Findings from the 2007 Family PACT Client Exit Interviews

December 2010

Suggested citation:

Biggs MA, Rostovtseva D, Brindis CD. *Findings from the 2007 Family PACT Client Exit Interviews*, San Francisco, CA.: Bixby Center for Global Reproductive Health, University of California, San Francisco, CA, 2010.

This report was prepared by the University of California, San Francisco (UCSF), Bixby Center for Global Reproductive Health and was supported by funds from the State of California, Department of Public Health, Office of Family Planning. All analysis, interpretations, or conclusions reached are those of UCSF, not the State of California.

Email: FamPACT@cdph.ca.gov

www.familypact.org

Contract # 05-45122

To obtain a copy of this document in an alternate format, please contact:

California Department of Public Health
Office of Family Planning
Family PACT Program
P.O. Box 997420, MS 8400
Sacramento, CA 95899-7420
Telephone: (916) 650-0414
Fax: (916) 650-0454

Please allow at least 10 working days to coordinate alternate format services.

This report was prepared by staff of the Bixby Center for Global Reproductive Health in the Department of Obstetrics, Gynecology, & Reproductive Sciences at the University of California, San Francisco

Findings from the 2007 Family PACT Client Exit Interviews

Claire Brindis, DrPH
Principal Investigator

Primary Authors
Antonia Biggs, PhD
Daria Rostovtseva, MS

Contributors
Nancy Berglas, MHS
Joan Chow, MPH, DrPH
Jaycee Karl
Mary Menz, PHN, BSN
Carrie Lewis, MPH
Heike Thiel de Bocanegra, PhD
Leslie Watts, MS

Sub-Contractor
Public Health Institute
Sue Holtby, MPH
Christy McCain, MPH
Nicole Lordi

December 2010

TABLE OF CONTENTS

LIST OF TABLES

LIST OF GRAPHS

FINDINGS FROM 2007 FAMILY PACT CLIENT EXIT INTERVIEWS

EXECUTIVE SUMMARY

As part of the evaluation of the Family PACT Program, the 2007 Client Exit Interview (CEI) study was designed to help evaluate the success of California's 1115 Medicaid family planning demonstration waiver, by assessing adolescent, male and adult clients' a) experiences with service delivery, including satisfaction with services, contraceptive practices, and STI testing and treatment, b) experiences accessing services, and c) access to primary care services for their other health needs. Moreover, this study examined the potential impact on clients' access to services if the Deficit Reduction Act (DRA) verification requirements were to be implemented in Family PACT. Findings from this study will help determine whether services are appropriately tailored to meet the needs of clients, and to identify ways to help improve service delivery and adherence to Program Standards.

For this study, adolescent and adult Family PACT clients were interviewed immediately following a clinical visit. The sample consisted of 1,497 clients – mostly adult (82%), female (88%), and Hispanic (67%) – at 73 high-volume provider sites in 13 California counties. Participants were interviewed by trained bilingual and bicultural interviewers in either English or Spanish. Results were compared with a similar study conducted in 2003. Overall findings include:

Adolescents' ratings of access to services were good, but awareness of confidentiality provisions decreased.

- 71% of teen (19 and under) clients reported that they were told about the services they could receive with their Family PACT card, and 91% were told that information about their visit was confidential.
- 86% of clients under age 18 knew before their visit that they didn't need their parent's permission to get services, decreasing from 98% in 2003.
- 84% of teen clients said they were "not at all" worried that someone would find out about their visit.

Male clients' access to services did not differ significantly from female clients.

- Males were equally likely as females to be told about the Family PACT services available to them, that information about their visit is confidential, and equally likely "not to worry" that someone will find out about their visit.
- Males' satisfaction with services did not differ from that of female clients on any measure.
- Males (40%) were significantly more likely than females (14%) to be new clients.

Most clients are in need of effective contraception and usually left their visit with an equally or more effective birth control method than they were using prior to the visit.

- 65% of clients said they plan to have a child in the future. On average clients wanted to wait 4.3 years (6.6 years for females and 3.4 for males), demonstrating their need for high-efficacy, reversible birth control methods.
- Nearly half (49%) of new female clients left their visit with a more effective method than they came in with.
- One-fifth (20%) of established female clients adopted a more effective method at their visit, 74% left with the same method, and about 7% left their visit with a less effective method.
- The proportion of female clients who received emergency contraception at the interview visit has remained stable since 2003 at 16%.

Sexually Transmitted Infection (STI) service quality improved over time.

- 41% of all clients recalled being tested for an STI at the visit. Of those tested, 51% were told that the results may have to be reported to the local health jurisdiction, up from 33% in 2003.
- 9% of all respondents were given medication or a prescription to treat an STI on the day of the interview, of which less than two-thirds (57%) picked up their medication.
- 57% of STI-treated clients discussed with their provider the need for their partner to be tested and/or treated.
- STI risk assessment increased significantly over time on most measures. In 2007:
    - 58% of all clients were asked about the number of sexual partners they had had, an increase from 41% in 2003.
    - 54% were asked if they had had an STI in the past year, increasing from 44% in 2003.
    - 42% were asked about the gender of their partners, up from 13% in 2003.
    - 41% were asked about their sexual practices (no data for 2003).
- 47% of clients received condoms at the visit, similar to 2003.

Access to primary care services increased since 2003.

- 25% of clients reported that the Family PACT provider had asked about their usual source of health care, up from 18% in 2003.
- 26% named their Family PACT provider as their usual source of general health care, up from 18% in 2003. Over one-quarter (27%) said they have no usual source of care, down from 29% in 2003.
- 39% of clients said they had a non-family planning health concern in the past year, of which 59% reported they had received all the care they needed, 7% for most concerns, and 33% did not get care (down from 35% in 2003).
- There was a significant increase in the proportion of respondents who were referred by their Family PACT provider to another doctor for general health concerns from 6% in 2003 to 10% in 2007.
- The proportion of clients who said they or their family pay for general health out-of-pocket increased significantly from 50% in 2003 to 63% in 2007.
- 26% of clients reported that someone at the Family PACT provider's office told them they may be eligible for Medi-Cal, of which 66% were instructed on how to apply for Medi-Cal.

Many clients may be unable to meet DRA documentation requirements.

- 71% of newly enrolled clients were asked for their Social Security number (SSN).
- 20% of clients who were asked for their SSN felt uncomfortable providing it.
- The proportion of clients who stated that it would be difficult or not possible to provide documentation varied by documentation type: 59% for a passport/green card, 40% for an income statement, 25% for a birth certificate, and 13% for a picture ID.

Overall satisfaction with services was high, and increased significantly. In 2007:

- 99% of respondents said they were satisfied with their services overall, up from 98% in 2003.
- 98% felt that the staff was courteous and helpful, up from 96% in 2003.
- 95% felt that the staff makes an effort to find out their needs, up from 93%.
- 96% were satisfied with the level of privacy while talking to the non-clinical staff, up from 91%.
- Clients waited an average of 36 minutes to be seen by the provider, down from 48 minutes in 2003.

Findings from these interviews indicate that the Family PACT Program continues to offer a wide range of quality services, with high satisfaction ratings among its recipients, and with marked improvements in

several areas from the previous survey conducted in 2003. Findings also suggest that the stricter eligibility requirements could negatively impact many Family PACT clients, particularly adolescents and Hispanics, because of difficulties or discomfort providing needed documentation.

FINDINGS FROM 2007 FAMILY PACT CLIENT EXIT INTERVIEWS

INTRODUCTION

In December 1999, the California State Office of Family Planning's (OFP's) Family PACT (Planning, Access, Care and Treatment) Program received a federal Medicaid 1115 family planning waiver for a demonstration project to support family planning and reproductive health service delivery and to expand access to adolescent, male and underserved female populations. The terms and conditions of the waiver require an evaluation of the program's progress in meeting the goals set forth in the demonstration project. The Bixby Center for Global Reproductive Health at the University of California, San Francisco (UCSF) is contracted by OFP to provide comprehensive program monitoring and evaluation to meet the requirement of the waiver.

The four goals stated in California's Centers for Medicare and Medicaid Services (CMS) demonstration project waiver application are to increase access to family planning services among: 1) adolescents, 2) males, and 3) women living in areas of high unmet need, and 4) to ensure client access to primary care services. Interviews with Family PACT clients following their family planning visit can help to assess clients' experiences accessing Family PACT services, whether Family PACT services are sensitive to clients' needs, in adherence to program and national standards of care, and whether clients have access to primary care services. Client satisfaction can help assess whether clients will return for future visits and refer their friends and family to services. The purpose of this study is to assess these issues through *Client Exit Interviews* (CEI). The CEI supplements other data sources that are part of the overall program evaluation—Family PACT administrative data (paid claims and client enrollment), medical record reviews, and surveys with providers. Unlike these other data sources, the CEI offers the opportunity to record clients' perspectives regarding the services they received and why they chose to access Family PACT services. This study builds upon the first set of client exit interviews since the implementation of the waiver, which was conducted in 2003.[1] It assesses changes over time by comparing findings to the previous study, as well as examines more recent issues that may impact Family PACT services. For example, the effect of stricter eligibility requirements as stipulated by the 2005 Deficit Reduction Act (DRA) and the new suggested waiver goal of ensuring access to primary care are elements that can be studied through the use of these client exit interviews.

[1] Biggs A, Brown A, Brindis C. Bixby Center for Global Reproductive Health. UCSF. 2005. *Family PACT Program evaluation: Summary findings from client exit interviews*, San Francisco, CA. Submitted to CA Department of Public Health, Office of Family Planning.

RESEARCH OBJECTIVES

Study objectives. The primary study objectives of the 2007 CEI were to assess the degree to which Family PACT services are accessible to clients and are of high quality by describing client experiences with Family PACT services. For the first time, at the end of the interviews clients were asked for their Family PACT identification number (Health Access Program, or HAP number). The HAP number served to link CEI survey responses with program claims data so that a full picture of services received at randomly selected visits could be obtained. Claims data matching served to validate the data collected in both the CEI and claims databases, as well as to determine whether clients received appropriate services following their CEI visit. The following are the study's primary evaluation questions:

1) Are Family PACT services accessible to all clients and in particular to adolescents and males?

2) Are Family PACT clients receiving services that are of high quality?

3) Does Family PACT facilitate clients' access to primary care services?

4) How would impending DRA requirements impact Family PACT clients?

5) Are Family PACT clients satisfied with services received?

Study rationale. Research and experience show that client exit interviews can serve as a complementary data source to administrative data and chart reviews, that can help determine areas of service where quality of family planning service delivery could be improved. The 2007 CEI helps evaluate objectives under three of the four waiver goals[2] by assessing whether adolescent, male and adult Family PACT clients have adequate access to Family PACT and primary care services. Findings from this study will help determine whether services are appropriately tailored to meet the unique needs of its clients and to identify ways to help improve service delivery. (See Appendix A for a literature review on the development of the research design.)

In addition to the above evaluation questions, the CEI offers the opportunity to answer evaluation questions for other OFP evaluation studies not covered in this report. For example, some of the questions included in the CEI interview tool were elaborated to better understand access issues for participants of the State's Office of Family Planning's Teen Pregnancy Prevention (TPP) programs, including the Teen SMART Outreach (TSO) program.[3] Also, some of the elements included in the CEI survey were developed to serve as inputs in the pregnancies averted calculations for the program's cost-benefit analysis (findings of which will be presented in separate evaluation reports).

---

[2] The goal of increasing access to family planning among women living in areas of high unmet need is not assessed by the CEI.

[3] When this study was conceived the Office of Family Planning funded four Teen Pregnancy Prevention (TPP) programs. These included the Community Challenge Grants (CCG), Information and Education (I&E), Male Involvement Program, and the Teen Smart Outreach (TSO) programs, Since the development of this study, two of the four TPP programs (TSO and MIP) have been eliminated from the state budget, and one (I&E) was substantially reduced.

DESIGN AND METHODOLOGY

STUDY CONTRIBUTORS

With feedback from the California Office of Family Planning (OFP), the study framework, survey design, sampling, data preparation and analysis were conducted by staff from the University of California, San Francisco (UCSF), Bixby Center for Global Reproductive Health. Staff from the California Department of Public Health (CDPH), Sexually Transmitted Disease Control Branch, contributed to the development of STI-related questions on the survey and the analysis and interpretation of these items. Data collection was conducted by the Public Health Institute (PHI), including the data entry, recruitment and training of interviewers and coordination of all fieldwork activities. Quality assurance, data analysis, and summary of findings were conducted by both UCSF and PHI.

SAMPLING DESIGN AND RESPONSE RATES

Sampling Design. The goal of the 2007 sampling design was to obtain a representative sample of Family PACT clients that would reflect the geographic, age (adult vs. adolescent), and gender distributions of clients in the program. The sampling frames for both the 2003 and 2007 Client Exit Interviews (CEI) included enrolled, delivering clinician Family PACT providers in 13 counties: Alameda, Butte, Fresno, Humboldt, Los Angeles, Monterey, Orange, Placer, Sacramento, San Joaquin, San Bernardino, San Diego and Santa Clara. The 2007 CEI provider sample was drawn from the universe of clinician providers who served clients in fiscal year (FY) 2005-06. In FY 2005-06, there were a total of 1,568 enrolled delivering clinician providers in these counties. Providers who served fewer than an average of 12 Family PACT clients per day were excluded from the sampling frame, as were disenrolled and referral providers, those who only performed laboratory or pharmacy services (i.e., no clinical services) and those under investigation (usually due to billing irregularities that may indicate fraud), leaving a potential of 227 providers to be sampled. A total of 73 providers were randomly selected and included in the final sample. Table 1 shows the distribution of completed interviews and the number of participating sites by county. The number of providers sampled per county was proportional to the number of Family PACT clients served in that county in FY 2005-06. Los Angeles had the largest number of provider sites (36), and the smaller counties of Butte, Humboldt and Placer had only one site each. When compared to the 2003 sampling design, we believe the 2007 sampling frame more closely represents the Family PACT population as a whole.

A total of 1,497 clients were interviewed. The proportion of interviews in each county was reflective of the number of clients served in that county. The number of interviews completed per county ranged from two in Placer County to 731 in Los Angeles County. Fifty-nine percent (59%) of the interviews were conducted in English. Los Angeles and Fresno were the only counties where more interviews were conducted in Spanish than in English. More interviews were done at high-volume providers to make up for the lower-volume providers and achieve an overall average of 19 interviews per provider, ranging

from two to 46. The one provider where only two interviews were completed (an outlier), was in a rural county and it took the interviewer 10 hours to encounter two Family PACT clients, despite efforts to only sample providers who served a minimum of 12 clients per day.

Table 1. Completed Interviews in 2007, by County and Interview Language

County	Total Interviews Completed		English	Spanish	Total Sites	
	N	%	n	n	n	%
Alameda	52	3%	39	13	3	4%
Butte	28	2%	28	0	1	1%
Fresno	60	4%	29	31	3	4%
Humboldt	17	1%	17	0	1	1%
Los Angeles	731	49%	321	410	36	51%
Monterey	35	2%	25	10	1	1%
Orange	92	6%	79	13	5	7%
Placer	2	<1%	2	0	1	1%
Sacramento	82	5%	74	8	3	4%
San Bernardino	100	7%	56	44	4	5%
San Diego	186	12%	135	51	9	12%
San Joaquin	36	2%	32	4	2	3%
Santa Clara	76	5%	47	29	4	5%
Total	1497	100%	885	612	73	100%

*Totals may not add up to 100% due to rounding
Source: 2007 Family PACT Client Exit Interview.

Sampling design differences between 2003 and 2007. Several changes to improve the 2003 design were made in 2007 to ensure a random sample that was representative of the Family PACT client population. In 2003, providers were randomly selected, but the number of providers selected in each county was based on a purposive distribution that would ensure geographic diversity of the sample. In 2007, the number of providers randomly selected in each county was proportional to the number of Family PACT clients in that county. For example, in 2003, 26% of all interviews were completed in Los Angeles County whereas in 2007, 49% of all interviews were in Los Angeles County.

In 2003, sampling quotas were set for adult females and males (age 20 and older), and adolescent females and males (age 19 and younger), based on the total distribution of these four age/gender categories in the program. In 2007, the goal was to interview 20 clients at each selected site, regardless of age or gender, but the provider sample was weighted before selection so that sites serving larger numbers of adolescent clients would have a greater probability of being included in the sample. These two different sampling designs resulted in a greater proportion of adolescents and public sector respondents in 2003 than in 2007. Specifically, 31% of the 2003 sample was age 19 and younger whereas 18% of the 2007 sample was in that age group, and 75% of clients in the 2003 sample were seen by public providers compared to 61% in 2007. As noted later in the report, these differences in distributions may have contributed to some of the significant differences found between 2003 and 2007.

Response Rates. The overall response rate in 2007 was 90%, and there was only one incomplete interview. The refusal rate was 10.8% among adult females, 7.5% among adult males, and 8.4% among adolescent females. There were no refusals among adolescent males.

All respondents were asked for their HAP numbers, so that their CEI responses could be matched to claims data (described in Data Analysis section). Eighty-three percent (83%) of respondents were willing to give their Family PACT HAP numbers, 5% gave the number but were a bit reluctant, 1% gave the number but were very reluctant, and 9% refused to give the HAP number. An additional 2% said their HAP number was not available. Among the 136 who refused, 75 were Spanish speakers and 61 were English speakers. (Note: researchers received calls from two providers saying they were happy to participate in the survey, but would advise their clients not to give their HAP numbers.)

QUESTIONNAIRE DEVELOPMENT

A thorough review of the research literature was conducted to help develop the CEI tool and is included in Appendix A. To avoid any response bias (where the respondent answers questions in the way they think the interviewer wants them to answer rather than according to their true beliefs), interview questions were designed so that they were not leading, did not suggest a particularly "right" answer, and were not embarrassing to the respondent to answer.

The questionnaire focused on client satisfaction, common barriers faced by males and adolescents in accessing services, indicators of service quality as per client recall, and the federal DRA verification requirements. Questionnaires were developed in English and Spanish. The questionnaire was translated into Spanish by a professional, certified translator, and reviewed by bilingual researchers for accuracy. A pretest was conducted with 15 Family PACT clients in a non-sampled county (Santa Cruz) in July 2007. Ten adult females, two adolescent females, two adult males, and one adolescent male were administered the oral questionnaire. Eleven interviews were conducted in English and four in Spanish. Pretest respondents were debriefed after their interviews about the content, wording, clarity, flow and Spanish translation. The Spanish and English versions of the questionnaire were revised based on pretest results. See Appendix D for the final CEI survey in English.

DATA COLLECTION

Interviewer Recruitment and Training. Fourteen female bilingual interviewers were recruited to conduct interviews in English and Spanish. All were experienced interviewers with knowledge of family planning services. Two interviewer training sessions were held in August 2007, one in Los Angeles and one in Oakland. A training manual was developed and distributed to each interviewer. The trainings covered general interviewing guidelines, handling sensitive issues, confidentiality, data collection protocols, question-by-question reviews of both English and Spanish versions of the questionnaire, role playing, and record keeping. Data were collected from September 2007 through March 2008. During this period, PHI staff had ongoing telephone and email correspondence with the interviewers to clarify how to code specific questions and to troubleshoot with providers. PHI and UCSF communicated regularly regarding the data collection process to streamline activities, improve accuracy and consistency of methods,

troubleshoot any issues, and to ensure that overall the data collection procedures were of the highest quality.

Human Subjects Approval. Human subjects research approval was received from the UCSF Committee for Human Research, the State of California Health and Human Services Agency's (CHHS) Committee for the Protection of Human Subjects, and the PHI Institutional Review Board. Confidentiality was emphasized during the training, and interviewers were required to sign a statement of confidentiality on the day of the training. They were also informed that their contract would be terminated if they breached the confidentiality agreement.

Clients who participated in the CEI were required to sign a consent form, approved by all three human subjects committees (UCSF, CHHS, and PHI). The consent form detailed the purpose of the CEI study, the voluntary nature of participation, the risks and benefits to CEI participants, and gave project staff contact information. Clients received $20 in cash as a sign of appreciation for participating. Respondents were given the option to refuse any question without penalty in terms of service provision. Those willing to share their HAP number signed a separate "Authorization for Release of Protected Health Information" form. Refusal to give one's HAP number did not affect participation or receipt of the $20.

Data Collection Protocol. Interviewers were assigned to specific providers and were responsible for contacting their providers to set up interview dates. Once on-site, each interviewer posted a sign soliciting participation in the survey. At most provider sites, the staff helped recruit participants as clients checked in and out. Interviewers briefed all clinic staff about the project, including medical assistants and clinicians. In some cases, interviewers went into the waiting room to explain the interview process, but in most instances clients were told about the interviews at the front desk and were reminded to participate as they were checking out, or were approached again by the interviewer before leaving. Interviews were conducted in a private space to protect confidentiality. Prior to being interviewed, respondents were given the consent form described above, and they were given $20 upon completion of the interview. The average interview length was 13 minutes, ranging from 10 to 45 minutes.

To avoid a bias in provider behavior, clinicians and staff were blinded in regards to the survey content. They were not allowed to review the survey topics before the interviews took place and therefore did not know what they were being evaluated on. While the front office staff and medical assistants were aware of the survey and provided help with client recruitment, it is unknown to what extent the clinicians were aware of the presence of interviewers.

Quality Control. Quality control included both data collection and data entry verification. For data collection, PHI staff spoke by telephone with one randomly selected provider from each interviewer's list of assigned providers to ensure that the interviews had been conducted and that there were no problems with the interviewers. There were two instances of miscommunication reported by the providers, and PHI satisfactorily resolved them. There were no other problems reported by the providers.

All data was first entered onto a hardcopy during the interview. Later, PHI entered all data into an SPSS database. Data entry verification involved the re-entry of 15% of the questionnaires, which were randomly selected from both English and Spanish language interviews. All discrepancies were checked against the hard copies and corrected as needed in the data set. In addition to re-entry, reliability checks were conducted by analyzing pairs of variables that should have complementary responses, and by

identifying outlier data. These too were checked against the hard copies and corrected when inconsistencies were identified.

DATA ANALYSIS

Frequencies and cross-tabulations were run in SPSS 12.0 and SAS 9.1. Tests of statistical difference were conducted using the Chi-square test and *t*-test. In cases where means of more than two groups were compared (such as when comparing a quantitative variable by race/ethnicity or age subgroups), a one-way ANOVA was conducted using Proc GLM with contrasts in SAS 9.1. For nominal variables, simple logistic regression was conducted using Proc Logistic in SAS 9.1. In both types of analysis, Whites and clients ages 19 and under or over age 30 were used as a reference group. In analyzing the effect of interpreter use, English speakers were used as a reference group. All groups that differed significantly from the reference group are indicated with an asterisk in the data tables and the results are discussed in the text. Since the data were collected at a limited number of provider sites, data may be correlated and clustered at the provider level. In this report these effects were not accounted for; however, further evaluation of the data should account for the potential impact of clustering on statistical significance of results. Cases with missing, refused and don't know responses were excluded from the analysis, unless "don't know" was a valid response. If a question was skipped by design, the case was also excluded from the analysis. These are indicated in the titles of the tables, and the number of respondents who responded to the question is shown. The amount of missing data was minimal and not a significant issue in this data.

The interview records were matched to Family PACT administrative (paid claims and client enrollment) data using the HAP numbers provided by clients during the interview. A total of 158 clients (11% of sample) did not provide a HAP number (136 refused, 20 said that it was not available, and 2 records were missing a reason). Of the remaining 1,339 records, 1,330 were successfully matched to the client file (99%). Of the 1,330 clients, 22 were due for recertification for Family PACT services at the time of the interview but did not get recertified at the interview visit. Of these, 4 were recertified 3-6 months after the interview, and the rest have not been recertified at all as of November 2008 (8 months after the last interview in the sample). Although clients lacking current certification are ineligible for Family PACT services, failure to recertify a client is only one of the reasons why providers may fail to bill for services delivered. As additional reasons for not billing could not be accounted for in these data, clients lacking current certification at the time of the interview were retained in the sample. The final sample linked to administrative data and used in this analysis included 1,330 records. For all analyses matching to claims, we assessed whether the addition of denied claims changed the results. It most cases it did not, unless otherwise indicated.

SAMPLE CHARACTERISTICS

The 2007 sample included 1,497 Family PACT clients, the majority of whom were age 20 and older (82%), female (88%) and Hispanic (67%) (Table 2). The education level of respondents varied greatly, from 1% who had no formal education to 10% who had a 4-year college degree or higher. Most of the respondents (83%) were "established" Family PACT clients, meaning that the visit at which they were interviewed was not their first Family PACT visit.

