

Health Centers and Family Planning: Results of a Nationwide Study

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Executive Summary

Community health centers (CHCs) provided primary health care to over 20 million patients in 2011, 60% of whom are women and 25% of whom are women of childbearing age. Health centers play a central role in women's health, because of their mission to furnish a full range of primary and preventive care services, including family planning and birth control for women of reproductive age. As a result of the Affordable Care Act, which provide for historic insurance expansions, broad first-dollar coverage of family planning services, and direct investment in CHCs, it is projected that health center capacity will virtually double by 2019, and accordingly, the role of health centers in the provision of women's health care services can be expected to grow significantly. This study examines how health centers fulfill their family planning mission.

Study Methodology

Nationwide survey. Following a meeting of experts, the project team developed and pre-tested an e-mail survey instrument, which was fielded to federal health center grantees in operation during 2011. The purpose of the survey was to gather detailed information regarding the family planning and reproductive health services offered by health centers as well as service organization and delivery. Survey questions focused on respondents' overall approach to family planning across all sites, as well as the services found at the responding grantee's largest medical site, selected as an indication of the widest range of services offered to patients. The survey was sent to the medical directors and chief executive officers of 959 federal health center grantees and we received responses from 423 grantees, for a 44% response rate.

Case studies. In addition to the nationwide survey, the research team conducted in-depth case studies to probe more deeply into how health centers provide family planning and reproductive health care, as well as the barriers to care. The case studies were designed to provide a clearer understanding of the issues health centers face in furnishing preventive and family planning services, and to identify internal and external factors that act as either barriers to or facilitators of care, gaps in care, and successful strategies, care models, and best practices. Six health centers were recruited for full in-depth case studies, while an additional three health center sites were selected for targeted review.

Key Findings

Scope of on-site care. Virtually all community health centers provide family planning services, and 87% of all service sites deliver what can be characterized as a "typical" package of care, defined as testing and treatment for sexually transmitted infections (STI), prescription and/or delivery of oral contraceptives plus one additional contraceptive method (e.g. injectables, IUDs, emergency contraception pills, condoms or hormonal implants). At the same time, their scope of care and approach to service delivery varies widely; 19% of survey respondents reported that their largest sites both prescribe and dispense all forms of contraception on-site. Injectable and barrier method contraceptives represent the methods most commonly available on-site. Some of the most common types of contraceptive services, such as birth control pills, frequently are unavailable for on-site dispensing, despite their low cost and the importance of immediate availability in promoting access to care.

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Referrals for care. Virtually all health centers maintain referral arrangements for services they do not offer on-site such as vasectomies, female sterilization, follow-up specialized care, follow-up for irregular findings from cervical cancer screenings, and infertility treatment. The formality of referral arrangements varies across centers and by type of service.

Key factors associated with comprehensive health center services. More comprehensive family planning services, including a broader range of contraceptive methods, are associated with certain characteristics: size; a Western or urban/suburban location; the presence of obstetrical and gynecological clinical staff and dedicated family planning counselors; and a policy environment that promotes access to care, including more generous Medicaid adult eligibility standards.

Health centers that participate in Title X. Twenty-six percent of respondents report participating in the Title X family planning program. Title X participation was the single strongest predictor of on-site, comprehensive family planning services (outreach, counseling, and a broad range of methods) at the largest service site for each reporting health center. Respondents that participate in Title X tend to have larger staff and to be located in urban/suburban settings, and in the Northeast or West. They tend to have higher proportions of patients who are uninsured, Medicaid eligible, adolescents, and women of childbearing age and a lower proportion of non-Hispanic white patients, suggesting that their services are of particular importance to minority women. Title X provides additional resources to develop more robust programs, including counseling, while establishing extensive and specific performance guidelines.

The policy climate. The overall policy climate in which health centers operate, including both Medicaid eligibility levels for adults as well as other state policies such as laws that specifically enable greater access to family planning services, is associated with more comprehensive health center family planning services.

Challenges to the provision of family planning services. Health centers struggle to maintain the scope and quality of family planning services. Major drivers of this challenge include: the cost of care coupled with the financial realities associated with serving low-income populations; difficulties attracting and retaining specialized clinical and counseling staff; the unique considerations associated with serving adolescents; and issues associated with how best to communicate the value and importance of family planning services to patients and communities.

Recommendations

Adapting family planning guidelines to health center practice. Clear guidance on family planning in health center settings is lacking. The Health Resources and Services Administration (HRSA), which oversees the health centers program, could consider adapting to health center practice settings the comprehensive family planning guidelines expected to be issued by HHS in 2013. For these updated practice guidelines to be effective within the complex realities of health center practice, an additional translational step becomes essential. HRSA might, for example, establish a working group to review the HHS guidelines and use them as the basis to delineate minimum expectations for health center practice arrangements with respect to on-site services, referral arrangements, outreach and counseling. Such guidance also could set performance measurement standards for services and staff training and development.

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Family planning practice re-design and quality improvement. Second, we recommend a family planning practice re-design and quality improvement effort paralleling previous health center quality improvement initiatives. Such an initiative could bring together persons knowledgeable in clinical and administrative health center practice in order to tackle the practical and structural issues that arise in achieving excellence in family planning, including such issues as how to manage special population outreach, best practices in counseling and securing on-site services, how to develop referral arrangements, and how to address issues of patient privacy and confidentiality. Results could be disseminated through in-person meetings of clinician and management networks as well as via effective, broad based and low-cost web-based training.

Bringing value-based purchasing and health home techniques to family planning. The Centers for Medicare and Medicaid Services (CMS) is now pursuing value-based purchasing initiatives that develop payment models to incentivize improvements in quality performance. We recommend that HRSA and CMS consider establishing such an initiative for payment of family planning services, in collaboration with state Medicaid directors, managed care organizations, and experts in the provision of health services to medically underserved populations. The goal would be the development of payment models that incentivize the provision of comprehensive family planning services in health centers as well as in other settings, such as Title X-financed clinics, in order to foster the creation of family planning health homes. An ideal payment model would emphasize comprehensive on-site care, access to a fuller range of contraceptive services, the development of well-structured referral arrangements that address more complex procedures, and strong outreach and counseling programs. These value-based purchasing models could be disseminated to Medicaid programs, Medicaid managed care organizations and entities offering alternative benefit plans to newly eligible populations, qualified health plans (QHPs) sold in health insurance Marketplaces, and health plans that participate in the Basic Health Programs established under the ACA.

Fostering health center/Title X collaborations. In many communities, health centers participate in Title X, but in many more, these two essential safety-net providers offer services independently of one another. This variation reflects patient and community preferences; some patients prefer to receive all necessary primary health care under one roof, while many others desire separate systems of health care for primary care and family planning needs. Because both models are important, we recommend investment -- by HRSA and the Office of Population Affairs -- or by other entities -- in Title X/health center collaboration models that strengthen the collaboration options and provide detailed best-practice support assistance.

Finally, we note the *importance of additional research* into patient care-seeking patterns and preferences, community and patient engagement, and most importantly, perhaps, a more in-depth examination of current Medicaid payment practices related to family planning services. Repeatedly we were told that despite the special FQHC payment method that emphasizes comprehensive, bundled services, as well as broad state flexibility to incentivize certain types of Medicaid practices, state family planning payment methods do not favor investment in key staff, the on-site provision of contraceptive methods, or comprehensive outreach and counseling. Learning more about current state family planning payment approaches is of enormous importance to any value-based purchasing initiative and would greatly aid efforts to upgrade the quality and comprehensiveness of care.

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Introduction

Community health centers represent the nation's single largest primary health care system serving medically underserved populations. In 2011, 1128 federal health center grantees operating in some 8,500 delivery sites furnished care to more than 20 million patients; total patient visits exceeded 80 million that year.¹ An additional 100 “look-alike” health centers that meet all requirements of the federal program but that do not receive federal grants provided care to 1 million patients.

Health centers' role in primary health care has grown steadily over the past two decades and is expected to grow further as a result of the Affordable Care Act's health insurance expansions coupled with its \$9.5 billion Health Center Growth Fund.² Together these two elements of the ACA are expected virtually to double health center capacity by 2019.³ Further strengthening the quality and accessibility of care at health centers thus emerges as a national health policy priority.

One of the most important services furnished by all health centers is reproductive care for women of childbearing age. Understanding health center performance in the area of preventive services related to reproductive health, and family planning services in particular, becomes especially important. No prior study ever has comprehensively examined health centers' role in family planning. For this reason, the Geiger Gibson/RCHN Community Health Foundation Research Collaborative and the Jacobs Institute of Women's Health undertook this special analysis, whose purpose is to examine the role of health centers in family planning.

For purposes of this study, the term “family planning” encompasses several distinct components of care: outreach to at-risk populations; education and counseling; screening, testing, and treatment for conditions that can affect reproductive and overall health; and access to a range of primary birth control methods. This study explores health center performance in connection with the overall patient population of reproductive age, but it focuses especially on services for women, because of the ACA's emphasis on preventive benefits for women's health.⁴

The report begins with a background and overview that describes health centers, critical issues related to the importance of family planning services and care-seeking behavior, and the financial, social, political and cultural factors that might be expected to influence health center performance. We then present the principal findings from a study carried out over the 2011-2012 time period, which examined family planning services at health centers. The evidence presented in this report comes from two sources: a nationwide survey of all federally funded

¹ HRSA, 2011 UDS.

² Rosenbaum S, Shin P, & Paradise J. (2012). Community Health Centers: the Challenge of Growing to Meet the Need for Primary Health Care in Medically Underserved Communities. *Kaiser Commission on Medicaid and the Uninsured*. Accessed March 31, 2012. Available at: <http://www.kff.org/uninsured/upload/8098-02.pdf>.

³ Ku L, Richard P, Dor A, Tan E, Shin P & Rosenbaum S. (2010). Strengthening Primary Care to Bend the Cost Curve: The Expansion of Community Health Centers through Health Reform. *Geiger Gibson/RCHN Community Health Foundation Research Collaborative, Policy Research Brief No. 19*. Accessed March 31, 2012. Available at: http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_895A7FC0-5056-9D20-3DDB8A6567031078.pdf

⁴ Public Health Service Act §2713, added by PPACA §1001.

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health centers; and nine case studies, whose purpose was to gain greater insight into health centers' experiences in the provision of preventive health care for women of childbearing age. We conclude with discussion of implications of our findings for health center practice and policy.

Background

Health Center Patients, Services and Funding

From their earliest days as small demonstration projects launched in 1965 by the Office of Economic Opportunity, health centers have grown into the single largest source of primary health care for medically underserved communities and populations. Codified at Section 330 of the Public Health Service Act and overseen by the Health Services and Resources Administration (HRSA), health centers operate in accordance with five basic requirements: (a) location in or service to a community or population designated as medically underserved; (b) governance by a community board, the majority of whom are patients of the health center; (c) a duty to furnish care to the entire community regardless of age, health status, income, or other factors unrelated to the need for care; (d) financial assistance through prospective adjustment of charges in relation to family income; and (e) provision of a comprehensive range of primary health care services. Family planning has been a core requirement of all health centers since the program was first established as part of the Public Health Service Act in 1974.

Virtually all health center patients are low-income. In 2011, over 92% had family incomes below twice the federal poverty level, and more than 70% had below-poverty income.⁵ Compared to the general population, health center patients are nearly five times more likely to have below-poverty income (72% of health center patients versus 15% of the total U.S. population),⁶ nearly two-and-a-half times more likely to be uninsured (36% versus 16%), and nearly two-and-a-half times more likely to receive Medicaid (39% compared to 16%).⁷

Health center patients are disproportionately members of racial and ethnic minority groups; Latinos and African Americans represent nearly half the patient population. Children under 18 comprise 32% of health center patients (females age 15-18 are also included in the count of all women of childbearing age); although elderly patients represent only 7% of the patient population overall, their numbers have grown far more rapidly than either the growth of the elderly population or the expansion of health centers would account for.⁸

Their poverty and residence in medically underserved communities mean that health center patients experience elevated health risks. Visits to health centers are significantly more likely than visits to private physicians to involve treatment for one or more serious and chronic

⁵ Rosenbaum S, Shin P, & Paradise J. (2012). Community Health Centers: the Challenge of Growing to Meet the Need for Primary Health Care in Medically Underserved Communities. *Kaiser Commission on Medicaid and the Uninsured*. Accessed March 31, 2012. Available at: <http://www.kff.org/uninsured/upload/8098-02.pdf>.

⁶ The federal poverty guideline for a family of three in the 48 contiguous states and D.C. is \$19,090 in 2012.

⁷ Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2011 and 2012 Current Population Survey (CPS: Annual Social and Economic Supplements).

⁸ HRSA, 2011 UDS.

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conditions (18% versus 14%).⁹ Mental illness, diabetes, asthma, and hypertension are particularly likely to occur in health center patients at elevated rates.¹⁰

Women's reliance on health centers is striking. Females comprise 59% of all people served by health centers, and women of childbearing age alone represent 28% of the health center patient population.¹¹ In 2011, health centers served an estimated 24% of all low-income women of childbearing age in the U.S.,¹² while the number of female patients who are women of childbearing age has doubled over the past decade, from 2.8 million to 5.6 million.¹³

Health centers have a long-standing history as key providers of school-based health care for adolescents. In 2004, the latest year for which comprehensive data are available, over 500 school-based health centers were operated by or in partnership with federal health center grantees.¹⁴

Like all health care providers, community health centers operate in accordance with both state and federal laws related to the regulation of health professions and health care entities, regulation of business operations, provider payment, the provider-patient relationship (including the confidentiality of health information), and health information privacy.¹⁵ Health centers that also receive funding under Title X of the Public Health Service Act, the federal family planning program, are covered by that law's special federal protections related to the confidentiality of care for both adults and minors, which preempts more restrictive state laws.¹⁶ Health centers that do not participate in Title X do not have this special protected status, since Section 330 contains no similar federally preemptive confidentiality provision and has never been interpreted by HRSA as establishing such a standard.

