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Health Centers and Family Planning Update

Implications of the 2014 Quality Family Planning Services Guidelines Issued by the CDC and the Office of Population Affairs

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Executive Summary

The nation's 1,200 community health centers, operating in over 8,000 urban and rural locations nationally, represent the single largest source of comprehensive primary health care to low-income women of childbearing age. In 2012, health centers served more than 5 million women of childbearing age, and these numbers are expected to grow as a result of the Affordable Care Act, which dramatically expanded access to health insurance for low-income populations and made a direct investment in health center growth.

Family planning is a required service at all health centers. In a 2013 study of health centers and family planning, the first of its kind ever undertaken, researchers at the Milken Institute School of Public Health at George Washington University found that although virtually all health centers furnish family planning services, the strength and quality of their services varied significantly. The report made recommendations designed to improve the quality of family planning at health centers, better integrate family planning and contraceptive access into routine care at health centers, and foster collaboration in communities in which health centers and Title X family planning clinics operate alongside one another. The 2013 study anticipated the release of HHS guidelines that would establish standards for family planning services in primary health care settings.

In April 2014, the Centers for Disease Control and Prevention and the Office of Population Affairs released these new guidelines for quality family planning services. The workgroup that developed the guidelines included representatives from HRSA and front-line health center clinical experts. These guidelines, as well as findings from GW's 2013 report, provide an important roadmap that can be used by HRSA to develop a strategy for ensuring that the 2014 guidelines are effectively translated and integrated into health center practice.

A HRSA strategy should encompass the development of a workgroup whose task is to expeditiously translate the guidelines into health center practice. Such a work group ideally would consist of HRSA staff, health center clinical and management experts, family planning and women's health experts, and representatives of other federal agencies with expertise in reproductive health and family planning. HRSA's quality improvement strategy also should include the development of actionable performance measures, training and technical assistance, special supplemental grant awards to support quality improvement efforts and expansion of family planning services, and collaboration with CMS to identify purchasing strategies that can promote the goals of the guidelines, as translated and made actionable in a health center setting.

Introduction

In March 2013, the Jacobs Institute of Women's Health and the Geiger Gibson/RCHN Community Health Foundation Research Collaborative, both part of the Milken Institute School of Public Health at the George Washington University, published *Health Centers and Family Planning: Results of a Nationwide Study*.¹ An in-depth analysis of community health centers' family planning services (required under §330 of the Public Health Service Act), the study and its subsequent peer-reviewed articles contained extensive findings regarding the provision of contraceptive services and made a series of recommendations for improving the scope and quality of care.^{2,3} The study found that although all health centers provide some level of family planning services consistent with federal requirements, much remained to be done to improve the scope and quality of care.

In April 2014, the United States Department of Health and Human Services released a report titled "Providing Quality Family Planning Services" (hereinafter cited as "guidelines").⁴ Its purpose is to provide a roadmap for family planning services in health care settings; to this end, the report sets forth comprehensive evidence-based treatment guidelines for provision of quality family planning (QFP) services. An expert work group,⁵ including representatives from the Health Resources and Services Administration (HRSA) and front-line health center clinicians and led by the CDC and the HHS Office of Population Affairs (OPA), developed these guidelines. HRSA's involvement was key, given the agency's role in overseeing the community health centers program and its expertise in broad oversight of quality improvement efforts in health center settings.

Community health centers, which served more than 21 million people in 2012, represent the single largest affordable system of comprehensive primary health care for medically underserved communities and populations. The Affordable Care Act (ACA) dramatically expanded this longstanding national commitment to primary health care access dating to 1965, by making a major investment in health center expansion. This special funding, coupled with the ACA's watershed Medicaid and health insurance expansions, positions health centers to significantly extend their reach and strengthen their performance. More than one-quarter of all health center patients are women of reproductive age. In 2012 more than 5.7 million women of reproductive age received care from health centers, an increase of 9 percent since 2009, when the national health reform debate began.

