

Understanding the Needs of Illinois Family Planning Providers to Improve Contraceptive Access

Research Report
June 2020



Executive Summary

Background

Proposed approaches to expanding access to contraception must meet the needs of both providers and patients. With funding from the Pritzker Family Foundation, Ci3 at the University of Chicago conducted a two-phase statewide needs assessment of family planning providers. The needs assessment, developed in partnership with the Illinois Contraceptive Justice Coalition, aims to support the Foundation's efforts to increase providers' capacity to provide comprehensive, compassionate contraceptive care and counseling.

Methods

The needs assessment was conducted in two phases. In the first phase we conducted phone interviews with 25 reproductive health leaders across the state from November 2018 to January 2019. Questions focused on practical needs of providers, priority areas to improve capacity for providing family planning services, and avenues for expanding contraceptive access. In Phase II we conducted a mailed survey between October 2019 and March 2020 to assess contraceptive knowledge, attitudes, and practices among a statewide representative sample of contraceptive providers.

Interview findings

Themes from key informant interviews centered on the benefits of shared-decision-making models of contraceptive care as well as the need for more hands-on training in contraceptive provision and patient-centered counseling. Providers also cited the need for improved financial support (through programs like Title X) and reimbursement for contraceptive counseling and care (including telemedicine), more outreach to rural communities, public and in-school education on contraception, and special attention to the needs of adolescents.

Survey findings

Key findings from the statewide survey of family planning providers focused on the availability of a range of contraceptive methods, training needs around longer-acting contraceptive methods, general training needs, meeting the needs of adolescent patients, and meeting the needs of LGBTQ+ patients. Findings suggest that most Illinois family planning providers offer a range of contraceptive methods to patients the same day they seek care, either through on-site administration of DMPA or long-acting reversible contraceptive (LARC) methods or via prescription for methods that can be obtained at a pharmacy. At the same time, some providers reported barriers to offering longer-acting methods, most commonly costs, provider training, and provider interest. Family medicine providers, and providers who practice in publicly-funded settings expressed the greatest interest in training on LARC methods. Providers were most interested in training on topics that support greater person-centered contraceptive care, including patient-centered counseling. CME credits were the most-preferred incentive for training. Although knowledge of and comfort with best practices for adolescent care are generally high, family medicine and urban providers were least likely to offer time alone with adolescents. Finally, while providers report comfort with serving LGBTQ+ patients, less than half of providers include sexual orientation and gender identity on patient charts.

Recommendations

Opportunities for expanding contraceptive access in Illinois include: ensuring the same-day availability of a range of contraceptive methods that meet patient needs and desires; incorporation of performance measures that reflect patient-centered care; expanding LARC training for interested physicians; increasing comfort with provision of LARC for adolescents without parental permission; encouraging time alone for adolescent patients; development of a patient education and communication strategy; and improving comfort with inclusive practices for LGBTQ+ patients.

Introduction

There is increasing evidence that coordinated statewide efforts can significantly increase access to high quality contraceptive care. These systemic approaches involve eliminating barriers related to contraceptive costs, clinician training, increasing patient awareness, and ensuring that contraceptive counseling is patient-centered and free from contraceptive coercion. A reproductive justice-informed perspective seeks to honor individual needs and values, ensures access to the full range of methods, and creates space for informed patient choice. Ideal healthcare takes into account various dimensions of a patient's identity including: race, sex, gender, sexual orientation, age, income, ability, immigration status, primary language, and geographic location. The Person-Centered Contraceptive Care Framework provides guidance for how to integrate a reproductive justice approach when creating and evaluating efforts to improve equitable access to quality contraceptive care.¹ As states move to expand contraceptive access, it is important to understand how best to support patients, providers and communities.

Statewide Provider Needs Assessment

Healthcare providers face a range of barriers in offering the full scope of contraceptive options to patients. Proposed solutions must meet the needs of both providers and patients. With funding from the Pritzker Family Foundation, Ci3 at the University of Chicago conducted a two-phase statewide needs assessment of family planning providers. The needs assessment aims to support the Foundation's efforts to increase providers' capacity to provide comprehensive, compassionate contraceptive care and counseling. This assessment was developed in partnership with the Illinois Contraceptive Justice Coalition and intended to inform the development of a statewide initiative that includes programs, policies, and projects to improve access to a full range of contraceptive services for patients in Illinois.