Federally funded health centers automatically qualify for certification as "federally qualified health centers (FQHCs)" under Medicare and Medicaid, for purposes of both coverage and payment. The Medicaid FQHC benefit encompasses physician services, the services of nurse practitioners and physician assistant services, and ancillary costs related to professional services. The Medicaid FQHC payment system (which also applies to the Children's Health Insurance Program (CHIP) as well as to payments by Qualified Health Plans sold in Health Insurance Marketplaces) is a prospective negotiated encounter-based rate paid on a bundled basis. The FQHC payment system reflects the cost of furnishing both FQHC services as well as "other ambulatory" services covered by Medicaid and furnished to Medicaid patients. Examples of "other ambulatory" services are prescribed drugs and devices, preventive services covered

⁹ Rosenbaum S, Shin P, & Paradise J. (2012). Community Health Centers: the Challenge of Growing to Meet the Need for Primary Health Care in Medically Underserved Communities. *Kaiser Commission on Medicaid and the Uninsured*. Accessed March 31, 2012. Available at: <http://www.kff.org/uninsured/upload/8098-02.pdf>.

¹⁰ *Id.*

¹¹ HRSA, 2011 UDS.

¹² Based on 2011 UDS and 2011-2012 Census data.

¹³ 2000 and 2010 UDS.

¹⁴ Swider SM & Valukas A. (2004). Options for sustaining school-based health centers. *J School Health*. 74(4); 115-118.

¹⁵ Rosenbaum S, Abramson S & McTaggart P. (2009). Health Information Law in the Context of Minors, *Pediatrics* 123 No. Supplement, 5116-5121.

¹⁶ Office of Public Health and Science, Office of Population Affairs. (2001). *Program Guidelines for Project Grants for Family Planning Services* § 5.2 United States Department of Health and Human Services. Accessed March 26, 2012. Available at: <http://www.hhs.gov/opa/pdfs/2001-ofp-guidelines.pdf>.

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under a state Medicaid plan (such as a “well-woman” exams and certain preventive screening services)¹⁷ and family planning services and supplies. In many states, pharmaceuticals and devices may be paid for separately, however, and states can vary in what they do or do not recognize as allowable costs in paying for family planning services and supplies.

Medicaid represents the single largest source of health center financing; in 2011 Medicaid payments accounted for over 38% of all health center revenues, a close approximation to the presence of Medicaid patients in health centers (39% of patients served).¹⁸ Although uninsured patients comprise 36% of all people who use health centers, health centers’ Section 330 grants intended to offset the cost of care to the uninsured reflect roughly 17% of health center revenues; direct payment by patients account for approximately 6% of health center revenues. Health centers therefore rely on other public and private grants and contracts in addition to their Section 330 funding, including awards under programs such as Title X, in order to help defray their costs. Indeed, state and local grants and private contracts amount to 14% of health center financing. (Figure 1).

Health centers’ role in Medicaid is significant, since they serve an estimated 16% of beneficiaries nationwide.¹⁹ Studies of “high share” Medicaid practices suggest that health centers comprise approximately 18% of such practices, which tend to be dominated by health care safety net providers such as health centers, public hospitals, and children’s hospitals.²⁰ Health centers frequently are the principal source of primary care in Medicaid managed care networks, and they are expected to play a significant role in networks developed for Medicaid expansion enrollees as well as residents of medically underserved communities who gain health insurance coverage through subsidized enrollment in qualified health plans offered through state Exchanges.

¹⁷ The ACA mandates coverage of preventive women’s health services under all health plans sold in the individual and group health markets. The ACA also classifies preventive services as an “essential health benefit” for purposes of coverage through state health insurance Exchanges and Medicaid “benchmark” coverage for newly eligible persons. PPACA §§1302 and 2201. However, the ACA does not guarantee coverage of preventive health benefits for currently eligible beneficiaries other than beneficiaries who are under age 21 and entitled to coverage for early and periodic screening diagnosis and treatment (EPSDT) benefits. Thus, very poor adult women currently eligible for Medicaid as parents or persons with disabilities or on the basis of pregnancy in the case of women may not be entitled to a well-woman exam except to the extent that such an exam is recognized by the state as part of a family planning visit.

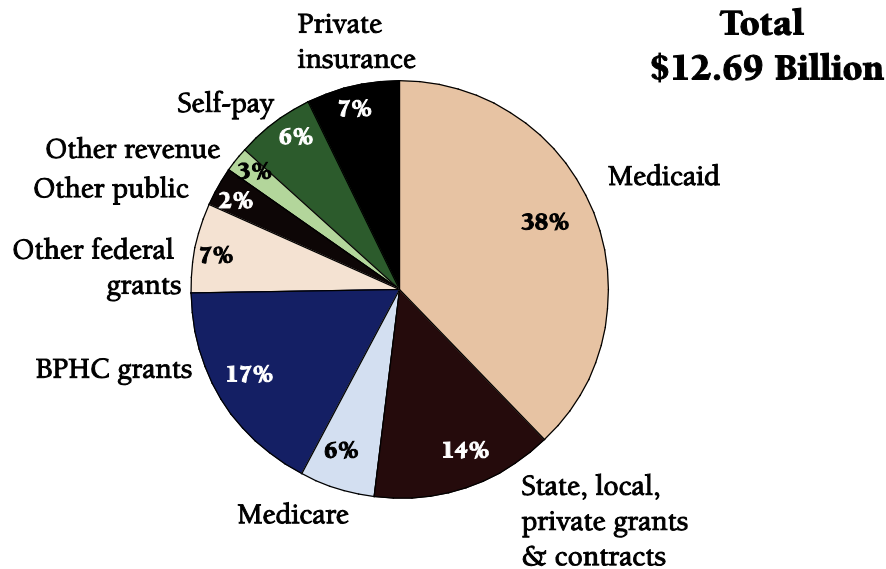
¹⁸ HRSA, 2011 UDS.

¹⁹ Based on 2011 UDS and Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau’s March 2011 and 2012 Current Population Survey (CPS: Annual Social and Economic Supplements).

²⁰ Sommers A, Paradise J & Miller, Carolyn. (2011). Physician Willingness and Resources to Serve More Medicaid Patients: Perspectives from Primary Care Physicians. *Medicare and Medicaid Research Review (1)* 2 pp. E1-E17.

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Figure 1. Sources of Health Center Revenue, U.S., 2010



Source: 2010 UDS, HRSA. Prepared by: GWU for Kaiser Commission on Medicaid and the Uninsured

Voluntary family planning is a required primary care service at all health centers.²¹ Beyond required primary health care services, health centers provide a broad array of services that address patients' physical, mental, and dental health needs (see Table 1).

Health centers have been widely recognized for the quality of their services. Numerous studies document the quality of CHC care, particularly with respect to preventive services, with outcome measures that equal or exceed performance in private practice settings.^{22,23,24,25} For example, while uninsured women are significantly less likely nationally to receive Pap smears

²¹ 42 U.S.C. §254b(b)(1)(A)(iii)(gg).

²² Rothkopf J, Brookler K, Wadhwa S, & Sajovetz M. (2011). Medicaid Patient Seen at Federally Qualified Health Centers Use Hospital Services Less Than Those Seen by Private Physicians. *Health Affairs* 30 (7); 1335-1342.

²³ Shi L, Tsai J, Collins Higgins, P & Lebrun L. (2009). Racial/ethnic and socioeconomic disparities in access to care and quality of care for US health center patients compared with non-health center patients. *Journal of Ambulatory Care Management* 32(4): 342 – 50.

²⁴ Dor A, Pylypchuk Y, Shin P, & Rosenbaum S. (2008). Uninsured and Medicaid Patients' Access to Preventive Care: Comparison of Health Centers and Other Primary Care Providers. *Geiger Gibson/RCHN Community Health Foundation*. Research Brief #4. Accessed March 31, 2012. Available at:

http://www.gwumc.edu/sphhs/departments/healthpolicy/CHPR/downloads/RCHN_brief4_8-13-2008.pdf

²⁵ Falik M, Needleman J, Herbert R, Wells B, Politzer R, & Benedict, MB. (2006). Comparative Effectiveness of Health Centers as Regular Source of Care. *Journal of Ambulatory Care Management* 29 (1):24-35.

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than their insured counterparts (67% of uninsured women versus 83% of insured women),²⁶ uninsured women served in health center settings are 22% more likely than those served in private practice settings to receive Pap smears, 17% more likely to receive breast exams, and 16% more likely to receive mammograms.²⁷ Patient satisfaction levels are high, even among those patients who acquire insurance and despite the resulting access to a potentially broader range of health care providers, choose to remain health center patients.²⁸

Table 1. Required Primary Health Care Services at Community Health Centers

- Health services related to family medicine, internal medicine, pediatrics, obstetrics, or gynecology, that are furnished by physicians and where appropriate, physician assistants, nurse practitioners, and nurse midwives
- Diagnostic, laboratory, and radiologic services
- Preventive health services including: prenatal and perinatal care; appropriate cancer screening; well-child services; immunizations for vaccine-preventable diseases; screenings for elevated blood lead levels, communicable diseases, and cholesterol; pediatric eye, ear, and dental screenings to determine the need for vision and hearing correction and dental care; voluntary family planning services; and preventive dental services
- Emergency medical services
- Pharmaceutical services as may be appropriate for particular centers
- Referrals to providers of medical services (including specialty referral when medically indicated) and other health related services (including substance abuse and mental health services)
- Patient case management services (including counseling, referral and follow-up services) and other services designed to assist health center patients in establishing eligibility for and gaining access to Federal, State and local programs that provide or financially support the provision of needed medical, education, social, housing, or related services
- Services that enable individuals to use the services of the health center including outreach and transportation services, and if a substantial number of the individuals in the population served by the health center are of limited English-speaking ability, the services of appropriate personnel fluent in the language spoken by a predominant number of such individuals
- Education of patients and the general population served by the health center regarding the availability and proper use of health services

42 C.F.R. §51c.102(b)

²⁶ National Center for Health Statistics. Health, United States, 2009: With Special Feature on Medical Technology. Hyattsville, MD. 2010. Accessed August 20, 2012. Available at: [http://www.cdc.gov/nchs/data/09.pdf](http://www.cdc.gov/nchs/data/hus/09.pdf).

²⁷ Dor A, Pylypchuk Y, Shin P, & Rosenbaum S. (2008). Uninsured and Medicaid Patients' Access to Preventive Care: Comparison of Health Centers and Other Primary Care Providers. *RCHN Community Health Foundation*. Research Brief 4. Accessed March 31, 2012. Available at: http://www.gwumc.edu/sphhs/departments/healthpolicy/CHPR/downloads/RCHN_brief4_8-13-2008.pdf.

²⁸ Ku L, Jones E, Shin P, Rothenberg Byrn F, & Long SK. (2011). Safety-Net Providers After Health Care Reform: Lessons From Massachusetts. *Archives of Internal Medicine*. 171 (15); 1379-1384.

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The efficiencies and quality outcomes achieved by health centers reflect their organizational approach to health care delivery. The health center model relies on a staff-model, team-based concept of health care practice, a high degree of clinical integration, adherence to clinical quality practice standards, and clinical quality improvement and performance measurement activities as a condition of grant award.²⁹ Data drawn from a national survey of patient costs in different treatment settings indicate that compared to other ambulatory care settings, patients who receive a majority of their ambulatory care in community health center settings show annual overall medical expenditures that are 24% lower, as well as a 25% lower level of overall expenditures for ambulatory care.³⁰ Health centers have been wide adopters of electronic health records and related health information technology, and are active participants in state and federal efforts to create “medical homes” for patients.^{31,32,33} Finally, health centers are a major source of jobs and economic investment in their communities. Health centers employ some 46,000 health care professionals, thousands of administrative staff, and generate an estimated eight-to-one return on investment.³⁴

At the same time, health centers face major challenges. The first is the realities of attempting to furnish care to large numbers of uninsured and underinsured patients. A second involves the challenges associated with the recruitment and retention of clinical and administrative staff. A third is the barriers to specialty care referrals faced by health centers, whose referral arrangements must be open to insured and uninsured patients alike. An additional important challenge, arising from health centers’ unique obligation to serve patients of all ages, involves balancing human and financial resources against an ever-growing need for affordable and accessible health care across the entire lifespan of their patient populations. The pressure on health centers to grow to meet need has intensified in recent years as other safety net providers have lost funding during the economic downturn. The need to make up lost ground on access to family planning and birth control services has been no exception.³⁵ In view of their mission,

²⁹ George Washington University. Quality Incentives for Federally Qualified Health Centers, Rural Health Clinics and Free Clinics: A Report to Congress. (DHHS, January 23, 2012).

³⁰ Richard P, Ku L, Dor A, Tan E, Shin P, & Rosenbaum S. (2012). Cost savings associated with the use of community health centers. *Journal of Ambulatory Care Management*. 35(1); 50-59.

³¹ Cunningham M, Lara A & Shin, P. (2011). Results from the 2010-11 Readiness for Meaningful Use of HIT and Patient Centered Medical Home Recognition Survey. *Geiger Gibson /RCHN Community Health Foundation Research Collaborative, Policy Research Brief No. 27*. Accessed March 31, 2012. Available at: http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_6461F0DD-5056-9D20-3D7593CB6AE409B5.pdf.