¹ Wood SF, Goldberg DG, Beeson T, Bruen BK, Johnson K, Mead KH, Shin P, Lewis J, Artis S, Hayes K, Cunningham M, Lu X & Rosenbaum S. (2013). Health centers and family planning: results from a nationwide study. *Health Policy Faculty Publications*. Paper 60. http://hsrc.himmelfarb.gwu.edu/sphhs_policy_facpubs/60/ (Accessed online April 28, 2014)

² Wood SF, Beeson T, Bruen B, Goldberg DG, Mead KH & Rosenbaum S (2014). Scope of family planning services delivered in Federally-Qualified Health Centers. *Contraception*. 89(2), 85-90.

³ Beeson T, Wood SF, Bruen B, Goldberg DG, Mead KH & Rosenbaum S. (2014). Accessibility of Long Acting Reversible Contraceptives (LARCs) in Federally Qualified Health Centers (FQHCs). *Contraception*. 89(2), 91-96.

⁴ Providing Quality Family Planning Services, *Morbidity and Mortality Weekly Report* (April 25, 2014) http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6304a1.htm?s_cid=rr6304a1_w (Accessed online April 28, 2014)

⁵ *Providing Quality Family Planning Services*, op cit. p. 52

The women served by health centers are deeply impoverished; more than 70 percent of all health center patients have family incomes below the federal poverty level.⁶ It is among this population that the risk of unintended pregnancy is its greatest. Women who are poor experience unintended pregnancy at a rate five times higher than those who are not.⁷ Unintended pregnancy is significantly associated with maternal and infant mortality, developmental disabilities and delays in childhood, and generational impoverishment.^{8,9,10,11}

This initiative to increase access to primary care through health centers, coupled with the Affordable Care Act's mandatory coverage of women's preventive services under both public and private health insurance, creates an opportunity for health centers to significantly improve the quality of services aimed at preventing unintended pregnancy, one of the most important factors in the health and economic and social well-being of women, infants, children, and families. Health centers' potential impact on population health is especially great.

This update summarizes the key findings and recommendations from GW's 2013 study, summarizes the guidelines' principal recommendations, and discusses their implications for health centers.

GW's 2013 Health Center Family Planning Study

Study aim and methods. The 2013 nationwide study was designed to measure the quality of contraceptive services at health centers. A national survey was coupled with case studies designed to probe more deeply into how health centers provide contraceptive care as part of their overall family planning programs, as well as the barriers they face in furnishing such care.

Key findings. We found that virtually all health centers provide access to contraceptive services and other services related to family planning and reproductive health. Nearly 9 in 10 health centers (87 percent) provide what the study defined as a "typical" package of care: testing and treatment for sexually transmitted infections; prescribing (and in most cases, dispensing) oral contraceptives plus one additional contraceptive method such as Depo-provera shots, long-acting reversible contraceptives (LARCs), emergency contraception, and condoms. At the same time, however, fewer than one in five health centers (19 percent) reported furnishing all

⁶ Bureau of Primary Health Care. (2013). Uniform Data System (UDS) National Report, 2012.

⁷ Finer LB & Zolna MR. (2014). Shifts in intended and unintended pregnancies in the United States, 2001-2008. *Am J Pub Health*, 104(S1); S44-S48.

⁸ Gipson JD et al. (2008). The effects of unintended pregnancy on infant, child, and parental health: a review of the literature. *Stud Fam Plan*. 39(18), 23-25.

⁹ Orr, ST. (1997). Unintended pregnancy and the psychosocial well-being of pregnant women. *Women's Health Issues*, 7(1), 38-46.

¹⁰ Crissey S. (2006). Effect of pregnancy intention on child well-being and development: Combining retrospective reports of attitude and contraceptive use. *Population Research and Policy Review*, 24(6), 594-615.

¹¹ Myrhmam A, Olsen P, Rantakallio P, & Laara E. (1995). Does the wantedness of a pregnancy predict a child's educational attainment? *Family Planning Perspectives*, 27(3), 116-119.

contraceptive methods on-site at their largest service site (most health centers have multiple service sites).

We also found that virtually all health centers reported referral arrangements for services not offered on-site (such as vasectomies, sterilization, and further diagnosis and treatment for conditions flowing from health examination findings). But the strength of these referral arrangements varied considerably.