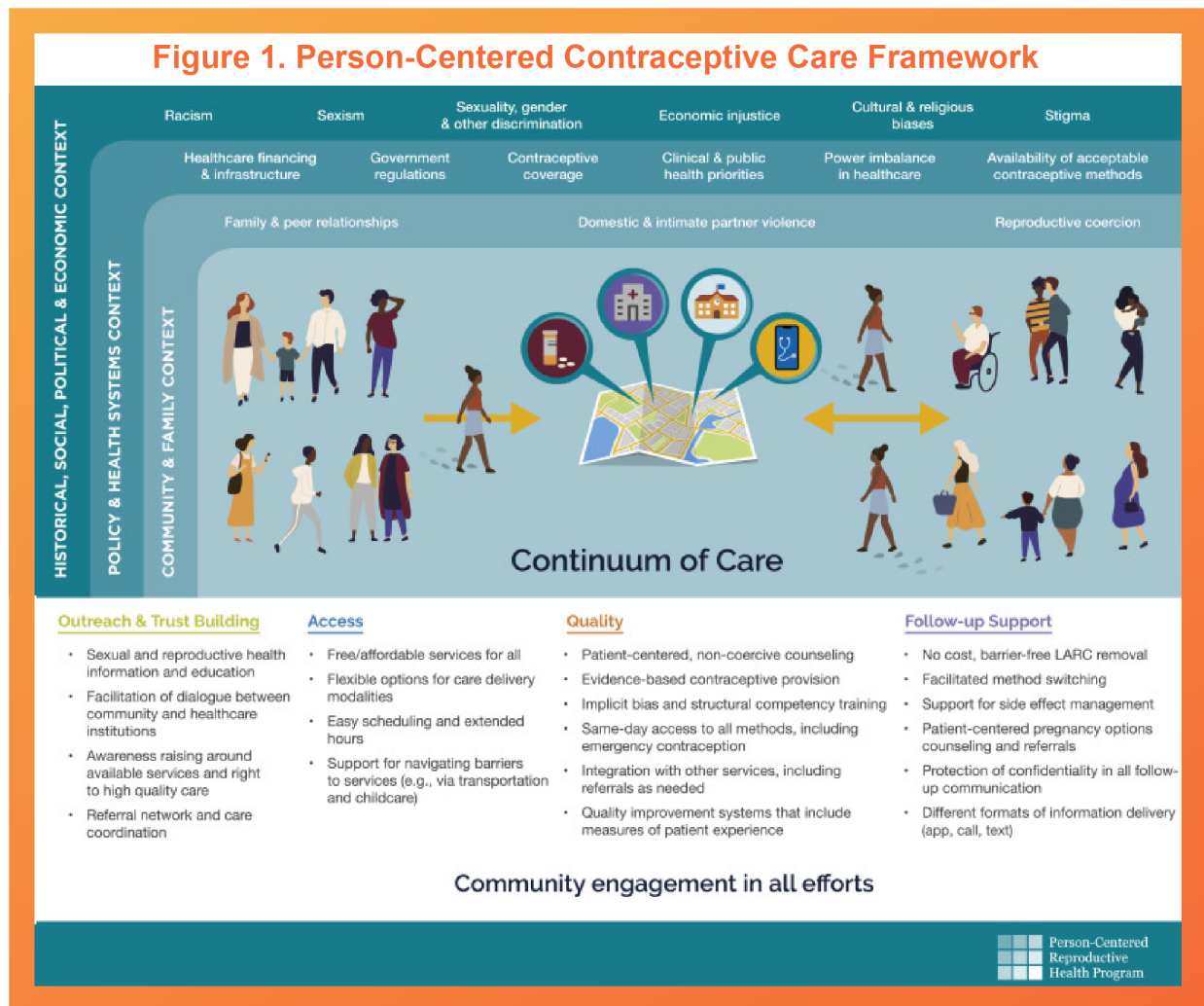
Through this assessment, we sought to understand the landscape of contraceptive care in Illinois. Our approach, considers factors contained in the Person-Centered Contraceptive Care Framework, including outreach and trust building, access, quality and follow up support (Figure 1).



The Needs Assessment was conducted in two phases. Phase I was key informant interviews regarding prior and ongoing efforts to expand contraceptive access, and to identify statewide priorities. Phase II was a survey based on themes from the key informant interviews, assessing contraceptive knowledge, attitudes, and practices among a statewide representative sample of contraceptive providers.

¹ Holt, K. et al., (2020) Beyond same-day long-acting reversible contraceptive access: a person-centered framework for advancing high-quality, equitable contraceptive care. *American Journal of Obstetrics and Gynecology*, 222 (4). Accessed from: <https://www.sciencedirect.com/science/article/pii/S0002937819327000>

Figure 1. Person-Centered Contraceptive Care Framework



Methods

Phase 1: Key Informant Interviews

From November 2018 to January 2019 we conducted phone interviews with 25 reproductive health leaders who could provide insight to barriers and facilitators of contraceptive care provision in Illinois. Questions focused on practical needs of contraceptive service providers, priority areas to improve capacity, and avenues to expand contraceptive access.

The sample, from across Illinois, included 11 obstetrician gynecologists (OBGYNs), three family medicine physicians, two nurses, two midwives, two nurse practitioners, and six administrators or other relevant stakeholders. The sample also included variation in clinic type, including ten representatives from federally qualified health centers (FQHC), eight representatives from health or hospital systems, seven representatives from public health agencies, and one other relevant representative. Ten of the represented clinics or systems received Title X funding. Finally, our sample included geographic diversity; we interviewed 14 participants who could speak to issues in Cook County, six participants who could speak to statewide issues, and eight participants who could speak to regional issues outside of Cook County.

Phase II: Survey

Survey development

The survey was informed by a provider survey developed by the Centers for Disease Control and Prevention's Division of Reproductive Health, findings from our Phase I results, and feedback from the Contraceptive Justice Coalition and the Illinois Department of Public Health (Appendix A). The survey included questions on provider and patient characteristics; contraceptive method availability; contraceptive knowledge, attitudes and practices; and training needs. Surveys were pilot tested with physicians representing each targeted specialty, nurse practitioners, certified nurse midwives, and epidemiologists.

Eligibility and Sampling

We aimed to hear from a representative sample of providers who offer contraceptive care. According to the literature, among the women who seek private sector care, approximately 66% receive care from obstetrician-gynecologists (OBGYNs), 18% receive care from family medicine physicians, 9% receive care from internal medicine physicians, and 8% receive care from other provider types.² Additionally, 34% of women of reproductive age seek care from publicly funded clinics.³ The women who seek publicly-funded contraceptive services receive care from county health departments, Planned Parenthood facilities, community health centers, and other clinics. The majority of these publicly-funded clinics receive Title X funding.