³² Sommers A, Paradise J & Miller, Carolyn. (2011). Physician Willingness and Resources to Serve More Medicaid Patients: Perspectives from Primary Care Physicians. *Medicare and Medicaid Research Review (1)* 2 pp. E1-E17.

³³ Ku L, Shin P, Jones E & Bruen B. (2011). Transforming Community Health Centers into Patient Centered Medical Homes: the Role of Payment Reform. *Commonwealth Fund Report*. Accessed March 31, 2012. Available at: <http://www.commonwealthfund.org/Publications/Fund-Reports/2011/Sep/Transforming-Community-Health-Centers.aspx>.

³⁴ Rosenbaum S, Shin P. (2011). Community Health Centers and the Economy: Assessing Centers’ Role in Job Creation Efforts. *Geiger Gibson/RCHN Community Health Foundation Research Collaborative, Policy Research Brief #25*. Accessed on March 31, 2012. Available at: http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_63C7B816-5056-9D20-3D6FC84132695FF2.pdf.

³⁵ For example, an assessment of the impact of Texas’ decision to defund dozens of clinics participating in its state-funded family planning program has reported on the impact of this decision on health centers, which have struggled to respond to the

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health centers are faced with the prospect of having to balance depth of care for any particular health need against their ability to respond to the full range of patients who seek their care.

In extreme cases, this tradeoff between access and financing may require eliminating under-financed services (for example, having to end restorative dental care for adults entirely when a state Medicaid program eliminates coverage of adult dental care).³⁶ More often, however, health centers' tradeoffs may be less dramatic; rather than eliminating any one service entirely, health centers may search for the least costly, yet reasonably effective, approach to treatment. This may mean offering a clinically appropriate but smaller range of treatment options (e.g., fewer pharmaceutical options, not stocking the latest or costliest drugs and devices, particularly in states with more limited Medicaid eligibility levels or more stringent coverage limits, or not offering procedures that require staff with specialized and more advanced training). The need to aggressively manage costs also may mean instituting somewhat longer waiting times for appointments while still trying to handle same-day and walk-in appointments; managing with less staffing depth; maintaining fewer locations and shorter hours; or undertaking less patient outreach.

In balancing the pressures that bear on their practices, health centers may opt for a level of health care that while clinically appropriate, does not necessarily represent the most desirable and appropriate range of care options available to patients. This would be particularly true in the case of newer treatments and procedures whose cost is high and which may require additional in-service training or procedure certification for clinical staff, or which may have additional equipment requirements or high stocking costs. In addition, some newer treatments or procedures may be in less demand or may be less well financed through public and private health insurance. These procedures may be unaffordable to those patients in need of care who are not in a position to pay for a particular treatment.

Of course, health centers are not alone in having to balance the affordability of care against the availability of the newest technologies and innovations. But the average patient income level at health centers, coupled with the sheer size of their uninsured patient populations, place health centers in an especially challenging position, because they must balance the scope and depth of any set of patient-specific treatment options against a minimally reasonable level of care across the full age spectrum.. This need to balance scope and depth against more basic access has grown, not only in the face of the economic downturn but also as a result of legislation enacted in 2011 that reduced health center grant funding by \$600 million. This reduction led, in turn, to the diversion of an equal amount of funding from the Affordable Care Act's Health Center Growth Fund.³⁷ Added to the loss of federal funding has been a 40% drop in

loss of dozens of providers. Carolyn Jones, One Year Later, Cuts to Women's Health Have Hurt More than Just Planned Parenthood (Women's Health and Family Planning Association of TX, Aug. 15, 2012)

³⁶ Rosenbaum S, Shin P, & Paradise J. (2012). Community Health Centers: the Challenge of Growing to Meet the Need for Primary Health Care in Medically Underserved Communities. *Kaiser Commission on Medicaid and the Uninsured*. Accessed March 31, 2012. Available at: <http://www.kff.org/uninsured/upload/8098-02.pdf>.

³⁷ Shin P, Rosenbaum S, Shin P, & Paradise J. (2012). Community Health Centers: the Challenge of Growing to Meet the Need for Primary Health Care in Medically Underserved Communities. *Kaiser Commission on Medicaid and the Uninsured*. Accessed March 31, 2012. Available at: <http://www.kff.org/uninsured/upload/8098-02.pdf>.

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state and local health center funding in recent years, a result of the lingering economic impact of the recession.³⁸

Family Planning as Part of Preventive Reproductive Health Care

Because family planning is a required health center service, it is important to place family planning within a broader context of preventive health care for women of reproductive age. One element of this broader range of services is sometimes termed “pre-conception” care, which includes services that identify and modify biomedical, behavioral, and social risks to a woman's health or pregnancy outcome through prevention, as well as treatment and management in order to address health problems that must be acted on before conception (or early in) pregnancy.³⁹ A second element is sometimes referred to as inter-conception care and consists of comprehensive care between pregnancies to maintain health and reduce reproductive health risks during childbearing years. A third element consists of screening and treatment of sexually transmitted infections (STI). A final and fourth element of preventive care is education and counseling about health and sexual activity along with effective birth control services through a range of contraceptive methods in the case of women who are sexually active.⁴⁰

This multi-faceted concept of preventive health care for women includes well-woman visits, family planning counseling and FDA approved contraceptive methods, and screening and treatment of STIs. These are reflected in preventive benefit guidelines issued by HRSA in 2011,⁴¹ and based on a comprehensive scientific analysis conducted by the Institute of Medicine.⁴²

When the ACA is fully implemented in 2014 virtually all insured women of childbearing age will be entitled to these benefits, either through Medicaid or through enrollment in Qualified Health Plans or non-grandfathered employer-sponsored or individual coverage. In the case of health center patients, Medicaid of course emerges as the most important source of coverage. Female health center patients of childbearing age, if insured, will be covered for these services either through the traditional Medicaid program (which already covers these benefits) or through Alternative Benefit Plans, in the case of newly eligible women. Many of these preventive services also fall under the definition of family planning services and supplies, a required Medicaid benefit for all beneficiaries.

Contraception, a central element of family planning, has been recognized as one of the great public health achievements of the 20th century. Access to birth control is essential for all

³⁸ National Association of Community Health Centers. (2011). Community Health Centers Face Growing Demand from Newly Uninsured Patients. *State Policy Report #39*. Accessed March 31, 2012. Available at: <http://www.nachc.org/client/2011%20State%20Funding%20Report%20SPR394.pdf>.

³⁹ Johnson K, Posner SF, Bierman J, Cordero J, Atrash HK, Parker CS, Boulet S, Curtis MG. Recommendations to Improve Preconception Health and Health Care, United States. *MMWR- Recommendations and Reports*. 2006;55(RR06);1-23.

⁴⁰ National Institute of Child Health and Development. (2008). Reproductive Health: What Is Reproductive Health. *National Institutes of Health*. Accessed April 4, 2012. Available at: http://www.nichd.nih.gov/health/topics/reproductive_health.cfmNEEDS

⁴¹ <http://www.hrsa.gov/womensguidelines/>

⁴² Committee on Preventive Services for Women. (2011). Clinical Preventive Services for Women: Closing the Gaps. *The Institute of Medicine*. Accessed April 4, 2012. Available at: http://www.nap.edu/catalog.php?record_id=13181.

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sexually active individuals, and it is especially so for women. On average, women seek to prevent pregnancy over a 30-year time period; by contrast, women actively seek to become pregnant or experience pregnancy for a five-year period. One study has estimated that of more than 66 million women of childbearing age in 2008, 36 million needed contraceptive care, while nearly half of this group -- more than 17.4 million women -- needed publicly funded contraceptive services as a result of low-income, age (under 20 years), or both.⁴³

Because preventive care related to reproductive health spans both services specific to reproduction as well as primary health care designed to keep all people healthy, women of all incomes may seek reproductive health care from multiple health care providers. Over half of all women who report having a regular source of health care report receiving care from two or more providers.⁴⁴ Typically care may be split between general primary care providers and providers specializing in obstetrics and gynecology.⁴⁵ There is no clearly preferred source or approach to women's health care. Women's tendency to use multiple sources of treatment for their ongoing reproductive health care needs presumably holds true for women who receive care at community health centers, although the fact that health center patients reside in medically underserved communities can be expected to limit their options. Because of the potential risk for medical underservice, health centers' ability to furnish both primary care and the full range of family planning services assumes special importance.

Health Center Practice in a Family Planning Context

As with all forms of health care, health center practice is shaped by a myriad of factors related to economic, legal, policy, political, practical, clinical, social and cultural considerations.

Federal grant conditions

One major consideration is the conditions of practice placed on health centers as recipients of federal grants. The Bureau of Primary Health Care (BPHC), the division within the Health Resources and Services Administration (HRSA) that oversees the health center program, has elected not to promulgate extensive treatment guidelines for any aspect of health center practice, including family planning. Instead, BPHC expects that across all conditions and the age spectrum, health center clinicians will adhere to evidence-based practice standards drawn from the range of primary care and related specialty fields, such as guidelines established by the American Academy of Pediatrics, gerontological societies, or, in the case of reproductive health, the American College of Obstetrics and Gynecology.⁴⁶ BPHC does not recommend that health centers utilize the comprehensive guidelines that govern the Title X family planning program, although Title X-participating health centers are, of course, bound by that program's standards.

⁴³ Guttmacher Institute, (2010). Contraceptive Needs and Services, 2008 Update. Available at: <http://www.guttmacher.org/pubs/win/contraceptive-needs-2008.pdf>.

⁴⁴ Ranji U, Salganicoff A. (2011). Women's Health Care Chartbook: Key Findings from The Women's Health Survey. *The Kaiser Family Foundation*. Accessed March 31, 2012. Available at: <http://www.kff.org/womenshealth/upload/8164.pdf>.

⁴⁵ *Id.*

⁴⁶ HRSA-BPHC Policy Information Notice 98-23: Health Center Program Expectations, August 17, 1998. Available at: <ftp://ftp.hrsa.gov/bphc/docs/1998pins/PIN98-23.PDF>

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The Bureau's approach enables health centers to adjust their standards to local practical and economic conditions. At the same time, however, the absence of clear clinical practice expectations may mean that health centers lack the comprehensive guidance that increasingly is a hallmark of evidence-based practice.⁴⁷ The absence of comprehensive federal clinical practice guidelines might result in greater variation in how health centers approach any particular clinical service generally, and family planning in particular. By contrast, health centers that participate in Title X might be expected to offer more robust programs given the availability of targeted funding and heightened performance expectations. The relationship between Title X funding and stronger family planning performance has been documented by at least one study that examined the impact of Title X on clinical performance in the area of family planning.⁴⁸

Financial and community perception considerations

Beyond formal agency expectations, the health services research literature underscores the fact that multiple financial, legal, social, cultural, community-based, and political factors can influence the design and operation of health care organizations.^{49,50,51,52} State laws governing the practice of health care and the relationship between health professionals and patients may be of importance. Health insurance coverage and payment policies also matter, particularly in the case of providers such as health centers that serve high numbers of low-income, uninsured patients. In a family planning context, the absence of binding federal expectations on the scope of state family planning coverage means that states may exclude or limit coverage of certain types of procedures from coverage as a family planning service. For example, given Medicaid's dominance as a payer of health center services, the absence of coverage for certain birth control drugs or devices could be expected to significantly affect health centers' ability to stock certain drugs or devices or invest in the specialized training that use of more technologically advanced procedures might require. Furthermore, as noted previously, despite the bundled nature of the FQHC payment mechanism, many Medicaid agencies may exclude drugs and devices from the FQHC payment rate and may instead pay for these services separately and more discounted rates.

These types of financial considerations can be expected to have practice-wide implications for health centers. Health centers cannot discriminate among patients based on their insurance status, meaning that the same range of services must be available to both insured and

⁴⁷ For a review of federal oversight of health center practice see U.S. Government Accountability Office. (2012) Health Center Program: Improved Oversight Needed to Ensure Grantee Compliance Requirements. Accessed August 20, 2012. Available at: <http://www.gao.gov/assets/600/591177.pdf>.

⁴⁸ Frost JJ, Gold RB, Frohwirth L, & Blades N. (2012). *Variation in Service Delivery Practices Among Clinics Providing Publicly Funded Family Planning Services in 2010*. The Guttmacher Institute. Accessed August 30, 2012. Available at www.guttmacher.org/pubs/clinic-survey-2010.pdf.

⁴⁹ Ramírez-Valdivia M, Maturana S, & Salvo-Garrido S. (2011). A Multiple Stage Approach for Performance Improvement of Primary Healthcare Practice, *Journal of Medical Systems*. 35 (5):1015-102.

⁵⁰ Marathe S, Wan TT, Zhang J, & Sherin K. (2007). Factors influencing community health centers' efficiency: A latent growth curve modeling approach. *Journal of Medical Systems*. 31: 365–374.

⁵¹ McAlearney JS. (2002). The Financial Performance of Community Health Centers, 1996-1999. *Health Affairs (2)* 21:2219-225.

⁵² U.S. General Accounting Office. (2000). *Community Health Centers: Adapting to Changing Health Care Environment Key to Continued Success*.

