Privacy and Confidentiality Practices In Adolescent Family Planning Care At Federally Qualified Health Centers

CONTEXT: *The confidentiality of family planning services remains a high priority to adolescents, but barriers to implementing confidentiality and privacy practices exist in settings designed for teenagers who are medically underserved, including federally qualified health centers (FQHCs).*

METHODS: *A sample of 423 FQHCs surveyed in 2011 provided information on their use of five selected privacy and confidentiality practices, which were examined separately and combined into an index. Regression modeling was used to assess whether various state policies and organizational characteristics were associated with FQHCs' scores on the index. In-depth case studies of six FQHCs were conducted to provide additional contextual information.*

RESULTS: *Among FQHCs reporting on confidentiality, most reported providing written or verbal information regarding adolescents' rights to confidential care (81%) and limiting access to family planning and medical records to protect adolescents' confidentiality (84%). Far fewer reported maintaining separate medical records for family planning (10%), using a security block on electronic medical records to prevent disclosures (43%) or using separate contact information for communications regarding family planning services (50%). Index scores were higher among FQHCs that received Title X funding than among those that did not (coefficient, 0.70) and among FQHCs with the largest patient volumes than among those with the smallest caseloads (0.43). Case studies highlighted how a lack of guidelines and providers' confusion over relevant laws present a challenge in offering confidential care to adolescents.*

CONCLUSIONS: *The organizational practices used to ensure adolescent family planning confidentiality in FQHCs are varied across organizations.*

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Federally qualified health centers (FQHCs) offer essential primary care services to patients who are low-income or otherwise medically underserved, including nearly three million youth aged 12–18, or one in 10 U.S. adolescents.[1] Administered by the Bureau of Primary Health Care within the Health Resources and Services Administration, FQHCs form a safety net delivery system consisting of more than 1,200 organizations that serve more than 21 million patients per year at sites in all 50 states, the District of Columbia and U.S. territories.[1] Since the inception of the health center program in 1974, FQHCs have provided "voluntary family planning" as a required service, yet program guidelines offer no definition of this service.[2]

Adolescents may face considerable challenges when accessing family planning services in FQHCs and other clinical settings. Among them is the ability to access services in a private and confidential manner. Confidentiality protections for family planning care are of primary importance to teenagers; adolescents are less likely to discuss sensitive health issues or return for follow-up care, and are more likely to delay or avoid this type of care, if parental involvement is required.[3–5] Female adolescents who report confidentiality as a concern are more likely to be exposed to sexual risk than others and are, therefore, in greater need of these services.[6] Furthermore, many adolescents do not know where to access confidential family planning services or do not trust that their sensitive health information will be protected.[5–10] Maintaining privacy and confidentiality in adolescent services is chief among critical efforts that would likely improve adolescent utilization of preventive health services, including family planning.[11,12]

Despite adolescents' need for confidential care, several barriers may prevent FQHCs and other family planning providers from implementing certain privacy or confidentiality practices. Minor consent laws vary by state. For example, 26 states plus the District of Columbia allow minors to consent to contraceptive services, but 20 other states limit this right to certain categories of minors.[13] Moreover, providers often feel that they have inadequate training in dealing with sensitive adolescent health topics, are confused about legal regulations on confidentiality and are unsure of their ability to provide confidential care.[14] Issues related to billing and reimbursement for confidential services, privacy in medical records and office procedures to ensure confidential services for adolescents are additional obstacles at the system level.[4,9,15,16] In some cases, these barriers may severely limit providers' ability to fully serve their adolescent patients.

Given the important role FQHCs play in providing essential care to low-income adolescents, it is critical to understand how confidential services are delivered in this setting. Confidentiality practices may differ across FQHC

organizations for a variety of reasons. Section 330 of the Public Health Service Act, which established the FQHC program, provides a set of guidelines with which all FQHCs are required to comply, including a requirement that they offer voluntary family planning. It does not, however, define the services or organizational practices that are necessary to deliver such care;[2] nor does it explicitly require confidentiality for all services provided. Instead, all FQHCs must be responsive to the prevailing state laws on parental notification and consent, which are key factors in delivering confidential family planning care to adolescents. However, Title X, a federally funded comprehensive family planning program, offers specific guidance for adolescent services and confidentiality practices, along with federal statutory requirements to ensure confidentiality for all patients regardless of state law. FQHCs that participate in the Title X program receive greater guidance, support and resources for ensuring confidentiality, but only a minority of FQHCs (29% of those surveyed in one study[17]) participate in the program. The differing standards under which the majority of FQHCs operate suggest that considerable variation and confusion may exist in the way organizations provide private and confidential services.