Table 2. Client Exit Interview Sample Characteristics, 2007 (N=1497)

Sample Characteristic	**n**	**%**
Age (years)		
19 and under	262	18%
20+	1234	82%
Gender		
Female	1317	88%
Male	180	12%
Interview Language		
Spanish	885	59%
English	612	41%
Race/Ethnicity		
Hispanic	992	67%
White	237	16%
African American	104	7%
Asian/Pacific Islander/ Filipino	97	7%
Native American/Other	52	3%
Highest Level of Education Completed		
Did not go to school	13	1%
Some primary (<8 years)	203	14%
Some secondary (8-12 years)	402	27%
High school diploma/GED	308	21%
Vocational/technical degree	65	4%
Some college, no degree	251	17%
2-year college degree/AA	108	7%
4-year college degree or higher	145	10%
Client Status with the Program		
New	256	17%
Established	1237	83%
Total	1497	100%

* Subtotals may not add up to 1497 due to missing or "Don't know" responses
Source: 2007 Family PACT Client Exit Interview.

Relationship Status. Overall, 22% of the CEI clients were married, 61% were single but in a relationship, and 17% were single and not in a relationship (Table 3). Significantly higher percentages of adolescents were in the two single categories, compared with adults. Clients interviewed in Spanish were more likely to be married than those interviewed in English (38% vs. 11%, respectively). Hispanic and Asian/Pacific

Islander clients were the most likely to be married (29% and 18%, respectively), while White, African American and Native American/Other clients were more likely to be single and not in a relationship.

Table 3. Relationship Status, by Age, Interview Language, Race/Ethnicity (n=1495)

Client Demographics	**Married**		**Single, in a relationship**		**Single, not in a relationship**	
	n	%	n	%	n	%
Age (years)						
19 and under	9	3	192	74**	60	23**
20+	324	26**	714	58	195	16
Interview Language						
English	99	11	598	68**	186	21**
Spanish	234	38**	309	51	69	11
Race/Ethnicity						
White†	16	7	161	68	60	25
Hispanic	289	29**	568	57**	133	13**
African American	9	9	69	66	26	25
Asian/Pacific Islander	17	18**	62	64	18	19
Native American/Other	2	4	34	65	16	31
Total	333	22	907	61	255	17

† White served as the reference group
** $p<.01$
Note: Subtotals may not always match due to missing responses.
Source: 2007 Family PACT Client Exit Interview.

Partner Enrolled in Family PACT. Knowledge regarding whether clients' partners are enrolled in the program is important in assessing the extent to which STI partner management strategies can be implemented. Family PACT recommends that all sexual partners of clients treated for STIs should be tested and treated. Partners who are enrolled can receive treatment at no cost. When asked whether their partner was enrolled in the Family PACT Program, 20% of CEI clients said yes, 77% said no and 3% did not know (Appendix C, Table 57). Males were significantly more likely than females to say their partner was enrolled in the program. Spanish-speakers were significantly more likely than English-speakers to have a partner enrolled, and Hispanic and African American clients were more likely than Whites to have a partner enrolled in the program. A higher proportion of clients interviewed at private sector providers had a partner in the program than those at public sector providers. Among those who were married, 25% had partners enrolled in Family PACT, compared to 19% for those who were single and in a relationship ($p=0.026$) (data not shown).

Provider sector. Provider sector was determined based on provider enrollment information as recorded in administrative program records. Overall, 61% of the CEI sample was interviewed at public sector providers and 39% were interviewed at private sector providers. The CEI sample included a significantly higher proportion of males at private providers than at public providers (19% vs. 8%, respectively), whereas in the program as a whole approximately equal proportions of males go to private and public sector providers (13% vs. 11%, respectively). Hispanic clients were more likely to be seen by private sector providers, while White, Asian/Pacific Islander, and Native American/Other clients were more likely to go to public sector providers. There was no difference by provider sector among African American clients (Table 4).

Provider Specialty. Provider specialty was determined by interviewers in consultation with staff at each participating site. For analysis purposes, specialty varieties were grouped into Family Planning/Women's Health and Primary Care/Multi-Specialty categories. The Family Planning/Women's Health category also includes OB/GYN specialties. The latter included providers specializing in adolescent health, primary care, multiple specialties and in other specialties. Overall, 53% of clients in the CEI sample were seen by Family Planning/Women's Health providers, compared with 47% who interviewed at Primary Care/Multi-Specialty providers. Adolescents and adults did not differ in the provider specialty they visited (Table 4). Female, English-speaking, White, and Asian/Pacific Islander clients were significantly more likely to be seen by Family Planning/Women's Health providers than at Primary Care/Multi-Specialty providers, while males, clients who were interviewed in Spanish, and Hispanic clients were more likely to be seen by Primary Care/Multi-Specialty providers.

Table 4. CEI Sample Demographics, by Provider Sector and Specialty (N=1497)

	Provider Sector				**Specialty**				**Total**
	Public		**Private**		**Family Planning/ Women's Health**		**Primary Care/ Multi-Specialty**		
Client Demographics	n	%	n	%	n	%	n	%	%
Age (years)									
19 and under	189	21*	73	13	137	17	125	18	18
20 and over	730	79	504	87***	647	83	587	82	82
Gender									
Female	850	92***	467	81	727	93***	590	83	88
Male	70	8	110	19***	58	7	122	17***	12
Interview Language									
English	674	73***	211	37	531	68***	354	50	59
Spanish	246	27	366	63***	254	32	358	50***	41
Race/Ethnicity									
White	215	24***	22	4	162	21***	75	11	16
Hispanic	505	56	487	84***	447	57	545	77***	67
African American	61	7	43	7	58	7	46	6	7
Asian/Pacific Island.	84	9***	13	2	74	9***	23	3	7
Native Americ./Other	40	4*	12	2	32	4	20	3	3
Total	920	100	577	100	785	100	712	100	100

*p=<.05, ***p<.001
Note: Subtotals may not always match due to missing responses.
Source: 2007 Family PACT Client Exit Interview.

Provider Practice Types. The information on provider practice type was also obtained by interviewers on-site. Table 5 shows the number and percent of CEI respondents by provider practice type. Twenty-six percent (26%) of clients were seen at Planned Parenthood sites, 23% at group medical practices, and 22% at some other type of community clinic, neighborhood health center or free clinic. It should be noted that, although most of the practice type categories are not comparable between 2003 and 2007, almost twice as many Planned Parenthood clients were interviewed in 2003 than in 2007 (48% vs. 26%, respectively), and 14% were seen at county clinics in 2003 compared with only 6% in 2007. This reflects the differences in provider sector (public vs. private) mentioned earlier and may contribute to some of the significant differences highlighted in this report.

Table 5. Distribution of CEI Respondents, by Practice Type (n=1497)

Practice Type	n	%
Planned Parenthood	397	27%
Group Medical Practice	378	25%
Other Community Clinic/Neighborhood Health Center/Free Clinic	333	22%
Solo Medical Practice	170	11%
County/City Health Department	95	6%
College-based Student Health Center	65	4%
FQHC/Rural/Indian Health Service Clinic	43	3%
Hospital-Based Outpatient Clinic	16	1%

Source: 2007 Family PACT Client Exit Interview.

Internet Use. Client Internet use was assessed as an additional demographic characteristic to provide information about the extent to which the Internet can be used to inform clients about Family PACT services. Overall, 39% of CEI clients said they used the Internet every day, while 32% "never" used it (Table 6). There were several clear demographic differences in the Internet use. Adolescent clients (age 19 and younger) used the Internet significantly more often than clients age 20 and older. White, Asian/Pacific Islander, Native American/Other and clients interviewed in English were more likely to use the Internet every day compared with clients who were Hispanic, African American, or were interviewed in Spanish. Clients who were interviewed at private sector providers used the Internet significantly less frequently than those at public sector providers.

Table 6. Internet Use, by Age, Interview Language, Race/Ethnicity, Provider Sector (n=1491)

Client Demographics	Everyday		Few times/week		Few times/month		Never	
	n	%	n	%	N	%	n	%
Age (years)								
19 and under	134	51***	59	23***	42	16	27	10
20+	453	37	175	14	147	12	453	37***
Interview Language								
English	548	62***	172	20***	114	13	49	6
Spanish	40	7	62	10	75	12	431	71***
Race/Ethnicity								
White†	192	81	32	14	9	4	3	1
Hispanic	222	23***	158	16	145	15***	463	47***
African American	57	55***	24	23*	14	13*	9	9*
Asian/Pacific Islander	74	76	11	11	9	9	3	3
Native American/Other	36	69	6	11	8	15*	2	4
Provider Sector								
Private	122	21	92	16	82	14	279	49***
Public	466	51***	142	16	107	12	201	22
Total	588	39	234	16	189	13	480	32

† White served as the reference group
*p<.05, *** p<.001
Note: Subtotals may not always match due to missing responses.
Source: 2007 Family PACT Client Exit Interview.

REPRESENTATIVENESS OF THE CEI SAMPLE

CEI Clients. The client CEI sample mirrored the Family PACT Program in all but a few categories. Adolescents comprised 18% of the CEI sample and 19% of the Family PACT population in FY 2006/07, 82% of CEI respondents were adults as were 81% of program clients. The CEI client sample exactly mirrored the proportion of female and male clients in the program—88% female and 12% male.[4]

In terms of differences, the CEI sample had a larger proportion of English speakers than the Family PACT Program as a whole (59% vs. 48%, respectively), probably because the interviews were only done in English and Spanish, so clients who could not communicate in either of these languages were excluded. Spanish-speakers comprised 41% of the CEI sample, a lower proportion than the Family PACT population (48%). The racial/ethnic distribution of the CEI sample was very close to the distribution of the program. The proportion of Hispanics in the CEI sample was 67% vs. 65% in the program. For Whites it was 16% vs. 20%, for African Americans 7% vs. 6%, for Asian/Pacific Islanders 7% vs. 6%, and 3% were Native American or Other race/ethnicity in both the program and the sample. In both the sample and the program, higher proportions of adolescents, females, English-speakers and clients of non-Hispanic ethnicity were seen at public sector providers than at private providers.

CEI Providers. The CEI provider sample included 28 private (38%) and 45 public sector providers (62%), whereas in the program as a whole this ratio is reversed (62% private vs. 38% public sector providers). However, due to a higher volume of clients at public sector providers, more clients were interviewed at public than private sector sites (61% vs. 39%), which is roughly comparable to the distribution of clients served by public and private sector providers in the program (69% vs. 34%, respectively, with 3% of clients served by providers of both sectors). Slightly more than half of the sites that participated in the 2007 CEI specialized in Family Planning/Women's Health (39, or 53%) and the rest were Primary Care/Multi-Specialty sites (34, or 47%). Representativeness of the provider sample by specialty cannot be assessed as there is no comparable program-wide statistic.

PRESENTATION OF FINDINGS

The main CEI findings for 2007 are presented in the following section. Many of the tables represent findings by demographic and provider characteristics. The tables present findings for different demographic groups and for the total sample. The totals for each group are not always equal because some cases were missing a variable (e.g., race/ethnicity) or missing a response to a question. As a convention, therefore, the totals in the bottom rows of the tables are based on the total for the variable with the largest sample size. Changes between 2003 and 2007 are described after each section, where applicable, under the heading "➢*Changes from 2003 to 2007.*"

[4] Swann D, ed. Bixby Center for Global Reproductive Health. UCSF. 2008. *Family PACT Program report, FY 06/07*, Available at: http://www.familypact.org/en/research/reports.aspx, accessed April 15, 2009.

FINDINGS

REASON FOR VISIT

Reason for Visit. Reasons for visiting a family planning provider are important to understand as they provide an indication of potential entry points into Family PACT services, as well as the issues that motivate clients to visit a provider. This information can also be a means for assessing the appropriateness of the services received during the visit. Respondents were asked the main reason for their visit on the day of the interview, although they could give multiple responses. Overall, 46% of females came for birth control, 31% for an exam, checkup or Pap smear, and 11% for an STI check or test result (Table 7). Adolescent females were more likely than adult females to come for STI services, pregnancy tests and emergency contraception (EC) or unprotected sex. Higher percentages of adult females came for exams and diagnostic tests or results than adolescents. New female clients were more likely than established clients to come in for birth control, STI checks and pregnancy tests, whereas higher percentages of established female clients reported exams and diagnostic tests or results as their reasons for visiting the provider that day.

Table 7. Reasons for Today's Visit† by Age and New vs. Established Clients, Females (n=1317)

Reason for Visit	Age				New vs. Established				Total	
	19 and Under		20 and Older		New		Established			
	n	%	n	%	n	%	n	%	n	%
Birth control	112	48	488	45	96	52*	504	45	601	46
Exam/checkup/Pap	41	17	367	34***	47	25	359	32*	408	31
STI check/results	40	17*	103	10	29	16*	114	10	143	11
Had symptoms	19	8	93	9	17	9	95	9	112	9
Diagnostic test/results	12	5	109	10***	1	<1	120	11***	121	9
Pregnancy test	31	13***	73	7	27	15***	77	7	104	8
EC/unprotected sex	17	7*	27	3	6	3	38	3	44	3
Other	12	5	39	4	3	2	47	4	51	4

†Clients could mention more than one reason, so the totals are greater than 100%.
* p<.05, ***p<.001
Source: 2007 Family PACT Client Exit Interview.

Among males, an STI check was the most common reason for the visit, regardless of age or whether they were new to the provider (Table 8). Higher percentages of adult than adolescent males came in for exams, whereas adolescent males were more likely than adult males to report birth control as the reason for visiting the provider that day. A higher percentage of new male clients came in for STI checks than established male clients, and established male clients were more likely than new male clients to come in for birth control and diagnostic tests or results. (Differences between cell sizes that were too small to be statistically stable are not included in the table.)

Table 8. Reasons† for Today's Visit, by Age and New vs. Established Clients, Males (n=180)

Reason for Visit	Age				New vs. Established					
	19 and Under		20 and Older		New		Established		Total	
	n	%	n	%	n	%	n	%	n	%
STI check/results	17	63	89	59	56	79*	50	47	106	60
Exam/checkup	3	11	31	21*	14	20	20	19	34	19
Birth control	6	22*	17	11	7	10	16	15*	23	13
Diagnostic test/results	3	11	18	12	2	3	19	18***	21	12
Other	0	0	11	7	3	4	8	7	11	6
Had symptoms	1	4	5	3	3	4	3	3	6	3
EC/unprotected sex	0	0	3	2	1	1	2	2	3	2

†Clients could mention more than one reason, so the totals are greater than 100%.
*p<.05, ***p<.001
Source: 2007 Family PACT Client Exit Interview.

Reason for Visit in CEI Compared to Claims Data. CEI clients were matched to Family PACT administrative data to assess whether clients who reported specific reasons had a corresponding claim for those same services. Among the female clients matched, 362 reported annual exam as their reason for the visit. According to paid claims data, 59% of these women received a Pap test at the visit. As the Family PACT Program does not recommend annual cervical cancer screening for all women,[5] this proportion should serve as a utilization measure rather than a quality indicator.

Among the male and female clients matched, 216 reported a confirmed or suspected STI exposure or STI check as their reason for the visit. We analyzed paid claims with dates of service up to 30 days before or 90 days after the visit to determine if these clients received any STI-related services. If the client was provided a drug that treats both an STI and other conditions, we assumed that the drug was for an STI. Of clients presenting for an STI-related reason according to the CEI survey, 86% (186 out of 216) received an STI test or were dispensed a medication to treat an STI according to paid claims; of those 186 clients, 36 clients (19%) received both an STI test and a medication to treat an STI, 9 clients (5%) received only a medication to treat an STI, and 141 (76%) received only an STI test. High levels of STI testing and treatment for CEI clients are consistent with STI-related reasons for visit.

We also compared women who reported a pregnancy test as their reason for the visit in the CEI with their paid claims data to assess the extent to which these match. Of women who reported a pregnancy test as a reason for the visit and who were matched to the administrative client file, 66% (57 out of 87) had a paid claim for a pregnancy test performed at the visit. The reason why there was no claim for a pregnancy test that day is unknown, but is likely due to several reasons (the client's program certification may have lapsed, the test may not have been clinically indicated based on the client's menstrual history, or the test may have been charged to a different payer source).

[5] Bixby Center for Global Reproductive Health. *Clinical Practice Alert: Cervical Cancer Screening*; UCSF: Sacramento, CA, 2005.

PREGNANCY, BIRTH HISTORY, FUTURE PLANS FOR CHILDREN, AND PRECONCEPTION CARE

The overall goal of Family PACT is to ensure that low-income women and men have access to reproductive health information, counseling and family planning services to maintain optimal reproductive health and to reduce the likelihood of unintended pregnancy. Client-centered counseling, as the cornerstone of the program, is tailored to the individual's reproductive life plan.

Family PACT benefits include pregnancy tests, and in accordance with Program Standards, providers are asked to provide education and counseling about all options appropriate to a pregnancy test result. The results of CEI clients' pregnancy, birth history, and future plans for children, as well as any preconception care services received, are presented below.

Currently Pregnant. Once a woman is pregnant, she is ineligible for Family PACT services and is generally referred to Medi-Cal for pregnancy related services; however, she is eligible for a pregnancy test and associated counseling under Family PACT. Two percent (2%) of female clients interviewed reported that they were pregnant at the time of the interview (n=30) (Table 9). An additional 13 males said their spouse or partner was pregnant at the time of the visit, for an overall rate of 3% among respondents. Of the 43 female and male clients who reported that they are or their partner is pregnant, 27% (n=11) said the pregnancy was planned. There were no statistical differences among demographic groups in whether the pregnancy was planned, perhaps because the numbers are very small (Appendix C, Table 58).

Table 9. Currently Pregnant among Female Clients, by Age, Interview Language, Race/Ethnicity (n=1305)

Client Demographics	**n**	**%**
Age		
19 and under	5	2
20+	25	2
Interview Language		
English	18	2
Spanish	12	2
Race/Ethnicity		
Hispanic	18	2
White	3	1
African American	2	2
Asian/Pacific Islander	6	7***
Native American/Other	1	2
Total	30	2

*** p<.001

Source: 2007 Family PACT Client Exit Interview.

Services to Women Who Report Being Pregnant According to Claims Data. Pregnant clients are ineligible for any services other than pregnancy testing and counseling unless the positive test result occurred after services already had been provided. We searched paid claims for the dates of service matching the CEI date to identify services provided to pregnant clients. Among women who reported being pregnant and whom we were able to match to administrative data (n=26), 77% (n=20) received at least one Family

PACT service at the visit according to claims. For the remaining women (n=6, or 23%), there were no claims with a date of service matching the interview visit date. All women who received at least one service received both a pregnancy test and counseling, while two women also received an STI-related service.

Birth Control Used Prior to Pregnancy. Of the 30 women who were pregnant at the time of the interview, 28 responded to the question about birth control method they were using before the interview visit (Table 10). Seven (7) of these pregnancies were planned and 21 were unplanned. Among women who had a planned pregnancy, three of seven reported not using a method before the interview visit. Among women with unplanned pregnancy, about one-third reported not using a contraceptive method while two-thirds reported using a method prior to becoming pregnant.

Table 10. Use of Birth Control Before Visit by Pregnant Female Clients, by Pregnancy Planned/Unplanned (n=28)

Method Before Visit	**Pregnancy**			
	Planned		**Unplanned**	
	n	%	n	%
No method	3	43%	6	29%
Some method	4	57%	15	71%
Total	7	100%	21	100%

Source: 2007 Family PACT Client Exit Interview.

Birth History. Nearly half of all CEI respondents (49%) had no children, 18% had one child, 17% had two, 10% had three, and 6% had four (Appendix C, Table 59). As expected, a significantly higher percentage of adolescent clients than adults had no children. In addition, English-speaking clients were far more likely than Spanish-speaking clients to have no children. Analyzed by race/ethnicity, White clients were the least likely to have children, while Hispanic clients were significantly more likely to have children than all other racial/ethnic groups. Spanish speakers and Hispanic clients were, on average, older than clients in all other racial/ethnic groups, which partly explains the differences in parity.

Parity in CEI Compared to Claims Data. To assess the validity of the program's administrative parity data, female clients' report on the number of live births was compared to parity recorded in the administrative client file. Parity recorded at the client recertification nearest to the date of the interview but prior to or on the interview date was used for comparison to the interview data. The overall match between parity recorded in the client file and parity reported in CEI was 90%. Among women who reported zero parity at the interview, 97% had zero parity recorded in the client file.

Future Pregnancy Plans. Birth spacing is an important aim of the Family PACT Program. Women who can plan the number and timing of the birth of their children enjoy improved health, experience fewer unplanned pregnancies and births, and are less likely to have an abortion.[6] An understanding of clients' pregnancy intentions gives the program information as to whether clients are in need of shorter or longer-acting birth control methods. In addition, it helps to estimate the proportion of pregnancies which are delayed versus prevented, as part of the program's cost-benefit analysis (findings which will be presented

[6] Singh S. et al. Adding It Up: The Benefits of Investing in Sexual and Reproductive Health Care; New York: The Alan Guttmacher Institute and United Nations Population Fund; 2003; World Health Organization. Health Benefits of Family Planning; Family Planning and Population, Division of Family Health. 1994.

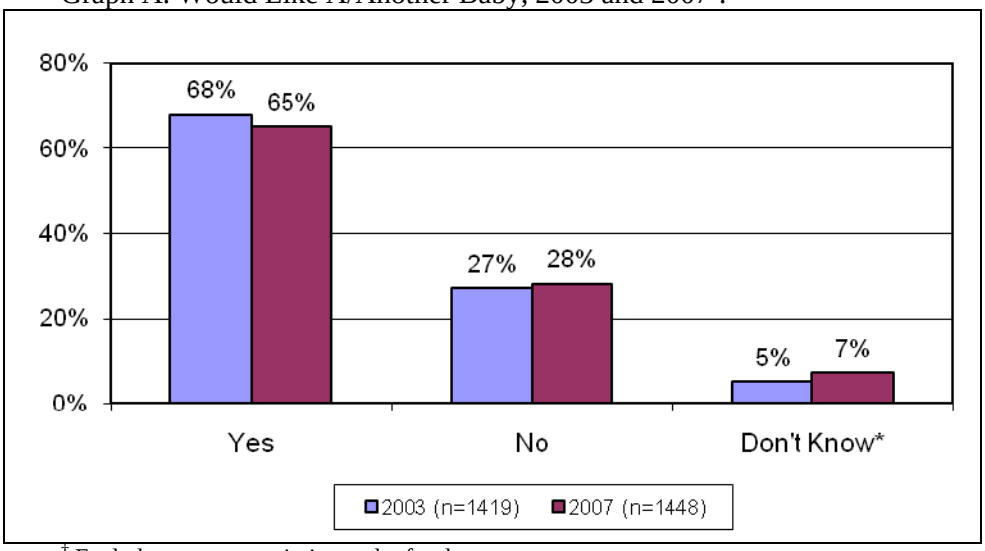
in a separate report). CEI findings indicate that 41% of respondents reported that a provider had asked them in the past 12 months if and when they want to have a baby (either their first or an additional child, data not shown). A higher proportion of females than males were asked, as were clients at private and Primary Care/Multi-Specialty providers.

Among clients not currently pregnant (or partner not pregnant), 87% of adolescents said that in the future they plan to have a child, which is significantly higher than the 60% of those age 20 and older who plan to do so. There were no significant gender differences (Appendix C, Table 60).

On average, those who planned to have either their first or an additional child planned to wait for 4.3 years (SD=3.0) (data not shown). Female clients wanted to wait 6.6 years (SD=3.1) and male clients wanted to wait 3.4 years (SD=2.5), a statistically significant difference ($p<.05$). Adolescent clients wanted to wait significantly longer than adult clients (an average of 6.6 years, SD=3.6 vs. 3.7 years, SD=2.5, $p<.001$). Among female clients who already had one or more live births and wanted to have another child in the future, the average desired wait time was 3 years (SD=2.7). For males who already had one or more children and wanted to have another child in the future, the desired average wait time was 2 years (SD=1.6).

- *Change from 2003 to 2007.* Graph A shows the 2003 and 2007 distributions of whether male and female clients would like to have a/another baby. The proportion of clients who do not want any or any more children remained constant at about 28%, and about two-thirds of respondents in both years said they did want a/another child. The percent who said they don't know if they want a/another child grew slightly, but significantly, from 5% in 2003 to 7% in 2007.

Graph A. Would Like A/Another Baby, 2003 and 2007†.