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uninsured patients. While uninsured patients could be charged an income-adjusted fee, the financial situation of uninsured health center patients is such that as a practical matter, health centers would lack the revenues needed to stock and make available costly newer technology for patients other than those who are insured. As a result, for those drugs and devices that are more costly, health centers may lack the financial means to make the service readily available. The cost problem associated with stocking and maintaining more costly types of birth control has been noted in other studies, including studies of Title X-funded clinics.⁵³

Finally, worthy of note and yet difficult to document, are practice choices flowing from health centers' perceptions regarding community attitudes and beliefs. Health centers are governed by community boards, which may or may not support comprehensive family planning programs. Equally likely, however, is that health center staff may draw certain assumptions about the extent to which their boards and communities want their clinics to emphasize certain services. Whether health centers' decision to emphasize or de-emphasize certain services within their practices is the result of consultation with board members or patients or instead, an assumption about how such a focus would be perceived in their communities, is a question that lies beyond the scope of this study and one that may merit further exploration. But other research suggests that provider beliefs, preferences and cultural attitudes shape practice, particularly in the case of reproductive health.^{54,55} There is no reason to assume otherwise in the case of health centers, particularly given the absence of strong agency expectations and the complex circumstances under which health centers practice.

Federal and state Medicaid policy.

It is difficult to overstate the importance of Medicaid eligibility standards and program expectations. Under federal Medicaid law, family planning services and supplies are required services for all "categorically needy" beneficiaries. Medicaid maintains generous eligibility standards for pregnancy and postpartum coverage, and beginning in 2014, all adolescents under 18 with family incomes up to 138% of the federal poverty level will be entitled to coverage. However, Medicaid eligibility levels for non-pregnant parents and caretakers can be exceptionally low, and in most states, individuals of childbearing age who are neither pregnant, nor parents or caretakers of minor dependent children, nor disabled would not be entitled to coverage at any income level. However, Medicaid eligibility levels for non-pregnant parents and caretakers can be exceptionally low, and in most states, adults are not eligible for coverage unless pregnant, parents or caretakers of minor dependent children, or disabled."⁵⁶ Under a special state option initially created using the HHS Secretary's federal demonstration authority⁵⁷ and later codified as a state Medicaid coverage option under the Affordable Care Act, 29 states

⁵³ Frost JJ, Gold RB, Frohwirth L, & Blades N. (2012). *Variation in Service Delivery Practices Among Clinics Providing Publicly Funded Family Planning Services in 2010*. The Guttmacher Institute. Accessed August 30, 2012. Available at www.guttmacher.org/pubs/clinic-survey-2010.pdf.

⁵⁴ Dehlendorf C, Rodriguez MI, Levy K, Borrero S & Steinauer J. (2010). Disparities in family planning. *AJOG*. 202(3); 214-220.

⁵⁵ Smedley B, Stith A, Nelson A. (2003). *Unequal treatment: confronting racial and ethnic disparities in healthcare*. Washington, DC: The National Academies Press.

⁵⁶ For a state-by-state review of Medicaid eligibility for adults see Kaiser Family Foundation, *State Health Facts*.

⁵⁷ Section 1115 of the Social Security Act, 42 U.S.C. §1315.

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provide expanded Medicaid eligibility for family planning and family planning-related services to some or all low-income men and women, although only seven states offer expanded eligibility to persons under 18.⁵⁸ Research suggests that as a general matter, more generous Medicaid eligibility standards for adults are associated with more comprehensive and accessible health center services because of Medicaid's prominent role in health center financing.⁵⁹ As a result, health centers located in states with more generous adult coverage (either generally or for family planning services) might be expected to offer more robust family planning programs.

Federal family planning guidelines afford state Medicaid agencies considerable latitude in defining the scope of their family planning coverage. States have latitude in determining the precise range of procedures that will be recognized as a family planning service. Although federal law allows states to claim enhanced federal Medicaid funding (at a 90% contribution rate) for all FDA-approved over-the-counter and prescribed drugs and devices,⁶⁰ expansive coverage is not mandatory.

Similarly, CMS gives considerable coverage latitude to states that offer expanded Medicaid eligibility for family planning. States using this eligibility option also can elect to cover both family planning and family planning "related" services; coverage of related services qualifies for federal contributions at a state's normal, non-enhanced federal payment rate. Among the related services states may cover are: STI treatment and follow-up care including re-screenings; annual visits for men; drugs to treat lower genital tract and genital skin infections; and other medical, diagnostic, and treatment services customarily furnished in a family planning setting, such as human papilloma virus (HPV) immunizations and treatments for certain major complications of family planning (e.g., perforated uterus resulting from an intrauterine device insertion or complications from sterilization).^{61 62}

The absence of robust clinical standards more generally.

Health centers are expected to identify relevant professional standards of clinical practice and to apply those standards to their own performance. But where family planning is concerned, clinical practice standards are limited. For example, unlike the Title X program, professional and scientific guidelines on contraceptive practice such as those issued by the CDC⁶³ or the American College of Obstetricians and Gynecologists (ACOG) set broad parameters rather than detailed specifications. For example, in the case of women ages 19-39 years of age, ACOG calls

⁵⁸ Guttmacher Institute. (2012) State Policies in Brief: Medicaid Family Planning Eligibility Expansions. Accessed March 5, 2012. Available at: http://www.guttmacher.org/statecenter/spibs/spib_SMFPE.pdf.

⁵⁹ Shin P, Rosenbaum S & Paradise J. (2012). Medicaid and Community Health Centers: the Relationship between Coverage for Adults and Primary Care Capacity in Medically Underserved Communities. *Kaiser Commission on Medicaid and the Uninsured*. Available at: <http://www.kff.org/medicaid/8293.cfm>.

⁶⁰ 42 U.S.C. §1396a(a)(10)(A) and 1396d(a)(4)(C).

⁶¹ Centers for Medicare and Medicaid Services. (2010). State Health Official Letter Re: Family Planning Services Option and New Benefit Rules for Benchmark Plans. Accessed March 4, 2012. Available at: <http://www.cms.gov/smdl/downloads/SMD10013.pdf>.

⁶² The federal medical assistance payment formula provides for 90% federal funding for family planning services and supplies. The federal contribution for related services is at the state's normal federal financial contribution level. 42 U.S.C. §9902(2).

⁶³ Centers for Disease Control and Prevention. (2010). U.S. Medical Eligibility Criteria for Contraceptive Use, 2010. *Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion*. Accessed March 4, 2012. Available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5904a1.htm?s_cid=rr5904a1_w.

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for “contraceptive options for prevention of unwanted pregnancy, including emergency contraception” but does not list all forms of contraception.⁶⁴ Extensive ACOG guidelines provide additional information on aspects of clinical practice such as increasing the use of implants and intrauterine contraceptive devices as a “first-line” contraceptive method.⁶⁵

Health center clinicians may be involved in one or more active health center clinician networks. Through general collaboration, coupled with specific efforts to design and carry out multi-site quality improvement initiatives, these networks effectively act as a health center-specific professional society, developing and disseminating clinical practice standards across multiple health centers. To the extent that such networks focus on women’s preventive health and family planning practice, their recommendations might be expected to carry significant weight across all health centers. To date, however, preventive services for women, including family planning, have not received clinician network focus.

Another source of guidance regarding comprehensive preventive care for women might be the evidence-based measures used to examine clinical quality performance. But these measures offer only relatively limited performance benchmarks for women’s preventive care. For example, HEDIS[®], a commonly used system for measuring health care quality, focuses on anticipatory guidance around “contraception” in the case of adolescent well care, cervical cancer screening through the use of Pap tests, and postpartum visits within 21-56 days of delivery date.⁶⁶ But these measures do not specify access to comprehensive birth control methods or education and counseling for sexually active patients, even though reducing unintended pregnancy is, as noted, considered a performance-based measure of population health. Furthermore, Medicaid quality performance measurement standards commonly lack a family planning or birth control component.

Title X participation.

As Figure 1 illustrates, health center funding is derived from multiple sources, one of which may be Title X. Unlike the health centers program, Title X operates under extensive and specific federal performance guidelines, owing to the fact that the Title X statute is far more specific on the nature of the service to be offered, a not surprising fact given the singular purpose of Title X. For example, unlike §330, Title X specifies provision of a broad range of acceptable and effective family planning methods and services including natural family planning methods,

⁶⁴ American Congress of Obstetricians and Gynecologists. (2012). Well Woman Care: Assessments and Recommendations. Accessed March 4, 2012. Available at:

http://www.acog.org/About_ACOG/ACOG_Departments/Annual_Womens_Health_Care/Assessments_and_Recommendations

⁶⁵ American Congress of Obstetricians and Gynecologists. (2009). Increasing Use of Contraceptive Implants and Intrauterine Devices to Reduce Unintended Pregnancy. *Committee on Gynecologic Practice Long-Acting Reversible Contraception Working Group Number 450*. (Reaffirmed 2011). Accessed March 4, 2012. Available at:

http://www.acog.org/Resources_And_Publications/Committee_Opinions/Committee_on_Gynecologic_Practice/Increasing_Use_of_Contraceptive_Implants_and_Intrauterine_Devices_To_Reduce_Unintended_Pregnancy.

⁶⁶ National Committee for Quality Assurance. (2012). HEDIS 2012 Measures. Accessed March 31, 2012. Available at: <http://www.ncqa.org/tabid/1415/Default.aspx>.

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infertility services, and services for adolescents.⁶⁷ Implementing regulations parallel this statutory language.⁶⁸

The specificity of Title X has a measurable impact on entities that receive its funding. A study conducted by the Guttmacher Institute, which found considerable variation in the range of services available from Title X-funded grantees, also showed that Title-X funded sites are more likely to offer specific types of contraceptive services on-site and a higher number of contraceptive methods compared to clinics that did not receive Title X funding.⁶⁹ A separate study found that compared to private physicians' offices, Title X clinics are more likely to have a broad range of on-site contraceptive drugs and devices and stock slightly more expensive contraceptives at similar rates to private physicians' offices.⁷⁰

Title X agency guidance is especially extensive, and the range of expected services is broad. The guidance offers comprehensive definitions of client education, counseling services, history, physical assessment and laboratory tests, fertility regulation (both reversible and permanent contraception), fertility services, infertility services, adolescent services, identification of estrogen-exposed (DES) offspring, and testing for sexually transmitted diseases and HIV/AIDS. Title X guidance rests on an underlying assumption that clinics will offer a broad range of contraception, but the guidance does not explicitly require all of its grantees to furnish every approved type of prescribed or over-the-counter procedure. Separate and detailed Family Planning Annual Report (FPAR) requirements apply to Title X grantees, a derivative of the Uniform Data System (UDS) used for health center grantee reporting.

Health center size and staffing.

Staffing arrangements can be expected to enormously influence health center services. Size and staffing are, in turn, influenced by the ongoing challenges associated with the ability to obtain capital financing, anticipated revenues from patient operations, sources of financing, and the ability to recruit and retain certain types of staff.

State social and political environments.

A state's social and political culture can be expected to influence the choices made by health care providers, including health centers. Through the formulation and implementation of policy, state and local governments can create more or less friendly environments in which to address certain conditions of population health.^{71,72} Where family planning is concerned, state

⁶⁷ 42 U.S.C. §300.

⁶⁸ 42 C.F.R. §59.5.

⁶⁹ Frost JJ, Gold RB, Frohwirth L, & Blades N. (2012). *Variation in Service Delivery Practices Among Clinics Providing Publicly Funded Family Planning Services in 2010*. The Guttmacher Institute. Accessed August 30, 2012. Available at www.guttmacher.org/pubs/clinic-survey-2010.pdf.

⁷⁰ Centers for Disease Control and Prevention. (2011) Contraceptive Methods Available to Patients of Office-Based Physicians and Title X Clinics – United States, 2009-2011. *Morbidity and Mortality Weekly Report*. 60 1; 1-4. Accessed August 20, 2012. Available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6001a1.htm?s_cid=mm6001a1_w

⁷¹ Institute for Alternative Futures. (2012). Community Health Centers Leveraging the Social Determinants of Health. *Kresge Foundation*. Accessed March 31, 2012. Available at: <http://www.altfutures.org/pubs/leveragingSDH/IAF-CHCsLeveragingSDH.pdf>.

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political environments might be measured by laws regulating access to services by minors, laws funding (or barring funding) for contraceptive services aimed at vulnerable communities, and laws requiring (or barring) school-based sex education programs. State Medicaid eligibility standards also highly influence health center operations. Together, laws regulating and financing health care help define the political and cultural environment in which health centers operate.

The presence of other community resources to care for underserved and uninsured populations.

Because of the challenges they face in marshaling limited resources to meet broad community need, health centers might be expected to adjust their services to take into account other sources of care for medically underserved populations. Thus, health centers operating in the same community as clinics that specialize in family planning services might offer basic family planning services at their sites, with referral arrangements to specialized providers for patients who seek additional types of care.

Study Design

The purpose of this study was to systematically examine the design, organization, and operation of women's family planning and reproductive health services at health centers. This study defines "family planning" in accordance with the general structure of Title X, standards developed by the CDC, and a framework used by the Guttmacher Institute. Our definition encompasses four major groups of services: (1) counseling and education; (2) contraceptive drugs and devices; (3) related diagnostic tests (e.g., for pregnancy, STI, and HIV); and (4) treatment after diagnosis. This definition does not mean that providers offer all procedures falling within any specific service class, but it does establish certain broad service parameters. For example, a health center might offer only certain forms of contraceptive methods but still would be considered as offering this class of services.

In designing this study, the research team was guided by expert advisors drawn from the worlds of health center practice and family planning and reproductive health. The study consisted of an electronic survey of health centers, and a field study of selected health centers carried out through both on-site and telephone interviews designed to elicit deeper responses.

Nationwide survey.