For private physicians, we sampled obstetrician/gynecologists (OBGYN), pediatricians, family and internal medicine physicians in Illinois from the American Medical Association Masterfile, all of whom were board certified. We created a sampling framework based on prior literature (50% OBGYN, 25% pediatric, and 25% internal and family medicine). With respect to publicly-funded clinics, we included all licensed school-based health centers, federally qualified health centers (FQHCs), and current and former (as of July 2019) Title X recipient clinics in our sample.

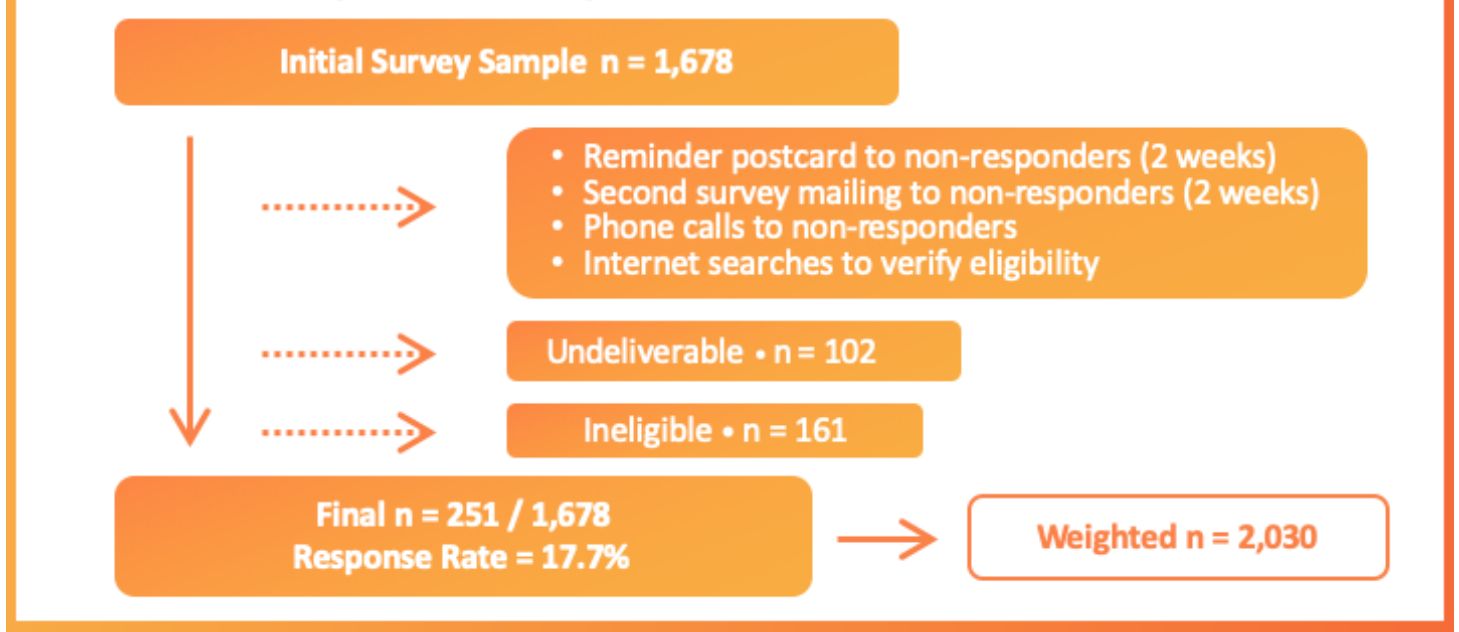
Survey implementation

Between October 2019 and March 2020, we surveyed a representative sample of family planning providers in Illinois. This sample included 1,062 OBGYNs, pediatricians, and family medicine physicians, as well as 616 federally qualified health centers, school-based health centers and clinics that had received Title X funding (Figure 2). Private physicians and one provider from each public clinic were eligible to participate if they provided family planning services to women of reproductive age at least twice weekly. A family planning service was defined as any service related to postponing or preventing conception and may include a medical examination related to provision of a method, contraceptive counseling, method prescription, or supply visits. A patient could receive a family planning service even if the primary purpose of her visit was not for contraception. Survey packets included a cover letter to introduce the survey, an eligibility sheet, and the survey. We included a \$2 cash incentive in the packet and a stamped return envelope. To ensure the optimal response rate, additional touch points including a reminder postcard and second survey packet were mailed two and again four weeks after the initial mailing.

² Sarah Hudson Scholle, Judy C Chang, Jeffrey Harman, Melissa McNeil. Trends in women's health services by type of physician seen: data from the 1985 and 1997–98 NAMCS. *Women's Health Issues*, Volume 12, Issue 4, 2002;165-177.

³ Guttmacher Institute, October 2019. Publicly Supported Family Planning Services in the United States.

Figure 2. Survey Implementation and Sample



Response rate and sample weighting

Response rate

Two hundred and fifty-one providers across Illinois completed the survey. The Council of American Survey Research Organizations (CASRO) response rate was calculated by assuming that the proportion of healthcare providers eligible was the same for healthcare providers with known and unknown eligibility. After accounting for ineligibility, the overall CASRO response rate for the survey was 17%. Response rates for each subspecialty were:

- OB/GYN: 26%
- Pediatricians: 34%
- Internal and Family Medicine: 18%
- Public clinics: 22%

Sample weighting

The sample was weighted to reflect the probability of selection and the non-response rate by specialty and setting. The final weighted total sample included 2,030 providers.