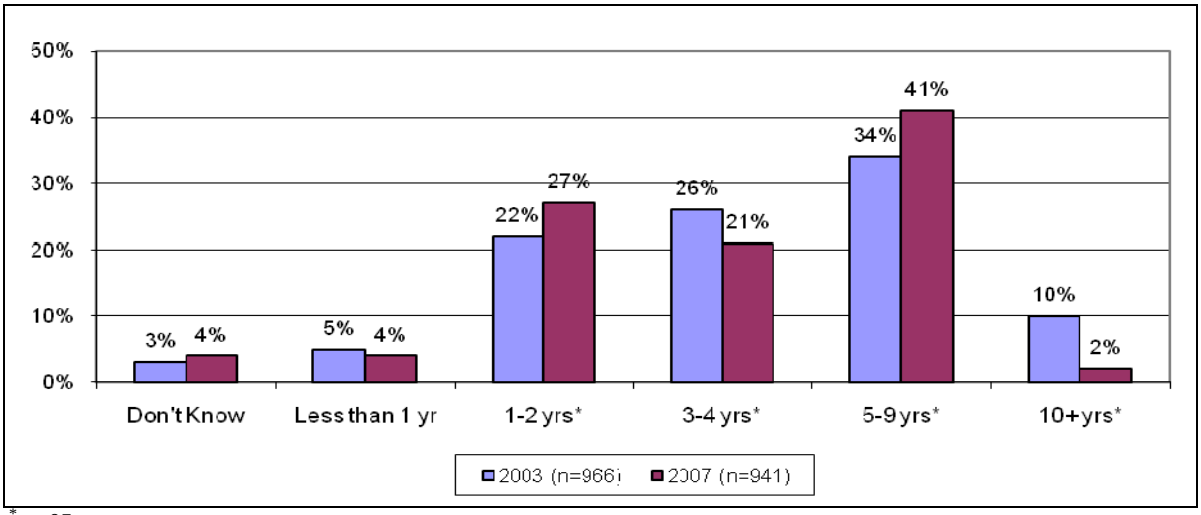


† Excludes pregnant, missing and refusals.
*$p<.05$
Source: 2007 Family PACT Client Exit Interview.

- There were several significant changes in the distribution of when respondents want a/another child, as shown in Graph B. The proportion of those who would like to have a baby in three to four years decreased significantly from 26% to 21%. The percent of respondents who want to wait five to nine years increased from 34% in 2003 to 41% in 2007, and those who want to wait

ten or more years dropped from 10% of the sample in 2003 to 2% in 2007. The last statistic may be explained by the fact that 31% of respondents in 2003 were age 19 and under whereas only 18% of respondents in 2007 were in their teens. Regardless, these findings show the variability in clients' needs.

Graph B. When (Next) Baby Wanted, Among Females and Male Clients† Who Want A/Another Baby, 2003 and 2007



*p<.05
† Excludes client pregnant (for females) or partner pregnant (for males), missing and refusals.
Source: 2007 Family PACT Client Exit Interview.

Client Assessed for Folic Acid Intake and Other Preconception Care. The intent of the Family PACT Program is to provide access to comprehensive family planning services in order to help clients achieve the optimal timing, number and spacing of children. A 2008 *Clinical Practice Alert* on preconception care reminded providers that they should offer clients education and counseling regarding a healthy pregnancy, if and when the client chooses to become pregnant in the future. When pregnancies are planned, clients have the opportunity to receive preconception care such as education on nutrients that are needed for a healthy pregnancy. One example is explaining the importance of folic acid intake in the prevention of spina bifida. Twenty-six percent (26%) of all female respondents said they had been asked by a provider in the past 12 months if they take folic acid (Table 11). Clients age 20 and older and those seen by private sector providers were more likely than those age 19 and under and those seen by public sector providers to have been asked about taking folic acid. Thirty-six percent (36%) of women were asked about any health concerns that may affect a baby, should the client become pregnant. Private sector providers were more likely than public sector providers to discuss other health concerns that may affect a baby.

Table 11. Provider Asked About Folic Acid/Health Concerns That May Affect a Baby if Client Becomes Pregnant, Among Females, by Age, Provider Sector and Specialty (n=1317)

Client Demographics	**Folic Acid**		**Health Concerns**	
	n	%	n	%
Age				
19 and under	44	20	79	35
20+	286	28**	385	36
Provider Sector				
Private	167	37**	197	43***
Public	163	20	267	32
Provider Specialty				
Family Planning/Women's Health	183	26	255	36
Primary Care/Multi-Specialty	147	26	209	36
Total	330	26	464	36

**p<.01, ***p<.001

Source: 2007 Family PACT Client Exit Interview.

BIRTH CONTROL SERVICES

The primary goal of the Family PACT Program is to reduce unintended pregnancies by improving access to contraceptive services. The program ensures that all its clients have access to all Family PACT-approved family planning methods either on-site or by referral. The CEI study provides a unique opportunity to assess from the client's perspective, providers' discussions and interactions with their clients regarding birth control, and clients' adoption of new contraceptive methods, method continuation, and method switching.

Contraceptive Methods Discussed. Clients were asked whether their doctor or nurse had talked to them about their birth control needs, and which methods were discussed. Over three-quarters (78%) of male and female clients talked about birth control at their visit (Table 12). It should be noted, however, that among the 22% who said they did not, some did not feel the need to discuss birth control (e.g., they were there for contraceptive refills, Depo Provera injections, or test results). Female clients were more likely than males to report that they had discussed birth control with their doctor/nurse. Clients seen at Family Planning/Women's Health specialty clinics were more likely to discuss birth control at the visit than clients at Primary Care/Multi-Specialty providers. Also, new and established clients did not differ significantly in the proportions who talked about birth control at the interview visit with their provider.

Table 12. Doctor Talked about Birth Control Needs, by Age, Gender,[†] Provider Sector and Specialty, Client Status (n=1454)

Client Demographics	**n**	**%**
Age (years)		
19 and under	207	82
20+	929	77
Gender		
Female	1024	80***
Male	113	68
Provider Sector		
Private	442	79
Public	695	78
Provider Specialty		
Family Planning/ Women's Health	567	75
Primary Care/ Multi-Specialty	570	82***
Client Status		
New	200	83
Established	933	77
Total	1137	78

[†] Excludes female clients who reported that they were pregnant at the time of the interview visit.
*** $p<0.01$
Source: 2007 Family PACT Client Exit Interview.

Table 13 presents the distribution of methods that were discussed at the visit. For the purposes of this analysis, the birth control methods discussed were collapsed into three tiers based on efficacy,[7] defined as follows:

- Tier 1 (High Efficacy): sterilization, IUC, and contraceptive implants and injections
- Tier 2 (Medium Efficacy): oral contraceptives (OCs), patch and ring
- Tier 3 (Low Efficacy): condoms and other barrier methods, fertility awareness method (FAM), lactation amenorrhea method (LAM), natural family planning (NFP), abstention, emergency contraception (EC) and other methods

As seen from the table, medium-efficacy (Tier 2) methods were mentioned most frequently (59%), followed by low-efficacy (Tier 3) methods (44%) and high-efficacy (Tier 1) methods (31%). Providers were more likely to discuss Tier 2 methods with adolescents than with clients age 20 and older (68% vs. 57%, respectively). Males were more likely than females to talk about Tier 3 methods; however males only have two contraceptive options—condoms and sterilization. Non-pregnant females were more likely to discuss Tier 2 methods compared to females who were pregnant at the time of the interview visit. Private sector providers reportedly discussed Tier 1 and 3 methods more often than public sector providers, and Primary Care/Multi-Specialty providers were more likely than Family Planning/Women's Health providers to discuss methods from all three tiers. Providers discussed Tier 3 methods with new clients more often than with established clients (59% vs. 41%, respectively).

[7] The definition of tiers was adapted from: Nelson A et al. (2006). Intrauterine Copper Contraceptive: Update and Opportunities. Supplement to *The Journal of Family Practice*, October 2006, pp. S1-S8.

Table 13. Birth Control Methods Discussed, by Age, Gender, Provider Sector and Specialty and Clients Status (n=1497)

Client Demographics	Low Efficacy Method (Tier 3)		Medium Efficacy Method (Tier 2)		High Efficacy Method (Tier 1)	
	n	%	n	%	n	%
Age						
19 and under	121	46	178	68***	92	35
20+	545	44	698	57	371	30
Gender						
Male	123	68***	31	17	18	10
Non-Pregnant Female	535	42	838	65***	439	34
Pregnant Female	8	27	8	27	6	20
Provider Sector						
Private	320	55*	351	61	219	38***
Public	346	38	526	57	244	27
Provider Specialty						
Family Planning/Women's Health	309	39	441	56	222	28
Primary Care/Multi-Specialty	357	50**	436	61*	241	34*
Client Status						
New	152	59***	149	58	78	30
Established	513	41	724	59	385	31
Total	666	44	877	59	463	31

† Respondents were able to mention up to 10 methods. Within each demographic group, the percents represent any mention of a method group (for example if a client mentioned more than one high-efficacy method it is only represented here once). However, if a client discussed a medium-efficacy and high-efficacy method, the values are presented in both the medium and high-efficacy columns; thus, percents do not add up to 100.

*p<.05, ***p<.001

Source: 2007 Family PACT Client Exit Interview.

Tables 14 and 15 show the individual methods that providers discussed with clients. Almost two-thirds of adolescent clients reported having discussed OCs (63%), 41% condoms and 32% injectable contraception. About half (51%) of clients 20 years and older reported having discussed OCs and 42% condoms. OCs and condoms were the methods providers discussed most often with clients of both genders. Female clients were more likely to report having discussed OCs than males (58% vs. 17%) while males were more likely to report having discussed condoms (67% vs. 38%). Discussion of female contraceptive methods with a significant proportion of male clients suggests that providers encourage male involvement in contraceptive decision making.

Table 14. Birth Control Methods Discussed, by Age, Gender (n= 1467)[†]

Birth Control Method	Age				Gender				Total	
	19 and under		20+		Female		Male			
	n	%	n	%	n	%	n	%	n	%
Sterilization	0	0	23	2	19	1	4	2	23	2
IUC	22	9*	171	14	189	15***	4	2	193	13
Implant	2	1	14	1	14	1	2	1	16	1
Injection	82	32***	254	21	323	25***	13	7	336	23
OCs	163	63***	617	51	749	58***	30	17	779	53
Patch/Ring	72	28***	225	19	289	22	8	4	297	20
EC	21	8	69	6	83	6	8	4	90	6
Condoms	106	41	502	42	487	38	121	67	608	41
Other low-efficacy	9	4	63	5	63	5	9	5	72	5
No methods	47	18	281	23	271	21	57	32***	328	22

[†]Excludes 30 female clients who were pregnant at the time of the visit.
*p<.05, ***p<.001
Source: 2007 Family PACT Client Exit Interview.

Table 15 shows that private sector providers were more likely to have discussed IUCs, implants, injections, patch and ring, condoms and other low-efficacy methods with their clients than public sector providers. New clients were more likely than established clients to talk about condoms (54% vs. 39%, respectively) but the discussion of other methods was fairly evenly distributed between the two groups. Discussion of condoms with new clients is particularly appropriate as new clients are most likely to adopt a contraceptive method at the visit and should be informed about the use of condoms for backup or as protection against STIs.

Table 15. Birth Control Methods Discussed, by Provider Sector and Client Status, Among Males and Females (n=1467)[†]

Birth Control Method	Provider Sector				Client Status			
	Private		Public		New		Established	
	n	%	n	%	n	%	n	%
Sterilization	13	2	10	1	6	2	17	1
IUC	94	16*	99	11	28	11	165	14
Implant	11	2*	5	1	2	1	14	1
Injection	164	29***	172	19	62	25	174	23
OCs	320	56	459	51	141	56	635	52
Patch/Ring	138	24*	159	18	60	24	236	19
EC	31	5	59	7	17	7	73	6
Condoms	307	54*	301	34	135	54***	472	39
Other Low-efficacy	44	8*	28	3	18	7	54	4
None	123	21	205	23	45	18	283	23

[†]Excludes 30 female clients who were pregnant at the time of the visit.
*p<.05, ***p<.001
Source: 2007 Family PACT Client Exit Interview.

Clients' Ability to Ask Their Birth Control Questions. Among clients who said they had questions for the provider about birth control, most (91%) said they were able to ask all of their questions during their visit (Appendix C, Table 61). There were no statistical differences by client or provider characteristics.

Received Birth Control at Visit. Sixty percent (60%) of female clients said they received some form of birth control at their visit. Among those who got birth control, 69% were there to get a refill or renew their birth control prescription, 16% said they were switching methods, and 14% were beginning a method for the first time (Table 16). Of those who did not receive a birth control method at the visit, 90% reported a specific method they planned to use after the visit and 10% reported that they will use no method.

Table 16. Method Adoption and Switching, Among Female Clients Who Got Birth Control at Visit (n=794)

Client…	**n**	**%**
Got a refill/renewed birth control	542	69
Switched birth control methods	129	16
Began birth control for first time	114	14
Other	9	1
Total	794	100

Source: 2007 Family PACT Client Exit Interview.

Clients' Receipt of Birth Control According to Claims Data. While clients were asked whether they were dispensed or prescribed a method of contraception at the visit, we did not ask specifically whether the client received a method on-site, was instructed to fill a prescription at the pharmacy, or both. To assess whether the receipt of contraception is confirmed by claims data, we searched paid claims for contraceptive supplies within 60 days of the interview date. For clients with multiple claims for contraception, claims with the earliest date of service were evaluated. According to claims data, of clients who reported receiving birth control at the visit and who were matched to administrative data, 76% received contraceptive supplies within 30 days of the visit, and an additional 3% received their supplies within 60 days. Approximately two-thirds of clients received their supplies through on-site dispensing (Table 17). Of those who reported receiving contraception or a prescription for contraception and had a claim for on-site dispensing, 96% were dispensed contraceptives on the day of the visit; of those with a claim for pharmacy dispensing, 62% filled their prescription on the day of the visit, 21% filled it within two weeks of the visit and the rest filled it between 14 and 60 days of the visit (data not shown).

A lack of claims for dispensed/prescribed contraception may be due to the clients not filling their prescriptions, or dispensing of free samples or provider failure to successfully bill for services provided. The contribution of each of these factors is unknown.

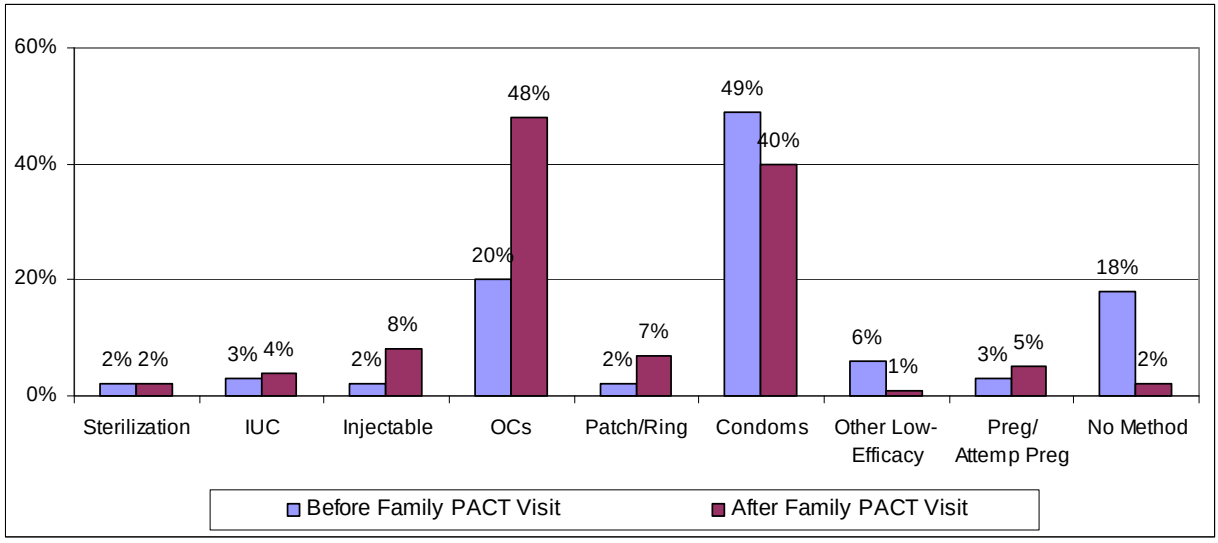
Table 17. Receipt of Contraceptive Methods According to Claims Data, among Male and Female Clients Who Reported that they were Dispensed or Prescribed a Method at the Visit (n=711)

Method Dispensed According to Claims Data			Dispensed By			
			On-Site		Pharmacy	
Within…	n	%	n	%	n	%
30 days	541	76	346	64	201	37
45 days	558	78	348	62	210	38
60 days	563	79	351	62	212	38

Source: 2007 Family PACT Client Exit Interview and claims data current through December, 2008

Birth Control Methods Used Before and After Family PACT Visit. Graphs C and D show the birth control methods reported by new and established female clients before and after their visit. Clients could name more than one method; therefore, the categories are not mutually exclusive. The proportion of new clients using OCs following their visit more than doubled, from 20% to 48%, while those using no method decreased from 18% to 2%. Injectable contraceptive use quadrupled among new clients (from 2% to 8%), while the proportion of clients using low-efficacy methods decreased from 6% to 1%.

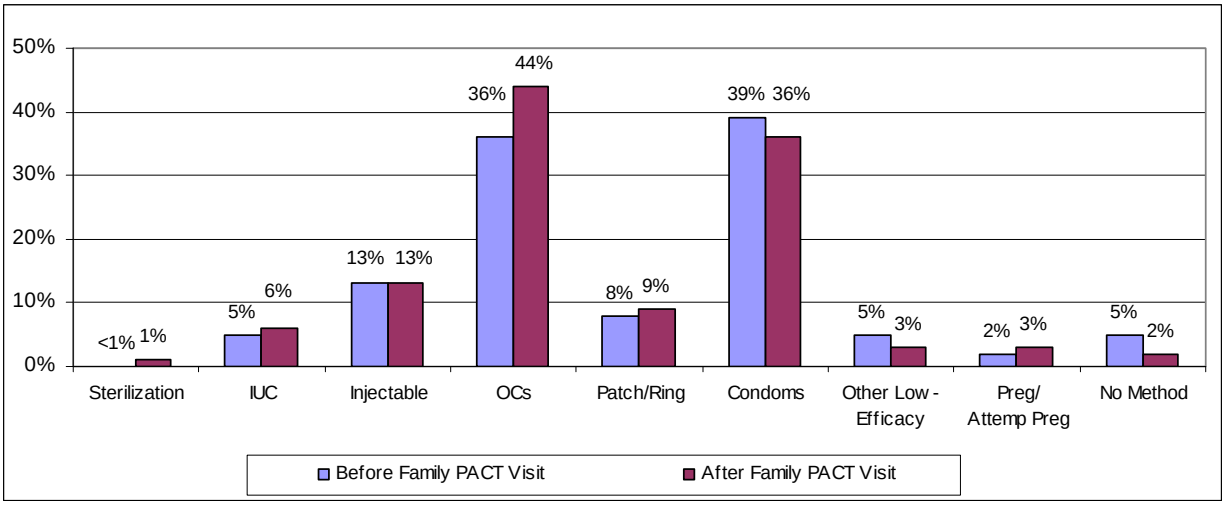
Graph C. Contraceptive Method† Before and After Family PACT Visit, Among New Female Clients (n=175)‡



†Clients could name more than one method.
‡Excludes missing, don't know and refusals.
Source: 2007 Family PACT Client Exit Interview.

Among established clients, the differences were more subtle, with an increase in OC adoption and a slight decrease in condom and other low-efficacy method use. Further analysis of method switching patterns is discussed later in this section.

Graph D. Contraceptive Method† Before and After Family PACT Visit, Among Established Female Clients (n=1116)‡



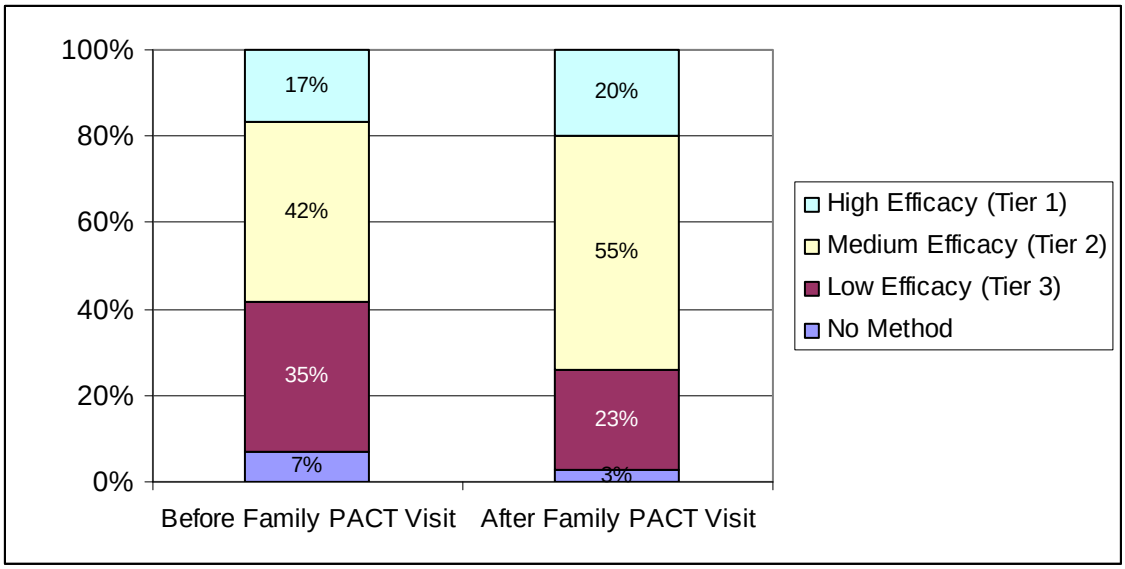
†Clients could name more than one method.
‡Excludes missing, don't know and refusals.
Source: 2007 Family PACT Client Exit Interview.

Contraceptive Efficacy and Method-switching. The efficacy of contraceptive methods used by females prior to the interview was compared with that of the methods clients left with. For this analysis, the birth control methods were collapsed into the same three tiers described earlier, with the addition of a fourth group for those using no method, and ranked from highest efficacy to lowest efficacy, defined as follows:

- Tier 1 (High Efficacy): sterilization, IUC, and contraceptive implants and injections
- Tier 2 (Medium Efficacy): OCs, patch and ring
- Tier 3 (Low Efficacy): condoms and other barrier methods, FAM, LAM, NFP, abstention, EC, and other methods
- No method

Each woman was assigned the most effective method she used before the visit and the most effective method she planned to use after the visit. Only non-pregnant females not seeking pregnancy, who had a method recorded at the beginning and the end of the visit were included in the analysis (n=1241). At the end of the visit, only 3% were using no method, 23% were using a low-efficacy method from Tier 3, 55% were using a medium-efficacy method from Tier 2 and 20% were using a high efficacy method from Tier 1 (Graph E).

Graph E. Grouped Birth Control Methods, Before and After Family PACT Visit, Among Non-Pregnant Female Clients Not Seeking Pregnancy (n=1241).



Source: 2007 Family PACT Client Exit Interview.

Overall, 24% of non-pregnant female clients not seeking pregnancy adopted a more effective method at their visit, 6% left the visit with a less effective method, and 70% left with the same method efficacy they were using prior to the visit (Table 18).

Table 18. Efficacy of Method† at End of Visit Compared to Method at Start of Visit, Among Female Clients not Seeking Pregnancy, by Age, Provider Sector, Client Status (n=1241).‡

Client Demographics	**More Effective**		**Less Effective**		**Same Efficacy**		**Total**	
	n	%	n	%	n	%	n	%
Age (years)								
19 and under	78	35***	13	6	131	59	222	100
20+	215	21	61	6	742	73	1018	100
Provider Sector								
Private	108	24	31	7	306	69	445	100
Public	185	23	43	5	568	71	796	100
Client Status								
New	82	49***	4	2	80	48	166	100
Established	210	20	70	7	792	74	1072	100
Total	293	24	74	6	874	70	1241	100

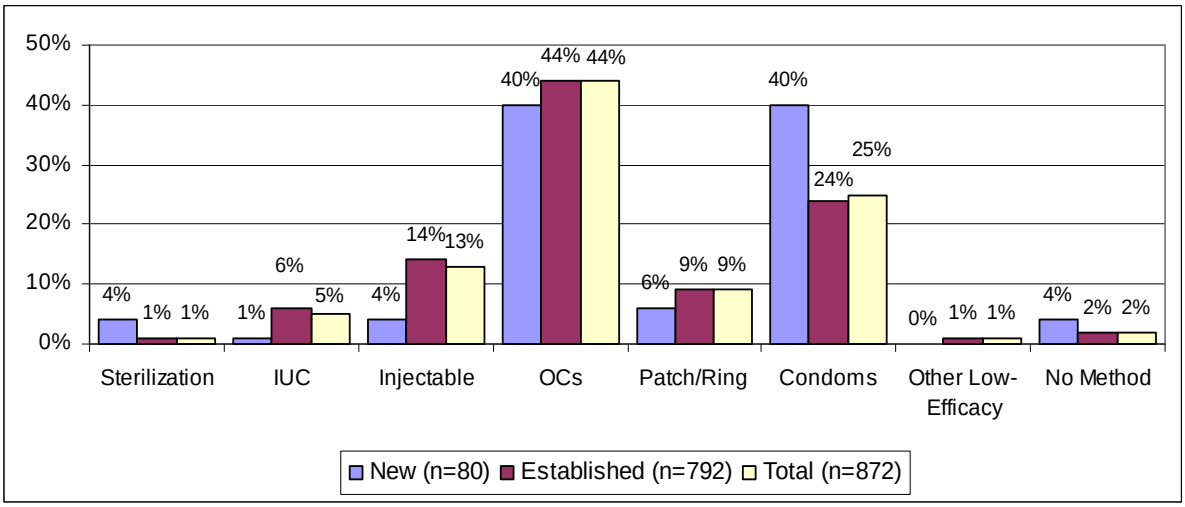
†Based on the primary, most effective method.
‡ Clients who were pregnant or attempting pregnancy were excluded from the analysis.
***p<.001
Source: 2007 Family PACT Client Exit Interview.