Following a meeting of experts, the project team developed and pre-tested an e-mail survey instrument, which was fielded to federal health center grantees in operation during 2011. The purpose of the survey was to gather detailed information regarding the family planning and reproductive health services offered by health centers as well as service organization and delivery. Survey questions focused on respondents' overall approach to family planning across all sites, as well as the services found at the responding grantee's largest medical site, selected as an indication of the widest range of services offered to patients.

⁷² Takach M & Buxbaum J. (2011), Developing Federally Qualified Health Centers into Community Networks to Improve State Primary Care Delivery Systems. *Commonwealth Fund*. Accessed March 31, 2012. Available at: http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2011/May/1499_Takach_developing_FQHCs_into_community_networks_v2.pdf.

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Specific questions were included regarding numerous matters: the range of contraceptive services offered; on-site availability of prescription drugs and devices; approaches to special populations such as adolescents; school-based education and care; staffing arrangements; screening, testing, and treatment practices; and collaborations with other community providers. The survey also inquired about health center practices in areas such as patient confidentiality, with a focus on confidentiality measures involving adolescents. Questions related to practice approaches, such as open-access scheduling for women's health care also were included. In addition, the survey asked questions regarding the presence of other resources within health centers' catchment areas, such as Title X clinics, and whether respondents received Title X family planning funding. Finally, the survey asked questions regarding the types of barriers encountered in furnishing preventive women's health and family planning services.

The survey was sent to the medical directors and chief executive officers of 959 federal health center grantees for whom we had current contact information out of a universe of Section 330 grantees of approximately 1,130. We received responses from 423 grantees, for a 44% response rate.

A comparative analysis of the survey data showed that respondents were similar to non-respondents on most characteristics, while differing in certain key areas. Respondent grantees tended to be larger than non-respondents grantees, averaging more than 20,000 unique patients and 10.3 full-time-equivalent (FTE) physicians on staff, compared to averages of 14,000 patients and 6.7 FTE physicians on staff for non-respondents. Respondent and non-respondent grantees showed similar patient mixes (e.g., approximately 40% uninsured and 31-34% covered by Medicaid). Respondents and non-respondents showed similar percentages of women of childbearing age (28%-29%), the primary population targeted for family planning services. The geographic distribution of the respondents generally was comparable to non-respondents across the 10 federal health center regions delineated by HRSA. However, over-representation exists with respect to HRSA Region 1 (CT, MA, ME, NH and VT), while significant under-representation exists with respect to HRSA Region 3 (DC, DE, MD, PA, VA and WV).

Because the survey population is not large enough to create reasonable weights across the 10 HRSA regions, estimates have been adjusted based on the distribution of health centers by the U.S. Census Bureau Regions (West, Midwest, South, and Northeast). Through weighting adjustments, we have been able to improve the representativeness of the responses in relation to the size and regional distribution of the community health center. However, the weights do not fully correct for over-representation of HRSA Region 1. Since health centers in the Northeast tend to offer more comprehensive care, findings related to comprehensiveness may therefore be slightly over-stated.

“Typical” family planning service measure. For that portion of our survey that focused on grantee-level information, we sought to determine what health centers might “typically” (or usually) provide at their various service sites. For this aspect of the study we used the survey data to determine the most commonly prescribed methods in order to create a definition of “typical.” A “typical” package was defined to include STI testing and treatment, prescription and/or delivery of oral contraceptives plus one additional contraceptive method (e.g. injectables, IUDs, emergency contraception pills, condoms or hormonal implants).

Comprehensiveness of methods measure. A composite index score was created in order to measure comprehensiveness of contraceptive methods offered at each community health centers'

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largest site based on survey responses. This score was used to identify and describe the factors supporting or impeding comprehensive family planning care. Using the CDC definition of comprehensive contraceptive services, the research team assigned point values for the availability of services at respondents' largest sites for eight categories of contraceptive methods prescribed. Availability of each selected method was given a single point value; methods were weighted an additional point value, ranging from 0.5 to 1.0, for on-site delivery based on the complexity of providing the service at the health center. The maximum score possible was 12.5. Next, multivariate regression modeling was conducted to explore key factors associated with health centers' comprehensiveness index.

We employed this largest site approach for measuring the degree of comprehensiveness, rather than comprehensiveness at the grantee level, because within any health center grantee there are likely to be varying sites of multiple size and complexity; indeed, health center respondents averaged nearly 5 service sites per grantee. Thus, in order to bring greater comparability to our analysis, we asked health centers to report on the comprehensiveness of care within their largest service sites. Sites that both prescribed and dispensed given method on-site received a bonus for each method for which this was the practice.

Select Contraceptive Methods in Comprehensiveness Index

- Oral contraceptives/extended oral contraceptive regimen (0.5 additional point for on-site delivery)
- IUD: Mirena and/or ParaGard (1 additional point for on-site delivery)
- Injectables (1 additional point for on-site delivery)
- Patch and/or vaginal ring (0.5 additional point for on-site delivery)
- Barrier methods including male/female condoms, and/or diaphragm/cervical cap, and/or sponge (no additional point for on-site delivery)
- Natural family planning (no additional point for on-site delivery)
- Emergency contraception (0.5 bonus for on-site delivery)

Case studies.

In addition to the nationwide survey, the research team conducted in-depth case studies to probe more deeply into how health centers provide family planning and reproductive health care, as well as the barriers to care. The case studies were designed to provide a clearer understanding of the issues health centers face in furnishing preventive and family planning services, and to identify internal and external factors that act as either barriers to or facilitators of care, gaps in care, and successful strategies, care models, and best practices.

Case study sites were selected using a maximum variation sampling approach that included a variety of health center grantees in terms of size, scope of practice, staffing and patient mix, and geographic location. The sampling methodology also took into account variations in state Medicaid policies, ranging from extensive involvement through family

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planning waiver programs to policies aimed at reducing or curtailing state funding for family planning services. Six health centers were recruited for full in-depth case studies, while an additional three health center sites were selected for targeted review. Staff interviewed a range of clinical and administrative staff, and the interviews resulted in detailed information regarding health centers' approach to family planning and primary reproductive health care. In particular, the interviews yielded important information related to the provision of preventive care and family planning, including on-site care and contraceptive dispensing, off-site referrals, patient care-seeking patterns, payment arrangements, staffing issues, information sharing capabilities with off-site providers, and costs associated with the provision of family planning services. Through case studies, the research staff gained a better understanding of the factors that support and/or impede the provision of comprehensive care.

Policy environment.

To account for factors that influence health care practice and the availability of family planning services, particularly in the case of adolescents, the research team categorized relevant state public policy. We divided state policies into two distinct categories: those affecting access to care more generally (such as Medicaid eligibility income levels); and those that affect family planning availability specifically, such as confidentiality and privacy laws. The bodies of law used reflect policies identified by the National Institute for Reproductive Health as heightening or reducing barriers to contraceptive services. The research team used the most currently available policy data and information. Policies were assigned weights and values for scoring, and states were scored and then categorized by total score ranging across degrees of restrictiveness (non-restrictive, somewhat non-restrictive, neutral/mixed, somewhat restrictive, restrictive). In assigning values to policies, researchers gave greater value to policies that experts tend to associate with a higher level of access to birth control services by both minors and adults: laws that enable choice by minors and remove consent-based barriers to access; sex education laws; laws that enable one or more classes of health care providers to refuse to prescribe or dispense birth control drugs or devices, and laws that make birth control services more accessible to low-income populations. This overall categorization was used to determine whether a state's policy environment had a significant impact on the availability of comprehensive family planning services at health centers' largest sites through multivariate regression modeling. We used similar methods to conduct another sub-analysis which looked at the role of other policies such as minors' access to contraceptives, school-based sex education programs, and state family planning funding restrictions (exclusive of Medicaid coverage) in independently predicting comprehensiveness of family planning services.

We also conducted two sub-analyses of different policy and financing factors in order to determine if they independently predicted comprehensiveness scores. The first analysis categorized states by their level of Medicaid coverage, using a similar scoring and categorization methodology as described above. States were then coded as having broad, mid-range, or narrow Medicaid coverage based on income eligibility. The criteria used to categorize Medicaid coverage included the following: 1) state extension of coverage either via the ACA family planning waiver option or as a state plan amendment to all categories of low-income adults AND that cover all low-income adults (including parents/caretakers) at or above 100% of FPL; 2) states that both extend coverage for low-income adults via the ACA option to implement coverage of low-income adults ahead of the 2014 expansion date or as a Section 1115 demonstration group AND set the income level for adults at least at 75% of the FPL; 3) states

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that have raised income eligibility for parents to at least 75% of the FPL; 4) states that have not addressed general Medicaid eligibility for adults.

States were given higher scores for broader Medicaid expansions and were not given points if they have not yet expanded coverage in one of the ways described above. States could receive a maximum score of four points and a minimum score of negative one point. Using these scores, we then conducted multivariate regression analysis to assess the relationship between state Medicaid eligibility policies and the availability of comprehensive family planning contraceptive services in health center settings.

Components of State Policy Environment Measurement

- Laws governing minor access to contraceptives
- State funding of contraceptive services for minors
- State family planning funding restrictions
- School-based sex education programs
- Provider refusal laws
- Insurance coverage of contraceptives
- Medicaid eligibility for adolescents
- Medicaid adult eligibility
- Medicaid family planning expansions

Findings

Overall Findings from the Grantee-Level Survey

The following results reflect the characteristics and services offered by the 423 respondent health center grantees, representing 1,940 primary care delivery sites, the vast majority of which (at least 1,781) furnish some level of family planning services.⁷³

Availability of Family Planning Services across Health Center Sites

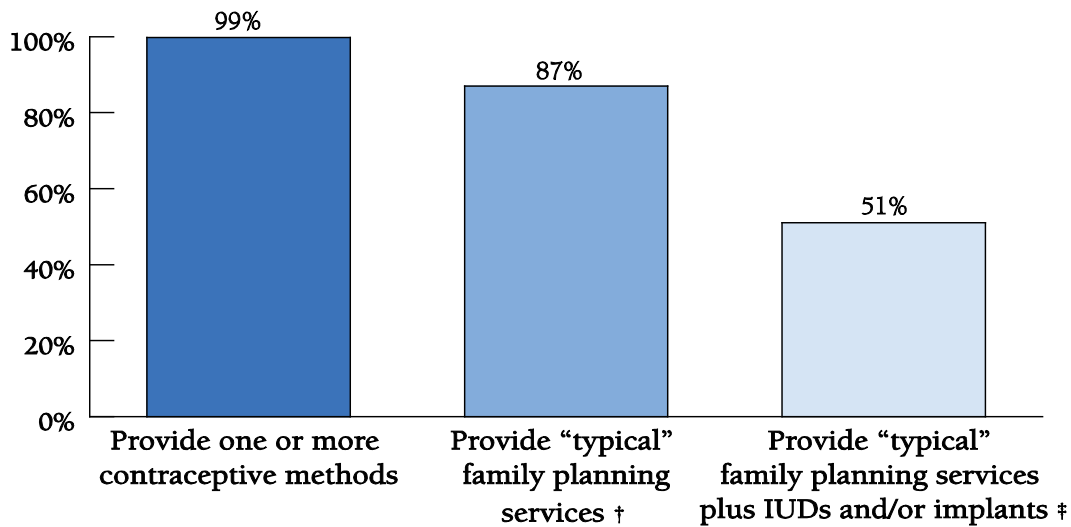
Virtually all health centers reported that they provide at least one contraceptive method (99.8%) at one or more service sites. In addition, as required by federal law all health centers maintain referral arrangements for contraceptive services not furnished on-site. Figure 2 shows

⁷³ The actual number of sites offering family planning services is likely to exceed the reported number. The survey question capped the maximum number of sites per organization at 15.

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that 87% of the respondent 1,940 health center medical sites offered what we defined as “typical” family planning services. Across all responding health centers, 51% of all sites offered typical family planning services *plus* either IUDs or hormonal implants. Slightly more than half of all health centers sites make available oral contraceptives (the most popular form of contraceptive) and dispense them on-site, while 36% also provide IUDs or hormonal implants.

Figure 2. Health Center Provision of Family Planning Services



† Percent of grantee's primary medical care sites that offer what is here defined as a “typical” service package, including: STI testing/treatment, plus oral contraceptives, plus one other contraceptive method (e.g., injectables, IUDs, emergency contraception pills, condoms, hormonal implants).

‡ Percent of grantee's primary care sites that offer STI testing/treatment, plus oral contraceptives, plus IUDs and/or hormonal implants, plus one other contraceptive method.

Findings from Survey Responses for Health Centers' Largest Sites

Findings from the surveys of health centers' largest sites expand upon and enrich the overall health center findings. This information sheds light on both specific approaches to family planning practice, as well as the relationship between health center participation in Title X and the depth and scope of family planning practice at the largest site.

