

Reproductive Health Needs Assessment 2017

LOUISIANA DEPARTMENT OF HEALTH
OFFICE OF PUBLIC HEALTH- BUREAU OF FAMILY HEALTH
REPRODUCTIVE HEALTH PROGRAM



Prepared by the Reproductive Health Program in the
Bureau of Family Health

Amy Zapata, MPH	Director, Bureau of Family Health
Callie Wise, MPH	Program Manager
Gail Gibson, RN, MN, FABC	Statewide Nurse Consultant
Randy Leggett, MPH	Continuous Quality Improvement Manager
Rachael Kramas, MPH	Outreach Coordinator
Davondra Brown, M.Ed, CHES	Reproductive Health Education/Access Manager

Contact Information:

LDH – OPH – Bureau of Family Health
Reproductive Health Program
1450 Poydras Street
20th Floor
New Orleans, LA 70112
(504) 568-5330

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2017 Reproductive Health Needs Assessment

The Office of Public Health (OPH) Bureau of Family Health (BFH) Reproductive Health Program (RHP) staff conducted a comprehensive assessment of needs, opportunities, and resources as part of the process of evaluating the program in preparation for applying for the 2017 Title X Grant. The findings of this 2017 Reproductive Health Needs Assessment are presented here and include: 1) a snapshot of Louisiana: its administration and population, state health indicators and outcomes, and changing healthcare landscape; 2) a multi-component assessment of the population's perception of and need for reproductive health services, drawn from surveys, focus groups, and interviews with current clients, community members, adolescents, Title X providers, and community partners.

State Snapshot: Louisiana's Administration and Population, State Health Outcomes and Indicators, and Changing Healthcare Landscape

Administration and Population

The Louisiana Department of Health (LDH) is the state-level agency concerned with the health and wellness of the residents of Louisiana. The department includes the Office of Public Health (OPH) which is the main entity tasked with promoting and protecting the health of communities in the state. Under the umbrella of OPH, the Bureau of Family Health (BFH) directs a variety of programs and projects that provide support and direct services to promote the health of pregnant women, mothers, infants, children, youth, families, and men and women of childbearing age. Within BFH, the Reproductive Health Program (RHP) directly administers the Title X Family Planning Services Grant, bringing Title X services to communities statewide. As an agency within BFH, RHP is able to partner efficiently with other programs

servicing women, men, adolescents, and families to connect Louisianans with comprehensive wrap-around services.

Louisiana's population in 2015 was 4.67 million people¹, celebrating a distinct multicultural heritage drawn from the Spanish, French, and African peoples who settled in the area starting from the 1700s. Whites make up about two-thirds of the population in Louisiana, but there is also a large black minority, one of the largest in the United States. Hispanics/Latinos (of any race) make up 5% of the population, a number that has been trending upwards in the years since Hurricane Katrina.

<i>Race/Ethnicity</i>	<i>Percentage of Population (2015)</i>
White	63.2
Black	32.5
American Indian/ Alaska Native	0.8
Asian	1.8
Hispanic/Latino	5.0
Two or more races	1.6

Table 1: Race and Ethnicity in Louisiana
Source: ACS Community Survey Estimates 2015

Today, the population remains diverse racially and ethnically, with surprising linguistic diversity as well: 8.6% of people speak a language other than English at home. The most widespread language spoken in the state besides English is Spanish, but there are also important French-speaking and Vietnamese-speaking communities around the state¹. Louisiana also has the distinction of being the state with the highest proportion of residents who were born in the state². This non-transiency leads to a strong sense of connectedness within communities with deeply rooted traditions and family ties.



Figure 1: Map of Louisiana and its Nine Administrative Regions

Louisiana is divided into 64 parishes (equivalent to counties), which are organized by LDH into nine administrative regions. Each of the nine regions is associated with a regional urban center, which serves as an administrative, service, and cultural hub of the region. The large metropolitan areas of New Orleans and Baton Rouge each boast populations of over 1 million residents; smaller urban areas of Houma, Lafayette, Lake Charles, Alexandria, Shreveport, Monroe, and Hammond

anchor the other seven administrative regions. Over 1 million individuals are settled throughout small towns and rural areas, which include difficult-to-reach communities isolated by geography and a lack of transportation infrastructure.

Economic Environment

A geographically unique state, Louisiana is defined by its waterways and ever-shifting coastlines, which provide the basis for much of the state's economic foundation and cultural heritage. Commercial fishing competes with oil and gas interests in the Gulf of Mexico; both industries are critical to the Louisiana economy. The oil and gas industry increasingly underpins the state economy, with offshore drilling platforms, refineries, petroleum processing facilities, and natural gas pipeline work making up major sectors of employment. The shipping industry also leverages the natural landscape to its advantage. The Mississippi River Delta region's deepwater ports facilitate ocean-going vessels as far inland as New Orleans, connecting the agricultural and manufacturing centers of interior of the United States with the rest of the world through Louisiana's ports. The Port of South Louisiana is the largest port by volume- not only in the United States, but in the entire western hemisphere³; the ports of New Orleans, Baton Rouge, Plaquemines, and Lake Charles all rank in the top fifteen⁴. Travel, hospitality, and tourism industries are also well-positioned to take advantage of the state's history, culture, and geography. However, the wetlands, rivers, marshes, and bayous that contribute such value to the state are also vulnerable to climate change and related major weather events that greatly affect people who live in Louisiana.⁵

The state's major industries- oil and gas, shipping, and travel and tourism- are also remarkably sensitive to larger economic forces. Downturns in these industries, as evidenced in recent years, have deep and lasting effects on local economies. In times of recent economic uncertainty, the need for publicly supported services have increased at the same time as state funds available for such services decreased. The state has been balancing severe cutbacks to the budget over several years with impacts in the areas of health, education, and social services. The same economic factors that create increased need for

services require Title X clinics to work with greater efficiency and effectiveness as state resources are constrained. Federal funding represents an important investment and a stabilizing force in maintaining access to critical services.

As of 2015, 19.6% of Louisiana residents live in poverty, the third-highest proportion in the nation.¹ This single measure does not fully describe the complexities of poverty and need in some parts of the state. The proportion of people living in poverty is at or below the national average in only five of the state's 64 parishes; north Louisiana in general and the delta region in particular struggle with generational poverty and complex socioeconomic problems that contribute to the many health challenges faced in these communities. In East Carroll Parish, for example, the proportion of people living in poverty is 43.7%, more than triple the national average. Over 37% of the population in the state is considered "low income" (measured as living within 200% of the poverty line), as compared to 32% nationwide.⁶ The per capita income for the state (2015) is nearly 15% below the national average, only \$24,981.¹

Traditional measures of economic need, such as mean income, may obscure the level of need at the lower end of the economic spectrum. Looking at income inequality through the Gini Index is another way of illustrating economic areas of need. When applied to Louisiana's census data in 2015, the Gini Index was determined to be .487.⁷ This ranks Louisiana fourth highest in the nation, meaning that the distribution of wealth within the state is extremely unequal, on par with nations like El Salvador (Gini coefficient of .483) and Nigeria (Gini coefficient of .488).⁸

Social Indicators

Louisiana faces persistent social inequalities as well. In measures of educational attainment, the state lags behind the national average in both high school graduation rates and higher-education achievements.⁹ Only 83% of Louisianans are high school graduates or higher, yet again this varies by parish; in Evangeline Parish, in central Louisiana, for example, the percent of population that are high school graduates or

higher is only 69%. Educational opportunities are closely linked to neighborhood and community resources. Within the built environment, residential segregation⁹ and housing inadequacy¹⁰ further factor into creating and sustaining concentrated areas of disadvantage. Over 22% of households in Louisiana are located in census tracts designated as concentrated areas of disadvantage, compared to 16% nationally.¹¹ The chronic stress of these environments and the disparities in educational attainment contribute to limited social mobility in many areas of the state and greatly affect health outcomes. Incarceration is one of the most dramatic risk factors, and at the same time, by-products of limited social and economic opportunities, particularly for youth from these areas of disadvantage.¹² Louisiana's incarceration rate (2013) is by far the highest in the America and the world, at 1,040 inmates per 100,000 adults.¹³ This is nearly double the national average of 704 per 100,000. These high rates of incarceration disproportionately affect black residents of the state.¹³ The strong demonstrated relationship between incarcerated populations, disrupted social networks, high-risk sexual behavior, and high rates of sexually transmitted infections (STIs) and human immunodeficiency virus (HIV) underscore the need to pay special attention to preventing transmission and providing treatment given the prevalence of such strong risk factors.¹⁴ The RHP is working to address this important issue in multiple ways. In addition to community-based Title X services, the RHP is partnering with the Orleans Parish Prison and the OPH STD/HIV Program (SHP) to provide rapid STI/HIV screening and treatment within this high volume New Orleans prison. The RHP is also collaborating with Louisiana Medicaid and the Department of Corrections to streamline connections to reproductive health care for recently released inmates in order to improve outcomes and reduce barriers to care.

Economic and social disparities such as these can be linked through the social determinants of health model to persistent gaps in other areas. Louisiana consistently ranks at the bottom of national rankings in health, education, income, and other measures that influence the opportunity for residents to live a long

and healthy life. These social conditions are shaped by the historical and institutional structures that create and sustain concentrated areas of disadvantage, particularly for communities of color.