Adoption of higher efficacy methods differed significantly by age, with a higher proportion of adolescents adopting more effective methods than those 20 years and older (35% vs. 21%, respectively). This statistical age difference is primarily explained by the fact that 73% of adult clients retained the same level of method efficacy they were using before the visit, and that adolescents were more likely to be new clients than adults (28% vs. 14%, respectively). The proportion of new clients (defined as having received

a HAP card the day of the interview visit) who left with a more effective method than they came in with was more than twice that of established clients (49% vs. 20%, respectively), indicating Family PACT's success at the initial visit and success in helping established clients to continue to adopt more effective methods. There were no statistical differences by provider sector.

The 70% of clients who did not switch the efficacy of their methods, drives the overall distribution of method use at the end of the visit. Of the 872 clients who retained the method efficacy they came in with, 44% were using oral contraceptives, 9% were using the vaginal ring or patch, 25% were using condoms, 19% were using IUCs, injections or sterilization, and 3% were using other low-efficacy methods or no method (Graph F).

Graph F. Birth Control Method† among Female Clients Who Used the Same Efficacy Method Before and After Family PACT Visit (n=872)



†Based on the primary, most effective method.
Source: 2007 Family PACT Client Exit Interview.

- *Changes from 2003 to 2007.* Family PACT clients' patterns of method switching did not change significantly between 2003 and 2007. Most clients retained the same method efficacy they came in with (67% in 2003 and 70% in 2007), and over 70% of those who did not switch methods were using a medium or high-efficacy method. Nearly one-fourth of respondents in each year switched to a more effective method and 6-9% switched to a less effective method. There were no significant differences between 2003 and 2007 in any of these categories.

Contraceptive Use after Visit, According to Claims Data. CEI clients were asked what methods they planned to use after the visit. To assess the proportion of clients who received the methods they intended to use, we searched paid and denied claims with dates of service up to 30 days before or 120 days after the day of the interview. We considered only methods that could be identified from claims and excluded all behavioral and partner-dependent methods (NFP/FAM, withdrawal, LAM, abstinence, and vasectomy). For IUCs, we included only women who adopted this method at the visit to avoid counting women who were continuous users of the method. Contraceptive implants were excluded because only one client reported this method at the interview.

Of women who reported at least one method identifiable from claims, 78% were dispensed a method according to claims. Follow-through was the highest for the ring (88%), patch (76%), injection (74%) and OCs (73%). Follow-through for the IUC was low at 21%. Follow-through for barrier methods (58%) should be treated with caution because condoms do not require a prescription, and clients could have obtained them outside of Family PACT. Numbers for tubal ligation and EC are small and may not be reliable (Table 19). Clients who were dispensed OCs in quantities of up to 13 pill packs may have not needed a refill in the follow-up period. Therefore as a sensitivity test, we expanded the follow-up period for OCs to 360 days before and 120 days after the visit (regardless of the amount dispensed), which increased the follow-through to 80% (data not shown).

Table 19. Methods Clients Planned to Use Compared to Methods Dispensed According to Claims, Among Female Clients Who Reported that They Will Use a Method after the Visit (n=1111)[†]

Contraceptive method[‡]	Method dispensed[§]		Method women said they will use after visit
	n	%	n
Oral contraception	359	73%	495
Barrier methods	243	58%	417
Injection	110	74%	149
Ring	49	88%	56
Patch	39	76%	51
IUC[††]	7	21%	33
Emergency contraception	2	40%	5
Tubal ligation	0	0%	4
Any method	866	78%	1111

[†] Excludes clients who reported that they were pregnant at the time of the interview visit. Excludes clients who only reported methods which cannot be identified from claims data, including behavioral methods and methods used by the partner (vasectomy).
[‡] Methods are not mutually exclusive.
[§] Based on paid and denied claims 30 days prior or up to 120 after the visit.
[††] Includes only women who switched to IUC at the visit.
Source: 2007 Family PACT Client Exit Interview and claims data current through December, 2008

Likelihood of Using Method at Every Sexual Encounter. Clients who reported using condoms, the diaphragm or cervical cap, rhythm method or withdrawal were asked how likely it was that they would use this method every time they had sex. Almost all (95%) said they were very likely or somewhat likely, with little variability (data not shown). New and established clients were equally likely to say they would use their method every time they had sex.

Provision of Contraceptive Counseling. Clients were asked whether providers discussed advantages and disadvantages/side effects of birth control methods they planned to use after the visit. We considered that contraceptive counseling was provided if the client reported that either advantages or disadvantages/side effects of the method were discussed. According to this definition, 77% of clients reported to have received contraceptive counseling (Table 20). CEI clients seen by private sector providers and clients of Primary Care/Multi-Specialty providers were significantly more likely to report to have received contraceptive counseling than clients seen by public sector providers and Family Planning/Women's Health providers. Clients who reported they had adopted a new method were significantly more likely than clients who did not adopt a new method to have had contraceptive counseling. There was no statistical difference in birth control discussion between new and established clients.

Table 20. Provision of Contraceptive Counseling by Provider Sector, Specialty, Client Age, Gender, Status and Whether Client Adopted a New Method at Visit (n=1415)†

Provider and Client Characteristics	Contraceptive Counseling Provided‡	
	n	%
Provider Sector		
Private	441	80*
Public	649	75
Provider Specialty		
Family Planning/Women's Health	549	74
Primary Care/Multi-Specialty	541	80*
Client Age		
Under 20	200	83*
20+	889	76
Client Gender		
Female	971	77
Male	119	75
Client Status		
New	172	76
Established	916	77
Client Adopted a New Method§		
Yes	386	82***
No	704	74
Total	1090	77

*p<.05, ***p<.001
†Excludes pregnant females and males whose partner is pregnant.
‡Defined as provider discussed advantages or disadvantages/side effects of the method client will use after the visit.
§Client reported a method she/he will use after visit that she/he did not use before visit, excluding switching to no method.
Source: 2007 Family PACT Client Exit Interview.

Provider Discussed IUCs. The use of high-efficacy methods, such as IUCs, is of particular interest to the Office of Family Planning. IUCs are among the few long-acting reversible methods available to Family PACT clients and the subject of several Family PACT evaluation studies. A 2006 *Clinical Practice Alert* aimed to educate providers about IUCs, by dispelling common myths and informing them about the appropriate use of IUCs. Twenty-seven percent (27%) of female clients said they had discussed IUCs with their provider at the interview visit (Table 21). This proportion is largely driven by non-users of the method, who were significantly less likely to discuss the IUC at the visit compared to current users (25% vs. 71%). Clients 20 and older were more likely than adolescents to have discussed IUCs (29% vs. 19%, respectively). Clients seen by private sector providers were significantly more likely than those seen at public sector providers to have discussed IUCs, and clients seen by Primary Care/Multi-Specialty providers were more likely than Family Planning/Women's Health clients to have discussed IUCs at their visit.

Table 21. Provider Discussed IUCs, by Age, Provider Sector and Specialty, Client Status and Current IUC Use, Among Female Clients (n=1265).[†]

Client Demographics	**n**	**%**
Age (years)		
19 and under	42	19
20+	297	29**
Provider Sector		
Private	158	35***
Public	181	22
Provider Specialty		
Family Planning/Women's Health	154	22
Primary Care/Multi-Specialty	185	32***
Client Status		
New	42	25
Established	296	27
Current IUC User		
Yes	39	71***
No	300	25
Total	339	27

[†] Excludes 30 female clients who reported that they were pregnant at the time of the interview visit.
**p<.01, ***p<.001
Source: 2007 Family PACT Client Exit Interview.

IUC Adoption after Discussion with Clinician, According to Claims Data. Of 1166 female clients matched to claims, 271 (23%) did not use the IUC before the visit and reported having discussed the IUC with clinician at the visit. To evaluate the proportion of women who adopted an IUC subsequent to the discussion, we searched paid claims with procedure codes for IUC insertion or device dispensing within 365 days of the interview date. Of 271 non-users who reported discussing the IUC with clinician, 12 (4%) adopted an IUC within 365 days of the visit according to claims data. Five clients adopted the method within two months of the visit, and seven clients adopted the method between 2 and 12 months of the visit.

Reasons for Not Using an IUC. To understand the beliefs, fears and possible misconceptions about IUCs, clients who were not using an IUC were asked why they were not currently using one. The top reason for not using an IUC was lack of information: many clients didn't know much about IUCs or had never even heard of them. The second most common reason for not using an IUC was that women were happy with their current method and had not thought about changing to an IUC (Table 22). Of those who stated this reason, 81% were using either a high or medium-efficacy method already. This question also produced a myriad of other responses, many indicating misconceptions or concerns about side effects, such as, "It causes abortion," "I won't be able to get pregnant afterwards," "It might fall out," "I'm too young to use it/I haven't had kids yet", "I smoke", "afraid of other side effects," "don't want a foreign object in my body," "doctor said it's not right for me", and "fear of pain or pain on insertion".

Table 22. Reasons for Not Using IUC, Among Female Clients (n=1177)

Reason	n	%
Don't know enough about it	488	41
Happy with current method	202	17
Afraid of other side effects	186	16
Don't want foreign object in body	169	14
Fear of pain / pain on insertion	134	11
Doctor said it's not right for me	61	5
Plan to get pregnant soon	52	4
Used it before and did not like it	52	4
Don't think IUC protects from pregnancy	51	4
Fear of bleeding	47	4
Fear of infertility	44	4
Other	89	8
Total	1177	100

† Excludes female clients who reported that they were pregnant at the time of the interview visit.
Source: 2007 Family PACT Client Exit Interview.

Table 23 shows the age, language and racial/ethnic distributions of the top five reasons women gave for not using an IUC. No statistical testing was done because clients could give up to 6 reasons; thus, response frequencies are not mutually exclusive. However, at face value it is clear that younger clients were less informed about IUCs than clients 20 and older (63% don't know enough about it vs. 37%, respectively), and older clients were more worried about side effects than younger clients (17% vs. 8%, respectively). Clients interviewed in English were more likely than Spanish-speakers to report that they didn't know enough about the IUC and state that they did not want a foreign object in their bodies. Clients who were interviewed in Spanish were more likely than English-speakers to report being afraid of side effects. One explanation may be that hearsay has come into play with regards to IUC use. Some clients relayed anecdotes from their friends and family regarding IUCs.

Table 23. Top Five Reasons† Women Are Not Using IUCs, by Age, Interview Language and Race/Ethnicity (n=1177)

Client Demographics	Don't Know Enough		Happy with Current Method		Afraid of Other Side Effects		Don't Want Foreign Object		Fear of Pain/ Pain on Insertion	
	n	%	n	%	n	%	n	%	n	%
Age (years)										
19 and under	132	63	29	14	17	8	29	14	28	13
20+	356	37	173	18	169	17	140	14	106	11
Interview Language										
English	349	48	117	16	92	13	140	19	75	10
Spanish	139	31	85	19	94	21	29	6	59	13
Race/Ethnicity										
Hispanic	284	38	132	18	136	18	79	10	87	12
White	107	51	39	19	22	10	42	20	23	11
African American	28	35	10	13	11	14	18	23	8	10
Asian/Pacific Islan.	45	56	13	16	9	11	15	19	10	13
Native Amer./Other	19	45	6	14	7	17	13	31	5	12
Total	488	41	202	17	186	16	169	14	134	11

†Respondents could mention more than one reason.
Source: 2007 Family PACT Client Exit Interview.

Birth Control Method Clients Would Use if They Had to Pay Out-of-Pocket. The intent of this question was to get an idea of clients' contraceptive practices in the absence of the Family PACT Program. However, this hypothetical question was often difficult for clients to answer, and some asked for a monetary value for the different methods. The top two methods mentioned by CEI respondents were condoms (which are the cheapest), with 52% of men and women reporting they would use this method, followed by oral contraceptives (25%) (Table 24). Five percent (5%) of respondents didn't know what method they would use. Other clients said they would use "whatever is cheapest", that they would "buy Depo Provera from Tijuana" or "get my pills abroad where they're affordable."

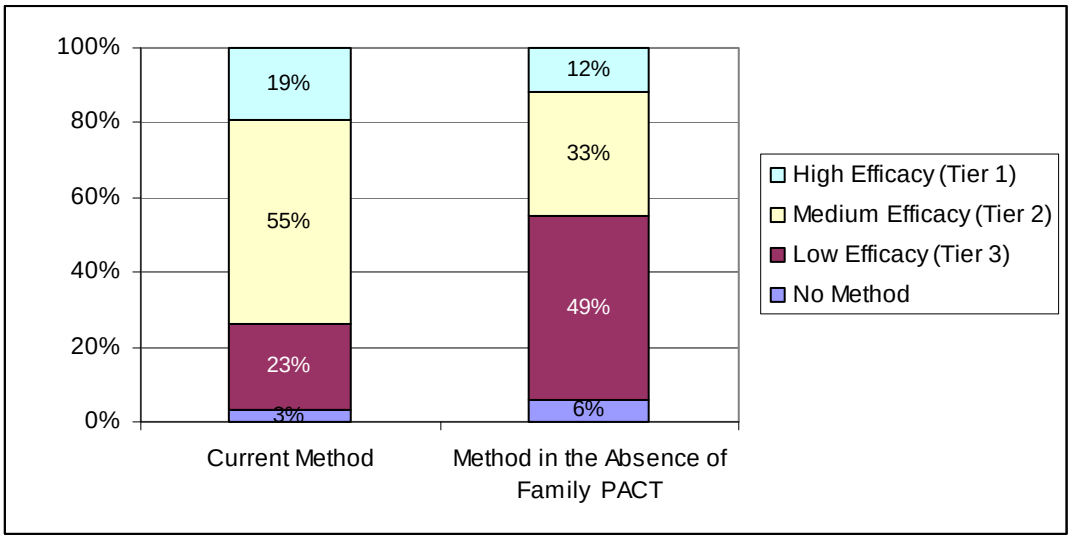
Table 24. Birth Control Method Client Would Use If Had to Pay†, by Gender

Birth Control Method	Female (n=1317)		Male (n=180)		Total (n=1497)	
	n	%	n	%	n	%
Condoms	638	48	134	74	772	52
Oral contraceptives	366	28	11	6	377	25
Injections	95	7	0	0	95	6
Intrauterine contraception	46	3	0	0	46	3
Patch	26	2	0	0	26	2
Ring	26	2	0	0	26	2
Rhythm method/NFP	12	1	2	1	14	1
Abstinence	13	1	1	1	14	1
Withdrawal	14	1	1	1	15	1
Tubal ligation	5	<1	0	0	5	<1
Vasectomy	3	<1	3	2	6	<1
Implants	4	<1	0	0	4	<1
Diaphragm/cervical cap	2	<1	0	0	2	<1
Spermicides	7	1	0	0	7	<1
Emergency contraception	3	<1	2	1	5	<1
Don't Know	66	5	11	6	77	5
No method	87	7	20	11	107	7

†Answers are not mutually exclusive.
NFP refers to natural family planning method.
Source: 2007 Family PACT Client Exit Interview.

In order to assess the impact of losing Family PACT coverage, we grouped and ranked the methods that clients would use if they had to pay for their own birth control and compared them with their current method, as of the end of their visit. Only non-pregnant females who were not attempting pregnancies were included in the analysis; the 66 female clients who said they did not know which method they would use if they had to pay were also excluded from the analysis. Graph H shows the differences in each grouping of birth control methods. The use of low-efficacy methods would more than double (from 23% to 49%), while the use of medium and high-efficacy methods would decrease. These shifts towards lower method efficacy and the resulting higher likelihood of contraceptive failure and discontinuation, would likely lead to higher rates of unintended pregnancies for adolescent and adult women in California, if they didn't have access to the Family PACT Program.

Graph G. Comparison of Current Method (with Family PACT) and Method Female Clients Would Use if They Had to Pay for Birth Control (n=1183)†



†Based on the primary, most effective method. Clients who were pregnant or attempting pregnancy were excluded from the analysis.
Source: 2007 Family PACT Client Exit Interview.

Overall, 43% of CEI clients would continue using the same method they are currently using, even if they had to pay for it (Table 25). A similar proportion (42%) would use a less effective method, and 9% would actually use a more effective method if they had to pay. One explanation for those who said they would *improve* their method if Family PACT services were not available is that people may think about getting a long-term method, such as an IUC or sterilization, for which there would only be a one-time cost and no further monthly costs to bear. Almost half of the responses among those 16% planned to use a high-efficacy method (46%), while 45% would have chosen a medium-efficacy hormonal method. Adolescents and those aged 20 and older did not differ in their patterns of adopting a more or less effective method if they were required to pay for birth control services.

Table 25. How Birth Control Methods Would Change if No Family PACT Services Available, Among Female Clients, by Age (n=1236)

Method changes	**Age (Years)**				**Total**
	19 and Under		**20 and Older**		
	n	%	n	%	%
Would Change to Lower Efficacy Method Without Family PACT	94	42	421	42	42
Would Not Change Methods Without Family PACT	107	48	505	50	50
Would Change to Higher Efficacy Method Without Family PACT	24	11	85	8	9
Total	225	100	981	100	100

† Excludes female clients who reported that they were pregnant at the time of the interview visit. Totals may not add to 100% due to rounding.
Source: 2007 Client Exit Interview.

Would Clients Have Sex Without Birth Control? Overall, almost a third (31%) of all CEI respondents said that they would have sex regardless of whether or not they had birth control (Table 26). Almost half

(48%) said they would not have sex without birth control, and the remaining 22% said "maybe/ sometimes" or "don't know."

Table 26. Would Client Have Sex without Birth Control, by Age and Gender (n=1495)

Sex without birth control?	Age (Years)				Gender				Total
	19 and Under		20 and Older		Female		Male		
	n	%	n	%	n	%	n	%	%
Yes	88	34	371	30	404	31	55	31	31
Sometimes/Maybe	57	22	238	19	254	19	41	23	20
No	108	41	604	49	632	48	81	45	48
Don't Know/Refused	9	3	20	2	26	2	2	1	2
Total	262	100	1233	100	1317	100	179	100	100

Source: 2007 Family PACT Client Exit Interview.

Emergency Contraception. Forty-five percent (45%) of female clients said the doctor or nurse talked to them about EC at the interview visit (Table 27). The proportion was significantly higher among adolescent than among adult clients.

Table 27. Doctor Discussed Emergency Contraception at Current Visit, by Age, Provider Sector and Specialty, among Female Clients (n=1316)

Client Demographics	n	%
Age		
19 and under	137	58***
20+	455	42
Provider Sector		
Private	210	45
Public	382	45
Provider Specialty		
Family Planning/Women's Health	334	46
Primary Care/Multi-Specialty	258	44
Total	592	45

***p<.001
Source: 2007 Family PACT Client Exit Interview.

In 2005, Family PACT providers were issued a *Clinical Practice Alert* reminding them that advanced provision of EC should be offered to all women using reversible methods of contraception (especially barrier methods), as well as women who test negative for pregnancy when pregnancy is not desired. Sixteen percent (16%) of female clients received EC or a prescription for EC at their interview visit Appendix C, Table 62). Adolescents were significantly more likely to receive EC or a prescription for EC than adults. Clients at public sector and Family Planning/Women's Health providers were significantly more likely than clients at private sector and Primary Care/Multi-Specialty providers to receive EC or a prescription for EC. Among the 214 women who received EC or a prescription at the interview visit, 13% left with a high efficacy method, 64% with a medium efficacy method, 22% with a low efficacy method, and 1% with no method. Only six of the 80 clients who received EC for immediate use said the reason for their visit was a pregnancy test (an indicator of unprotected sex).

- *Change from 2003 to 2007.* The percent of female clients who received EC at the interview visit remained steady at 16% in both 2003 and 2007. Respondents were asked if they got EC for

immediate use that day, for future use or for both (Table 28). The proportion who received it for immediate use decreased slightly from 7% to 5%, while the proportion who received it for future use or for future and immediate use increased slightly from 9% to 10%.

Table 28. EC Distribution in 2003 and 2007

Client received EC for….	2003		2007	
	n	%	n	%
Immediate Use at Current Visit	83	7**	61	5
Future Use	109	9	127	10
Both Immediate and Future Use	1	<1	19	1***
Did Not Receive EC at Visit	1028	84	1102	84
Total	1221	100	1309	100

**p<.01, ***p<.001
Source: 2007 Family PACT Client Exit Interview.

SEXUALLY TRANSMITTED INFECTION SERVICES

Screening and treatment of sexually transmitted infections (STIs) are critical components of Family PACT's comprehensive services to maintain optimal reproductive health. The CEI provides the opportunity to assess providers' interactions with clients regarding STIs, to determine whether clients' risk for STIs was properly assessed, and to further assess STI follow-up using claims data. In this section, when testing for differences by age group, the over 30 age group served as a reference group, because of its significantly lower STI incidence, whereas in other sections adolescents served as the reference group.

STI Risk Assessment. According to national standards, all clients at their annual visit, new clients, clients who report they have had unprotected sex (e.g. if they came in for emergency contraception or a pregnancy test), and clients who come in for an STI check or report an STI contact should have an STI risk assessment. Family PACT Standards stipulate that a comprehensive health history, including a sexual and contraceptive history, should be updated every 2 years. This can be done as a self-administered or face-to-face STI risk assessment which includes information on vaginal, oral, or anal sex, the number and gender of their sexual partners and whether they have had any STIs recently. Clients were most likely to be asked about the number of sexual partners they have had and whether they have had an STI in the past year (Table 29). Fifty-eight percent (58%) of all clients and 70% of new clients were asked about the number of sexual partners they have had. Over half (54%) of all respondents and 72% of new clients said they were asked during their visit if they had had an STI in the past 12 months. Almost half (48%) of all respondents and 60% of new clients were asked if they know how to reduce their risk of getting an STI. Forty-two percent (42%) of all respondents and 61% of new clients were asked about the gender of their partner(s). Overall, 41% of all clients, and 60% of new clients were asked about their sexual practices, including vaginal, anal and oral sex.

Among clients who should have received an STI risk assessment (i.e., clients who reported for an annual exam, STI-related reason or unprotected sex), females were significantly less likely than males to have been asked the STI risk assessment questions. Overall, among females who came for a reason that warranted an STI risk assessment, the proportions of those who were asked each question are only

slightly higher than the overall proportion for females and are well below the overall proportions for males.

Table 29. Client Was Asked STI Risk Assessment, by Gender, Client Status and Select Reasons for the Visit

	All Clients						New Clients				Reported Reason for the Visit									
											Annual Exam/Checkup				STI Check/ Exposure/Test Results				Unprotected Sex†	
	Female (n=1317)		Male (n=180)		Total (N=1497)		Female (n=183)		Male (n=72)		Female (n=407)		Male (n=34)		Female (n=257)		Male (n=117)		Female (n=144)	
Client asked…	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
About number of sexual partners	728	55	129	72***	857	58	119	65	57	80*	266	65	28	85*	136	53	85	73***	66	46
If had an STI in past 12 months	667	51	131	74***	798	54	121	67	58	83*	236	58	26	76*	130	51	90	76***	60	41
If knows how to reduce risk of STI	576	44	128	73***	704	48	99	54	54	75*	177	44	26	76***	123	48	85	72***	50	35
About gender of partner	507	39	118	66***	625	42	99	54	57	79*	171	42	24	72***	107	42	80	67***	42	29
About sexual practices	498	38	120	67***	618	41	98	54	54	75*	170	42	24	71*	98	38	78	66***	49	34

*p<.05, ***p<.001

†Reasons for visit included pregnancy test or emergency contraception.

Source: 2007 Family PACT Client Exit Interview.

Overall, older, male, Hispanic, and African American clients and those seen at private sector providers, were more likely to be asked sexual risk assessment questions than younger, female, and white clients, and those seen at public sector providers (See Appendix C, Tables 64-68).