Data analysis

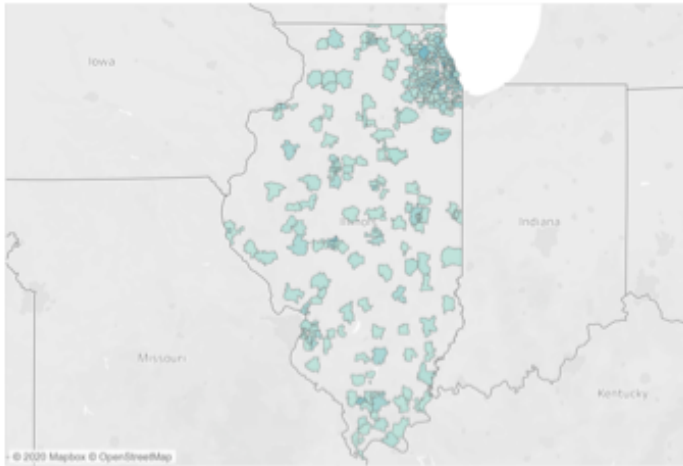
Descriptive statistics and Rao-scott chi-square tests were employed to explore sample and practice characteristics. Rao-scott chi-square tests are used when analyzing complex survey data. Data were analyzed using SAS version 9.4.

Sample Description

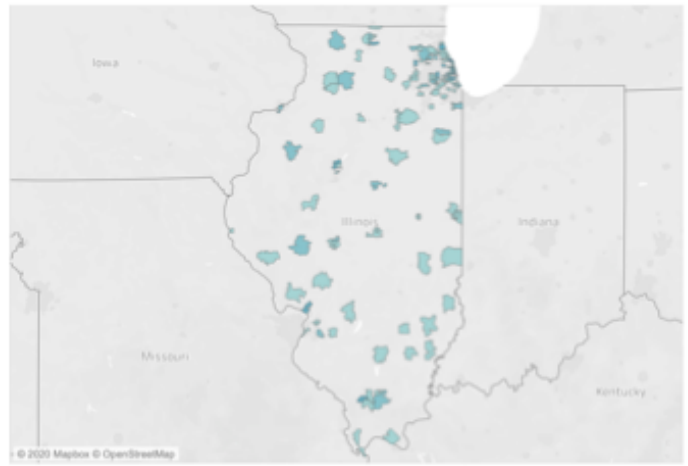
The final sample reflected the distribution of providers who offer the bulk of family planning services across the state of Illinois (Figure 3). Additional data on the demographic and practice characteristics of sampled providers can be found in Appendix B.

Figure 3. Geographic Distribution of Respondents

Sampled Providers



Enrolled Providers



The final sample included providers who specialized in the following areas: 54% OBGYNs, reproductive health, or family planning specialists (referred to as OBGYNs), 30% Family Medicine specialists, and 16% Pediatric specialists. Eighty-two percent of respondents identified themselves as physicians. Respondents also identified themselves as nurse practitioners (10%), physician assistants (3%), certified nurse midwives (3%) and nurses (1%). In relation to demographics, respondents were predominantly non-Hispanic white (70%), cisgender women (72%) and completed their formal medical education more than 15 years ago (32%) (Appendix B).

Practice Characteristics

More than half (53%) of respondents selected group/solo practice as the primary setting in which they provided family planning services. An additional 25% of providers primarily provided family planning services in a community health center. A smaller number of providers reported a university setting (7%), school-based health centers (5%), and hospitals (5%) as their primary setting. Most of the respondents (65%) indicated that their practice did not receive funding from the Title X program in the last year. For the purposes of the analyses, practice setting was recategorized into “public” settings (FQHC, SBHC, Title X, and family planning clinics) and “private” settings (group/solo practice, hospitals and university settings). With respect to urbanicity, 40% of the total sample practiced in urban settings, 45% practiced in suburban settings and 15% practiced in rural settings. One third of respondents (35%) provided family planning services to 11-30 women per week, 19% provided family planning services to 31-50 women per week and 18% provided family planning services to more than 76 women per week. One quarter (23%) of our sample provided family planning services to more than 50% of their patients with a further 35% providing family planning services to more than 75% of their patients.

**Primary Provider Settings
for Family Planning Services**



- 53%** Group/Solo Practice
- 25%** Community Health Center
- 7%** University Setting
- 5%** Hospitals
- 5%** School-based Health Centers

Respondents provided estimates regarding the demographic characteristics of their patient populations. Providers in the sample care for a variety of patients; 44% of providers reported that less than one quarter of their reproductive age patients pay for their visit using Medicaid or public funding while 40% reported that more than 50% of their patients pay for their visit using Medicaid or public funding. Similarly, 40% of providers reported that less than one quarter of patients pay \$0 out of pocket for contraception with a further 40% reporting that more than 50% of their patients pay \$0 out of pocket for contraception. The majority (70%) indicated that patients with low English proficiency made up less than a quarter of their patients, while 97% reported that patients with disabilities make up less than a quarter of their patients. Similarly, 99% reported that gender minority patients make up less than a quarter of their patients.

Results

The results of the needs assessment are organized to first describe the themes from the key informant interviews, followed by short briefs on the key topics that arose in the survey findings, including: contraceptive method availability; LARC comfort and training needs; general training needs; meeting the needs of adolescent patients; and meeting the needs of LGBTQ+ patients.

Themes from Interviews with Illinois Reproductive Health Leaders

We conducted phone interviews with 25 reproductive health leaders across the state from November 2018 to January 2019. Questions focused on practical needs of providers, priority areas to improve capacity for providing family planning services, and avenues for expanding contraceptive access. Resulting themes offer insight as advocates, policymakers, and funders consider priorities for action.