State Health Outcomes and Indicators

Chronic Health

Louisiana perennially ranks close to the bottom of overall health rankings compared to the rest of the United States, indicating that its residents are part of one of the least healthy populations in America. Data from the Robert Wood Johnson Foundation (2015) shows that one in five Louisianans describe their health status as only “fair or poor” - one of the worst proportions in the United States.¹⁵ Extremely high rates of obesity¹⁶, heart disease¹⁶, diabetes¹⁷, and tobacco use¹⁸ are both risk factors for additional health problems as well as poor outcomes in themselves. Life expectancy in Louisiana is about three years shorter than the national average, and nearly six years shorter than the healthiest states.¹⁹ Statistically speaking, a person from Louisiana can expect to live a shorter and less healthy life compared to people in other parts of the United States.¹⁹ Furthermore, this gap is wider for communities of color, who experience higher rates of chronic and acute health problems and differences in accessing care.²⁰ Communities around Louisiana struggle with alcohol and substance abuse; this emerging problem coincides with a lack of investment in mental and behavioral health resources statewide.²¹ Finally, residents of Louisiana struggle with one of the heaviest burdens of cancer, as one of the few states that experience both high rates of cancer incidence and mortality.²² In fact, an 85-mile industrial corridor between New Orleans and Baton Rouge has earned the nickname, “Cancer Alley” because of the high rates of cancer in that section of the state.

Maternal and Child Health

Louisiana also faces major challenges within the field of maternal and child health. In 2014, 58.2% of respondents to the Louisiana Pregnancy Risk Assessment System reported that their pregnancies were

unplanned,²³ reflecting a need for better access to effective birth control as well as continued outreach and education on the importance of preconception and interconception care. The state also ranked poorly in terms of teen pregnancy: nearly 43 births per 1000 were to teen mothers.²⁴ High risk factors and poor health outcomes prevail across the state: 1 in 15 infants were born to a woman receiving late or no prenatal care.²⁵ Lack of prenatal care can increase the risk of complications during pregnancy and lead to worse outcomes for mothers and infants, such as gestational diabetes, preterm birth, and low birth weights. Infants considered low birthweight (LBW) or very low birthweight (VLBW) struggle to survive and face increasingly adverse odds and worse health outcomes; in this measure, Louisiana ranks 2nd worst in the nation.²⁶ Nearly 1 in 9 of all live births in the state in 2014 LBW/VLBW, and for communities of color, this rate is much higher. Black infants in Louisiana were nearly twice as likely as white infants to be born with LBW/VLBW.²⁶ Women who have previously delivered an infant that is LBW/VLBW are at higher risk to have another; without access to effective contraceptive services to allow time for recovery between pregnancies, that risk compounds. Breastfeeding has been shown to provide key health benefits to infants and mothers, yet in Louisiana, only 56.7% of infants were ever breastfed, compared to 79.2% nationally.²⁷ This high-risk environment has consequences for mothers and for children: based on Louisiana Vital Records data, there were 7.8 infant deaths per 1000 live births in 2014.²⁸ According to CDC data, this ranks Louisiana fourth-worst in the nation in infant mortality.²⁹

Reproductive Health

Sexual and reproductive health concerns also feature prominently in discussions of health needs.

Louisiana's rates of HIV and other STIs such as syphilis, chlamydia, and gonorrhea are some of the most concerning in the nation. Syphilis rates for the state are much higher than the national average and the parish-level breakdown is equally startling. The most recent data from 2013 shows that Louisiana has the highest rate of congenital syphilis, the highest rate of gonorrhea, the second highest rate of chlamydia, and the third highest rate of primary and secondary syphilis compared to the nation.³⁰ The Shreveport

area, in northwest Louisiana, has had the greatest number of new syphilis diagnoses and the highest rates in the state since 2008.³⁰ Similarly, the Monroe area, in northeast Louisiana, had the highest gonorrhea rates in the state in 2013.³⁰ Title X sites in these areas are working diligently towards reversing these trends by stepping up the number of clients screened for STIs. Caddo Parish Health Unit (in which Shreveport is located) screened fully 90% of all clients last year for gonorrhea, chlamydia, and syphilis.³¹ In Ouachita Parish, where Monroe is located, 86% of all clients received screening for syphilis and 91% of patients received screening for gonorrhea and chlamydia.³¹

The Baton Rouge and New Orleans metropolitan areas rank second and third, respectively, for the highest rates of HIV infection (by metropolitan area) in the country.³⁰ HIV risk statewide is also extremely high: the lifetime risk of HIV diagnosis is 1 in 56, a risk surpassed nationwide by only four states.³² The impact of STIs and HIV on communities of color within the state is strikingly disproportionate. In 2013, the gonorrhea rate among blacks was 11 times higher than that of whites. Although blacks only make up 32% of the population, they accounted for 74% of all new HIV diagnoses in 2013.³¹

2014 data from the Behavioral Risk Factor Surveillance System (BRFSS) reveals concerning trends in women's preventive health. 84.9% of women aged 21-65 (with no hysterectomy) in the state have had a pap smear within the last 2 years, which is about average nationally, but this drops to 71.1% for Hispanic women in Louisiana, the worst in the United States.³³ Women in Louisiana face one of the highest incidences of cervical cancer diagnoses in the United States: 8.2 per 100,000 women.³⁴ When women finally access care and treatment, it is often too late: the mortality rates from both cervical and breast cancer are one of the highest in the nation.³⁵

Louisiana's Healthcare Landscape

Access, Coverage, and Provider Shortages

Louisiana faces many challenges in the way health care is accessed and delivered. In the three years since the last Title X needs assessment, three major changes have affected the state's healthcare system: the statewide public hospital system became privatized in 2014, major portions of the Affordable Care Act were implemented, and Medicaid eligibility was expanded in 2016.³⁶ These events continue to affect and influence the way people interact with the healthcare system in communities around Louisiana. The latest census data shows that residents of Louisiana are one of the least insured populations in the United States, with 13% of adults lacking coverage of any kind.¹ In addition to problems with coverage and affordability, provider shortages are also a chronic problem: 62 of 64 parishes in the state contain a Health Professional Shortage Area (HPSA), and only 41.9% of need for mental health providers is met.³⁶ Although several medical residency programs operate in the state, only 47% of physicians completing residencies in Louisiana choose to stay and practice in state, creating a deficit of experienced and well-trained physicians and health professionals.³⁷ Physicians-in-training who receive clinical training at any of the medical institutions whose missions preclude them from providing family planning services may have limited opportunities to learn a variety of contraceptive techniques before completing training. This affects medical residency programs in family medicine, rural family medicine, obstetrics and gynecology,

and primary care.

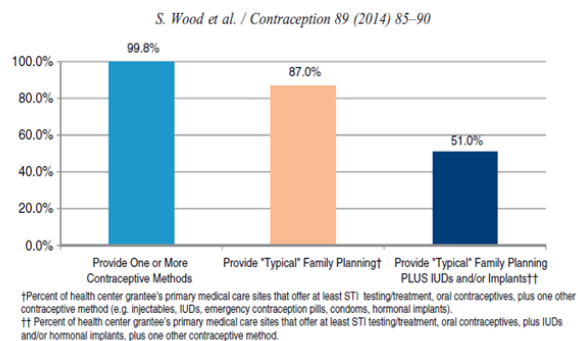


Figure 2: Comparison of contraceptive methods available at FQHCs Source: S. Wood et. al, 2014

National data shows that Federally Qualified Health Centers (FQHCs) help close gaps in provider shortages, but the scope and quality of these services vary greatly, and reproductive-health- focused providers have distinct

advantages over FQHCs.³⁸ Further data backs this up: a 2014 study showed that while 99.8% of FQHCs provide one or more contraceptive methods, only 87% provide “typical” family planning, defined as STI testing and treatment; oral contraceptives; and one other contraceptive method. Only 51% of FQHCs provide “typical” family planning services plus one other contraceptive method, in addition to IUDs and/or hormonal implants.³⁹ The Title X program’s focus on service quality, scope of practice, and confidentiality plus the skills and experience in the area of reproductive health meets an important need within the state.

Shifting Sources of Healthcare Delivery

From the 1930s until 2014, Louisiana’s health care system was separated into two tiers of care. A state-funded network of public hospitals and clinics around the state served those unable to afford private insurance or the full cost of care, while an entirely separate healthcare system served those who could afford care from private providers.⁴⁰ Public hospitals were often the primary institutions serving low-income families’ health needs for generations; however, in recent years citizens and lawmakers raised concerns about the cost and quality of care provided and the inherent injustice of a two-tiered public/private system.⁴⁰ The last public hospital in the state was fully transitioned to private partners in 2014. These private partners who took over operations at the formerly public clinics are not required to provide care that conflicts with the missions of their organization; at least two of the formerly safety-net facilities do not provide birth control because of their religious affiliations.⁴⁰ Family planning services in these communities must now be accessed through an alternate provider. For families who historically relied on the long-standing public hospital system, there is a sense of confusion and uncertainty about where they can access affordable, quality health care services.