- *Change from 2003 to 2007.* The proportion of those who were asked if they had had an STI in the past 12 months increased from 44% to 54% between 2003 and 2007 (Table 30). Fifty-eight percent (58%) of respondents in 2007 were asked about the number of sexual partners they had in the past 12 months, up from 41% in 2003, and 42% were asked about the gender of their partners, up from 13% in 2003.

Table 30. Clients Assessed for STI Risk, 2003 and 2007, by Gender

Client asked today about…	Females				Males				Total			
	2003 (n=1216)		2007 (n=1313)		2003 (n=248)		2007 (n=178)		2003 (n=1464)		2007 (n=1491)	
	n	%	n	%	n	%	n	%	n	%	n	%
STI in past 12 months	518	43	667	51***	119	48	131	74***	637	44	798	54***
Number of sexual partners	489	40	728	55***	113	46	129	72***	602	41	857	58***
Gender of sexual partners	137	11	507	39***	50	21	118	66***	187	13	625	42*

***p<.001 (differences between 2003 and 2007)
Source: 2007 Family PACT Client Exit Interview.

STI Testing. Forty-one percent (41%, or n=611) of respondents reported being tested for an STI at their interview visit (Table 31). A significantly higher percentage of males were tested than females (68% vs. 37%, respectively). This is consistent with the higher likelihood of males presenting with symptoms and coming in for an STI test than females, as noted in prior studies.[8] Younger female clients were more likely to be tested compared to older females, but there was no similar association among males. Testing rates were also higher among clients who reported for STI-related reasons (62%) and among those who reported for annual exam/checkup (58%). There were substantial age differences among females who came for an annual exam and reported receiving an STI test: 66% of females under 20 who came for an annual exam reported receiving an STI test, compared to 64% of females aged 20-25, 55% of females aged 26-30, and 48% of females over age 30 (not shown in table). Of females who came for an annual exam and reported an STI test, 63% reported having been tested for chlamydia, with similar age differences ranging from 81% for females under age 20 to 44% for females over age 30 (not shown in table).

[8]Thiel de Bocanegra, H., Rostovtseva, D., Menz, M., and Karl, J. *The 2007 Family PACT Medical Record Review: Assessing the Quality of Services.* Sacramento, CA.: Bixby Center for Global Reproductive Health. University of California, San Francisco. 2008.

Table 31. Client Tested for a Sexually Transmitted Infection (STI) at Visit, by Gender (n=1495)

Client Demographics	**Female** (n=1317)		**Male** (n=180)		**Total** (n=1495)	
	n	%	n	%	n	%
Age (years)						
19 and under	96	41*	18	67	114	44
20-25	192	40*	33	65	225	42
26-30	86	35	28	78	112	40
Over 30†	116	32	44	68	160	37
Race/Ethnicity						
White‡	83	37	10	77	93	39
Hispanic	323	38	88	68	411	41
African American	29	35	12	63	41	39
Asian/Pacific Islander	28	31	5	71	33	34
Native American/Other	20	44	6	86	26	50
Provider Sector						
Private	175	37	79	72	254	44
Public	313	37	44	64	357	39
Provider Specialty						
Family Planning/Women's Health	274	38	43	74	317	40
Primary Care/Multi-Specialty	214	36	80	66	294	41
Reason for the visit§						
STI check/exposure/unprotected sex (EC, pregnancy test, diagnostic test)	151	52	93	92	244	62
Annual exam/checkup/Pap	231	56	25	74	256	58
Had symptoms	42	38	NA	NA	45	38
Other (birth control, follow-up, test results & other)	210	29	18	33	228	29
Total	488	37	123	68*	611	41

† Clients over age 30 served as the reference group.
‡ White served as the reference group.
§ Client could report reasons from more than one category, therefore tests of statistical significance were not performed.
N/A=not available because sample size was too small to calculate.
*$p<0.05$
Source: 2007 Family PACT Client Exit Interview.

Among those tested, 68% reported that they were tested for chlamydia, 64% for gonorrhea, 58% for HIV/AIDS, 28% for syphilis, and 11% for genital herpes (Table 32). Fewer than 10% reported being tested for each of the other STIs (such as HPV, trichomoniasis, genital herpes, and other pathogens including nongonoccocal urethritis (NGU)). Men were more likely than women to say they were tested for HIV/AIDS and syphilis. Over half of those tested (51%) were told that the provider was mandated to report results to the local health jurisdiction, and there were no significant differences in who was told about reporting requirements.

Table 32. Sexually Transmitted Infections Client Was Tested For (n=609)

STI	Female		Male		Total	
	n	%	n	%	n	%
Chlamydia	328	68	84	68	412	68
Gonorrhea	303	62	85	69	388	64
HIV/AIDS	265	54	86	70**	351	58
Syphilis	119	25	51	41**	170	28
Genital herpes	43	9	21	17	64	11
Human papilloma virus (HPV)	40	8	14	11	54	9
Pelvic inflammatory disease	34	7	0	0	34	6
Trichomoniasis	18	4	7	6	25	4
Other pathogens (including NGU)	11	2	5	4	16	3

** $p<0.01$

Source: 2007 Family PACT Client Exit Interview.

STI Testing According to Claims Data. CEI clients were asked whether they received an STI test at the visit and if so, for what infection. We analyzed paid claims within 30 days of the date of the visit to assess whether client self-reports are confirmed by claims data (see Appendix A for details about methodology and procedure codes). Overall, we found an indication that a test was billed for 75%-79% of clients who reported receiving a test, depending on matching criteria. The proportion of tests found was the highest for chlamydia, gonorrhea and HIV tests. Less frequently mentioned tests were also less likely to be matched to claims. Inclusion of secondary diagnosis as an additional matching criterion improved the results slightly (Table 33).

Table 33. Tests for STIs According to Claims‡, Among CEI Clients who Reported Receiving a STI Test at the Visit (n=493) †

STI	Total Clients Who Reported a Test in CEI	STI Test Confirmed in Claims (based on Procedure or Secondary Diagnosis codes)	
	n	n	%
Chlamydia	370	270	73
Gonorrhea	347	245	71
HIV/AIDS	313	212	68
HPV/Genital Warts	50	3	6
Syphilis	162	94	58
PID	32	11	34
Trichomoniasis	23	6	26
Genital Herpes	61	2	3
NGU	15	0	0
Any of the above	493	389	79

† Excludes clients not matched to claims data.

‡ Includes paid and denied claims up to 30 days after the day of the visit.

Source: 2007 Family PACT Client Exit Interview and claims data current through December 2008.

STI Treatment. Nine percent of respondents (9%, or n=134) were given medication or a prescription to treat an STI on the day of the interview (data not shown). Overall, a significantly higher percentage of males than females said they were treated (19% vs. 8%, respectively, $p<.05$). Of the 134 clients treated, 79% reported that they were treated and tested that day (an indicator of presumptive treatment), 69%

received condoms, and 57% had discussions with their provider about the need for their partner to be tested and/or treated (Table 34). These proportions were higher among male clients compared to female clients; 85% of males vs. 77% of females reported treatment on the same day, 79% of males vs. 66% of females received condoms, and 71% of males vs. 53% of females had discussion about the need for partner to be tested/treated. Among those who discussed with their provider the need for their partner to be tested or treated for STIs, 81% also discussed how their partner can get STI services.

Table 34. Other Services Received by Clients Who Said They Were Treated for an STI (n=134)

Among Clients Treated for an STI…	**n**	**%**
Client Tested that Same Day for an STI (presumptive treatment)	106	79%
Client Received Condoms	93	69%
Provider Discussed Need for Partner to be Tested/Treated for STI	77	57%
Provider Discussed How Partner Can Get STI Services (n=77)	62	81%

Source: 2007 Family PACT Client Exit Interview.

STI Treatment According to Claims Data. CEI clients were asked whether they received medication or a prescription for medication to treat an STI. We analyzed paid claims within 30 days of the visit to assess the proportion of clients who self-reported receiving STI treatment (either medication or a prescription) and who were dispensed an STI medication according to claims. Of the CEI clients matched to claims, 122 clients reported receiving STI treatment (medication or prescription) at the visit. Of those, 57% were dispensed an STI medication according to claims. This proportion was lower among clients who reported receiving a prescription for medication compared to those who reported receiving the medication on-site (51% vs. 57%, respectively, Table 35). It should be noted that medication samples and free STI drugs available through other programs or grants are not reflected in claims data; therefore, the proportion of clients treated according to claims may underestimate the actual proportion of clients who received treatment on-site. Even so, the proportion of clients who pick up their prescriptions is surprisingly low; more than two-fifths appear not to be getting needed mediation.

Table 35. Client Self-Reports of STI Treatment Confirmed by Claims Data (n=122)[†]

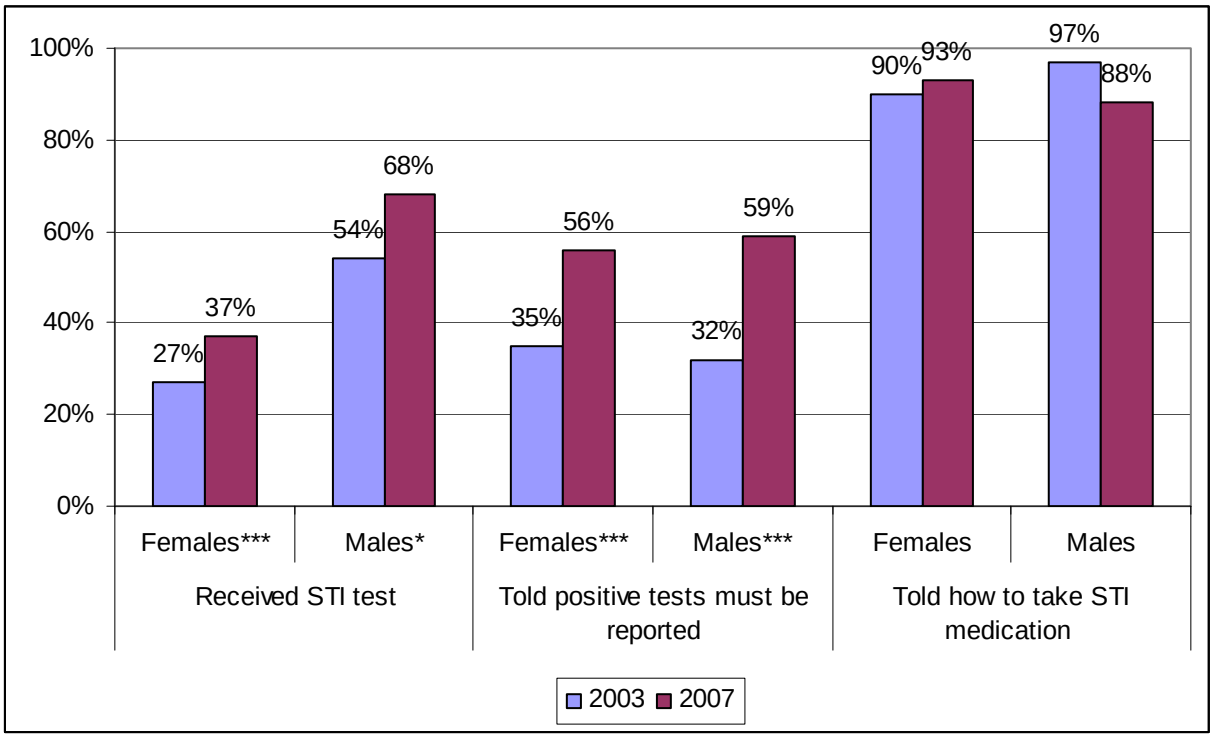
Among Clients who Reported Receiving STI Treatment, Treatment was:	**Treatment Given According to Claims[‡]**				**Total**
	Dispensed On-Site or at Pharmacy		**Not Dispensed**		
	n	%	n	%	n
Dispensed on-site	29	57	22	43	51
Prescribed	32	51	31	49	63
Both dispensed and prescribed	8	100	0	0	8
Total	69	57	53	43	122

[†] Excludes 12 clients not matched to claims data.
[‡]Includes claims for medication to treat an STI dispensed up to 30 days after the date of the visit.
Source: 2007 Family PACT Client Exit Interview and claims data current through December, 2008

- *Change from 2003 to 2007.* The proportion of clients who reported receiving an STI test at the visit increased significantly between 2003 and 2007 for both females and males (Graph I).

Among clients who were tested for an STI on the day of the interview, the proportion who were told that some positive tests must be reported to the local health jurisdiction increased significantly, from 33% in 2003 to 51% in 2007 (p<.001). Among those who were treated for an STI on the day of the interview, 93% of both the 2003 and 2007 samples reported that the doctor or nurse explained how to take their medication.

Graph H. Client Tested for an STI (based on self-report), Told Positive STI Tests Are Reported†, and Told How to Take STI Medication‡, 2003 and 2007.



*p<.05, *** p<.001
† Among clients who were tested for an STI on the day of the interview
‡ Among clients who were treated for an STI on the day of the interview.
Source: 2007 Family PACT Client Exit Interview.

STI Prevention. Almost half (47%) of all respondents received condoms or a prescription for condoms at the interview visit. Adolescents, males, non-Hispanics, and private sector clients were more likely to report receiving condoms (Appendix C, Table 63). Among clients tested for an STI, 59% received condoms or a prescription for condoms. As noted earlier, 69% of those who were treated for an STI received condoms.

- *Change from 2003 to 2007.* There was no significant difference in the percentage of clients who received condoms at the visit—47% in both years. However, the proportion of males who received condoms increased from 61% in 2003 to 71% in 2007. The female proportion remained constant at 44% (data not shown).

HIV Serostatus and Testing. Forty-two percent (42%) of all clients (Table 36) and 52% of new clients (data not shown) were asked at the visit if they know their HIV status. Clients ages 30 and older, males, Hispanics, and clients seen by private sector providers, were more likely than other groups to have been

asked if they know their HIV status. Thirty-nine percent (39%) of clients reported being offered an HIV test the day of the interview. Males were almost twice as likely to have been offered a test as female clients. Clients at private sector providers and those seen by Primary Care/Multi-Specialty providers were more likely to have been offered an HIV test than clients at public sector providers and those seen by Family Planning/Women's Health providers.

Respondents who were not offered an HIV test (n=909) were asked if they would have accepted testing had the test been offered. Almost two-thirds (61%) said they would have accepted, 9% said maybe, and 27% would have declined testing. Another 2% said that they did not know or the data was missing. Hispanics were significantly more likely than Whites or Asian/Pacific Islanders to say they would have been tested had it been offered (data not shown).

Table 36. Client Knowledge of HIV Status and Offered HIV Test, by Gender (n=1497)

Client Demographics	Asked if Knows HIV Status						Offered HIV Test					
	Female (n=1317)		Male (n=180)		Total		Female (n=1317)		Male (n=180)		Total	
	n	%	n	%	n	%	N	%	n	%	n	%
Age (years)												
19 and under	86	37	12	44*	98	38*	88	37	18	67	106	41
20-25	168	35*	29	56*	197	38*	170	36	34	67	204	39
26-30	103	43	21	58	124	45	77	32	24	67	101	37
Over 30†	156	43	47	72	203	48	122	34	48	74	170	40
Race/Ethnicity												
White‡	64	29	5	38	69	30	73	33	10	77	83	35
Hispanic	372	43*	86	66	458	47***	316	37	87	67	403	41
African American	28	33	13	65	41	40	22	26	15	79	37	36
Asian/Pacific Islander	24	27	2	29	26	27	24	29	5	71	29	30
Native American/Other	19	42	3	43	22	44	17	38	5	71	22	42
Provider Sector												
Private	209	45*	76	69*	285	50***	195	42*	77	70	272	47***
Public	306	36	33	47	338	37	262	31	47	68	309	34
Provider Specialty												
Family Planning/Women's Health	267	37	28	49	295	38	238	33	39	67	277	36
Primary Care/Multi-Specialty	247	42*	81	66*	328	47*	219	37	85	70	304	43*
Total	514	39	109	61***	623	42	457	35	124	69**	581	39

†Clients over age 30 served as the reference group.
‡ White served as the reference group.
*p<.05, ***p<.001
Source: 2007 Family PACT Client Exit Interview.

PROVIDER EFFORTS TO ENSURE CLIENT UNDERSTANDING

A key component of service quality lies in the interaction between clients and providers. Family PACT providers have the responsibility of informing their clients of their rights and options, and of any services that may be available to them and their partners. Providers also can have a strong influence in the initial adoption, effective use, and continuation of contraceptive methods.

Provider Explained Services. Seventy-one percent (71%) of clients said they were told about the services they could receive with their Family PACT card (Table 37). Hispanic clients and clients seen by private sector providers were more likely to report being informed of Family PACT services than non-Hispanic clients and those seen by public sector providers. A higher percentage of clients seen by Primary Care/Multi-Specialty providers had Family PACT services explained to them than those seen by Family Planning/Women's Health providers.

Table 37. Provider Explained Family PACT Services, by Age, Gender, Interview Language, Race/Ethnicity, Provider Sector and Specialty, and Client Status (n=1468)

Client Demographics	**n**	**%**
Age (years)		
19 and under	183	71
20+	853	71
Gender		
Female	907	70
Male	130	75
Interview Language		
English	608	71
Spanish	429	71
Race/Ethnicity		
White†	147	64
Hispanic	710	73**
African American	71	72
Asian/Pacific Islander	67	69
Native American/Other	33	65
Provider Sector		
Private	436	76***
Public	601	67
Provider Specialty		
Family Planning/Women's Health	487	63
Primary Care/ Multi-Specialty	550	78***
Client status at provider		
New	182	71
Established	854	71
Total	1037	71

† White served as the reference group.
**p<.01, ***p<.001
Source: 2007 Family PACT Client Exit Interview.

Confidentiality. One Family PACT Standard is to assure confidentiality for clients. This includes not only the protection of all client records as stipulated by HIPAA regulations,[9] but also requires that clients' personal privacy and dignity be respected, that clients be informed about confidentiality rights and that all personal information be treated as privileged communication. Awareness of confidentiality provisions is also an important measure of client access. Almost 9 in 10 clients (88%) were told that information about their visit was confidential (Table 38). There were no differences among demographic groups or provider sectors. Similarly, 90% of clients said they were "not at all" worried that someone would find out about their Family PACT visit (Table 39). Adult clients were more likely than adolescent clients to say they were "not at all worried." A higher percentage of clients seen by Primary Care/Multi-Specialty providers said they were "not at all worried," versus those at Family Planning/Women's Health providers, who were more likely to say they were "somewhat" worried. This suggests that providers specializing in Family Planning/Women's Health may have a greater need to inform their clients about the confidentiality of services than Primary Care/Multi-Specialty providers, because the purpose of a client's visit at Family Planning/Women's Health providers may be more obvious to others.

Table 38. Clients Was Told That Visit Information is Confidential, by Age, Gender, Interview Language, Provider Sector and Specialty (n=1485)

Client Demographics	**n**	**%**
Age		
19 and under	237	91
20+	1063	87
Gender		
Female	1140	87
Male	161	91
Interview Language		
English	760	87
Spanish	541	89
Provider Sector		
Private	510	89
Public	791	87
Provider Specialty		
Family Planning/ Women's Health	677	87
Primary Care/Multi-Specialty	624	88
Total	1301	88

Source: 2007 Family PACT Client Exit Interview.

- *Change from 2003 to 2007.* Although 88% of clients in 2007 were told that information about their visit was confidential, that percent was significantly lower than the 92% who were told about confidentiality at the interview visit in 2003 ($p<.01$) (data not shown).

[9] HIPAA (Health Insurance Portability and Accountability Act), enacted by Congress in 1996, required implementation of the Privacy Rule protecting personal health information (PHI) on April 14, 2003. This was followed by implementation of the Transactions and Code Sets Rule governing electronic transfer of PHI on October 16, 2003.

Table 39. How Worried That Someone Will Find Out About Visit, by Age, Gender, Interview Language, Provider Sector and Specialty (n=1478)

Client Demographics	Very		Somewhat		Not at All	
	n	%	n	%	n	%
Age						
19 and under	11	4	32	12*	218	84
20+	36	3	76	6	1104	91*
Gender						
Female	41	3	94	7	1166	90
Male	6	3	14	8	157	89
Interview Language						
English	25	3	71	8	782	89
Spanish	22	4	37	6	541	90
Provider Sector						
Private	14	3	25	4	530	93
Public	33	4	83	9*	793	87
Provider Specialty						
Family Planning/Women's Health	26	3	69	9*	678	88
Primary Care/Multi-Specialty	21	3	39	6	645	91*
Total	47	3	108	7	1323	90

* p<.05
Source: 2007 Family PACT Client Exit Interview.

Eighty-six percent (86%) of minors (younger than age 18) were aware before their visit that they did not need parental or guardian permission to receive Family PACT services (Table 40). There were no significant differences by gender, interview language, provider sector or whether the client was new or established.

Table 40. Minors' (ages 17 and younger) Knowledge Before Visit that Parent/Guardian Permission Not Needed, by Gender, Interview Language, Provider Sector (n=92)

Client Demographics	n	%
Gender		
Female	76	87
Male	3	60
Interview Language		
English	74	86
Spanish	5	86
Provider Sector		
Private	10	71
Public	69	89
Client Status		
New	23	85
Established	56	86
Total	79	86

Source: 2007 Family PACT Client Exit Interview.

- *Change from 2003 to 2007*. The percentage of clients under age 18 who knew before their visit that they didn't need their parent's permission to get services decreased from 98% in 2003 to 86% in 2007 (p<.001). Among those who knew they did not need their parent's permission, there

were no differences between 2003 and 2007 in the sources of that information. Over 80% learned about it from friends, family or health care providers (data not shown).

Need for Interpreter. The Family PACT Program's Standards stipulate that "all services shall be provided in a culturally sensitive manner and communicated in a language understood by the client." Thus, an important quality indicator is the extent to which Limited English Proficiency (LEP) clients in need of an interpreter have access to one. Eight percent (8%) of respondents (n=116) said they needed an interpreter at their visit. Among those, only three respondents did not get one. Of the 113 who had an interpreter, 95% reported that the interpreter was a clinic staff. Ninety-seven percent (97%) of those who had an interpreter said that everything in the conversation was translated, and 86% were "very confident" and 12% were "somewhat confident" that the interpretation was accurate (data not shown).

We defined a client to be LEP if the interview was conducted in Spanish and she or he reported that they were served with an interpreter or that they did not need an interpreter because the clinician spoke Spanish (excluding those who said that they did not need an interpreter because they speak English well), which resulted in 575 clients. Of those, 19% used an interpreter and 81% were able to communicate with their provider in their own language. It should be noted that LEP clients who spoke languages other than Spanish were excluded from the survey.

To evaluate the impact of interpreter services on quality of communication and history taking, we compared provider performance on selected indicators for three groups of clients: English speakers, language-concordant clients (LEP clients who were served by a bilingual provider), and language-discordant clients (LEP clients who were served with the help of an interpreter). Clients were asked a series of questions regarding their interaction with the provider (Table 41). Consistent with the expectation, both language-concordant and language-discordant clients were less likely than English speakers to report having understood everything the doctor was saying. Notably, clients served by a bilingual provider were more likely than English speakers or clients helped by an interpreter to report that they needed more time with the doctor and that the doctor discussed advantages and disadvantages of the method they were planning to use, but they were less likely to report that they were able to ask all the questions they had about birth control. English speakers were less likely than both language-concordant and language-discordant clients to report that they had been asked a series of STI risk assessment questions or to be told that they might be eligible for Medi-Cal.

Table 41. Quality of Care by Type of Interpretation Provided at the Visit (n=1420)

Quality Indicator	**English Speakers**[†] (n=845)		**Language-Concordant** (bilingual provider) (n=463)		**Language-Discordant** (interpreter) (n=112)	
	n	**%**	**n**	**%**	**n**	**%**
Client understood everything the doctor was saying	797	94	394	85***	90	80***
Client needed more time with provider	140	17	104	23*	21	19
Contraceptive counseling						
Doctor talked to client about his/her birth control needs	656	78	359	78	82	73
Client able to ask all questions about birth control[‡]	540	92	262	86*	60	90
Doctor discussed advantages of the BC method[§]	556	70	348	78*	81	76
Doctor discussed side effects of the BC method[§]	529	67	331	74*	74	69
STI Assessment: At the visit, doctor asked…						
Whether client had an STI in the past 12 months	404	48	279	61***	69	69*
About the number of sexual partners	450	53	290	63*	70	63
About gender of sexual partner	313	37	220	48	58	53
Whether client knows his/her HIV status	299	36	233	50***	56	50*
Whether client knows how to reduce risk of STI	350	42	253	55*	56	51
About client's sexual practices	326	39	199	43	50	45
Client told that he/she might be eligible for Medi-Cal	178	21	147	32***	37	34*
Client was explained how to apply for Medi-Cal[††]	113	64	95	69	26	72

[†] English speakers served as the reference group.
[‡] Among clients who had questions about birth control.
[§] Excludes pregnant females and males whose partner is pregnant.
[††] Among those who were told that they might be eligible for Medi-Cal.
*p<.05, ***p<.001
Source: 2007 Family PACT Client Exit Interview.