High-quality contraceptive care

Most providers observed that patients would define “high-quality contraceptive care” to mean having their questions and preferences heard by the provider and being able to gain affordable access to the method of their choice. For a number of participants, high-quality care included recognizing historical biases; as one participant acknowledged, *“From the standpoint of their economic status, racial status, I think patients may sometimes feel like that they historically had potentially negative interactions with their healthcare providers or if there's biases from their healthcare providers, and [so it's important to make] sure we have as open and honest conversations as possible.”* A number of providers noted the value of shared-decision making models of care that could help mitigate provider-patient power imbalances. Several participants noted the particular need for an evaluated and standardized contraceptive counseling model.

Training needs

Many participants suggested that providers, particularly non-OBGYN providers, need more training on the provision of specific contraceptive methods, how to provide patient-centered contraceptive counseling, and how to acknowledge and address their own implicit biases. One participant described the need both as a training opportunity but also an opportunity to reconsider how best to educate patients in a fast-paced clinic setting, *“Providers may not be offering all the methods because maybe they themselves don't have the skill set or the healthcare entity they work with doesn't support them to do it. Of course, time is always the issue when we talk about how do we do full contraceptive counseling in a 15-minute slot. I think there's creative ways around that. I think most providers would say it's hard to do full education.”*

Participants generally agreed that training opportunities should be convenient and effective. Most participants recommended some type of tailored high-volume hands-on training or shadowing experience, especially for LARC methods. One participant explained, *“I think you're gonna need to find a way where people need the training, say it's the rural practitioners, need to be able to go somewhere and have high volume training for a certain period of time or we send someone to them, pay a provider to go there and be there onsite and do X number of procedures supervised. That's how we're gonna get people trained adequately.”*

In addition to specific training opportunities, several participants, including some in rural areas, mentioned the value of mentorship or an established network of providers who could be available for guidance and sharing of best practices. Finally, participants discussed the value of financial support for training opportunities, including clinic reimbursement for provider time to incentivize training.

Novel Tech Approaches to Contraceptive Care

Participants were asked to comment on a variety of ways in which technology might be used to improve access to contraception. Many participants emphasized the need for telehealth and other technology-based health initiatives to be assessed for quality and comprehensiveness of care, scope of practice considerations, and liability concerns. Participants also highlighted the need for these approaches to be adequately reimbursed, with billable codes and protocols for submitting claims, and the importance of dedicated technology support staff. *“Someone may think [telemedicine] is a great idea but it takes a lot of work. Also, reimbursement for non-in-person visits, virtually nonexistent. So it has to be basically telemedicine or apps medicine, it has to be a self-*

pay service because currently insurance is also very much caught up in brick and mortar.” Some participants pointed to the potential to leverage waiting room or other online counseling programs as a way to educate patients about method options to support conversations with clinicians at the time of the visit.

Care for adolescents

When it comes to adolescents seeking care, participants recognized that high-quality contraceptive care may look different for adolescents, considering the various factors that influence their access to clinical care and their reproductive health decision-making. Several participants reported additional considerations for adolescent patients, including: spending time to understand how well an adolescents might tolerate different side effects; explicitly offering “trial periods” to explore methods, and having a range of methods onsite to make it easier for adolescent patients to obtain their chosen method. Most participants discussed the value of creating clinic-wide policies for one-on-one time with all patients as a standard practice. Participants also recommended that clinics evaluate protocols to provide confidentiality and explain any limits to patients. Participants also discussed the value of sexual health education in the classroom.



It just has to be your clinic’s standing practice that you always see every patient alone. And our age is 12. We don’t always do it for a completely acute visit like for an earache or pneumonia. But if it is an annual exam visit or a well-child visit after age 12, they are absolutely always seen alone during that visit. Because [if] it’s not standardized and universal, then you’re gonna get push back and it’s not gonna happen.

- Key informant



Financial Support

Participants also discussed the importance of comprehensive public and private insurance reimbursement, with compensation for the time needed to conduct thorough contraceptive counseling. Specifically, several providers called for more uniform coverage of contraceptive products across Medicaid managed care organizations and a longer coverage period postpartum for pregnancy-eligible enrollees. At the same time, a few participants suggested that greater education for providers and clinics around billing best practices could also prove useful. As this participant explained, *“A lot of times, what I have learned in my many years of working with providers and billing, it is more of a perception that there’s problems. Then when we do a deep dive, look at this patient, look at the code, look at the reimbursement, everything went fine. So much of it seems daunting. I don’t know. I don’t think it’s billed correctly because they’re just confused.”*

A large number of providers also pointed to the Title X program (particularly as it was structured in previous years) as an important model for high-quality, affordable, confidential contraceptive access—a model that should be supported (or replicated) at the state level. As one participant described, *“Title X is truly the perfect model from a financial standpoint and from a confidentiality standpoint. If we could replicate that or create that somehow through other funding, that would be fantastic or Medicaid could make their services more confidential ... They already are fairly confidential, which is nice, but maybe even if there’s a way for those that aren’t on Medicaid to get that same benefit, that’s where Title X really comes in. Or expanding that Title X model somehow.”*

Education & engagement

Participants also pointed to the need for broad public education initiatives around contraception. Such an initiative could include public campaigns to raise awareness about different contraceptive methods, so that providers don’t have to spend time providing a full introduction of all methods in the exam room. Participants also talked about the need for mandated comprehensive sexual health education in schools. Finally, participants reflected on the need to specifically reach out to primary care providers, rural providers and clinics, and community stakeholders as part of any state-wide efforts to improve contraceptive access.

Contraceptive Method Availability among Illinois Family Planning Providers

BACKGROUND

Same-day contraceptive provision has been shown to increase uptake and long-term use. Between October 2019 and March 2020, we conducted a survey of family planning providers and publicly-funded clinics in Illinois. Our survey sought to examine healthcare provider knowledge, attitudes and practices regarding contraceptive provision. This brief highlights findings on same-day contraceptive method availability (measured as either having a contraceptive method on-site or same-day prescribing) among Illinois family planning providers.