Largest Site Practice Characteristics

The majority of health centers reported that their largest site was urban (52%) while 48% identified their largest site as either rural or suburban. In addition, 52% of health centers reported that their largest site operated an open access model of care delivery specifically for women's health, meaning that same-day appointments are available.⁷⁴

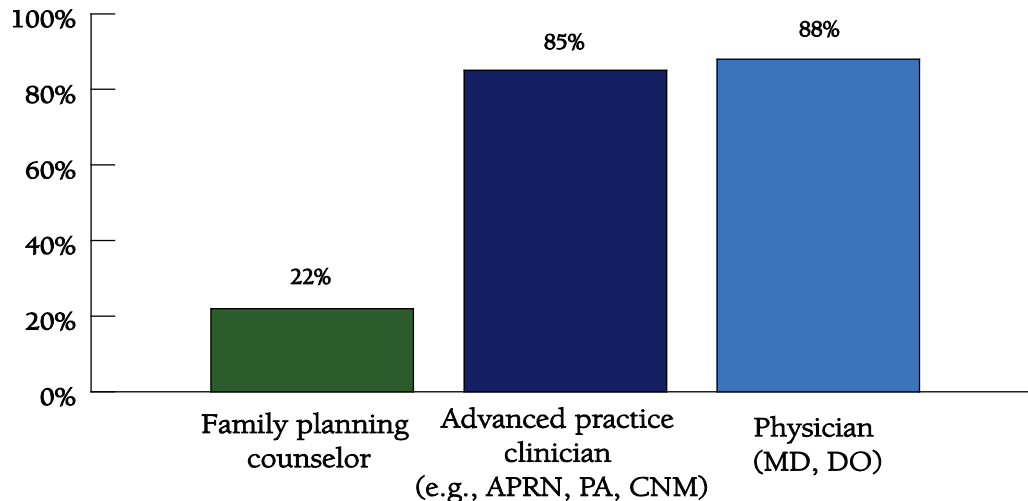
⁷⁴ Murray M & Berwick DM. (2003). Advanced access: reducing waiting and delays in primary care. *JAMA*. 289(8); 1035-40.

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Staffing Patterns

Overall, 22% of respondents reported that their largest site employed health counselors or educators to provide family planning counseling; 88% and 85% of respondents, respectively, reported that physicians and advanced practice clinicians (nurse practitioners, physicians assistants, or certified nurse midwives) provide family planning counseling (Figure 3).

Figure 3. Use of Family Planning Counseling At Largest Health Center Sites, By Type of Clinician



Prescribing and Dispensing Practices

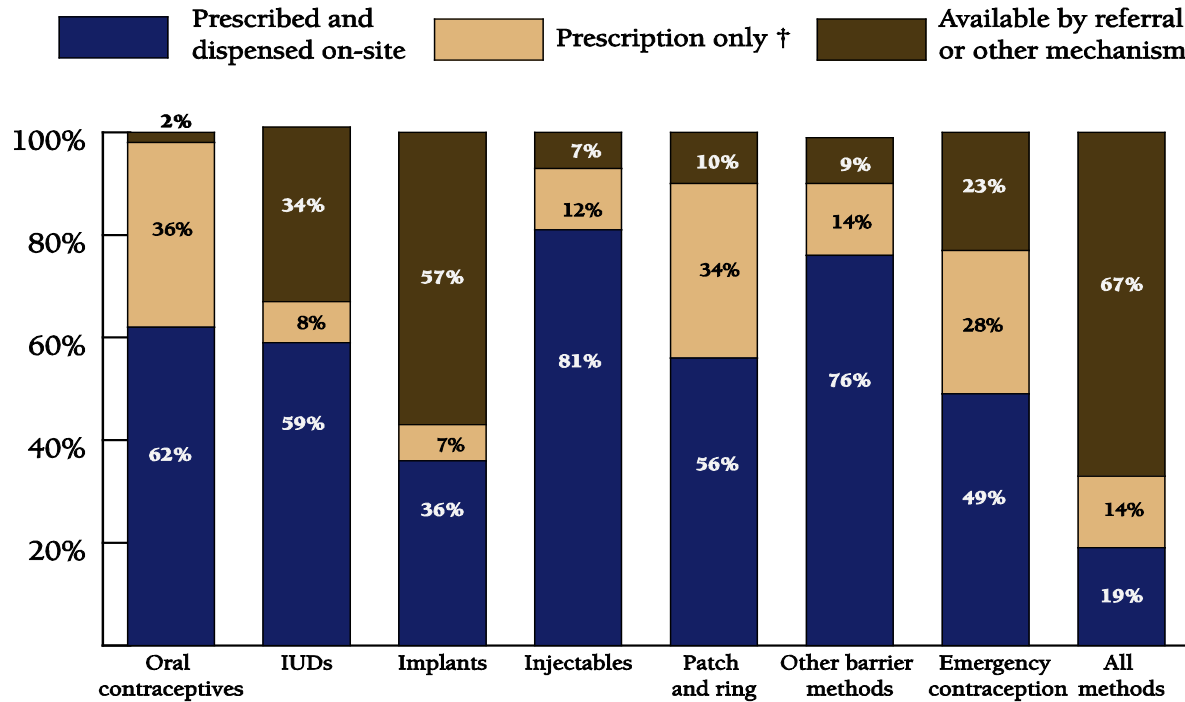
Figure 4 describes the availability of select contraceptive methods at health centers' largest sites, whether through prescription or on-site delivery or dispensing. This figure may be influenced by the presence of a pharmacy on-site at a health center, which may be quite variable across CHC organizations.⁷⁵ In the case of oral contraceptives, 62% of respondents reported that their largest sites prescribe and dispense on-site; 36% reported prescribing only. Similarly, 59% of respondents report on-site IUD prescribing and dispensing, while 8% only prescribe. Thirty-four percent of respondents reported that IUDs are available at the largest site only by referral or other arrangement. A smaller proportion reported on-site prescribing and dispensing of implants (36%) while the majority (57%) reported that implants are available by referral or other arrangement. Eighty-one percent make injectables available on-site through prescription and administering, while 7% refer for this service. Nineteen percent reported that their largest sites both prescribe and dispense delivery of all contraceptive methods on-site. Forty-nine percent reported that emergency contraception was prescribed and dispensed on-site.

⁷⁵ Barner JC, Brown CM, Shepherd MD, Chou JY & Yang M. (2002). Provision of pharmacy services in community health centers and migrant health centers. *J Am Pharm Assoc.* 42(5); 713-722.

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As a follow-up to questions about prescribing behavior, health centers were asked to respond to the question regarding their largest sites: “what usually happens when dispensing or prescribing the following contraceptive methods: oral, injectables, IUDs, implants?”. Qualitative analysis of 57 responses indicated that lack of staff, inability to obtain the implant (resulting in trained staff not doing the procedure) were common problems.

**Figure 4. Prescribing and Dispensing of Contraceptive Methods
Among Largest Health Center Sites**



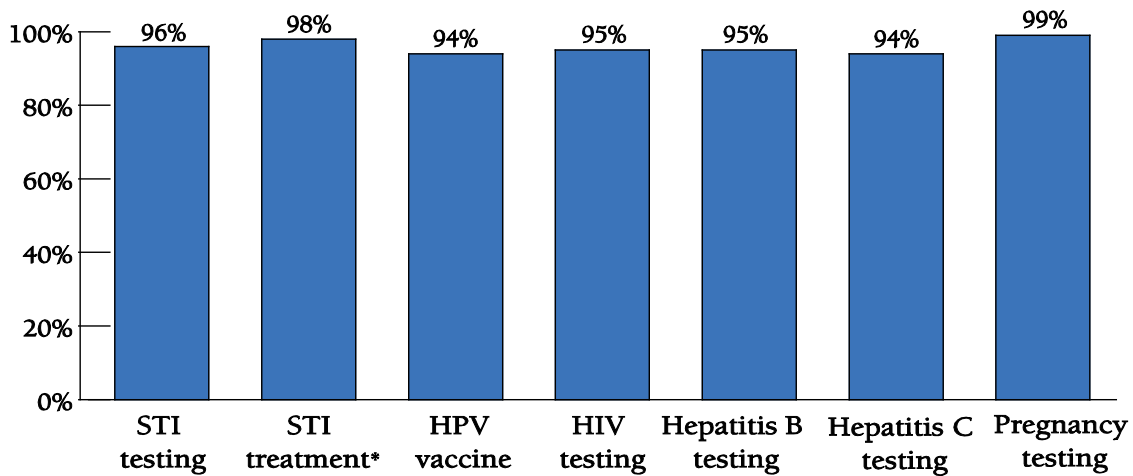
† Prescription only means that the health center site provides prescription and, in some cases, client obtains contraceptive method from outside pharmacy and returns to clinic for administration or insertion, as appropriate.

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Testing and Treatment Practices

Virtually all respondents reported that their largest sites perform diagnostic screening and testing for HIV, STI, Hepatitis B, Hepatitis C, and pregnancy on-site, as shown in Figure 5. Diagnostic STI testing was available on-site at 96% of the largest sites; 98% reported on-site treatment for STIs.⁷⁶ Ninety-five percent of largest sites offer on-site HIV and Hepatitis B testing, followed closely by 94% of largest sites offering on-site Hepatitis C testing. Ninety-nine percent offered on-site pregnancy testing while 94% reported on-site HPV vaccines.

Figure 5. On-site Pregnancy Testing and Infectious Disease Testing and Treatment At Largest Health Center Sites



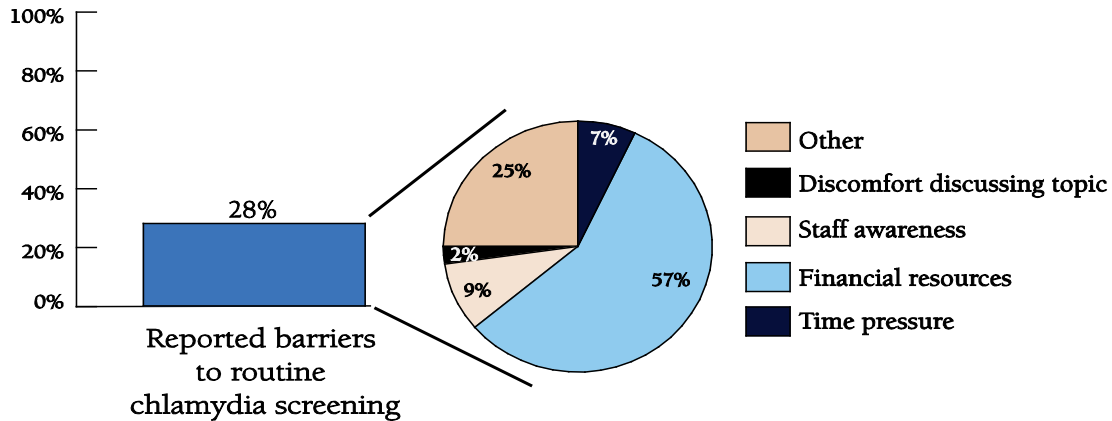
Chlamydia Screening and Treatment

Routine chlamydia screening of all sexually active young women age 25 and under is considered extremely important in finding and treating this most common form of STI. Routine screening is especially important, since up to 70% of all infections are asymptomatic, and because infection is associated with pelvic inflammatory disease, ectopic pregnancy, infertility, and perinatal infections.⁷⁷ Fifty percent of respondents reported that their largest sites routinely screen the target population for chlamydia. More than 25% reported routine screening barriers such as cost, time pressure, staff awareness, and discomfort discussing the topic (Figure 6).

⁷⁶ In these cases, treatment includes both the prescription and/or application of treatment, if necessary.

⁷⁷ Centers for Disease Control and Prevention. (2004). Chlamydia Screening Among Sexually Active Young Female Enrollees of Health Plans – United States, 1999-2001. *Morbidity and Mortality Weekly Report*. Accessed March 31, 2012. Available at: <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5342a1.htm>.

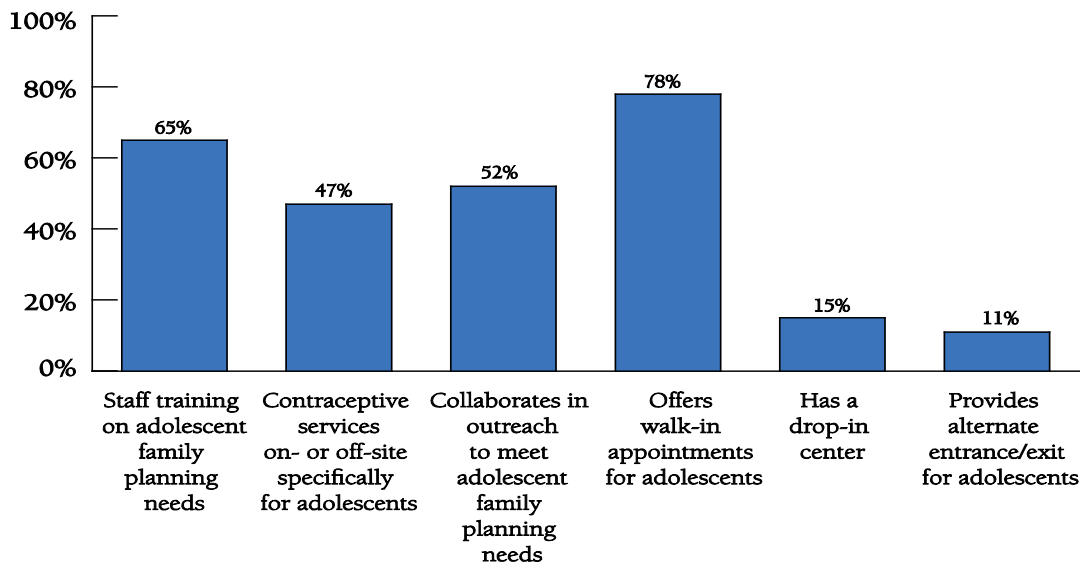
Figure 6. Barriers to Routine Chlamydia Screening Among Largest Health Center Sites



Services for Adolescents

In 2010, health centers served 1.5 million adolescents ages 13 to 17. Sixty-five percent of respondents reported that staff at their largest site receive training in the family planning needs of adolescents, while over half (52%) report that their largest sites collaborate with other entities in outreach activities to meet adolescents’ family planning needs. Furthermore, 47% reported that their largest site provided either on-site or off-site contraceptive services specifically targeted at adolescents. Figure 7 illustrates that health centers’ largest sites also provide other additional accommodations for adolescents including walk-in appointments for adolescents (78%), a drop-in center (15%) and alternate entrances and exits for adolescents (11%).