OTHER RISK ASSESSMENT AND WRITTEN MATERIALS CLIENT RECEIVED

Comprehensive reproductive health care includes an assessment of clients' physical and psychosocial health risks. The tables in this section show the proportions of clients who were asked about interpersonal violence (whether "anyone has been threatening you or hurting you physically"), drug, alcohol and tobacco use, diabetes and hypertension in the past 12 months (Note: Because clients were asked about experiences with risk assessment at the provider site in the past year, their answers may refer to experiences with other clinicians not seen at the interview visit.) Thirty-six percent (36%) of respondents said that during the past 12 months a provider had asked them if anyone had threatened or physically hurt them (Table 42). A higher proportion of female clients were asked about interpersonal violence than male clients. There were no other demographic differences.

Table 42. In Past 12 Months, Provider Asked Client If Threatened or Physically Hurt, by Age, Gender, Provider Sector and Specialty (n=1491)

Client Demographics	**n**	**%**
Age (years)		
19 and under	99	38
20+	432	35
Gender		
Female	484	37*
Male	48	27
Provider Sector		
Private	196	34
Public	336	37
Provider Specialty		
Family Planning/Women's Health	271	35
Primary Care/Multi-Specialty	261	37
Total	532	36

*p<.05
Source: 2007 Family PACT Client Exit Interview.

- *Change from 2003 to 2007*. There was a significant increase in the percent of clients who were asked if they had been threatened or physically hurt in the past 12 months, from 14% in 2003 to 36% in 2007 (p<.001) (data not shown). This finding reflects well on OFP's efforts to increase assessment among providers, including implementation of a standardized tool, dissemination of a *Clinical Practice Alert*, and guidelines on how to develop procedures for handling issues related to intimate partner violence at Family PACT sites.[10]

Seventy percent (70%) of respondents reported that a provider asked about their drug and alcohol use (Table 43). Males and clients interviewed at private sector and Primary Care/Multi-Specialty providers had significantly higher rates of being asked about alcohol and drug use than females, and clients seen at public sector and Family Planning/Women's Health providers. Overall, 78% of clients were asked about

[10] See www.familypact.org for a copy of the standardized medical history tool, *Clinical Practice Alert* and guidelines.

smoking tobacco. Clients at Primary Care/Multi-Specialty providers reported higher rates of being queried about smoking than clients seen by Family Planning/Women's Health providers.

Table 43. In Past 12 Months, Provider Asked Client about Drug and Alcohol Use, Smoking, by Age, Gender, Provider Sector and Specialty

Client Demographics	**Asked about Drug/Alcohol Use** (n=1485)		**Asked about Smoking** (n=1488)	
	n	%	n	%
Age (years)				
19 and under	176	68	199	77
20+	861	70	957	78
Gender				
Female	896	69	1007	77
Male	142	80*	150	83
Provider Sector				
Private	430	75*	459	80
Public	608	67	698	76
Provider Specialty				
Family Planning/Women's Health	515	66	588	75
Primary Care/Multi-Specialty	523	74*	569	81*
Total	1038	70	1157	78

*p<.05
Source: 2007 Family PACT Client Exit Interview.

- *Change from 2003 to 2007.* There was a significant increase in the proportion of clients who were asked about their alcohol and drug use, up from 29% in 2003 to 70% in 2007 (p<.001) (data not shown).

As Table 44 indicates, 65% of clients had been asked in the past 12 months if they have diabetes, and 67% were asked if they have high blood pressure. The significant differences were the same for both queries: clients age 20 and older and those seen by private sector providers had higher rates of being asked than younger clients and those seen by public sector providers.

Table 44. In Past 12 Months, Provider Asked Client about Diabetes and High Blood Pressure, by Age, Gender, Provider Sector and Specialty

Client Demographics	**Asked about Diabetes** (n=1476)		**Asked about High Blood Pressure** (n=1477)	
	n	%	n	%
Age (years)				
19 and under	147	58	154	60
20+	813	67*	841	69*
Gender				
Female	848	65	871	67
Male	112	64	124	70
Provider Sector				
Private	408	71***	424	74***
Public	552	61	571	63
Provider Specialty				
Family Planning/ Women's Health	498	65	526	68
Primary Care/Multi-Specialty	462	66	469	67
Total	960	65	995	67

*p<.05, ***p<.001
Source: 2007 Family PACT Client Exit Interview.

Received Written Educational Materials. Slightly less than half (46%) of CEI respondents reported receiving written materials at their current visit (data not shown). There were no differences by age, gender, provider sector or provider specialty. Almost all of the clients who received materials said they were in a language they could understand (99%); this is not surprising, given that clients were only interviewed in English and Spanish, the two most common languages spoken in California, in which all educational materials are available. Note that distribution of written materials is not required by Program Standards.

Table 45 shows the five topics that were mentioned most often as being covered in the written materials. Fifty-five percent (55%) of the 683 clients who received written materials got handouts about birth control, including condoms, and 43% received materials about STIs, including HIV and Hepatitis B. Twelve percent (12%) received written information about cancer screening, 11% about emergency contraception, and 5% got handouts about HPV. These percents are not mutually exclusive because respondents were asked about all of the written materials they received.

Table 45. Topics Covered in Written Materials (n=683)

Top Five Topics Covered in Written Materials	**n**	**%**
Birth control, including condoms	378	55
STI, including HIV/Hepatitis B/others	292	43
Cancer screening	83	12
Emergency Contraception	78	11
Human papilloma virus (HPV)	36	5

Source: 2007 Family PACT Client Exit Interview.

GENERAL HEALTH AND REFERRALS

Facilitating referrals of Family PACT clients to accessible sources of primary care was proposed to be added as the fourth goal of the Family PACT 1115 Medicaid demonstration waiver application. This additional waiver goal directed Family PACT providers to (a) refer Family PACT clients to primary care providers when needing primary care services, and (b) establish and increase partnerships with primary care clinics, including Federally Qualified Health Centers (FQHCs) and other community health centers to facilitate primary care referrals and follow up when needed. Family PACT providers were advised that they would be required to establish primary care referral networks and provide referrals as necessary to their Family PACT clients according to these guidelines, although the goal has not yet taken effect under a new waiver. The CEI study examined to what extent providers assess clients' primary care needs and their access to primary care services, and to what extent providers refer clients in need of these services. The following section presents CEI findings related to primary care services and referrals.

Assessment of Client Access to Primary Care. Twenty-five percent (25%) of respondents said they were asked if they have a place to go for general health care during their current visit (Table 46). Significantly more males (32%) than females (24%) were asked. When compared to Whites (21%), African American (35%) and Native American/Other (36%) clients were significantly more likely to be asked. Clients seen at Primary Care/Multi-Specialty sites were more likely to have been asked compared to those who visited Family Planning/Women's Health providers. There were no significant differences by age group or provider sector.

Table 46. In Past 12 Months, Provider Asked Client if Client Has a Place to Go for General Health Concerns, By Age, Gender, Race, Provider Sector and Specialty (n=1469)

Client Demographics	**n**	**%**
Age (years)		
19 and under	68	27
20+	305	25
Gender		
Female	316	24
Male	57	32*
Race/Ethnicity		
White†	47	21
Hispanic	252	27
African American	36	35*
Asian/Pacific Islander	18	19
Native American/Other	18	36*
Provider Sector		
Private	156	27
Public	217	24
Provider Specialty		
Family Planning/Women's Health	177	23
Primary Care/Multi-Specialty	196	28*
Total	373	25

† White served as the comparison group.
*p<.05
Source: 2007 Family PACT Client Exit Interview.

- *Change from 2003 to 2007.* Twenty-five percent (25%) of respondents in 2007 reported being asked by their Family PACT provider if they have a place to go to for general health care, compared with only 18% in 2003.

Clients' Usual Source of Care. Over one-quarter (27%) of clients reported that they have no usual source of general health care (Table 47) and a similar proportion (26%) said their Family PACT provider is their usual source of care, 24% go to a private doctor's office, 12% go to a neighborhood, county or government clinic, and about 8% go to the hospital emergency room for general health care. An additional 2% go to a school-based health center, and 1% go some other place.

- *Change from 2003 to 2007.* Table 47 shows the distribution of where clients go for general health care. The largest proportion of respondents in both 2003 and 2007 said they have no usual source of general health care (29% and 27%, respectively). There was a significant increase in the percent who said their Family PACT provider is their usual source of general health care, from 18% in 2003 to 26% in 2007. Some of the changes noted in this section may be due to the different distribution of public and private sector providers in the 2003 and 2007 samples.

Table 47. Usual Source of General Health Care, 2003 and 2007

	2003 (n=1464)		**2007** (n=1482)	
Source of General Health Care	n	%	n	%
No place	421	29	404	27
Family PACT provider	268	18	383	26***
Private doctor/Kaiser/other HMO/Urgent care	384	26	352	24
Neighborhood/county/government clinic	186	13	184	12
Hospital emergency room	151	10	114	8
School-based center/student health	29	2	33	2
Other	25	2	12	1

***p<.001
Source: 2007 Family PACT Client Exit Interview.

Primary Care Needs. Thirty-nine percent (39%) of clients (n=588) said they had a health concern in the past 12 months that was not related to family planning (data not shown). Seven conditions accounted for 72% of the concerns reported by respondents: cold/sore throat/flu (33%); headaches (10%); skin infection (7%); stomach/intestinal problems (7%); back problems (6%); diabetes (5%); and asthma (4%). A variety of other conditions accounted for the remaining 28%. Among those who needed care for their non-family planning related health concerns, 59% reported that they had received care for all concerns, 7% for most concerns, and 33% did not get care for their health concern.

Payment for non-Family PACT services. Among the 73% of clients (n=1,078) who said they do have a usual place to go for general health concerns, 63% said they or their parents pay for their general health care out-of-pocket. Thirty percent (30%) said they have insurance that covers most or all of the cost, and 7% said the doctor or clinic covers most or all of the cost. Among all clients regardless of whether they had a usual source of primary care, adolescents were significantly more likely to say they have insurance to cover their primary care needs (34%), compared to 25% of clients ages 20-25, 16% of clients ages 26-30 and 14% of clients over age 30. It is likely that younger clients seek Family PACT services to protect

their confidentiality at a higher rate than older clients, despite having insurance. It is also possible that these younger clients erroneously said they were insured because they considered their enrollment in Family PACT as their primary care insurance. It is likely that for the small proportion (19%) of adults (age 20 and older) who reported being insured also had confidentiality concerns or difficulty getting their birth control method through their primary care insurance.

- *Change from 2003 to 2007*. There was a significant increase in the proportion of clients who said they or their family pay for general health care services out-of-pocket, from 50% in 2003 to 63% in 2007 ($p<.001$). That rise was reflected in a decrease in the percent who said insurance or the provider pays for their care, decreasing from 50% in 2003 to 37% in 2007 ($p<.001$).

Referrals. About ten percent (10%) of all clients (n=157) reported being referred to another provider for non-family planning concerns within the past 12 months. Of these, 56% received written contact information so they could make an appointment, 25% had the appointment made for them by the Family PACT provider, and 19% were told where to go but were not given written information. Of clients who had a non-family planning related health concern in the past 12 months (n=588), 14% received a referral for general health care services. Of those who had a general health concern and did not get a referral, 30% indicated their Family PACT provider as their usual source of care and may have not needed a referral; another 42% indicated private doctor's office, county or school-based clinic, or a health maintenance organization as their usual source of care and also may not have needed a referral. Therefore, an estimated 28% of clients were not referred to service although they had a current general health concern and no usual source of care.

Fifty-six percent (56%) of clients who were referred were told what paperwork they needed, and 57% were told whether or not they would have to pay for the care (data not shown). Seventy-nine percent (79%) were encouraged to call the referring provider if they had any questions about the referral. Among clients who had no usual source of general health care, or their usual source was not their Family PACT provider (n=1114), 10% received a referral to another clinic or doctor for general health care concerns—the same percent as the overall sample.

- *Change from 2003 to 2007*. There was a significant increase in the proportion of respondents who were referred by their Family PACT provider to another doctor for general health concerns, from 6% in 2003 to 10% in 2007 ($p<.001$) (data not shown). Although in 2007 the majority of those referred (56%) still received written contact information for the referral, that percent was significantly lower than it was in 2003 (78%, $p<.001$). The proportion of clients whose provider made the referral appointment for them rose from 10% in 2003 to 25% in 2007 ($p<.01$). This difference may also be to nonequivalent provider samples for each survey year.

Medi-Cal Eligibility. Twenty-six (26%) percent of respondents reported that someone at the Family PACT provider's office told them they may be eligible for Medi-Cal (data not shown). This proportion was significantly higher among clients served by private sector and Primary Care/Multi-Specialty providers compared to public sector and Family Planning/Women's Health providers (31% for private vs. 22% for public, $p<.001$; 31% for Primary Care/Multi-Specialty vs. 21% for Family Planning/Women's Health). Of clients who were told that they might be eligible, 66% were instructed on how to apply for Medi-Cal.

Client Exit Interviews provide a unique opportunity to assess how clients learn about Family PACT providers, why they choose their providers, and what physical barriers they may be experiencing in accessing care, such as transportation and wait time. This information is useful for program planning and outreach. In this section we report how clients selected their providers, what modes of transportation they used to get there and how long they had to wait to be seen.

How Client Found Provider. Table 48 shows how clients first heard about the provider they were seeing on the day of the interview. They could mention up to three ways. The most often-mentioned way was through a family member, friend or partner (59%), followed by "passing by it" (16%), and through a referral (7%). An additional 5% found out about the provider through a presentation at school, and another 5% through a TV/radio/billboard/kiosk advertisement. Eight percent (8%) of clients found the provider through "other" means, including the phonebook (n=22) and Family PACT 1-800 number (n=13).

Table 48. How Client Found Provider, by Age

How Client Found Provider†	Age (Years)				Total (n=1489)	
	19 and Under (n=262)		20 + (n=1226)			
	n	%	n	%	n	%
Family/friend/partner	159	61	712	58	872	59
"Passed by it"	36	14	202	16	238	16
Referred by another provider	13	5	84	7	97	7
Presentation at school	23	9	51	4	74	5
TV/radio/billboard/kiosk ad	8	3	66	5	74	5
Internet, not Family PACT site	8	3	53	4	61	4
Family PACT website	2	1	20	2	22	1
Other	25	10	92	8	117	8

†Totals are greater than 100% because clients could give more than one answer.
Source: 2007 Family PACT Client Exit Interview.

- *Change from 2003 to 2007.* We compared the most common ways respondents found their Family PACT providers in 2003 and in 2007, although the variables are not strictly comparable since the 2003 interview asked for the main source of information about the provider, while the 2007 interview asked for up to three sources. The majority of clients in both years (58% and 59%, respectively) heard about their providers through family members and friends (data not shown). There were significant ($p<.05$) increases in the percents who said they "passed by it" (12% in 2003 to 16% in 2007), heard about it through their school (from 3% to 7%), or found it on the Internet (Family PACT site and other sites combined; 3% to 5%). The increase in the school category may be explained by the fact that the 2007 sample of providers included university health clinics, whereas the 2003 sample did not. There was a significant decrease in

the percent who reported finding the provider in the phonebook—from 5% in 2003 to 2% in 2007 ($p<.05$).

Reasons Clients Chose Provider. When asked why they chose to come to the provider, clients could mention up to three reasons. Table 49 shows the reasons that were mentioned most often. In 2007, 45% said they chose the provider because of the convenient location, and 20% came on the recommendation of friends or family. Twenty-four percent (24%) said they chose the provider because the care is good, 14% mentioned free or low cost services, 7% said they like or trust the staff, and 4% said they chose the provider because the services are confidential.

Table 49. Reasons Client Chose Provider, 2003 and 2007

	2003 (n=1468)		**2007** (n=1489)	
Why Client Chose Provider	n	%	n	%
Convenient location	562	38	671	45*
Care is good	150	10	362	24***
Friend/family recommended it	246	17	296	20*
Free/low cost services	189	13	216	14
Like/trust staff	63	4	104	7*
Confidential services	85	6*	60	4

*$p<.05$, ***$p<.001$
Source: 2007 Family PACT Client Exit Interview.

- *Change from 2003 to 2007.* The reasons for choosing their Family PACT providers changed between 2003 and 2007, although in 2003 only one main reason was collected and in 2007 respondents could mention up to three reasons (as with the "how found provider" variable discussed above). There was an increase in the percent who chose the provider because of convenience (from 38% to 45%), and increases in the proportions who said "the care is good" (from 10% to 24%), recommendations of family members and friends (from 17% to 20%) and that they like or trust the staff (from 4% to 7%) as reasons they chose their current Family PACT provider. There was a decrease in the proportion that cited confidential services as a reason for choosing the provider—down from 6% in 2003 to 4% in 2007.

Transportation. The distribution of transportation modes to the provider is shown in Table 50. Almost three-fourths (73%) of respondents drove or were driven in private vehicles. Thirteen percent (13%) walked, and another 13% took public transportation. A greater percentage of those 20 and older drove themselves, and a greater percentage of adolescents were driven by someone else.

Table 50. Transportation to Clinic on Day of Interview, by Age (n=1497)

Mode of Transportation	Age (years)				Total	
	19 and Under		20 and Older			
	n	%	n	%	n	%
Drove myself	103	40	698	57*	801	54
Driven by someone else	82	32*	201	16	283	19
Public transportation	30	12	164	13	194	13
Walked	37	14	152	12	189	13
Clinic provided transportation	5	2	14	1	7	<1
Bike, skate, scooter	1	<1	4	<1	5	<1
Taxi	1	<1	1	<1	2	<1
Total	259	100	1234	100	1497	100

*p<.05
Source: 2007 Family PACT Client Exit Interview.

On average, clients spent about 17 minutes to get to their provider (Table 51). It took adults an average of four minutes longer than it took adolescents (18 vs. 14 minutes), and it took Spanish-speaking clients an average of five minutes longer to reach the provider than English-speaking clients (20 vs.15 minutes).

Table 51. Travel Time to Provider, by Age and Interview Language (n=1494)

Client Demographics	Mean # of Minutes	Standard Deviation
Age (years)		
19 and under	14	11.75
20+	18*	15.03
Interview Language		
English	15	11.71
Spanish	20*	17.61
Overall Average Time	17	14.56

*p<.05
Source: 2007 Family PACT Client Exit Interview.

Waiting Time at Provider. Clients waited an average of 36 minutes to be seen by the provider. Those at public providers waited significantly longer than those at private providers (39 vs. 31 minutes, respectively, p<.05), and those at Family Planning/Women's Health providers waited longer than those at Primary Care/Multi-Specialty providers (40 vs. 32 minutes, respectively, p<.001).

- *Change from 2003 to 2007.* The average length of time clients waited to be seen on the day of the interview decreased from 48 minutes in 2003 to 36 minutes in 2007 (p<.001) (data not shown). This may partly be due to the differences in provider sample – in 2007, 39% of interviews were collected at private provider sites compared to 25% in 2003. Private provider sites had shorter waiting times in 2007 but not in 2003.

CLIENTS' ABILITY TO PROVIDE DOCUMENTATION

The Centers for Medicare and Medicaid Services (CMS) and the State of California are currently negotiating the terms and conditions of the Family PACT waiver renewal, which may impact eligibility verification requirements. CMS has indicated that Family PACT applicants may be required to give their Social Security number (SSN) and evidence of their citizenship and identity by providing original or certified documents such as a birth certificate, passport, or picture ID, and that income eligibility must be verified by an income statement. The CEI assessed to what extent these requirements would impact Family PACT clients.

Client Asked for Social Security Number. As part of the Family PACT enrollment process, providers must ask all new clients for their SSN. Although currently clients unable to provide an SSN are not denied services, this may become a new eligibility requirement as part of stricter eligibility verification requirements to get federal financial participation for program costs. Table 52 shows that 71% of new clients were asked for their SSN. Clients interviewed in English were more likely than clients interviewed in Spanish to be asked for their SSN (79% vs. 59%, respectively). Ninety percent (90%) of White clients were asked for their SSN whereas only 64% of Hispanic clients were. Public sector providers were more likely than private providers to ask new clients for their SSN, and Family Planning/Women's Health providers were more likely than Primary Care/Multi-Specialty providers to ask for SSNs.

Table 52. New Client Was Asked for Social Security Number, by Age, Interview Language, Race/Ethnicity, Provider Sector and Specialty (n=256)

Demographic	**n**	**%**
Age (years)		
19 and under	58	78
20+	125	69
Interview Language		
English	131	79***
Spanish	52	59
Race/Ethnicity		
White†	45	90
Hispanic	96	64***
African American	13	72
Asian/Pacific Islander	17	81
Native American/Other	8	67
Provider Sector		
Private	66	60
Public	117	81***
Provider Specialty		
Family Planning/Women's Health	107	84***
Primary Care/Multi-Specialty	76	60
Total	183	71

† White served as the reference group.
***p<.001
Source: 2007 Family PACT Client Exit Interview.

Clients' Comfort Giving out Social Security Number. A Likert scale was used to assess clients' comfort level with giving out their social security number, with 1 equal to "very comfortable" and 5 equal to "very uncomfortable." All clients, both new and established, who were asked for their SSN were included in this analysis (n=618). Overall, more than half (53%) felt very comfortable providing their SSN, 18% felt somewhat comfortable, and 20% felt either somewhat or very uncomfortable. Table 53 shows the responses to this question; statistical testing was done using the mean scores of the 5-point scale. There were significant differences by interview language and race/ethnicity. Hispanics and clients who were interviewed in Spanish were less comfortable giving out their SSN than clients in other ethnic/racial groups and those interviewed in English. There were no differences by age or provider sector.

Table 53. Clients' Comfort Giving Social Security Number, Among Clients Asked for SSN, by Age, Interview Language, Race/Ethnicity and Provider Sector (n=618)

Client Demographics	**Very Comfortable**		**Somewhat Comfortable**		**Neither Comfortable nor Uncomfortable**		**Somewhat Uncomfortable**		**Very Uncomfortable**	
	n	%	n	%	n	%	n	%	n	%
Age (years)										
19 and under	75	59	19	15	7	6	13	10	13	10
20+	251	51	90	18	51	10	73	15	25	5
Interview Language										
English	264	60	83	19	18	4	50	11	23	5
Spanish	63	35	26	14	40	22	36	20	15	8
Race/Ethnicity										
White†	92	67	19	14	7	5	13	9	7	5
Hispanic*	149	43	65	18	49	14	57	16	29	8
African American	27	73	4	11	1	3	5	13	0	0
Asian/Pacific Island.	33	62	13	25	1	2	5	9	1	2
Native Amer./Other	19	63	6	20	0	0	4	13	1	3
Provider Sector										
Private	90	50	30	17	25	14	30	17	4	2
Public	237	54	79	18	33	8	56	13	34	8
Total	327	53	109	18	58	9	86	14	38	6

† White served as the reference group.
p<.05 (based on mean score, not percents)
Subtotals may not always match due to missing responses. Row percents may not add up to 100% due to rounding.
Source: 2007 Family PACT Client Exit Interview.

Difficulty of Providing Documentation. Clients were asked how difficult it would be for them to bring a picture ID, birth certificate, passport, and income statement to the clinic. Clients responded on a 6-point Likert scale, with 1 equal to "very easy," 5 equal to "very difficult" and 6 equal to "don't have one/impossible to provide." For statistical testing, the responses were combined into two groups: (1) very or somewhat difficult or don't have, and (2) all other responses excluding missing, refused and Don't Know. Overall, clients reported that a passport would be the most difficult document to provide, with 59% of clients reporting that it would be very or somewhat difficult to provide it or that they don't have it (Table 54). Picture ID appears to be the most accessible document as only 13% of clients responded that it would be difficult for them to provide it or that they don't have it.

Fifty-six percent (56%) of adolescent clients reported it would be somewhat or very difficult to provide an income statement or that they don't have it, compared to 37% of adult clients (p<.05), probably because a smaller proportion of adolescents work compared to adults. Spanish-speakers would have a harder time providing a picture ID and passport than clients who were interviewed in English. Twenty-five percent (25%) of Spanish-speaking clients reported it would be somewhat or very difficult to provide a picture ID or that they don't have one, and 67% reported that it would be somewhat or very difficult to provide a passport or that they don't have one, compared to 4% and 54% of English speakers, respectively; however, English-speaking respondents would have a harder time providing a birth certificate than Spanish-speakers. Hispanics and Native Americans and Others will have more difficulties providing a picture ID compared to White clients. A passport would be more difficult to provide for Hispanic, African American, and Asian/Pacific Islander clients compared to Whites. However, a birth certificate would be easier for Hispanics and African Americans to provide, compared to Whites. There were no racial/ethnic differences in ability to provide an income statement. By provider sector, it would be more difficult for clients at a private provider to show a picture ID and passport than it would be for those at a public sector provider.