Our research was able to identify certain key factors associated with stronger health center programs that offered more comprehensive on-site services. Above all, health centers that received additional Title X family planning program funding were found to provide a broader scope and range of on-site services and were more likely to develop and support “champions” among the on-site clinical staff. The presence of OB/GYN medical staff and dedicated family planning counselors as part of a treatment team was also associated with more comprehensive on-site services. In addition, more generous State Medicaid adult eligibility policies and a state legal environment that promoted easier access to care among especially vulnerable patients (such as teens) also were associated with stronger on-site family planning programs.

Interviews with health center staff underscored the role that resources play in both establishing strong family planning programs and ensuring their ongoing operation. In this respect, the presence of Title X funding in the strongest health center programs can be seen as a proxy for an infusion of resources that facilitates an upgrade of capabilities, particularly with respect to counseling and funding. Such additional resources appeared to enable health centers to maintain a supply of prescription drugs and more effective and expensive devices onsite in order to promote easier access. Challenges include the difficulties associated with recruiting staff, ensuring staff training and skills development, the unique issues of confidentiality that arise in the case of adolescents, and educating patients and communities (including governing boards) about the importance of maintaining strong family planning programs.

Recommendations. The study produced recommendations that fall into four major areas: tailored policy guidance; practice re-design and quality improvement; value-based purchasing; and collaboration.

1. Develop family planning guidance tailored to health centers in order to help them adapt their practices to evidence-based guidelines. Anticipating the issuance of the guidelines, the study recommended that HRSA establish a workgroup comprised of experts in health center practice, health center management, women’s health, and family planning that could move expeditiously to translate new guidelines into more specific guidance applicable to the unique circumstances of health center practices. Such specific guidance also could address health center/Title X clinic collaborations in communities in which both types of clinics work alongside one another.

2. *Establish a family planning practice re-design and quality improvement effort as part of an overall primary care quality initiative.* The report recommended development of a practice re-design and quality improvement initiative to help address the integration of family planning into routine primary care and establish performance improvement measures that could be integrated into performance reporting under the national health center performance reporting system.

3. *Develop value-based purchasing models for use in health center settings.* The study recommended the development of value-based purchasing models for use within the Medicaid federally qualified health center (FQHC) payment system that reward comprehensive care and promote cost-savings from unintended pregnancies and their consequences.

4. *Foster health center/Title X clinic collaborations in communities in which both types of clinics operate alongside one another.* Finally the report recommended the development of collaboration models through joint guidance issued by HRSA and the HHS Office of Population Affairs (OPA).

Highlights of the CDC/OPA Family Planning Guidelines

The CDC/OPA guidelines are intended to apply to health care providers that specialize in the provision of family planning services, as well as to “private and public providers of more comprehensive primary care.”¹² The guidelines are comprehensive and apply to all women of reproductive age. They address three categories of services: (a) *family planning services*; (b) *related preventive health services*; and (c) *other preventive health services*. Together these categories address not only what should happen within the specific context of family planning but also how family planning should be integrated into broader primary care activities.

- a) The “family planning” service category consists of several distinct types of services: contraceptive services; pregnancy testing and counseling; helping clients achieve pregnancy; basic infertility services; preconception health services such as screening for obesity, smoking, and mental health; sexually transmitted disease services; and a determination through interaction with the patient of what “related preventive” health services or “other” preventive health services the patient might need.¹³
- b) The “related preventive health services” category encompasses services that are “considered to be beneficial to reproductive health, are closely linked to family planning services, and are appropriate to deliver in the context of a family planning visit but that do not contribute directly to achieving or preventing pregnancy.”¹⁴ Examples of such services would be breast and cervical cancer screening.

¹² *Providing Quality Family Planning Services*, op cit., p. 1.

¹³ *Id.*

¹⁴ *Id.* p. 5.

- c) The “other preventive services”¹⁵ category consists of provision of or referral to other preventive services not already identified for both men and women of reproductive age. Such screening services may include family medical history, cervical cancer screening, clinical breast exams, mammography, genital exams for adolescent males, and other recommended screening services.

