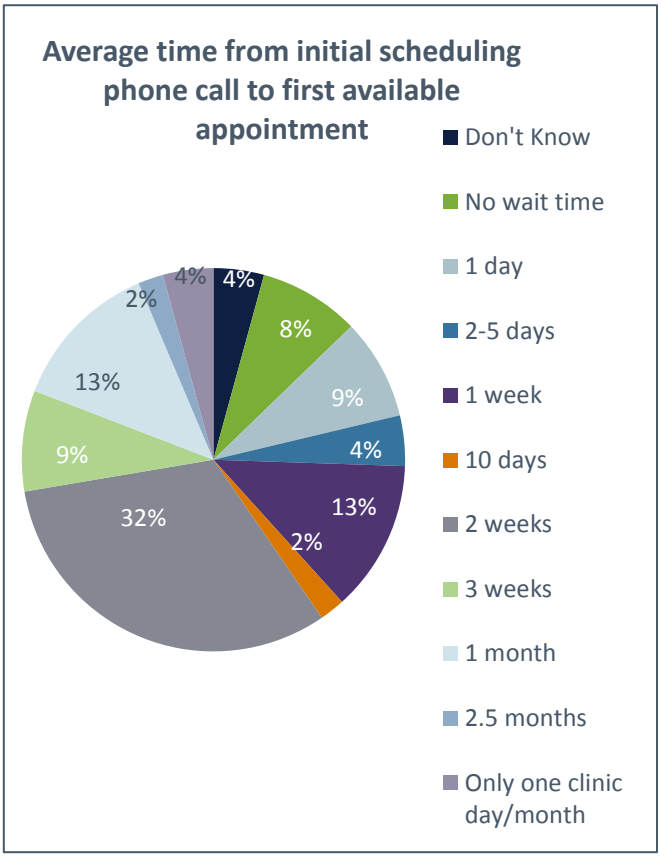
Figure 26



Clinic Staff Survey Results

A total of 47 clinic staff members from Regions 1, 3, 4, 5, 6, 8, and 9 responded to the assessment survey, including 14 staff nurses, 11 APRNs, 8 nurse supervisors, and 13 clerical staff members. This was the first year in which feedback from clerical staff was solicited. Responses to questions regarding clinic efficiency and function were based on a mix of staff estimates and clinic data.

Figure 27



All clinics reported that they schedule clients by appointment, and 55% also allow walk-ins. The average wait times to the first available appointment ranged widely, from no wait time to 2.5 months. The most common response was 2 weeks, though. All responses are shown in Figure 27.

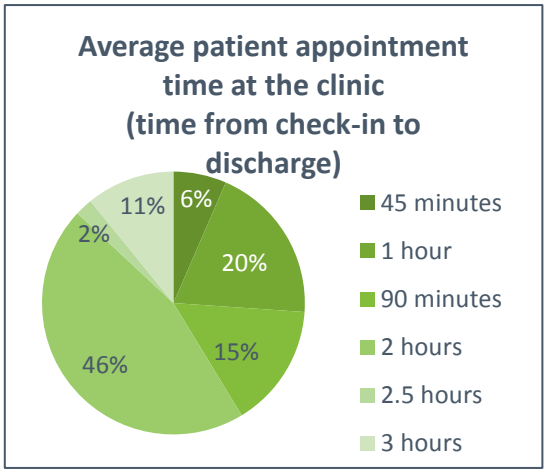


Figure 28

The average amount of time that a patient spends at the clinic for an appointment also varied greatly. Responses ranged from 45 minutes to 3 hours, with 2 hours being the amount of time most frequently reported, as shown in Figure 28. These responses are in accordance with the results of the patient satisfaction portion of the client survey, which indicated a need for improvement in wait times and appointment scheduling.

Clinic staff were also asked to report or estimate the average keep rate of their facility. When a range was provided, the higher end of the range was used. Responses ranged from 40% to 85%. The majority (52.2%) of clinic staff reported 50% or 60% keep rates. Responses in the 65%-75% range were given by 34.7% of clinic staff. And 10.9% reported keep rates of 80%-85%.

In response to the question, 'Do you provide family planning services for males in your clinic?,' 83% of respondents chose yes. The services for males listed by these respondents included condoms (31.9%), referral for vasectomy (27.7%), STD services (23.4%), and comprehensive reproductive health exams, which would encompass the three previous responses (23.4%). Approximately one in four respondents indicated that there are barriers to providing services to males. These responses indicate a need for further training and education of some staff on implementing a reproductive health model of care in clinic.