History of Title X in Louisiana

The LDH Office of Public Health (OPH) has been awarded the Title X grant for over 40 years. OPH, therefore, has a wealth of experience in administering the state’s Title X program and historically has

primarily provided services directly through the state's network of Parish Health Units (PHUs). These PHUs are supported by local investments, in addition to state funds, but are operated by the state Office of Public Health. PHUs provide a variety of public health functions and services aside from reproductive health, often including vital records, sanitarian services, immunizations, tuberculosis testing and treatment, Women, Infant, and Children (WIC) services, Disease Intervention Specialists (DIS), and are resource centers for Children and Youth with Special Health Care Needs (CYSHCN). Currently, the RHP oversees the provision of Title X services in 63 PHUs across the state, as well as in two contracted sites. Reproductive health services funded by state and federal programs such as Title X and Medicaid help families plan the number and spacing of their children; it also includes screenings and preventive care, as well as testing and treatment for STIs.³⁸ In Louisiana, publicly funded reproductive health services lead to enormous cost savings, through prevention of reproductive cancers, unintended pregnancies, and STIs. In 2010, it was estimated that the publicly funded reproductive health services provided at safety-net health centers saved \$128.5 million in public funds.⁴¹ 2015 data from The Guttmacher Institute shows that the number of women in need of publicly funded family planning is trending upwards nationally, and in Louisiana, an estimated 321,480 adolescents and low income women are in need of publicly funded services and supplies.⁴¹ The RHP currently meets 14.6% of need for publicly funded reproductive health services statewide.⁴¹ Indeed, the program has gone above and beyond in Catahoula, Bienville, Red River, and Richland Parishes, where over 50% of the need for publicly funded reproductive health services is met through the Parish Health Unit.

In addition to Title X funding, the RHP leverages additional funding sources to create a robust network of clinical services. Funding sources include Title V MCH Block Grant funds, CDC Preventive Health Block Grant funds, State General Funds, self-generated revenue from billing and collections, as well as previously mentioned parish in-kind support in the form of clinic buildings and maintenance, as well as additional clinical and clerical staff. In 2015, 53,190 individual patients were cared for through the Title X

program.³¹ 77.5% of clients at Louisiana Title X clinics were at or below the federal poverty line (FPL), and 95% of clients were below 250% FPL.³¹

The connection between social and economic status, access to quality healthcare, and health outcomes remains a cornerstone of public health training. In Louisiana, the social determinants of health are plainly evident and are a perfect example of the interplay between wealth, privilege, and health. Areas of the state with the least access to social and economic opportunity also see the worst health outcomes, whether it is chronic disease indicators, maternal/child health, or reproductive health. Given all these grave challenges faced in Louisiana in the areas of individual and community health, healthcare delivery and access, and health equity, the fact that reproductive health care sits at the center of these issues emphasizes the continued need for accessible, quality care for individuals in need. Furthermore, the future of reproductive health in Louisiana is uncertain given the rapidly shifting political climate and national trends that challenge the ability of providers to meet the reproductive health needs of clients. The Reproductive Health Program leverages Title X funds to provide critically needed services and care for women, men, and adolescents across Louisiana, and represents a major source of quality reproductive health care for people in desperate need around the state.

The Reproductive Health Program's community input assessment evaluates the need for and perceptions of reproductive health services among Louisiana residents and the communities served by the Title X program. The community input assessment surveyed clients, staff, community members, and community partners to evaluate the program's strengths and opportunities for improvement. Data collection focused on the many dimensions of client experience, including exploring potential barriers to care. The program also reached out to community members who were not current clients to examine how to better reach members of the community who were not already receiving services. The process also included opportunities for the community to directly provide their feedback on services provided and share ideas for the future. Special effort was made to reach out to men, adolescents, clients with limited English proficiency (LEP), and Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) clients to solicit their feedback and opinions. Data analysis identified areas for program development and outreach to better meet the reproductive needs of women, men, and adolescents in Louisiana.

Methods of Conducting Community Input Assessment

Data collection took place from September to November 2016 and consisted of four components: 1) A survey of current Title X clients; 2) A Title X staff survey; 3) Two self-assessment checklists completed by the RHP central office team relating to special populations- Adolescent and LGBTQ clients; and 4) Qualitative data collection conducted through focus groups and key informant interviews with partners, providers, and community members.

Client Survey

A client survey was developed for use with current Title X clients to evaluate client experiences and perceptions about services provided. All surveys were distributed in paper format to clients in Title X clinics and then returned to the RHP central office for data entry and analysis. The survey included sections asking about patient satisfaction, insurance status, barriers to care, reasons for choosing the PHU

for care, and preferred source of health information. Free text sections were provided for clients to share more detailed responses to questions regarding lack of insurance, reasons for choosing to seek services at a PHU, and experiences at the PHU, to better understand the role that Title X services play in meeting the needs of clients.

The survey was distributed in Spanish and English. All reproductive health clients at all Title X clinics across the state were asked to complete the survey during four weeks in September and October of 2016. The minimum sample size needed in order for the survey to be valid with a 95% confidence interval was determined to be 593. Each clinic was given a target number of surveys to collect, based on 5% of annual patient volume. Data was entered by trained data entry staff. For quality assurance, 10% of responses were checked by hand for the first four days of data entry. Data was entered and analyzed using Qualtrics software.

Title X Staff Surveys

RHP staff developed two staff surveys, one each for clerical and clinical staff at Title X sites, to gather input and buy-in from staff. Title X staff are trusted resources in their community and provided valuable feedback on the needs of the communities in which they live and work. Links to online versions of both surveys were distributed to field staff by email. 110 clerical survey responses and 123 clinical survey responses were received, an overall 59% response rate. Staff were asked to prioritize the areas in which they self-identified as needing additional training. Staff were also able to indicate the training format desired for each domain, in order to plan trainings and continuing education sessions to best support the staff providing Title X services.

Self-Assessments

The RHP developed two separate checklist-style self-assessments to evaluate how well Title X clinics are meeting the needs of two priority populations: 1) Adolescent clients and 2) LGBTQ clients. The

assessment tools were developed to measure adherence to national guidelines and evidence-based best-practice recommendations.

To assess LGBTQ-friendliness, the RHP utilized “best practice” guides for healthcare providers, developed by LGBTQ health advocacy groups and recommended by the American Medical Association. These guides were merged into a single document of selected elements to create a customized self-assessment tool.

RHP also partnered with a local LGBTQ advocate who reviewed the tool for completeness, relevance, and wording.

In creating an “adolescent-friendly” self-assessment, RHP partnered with the Adolescent School Health Program (ASHP) to create a cross-cutting tool that can also be used for assessment of the primary-care focused School-Based Health Centers (SBHC), to meet the needs of both programs. BFH is the administrator of the Title V Maternal and Child Health Block Grant in Louisiana and has identified National Performance Measure 10, increasing the number of adolescents with a preventive health visit in the previous year, as a state priority with crossover potential for the Title X program. The work plan for this indicator includes the creation of a checklist to assess adolescent-friendliness of OPH-affiliated clinics serving adolescents.

For both tools, the Outreach Coordinator and the statewide Nurse Consultant used these recommendations to identify three main domains to assess: 1) creating a welcoming & friendly environment, 2) patient/provider interaction, and 3) administrative support for clients. Indicators within each domain were used to evaluate whether the service delivery sites met the criteria needed to be considered “LGBTQ-friendly” or “Adolescent-friendly.” These evaluations also highlighted items at the program level that can be implemented in the upcoming grant cycle.

Qualitative Data

The Outreach Coordinator conducted focus groups and key informant interviews with a variety of stakeholders from around the state, including community partners, providers, and community members.

The interviews expanded on quantitative client survey data, exploring how people are using new Medicaid coverage benefits, illuminating attitudes towards reproductive health, and discussing the shifting nature of the healthcare landscape. The Outreach Coordinator took special care to invite community organizations who are informally partnered with various PHUs as either sources or destinations of referrals to share their experiences in care coordination.

Semi-structured interview tools were developed for the focus groups and key informant interviews based on past needs assessments and preliminary data from client survey. The Outreach Coordinator transcribed the focus groups and interviews from notes, and these transcripts were then coded by an epidemiologist from the Data to Action Team in the Bureau of Family Health. The Outreach Coordinator reviewed the codes and developed major themes that emerged from the groups.

Community Partner/Provider Focus Groups

Two focus groups gathering feedback from providers and community partners were conducted by the Outreach Coordinator in central and southwest Louisiana. These areas were chosen because of strong local partnerships as well as high reproductive health need. The focus group in central Louisiana included representatives from the OPH regional administrative staff, a PHU nurse, the director of a School-Based Health Center, and the outreach worker from a local Parish Hospital District. The focus group in southwest Louisiana included OPH regional administrative staff, OPH nurses and clerks from rural as well as urban PHUs, a representative from the local hospital, and representatives from two community-based health organizations with experience in outreach, advocacy, and education: Southwest Louisiana Area Health Education Center (SWLAHEC) and Southwest Louisiana AIDS Council (SLAC). Both focus groups were approximately 90 minutes in length.

Key Informant Interviews

The Outreach Coordinator also organized and facilitated semi-structured interviews with key informants around the state. These individuals were identified because of their work in similar settings or with similar populations as served by Title X clinics. Five interviews were held in southeast, northwest, and northeast Louisiana. The key informants interviewed work closely in community settings either in direct services or in a capacity which allows them to speak knowledgeably about their community. Participants included a School-Based Health Center nurse, a BFH Maternal and Child Health Coordinator, a home visiting nurse, and two outreach specialists for the home visiting nurse program. Each interview lasted approximately one hour.