Table 54. Difficulty of Providing Documentation, by Age, Interview Language, Race/Ethnicity, Provider Sector (N=1497)

Client Demographics	**Somewhat or Very Difficult to Provide or Do Not Have Documentation**							
	Picture ID		**Birth Certificate**		**Passport**		**Income Statement**	
	n	%	n	%	n	%	n	%
Age (years)								
19 and under	32	12	69	26	153	59	145	56*
20+	162	13	302	24	730	59	450	37
Interview Language								
English	39	4	255	29***	473	54	339	40
Spanish	155	25***	117	19	410	67***	256	42
Race/Ethnicity								
White†	7	3	88	37	121	51	98	42
Hispanic	177	18***	206	21***	607	61*	385	39
African American	4	4	16	15***	77	75***	44	42
Asian/Pacific Islander	1	1	43	44	37	38*	42	44
Native American/Other	5	10*	14	26	34	65	17	33
Provider Sector								
Private	116	20***	134	23	366	64*	232	40
Public	78	8	238	26	517	57	363	40
Total	194	13	372	25	883	59	595	40

† White served as the reference group.
*p<.05, ***p<.001,
Source: 2007 Family PACT Client Exit Interview.

Overall, clients' satisfaction with Family PACT services was very high. Ninety-one percent (91%) of respondents said they were "very satisfied" with the services they received on the day of the interview, and an additional 8% were "somewhat satisfied" (data not shown). A total of six respondents said they were neither satisfied nor dissatisfied, seven said they were somewhat dissatisfied, and only two said they were very dissatisfied. There were no statistical differences in the level of satisfaction by age or gender group. Hispanic clients reported significantly higher rates of satisfaction than other ethnic/racial groups. Ninety-four percent (94%) of Hispanic clients reported to be "very satisfied" with the services received that day compared to 85% of Whites, 88% of African Americans, 86% of Asian/Pacific Islanders, and 90% of Native American/Other clients**.**

Satisfaction with Privacy. Table 55 shows the levels of satisfaction with privacy when speaking to non-clinical (e.g., receptionist) and clinical (e.g. doctor or nurse) staff. Overall, 84% were "very satisfied" with the privacy when speaking to non-clinical staff, and 97% were "very satisfied" with privacy when speaking with a clinician. While the level of satisfaction with privacy when talking with non-clinical staff was lower than when speaking to a clinician, both rates were very high.

Table 55. Satisfaction with Privacy When Speaking to Staff (n=1496)

Client Satisfaction with Privacy…	**Very Satisfied**		**Somewhat Satisfied**		**Neither**		**Somewhat Dissatisfied**		**Very Dissatisfied**	
	n	%	n	%	n	%	n	%	n	%
When Speaking to Non-Clinical Staff	1256	84	177	12	20	1	35	2	8	<1
When Speaking to Clinical Staff	1443	97	43	3	2	<1	4	<1	1	<1

Source: 2007 Family PACT Client Exit Interview.

- *Change from 2003 to 2007.* Although there was a high level of satisfaction in 2003, clients' overall satisfaction with the Family PACT services they received that day increased between 2003 and 2007 (Table 56). Ninety-eight percent (98%) of clients in 2003 and 99% in 2007 said that they were, overall, very or somewhat satisfied with services they received. There was also a significant increase in satisfaction with the level of privacy they had when speaking with non-clinical staff: 91% in 2003 and 96% in 2007 said that they were very or somewhat satisfied with the level of privacy they had when speaking with receptionist and other non-clinical staff. Satisfaction with the level of privacy while talking to the doctor or nurse was nearly 100% in both years—99% in 2003 and nearly 100% in 2007 said they were very satisfied or somewhat satisfied with the privacy they had while talking with the doctor or nurse. Nearly all (98% and 99%) respondents in both years said they would recommend their provider to others.

Table 56. Client Satisfaction with Services, 2003 vs. 2007

Client Satisfaction	2003 (n=1472)		2007 (n=1496)	
	n	%	n	%
Very or somewhat satisfied with privacy				
When spoke with non-clinician staff	1341	91	1433	96*
When spoke with doctor or nurse	1457	99	1486	100
Completely or somewhat agree that…				
The people who work here are courteous and helpful	1415	96	1468	98*
The people who work here make an effort to find out my needs	1364	93	1426	95*
Staff treated me with respect	1453	99	1480	99
I felt comfortable in the waiting room	N/A	N/A	1380	92
Completely or somewhat disagree that…				
I needed more time to talk to the doctor/nurse	1058	72	1119	75
Very or somewhat likely…				
To return to this clinic/doctor in the future	1442	98	1476	99
Would recommend this clinic/doctor to family or friend	1446	98	1482	99
Overall, very or somewhat satisfied with services received today	1440	98	1482	99*

N/A= not available because the question was not asked in the 2003 survey.
*$p<.05$
Source: 2003 and 2007 Family PACT Client Exit Interviews.

CONCLUSIONS

Ten years after the expansion of the Family PACT Program that made contraceptive and STI services available to millions of low-income Californians, interviews with program clients indicate that Family PACT has been very successful in providing an array of services to its enrollees. Findings from the 2007 CEI study show that clients continue to receive comprehensive information about birth control options, and the majority leave their Family PACT visits with effective methods for preventing unintended pregnancies. A number of statistically significant changes occurred between 2003 and 2007 in the types of services received and in client satisfaction with care. Almost all of the changes indicated improvements in the program, both in clinical services and in client ratings of their Family PACT providers. The major findings and conclusions from the CEI study are listed below by evaluation question.

1) **Are Family PACT services accessible to all clients and in particular to adolescents and males?**

   Study findings indicate that Family PACT clients are in need of contraceptive methods, as most men and women surveyed, particularly adolescents, want to wait to have a/another child. If Family PACT clients were to lose their coverage, they report that their use of low-efficacy methods would more than double, potentially leading to higher rates of unintended pregnancies in California. This indicates continued need for the program's services. Moreover, wait times at provider sites were low and showed improvements since 2003, indicating that Family PACT providers are increasingly serving their clients in a timely manner, thereby facilitating client access.

   The CEI data suggest that issues related to confidentiality generally do not pose a barrier for Family PACT clients, as most (88%) were told that that information about their visit was confidential, nearly all were "not at all" worried that someone would find out about their visit, and 86% of adolescents knew they didn't need parental permission to get services. Males did not differ significantly from females on these measures. However, while these three confidentiality measures were high, they had decreased significantly since the previous survey conducted in 2003. This decrease may in part be a result of recent California initiatives which have threatened to limit adolescents' access to safe and confidential reproductive healthcare,[11] despite the program's consistent standards to promote and ensure client confidentiality. Furthermore, clients seen by Family Planning/Women's Health specialty providers and, not surprisingly, adolescents, had greater confidentiality and privacy concerns than adults and clients seen by Primary Care/Multi-Specialty providers. This suggests a need to encourage providers working with adolescents, and Family Planning/Women's Health specialty providers to evaluate whether clients are told about confidentiality provisions, whether their patients' confidentiality and privacy is ensured in their practice, and to improve these efforts if needed. Outreach and education efforts should continue to assure adolescents about the confidentiality of services and inform them that they do not need parental permission to access services.

[11] Propositions regarding parental notification for abortion by minors have been put on the ballot in California in 2005 and 2006, but both have failed.

It is unclear to what extent other programs, such as the OFP's TPP programs played a role in bringing adolescent clients to a Family PACT provider. According to this study, 9% of adolescents heard about their Family PACT provider through a presentation at school. Most adolescents however (61%), reported that they heard about the site via a friend or family member, indicating that "word-of-mouth" is the most powerful outreach tool. The difficulty lies in better understanding whether programs or outreach workers may have played a role, either directly or indirectly, in the friend or family category—whether a friend heard about the program from an outreach worker and passed it on. Further research is needed to better understand the role of outreach and education in clients' access of services. The recent elimination of OFP's Male Involvement Program and TSO programs, and drastic budgetary reductions in the I&E program[12] may result in fewer teens hearing about Family PACT and thus result in adolescent enrollment declines. OFP should continue to monitor any changes in enrollment as it does through the Family PACT Program's Annual Report, and consider studying to what degree adolescent enrollment declines can be attributed to the reduction and elimination of some of these TPP programs. Also, a future client exit interview study could assess any changes in how adolescents first heard about Family PACT.

2) **Are Family PACT clients receiving services that are of high quality?**

In both 2003 and 2007, 95% of female respondents left with a medium- or high-efficacy method of birth control, and about half of new clients in both years received a method that was more effective than the one they came in with. Nearly all clients who felt a need to discuss birth control, did so with their provider and reported they were able to ask all of the questions they wanted. In addition, few changes were observed in the provision of emergency contraception from 2003 to 2007, despite OFP's efforts[13] to remind providers about the importance of offering advance provision of EC for clients at higher risk of an unintended pregnancy. Additional efforts to disseminate this information to providers and encourage EC provision are recommended, for example, during case study presentations in webcasts as well as in any other provider trainings as appropriate.

Another area where providers can improve is in the information they give female clients about IUCs. It is among the most effective birth control methods but its use in the US is considered low.[14] In Family PACT, 6% of women received IUC-related services in FY 2006-07. Responses to the 2007 CEI showed that many women have limited or incorrect information about IUCs. The primary reason for not using an IUC was lack of information. Continued efforts to educate and inform providers regarding IUCs, including overcoming potential misinformation regarding who should and should not use IUCs, and the importance of relaying this information to their clients, is encouraged. Current IUC materials available to providers have been updated.

---

[12] See footnote 3.

[13] OFP issued an "Emergency Contraception" *Clinical Practice Alert* in 2005.

[14] Mosher WD, Martinez GM, Chandra A, Abma JC, Willson SJ. Use of contraception and use of family planning services in the United States: 1982-2002. *Adv Data.* Dec 10 2004(350):1-36.

Since 2003, OFP has implemented a series of efforts to increase and standardize risk assessments,[15] and to increase and improve the frequency of appropriate screening for STIs[16] and intimate partner violence.[17] These efforts have had an impact on provider practices as evidenced by significant improvements in these areas. In 2007, more clients were asked about domestic violence, alcohol and drug use, their STI history, and the number and gender of their sexual partners, compared with the percentage asked in 2003.

STI testing, treatment and prevention continued to be a key component of clients' experiences with Family PACT. The percentage of clients who were tested for an STI on the day of the interview rose from 31% in 2003 to 41% in 2007. There was also an increase in the proportion of those tested who were told about reporting requirements (from 33% in 2003 to 51% in 2007). However, the proportion of clients prescribed STI medication who eventually picked up their prescriptions was surprisingly low indicating a need for better follow-up to ensure that clients are being treated effectively. Further research is also needed to evaluate whether low prescription pick up rates are due to barriers in access. OFP should continue to encourage routine sexual risk assessments to inform appropriate testing for STIs through dissemination of standardized risk assessment/medical history tools and screening guidelines to providers. These materials should be reviewed and updated regularly to assure that they are current.

One of the strengths of the Family PACT Program is its diverse provider mix. Clients receiving care at private provider offices and Multi-Specialty/Primary Care sites were significantly more likely than those seen by public providers and Family Planning/Women's Health specialists to report that they had Family PACT services explained to them, had discussed high efficacy methods, received contraceptive counseling, and were screened for certain STI risks. Thus, public sector and Family Planning/Women's Health specialists may require additional support in order to improve on these quality of care indicators. These findings will be shared with Family PACT providers to continue to raise awareness of this disparity.

3) **Does Family PACT facilitate clients' access to primary care services?**

There was an increase in the proportion of clients referred by their provider for general health concerns (from 6% in 2003 to 10% in 2007), and in the quality of the referrals (that is, more providers scheduled the referral appointment for the client), indicating that Family PACT providers' efforts to increase clients' access to primary care services has improved overall. Clients were asked about their sources of care for general health concerns that are not covered by Family PACT and how they pay for that care. Over one-quarter of clients in both survey years said they have no usual source of care, but there was a significant increase in the proportion who named their Family PACT provider as their usual source of care, as well as in those who were asked by their provider if they have a place to go for general health care. In addition, one quarter of clients reported that their provider told them they may be eligible for Medi-Cal, of whom two-thirds were instructed on how to apply, indicating that

[15] OFP developed and disseminated standardized medical history and exam forms.
[16] OFP issued a "Gonorrhea and Chlamydia Screening" *Clinical Practice Alert* in 2006.
[17] OFP issued a "Intimate Partner Violence" *Clinical Practice Alert* in 2006, and disseminated "Identifying and Responding to Domestic Violence" by the Family Violence Prevention Fund and "Guidelines for Developing Office Policies and Procedures for Victims of Intimate Partner Violence at Family PACT sites"

Family PACT providers are appropriately screening clients for other insurance programs. One of the most significant changes reported by respondents was in how they pay for general health care. In 2003, 50% of those who said they have a place to go for general health care said they or their families pay for it, and 50% said insurance or the provider pays for it. By 2007, those proportions had shifted to 63% self-pay and only 37% covered by insurance or the provider. The real proportion of those who self-pay may be even higher since those who said they don't have a place to go may also self-pay. There is an increasing need for free or low-cost primary care services for Family PACT clients, as over one-quarter are without a usual source of care, and over one-third are not getting care for their primary care needs. OFP materials, such as tip sheets that guide providers in making primary care referrals should continue to be developed, updated and disseminated.

4) **How would impending DRA verification requirements impact Family PACT clients?**

While most Family PACT clients did not report great difficulty in providing documentation, if stricter eligibility verification requirements were implemented, many Family PACT clients may be denied services because they lack the necessary type of documentation. These requirements would have a disproportionate impact on Hispanic clients. Approximately one-quarter of Spanish-speaking (25%) clients and one-fifth of Hispanic (18%) clients reported that it would be somewhat or very difficult or not possible to provide a picture ID, while for White and English-speaking clients, this was as low as 3%-4%. In addition, Hispanic (24%) and Spanish-speaking (28%) clients felt significantly less comfortable giving out their Social Security number than White (14%) and English-speaking (16%) clients. While we expected adolescent clients to report greater discomfort and difficulty providing needed documentation than adults, they only reported greater difficulty providing an income statement, likely because many are unemployed. They were not significantly different than adults on any other documentation measure.

5) **Are Family PACT clients satisfied with services received?**

Satisfaction levels were even higher in 2007 than they were in 2003. In 2007, 91% of respondents said they were "very satisfied" with their services overall, compared with 88% in 2003. Satisfaction with the level of privacy while talking with non-clinical staff rose during the four-year period, and remained very high for privacy when talking to the doctor or nurse (95% in 2003 and 97% in 2007). Satisfaction ratings, although high in 2003, increased on three measures: whether provider staff were courteous and helpful, whether provider staff made an effort to find out the client's needs, and clients' overall satisfaction with services. Ratings were high and not significantly different on whether the provider treated the client with respect, whether the client would return to the clinic in the future, and whether the client would recommend this provider to family or a friend. The average waiting time to be seen by the provider decreased from 48 to 36 minutes. These continuing high levels of satisfaction suggest that overall, clients are happy with the quality of services received and are likely to continue using Family PACT services, which is imperative to ensure continuous contraceptive protection and to prevent STI transmission.

As reflected in this reports' findings, the Family PACT Program has continued to either maintain or improve a number of quality indicators that appear to have contributed to high levels of satisfaction. Both through self-report and client billing data, there are overall consistencies reflected in these findings. Areas

for continued improvement include STI screening and follow-up treatment, risk assessments, assurance of confidentiality, advance provision of EC, and strengthening education in long-acting reversible contraceptive methods. The overall positive results across a wide range of provider types and geographic areas of the State, as well as the multi-ethnic profile of clients, demonstrates not only the Family PACT Program's successful implementation but also strong commitment to continuous quality improvement.

APPENDIX A

LITERATURE REVIEW

Client Interviews as a Data Source. In-person surveys or patient interviews are particularly useful in measuring the subjective aspects of service provision that are difficult to measure with other evaluation methodologies, such as chart reviews or administrative data. In particular, client interviews can be used to answer questions regarding clients' perception of the provider-client interaction, and their experiences accessing services and with service delivery. Such data cannot be easily gathered through chart abstraction or administrative data. The structured, in-person survey administered to clients immediately following a visit allows more depth and understanding, by allowing the interviewer to follow-up on questions and ensure that clients understand the questions. Some of the major benefits of client interviews are that they are flexible, allow for open-ended questions, do not require that the respondent be able to read or write, allow the researcher to explain the study in person, and reach higher response rates as compared to mail in surveys.[18] However, interviews can be expensive and take a long time to arrange and conduct. Some respondents may give biased responses when face-to-face with a researcher, and suffer from recall bias.

Quality of Care. Most methods of defining and measuring quality of care are based on the six-element framework introduced in a seminal paper by Judith Bruce in 1990.[19]

- Choice of birth control methods
- Information given to users
- Technical competence
- Interpersonal relations
- Follow-up or continuity mechanisms
- Appropriate constellation of services

These elements represent aspects of services that clients experience as critical. The definition of quality provided within this framework has been accepted by most family planning organizations worldwide, and has received perhaps the strongest endorsement from the United States Agency for International Development (USAID) Office of Population and consequently from many cooperating agencies funded by USAID. While other frameworks have been developed since, they tend to expand upon the framework laid forth by Bruce.[20,21]

[18] Salant P, Dillman DA. 1994. How to Conduct Your Own Survey. NY: John Wiley and Sons.
[19] Bruce J. 1990. Fundamental Elements of the Quality of Care: A Simple Framework. *Studies in Family Planning*, 21 (2): 61-91.
[20] Askew I, Mensch B, Adewuyi A. 1994. Indicators for Measuring the Quality of Family Planning Services in Nigeria. *Studies in Family Planning*, 25 (5): 268-283.

This definition of quality of care encompasses both objective and subjective components. Objectively, products or services delivered should meet or surpass standards of safety, function, cleanliness and efficiency. This aspect reflects the medical community or provider perspective. In more recent years, the subjective side of quality, or the clients' opinions of their experience with the services, has been recognized as a valuable aspect of assessing quality and informing efforts to improve services and utilization.[22] For the purposes of this study, quality of care was measured by asking clients about the quality of interactions with the provider and staff, the degree to which they were informed about the services received, and whether they had access to the services they needed or wanted.

Client Satisfaction. Client exit interviews are particularly useful in assessing the subjective aspects of service provision that are difficult to measure with other evaluation methodologies. The importance of the personal experience of care and preference is reflected in the correlation between client satisfaction and compliance and continuity of care. Satisfied clients are more likely than dissatisfied clients to continue with the same provider, to use contraceptives effectively, and to encourage others in their community to use the program.[23,24] Thus, assessing client satisfaction is critical in informing any strategy to improve the use of services and reduce unmet need for contraception.

Client satisfaction studies may have a tendency towards overly positive results. This may jeopardize the validity of findings since stated satisfaction levels may fail to reflect true client perceptions. A common method of addressing this bias is to focus on a low threshold of dissatisfaction as a way to uncover shortcomings in service quality.[25] The survey developed for this study carefully considered this tendency by focusing on small variations in client satisfaction as they differ by gender and age group. This survey attempted to reveal greater variations in client satisfaction and includes client perceptions of confidentiality, client-provider interaction and addresses issues related to emergency contraception, and sexually transmitted infections (STIs).

Barriers to Family Planning Services Specific to Males. One of the primary objectives under the CMS demonstration project is to increase access to family planning services among males, who have traditionally not been included in such services. The lack of inclusion of males in reproductive health services has a two-fold effect, leaving numerous males without reproductive health care, education and knowledge, as well as indirectly impeding efforts to improve family planning and reproductive health for women. Thus, it should not be surprising that males also have higher rates of STIs, including new HIV infections, when compared to females.[26, 27] In addition, while there are national chlamydia screening

---

[21] Barnett B, 1997. Postpartum and postabortion reproductive health goals can differ, an important factor in providing high-quality services. *Network*. 17 (4).
[22] Williams T, Schutt-Ainé J, Cuca Y. 2000. Measuring family planning service quality through client satisfaction exit interviews. *International Family Planning Perspectives*. 26(2):63-71.
[23] Darroch J, Frost JJ. 1996. The family planning attitudes and experiences of low-income women. *Family Planning Perspectives.* 28, 261-299.
[24] Lipton HL Dizon-Mueller R, Brindis CD. 1985. Transactions with clients: suggestions for research, training, and action. In Lapham, Simmons Eds, *Organizing for Effective Family Planning Programs*.499-520 Washington, DC: National Academy Press.
[25] Williams et al. 2000. See reference 20.
[26] Centers for Disease Control and Prevention. *Sexually Trans mitted Disease Surveillance,2007*. Atlanta, GA: U.S. Department of Health and Human Services; December 2008
[27] Miller WC, Ford CA, Morris M, et al. Prevalence of chlamydial and gonococcal infections among young adults in the United States. *JAMA*. 2004;291:2229-2236

guidelines for females, there are no equivalent national chlamydia or updated gonorrhea screening guidelines for males, leaving some providers unsure about when to screen males for STIs. Since male Family PACT clients are more focused on STI prevention than female clients, males presenting for care in Family PACT offer providers the opportunity to assess males' STI risks, to provide them with appropriate STI testing and treatment, and to counsel them regarding their risks.

Barriers to Family Planning Services for Adolescents. It is critical to assess quality of care from the perspective and experience of adolescents, as their needs are distinct and unique. Adolescents face additional barriers that are not faced by adults when seeking family planning services. Confidential services, services that are sensitive to adolescent needs, and knowledge about where to go for services are important in increasing access to services for adolescents. During FY 06/07, 18% of Family PACT clients were adolescents ages 19 and under, similar to previous years. The number of adolescents served has remained stable over the last five years, declining less than 1% since FY 02/03.[28] However, there are still many adolescents in need of family planning services, not reached by Family PACT.

Studies have shown that adolescents are more likely to use contraceptives if the services are tailored to their needs, accessible and provided in a sensitive manner. For instance, a teen pregnancy prevention program in Pennsylvania demonstrated that after one year, adolescent clients who received in-depth counseling and education at a level they could understand were significantly more likely to continue using a contraceptive, regardless of problems with the method, than those in the control group. In addition, participants in the program had fewer pregnancies than those in the control group.[29]

Adolescents may also be reluctant to obtain reproductive health services if they believe that they need to have parental consent to receive services. In a study at three Planned Parenthood clinics in Los Angeles County, the main reason reported by adolescents for not going to their usual providers was that they did not want to involve family members.[30] However, adolescents are not always aware that many of the services available to them, including Family PACT services, are confidential.[31] Providers may not always assure adolescents about confidentiality because they themselves may be unclear of the Program Standards and policy. Clearly, ensuring confidential care, which Family PACT mandates, is of utmost importance, and has been shown to increase an adolescent's likelihood of utilizing services.[32,33] Results from the CEI are useful in assessing whether the unique needs of adolescents are being met in the Family PACT Program and point to areas that could be improved.

---

[28] Swann D, ed. Bixby Center for Global Reproductive Health. UCSF. 2008. *Family PACT Program report, FY 06/07*, Available at: http://www.familypact.org/en/research/reports.aspx, accessed April 15, 2009.
[29] Brindis C & Peterson S. 1996. Effective strategies to reduce teenage pregnancy. *Maternal and Child Health Resources*, 11(2): 1-4.
[30] Sugerman S, Halfon N, Fink A, Anderson M, Valle L, Brook RH. 2000. Family planning clinic patients: Their usual health care providers, insurance status, and implications for managed care. *Journal of Adolescent Health*, 27(1): 25-33.
[31] Biggs A, Brown A, and Brindis C. 2005. *Family PACT Program evaluation: Summary findings from client exit interviews*, UCSF: San Francisco, CA, June 2005. Submitted to the California Department of Public Health, Office of Family Planning.
[32] English A, Simmons P. 1999. Legal issues in reproductive health care for adolescents. *Adolescent Medicine*, 10(2): 181-194.
[33] Ford CA, Bearman PS, Moody J. 1999. Foregone health care among adolescents. *Journal of the American Medical Association*, 282(23):2227-2234.