FINDINGS

Most providers reported on-site availability of at least one contraceptive method (82%); on-site availability was higher among OB/GYNs (94%) than pediatric (72%), and family medicine (63%) providers. On-site availability of at least one method was significantly higher among publicly-funded (e.g., community health centers, family planning clinics, health departments, and school-based health centers) clinics (94%), compared to privately-funded (e.g., group/solo practice, hospital, or university) clinics (76%).

Providers reported the highest on-site availability of methods that require a provider for administration such as DMPA (“depo” or “the shot”) and long-acting reversible contraceptive methods (LARC), with more than half of providers reporting on-site availability of DMPA (61%), the levonorgestrel-releasing IUD (60%), implant (58%), and copper IUD (54%). While on-site availability was lower for methods that do not require a provider for administration such as birth control pills (26%), the patch (16%) and ring (22%), these methods were widely prescribed (71%, 73% and 65%, respectively). Combining estimates for on-site and prescription availability, nearly all providers offered same-day access to the pill, patch and ring.



The first row reflects percentage of providers with methods on-site; the second row reflects same-day prescription combined with on-site availability.

Reported barriers to on-site availability of longer-acting, more expensive methods (e.g., IUDs, DMPA, and implants) include cost/reimbursement, clinic flow, provider training, confidence, and interest. Provider-related barriers to on-site availability of IUDs and implants differed by specialty, with pediatricians reporting the most barriers (83% for IUDs and 63% for implants), followed by family medicine providers (53% for IUDs and 34% for implants), with OBGYNs reporting fewest barriers (8% for IUDs and 11% for implants).

IMPLICATIONS

Most providers offered same-day access to the pill, patch and ring (either on-site or through a prescription), and many providers offered on-site availability of longer acting methods. Given reliance on prescriptions for same day provision, providers should verify insurance coverage for the prescription. Efforts to improve reimbursement rates, public funding, and provider training may increase on-site method availability. Targeted outreach to build interest among and offer training to pediatric and family medicine providers may prove useful in expanding access. Training should include emphasis on the importance of offering a range of effective methods the same day a patient requests them.

Long-Acting Reversible Contraception (LARC) Comfort and Training Needs among Illinois Family Planning Providers

BACKGROUND

A person-centered contraceptive care framework includes access to the full range of contraceptive methods, including long-acting reversible contraception (LARC). While provider training and comfort providing LARC has increased, less is known about the differences among specialties and different clinical settings. Between October 2019 and March 2020, we conducted a mailed survey of family planning providers and publicly-funded clinics in Illinois. Our survey sought to examine healthcare provider knowledge, attitudes and practices regarding contraceptive provision. This brief covers topics pertaining to provider comfort with offering LARC methods.

FINDINGS

One quarter of respondents reported discomfort with providing IUDs and implants to patients (26% and 28%, respectively). Differences in comfort existed by specialty, OBGYNs reporting higher levels of comfort (99%) than family medicine providers (54%) and pediatricians (12%). Of note, suburban and rural providers reported higher comfort with LARC provision (79% and 71%, respectively) than urban providers (66%).

Interest in training was not inversely correlated to comfort. Just under half (48%) of all providers are interested in LARC training, with family medicine providers (60%) reporting the highest interest, followed by pediatricians (47%) and OB GYNs (40%). Training interest differed significantly by setting, with 79% of providers in public clinics and 36% of providers in private practices indicating interest in LARC training. Providers were most interested in online, interactive, and in-person training methods.

At the same time, 42% of providers reported barriers to providing LARC methods, with provider training and LARC cost cited as the most commonly reported barriers.

IMPLICATIONS

Family medicine providers and pediatricians face the most barriers to providing LARC methods. With interest across providers lower than expected, training efforts may be most successful when targeted to those with highest demonstrated interest, including family medicine providers, and providers who practice in publicly-funded settings such as federally qualified health centers and family planning clinics.



General Training Desires among Illinois Family Planning Providers

BACKGROUND

Person-centered contraceptive care can lead to improvements in a patient's experiences and care.⁴ Between October 2019 and March 2020, we conducted a mailed survey of family planning providers and publicly-funded clinics in Illinois. Reflecting some of the contexts along the continuum of person-centered contraceptive care in the framework⁵ our survey sought to examine healthcare provider knowledge, attitudes and practices regarding contraceptive provision, as well as preferences for training topics, incentives, and additional tools and resources.

FINDINGS

Training Topics

Respondents were very interested in receiving training to improve their provision of family planning services. Namely, three-quarters of respondents were interested in training in the following topics: patient-centered counseling (79%); the provision of LGBTQ-friendly services (78%); serving people with disabilities (76%); serving adolescents (74%); providing trauma-informed care (74%); and implicit bias (74%). More than half (56%) of respondents expressed interest in medication abortion training and nearly half reported interest in LARC training (48%). Urban and rural providers, and providers who practice in private settings expressed greatest interest in training across topics.

Training Incentives

Providers were most interested in receiving continuing medical education (CME) credits (83%) in exchange for participating in formalized trainings. Almost half of providers (47%) reported that receiving a training in their place of work would facilitate participation, as well as compensation for their time (43%) and their workplace (31%).

Tools & Resources

Forty percent of respondents indicated that they found tear sheets to be a very useful tool in contraceptive care provision; 36% found laminated summary sheets very useful, and 27% found posters very useful. In terms of resources, 61% of respondents indicated that they found professional organization publications to be a very useful source of information, 62% indicated that they found systematic review databases very useful, and 53% found professional meetings very useful.