In this article, we examine the measures that FQHCs take to ensure privacy and confidentiality in family planning services for adolescents. We also examine barriers to and facilitators of confidential family planning care in FQHCs.

METHODS

This article presents a mixed-methods analysis of data collected in a larger 2011 study of family planning services delivered in FQHCs.[17] The study involved a national survey of FQHC organizations, as well as six in-depth case studies of FQHCs in varied communities across the United States. The George Washington University Office of Human Research provided approval and oversight of this study.

Data

•***Quantitative.*** The original survey was developed with guidance from a technical expert panel that comprised FQHC clinicians and administrators, women's health specialists, policy analysts and other relevant experts. It was fielded among chief executive officers and chief medical officers in a universe of 958 FQHC organizations. Each responding FQHC received a $50 gift card for completing the survey. Because many health centers have multiple sites in which family planning services may be delivered, our survey asked only about services available at the organization's largest clinical site. More information on survey content and the study's methodology is presented elsewhere.[17–20]

We obtained data from the Health Resources and Services Administration's Uniform Data System on the total number of patients younger than 18, total patient volume and clinical staffing (number of obstetrician-gynecologist and certified nurse-midwife full-time equivalents) for each organization for the 2011 calendar year.[1] The system does not traditionally collect data specific to family planning educators or counselors on staff at FQHCs; however, our survey asked FQHCs whether a family planning educator was present at their largest medical site.

The survey also asked FQHCs to indicate which of the following practices they use to ensure privacy and confidentiality for their adolescent patients: providing written or verbal information to adolescents on their right to confidential sexual and reproductive health care; limiting access to family planning and medical records to the adolescent patient and other formally designated individuals; maintaining a separate medical record on family planning or sexual health services provided to adolescents; using a security block on electronic medical records to prevent inadvertent disclosures to unauthorized persons; and maintaining separate contact information for communications regarding family planning services. (These practices were identified by our technical expert panel as the ones most commonly employed by FQHC organizations.) We created a composite index score of these five practices and weighted them equally, for an aggregate score ranging from 0 to 5.

Also, the survey collected information on a number of organizational characteristics found in previous studies to be associated with family planning service delivery in FQHC settings.[17–20] The covariates examined were the presence of Title X funding; the size of the organization, according to patient volume (small, signifying fewer than 10,000 patients; medium, 10,000–19,999; large, 20,000 or more); and urban, rural or suburban location. We also examined the state policy climate in which the health center operates.

Policy climate was assessed using 2010 information on the presence or absence of state policies related to adolescent family planning prior to the implementation of the Affordable Care Act (ACA); this information, from analyses by Guttmacher Institute policy experts, was the most current available at the time of the study.[21–23] On the basis of the Guttmacher data and recommendations from our technical expert panel, we assigned values to policies for scoring; greater values were given to policies that our panel associated with higher levels of access to contraceptive services by minors. We were unable to determine the extent to which each of these laws and policies had been implemented or was being enforced. However, our policy climate variable does account for laws or policies whose enforcement was enjoined by the courts at the time of the analysis;[21–23] such laws or policies were not counted in the state policy climate score.

We reviewed policies in four categories (Table 1) and added the scores from each to assign an overall score to each state. The first category, minors' access to contraceptive services, assessed whether and to what extent states explicitly allow minors to consent to the receipt of birth control services independent of their parents or guardians (possible scores, 0–3). The second category, state funding of contraceptive services for minors, reflects whether states explicitly provide funding to support the provision

of family planning services for adolescents or explicitly prohibit the use of state funds for this purpose (–1 or 1). The next category, state family planning funding restrictions, indicates whether states bar certain types of entities (for example, ones that furnish a full range of reproductive health services, including abortion) from receiving funding (–1 if restrictions are in place). And the final category, school-based sex education programs, denotes whether states fund or provide sex education programs to school districts and whether they impose requirements on the content of programs (0, 1 or 3).