Figure 7. Adolescent Health Services and Supports Among Largest Health Center Sites



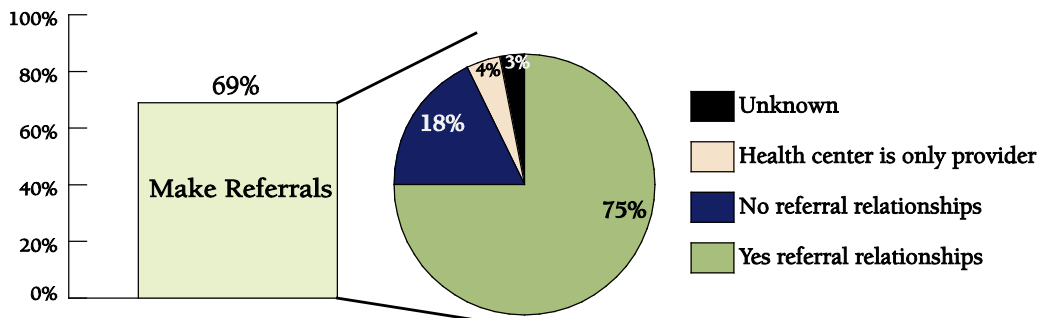
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Relationships Between Largest Sites and Independent Family Planning Clinics

Seventy-five percent report the presence of an independent family planning clinic in the community served by their largest site. Among those reporting an independent family planning clinic in their largest site's community, 62% reported receiving referrals and 69% reported making referrals for family planning services. As Figure 8 indicates, health centers both make and receive referrals, although receipt of referrals is slightly lower, raising the question as to why independent family planning clinics do not make more referrals given the limited scope of their care.

Several factors might account for these referral patterns. One might be the fact that health centers do not always know that patients who seek care have been referred; they might simply appear for care. Another factor might be that family planning programs might maintain relationships with other health care providers in their service area, such as public hospitals or physician practices who make their services accessible to patients referred by a family planning provider. Managed care and formal provider network arrangements that limit the range of referral options might operate as a third factor, since the Medicaid freedom-of-choice guarantee for family planning services in the case of managed care enrollees extends only to family planning procedures.⁷⁸ Health centers would be the referral source in situations in which they serve as the designated primary care provider, but potentially not otherwise.

Figure 8. Routine Referral Relationships Among Service Area Family Planning Providers and Largest Health Center Sites



⁷⁸ 42 U.S.C. §1396a (a)(23).

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The first factor – simply not knowing that patients have been referred from family planning programs – may be of particular importance. At the same time, the absence of a clear understanding of how patients are referred to or select the center may suggest that not all health centers maintain express agreements with family planning providers, as would be necessary to ensure a full and seamless flow of patients between the two types of providers, along with the exchange of information related to treatment.^{79,80,81}

Comprehensive Range of Methods at Health Centers' Largest Sites

While all health centers reported that they make some family planning services available, the range of contraceptive methods varied, even at health centers' largest sites. To better understand the predictors of comprehensiveness of methods at health centers' largest sites, we used the comprehensiveness index described in the methods section to measure availability of these services at the largest center site. The index scores for respondent health centers were widely distributed, with values ranging from 0.5 to the maximum score of 12.5. The mean comprehensiveness score for respondents was 9.24, with a median of 10.0 indicating that many health centers are able to make several contraceptive methods available either on-site or by prescription, but not necessarily all methods. Consistent with earlier findings, approximately 19% of responding health centers reported making all methods available on-site, corresponding to the maximum score of 12.5 on the index scale. At the same time, the distribution of the comprehensive score exhibited a leftward skew, indicating that a considerable proportion of largest sites offered less than the fullest level of comprehensive services.

Two separate OLS regression models were run to determine the most salient factors contributing to comprehensiveness scores. The multivariate regression modeling determined that several key factors were predictive of more comprehensive services, including being a large or medium sized health center (compared to small size), location in the Western region of the country, location in a suburban setting (compared to urban or rural), the presence of OB/GYNs on staff, and the presence of dedicated family planning counselors, although having a family planning counselor on staff was only marginally statistically significant in both models (See Table 3). Receipt of Title X funding was a strong predictor of comprehensiveness scores in both models, as was the overall local policy and financing climate within which health centers operate.

⁷⁹ This type of exchange of electronic health information, if done so in a secure fashion, would be permissible without specific informed consent under the HIPAA Privacy Rule, because it is related to patient treatment. 45 C.F.R. §164.502(a)(1)(ii). In the case of information related to substance use disorders, federal standards would require a specific informed consent. Depending on states law, informed consent would be required for certain conditions such as mental illness or HIV status. Since patients must consent to treatment generally, one would presume that consent to data exchange on relevant matters could be secured as part of the treatment consent process. In this regard, of course, the health center's ability to assure the confidentiality of patient information related to family planning services through information segregation procedures would be a key element of an agreement between a health center and a Title X program, in light of the special confidentiality standards that apply to all Title X programs.

⁸⁰ Klerman LV, Johnson KA, Chang C, Wright-Slaughter P, Goodman DC. (2007). Accessibility of Family Planning Services: Impact of Structural and Organizational Factors. *Matern Child Health J. Jan, 11(1):19-26.*

⁸¹ Goodman DC, Klerman LV, Johnson KA, Chang C, Marth N. (2007). Geographic access to family planning facilities and the risk of unintended and teenage pregnancy. *Matern Child Health J. Mar; 11(2):145-52.*

Table 3. Key Characteristics of More Comprehensive Largest Sites

- More likely to have Title X funding
- More likely to be a medium or large Community Health Center
- More likely to be located in a self-described urban or suburban setting
- More likely to be located in the West
- Staff includes an Ob-Gyn and Family Planning Counselors
- Broad or Mid-range Medicaid Coverage

The Impact of Title X Funding

The presence of Title X funding was the strongest predictor of comprehensive services among survey respondents. Further analysis was undertaken to better understand this relationship. Twenty-six percent of all grantee respondents reported receipt of Title X funding at their largest site.

First, Title X provides additional family planning resources. As the Guttmacher Institute has pointed out, the availability of additional grant resources plays a key role in helping safety net providers such as health centers develop the staffing and supply capabilities to offer more robust services that, in turn, can be sustained primarily through Medicaid funding.⁸² Second, unlike Section 330, Title X establishes extensive and detailed expectations regarding both the scope of services and emphasis on certain high-risk populations such as adolescents.

Characteristics of Title X Funded Health Centers

Health centers that participate in Title X are more likely to be in a self-described urban or suburban location (84%). They are also more likely to be located in the Northeast or West (63%), although the South is strongly represented, accounting for 24% of all CHC Title X participants.⁸³ Title X-participating sites have a similar proportion of uninsured patients (42% versus 40%), a slightly higher proportion of Medicaid patients (35% versus 31%), a higher proportion of patients who are women of childbearing age (31% versus 27%), a slightly higher proportion of adolescent patients (6% versus 4%), and a lower proportion of patients who are white non-Hispanic (44% versus 55%). Title X participants also have slightly more robust medical staff, as measured by FTE medical staff per 1,000 patients (3.0 versus 2.8). Finally, Title X participants report that a significantly higher proportion of their care is contraceptive management (11%

⁸² Frost JJ, Gold RB, Frohwirth L, & Blades N. (2012). *Variation in Service Delivery Practices Among Clinics Providing Publicly Funded Family Planning Services in 2010*. The Guttmacher Institute. Accessed August 30, 2012. Available at www.guttmacher.org/pubs/clinic-survey-2010.pdf.

⁸³ Regions described here are U.S. Census Bureau Regions.

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versus 4% of patients served and 5% versus 2% of all visits). This finding does not mean, of course, that Title X leads to these results or influence the types of health centers that seek Title X funding. Nor is there reason to think that Title X grant-making practices differ significantly in the Northeast or West or that health centers with larger white, Non-Hispanic populations are less likely to seek Title X participation. But if one considers Title X participation as a proxy for a dedicated program to improve access to comprehensive family planning services, our findings suggest that certain types of health centers – those in the Northeast or West, those with a higher proportion of minority patients, and those with more adolescents and higher Medicaid coverage – are more likely to seek to develop such programs.

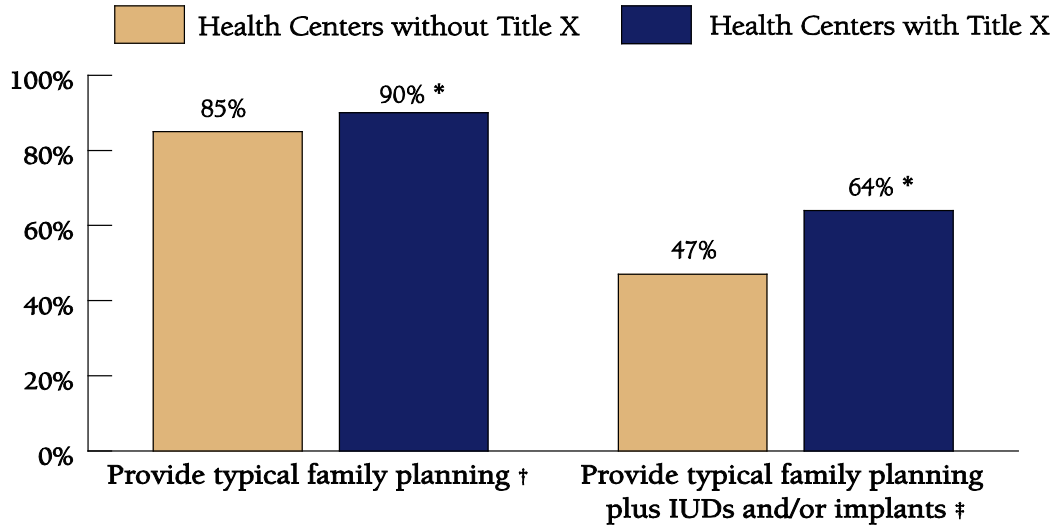
Table 4. Key Characteristics of Health Centers that Receive Title X Funding

- More likely to be located in a self-described urban or suburban setting
- More likely to be located in the Northeast or West
- A higher proportion of patients who are uninsured, Medicaid, adolescent, and women of childbearing age
- A lower proportion of white patients
- Larger medical staffs
- A larger number of patients receiving contraceptive management services, and more contraceptive management visits

Figure 9 shows that 90% of sites at Title X-funded health centers offer “typical” family planning services (according to our earlier definition of at least STI testing/treatment, oral contraceptives plus on other contraceptive method) compared with 85% of sites at health centers with no dedicated Title X funding. This difference is statistically significant (p-value < 0.05). Similarly, Title X funded health centers have a significantly higher proportion (64%) of sites that offer “typical” family planning plus IUDs and/or hormonal implants compared to health centers without Title X funding (47%).

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Figure 9. Health Centers Provision of Family Planning Services, By Title X Funding



† Percent of grantee's primary care sites that offer STI testing/treatment, plus oral contraceptives, plus one other contraceptive method (e.g., injectables, IUDs, emergency contraception pills, condoms, hormonal implants).

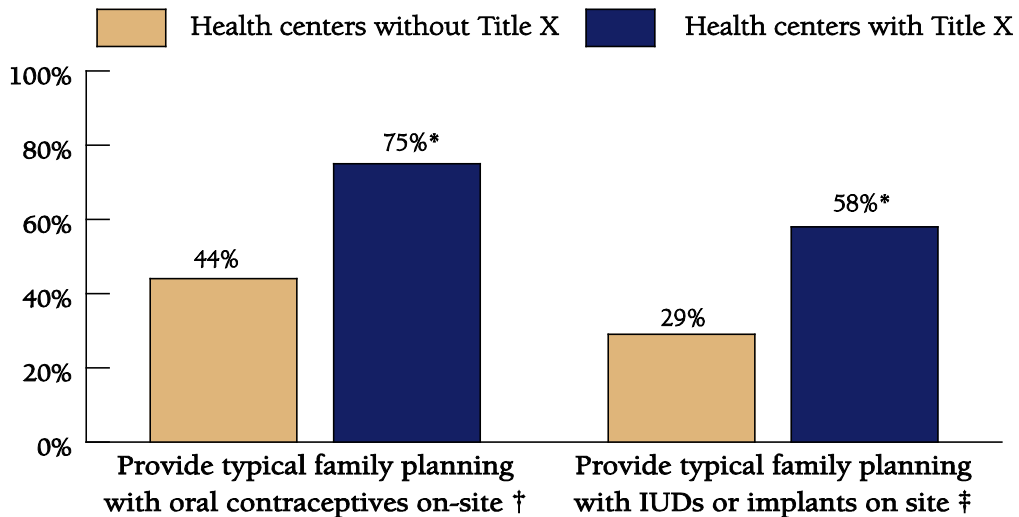
‡ Percent of grantee's primary care sites that offer STI testing/treatment, plus oral contraceptives, plus IUDs or hormonal implants, plus one other contraceptive method.

Title X-funded health centers have other important distinctions. . Figure 10 shows that 75% offer oral contraceptives on-site, compared to only 44% of health centers without Title X. Additionally, a significantly larger proportion of health centers with Title X funding (58%) are able to provide “typical” family planning with oral contraceptives on-site *plus* IUDs and/or implants than is the case for non-Title X health centers (29%).