Although the guidelines focus primarily on improving family planning services, they are presented in a manner that makes clear that the family planning visit should be treated as a gateway encounter for a full range of preventive services, whether directly or through referral to a source of health care with which a provider has a clearly established relationship. Thus, the provision of family planning services presents an opportunity to ensure access to a full range of preventive services relevant to overall health and wellness. Family planning services may represent the immediate reason for the visit, but under the guidelines, a family planning visit becomes a strategic entry point into primary care more generally.

This comprehensive approach translates especially well into comprehensive primary care settings, such as those found at health centers, because of their ability to offer a wide range of preventive health care services. Regardless of whether the immediate reason for the visit is primary care for any acute or chronic health problem, a general wellness service, or family planning, the guidelines’ key principal is that any one of these purposes becomes the gateway for achieving the other purposes of primary health care. Thus, the guidelines speak not only to improving family planning but to improving primary care more generally.

In all cases, the actual provision of services begins with an assessment of patient needs across the service spectrum outlined in the guidelines. In a family planning context, the provider/patient encounter also includes gaining an understanding of the patient’s reproductive life plan, the provision of pre-conception care, STD services and counseling, and other preventive health services. Care also includes contraceptive services and counseling, pregnancy testing and counseling, and basic infertility services where appropriate.

The CDC/OPA guidelines also identify suggested quality measures for evaluating family planning services provided in a range of settings that consider the structure of the services, the processes for provision of care and associated clinical outcome measures. While some of these measures were developed for Title X programs, all are broad measures that are easily adaptable to all primary care settings.

¹⁵ Id., p. 5

Recommendations for HRSA Action

Our recommendations were developed in consultation with a clinical leadership advisory group consisting of clinician leaders with expertise in family planning and drawn from health center clinicians from across the country (see the Acknowledgement page of this report for a full listing of these leaders). At a meeting held in March 2014, prior to the release of the guidelines, this advisory group shared their experiences regarding the challenges health centers confront in developing strong, on-site family planning programs. The observations from this group reflected the key findings from our 2013 study, and the group provided invaluable insight into the types of steps that would be needed in order to improve the quality of family planning service and its level of integration into primary health care.

The CDC/OPA guidelines, along with our 2013 study of family planning services and the information gleaned from our clinical leadership advisory group, suggest several future directions for improving access to comprehensive onsite services and strengthening the performance of health centers, which occupy a unique position in caring for underserved patients and populations because of their mission, location, community-centeredness, and their ability to furnish the full spectrum of care described in the guidelines.

Convene a workgroup that assists HRSA in translating the family planning guidelines into health center practice

The first recommendation is that HRSA convene a work group consisting of clinical and management leaders at health centers, experts in women's health and family planning, and other HHS agencies with special expertise in reproductive health and family planning, including CDC and the Office of Population Affairs. As the guidelines note, the expectation is that medical directors will use these recommendations to develop specific patient care guidelines and protocols that can be incorporated into routine primary care practice. This incorporation step would be facilitated by the formation of a work group that can expeditiously translate the guidelines into actionable recommendations regarding the organization and delivery of care, regardless of whether the entry point for a patient is a family planning visit or a primary care visit for any acute, chronic or other preventive care service.

This integration step is crucial, in our view. The point of the guidelines is not only to improve the quality of family planning services, but also to ensure that bridges are built across various types of primary health care, in order to minimize the potential for lost opportunities. Achieving integration between a health center's family planning services and its other primary care services will require careful assessment and adjustment of health center practice patterns where needed, in order to ensure appropriate care and treatment. This is especially true in the case of health centers that operate in multiple sites, since the range and scope of services may vary by site. In

this regard, electronic health records (EHRs) will play an important role in helping health centers to develop linkages across various clinical activities.

This work group also could focus on collaboration and the development of formal, solid affiliation arrangements in order to ensure smooth transitions where needed. These types of relationships are essential in communities in which both health centers and independent Title X family planning clinics are located. Affiliation and collaboration are also essential to ensure linkages with other community organizations whose work focuses on the social determinants of health and promoting access to services aimed at addressing the root causes of poor health.