For analytic purposes, we transposed the overall score to reflect a minimum possible value of 0 and a maximum possible score of 9, although no state achieved a perfect maximum score. The overall scores were then used to categorize each state's policy climate as favorable (scores from 6 to 8), neutral (4 or 5) or unfavorable (0–3).

•***Qualitative.*** The in-depth case studies, conducted in 2011–2012, were designed to explore the context of family planning service delivery in FQHC settings. Interview domains were characteristics of the patient population; accessibility of family planning services; scope of family planning care; organization and delivery of family planning services; linkages, care coordination and referral networks; and financing of family planning care. We employed a maximum variation sampling strategy to select sites with a range of organizational and policy characteristics.[19,20] Over the course of a two-day site visit, semistructured interviews were conducted with at least five FQHC staff we identified as being knowledgeable about and involved in adolescent family planning services—executive-level staff, such as chief executive officers and chief medical officers; clinicians; family planning program coordinators; and other administrative personnel. Participating organizations were offered a $500 gift card for their time and effort.

Analyses

•***Quantitative.*** We present descriptive analyses showing the distribution of FQHCs reporting each of the five confidentiality practices, as well as the average score on the index. We conducted bivariate analyses using chi-square tests of proportions to identify key elements associated with higher privacy and confidentiality practices scores. Then, the policy categories and the other organizational characteristics were used in multiple regression analysis to assess the correlates of FQHCs' overall privacy and confidentiality practices index measure.

•***Qualitative.*** Using content analysis of the interview transcripts, three investigators identified key themes regarding the major barriers to and facilitators of family planning delivery in FQHCs.

RESULTS

Quantitative Findings

•***Sample characteristics.*** We received complete responses from 423 organizations, for a response rate of 44%, during the six-month survey administration period. We compared these organizations with the universe of FQHCs on a variety of characteristics and observed some differences in size (respondents tended to be larger than nonrespondents) and regional distribution (there was greater representation in the Northeast region among respondents than among nonrespondents). To achieve a more representative sample, we applied weights to account for these differences, using patient volume as an indicator of organizational size and U.S. Census Bureau regions to account for geographic distribution.

Respondent organizations reported serving more than 1.25 million adolescents in 2011 (Table 2). Adolescents represented 14% of the patient population in these organizations; 56% of adolescents were female, and 44% were male. FQHCs in our sample represented more than 1,900 primary care sites delivering family planning services. Thirty-four percent of respondent organizations were small, 29% were medium-size and 37% were large. Twenty-nine percent received Title X funding at their largest primary care site. Some 51% of respondents indicated that their largest primary care site was in an urban location, while 37% were in rural areas and 10% in suburban locations; 2% of respondents did not report their geographic location. Responding FQHCs employed a total of 425 obstetrician-gynecologist full-time equivalents and 263 certified nurse-midwife full-time equivalents; 26% had a family planning educator on-site to deliver counseling. Finally,

TABLE 1. State policies related to sexual and reproductive health, and value assigned to each in an index of state policy climate, 2011

Policy	Value
Minors' access to contraceptive services	
State law permits minors to consent to services with no restrictions	3
State law permits most minors to consent, but imposes some limits (e.g., physician discretion to notify parents, minimum age); or state has no policy	2
State law permits two or more distinct categories of minors to consent (e.g., minors who are married, are parents or have had a prior pregnancy)	1
State permits consent only by married minors†	0
Funding of contraceptive services for minors	
State funds the provision of adolescent family planning services	1
State bars use of state funds for the provision of adolescent family planning services	–1
Family planning funding restrictions	
State bars the receipt of state funding by entities that furnish or promote access to lawful abortion services	–1
School-based sex education	
State offers a mandatory sex education program and requires provision of medically accurate information or inclusion of information about contraceptives (may also require coverage of abstinence education)	3
State provides for mandatory sex education program, but with no requirements regarding content; or state makes sex education programs voluntary, but requires programs to provide medically accurate information or to include information about contraceptives	1
State has no policy on sex education programs, either voluntary or mandatory; or state maintains a voluntary or mandatory sex education program that requires abstinence education, but does not require medical accuracy or contraceptive information	0