IMPLICATIONS

Providers are interested in training on a range of topics that could encourage greater person-centered contraceptive care, including patient-centered counseling. Resources from professional organizations, databases and meetings were highly rated. Offering CME credits was the most-preferred incentive for training.



⁴ Effective patient–physician communication. Committee Opinion No. 587. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2014;123:389–93.

⁵ Holt, K. et al., (2020) Beyond same-day long-acting reversible contraceptive access: a person-centered framework for advancing high-quality, equitable contraceptive care. *American Journal of Obstetrics and Gynecology*, 222 (4).

Meeting the Family Planning Needs of Young People in Illinois

BACKGROUND

Adolescents experience unique barriers to receiving person-centered healthcare, including confidentiality concerns, limited time alone with their providers, provider misperceptions about the safety and appropriateness of Long Acting Reversible Contraception (LARC) methods, and knowledge of consent laws. Between October 2019 and March 2020, we conducted a mailed survey of family planning providers and publicly-funded clinics in Illinois. Our survey sought to examine healthcare provider knowledge, attitudes and practices regarding contraceptive provision.

FINDINGS

Most (69%) respondents indicated that adolescents comprised a quarter or less of their patient population. Among pediatricians, adolescents comprised more than half of their population. Public providers see twice as many adolescents as private providers.

Overall, 83% of respondents were comfortable providing contraceptive care and counseling to their adolescent patients. Nearly all (90%) respondents were aware that adolescents can receive contraception without parental consent, with high levels of knowledge of parental consent laws demonstrated across all groups.

More than three-quarters (77%) of respondents were always comfortable asking parents to leave the room for time alone with adolescents. These estimates significantly differed by specialty (pediatrics=84%; OBGYN=82%; family medicine=64%) and urbanicity (urban=71%; suburban=79%; rural=90%) $p<0.05$.

In accordance with the Illinois law, more than half (53%) of respondents reported comfort providing LARC to adolescents without parental consent. Family medicine providers (42%), pediatricians (33%) and suburban providers (46%) reported lowest levels of comfort among the sub-groups.

IMPLICATIONS

Although knowledge of and comfort with best practices for adolescent care are generally high, training opportunities remain. Targeted training may most benefit suburban providers, and pediatricians who are uncomfortable offering LARC methods to adolescents. Training and sharing of best practices to offer alone time with adolescent patients may also benefit providers, especially family medicine and urban providers. Offering more on-site methods for adolescent patients may also improve access, as recommended by some key informants.



Illinois Family Planning Provider Attitudes and Practices when Providing Contraceptive Care to LGBTQ+ Patients

BACKGROUND

Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) individuals make up a growing proportion of family planning patients. Yet, scant data exist on provider comfort and practices serving LGBTQ populations. Between October 2019 and March 2020, we conducted a mailed survey of family planning providers and publicly-funded clinics in Illinois. Our survey sought to examine healthcare provider knowledge, attitudes and practices regarding contraceptive provision. For this brief, we sought to examine provider attitudes and practices regarding the provision of family planning services to LGBTQ patients.

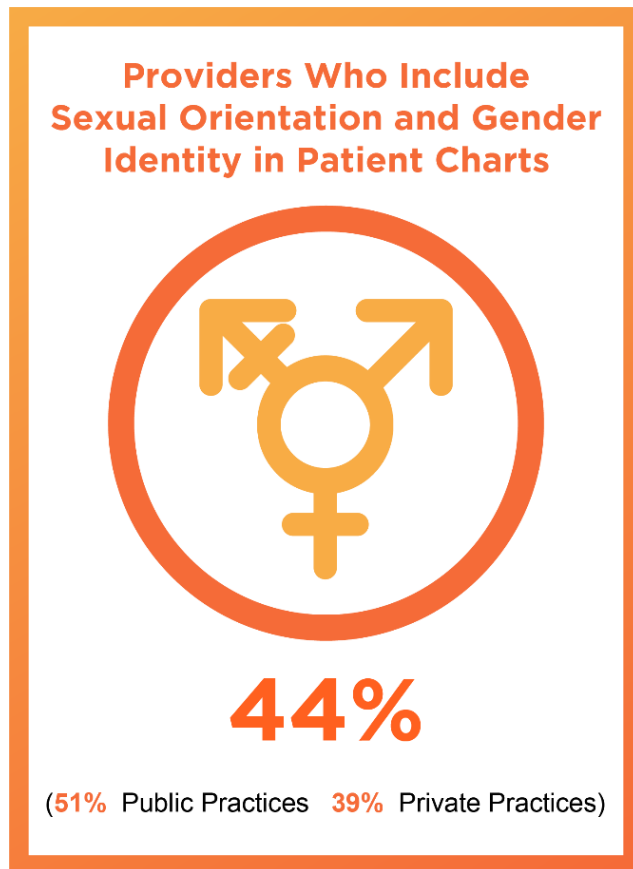
FINDINGS

Nearly half of providers (44%) always include sexual orientation and gender identity in patient charts. Including sexual orientation and gender identity in patient records significantly differed by practice setting (public=51%; private=39%) and urbanicity (rural=52%; urban=44%; suburban=40%). Similarly, 47% of all providers reported always using their patient's correct pronouns. Always using a patient's correct pronouns significantly differed by specialty (OBGYN=37%; family medicine=45%; pediatrics=49%), as well as by practice setting (public=51%; private=39%) and urbanicity (rural=53%; urban=44%; suburban=40%).

A higher proportion of all providers (68%) reported comfort providing contraceptive care to transgender patients. Results significantly differed by urbanicity (rural=86%; suburban=70%; urban=58%). Three quarters of providers are interested in training on how to care for LGBTQ populations (78%).