Develop minimum program expectations and performance measures

Based on recommendations from this work group, HRSA should develop minimum program expectations and performance measures related to family planning services in health centers. The guidelines recommend a number of standards and performance measures which offer a valuable starting point for program expectations and performance measures in health center settings. The findings from our 2013 study indicate certain areas where health centers' family planning performance needs strengthening: availability of a full range of contraceptive methods, including onsite long-acting and reversible contraception methods (e.g. IUDs and implants); onsite dispensing of oral contraceptives; counseling in reproductive life planning, the various forms of contraceptive options and their uses; and special counseling expertise and confidential services for adolescents and others.

These recommendations in turn necessitate the development of actionable performance improvement standards. How should the availability of broader contraception options be measured, both on-site and through referral arrangements? What level of counseling services should health centers be expected to offer? Who should serve as counselors? What level and type of training should health center clinicians receive in the use of more advanced contraceptive methods? How should patient confidentiality be addressed at health centers that do and do not participate in Title X programs (which establish confidentiality as a basic program requirement), and what protections should apply to patients covered through private insurance? Available research suggests that in general, state Medicaid and CHIP programs operate with an expectation of confidentiality of care.¹⁶ Such expectation of confidentiality for teens should be clearly added to HRSA program expectations and should be accompanied by associated reporting requirements related to consistency between health center practice and payer expectations.

¹⁶ Sonfield A & Gold RB. (2011). *Medicaid Family Planning Expansions: Lessons Learned and Implications for the Future* (Guttmacher Institute) <http://www.guttmacher.org/pubs/Medicaid-Expansions.pdf>

Provide supplemental funding to support onsite service expansion

In order to support the necessary practice upgrades for strengthening family planning programs and achieving greater integration between family planning services and other treatment and care, HRSA should provide supplemental direct funding to health centers to support on-site expansion of the family planning services envisioned under the guidelines. The results of our study underscore the extent to which higher health center performance on family planning is associated with the receipt of Title X funding. As we noted earlier, Title X funds can be considered a proxy for a direct investment in health center patient care capacity.

Not all health centers have access to Title X funding. Just as HRSA has invested in the past to improve the availability and quality of dental care, mental health services, and services related to cervical cancer screening, the release of the guidelines justifies a similar investment in capacity-building and quality upgrades: putting family planning counselors into place so that their services can be made available and supported through ongoing third-party payment; expanding the availability of a greater array of contraceptives on-site, especially financial support for higher-cost but more effective IUDs and implants; training clinicians and other staff; developing new approaches to clinical integration and patient flow; and upgrading EHR systems to accommodate a more integrated approach to family planning and other forms of preventive care. This investment would flow naturally from the recommendations of the HRSA work group discussed above, which could identify the highest priorities for family planning clinical, workforce, and infrastructure improvements.

Support technical assistance and training and regional quality improvement initiatives

In order to facilitate learning and sharing of best practices, HRSA should add family planning technical assistance and support to its current technical assistance offerings, using the state and national organizations receiving HRSA funding through national cooperative agreements. Such assistance would include useful practical information related to the range of recommendations from the HRSA work group, as well as supplemental funding to support regional quality improvement learning collaboratives with a focus on practice redesign and full integration of family planning services into all primary care practices. These regional initiatives could be conducted in partnership with local public health agencies, as well as with other clinical providers that furnish preventive health services and family planning. Partnerships between HRSA and OPA would ensure that training and technical assistance resources are used as efficiently as possible, and would be a positive step.

As part of quality improvement, there is a critical need for readily available training materials for health center staff. The lack of comprehensive training materials presents a major obstacle for community health centers that lack the knowledge and capacity to upgrade staff skills in order to be able to appropriately address patient counseling and care as well as practice needs. Specifically, training is needed in the

areas of IUD and implant insertions, supply acquisition and management, billing and coding for IUDs and implants, and ensuring proper knowledge among ancillary staff. Training programs that are developed should be directed at all staff, not only clinicians. This will help assure organization-wide recognition, awareness and support for expanded services. Of special importance is the inclusion of health centers' adolescent and adult medicine staff that may not be naturally oriented toward ensuring the inclusion of family planning services as part of comprehensive primary health care.