†Under the common-law mature-minor doctrine (recognized as constitutionally protected in medical decisions in *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52), adolescents who have not reached the age of maturity may make decisions about their health and welfare if they demonstrate the ability to articulate reasoned preferences on those matters. Not all states recognize this doctrine. *Sources:* Mature minor doctrine: Garner BA, ed., *Black's Law Dictionary,* ninth ed., St. Paul, MN: West Publishing Group, 2009. Minors' access to contraceptive services and funding of contraception for minors: reference 22. Family planning funding restrictions: reference 23. School-based sex education: reference 24.

TABLE 2. Selected characteristics of federally qualified health centers participating in a study of privacy and confidentiality practices used in the provision of family planning care to adolescents, 2011

Characteristic	% or no. (N=423)
Adolescents served	
No.	1,267,054
Gender	
Female	56
Male	44
As % of total patient population	14
Total no. of primary care sites providing family planning care	1,912
Size (annual no. of patients)	
Small (<10,000)	34
Medium (10,000–19,999)	29
Large (≥20,000)	37
Title X funding status	
Recipient	29
Nonrecipient	70
Not reported	1
Location	
Urban	51
Suburban	10
Rural	37
Not reported	2
Staffing	
No. of full-time equivalents	
Obstetrician-gynecologist	425.45
Certified nurse-midwife	262.76
% with a family planning educator	26
State policy climate	
Favorable	44
Neutral	25
Unfavorable	31

Note: Unless otherwise noted, data are percentages.

44% of FQHCs were located in a state with a favorable policy climate, while 25% and 31% were located in states with neutral and unfavorable policy climates, respectively.

•Privacy and confidentiality practices. FQHCs reported using a variety of mechanisms to ensure the privacy and confidentiality of adolescents' family planning care, but there was substantial variation in the range of these practices (Table 3). Among FQHCs providing data on privacy and confidentiality practices, 93% reported using at least one practice discussed in the survey, while 59% indicated that they used three or more. Only 5% reported employing all five of the provisions.

TABLE 3. Percentage distribution of federally qualified health centers, by number of practices they use to ensure privacy and confidentiality of adolescent family planning services

No. of practices	% (N=329)
0	7
1	9
2	26
3	34
4	20
5	5
Total	100

Notes: Based on FQHCs that provided privacy and confidentiality practice information. Percentages do not total 100 because of rounding.

Eighty-one percent of FQHCs reported that they provide either written or verbal information to patients that explains their rights to keep sexual and reproductive health information confidential, and 84% reported limiting access to adolescents' medical records to the adolescents themselves and other legally designated individuals (Table 4). Only 10% of respondents, however, reported maintaining a separate medical record regarding family planning or sexual health services for adolescents. Forty-three percent reported that they utilize a security block on electronic medical records to prevent unintended disclosures without patient approval, while 50% indicated that they maintain separate contact information for communication regarding family planning care. The mean score on the index assessing these practices was 2.59.

In bivariate analysis, FQHCs with Title X funding were significantly more likely than others to employ four of the five practices included in the index: providing written or verbal information on adolescents' rights to confidential services (91% vs. 78%), maintaining a separate medical record regarding family planning or sexual health services (14% vs. 8%), using a block on electronic medical records to prevent disclosures (51% vs. 40%) and maintaining separate contact information for communications regarding family planning (69% vs. 42%). FQHCs with Title X funding had a significantly higher score on the index than FQHCs without such funding—3.11 versus 2.40.

We observed few other differences in individual privacy and confidentiality practices by organizational characteristics. FQHCs appeared to adopt similar privacy and confidentiality practices regardless of size. Site location was associated with only one measure: A lower proportion of urban or suburban than of rural FQHCs reported limiting access to family planning medical records to the patient or a designated individual (83% vs. 95%). Policy climate, too, was associated with only one practice: The proportion of FQHCs that provided written or verbal information on adolescents' rights to confidential family planning services was higher in states with favorable or neutral policy climates (85%) than in states with unfavorable policy climates (73%).