Community Member Focus Groups: Adolescents, Women, and Men

The Outreach Coordinator organized four focus groups with community members around the state, taking place in the New Orleans metropolitan area, southeast Louisiana, and southwest Louisiana. These areas were strategically chosen because they tapped into existing community networks and meeting places. The focus groups provided direct feedback on Title X services and surveyed knowledge, attitudes, and practices related to navigating the healthcare system, reproductive health concerns, and barriers to achieving good health outcomes. Participants were reassured of confidentiality and were not asked to share their names, although most did give their ages. None of the focus groups utilized incentives for participants.

One of the Title X contract sites, the Tulane Adolescent Drop-In Center, is co-located with Covenant House, which serves runaway, at-risk, and homeless youth. With the assistance of the center's director and social worker a targeted focus group was conducted at this location with the purpose of surveying the knowledge, attitudes, practices, and needs of adolescent clients. The Outreach Coordinator and the staff social worker met with eight adolescents aged 16-21 for 90 minutes following the format of the other focus groups and using the same semi-structured tool. Participants were all users of the on-site

Title X clinic and several were current or former residents of Covenant House. The group consisted of young men and women, and they indicated no discomfort in participating in a mixed-gender discussion about reproductive health. One of the participants was already a parent. One transgender youth was present and participated in the discussion as well, providing valuable feedback.

Two women's focus groups were held, one each in southwest and southeast Louisiana. The Outreach Coordinator contacted a community organization in southwest Louisiana that conducts weekly support groups for men and women to seek permission to tap into these existing groups and solicit feedback.

The women's group consisted of eight women between ages 18-49. This focus group lasted approximately three hours and included time for normal support group activities. An additional focus group was held in the waiting room of the Aruna T. Sangisetty WIC Clinic in southeast Louisiana. The participants in this group were nine young mothers and grandmothers who were accessing services that day at the WIC clinic. The focus group lasted approximately three hours as clients rotated in and out of their scheduled appointments.

The Outreach Coordinator was able to receive permission to speak with the men's support group to gather men's perspectives on reproductive health. There were ten participants, several of whom identified themselves as men who have sex with men (MSM). The men ranged in age from 19-59. The focus group lasted approximately 3 hours.

Results and Discussion

Shifting Pressures in the Healthcare Landscape

Given the many changes to the foundations of the healthcare landscape over the last 36 months, clients and community partners both report a sense of confusion about where to access healthcare services and support programs. People in the community are no longer certain about eligibility or access points for social services. Likewise, provider focus groups frequently brought up the need to stay abreast of the services and programs offered through community organizations because of how fast services and programs were perceived to be changing. For example, a support group facilitator was still educating her clients on signing up for Take Charge Plus, a state health insurance program that covered family planning services prior to the Medicaid expansion, not realizing that clients had been auto-enrolled into Medicaid plans.

Clients do not always intuitively understand the difference between services available at doctor's offices, hospitals, and health centers compared to Title X clinics. During interviews with community members, individuals frequently were under the impression that the nearby PHU was affiliated with various other local health centers. Community members articulated a lot of confusion about how to discern differences between clinics and keep up with frequently changing insurance affiliations of clinics. One key informant in northeast Louisiana argued for more outreach attention on the branding of Title X clinics: better communicating the mission of providing services on a sliding fee scale that goes to zero; articulating the focus on confidentiality, quality care, and patient autonomy; and reminding stakeholders of the absence of residency requirements to receive reproductive services. For people in the community who may be choosing among several potential providers, they need to understand that the Title X services at PHUs are truly a valuable resource available to them.

Need for Care Navigation

Louisiana continues to close the coverage gap as Medicaid expansion reaches more people. However, with this, there will be an increased need for assisting clients with communicating with a managed care plan, understanding the incentives that come with participation in managed care plans, and making best use of the benefits they receive through coverage. A key informant pointed out that “even educated people have a hard time knowing how to use insurance,” yet the push for increased coverage has resulted in a system that relies heavily on reimbursement through managed care plans which are a new concept to many families in Louisiana. A key informant shared her perspective on how her clients struggle to navigate a system they do not perceive as intuitive:

“In the past, you had a two-tier system, which absolutely had its drawbacks, but people who couldn’t afford care could still go to the [public] hospital and get treated. They didn’t need insurance. So there’s these generations of people who never used insurance. They never had it, their mom never had it, their grandparents never had it. It just wasn’t part of the system [for them]. And now you have this big push towards insurance, and you have people who don’t even know the basics of it.”

Another provider agreed. “I feel like I’ve given people a ticket to get on a bus but I haven’t told them where the bus stop is, or when to get off the bus.” To help reduce paperwork and increase efficiency, there has been a shift to having some social service programs use online reference material and signups. A middle-aged man related the frustration of being told to sign up for Medicaid online: “It’s really hard, lots of people don’t have internet except maybe on their phone. Older folks, even over 35, might not have it at all. You think it would be easier if something’s online but that also might just be an extra step for someone.” A key informant in northwest Louisiana remarked, “We really ask the most out of the people who have the least amount of control over their lives,” who struggle to understand intricate eligibility rules and work out complex logistics to sign up for and actually receive the benefits of various social safety net programs.

Community members felt put off by the overwhelming bureaucracy of the new health coverage through Louisiana Medicaid. In one regional center, the local hospital simply stopped accepting one of the five

Medicaid plans, leading to confusion and dismay among focus group participants. During a discussion about this, the support group facilitator suggested switching plans during open enrollment to a new plan that better met the needs of a community member, who shook her head. “I don’t even know what that means. I don’t know how to start doing that. [pauses] I mean I’m not stupid, it’s just overwhelming. I feel like I don’t even know what’s going on.” An outreach worker at a parish hospital district in northern Louisiana shared that “the enrollment packages- the letters that people get- require so much reading, it’s almost too much for many patients to get through by themselves. I get patients through my outreach program- they call me- and they say, ‘What are all these letters? I don’t understand them.’ Or they’ll bring them in and ask you to read it to them and explain it. It’s not written in an understandable way.” Other community members around the state echoed that sentiment, feeling frustrated at dealing with a faceless bureaucracy that seems to speak a different language than they do. With their longstanding presence in the community and high level of trust, Title X clinics and providers can play a critical role in helping clients navigate this new system and connecting them with important services and primary care. Better care navigation in a changing landscape will be an important role that Title X clinics play, as they serve primarily low-income individuals who are often eligible for publicly funded services but unaware of how to connect with them.

Clinic Flow and Management

In the Title X staff survey, clerical staff ranked EHR training as one of their highest priorities, an indication of interest in integrating scheduling and documentation software into improving clinical processes. With continued attention to accurate billing and coding to appropriately bill payors, providers report that they are struggling to keep up with an ever-evolving billing system, although the program currently boasts a 90% clean claim rate. The Title X staff survey- in both clerical and clinical surveys- revealed that one of the most urgent needs for staff was in further training on billing and coding, ranked as “highest priority” by

46% of respondents. Improving billing and coding and reducing errors would result in increased efficiency and increased revenue from third-party payors.

Clients do not always see the clinic management techniques behind the scenes that contribute to better clinic flow, but they experience the effects. The number one patient complaint was frustration regarding wait times. Clients sometimes perceive that they wait too long for services and when they do wait, the delay goes unacknowledged, leading to further frustration. Some clients- particularly of smaller, rural clinics that are not open every day- report that they find it difficult to get an appointment at a convenient day or time. This was reflected in qualitative data of community members: the perception was that services at the Parish Health Unit (PHU) were of good quality, but that wait times were high. As one community member related, “the services sure are good, but you expect you got to wait.” One key informant in northern Louisiana pushed back, however, remarking that she felt wait times had really improved over the previous two years, but perhaps the reputation lingered. “You should really communicate the changes in the program to the community. It’s really improved, and they need to know they won’t wait as long as they used to,” she says.

Results of Client Survey

Demographics of Client Survey

All nine regions responded to the client survey, with 59 parishes and contract sites returning surveys for a total of 2,359 responses. Region 4 was slightly over-represented with by far the most responses per region. No responses were recorded from Cameron, Lincoln, Natchitoches, or Ouachita Parishes.

Race/Ethnicity	Survey Responses
Black	64%
White	29%
Hispanic (any race)	6%
Asian	1%
American Indian/Alaska Native	1%
Other	1%

The demographics of the client survey were representative of clients served by the Title X network, although not representative of the state population at large. Clients were given the option to choose multiple races, but few respondents did so. Just under two-thirds of all clients self-

Table 2: Race and Ethnicity of Client Survey Respondents (n=2359)

reported as black, about one-third self-reported as white, and 6% of all respondents self-reported as Hispanic (of any race). There were small populations of Asian respondents from around the state, tracking closely with known Vietnamese communities in a number of parishes. Finally, two small but important communities of American Indian/Alaska Native respondents were observed in survey responses. In LaSalle Parish, home to the Jena Band of the Choctaw Nation, a federally recognized tribe, 7% of all survey respondents self-identified as American Indian. Further west, in Sabine Parish, 17% of respondents to the survey self-identified as American Indian.