Table 6. Patient Education Material Quality

How would you rate the quality of the patient education materials you have available to you, in terms of:	Great	Good	Fair	Poor
The topics available	12 (27.9%)	25 (58.1%)	5 (11.6%)	1 (2.3%)
Accuracy	14 (32.6%)	26 (60.5%)	3 (7.0%)	0 (0%)
The literacy levels required to understand the materials	13 (30.2%)	25 (58.1%)	5 (11.6%)	0 (0%)
The languages provided	7 (16.3%)	27 (62.8%)	7 (16.3%)	2 (4.7%)
Attractiveness or how current/up-to-date they look	11 (25.6%)	27 (62.8%)	4 (9.3%)	1 (2.3%)

Table 6 depicts the questions used to assess staff needs related to educational materials. The areas in which the greatest needs were expressed were languages provided and topics

available. The most common topics needed specifically indicated by staff were birth control methods, STI/HIV, self breast and self testicular exams, and obesity/nutrition or chronic disease materials. When asked whether they thought clients would appreciate or benefit from having online educational tools available, staff responses were 37% Yes, 47% Somewhat, and 16% No.

Staff were also surveyed about outreach and advertising for the clinics. 61% of staff reported that their clinic does some kind of outreach, naming health fairs and the distribution of posters, pamphlets, and other educational materials as the most common methods. The majority of clinic staff reported that their clinic services are not currently being advertised. Staff indicated a variety of marketing tools and activities used in the past, though. The most frequently specified were brochures, distribution of materials at health fairs, posters, presentations to community groups, presentations to other healthcare providers, and radio. Staff were asked to indicate which previously used marketing tools or activities they thought had been the most effective. Health fairs, brochures or handouts, and family/friend referrals by word of mouth were the three most common responses.

Questions were included in the staff survey to gauge whether staff members think awareness in the community, clinic hours, and/or clinic location present barriers to clients accessing care. Of staff survey respondents, 26% disagreed or strongly disagreed with the statement: "The community to be served by this clinic is highly aware of its presence," indicating a need for increased outreach and marketing of services. In regards to clinic hours, 14% of staff surveyed agreed or strongly agreed that the hours when their clinic is open make it difficult to serve clients. Finally, 40% of staff reported that they think it is somewhat difficult for clients to get to the clinic and 60% reported that they think it is easy or very easy. The five groups cited as most affected by clinic location and transportation issues were 1) rural, 2) clients without their own transportation, 3) teenagers, 4) lower income clients, and 5) clients living in areas without public transit.

Lastly, the survey asked staff to use their experience to describe how they think their clinic is perceived by different groups in the community. Figures 29-32 depict the responses for each

group. Women and teens in the community were the group most often thought to highly regard the clinics. Staff thought that men and community organizations were the most likely to not even know that services were available. This is important to know for outreach considerations, as both represent important sectors of the community to inform about services. Men were also the only group for which any staff chose the response 'considered a last resort.'