In our multivariate regression analysis, Title X funding was positively associated with FQHCs' privacy and confidentiality index score (coefficient, 0.70—Table 5). Similarly, large FQHCs employed more privacy and confidentiality practices than small organizations (0.43). In this model, neither the relationship between state policy climate and FQHCs' privacy practices nor that between urban-rural location and the overall index held.

Qualitative Findings

The case studies support these findings and provide important context on the challenges FQHCs face as they try to provide adolescent family planning care. Among the six case study sites, three were located in urban centers, two in suburban communities and one in a rural location. Three

TABLE 4. Percentage of federally qualified health centers reporting selected privacy and confidentiality practices for adolescent family planning care, and centers' average score on privacy and confidentiality practices index, by selected characteristics

Practice	All (N=329)	Title X funding status		Size		Location		State policy climate	
		Recipient (N=100)	Nonrecipient (N=221)	Small (N=107)	Large/medium (N=222)	Rural (N=33)	Urban/suburban (N=296)	Favorable/neutral (N=231)	Unfavorable (N=98)
Provides written or verbal information to adolescents on confidentiality	81	91	78*	82	80	79	73	85	73*
Limits access to family planning and medical record to the patient or other designated individual	84	87	83	84	84	95	83*	83	85
Maintains a separate medical record for adolescent family planning	10	14	8*	7	12	6	10	10	9
Utilizes a security block on electronic medical records to prevent disclosures	43	51	40*	39	45	39	43	42	43
Maintains separate contact information for communication regarding family planning	50	69	42*	47	52	54	49	51	46
Index score (range, 0–5)	2.59	3.11	2.40***	2.48	2.68	2.61	2.52	2.63	2.52

*p<.05. ***p<.001. *Note:* Based on FQHCs that provided privacy and confidentiality practice information; eight FQHCs did not report Title X status.

sites were large FQHC organizations, two were medium-size and one was small. Two sites were recipients of Title X funding; the remaining four were not.

In all of the case studies, participants emphasized the need for special programs for adolescents, but noted that the biggest challenge was in providing confidential care for this population. Much of this concern appeared to center on two issues: FQHC staff's lack of clarity regarding state minor consent policies and the absence of confidentiality protocols, even for general family planning services. The case studies also revealed differences between Title X–funded clinics' and other clinics' understanding of whether and how to protect teenagers' confidentiality and the strategies used to ensure confidential care for this population.

Three respondents at one FQHC that did not receive Title X funding revealed different interpretations of their state's minor consent law, which allows minor consent for STD testing and treatment, but requires parental consent for contraceptives unless the minor is married. One participant said adolescents "can sign with no parent consent to get the care they need. Don't have to have documentation for emancipation." Another noted that "minors under age 16 may consent for STD treatment on their own. They may not consent for anything else unless the provider consents to it as an emergency." And a third said that adolescents "cannot get on contraception without a parent. Parents sign consents for Pap smears or pelvic exams for patients below 18."

At another site without Title X funding, in a state that requires parental consent for contraception but not for STD testing and treatment, a respondent noted that providers tend to fall back on parental consent for all services. The respondent stated, "In family medicine, if they are a minor, they have to have a parent's [consent] regardless of the service they are requesting."

The lack of clarity among center staff was seen in all case study sites that did not receive Title X funding and is likely an impediment to ensuring private and confidential care to adolescents where appropriate. Staff at Title X–funded community health centers, on the other hand, were much clearer on confidentiality requirements for adolescents because the guidelines that regulate Title X funding explicitly ensure confidential care for adolescents regardless of state policies. Interviewees at Title X–funded sites noted that they are trained to understand the explicit protections of those regulations. As one participant explained:

"Everyone completes competencies, and one of which is a module on Title X. Everyone has been trained in this specific area. We get all the background for providers on what is covered [by Title X], what isn't covered and how to document each visit, under the grant."