The gender breakdown of respondents were largely representative of annual client volume; 89% of total surveys were received from female respondents, and 11% from male respondents, although this varied by clinic. Orleans, Calcasieu, East Baton Rouge, Jefferson (Marrero location), and Caddo Parishes all reported some of the highest proportions of male respondents, which reflects the regional population centers and urban areas of the state. Although the option was given for respondents to identify themselves as transgender, no responses were received from any transgender individuals.

Patient Experience and Satisfaction With Services

Clients surveyed reported high rates of satisfaction with services: 98% of respondents reported that they were “happy” or “very happy” with reproductive health services received. Patients consistently ranked Title X clinics high in areas relating to customer service, overall satisfaction with services, patient trust in providers, and feeling welcomed by staff. Clients perceive Title X clinics to be supportive of their values and respectful of their beliefs. This consistently came up in qualitative data collection as well. Community members frequently indicated that one of the most important things they look for in a provider is simply someone who “treats [them] like a human being.” A key informant in northeast Louisiana shared her experiences in working with low-income young mothers in an extremely rural and impoverished area of the state: “[She] comes in [for services], and it’s already a struggle [to get there]. And oftentimes, she is a young mom just trying to do what she can do. She is already sensitive to being treated unfairly. She

already might have a chip on her shoulder... [she's] already on alert to small things that indicate that [she's] not welcome or is being judged. [She] picks up on it." This reinforces how meaningful it is that the Title X clinics received such high ratings when it comes to interacting positively with clients who may have different cultural backgrounds or life experiences.

Cost and Affordability

When it comes to cost and affordability, clients rate the value of services received highly. 88% of survey respondents responded that they always find the cost they are asked to pay to be reasonable.

Affordability was also rated highly as one of the reasons that clients chose to receive services at the Title X sites: 42% of all clients responded that cost was one of the main factors they consider when choosing the Title X clinic. One client shared that they come to the PHU for STI testing because it's "too expensive at my regular doctor." However, some providers note that they have seen shifts in how clients perceive value of services. As the Title X clinics improve their billing of third-party payers, clients are uncomfortable with not being able to see a clear menu of services and associated cost. In a focus group, providers shared that their client base "isn't coming as regularly, they aren't getting tested. They are afraid of the bill. They can't get a straight answer about how much [a service] is going to cost them and they assume it's unaffordable. It's not that we don't want to tell them, it just gets negotiated through Medicaid or their insurance first, but they get nervous about that." The lack of transparency when it comes to costs associated with care makes clients uncomfortable. Given the importance that clients place on affordability, outreach efforts need to clearly communicate the policy of Title X to provide care regardless of the ability to pay.

Client Insurance Status

Over half of clients who responded to the survey reported that they were covered under public insurance (such as LA Moms, Take Charge Plus, or Medicaid plans). 12% of clients had private insurance, and 11% were covered through Medicaid. Although 13.8% of the state lacks insurance coverage, 22% of the Title X

clients responding to the survey indicated they were uninsured. This varied by parish: in Assumption Parish, in southeast Louisiana, for example, 44% of respondents were uninsured. Small numbers of respondents utilized Tricare or other military health care, mostly in parishes containing the military installations of Ft. Polk and Barksdale Air Force Base.

The client survey differentiated between clients who were temporarily without coverage (less than six weeks without coverage) or long-term uninsured (over six weeks without coverage). Most of the respondents to the survey were long-term uninsured: 21% of all survey respondents had not had insurance coverage for over six weeks. Only 1% of survey respondents were temporarily uninsured; these clients were most often between forms of coverage, such as waiting for new coverage to begin through a job or waiting to hear back from Medicaid. Title X services help close that gap for individuals who find themselves temporarily lacking insurance coverage and would therefore face difficulty accessing care for reproductive health services, which are often time-sensitive and urgent.

The situation remains concerning for uninsured clients. Of the long-term uninsured respondents, 1 in 3 indicated that they had not gone anywhere else for health care in the previous 12 months. Only 5% of uninsured clients indicated they had used pharmacy services in the last 12 months, compared to nearly 14% of clients with private insurance, indicating that they have less access to prescription medications. 79% of uninsured clients did not have a primary care provider that they saw regularly for preventive care, underscoring the importance of Title X services for people who have very few options for other health screenings or encounters.

People lacking insurance coverage seemed to place value on different aspects of Title X service. They rated its affordability of services as most important to them; compared to clients with private insurance, for example, who ranked affordability as a lower priority than proximity/ease of getting to the clinic. Clients between coverage also selected “I didn’t know where else to go” more than any other group,

indicating that the safety net nature of the Parish Health Unit is still an integral part of the way the services are perceived by the community.

86% of clients of PHUs have some kind of insurance coverage, whether private or public, and of these insured individuals, 63% have a primary care provider. However, 10% of clients statewide indicated that they relied on Title X services because they were unwilling or unable to go to their regular provider for STI testing or family planning advice. In one parish, the former public hospital became privatized and no longer provides family planning services due to religious beliefs; 27.8% of respondents in this parish indicated that they now rely on Title X services at the Parish Health Unit to meet their needs because they do not want to go to their regular provider for reproductive health services. Several write-in comments on the survey addressed this gap, with one woman simply stating that her “insurance is through a [religious] hospital, therefore they don’t cover the cost of birth control pills.” This emphasizes the importance of the PHU as a safety net for individuals who may have access to some level of care but still face barriers when it comes to accessing important but sensitive elements of reproductive health care like contraceptive services.

Care Coordination

Following initial challenges in care coordination following privatization of the public hospital system, particularly in finding primary care providers who would accept new patients, providers and partners are now much improved in care coordination efforts. In the past, referrals were perceived to be much easier because the public hospitals had a long partnership with the Parish Health Units, to the point of even having specific liaisons detailed to help coordinate care. A provider in central Louisiana says: “After the change, the referral system really backed up,” however, the ability to provide effective and efficient linkages to care is now trending upwards. “I wouldn’t say it’s completely flawless now, but it’s improved from what it was at first,” the provider continues. Title X services continue to improve on this front, and clients do perceive clinics as being helpful in connecting them to other sources of care. 91.3% of clients

believe that Title X clinics are always helpful in arranging timely referrals for things like mammograms and colposcopies, though not unexpectedly, the areas needing most improvement in this area are rural parishes with fewer options for advanced medical services. Clients must be referred out to other medical providers for important services such as colposcopies for abnormal pap smears, mammograms, vasectomies, and tubal ligations. The Title X staff survey prioritized clinical management of abnormal pap smears in particular, reflecting the providers' awareness of the difficulty their clients may face in getting an appointment with a specialist on their own. Given the statistics regarding the high rates of cervical cancer and the low rates of pap smears for the general population, management of abnormal results and coordinating with referral partners remains an essential service provided by PHUs.

Health Concerns and Family Planning as a Priority for Clients

One of the major themes that emerged in the focus groups and key informant interviews as a potential barrier for clients is where health ranks as a priority for people in the community. Key informants and community members all described other concerns taking priority: care for both chronic and urgent health needs ranked well below more immediate concerns such as finding steady work and staying current on bills. Participants continually stated that their biggest concerns were economic in nature, "getting a job and then keeping a job" as one participant stated. One key informant described her clients driving over an hour each way to the closest urban center for "GED classes or a CNA training course. They take classes at the community college," investing precious time and effort to gain a certification that will afford financial stability. In a state with astonishingly high poverty rates, people are excruciatingly aware of their needs and are forced to make dramatic tradeoffs when it comes to health. When asked to describe their most pressing concerns in day-to-day life, a focus group of women in southeast Louisiana unanimously said it was jobs, bills, and their family's livelihood they were most concerned about. When pressed to describe where health fits in to these concerns, a respondent stated, "Short answer? [It] doesn't." Another respondent echoed her: "Women have no time to worry about their health. None."

In a discussion about how women prioritize their obligations, a group of women related:

Participant 4: Ha! It's easy. Mom is out there trying to make bills. She's working whenever she can, wherever she can, at whatever little job she can pick up, just trying to make money stretch. She spends so much time trying to keep her children fed and not get behind on the family's bills.... You spend every second of your day looking after everyone else and making sure everything is taken care of until you forget to do anything for yourself.

Moderator: What about something that, in the long run, pays off, like [looking after] your health? Or investing in a quality family planning method until the family is back on its feet?

Participant 5: It would be nice, but no one has money or time up front. It always feels like you are one or two paychecks behind, all the time. You can't afford to take a day off work [to get an appointment].

Participant 4: Or get someone to watch your kids while you take a day off work and go to the doctor's office.

Participant 1: Or take them with you and be running out of the office every five seconds because they're having a meltdown- they're tired, hungry, they want to go home. Making a scene, embarrassing you. Ah, I figured it out- that's why I don't go to the doctor! [laughs]

Notably, the concept of planning for the future doesn't always include family planning. One focus group was ambivalent about actively planning for children:

Moderator: Okay, so do you think that people are good at planning out when they are ready to have kids- talking [it over] with a partner, getting healthy, getting financially ready?

Participant 1: You know what- it's never a good time to have kids.

Participant 2: Yeah, it's something you can't really plan.

Participant 1: I mean, it would be nice, but it always happens when you aren't expecting it anyways. [...] [In my case] I came up pregnant after I stopped thinking about it!