In some cases, health center staff may hold personal values and beliefs that affect their ability to fully participate in the provision of some aspects of a comprehensive family planning program. These concerns need to be clearly acknowledged as part of recruitment and retention; such recognition will ensure that clinicians for whom some family planning services create personal conflicts do not face practice demands that exacerbate such conflicts. This will also ensure that health centers can fully overcome these conflicts in order to ensure that all patients receive the benefit of appropriate education and counseling and have the right to make fully informed personal health care choices, and access the broad spectrum of family planning services.

Develop value-based purchasing models for family planning services

HRSA should collaborate with the Centers for Medicare and Medicaid Services (CMS) to produce guidance on innovative approaches to family planning payment for both FQHCs and other service providers. It is by now well-established that payment reforms can incentivize practice re-design and quality improvement. Currently, many state Medicaid programs and private payers are engaged in an active search to find ways to promote improvements in clinical care that yield large health and economic payoffs. In this regard, there is no stronger example than family planning, because of the impact of unintended pregnancy on near-term health care costs and the long-term health of children and their families.

The basic FQHC payment approach calls for an all-inclusive encounter-based payment that captures the costs associated with ambulatory primary health care. Furthermore, health centers that participate in Medicaid managed care (the vast majority of health centers) are accustomed to quality performance reporting in addition to their basic HRSA reporting obligations. Understanding whether the Medicaid FQHC payment approach used by states and managed care plans is accurately capturing the reasonable costs associated with key performance measures such as counseling and stocking and furnishing the broadest possible range of contraceptive methods is essential to quality improvement.

To this end, an up-front HRSA investment in service improvement should be accompanied by modifications to existing state FQHC payment methodologies where needed, in order to more fully capture costs associated with quality family planning care. This means recognition of all reasonable costs as well as recognition of preventive

health and reproductive health counseling as a billable encounter. These payment improvements could be tied to specific performance improvement reporting. Furthermore, states could test alternative approaches to payment reform, borrowing from case payment and bundled payment concepts to fashion a global, all-inclusive payment for family planning services and supplies similar to the global payment approach used in maternity care. A collaboration between HRSA and CMS to produce guidance on approaches to family planning payment for both FQHCs and other service providers, coupled with technical assistance to encourage state adoption, would ensure that HRSA's investment in performance upgrades translates into sustained levels of performance improvement.

Conclusion

These five recommendations identify a pathway for HRSA to follow in order to fully adopt the new quality family planning guidelines and to improve the overall quality of care provided by FQHCs. The guidelines offer an important opportunity to expand access to family planning services, and to integrate services into a comprehensive primary care framework. The recommendations within this report echo the steps that HRSA has taken in the past to improve health outcomes in health center settings, and as importantly, are consistent with the ACA's emphasis on translating coverage into care.

About the Geiger Gibson/RCHN Community Health Foundation Research Collaborative

The Geiger Gibson Program in Community Health Policy, established in 2003 and named after human rights and health center pioneers Drs. H. Jack Geiger and Count Gibson, is part of the Milken Institute School of Public Health at The George Washington University. It focuses on the history and contributions of health centers and the major policy issues that affect health centers, their communities, and the patients that they serve.

The RCHN Community Health Foundation, founded in October 2005, is a not for-profit foundation whose mission is to support community health centers through strategic investment, outreach, education, and cutting-edge health policy research. The only foundation in the country dedicated to community health centers, the Foundation builds on health centers' 40-year commitment to the provision of accessible, high quality, community-based healthcare services for underserved and medically vulnerable populations. The Foundation's gift to the Geiger Gibson program supports health center research and scholarship. Additional information about the Research Collaborative can be found online at http://sphhs.gwu.edu/projects/geiger-gibson-program_or_at_rchnfoundation.org

About the Jacobs Institute of Women's Health

The Jacobs Institute of Women's Health (JIWH) is a nonprofit organization working to improve health care for women through research, dialogue, and information dissemination. Our mission is to:

- Identify and study women's health care issues involving the interaction of medical and social systems
- Facilitate informed dialogue and foster awareness among consumers and providers alike
- Promote problem resolution, interdisciplinary coordination and information dissemination at the regional, national and international levels

The Jacobs Institute works to continuously improve the health care of women across their lifespan and in all populations. The Jacobs Institute promotes environments where an interdisciplinary audience, including health care professionals, researchers, policymakers, consumers, and advocates come together to discuss ways to advance women's health