TABLE 5. Coefficients (and 95% confidence intervals) from multivariate regression analysis identifying associations between federally qualified health centers' characteristics and their privacy and confidentiality practices index score

Characteristic	Coefficient
Adolescents as % of all patients	–0.01 (–0.03–0.03)
No. of family planning sites	–0.01 (–0.06–0.04)
Size	
Small (ref)	na
Large	0.43 (0.06–0.79)*
Medium	–0.01 (–0.30–0.28)
Title X funding recipient	0.70 (0.43–0.97)***
Location	
Rural (ref)	na
Urban	–0.08 (–0.44–0.29)
Suburban	0.23 (–0.15–0.62)
Staffing	
Has family planning educator	0.24 (–0.05–0.52)
Has obstetrician-gynecologist full-time equivalent	0.01 (–0.06–0.09)
Has certified nurse-midwife full-time equivalent	–0.02 (–0.07–0.04)
State policy climate	
Unfavorable (ref)	na
Favorable	0.06 (–0.21–0.33)
Neutral	0.14 (–0.17–0.46)
Constant	*2.21 (1.62–2.80)*

*p<.05. ***p<.001. *Notes:* Based on 329 FQHCs that provided privacy and confidentiality practices information. ref= reference group. na=not applicable.

Case study participants at sites without Title X funding noted that possible conflict with parents may arise when there is a lack of protocols to protect adolescents' privacy and confidentiality. As one participant stated:

"I know that usually we are supposed to ask [parents] to leave, but it depends on the parents. There are some parents that are comfortable with it, but there are some that would think, 'Anything you have to tell my kids you have to tell me.'"

In contrast, participants at Title X–funded sites explained how confidentiality protocols are hardwired into their scheduling and electronic medical records system so that both staff and providers are aware when confidential services are needed. According to one respondent:

"In our scheduling system, we have the option to put 'confidential'; it's one of the tabs after phone number. When they're registering, it gets put in that and carries over to our electronic medical record system…so that now is a permanent part of the patient's record."

The absence of established protocols... may unduly compromise adolescents' privacy.

Sites with and without Title X funding noted that their adolescent populations appear not to be aware of confidentiality practices at their health centers and that outreach to this population is lacking. For example, one site that was not Title X–funded said it has specific drop-in hours for adolescents, but that they are not well used. A participant noted, "They have special hours [for adolescents], but I'm not certain as to the utilization.… It's not well utilized because of marketing and staffing changes—less staff for outreach."

FQHCs also reported the challenges raised when teenagers request separate billing for family planning services to maintain confidentiality. Most of the FQHCs without Title X funding noted that they try to accommodate teenagers' requests to waive fees or not to use their parents' insurance, but this means the organization must rely on Section 330 FQHC grants that provide funding for patients who are uninsured or otherwise unable to cover fees, or must find other sources of funding to cover the uncompensated care. Participants explicitly noted this tension. One commented, "Young adults can access care without proof of income. [We] used to have special waivers for copays, under other program funding, but it got cut." According to another participant, "The challenge is getting around billing issues, because proof of income is required to determine cost based on the sliding fee scale."

Title X funding appeared to be a safeguard for adolescent family planning, ensuring that adolescents could get confidential services at minimal or no charge. Participants often commented that Title X funding provides the organization with resources to cover the cost of care for teenagers who ask that their parents' insurance not be charged for the visit, while protecting their privacy as well.

Ultimately, varying interpretations of how confidentiality is represented in both clinical service delivery and payment issues appeared to be present in nearly all case study sites, regardless of whether they receive Title X funding or not.

DISCUSSION

FQHCs play a vital role in providing family planning services to teenagers and young adults. Protecting privacy and confidentiality is therefore critical to ensuring that underserved adolescents can get this care without substantial barriers. A vast majority (93%) of FQHCs employed at least one privacy and confidentiality practice, and nearly two-thirds (59%) implemented three or more practices. Far fewer reported that they maintain a separate medical record for adolescents for family planning and sexual health services (10%) or use a security block in electronic medical records to prevent disclosures (43%). Only a small proportion had implemented all or most of the available confidentiality practices.