Participant 2: Same. [...] I thought I couldn't get pregnant!

Data from the 2014 Louisiana Pregnancy Risk Assessment Survey [PRAMS] supports this, as only 41.8% of pregnancies in that year were planned.²² At the same time, among women not trying to become pregnant, 59.8% were not using birth control in the year prior.²² This ambivalence towards family planning- not wanting to become pregnant, but not doing anything to prevent it- represents a major area to focus education and outreach to clients, and the comprehensive nature of the Title X clinics would make it an ideal source of information.

Reasons for not using a contraceptive method prior to most recent pregnancy, for women not trying to become pregnant	Percentage
Didn't mind getting pregnant	32.4
Didn't think could become pregnant	26.1
Side effects from birth control	6.8
Problems acquiring birth control	5.5
Thought partner was sterile	5.7
Partner didn't want to use	11.7
Forgot to use	11.3
Other	9.8

Table 3: Reasons for not using contraception prior to most recent pregnancy. Source: LA PRAMS 2014 data

The 2014 PRAMS survey asked these women who were not actively trying to become pregnant why they chose not to use a contraceptive method. The biggest reason given was that they didn't mind getting pregnant, followed by they didn't think they could become pregnant, and then their partner didn't want to use any contraception. All of these reasons indicate an opportunity for better education and counseling for clients. Other reasons cited included problems acquiring birth control and problems with side effects. Again, Title X services could help close these gaps in accessing birth control and in finding an effective, acceptable method of contraception for clients.

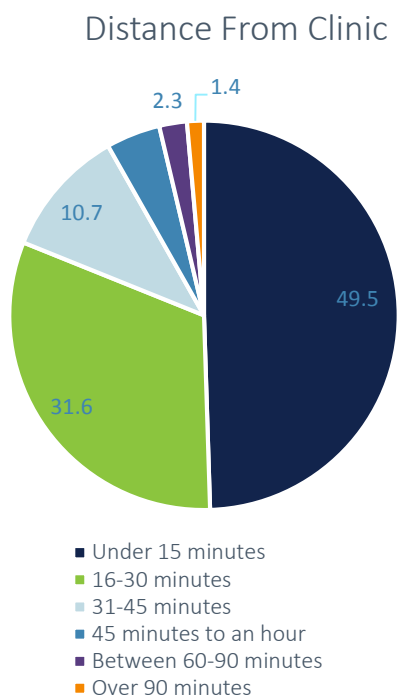
Several key informants mentioned that some communities find it difficult to talk about family planning and reproductive health because of religious objections or cultural norms surrounding sexual activity. However, clients surveyed rate the Title X clinics very highly in being respectful of their values and beliefs. For clients who may be navigating conflicting messages from cultural or religious spheres, Title X clinics would provide the widest range of methods and most accurate information to help them choose a contraceptive method they find acceptable and non-coercive. The emphasis on client-centered counseling and the focus on patient autonomy at the Title X clinics could be a major reason that these clinics were rated so highly in helping patients make a good choice for themselves.

Geography and Transportation Barriers

The client survey revealed a few important gaps when it comes to receiving reproductive health care. 1 in 10 clients reported traveling over 45 minutes to reach a clinic. Qualitative data supports this struggle to reach services in some areas of the state. Two key informants in northeast Louisiana relate the challenges their clients face in accessing care: "It's very hard to get to these rural areas. Services are extremely hard to get in these smaller communities. People really struggle to get around out here. Transportation is extremely challenging." If people do not have a car, there is no public transportation system in most parts of the state to rely on. Instead, as explained by an outreach worker in northern Louisiana, people expend

limited social capital by asking for favors from friends or acquaintances: “People get in the situation of trying to shift it around, and not always ask the same person.” A home visiting nurse agrees. “Sometimes my moms will just stay home. If they can’t walk somewhere, and if they don’t have a car, which is a lot of young moms, they just stay home and hope for the best.” A community member in southwest Louisiana expressed frustration with her experience trying to access care as a low-income mother of two with complex health concerns of her own:

“One of the big things is that [we] are people who are used to getting the run-around. People who are most low-income, like struggling the most to put diapers on their babies even, [we] are used to having to jump through the most hoops to get [our] little benefits. For medical care, [we] are the ones who are asked to hurry up and try and find a ride to this office at this time or that office in another parish, then get to a clinic, and then to a pharmacy, and then come back in a week for a follow-up, and then. So, like... not that [we] don’t have options for health care, just that it’s way complicated now. More than it used to be. Used to be you could just go to [the public hospital]. But that’s gone now [because that location does not accept all Medicaid plans].”



Transportation represents a major barrier to care for some individuals, and because of that, a Parish Health Unit might be the most appealing option for people seeking reproductive health services. The statewide network of locations and contract sites means that there is a Title X clinic in almost every parish seat. 48% of clients surveyed indicated that they came to the Parish Health Unit because it was “close or easy to get to.” Furthermore, 50% of clients stated that they traveled less than 15 minutes to reach the clinic on the day they completed the survey.

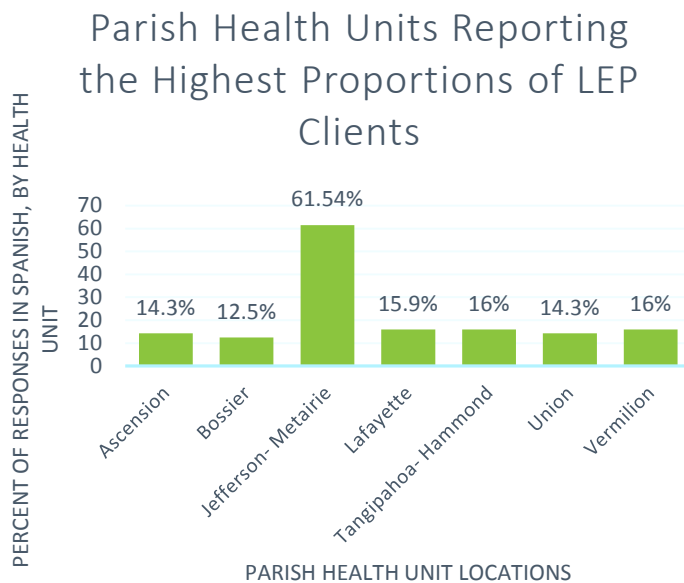
Communication with Providers and Staff

A high proportion of respondents to the client survey indicated that they prefer to talk to a nurse, doctor, or health educator with a question about their health. This varied by age: older clients were much more likely to report that they would prefer to discuss a question about reproductive health with a health provider. Clients younger than 18 reported more discomfort with bringing reproductive health questions to a provider, relying instead upon friends and family. One adolescent focus group participant shared, “In my mind, it’s like, the doctor’s duty to start that conversation. It’s hard to start that conversation when you’re 12, 13, 14, 15. But we want to know! Just can’t bring ourselves to ask. Sometimes we don’t know how to ask. Sex is [an] uncomfortable [topic].” This highlights the role that Title X providers can play in reaching out to clients in general, but especially adolescents, and starting that conversation that adolescents can find so difficult to bring up.

Due to cultural norms in Louisiana, even older clients may find it difficult to bring up questions about reproductive health. In focus groups and key informant interviews across the state, family planning and reproductive health were both consistently described as “personal issues.” One key informant’s take on it was that “It’s just private. Not taboo. But they are very private things that people won’t talk about in public. I mean... it’s not unacceptable to have the discussions, but it is expected to be a private matter. Done away from the public eye.” This highlights how Title X clinics can play a major role in educating clients and empowering them to make good decisions for themselves based on accurate information that they are not likely to receive elsewhere due to the sensitive nature of these topics and the cultural norms around them.

Special Populations

Clients with Limited English Proficiency



Surveys were translated into Spanish for clients with Limited English proficiency (LEP). 5% of all surveys were completed in Spanish, which is representative of Title X clients seen annually. There was extreme variability throughout the state: some PHUs returned no surveys completed in Spanish, but 65% of all surveys received from the Jefferson Parish Health Unit in Metairie were in Spanish. This PHU serves the highest volume of Spanish-

speaking clients by a large margin, an important note for future outreach efforts.

Survey results revealed surprising trends among the Spanish-speaking clients of the Title X services.

They give high marks to the Title X clinics' convenience and reliability: knowing that they could always be seen at the PHU was cited by LEP clients as the most important thing they consider when receiving services there. Nearly 1 in 3 also reported that proximity of clinics was one of the most appealing aspects of the services. 84% reported that they travel less than 30 minutes to reach the nearest Title X clinic. Spanish-speaking clients also rank the Title X clinics very highly on cultural competence, with fully 97.5% of LEP clients reporting that they always feel like staff respects them, their beliefs, values, and culture. However, challenges remain in serving LEP clients. Only 56% of LEP clients who had received STI testing reported that they completely understood what the tests were for; 33% reported that they did not

understand the tests at all. Even more disappointing, 46% of LEP clients who had received STI testing that day reported that a nurse had counseled them on ways to reduce the risk of contracting an STI, compared to 67% of English-speaking clients. Communication with LEP clients is currently conducted through a language line which allows the provider to access a translator by phone, which can be awkward and time-consuming. In write-in comments, one of the topics that emerged was understandably expressing the desire for more Spanish-speaking providers to help facilitate communication. In the meantime, further training of providers may be necessary to help them better communicate more clearly with LEP clients. The client survey also revealed the desire among Spanish-speaking clients for more written material to review and digest on their own. When receiving test results, 50% of LEP clients stated that they would prefer a written letter from the office, compared to only 17% of English-speaking clients. A large proportion of LEP clients also indicated that they would be interested in using the patient portal to interact with providers. 60.1% of LEP clients were unaware of the patient portal service but were interested in signing up: this represents an avenue for outreach and improved services for Spanish-speaking clients. A better selection of educational materials and media in Spanish would be ideal to help communicate with and counsel LEP clients.