Figure 29

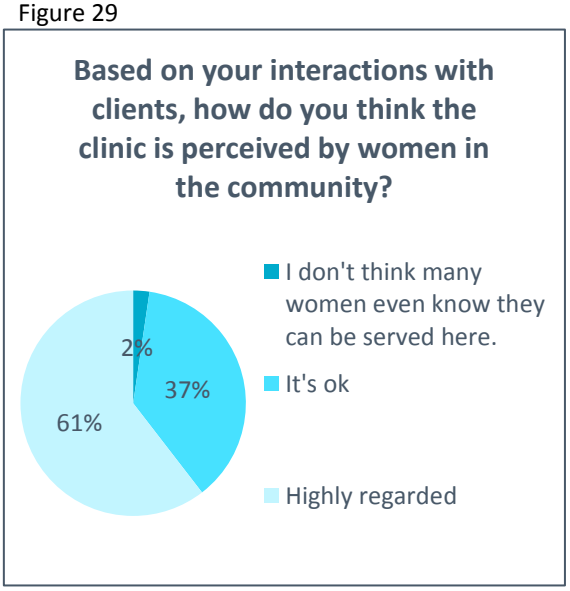


Figure 30

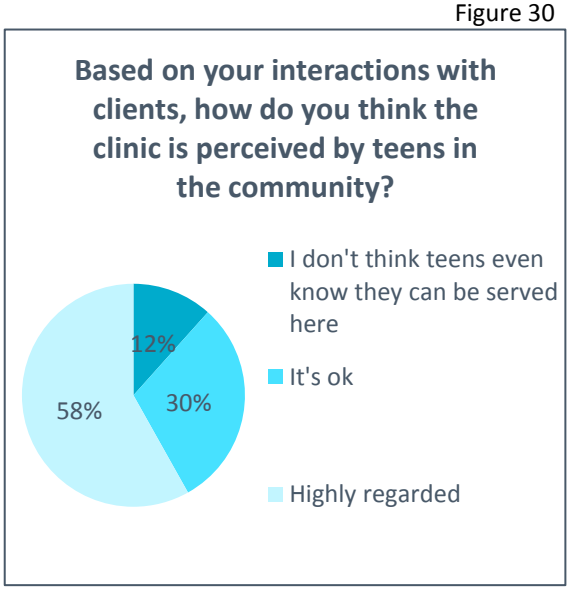


Figure 31

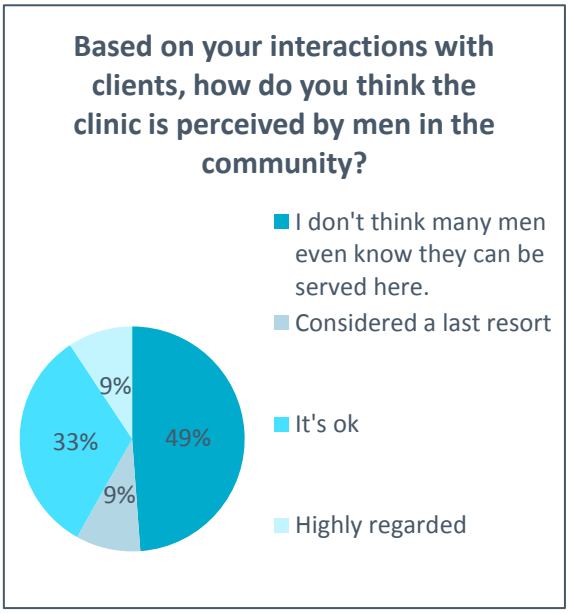


Figure 32

Study Limitations

The limitations to this study include the fact that client surveys were only provided in English and Spanish. Ideally, the survey would have been made available in Vietnamese as well. Similarly, the community member survey was only provided in English. Another limitation is that due to the fact that the majority of community member surveys were received from WIC clients, responses regarding barriers to accessing services may be biased. Given that WIC sites are located at the same PHUs as the reproductive health clinics, individuals who are able to get to their WIC appointments would be less likely to report logistical barriers in accessing reproductive health services and may not be representative of the community at large. Finally, because all community member surveys were distributed with the help of agencies providing community services, the responses are reflective of individuals already in some way being reached by public services and may not accurately represent the most difficult to reach populations who are not accessing any kind of public services.

Discussion

This statewide community input assessment demonstrates continued need for reproductive health services and education. Clients and community members alike expressed interest in gaining control of their reproductive health by indicating a desire to plan pregnancies, protect themselves from STIs, and gain access to reproductive health services. In particular, community members demonstrated a need for quality, comprehensive reproductive health care and counseling. This was seen amongst community members in both the low levels of adequate family planning education from providers being reported and in the large gap between individuals not wishing to become pregnant and those using contraceptives. This data depicts an opportunity to improve the use of reproductive life planning-oriented counseling techniques that adequately meet individuals' needs and empower them to achieve their goals, as well as properly addresses issues related to preconception care. Along the same lines, the RHP client base expressed a need for referrals to primary care providers and assistance in enrolling in health insurance coverage.

Adolescents reported interest in reproductive health education and services and a lack of

awareness about available resources, especially in regards to confidentiality policies. This in combination with low levels of adolescents reporting a health care professional having provided them with reproductive health education indicates a need for further outreach and education.

In accordance with past needs assessments clients continue to report family and friend word-of-mouth referrals as the most common ways in which they learn about available services. However community member and adolescent survey respondents reported frequent use of online and social media, indicating an opportunity to employ social marketing tools and outreach strategies to increase awareness in the community. Clinic staff indicated in their survey responses that health fairs and brochures or flyers were thought to be the most effective marketing tools, but these methods were not shown to be common ways in which clients find out about services. This discordance highlights a need for better training, education, and resources in the areas of outreach and marketing for regional field staff.

The high numbers of clients reporting that they would refer others to the clinic, in combination with positive responses to the patient satisfaction section of the survey indicate that staff are providing quality services and treating patients well. Areas for improvement identified by both client and staff surveys include clinic efficiency and the process for making appointments. Positive perceptions of services reported by community members also point to the high quality of services being provided.

Summary of Findings from the 2014 Reproductive Health Needs Assessment

This comprehensive assessment of needs, resources, and community perspective, has informed the Reproductive Health Program's strategic thinking around the Title X Project Plan going forward by making evident that: 1) There are strikingly high rates of unplanned pregnancy, sexually transmitted infection, and disparities in birth outcomes, impacting populations across the lifespan; 2) Disparities in overall health necessitate the leveraging of Title X as an access point to coordinated care; and 3) Greater community engagement is needed because while coverage and affordable care options exist, gaps remain in utilization. Over the next three years the RHP will work to implement a detailed Title X Project Plan which addresses the need described in this document through a combination of direct service provision, capacitation of primary care providers to deliver high quality reproductive health services, and increased community outreach and engagement.

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