Our case studies add to these findings by showing how providing confidential services is not always a clear-cut process. The complexity of parental consent laws leads to confusion among providers about when parental consent is needed. Moreover, in many FQHCs, a lack of protocols or procedures to ensure adolescent confidentiality appears to be undermining this important protection. The case studies suggest that additional provisions, such as electronic medical record protections and administrative processes that allow teenagers to bypass their parents' insurance and waive copays, are critical to providing confidential care without creating more barriers to these services. Although not explored in this study, explanations of benefits that may be sent to parents whose private health insurance is charged for an adolescent's visit may also present a conflict to adolescent patients' confidentiality. As more low-income individuals and families gain or maintain coverage under ACA expansions, strategies to navigate the implications of these documents and adolescent confidentiality should be addressed.[24] The privacy and confidentiality practices identified in this study may further the conversation on how FQHCs can continue to prevent patient confidentiality breaches for their adolescent patients.

The study also demonstrated that while certain contextual measures (Title X funding and organizational size) were associated with FQHCs' use of practices that protect adolescent privacy and confidentiality, others (notably, state policy environment, as defined here) were not. These findings suggest that other resource- and program-level characteristics are associated with how well equipped FQHCs are to implement these practices. Yet, the case study findings support the notion that confusion about state and federal requirements for adolescent confidentiality exists within FQHC organizations, which may further complicate the delivery of confidential services. The absence of established protocols that help providers maintain confidentiality within the possible confines of state laws may unduly compromise adolescents' privacy.

Limitations

Although our findings offer insights into the variety of organizational practices that FQHCs employ to ensure privacy and confidentiality for their adolescent patients, several

elements limit their utility. First, the list of privacy and confidentiality practices we explored is not comprehensive; FQHCs may use other practices to protect adolescent patients' privacy and the confidentiality of family planning services. One key example that came up in the case studies is the use of billing practices that can bypass parental insurance coverage and mitigate the need to communicate with parents regarding payment. Future survey efforts could explore these practices, particularly seeking the perspective of patients who need this level of confidentiality.

Additionally, we gave all five privacy and confidentiality practices equal weight in the index measure. However, certain practices may be more effective or more feasible to implement than others in certain FQHC settings. Greater insight into the practice environments of FQHCs is crucial to refining this index in a more applicable way. Furthermore, although the overall sample of respondents can be considered nationally representative, the generalizability of some findings specific to adolescent family planning is limited. For example, we collected data and analyzed the representativeness of the sample on the basis of total patient populations in the universe of FQHCs, rather than of the total number of adolescent patients or family planning visits. National FQHC data that would permit comparisons at the patient or visit level are limited; thus, interpretations assuming the generalizability of the findings should be made with caution.

Finally, this study accounts for the policy climates in which health centers operated before ACA implementation. The changing landscape of health insurance reform at the state and national levels confounds the dynamic nature of these policy climates, making the interpretation of these policy-related findings nuanced and complex as emerging issues and challenges continue to arise. Furthermore, we assessed only whether each state had a written law or policy statement on each item in the policy climate variable, not the actual implementation or enforcement of that policy. The summative value of the policy climate variable may only rudimentarily measure the complexity of each state's varying policy environment.

Conclusion

Confidentiality of services remains a critical priority for the reproductive health field, particularly among adolescents. The current family planning policy and funding environment in health centers provides little guidance on how family planning care should be delivered and what measures should be taken to ensure confidentiality and privacy, and no guidance exists explicitly for FQHCs.

In April 2014, the Office of Population Affairs, in partnership with the Centers for Disease Control and Prevention, released recommendations on the provision of high-quality family planning services to women and men.[25] These recommendations, which highlight the importance of confidential care for adolescents, are meant to serve as guidelines for clinical directors as they develop protocols for providing quality family planning and reproductive health care. Given the variability in how well FQHCs protect the confidentiality of teenagers, the Health Resources and Services Administration, as the agency overseeing FQHC funding and systems, could develop guidelines that adapt these recommendations for FQHCs, specifically addressing what measures FQHCs should take to protect adolescent privacy and confidentiality. Just as Title X guidelines clarify responsibilities and establish standards for program grantees, these guidelines would clarify legal responsibilities and establish standards for all FQHCs.

With this context in mind, FQHCs have a tremendous opportunity to develop and implement efforts to ensure the confidentiality of family planning services to better serve their teenage patients. Establishing clearly defined protocols and incorporating specific privacy measures into administrative and clinical processes are important steps that can be taken to achieve this goal.

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