Services for Limited English Proficiency Clients. The Family PACT Program Standards stipulate that "all services shall be provided in a culturally sensitive manner and communicated in a language understood by the client." Thus, an important quality indicator is the extent to which Limited English Proficiency (LEP) clients in need of an interpreter have access to one. The need for interpretation and method of interpretation have been shown to have a significant effect on the quality of the provider-patient interaction. Monolingual providers seeing LEP clients with the help of an interpreter were found to be less likely to take comprehensive medical history and more likely to order unnecessary medical tests than bilingual providers.[34] LEP clients were more likely after visits with a third-party interpreter than after visits with a bilingual provider to report having outstanding questions about their medical care.[35] Patient-provider interactions with an interpreter were also associated with an increased likelihood of medical errors,[36,37,38] decreased likelihood of client comprehension,[39] lower participation in preventive care,[40,41] and lower adherence to follow-up appointments.[42] In the 2007 Family PACT Medical Record Review, it was observed that clients seen with the help of an interpreter were significantly less likely to receive education and counseling services than clients who were seen by a bilingual provider.[43] Although the CEI did not interview clients who spoke languages other than Spanish, this study provided the opportunity to assess Spanish-speaking LEP clients' experiences with Family PACT services.

Deficit Reduction Act. The federal Deficit Reduction Act of 2005 (DRA), passed in 2006, establishes requirements for documentation of US citizenship and identity as a condition of Medicaid eligibility. CMS and the State of California are currently negotiating the terms and conditions of the Family PACT waiver renewal, including the implementation of DRA documentation requirements. In past communications, CMS has indicated that to claim federal matching funds for clients enrolled in the Family PACT Program, applicants must provide a valid Social Security number and that applicants must give evidence of their citizenship and identity by providing original or certified documents such as a birth certificate, passport, or picture ID. Income eligibility must be verified by an income statement. Experts fear that the new requirements will keep otherwise eligible citizens, particularly teens and other vulnerable populations, such as victims of domestic violence and the homeless, from receiving Medicaid

---

[34] David RA, Rhee M. The impact of language as a barrier to effective health care in an underserved urban Hispanic community. *Mt. Sinai J. Med.* 1998, *65* (5-6), 393-397

[35] Green AR et al. Interpreter services, language concordance, and health care quality. Experiences of Asian Americans with limited English proficiency. *J. Gen. Intern. Med.* 2005, *20* (11), 1050-1056.

[36] Flores G et al. Errors in medical interpretation and their potential clinical consequences in pediatric encounters. *Pediatrics*

[37] Flores G. The impact of medical interpreter services on the quality of health care: a systematic review. *Med Care Res Rev* 2005; 62(3):255-299.

[38] Lee KC et al. Resident physicians' use of professional and nonprofessional interpreters: a national survey. *JAMA* 2006; 296(9):1050-1053.

[39] Wilson E et al. Effects of limited English proficiency and physician language on health care comprehension. *J Gen Intern Med* 2005; 20(9):800-806.

[40] Solis JM et al. Acculturation, access to care, and use of preventive services by Hispanics: findings from HHANES 1982-84

[41] Woloshin S et al. Is language a barrier to the use of preventive services? *J Gen Intern Med* 1997; 12(8):472-477.

[42] Apter AJ et al. Adherence with twice-daily dosing of inhaled steroids. Socioeconomic and health-belief differences. *Am J Respir Crit Care Med* 1998; 157(6 Pt 1):1810-1817.

[43] Thiel de Bocanegra H, Rostovtseva D, Menz M, and Karl J. *The 2007 Family PACT Medical Record Review: Assessing the Quality of Services.* Sacramento, CA.: Bixby Center for Global Reproductive Health. University of California, San Francisco. 2008.

or Family PACT services because they cannot provide the documents required to prove their citizenship, identity, or income status. Currently, applicants to Family PACT complete a short two page application at their provider site and the eligibility is determined based on the client's self-report. Under DRA, applicants to Family PACT would be required to submit specified documents, such as birth certificates and passports, which many may have difficulty tracking down or paying for. Adolescents would also be required to show proof of citizenship or qualified immigrant status. Most low-income people and teens do not have passports, the primary document used to prove identity and citizenship under the new law. Alternatives include a birth certificate, which many do not have, plus another document such as a driver's license or a school ID with a photograph. However, individuals would be required to submit original documents or copies certified by the issuing agency; photocopies they might have at hand are not acceptable.

Since the law was enacted, a growing number of states have reported Medicaid enrollment declines and large backlogs of applications that are not being processed in a timely manner due to incomplete applications or because eligibility workers need more time to process each one. The Center for Budget and Policy Priorities (CBPP) reviewed the eligibility determination and enrollment patterns of seven states to learn the effect of the changes required by the DRA.[44] The effort to comply with the documentation requirement has increased states' administrative expenses, slowed eligibility decisions, and resulted in denials and terminations of assistance to eligible citizens. In Wisconsin, between August and March 2007, over 19,000 individuals lost or were denied assistance. The state's records reveal that 67% were citizens who could not produce required identification. Enrollment of children in Virginia's Medicaid program dropped by over 13,000 between July 1 and March 31, 2007. Medicaid enrollment in Louisiana declined by nearly 15,000 as of December 31, 2007. Kansas denied or terminated assistance to more than 18,000 people because of the requirement, of whom 16,000 are waiting to enroll or re-enroll because of the backlog. According to CBPP, the declines in enrollment have not been the result of improvements in the economy, nor the result of undocumented individuals leaving the program. Enrollment in the food stamp program and the State Children's Health Insurance Program (SCHIP) rose in every state that reported decreased Medicaid enrollment, neither of which requires the same types of original or certified documentation of identity and US citizenship.

To date, the Family PACT Program has not yet implemented the DRA requirements for applicants. UCSF analysis projects that implementation of the law is likely to have significant negative impact on program costs, enrollment and access to care among eligible California residents. The CEI serves as an additional tool to assess the potential impact of impending DRA requirements on Family PACT clients.

[44] Ross DC. (March 2007). New Medicaid Citizenship Documentation Requirement Is Taking A Toll: States Report Enrollment Is Down and Administrative Costs Are Up. Washington DC: Center on Budget and Policy Priorities. http://www.cbpp.org/2-2-07health.htm.

APPENDIX B

METHODOLOGY FOR STI-RELATED DATA RUNS

STI TREATMENT

Procedure codes searched for on-site dispensing of drugs to treat an STI included: Z7610, X7460, X7462, X5864, X5856, and X7716.

Drug classes searched for pharmacy dispensing of STI drugs included: ACYCLOVIR, AMOX TR/POTASSIUM CLAVULANATE, AZITHROMYCIN, BUTOCONAZOLE NITRATE, CEFOXITIN SODIUM, CEFPODOXIME PROXETIL, CEFTRIAXONE SODIUM, CEPHALEXIN, MONOHYDRATE, CIPROFLOXACIN HCL, CIPROFLOXACIN/CIPROFLOXA HCL, CLINDAMYCIN HCL, CLINDAMYCIN PHOSPHATE, CLOTRIMAZOLE, DOXYCYCLINE HYCLATE, FAMCICLOVIR, FLUCONAZOLE, IMIQUIMOD, METRONIDAZOLE, MICONAZOLE NITRATE, NITROFURANTOIN MACROCRYSTAL, NITROFURANTOIN/NITROFURAN MAC, OFLOXACIN, PENICILLIN G BENZATHINE, PODOFILOX, PODOPHYLLUM RESIN, PROBENECID, SULFAMETHOXAZOLE/TRIMETHOPRIM, TERCONAZOLE, TINIDAZOLE, and VALACYCLOVIR HCL.

Drugs classes used to treat urinary tract infections (NITROFURANTOIN MACROCRYSTAL, NITROFURANTOIN/NITROFURAN MAC and SULFAMETHOXAZOLE/TRIMETHOPRIM) were included in the search to account for dispensing of medications to clients who may have not made a distinction between an STI and a urinary tract infection or who were treated concurrently for multiple diagnoses.

STI TESTING

We searched paid claims within 30 days of the date of the visit to assess the proportion of clients who reported they received an STI test at the visit and who also had a claim for the test. The search was completed based on (1) procedure codes alone and (2) procedure codes supplemented by secondary diagnosis information. (See below for details about procedure codes and secondary diagnoses searched.) When a secondary diagnosis was found but not the procedure code, we assumed that the test had been performed but not billed. If a procedure code applied to more than one type of an STI test, we assumed that it was for the test reported by the client.

Laboratory procedure codes searched for STI testing included: 87178, 87179, 87110, 87490, 87491, 86632, 86631, 87270, 87320, 87590, 87591, 87081, 86592, 86593, 86781, 87164, 87166, 87285, 87252, 87207, 87274, 86701, 86702, 86703, 87340, 86287, 86289, 86704, 86291, 87205, 86255, 86689, 87620, 87621, 87622, 87800, 87801, 86694, 86695, Z5218 and Z5220.

Procedure codes discontinued prior to 2007 (87178, 87179, 86632, 86631, 87340, 86287, 86289, 86704, 86291, 86694 and 86695) were included in the search to account for claims indicative of STI testing but which were denied due to billing with obsolete codes.

Procedure codes and secondary diagnoses searched for specific STI tests are as follows:

STI Test	**Procedure Codes**	**Secondary Diagnoses**
Chlamydia	86631, 86632, 87110, 87270, 87320, 87490, 87491, 87178, 87179, 87800, 87801, Z5218, Z5220	099.41, 099.52, 099.53, 099.40, 616.0, V01.6
Gonorrhea	87178, 87179, 87800, 87801, 87081, 87590, 87591, Z5218, Z5220	098.0, 098.12, 098.15, 098.6, 098.7, 099.40, 616.0, V01.6
HIV	86701, 86702, 86703, 86689, Z5218, Z5220	none
HPV/Genital Warts	54050, 54056, 54100, 56501, 57061, 56605, 87620, 87621, 87622	078.0, 078.10, 078.11, 795.00, 795.01, 795.02, 795.03, 795.04, 795.04, 795.05, 622.11, 622.12, 233.1
HSV	86694, 86695, 87207, 87252, 87274, 87273	054.11, 054.12, 054.13, 608.89, 616.50
Syphilis	86592, 86593, 86781, 87164, 87166, 87285, Z5218, Z5220	091.0, 091.3, 092.9, 096, 097.1, 616.5, 608.89, V01.6
Trichomoniasis	87210, 83986, Q0111	131.01, 131.02, V01.6, 112.1, 616.10
NGU	87205	099.40, 09940
PID	85025, 85651, 85652, Z5218, Z5220	614.0, 614.2, 615.0

APPENDIX C

ADDITIONAL TABLES

SAMPLE CHARACTERISTICS

Appendix C, Table 57. Partner Enrolled in Family PACT, Among Clients in a Relationship, by Age, Gender, Interview Language, Race/Ethnicity and Provider Sector (n=1240)

Client Demographics	**Yes**		**No**		**Don't Know**	
	n	%	n	%	n	%
Age (years)						
19 and under	44	22	147	73	11	5
20+	207	20	806	78	26	3
Gender						
Female	185	17	901	81	31	3
Male	66	53*	53	42	6	5
Interview Language						
English	125	18	549	79	25	4
Spanish	126	23*	405	75	12	2
Race/Ethnicity						
White†	21	12	143	81	13	7
Hispanic	191	22***	648	75	20	2
African American	17	22*	59	76	2	3
Asian/Pacific Islander	11	14	67	85	1	1
Native American/Other	5	14	30	83	1	3
Provider Sector						
Private	128	26***	355	72	8	2
Public	123	16	599	80	29	4
Total	251	20	954	77	37	3

† White served as the reference group
*p<.05, *** p<.001
Note: Subtotals may not always match due to missing responses.
Source: 2007 Family PACT Client Exit Interview.

Appendix C, Table 58. Current Pregnancy Planned, Among Currently Pregnant/Partner Pregnant, by Age, Gender, Interview Language, Race/Ethnicity (n=43)

Client Demographics	**n**	**%**
Age		
19 and under	2	22
20+	9	28
Gender		
Female	7	24
Male	4	33
Interview Language		
English	5	22
Spanish	6	33
Race/Ethnicity		
Hispanic	8	29
White	1	33
African American	1	33
Asian/Pacific Islander	1	17
Native American/Other	0	0
Total	11	27

Source: 2007 Family PACT Client Exit Interview.

Appendix C, Table 59. Number of Live Births/Biological Children, by Age, Gender, Interview Language, Race/Ethnicity (n=1496)

Client Demographics	Zero		One		Two		Three		Four+	
	n	%	n	%	n	%	n	%	n	%
Age										
19 and under	220	84***	32	12	9	3	0	0	0	0
20+	518	42	242	20*	245	20***	145	12***	84	7***
Gender										
Female	644	49	243	18	232	18	128	10	69	5
Male	95	53	31	17	22	12	17	9	15	8
Interview Language										
English	633	72***	121	14	92	10	24	3	14	2
Spanish	106	17	153	25***	162	26***	121	20***	70	11***
Race/Ethnicity										
White†	209	88	17	7	7	3	1	<1	2	<1
Hispanic	343	35***	221	22***	215	22***	134	14***	79	8*
African American	62	60***	17	16*	15	14***	8	8*	2	2
Asian/Pacific Islander	77	79*	8	8	9	9*	2	2	1	1
Native American/Other	36	69***	9	17*	7	14***	0	0	0	0
Total	739	49	274	18	254	17	145	10	84	6

† White served as the reference group.
*p<.05, ***p<.001
Source: 2007 Family PACT Client Exit Interview.

Appendix C, Table 60. Planning to Have A/Another Child, by Age and Gender (n=1447)†

Client Demographics	n	%
Age		
19 and under	220	87***
20+	721	60
Gender		
Female	832	65
Male	110	67
Total	942	65

† Excludes female clients who reported that they were pregnant at the time of the interview visit.
*** p<.001
Source: 2007 Family PACT Client Exit Interview.

Appendix C, Table 61. Client Able To Ask All/Some/None of the Questions about Birth Control, by Age, Gender, Provider Sector and Specialty, and Client Status (n=1003)†

Client Demographics	All		Some		None	
	n	%	n	%	n	%
Age (years)						
19 and under	170	91	17	9	0	0
20+	739	91	69	9	7	1
Gender						
Female	828	91	81	9	7	1
Male	82	94	5	6	0	0
Provider Sector						
Private	326	87	43	12	5	1
Public	584	93	43	7	2	<1
Provider Specialty						
Family Planning/Women's Health	466	91	40	8	4	1
Primary Care/Multi-Specialty	444	90	46	9	3	<1
Client Status						
New	157	89	19	11	0	0
Established	746	91	66	8	6	1
Total	910	91	86	9	7	1

†Excludes 30 female clients who were pregnant at the time of the visit and clients who said that they had no questions or did not know.
Source: 2007 Family PACT Client Exit Interview.

Appendix C, Table 62. Female Client Received Emergency Contraception at Current Visit, by Age, Provider Sector and Specialty (n=1316)

Client Demographics	n	%
Age		
19 and under	64	27***
20+	150	14
Provider Sector		
Private	27	6
Public	187	22***
Provider Specialty		
Family Planning/Women's Health	154	21***
Primary Care/Multi-Specialty	60	10
Total	214	16

***p<.001
Source: 2007 Family PACT Client Exit Interview.

Appendix C, Table 63. Client Received Condoms or Prescription for Condoms at Current Visit, by Gender

Client Demographics	**Female** (n=1317)		**Male** (n=180)		**Total** (n=1487)	
	n	%	n	%	n	%
Age (years)						
19 and under	117	50*	23	85	140	53*
20-25	208	44	33	63	241	46
26-30	116	49*	20	56*	136	50
Over 30†	138	38	51	80	189	45
Race/Ethnicity						
White‡	87	39	9	69	96	41
Hispanic	395	46	97	75	492	50*
African American	38	45	11	55	49	47
Asian/Pacific Islander	33	37	4	57	37	38
Native American/Other	19	42	4	57	23	44
Provider Sector						
Private	196	42	82	75	272	47*
Public	383	45	45	64	309	34
Provider Specialty						
Family Planning/Women's Health	330	46	35	60	365	47
Primary Care/Multi-Specialty	249	42	92	76*	341	48
Total Received Condoms	579	44	127	71***	706	47

†Clients over age 30 served as the reference group.
‡ White served as the reference group.
*p<.05, ***p<.001
Source: 2007 Family PACT Client Exit Interview.

Appendix C, Table 64. Client was Asked if had an STI in past 12 months, by Gender and Client Status

Client Demographics	All Clients						New Clients					
	Female (n=1317)		Male (n=180)		Total (N=1482)		Female (n=181)		Male (n=70)		Total (n=251)	
	n	%	n	%	n	%	n	%	n	%	n	%
Age (years)												
19 and under	108	47*	15	58*	123	48*	38	60	6	75	44	62*
20-25	224	47*	32	63*	256	49*	48	72	12	80	60	73
26-30	136	57	29	83	165	60	17	63	12	75	29	67
Over 30†	198	55	55	85	253	60	18	75	28	90	46	84
Race/Ethnicity												
White‡	98	44	N/A	N/A	256	44	31	66	N/A	N/A	32	65
Hispanic	469	55*	101	78*	123	58***	61	69	49	83	110	75
African American	33	39	15	79*	165	47	8	57	N/A	N/A	11	61
Asian/Pacific Islander	35	39	N/A	N/A	253	42	12	63	N/A	N/A	14	67
Native American/Other	24	53	N/A	N/A	123	54*	7	78	N/A	N/A	10	83
Provider Sector												
Private	265	57*	89	81*	354	62***	42	70	40	83	82	76
Public	402	48	42	63	444	49	79	65	18	82	97	68
Provider Specialty												
Family Plan./Women's Health	359	50	40	71	399	51	75	73	21	100*	96	77*
Primary Care/Multi-Specialty	308	53	91	75	399	57*	46	59	37	76	83	65
Total	667	51	131	74***	798	54	121	67	58	83*	179	72

†Clients over age 30 served as the reference group. N/A=not available because sample size was too small to calculate.
‡White served as the reference group.
*p<.05, ***p<.001
Source: 2007 Family PACT Client Exit Interview.

Appendix C, Table 65. Client was Asked About Number of Sexual Partners at Visit, by Gender and Client Status

Client Demographics	All Client						New Clients					
	Female (n=1317)		Male (n=180)		Total (n=1497)		Female (n=182)		Male (n=71)		Total (n=253)	
	n	%	n	%	n	%	n	%	n	%	n	%
Age (years)												
19 and under	125	53	12	44***	137	53***	42	66	5	56*	47	64*
20-25	245	51*	35	67*	280	53*	42	63	12	80	54	66*
26-30	140	58	25	69*	165	60	17	63	12	75	29	67
Over 30†	217	60	57	88	274	64	18	75	28	90	46	84
Race/Ethnicity												
White‡	110	49	7	54	117	50	34	72	N/A	N/A	35	70
Hispanic	505	59	100	77	605	61*	61	69	49	83	110	74
African American	40	48	15	75	55	53	7	50	N/A	N/A	11	61
Asian/Pacific Islander	42	47	N/A	N/A	45	46	10	53	N/A	N/A	11	52
Native American/Other	23	51	N/A	N/A	26	50	5	56	N/A	N/A	7	58
Provider Sector												
Private	270	58	90	82	360	63*	38	61	41	87*	79	72
Public	458	54	39	56	497	54	81	68	16	67	97	67
Provider Specialty												
Family Planning/Women's Health	385	53	33	57	418	53	70	68	18	78	88	70
Primary Care/Multi-Specialty	343	58	96	80*	439	62***	49	62	39	81	88	69
Total	728	55	129	72***	857	58	119	65	57	80*	176	70

†Clients over age 30 served as the reference group. N/A=not available because sample size was too small to calculate.
‡White served as the reference group.
*p<.05, ***p<.001
Source: 2007 Family PACT Client Exit Interview.

Appendix C, Table 66. Client was Asked About Gender of Partner at Visit, by Gender and Client Status

Client Demographics	All Clients						New Clients					
	Female (n=1317)		Male (n=180)		Total (n=1487)		Female (n=183)		Male (n=72)		Total (n=255)	
	n	%	n	%	n	%	n	%	n	%	n	%
Age (years)												
19 and under	93	40	15	56*	108	41	37	57	7	78	44	59
20-25	168	35	29	56*	197	38*	37	55	12	80	49	60
26-30	104	43	24	67	128	47	11	41	12	71	23	52*
Over 30†	141	39	50	77	191	45	14	58	26	84	40	72
Race/Ethnicity												
White‡	63	28	5	38	68	29	28	57	N/A	N/A	30	58
Hispanic	364	42	92	71	456	47***	51	58	48	80	99	67
African American	224	29	15	75	39	38	5	36	N/A	N/A	8	44
Asian/Pacific Islander	29	32	N/A	N/A	32	33	7	37	N/A	N/A	9	43
Native American/Other	19	42	N/A	N/A	21	40	5	56	N/A	N/A	7	58
Provider Sector												
Private	204	411	83	75	287	50*	30	48	40	83	70	64
Public	303	36	35	50	338	37	69	57	17	71	86	59
Provider Specialty												
Family Planning/Women's Health	285	40	28	48	313	40	64	62*	20	87	84	66*
Primary Care/Multi-Specialty	222	38	90	74	312	44	35	44	37	76	72	56
Total	507	39	118	66***	625	42	99	54	57	79*	156	61

†Clients age 30 and older served as the reference group. N/A=not available because sample size was too small to calculate.
‡White served as the reference group.
*p<.05, ***p<.001
Source: 2007 Family PACT Client Exit Interview.

Appendix C, Table 67. Client was Asked If Knows How to Reduce Risk of STI, by Gender and Client Status

Client Demographics	All Clients						New Clients					
	Female (n=1303)		Male (n=176)		Total (n=1497)		Female (n=183)		Male (n=72)		Total (n=255)	
	n	%	n	%	n	%	n	%	n	%	n	%
Age (years)												
19 and under	121	52*	17	63	138	53	37	58	6	67	43	59
20-25	190	40	38	75	228	44	36	53	11	73	47	57
26-30	115	48	23	66	138	50	14	52	11	65	25	57
Over 30†	150	42	50	79	200	47	12	50	26	84	38	69
Race/Ethnicity												
White‡	67	30	6	46	73	31	23	47	N/A	N/A	25	48
Hispanic	424	50***	101	78*	525	54*	58	65*	45	75	103	69*
African American	33	39	13	81	46	46	4	29	N/A	N/A	7	39
Asian/Pacific Islander	29	32	N/A	N/A	33	34	8	42	N/A	N/A	10	48
Native American/Other	16	36	N/A	N/A	20	39	5	63	N/A	N/A	7	64
Provider Sector												
Private	241	52*	85	78*	326	57*	37	60	39	81	76	69**
Public	335	40	43	61	378	42	62	51	15	62	77	53
Provider Specialty												
Family Planning/Women's Health	297	41	34	60	331	43	55	53	18	78	73	57
Primary Care/Multi-Specialty	279	48*	94	79*	373	53***	44	56	36	73	80	63
Total	576	44	128	73***	704	48	99	54	54	75*	153	60

†Clients over age 30 served as the reference group. N/A=not available because sample size was too small to calculate.
‡White served as the reference group.
*p<.05, ***p<.001
Source: 2007 Family PACT Client Exit Interview.

Appendix C, Table 68. Client was Asked About Sexual Practices, by Gender and Client Status

Client Demographics	All Clients						New Clients					
	Female (n=1310)		**Male** (n=179)		**Total** (n=1489)		**Female** (n=181)		**Male** (n=72)		**Total** (n=253)	
	n	%	n	%	n	%	n	%	n	%	n	%
Age (years)												
19 and under	91	39	14	52*	105	40	34	53	6	67	40	55
20-25	175	37	29	57*	204	39	36	55	12	80	48	59
26-30	98	41	24	67	122	45	14	52	11	65	25	57
Over 30†	133	37	53	82	186	43	14	58	25	81	39	71
Race/Ethnicity												
White‡	69	31	7	54	76	32	28	57	N/A	N/A	30	58
Hispanic	346	40*	89	68	435	44***	49	57	45	75	94	64
African American	26	31	17	89*	43	42	5	36	N/A	N/A	9	50
Asian/Pacific Islander	31	34	N/A	N/A	35	36	9	47	N/A	N/A	10	48
Native American/Other	19	42	N/A	N/A	21	40	5	56	N/A	N/A	7	58
Provider Sector												
Private	183	39	81	74*	264	46*	31	51	38	79	69	63
Public	315	37	39	57	354	39	67	56	16	67	83	58
Provider Specialty												
Family Planning/Women's Health	275	38	34	59	309	40	62	59	19	83	81	63
Primary Care/Multi-Specialty	223	38	86	71	309	44	36	47	35	71	71	57
Total	498	38	120	67***	618	41	98	54	54	75*	152	60

†Clients over age 30 served as the reference group. N/A=not available because sample size was too small to calculate.
‡White served as the reference group.
*p<.05, ***p<.001
Source: 2007 Family PACT Client Exit Interview.

APPENDIX D

INTERVIEW TOOL