The needs of people with LEP were articulated well by the providers and key informants around the state. In central Louisiana, provider/partner focus group participants described knowing that there were populations of migrant workers in nearby communities in need of services but feeling like cultural barriers prevented them from conducting good outreach. "One thing we notice is that the men don't like someone to talk to the women without them there. I think this makes it hard to reach the women and harder to connect them with services they need." Other participants agreed: "I think there's a lack of trust in the institutions. I think they are worried that if they interact with the system, they will get reported on somehow." However, 97.3% of LEP clients also reported that they trusted the Title X clinics to keep their information confidential, an important consideration for communities that value this

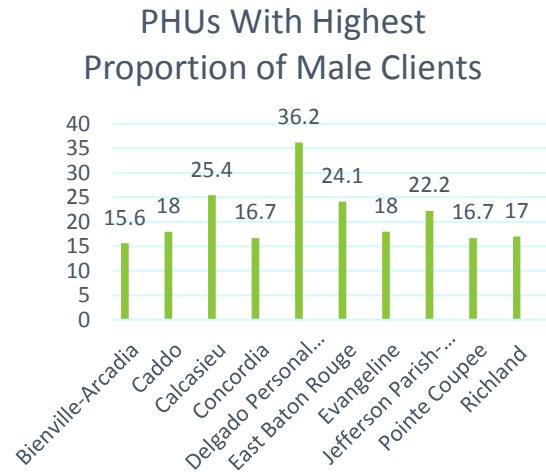
guarantee of privacy. Providers discussed the role that word-of-mouth information plays in the Latino community and seeking of services: “One [person] will come in. They will come back with two friends. Then they’ll come back with a whole car load of people.” Once clients know they are welcome and will be treated well, they come to trust the Title X clinics with their reproductive health concerns and recommend the services to their contacts. Outreach strategies targeting the Spanish-speaking community in Louisiana would be wise to leverage this information about the importance of word-of-mouth recommendations to reach potential clients through current clients.

Spanish-speaking clients were overwhelmingly more likely to report that they had not accessed medical care elsewhere: 60.3% of LEP clients had not gone anywhere at all for a health or medical concern in the previous 12 months, compared to only 14.7% of English-speaking respondents. 40.7% of LEP clients also reported that they chose services at the Title X clinics because they knew they could always be seen there, and a further 23% did not know where else to go. These findings illuminate that a Title X medical encounter might be the only interaction a client may have with a healthcare provider. This indicates that a Title X clinic would be a prime opportunity to offer screenings and referrals for medical care and social services.

Providers and key informants also noted small, scattered communities of Vietnamese speakers around the state, particularly in the central and southeastern parts of Louisiana, which was corroborated with data from the client survey. There are also increasing numbers of international workers at casinos in the southwest and northwest, and providers have noted growing Caribbean communities in the southwest as well. Additional outreach will be needed in the future to reach these new communities of LEP individuals.

Men

Male clients make up 21.2% of annual clinic volume for Louisiana’s Title X clinics, representing one of the highest proportions among Title X programs in the south. Urban centers of the state tend to see higher volumes of male clients, though smaller parishes in rural areas also serve large proportions of male clients. Male clients rated Title X services highly in the following areas: customer service, confidentiality, quality of counseling received, cost, and ease of referrals.



Focus groups discussed the gaps concerning male reproductive health clients. Providers and community members shared frustrations in meeting the needs of male clients as reproductive health has shifted to a comprehensive model. “I think the cost for male clients has gone up. It used to be they could come for just STD testing and come in through the back office and in and out. Now it’s an appointment, you spend time talking to them. I don’t think men get it, really.” A male community member stated, “I don’t really know... anytime I used to go just get a simple, straightforward test now it turns into a whole thing where I get pulled into a discussion about some other things [like reproductive life planning and getting screened for other health risks].” Although men express confusion about the time and costs associated with the shift towards a more comprehensive model of reproductive health care, the benefits of engaging men on reproductive health issues are clear. Encounters such as these are opportunities to share messages of prevention, answer questions about general sexual health, and provide screenings for important chronic health conditions like high blood pressure and diabetes.

A key informant brought up the limited way in which men are often engaged when it comes to reproductive health: “Men need to know what they can do either for themselves or to support their

partner,” as opposed to limiting the conversation with men to STI testing. A young male community member echoed this. “I think it’s important for dudes to know about [different] types of birth control... like if your girl is on a kind of birth control, you got to know about it too. So if she miss a pill and tells you it’s fine, you gonna know it’s not fine.” Data from the survey supports the need for increased education for male clients. Only 48% of male clients reported that they discussed their plans for having children or more children with a nurse at a recent reproductive health visit, compared to 77.2% of women. Only 37% of male clients stated they had talked about birth control options available to them at a recent family planning visit, compared to 81% of female clients. However, male clients did report a high satisfaction with understanding information about STI testing and treatment.

Women in the community feel this heavy burden of this responsibility to be in charge of family planning. “Men aren’t entirely aware of their role... you can talk to your partner, sure, but when it comes down to it, it’s all on the woman in the end,” a middle-aged mother from southeast Louisiana shared. A nurse from north Louisiana echoed this. “Women feel a lot of pressure. You hear things like, ‘My boyfriend doesn’t want to use condoms’ and that’s it- they don’t use condoms. They don’t have the tools to negotiate that conversation with someone who wants something very different out of that encounter.” Title X clinics could potentially play a much larger role in reaching out to men and helping shift the conversation with male clients to a more comprehensive discussion. An outreach worker in northeast Louisiana points out that oftentimes the only situations where she sees men in a reproductive health clinic is when they drive their partner to an appointment: “I’d like to see them next to their girlfriend, getting tested and counseled and talked to about birth control too. It doesn’t need to be a tense [discussion]. I would hope in the future that men would be invited to participate more and see what their partners are asked to do and how they can fit in.”

Adolescents

In the Title X staff survey, both clerical and clinical staff rated “Improve Clinic Adolescent-friendliness” as one of their highest priorities. Staff in focus groups repeatedly expressed the desire to reach out more to the adolescents in their community and wanted their clinic to reflect this welcoming attitude. In order to evaluate this, the adolescent-friendly self-assessment explored three broad categories in which the program could better orient services towards adolescent needs: 1) creating a welcoming environment, 2) patient/provider interactions, and 3) administrative support.

In the category of creating a welcoming environment, program staff evaluated available literature, posters, and media targeted to adolescent audiences. Although the program has approved some materials targeted to adolescent audiences, the materials are rather dated and not appealing to adolescents. Better literature and media targeted to adolescent clients would be a welcome addition to the outreach toolkit.

In terms of patient/provider interactions, the program scored relatively well. All program staff and providers have completed specific training about adolescent health and development, as well as training modules on how to communicate well with adolescent clients. However, the Training Needs Assessment results showed that Title X providers noticed a need for additional training on educating adolescent clients on the confidential nature of services and in confidential billing of services.

There are areas for improvement within administrative support of adolescent services, as well. None of the PHUs offer services outside of traditional business hours, though the Tulane Adolescent Drop-In Clinic, a contracted site, offers non-traditional hours after school and on the weekends that better suit adolescent needs. RHP recognizes that adolescents would be better served by expanding or shifting PHU hours of operation, but PHUs have less flexibility than contract sites in this regard.

Services for adolescents are also not marketed to young people in ways and via mechanisms that young people access; the Title X program is very limited by state government policies when it comes to engaging

potential clients on social media or conducting messaging campaigns. On the other hand, youth statewide were actively engaged in evaluating the program during the needs assessment process. Adolescents provided feedback in the client survey as well as in focus groups, providing valued feedback on how services could better meet their needs.

Adolescents gave high marks to clinic staff, who they felt were great at respecting their autonomy and helping them make a good decision; they were equally positive about the clinic environment and value of services. Out of all age groups, younger adolescents (14 and under) rated Title X services the lowest in patient privacy concerns - only 91% of clients stated they trusted clinic providers and staff to keep their information private and confidential, compared to 96.5% for all groups. This could reflect overall miscommunication about adolescent confidentiality requirements in Louisiana. In a focus group, adolescent clients repeatedly confused the differences between Title X clinics, private hospitals, crisis pregnancy centers, and FQHCs. From the perspective of an adolescent client, it was difficult to understand that providers in different settings would approach patient confidentiality differently. One focus group participant shared how a bad experience at a hospital colored her whole perspective towards adolescent privacy: "I went to the hospital with my mom [who was not my legal guardian at the time]. And someone came in and did some bloodwork and took a urine sample. And then the doctor comes in and just like that, tells me I'm pregnant. Doesn't ask my mom to step out or anything. Just all that information right in front of her, like he doesn't know the situation between us or how either of us was gonna react. Yeah, I was 17, but it wasn't right." Experiences like these deeply affect adolescents, and miscommunication about adolescent medical privacy can spread through word-of-mouth. One strategy to improve adolescent comprehension of Title X services would be to incorporate the suggestions of Title X staff: ensure that refresher training is in place for clerical and clinical staff to review confidential exams and confidential billing mechanisms, and most important, to communicate these mechanisms to adolescent clients.