IMPLICATIONS

Additional training may increase provider comfort serving LGBTQ populations. Few providers always include sexual orientation and gender identity in patient charts and only about half of all providers always use their patient's correct pronouns which can affect the patient-provider relationship and care. Family medicine and rural providers incorporate LGBTQ+ behaviors into their practices at higher rates than other subgroups.



Summary & Recommendations

Overall, providers in Illinois are doing well with respect to:

- Availability of at least one contraceptive method on site and high rates of prescribing for user-dependent methods
- Comfort with the provision of LARC methods—this is especially the case among OBGYN providers
- Comfort with serving adolescent patients and knowledge of laws regarding consent and confidentiality
- Willingness to participate in trainings to support the provision of family planning services—providers were most interested in trainings on aspects of patient-centered care.

At the same time, opportunities for expanding access include:

- Ensuring same-day availability of a range of contraceptive methods. The vast majority of providers offered same-day access to the pill, patch and ring (either on-site or through a prescription), and many providers offered on-site availability of longer acting methods. CDC guidelines recommend a broad range of contraceptive methods should be available onsite and suggest that when methods cannot be provided onsite or the same day, that providers should offer another method that the patient can use until they obtain the chosen method. Efforts to improve education around reimbursement strategies, increased reimbursement rates and reimbursement for time with patients, along with provider training may increase on-site method availability of a range of methods. As some key informants mentioned, this may particularly benefit adolescent patients who may be more likely to use a method if they can leave with it on the same day. At the same time, if providers are offering prescriptions for user-dependent methods, patient access can be furthered by verifying insurance coverage of a patient's desired method. Further, many key informants credited Title X funding for a clinic's ability to stock a range of affordable methods. The Title X program was also valued for its role in connecting providers statewide and facilitating training. Policy makers should consider replicating aspects of the Title X program that increase same day availability across the state, through on-site provision of a range of methods, prescriptions for methods that do not require providers for administration, and ensuring insurance coverage of desired methods.
- Incorporation of performance measures that reflect patient centered care. We recommend the adoption and incorporation of a performance measure around the provision of patient centered contraceptive care. A draft measure is in the final stages of receiving National Quality Forum (NQF) endorsement. This measure focuses on a key component of care quality, patient experience. Currently, the only endorsed performance measures of contraceptive care are focused on provision of contraception. A measure of patient-centered contraceptive care can serve as a balancing measure to ensure that patients' needs and preferences are centered in conversations about contraception. Further, the inclusion of patient centered contraceptive care as a performance measure encourages and supports clinicians in providing patient centered contraceptive care.
- Expanding LARC training for interested providers. There are a number of potential models for expanding contraceptive provision, specifically regarding LARC methods (e.g., broader training of non-OBGYN providers, helping patients navigate to clinics with infrastructure and experience to support LARC provision, etc.). Results suggest that targeted training and engagement efforts should focus on providers who reported lower knowledge and higher interest in training (e.g., family medicine providers, publicly-funded, and urban providers).

- Increasing comfort with provision of LARC for adolescents without parental permission. Findings suggest that while providers are generally knowledgeable about state consent laws, far fewer providers are comfortable offering contraceptive methods such as IUDs and implants to adolescents without parental permission. This may reflect outdated understanding of the safety of these methods for adolescents, eligibility criteria for adolescent patients receiving LARC methods, or more nuanced decision-making around offering longer-acting methods to this population, perhaps anticipating parental reactions or based on personal feelings about the appropriateness of LARC for adolescent patients. Either way, our findings suggest an opportunity to engage providers (particularly pediatricians and family medicine providers) on this topic and address concerns they may have in such a way that encourages them to honor adolescent patient preferences.
- Encouraging time alone for adolescent patients. Recommendations from professional organizations have long supported provision of confidential care to adolescents, recognizing the benefits of encouraging autonomy and the reality that some young people will forgo care if without it.⁶⁷ Key informant interviews widely recommended that providers establish clinic-wide policies to ensure adolescent patients have the opportunity to speak to a provider alone, along with supporting parent-child communications. Creating resources for providers
- Development of a patient education/communication strategy. While data from patients was out of the scope of this needs assessment, providers outlined the need for patients to understand various contraceptive methods. The need for patient education is especially concerning given the limited time allocated for contraceptive counseling in clinical visits. Findings suggest the need for a community education strategy on the various contraceptive methods available to patients. This would include comprehensive sexual health education for school-age individuals with information on their rights regarding confidential care.
- Improving comfort with and inclusive practices surrounding LGBTQ patients. Collecting sexual orientation and gender identity (SO/GI) data in healthcare settings is essential to providing high-quality, patient-centered care to LGBT individuals, as well as an important part of efforts to better understand and address LGBT population health disparities. The practice is recommended by the Institute of Medicine, Healthy Medicine 2020, and the Joint Commission. Findings in our study reflect potential discord between self-reported comfort levels and actual incorporation of inclusive practices, with few providers including sexual orientation and gender identity in patient charts. Our findings identify an opportunity to engage providers in training for inclusive practices, particularly for physicians in private settings and urban providers who reported the lowest levels of comfort serving LGBTQ+ patients.

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⁶ Joseph F. Hagan, Judith S. Shaw, Paula M. Duncan, Bright futures: Guidelines for health supervision of infants, children, and adolescents. 4th ed. American Academy of Pediatrics, Elk Grove Village, IL2017.

⁷ Carol Ford, Abigail English, Garry Sigman. Confidential Health Care for Adolescents: Position Paper of the Society for Adolescent Medicine, Journal of Adolescent Health 2004;35:160-167.

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