LGBTQ Clients

Patterned on the adolescent-friendly self-assessment, the LGBTQ assessment evaluated areas of the program that serve the needs of LGBTQ clients, also in the same three domains: 1) creating a welcoming environment for LGBTQ individuals, 2) patient/provider interactions, and 3) administrative support for LGBTQ clients.

In creating a welcoming environment for LGBTQ clients, program staff reviewed literature, materials, and media specifically targeted towards LGBTQ health needs. There were no approved posters depicting LGBTQ individuals, although there were some pamphlets and brochures for HIV/AIDS and other STIs that were targeted specifically to clients who are men who have sex with men (MSM). Media and patient education material targeted towards LGBTQ clients would communicate more of a welcoming atmosphere.

In the category of patient/provider interactions, the program scored well. The Electronic Health Record (EHR) allows clients to choose from a variety of gender identities, and clients are able to indicate their preferred gender pronoun with which to be addressed by staff. These measures help preserve dignity and set the stage for positive and open interactions with staff. All staff are well-trained on LGBTQ issues, having completed trainings on transgender sensitivity as well as care for LGBTQ patients. The RHP medical manual also integrates LGBTQ health issues into every patient interaction: depression, alcohol and substance abuse, and suicide are issues that disproportionately affect LGBTQ individuals, and screenings for these issues are completed for every Title X client.

One issue within the patient/provider domain that stood out as an area of opportunity was access to pre-exposure prophylaxis (PrEP). For individuals who are at very high risk of contracting HIV, regularly using PrEP represents one of the most important actions they can take to prevent infection. In particular, MSM or partners of people infected with HIV would be good candidates for PrEP and access to this medication is of critical importance to the LGBTQ community. PrEP is not currently available in the Title X clinics. The

RHP can better serve their clients by improving capacity to identify patients eligible for PrEP and ensuring effective referral pathways to PrEP providers exist and are formalized.

Administrative support for LGBTQ clients also revealed some areas for improvement. Although no specific complaints have been made about discrimination against LGBTQ clients, the program lacks a confidential, transparent reporting mechanism for conveying dissatisfaction with services. This mechanism would allow the program to track rare but serious incidents of discrimination. Also, while a non-discrimination sign is posted in each clinic, it was acknowledged that the sign could be more prominent. In the sometimes-tense climate towards LGBTQ individuals in the rural South, communication of a clear policy of non-discrimination could provide a strong message that they are welcome and they have recourse should they experience discrimination.

Focus groups and discussions with key informants and community members reinforced these findings. A trans woman and local LGBTQ health advocate who reviewed the assessment remarked that “Rainbow flags and human rights stickers don’t mean anything anymore. They’re just window dressing. I think what people in my community care about most is genuinely seeing themselves in the clinic- on posters, in media in the waiting room, in the way the staff actually interacts with you. Being able to regain your dignity by reporting someone who humiliates you. That’s the important stuff.” She continued, “It’s less important to have LGBTQ people on staff, and more important to have someone who genuinely cares about your well-being.” Within the male focus group, there were several MSM participants, most of whom were fathers as well. One of the recurring themes that these men brought up was a concern with the privacy of their health information. “The next worst thing after coming up positive [for an STI] would be someone else finding out about it,” one man said. Other men shared the need for education and outreach within the MSM community for confidential STI testing. “There’s such a stigma in small, rural towns. Sex isn’t talked about there. Do people know their risk [for STIs]? I’d say not really.... There’s a denial attitude- ‘I’m not this. I’m not that.’ And they never learn about these risks they [are] taking.” The

non-judgmental education and counseling component of Title X services are an important tactic for reaching these high-risk communities- particularly in small, rural areas with little other resources or commitment to non-discrimination based on sexual orientation.

Summary of Findings

The needs assessment identified major program strengths as well as opportunities for improvement. The client survey communicated many positive findings: high satisfaction with services overall, with emphasis on affordability and convenience. The client survey also showed that clients place high trust in Title X providers and value the professional advice and care shown during encounters. Clients expressed that they felt that their beliefs, culture, and values are respected and they are comfortable opening up and communicating with their providers. This is particularly important in areas of the rural south, where cultural norms may mean that clients may not feel comfortable discussing topics that are perceived as “private” with providers who have not earned their trust. The client survey also gained important feedback about how much the community relies upon reproductive health services at the PHU in times of unexpected need, such as when they cannot get contraceptives from their normal provider or they lose insurance coverage. Clients report that they are generally pleased with the care coordination services, though formalizing relationships with referral partners could improve patient experience in rural parishes. However, community members also have voiced their frustrations with navigating a greatly changed health system. Institutions that used to serve primarily low-income communities have closed or changed hands, and family planning services are no longer provided in at least two of these formerly public facilities. Policies about payment have shifted to rely on reimbursement through managed care plans; this leaves members of the community feeling confused and helpless when dealing with these plans, which are perceived as complicated and opaque. Title X can help meet the needs for care navigation for low-income clients, assisting them in understanding their benefits and helping them participate more in their care.

The Title X staff survey revealed the need for further support of clinic management processes. Continued specialized training on EHR software could help PHUs improve clinic flow and scheduling, leading to

reduced wait times, which was the number one concern among clients. Staff also requested more support in improving billing and coding practices, which would serve to reduce errors and increase efficiency and revenue. On the clinical side, staff has also prioritized areas of clinical care, in particular management of abnormal pap smears. Title X staff also expressed the desire to conduct more outreach, especially among adolescents and make their clinics friendlier to both adolescents and LGBTQ individuals.

The adolescent friendly self-assessment found that PHUs can be considered generally adolescent-friendly, although more updated media, literature, and outreach materials would help reach this population.

Unfortunately because of the affiliation with the state government, PHUs are extremely limited in the ways in which they can participate in social media campaigns or conduct outreach on social media platforms. Adolescent clients felt Title X clinics were positive environments and felt that staff helped them make good decisions while respecting their autonomy. However, adolescents were most concerned about their confidentiality; this ties in with the Title X staff survey which prioritized additional training on adolescent confidentiality laws and confidential billing mechanisms.

The LGBTQ self-assessment found that PHUs are also communicating a welcoming message to these clients. LGBTQ health issues are integrated into all patient interactions and staff are trained to not make assumptions about a client's reproductive plans based upon sexual orientation. Areas of opportunity include working to connect high-risk individuals with PrEP, developing more LGBTQ-friendly outreach materials, and developing a confidential, transparent reporting mechanism for reporting incidents of discrimination.

Male clients report high satisfaction with understanding information presented to them, but data also shows that the conversation with male clients could be expanded beyond STI testing. Focus group participants expressed interest in learning more about birth control options for women so they can better support their female partners. Men report that they felt pleased with the customer service, confidentiality of services, and ease of referrals. Urban areas of the state currently see the highest

proportion of male clients, but outreach in rural areas can be much improved through community engagement.

LEP clients in Louisiana are primarily from Spanish-speaking communities. These LEP clients are found throughout the state, though the highest volume of these clients are seen in suburban New Orleans. LEP clients feel that services at the PHU are reliable, affordable, convenient, and highly culturally competent. They also feel that staff respects them, their values, beliefs, and culture, and report that they most appreciate the proximity of clinics to their communities. However, one area that needs improvement in serving LEP clients is in the area of communication. Clients express a desire for more educational materials in Spanish and report that they would more prefer printed test results to read and digest on their own. They also report a high interest in signing up for the patient portal and using the online services available through the portal.

The very great extent to which reproductive services are needed in the communities served by the statewide Title X network are evidenced by the high rates of STIs, the high rates of unplanned pregnancies, and the lack of other providers willing or able to provide the same services. The Parish Health Units and contract sites that provide reproductive health services through Title X are located throughout the entire state, and are poised to deliver services immediately into low-income areas with little other options for reproductive care. The current clients served by the Title X clinics in the state report that they are extremely pleased with the services received and consider the PHUs to be a quality community resource. In a healthcare landscape that has changed so rapidly over the last several years, people connect the Parish Health Units to a sense of constancy and know they can always be seen there. Having been a Title X provider for the last 40 years, the leadership of Louisiana's Reproductive Health Program has experienced the delivery of family planning and reproductive health services in continually evolving health care delivery systems. Investments in staff training and process improvement combined

with a willingness to respond to changing community needs has resulted in a Title X program which clients trust to deliver the highest quality reproductive healthcare available in their community.

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* It is important to remember that while Louisiana PRAMS samples potential respondents and data are weighted to be reflective of all Louisiana moms delivering a live-born singleton, twin or triplet in Louisiana, the CDC recommends a response rate of at least 60 percent for data to be considered representative of the population. Louisiana's 2014 weighted response rate was 58 percent. Because Louisiana did not meet the recommended minimum threshold, data should be interpreted with caution. It is recommended that data be used as a guideline for program activities, understanding that the data represent estimates of population behavior and experiences.

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