Title X funding also is associated with special outreach to high-risk populations such as adolescents. Title X participation results in a 63% participation rate in school-based education and a 41% participation rate in school-based clinical services, compared to 38% and 24%, respectively, for health centers that do not participate in Title X. These differences are considered statistically significant (p-value =0.01).

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Figure 10. Health Center Provision of On-site Family Planning Services, By Title X Funding



† Percent of grantee's primary care sites that offer STI testing/treatment, plus oral contraceptives onsite, plus one other contraceptive method (e.g., injectables, IUDs, emergency contraception pills, condoms, hormonal implants).

‡ Percent of grantee's primary care sites that offer STI testing/treatment, plus oral contraceptives onsite, plus IUDs or hormonal implants, plus one other contraceptive method.

* Differences between Title X and non-Title X health centers are statistically significant at $p < .05$.

Staffing Patterns and Family Planning Counseling

Striking differences between Title X and non-Title X-funded health centers can be seen in the use of family planning counselors, shown to be important in achieving adherence, especially to oral contraceptive regimens.⁸⁴ For this reason, counseling is a covered Medicaid family planning service and was also included by the IOM in its women's preventive services recommendations.^{85,86} Forty-four percent of all Title X-funded health centers provided counseling at their largest sites; by contrast, counselors were available at only 14% of the largest sites not receiving Title X funding. Since statistically similar proportions of Title X and non-Title X-funded sites use physicians (82% vs. 86%, respectively) and advanced practice clinicians (86% vs. 89%, respectively) to provide family planning counseling, it appears that additional Title X resources play a key role in the presence of comprehensive counseling.

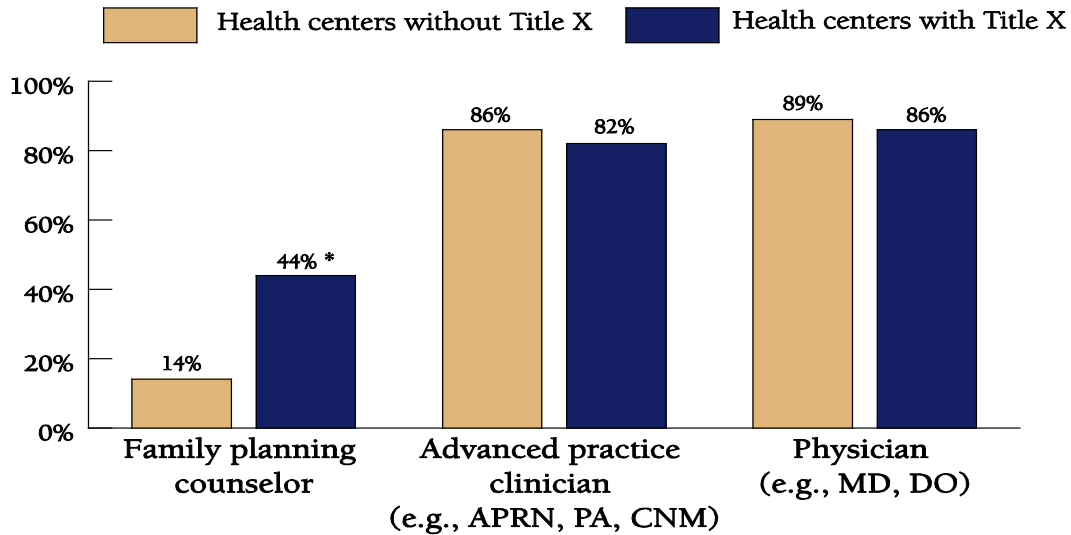
⁸⁴ Guttmacher Institute. (2008). *Improving Contraceptive Use in the United States*. Accessed April 4, 2012. Available at: <http://www.guttmacher.org/pubs/2008/05/09/ImprovingContraceptiveUse.pdf>.

⁸⁵ Guttmacher Institute. (2008). *Improving Contraceptive Use in the United States*. Accessed April 4, 2012. Available at: <http://www.guttmacher.org/pubs/2008/05/09/ImprovingContraceptiveUse.pdf>.

⁸⁶ Committee on Preventive Services for Women. (2011). *Clinical Preventive Services for Women: Closing the Gaps*. *The Institute of Medicine*. Accessed April 4, 2012. Available at: http://www.nap.edu/catalog.php?record_id=13181.

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Figure 11. Use of Family Planning Counseling, By Type of Clinician and Title X Funding



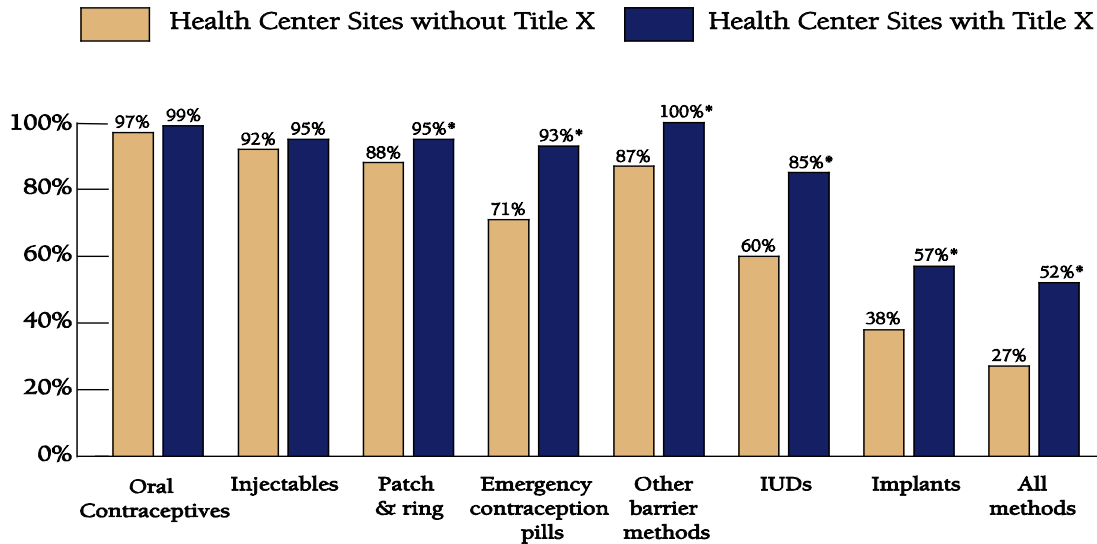
* Differences between Title X and non-Title X health centers are statistically significant at $p < .05$.

Contraception prescribing and dispensing

Figure 12 shows the differences in contraceptive practice based on whether the health center's largest site participates in Title X. Small differences can be seen in the availability of oral contraceptives, of both the daily and extended types, as well as in the use of injectable contraceptives and the patch and ring. Relatively small, but statistically significant differences also can be seen in the availability of other forms of contraceptives, such as diaphragms, sponges, male condoms, female condoms and spermicides. Larger significant differences are reported in the availability of emergency contraception, IUDs and implants. Most striking, perhaps, is the fact that 52% of largest sites that participate in Title X offer all forms of contraception, compared to only 27% of non-participating sites.

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Figure 12. Contraception Prescribing and/or Dispensing Among Largest Health Center Sites, By Title X Funding



* Differences between Title X and non-Title X health centers are statistically significant at $p < .05$.

Title X participation makes a large difference in the on-site availability of various forms of contraception. Among the largest sites at non-Title X-participating health centers, 53% provide oral contraceptives on-site and 44% offer prescription only. By contrast, 85% of the largest sites at Title X-participating health center report on-site availability of oral contraceptives, and 14% reporting prescribing only. Similar patterns can be seen with injectables, IUDs, and implants. In each case, Title X participation is associated with considerable differences in on-site availability, particularly in the case of IUDs and implants, both of which would require not simply the availability of counselors, but also the presence of specially trained clinical professionals capable of administering the contraception on-site.

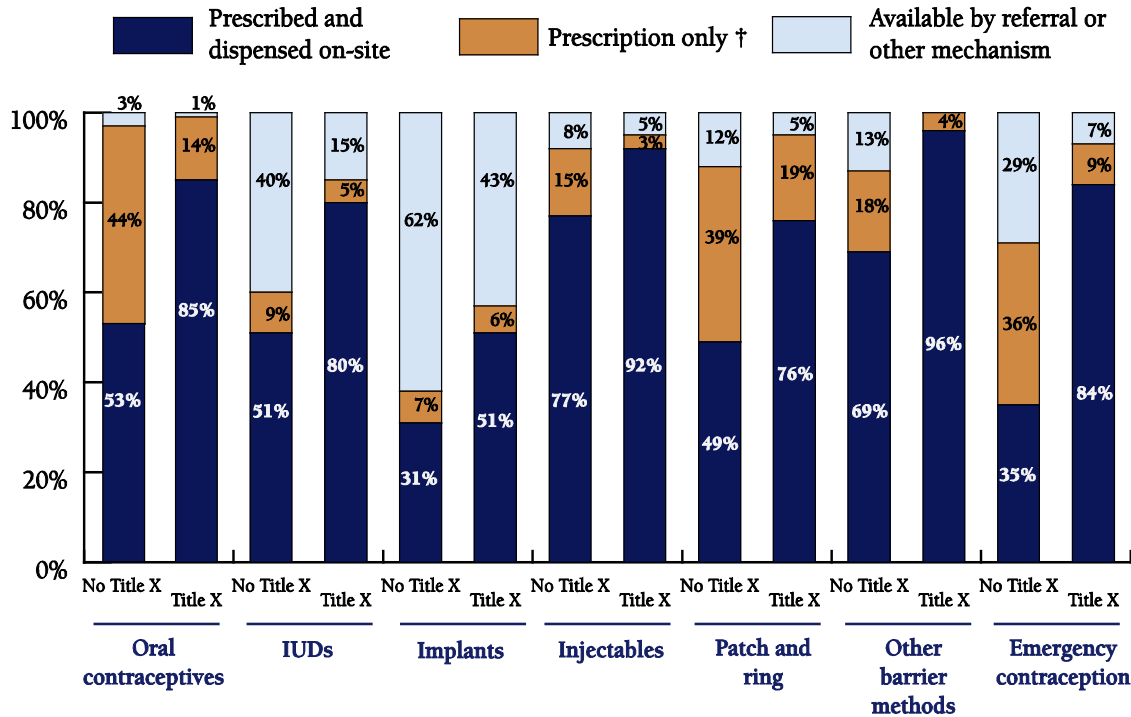
Health centers that do not receive Title X funding more commonly indicated that oral contraceptives are prescribed but prescriptions are filled elsewhere and that patients are referred for IUD and implant insertion. These respondents reported using patient assistance pharmaceutical programs as well as referral providers offering discounted procedures in order to manage costs to patients.

On-site Testing and Treatment Services

Although minor differences exist between Title X and non-Title X recipients with respect to on-site testing and treatment at their largest sites, the differences are minor although some are statistically significant. Title X does not appear to play a major distinguishing role where these services are concerned.

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Figure 13. On-site Access to Contraceptive Methods Among Largest Health Center Sites, By Title X Funding



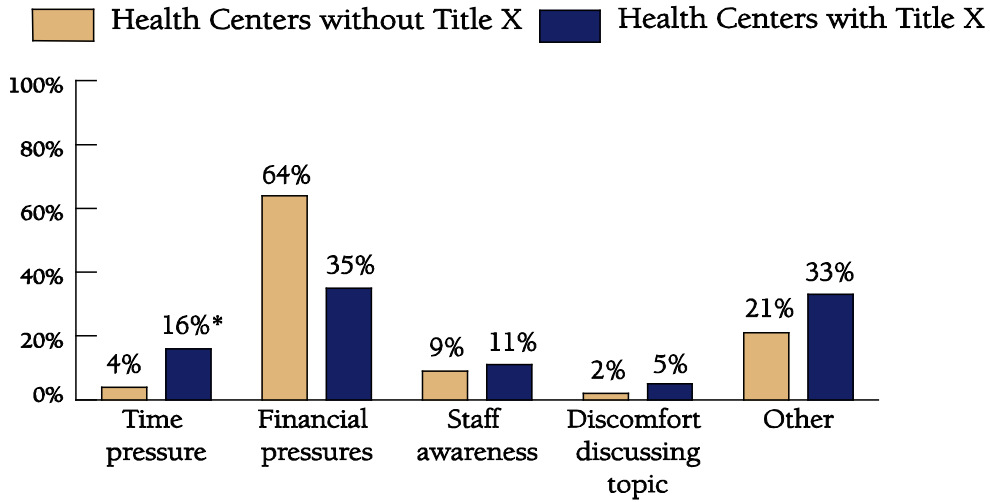
† Prescription only means that the health center site provides prescription and, in some cases, client obtains contraceptive method from outside pharmacy and returns to clinic for administration or insertion, as appropriate.

* Differences between Title X and non-Title X health centers are statistically significant at $p < .05$.

Routine Chlamydia Screening

Receipt of Title X appears to play an important role in routine chlamydia screening. A higher proportion of Title X-funded health centers' largest sites report that routine chlamydia screening is always provided for sexually active young women at their largest sites compared to health centers without Title X funding (60% versus 46%). Nonetheless, both Title X and non-Title X-funded programs show a deficit in routine screening in relation to clinical recommendations. Both Title X-funded and non-Title X-funded respondents were equally likely (29% and 28%, respectively) to report barriers. However, the two types of respondents reported different barriers, as noted in Figure 14. Title X recipient respondents were four times as likely as sites at non-participating health centers (16% versus 4%) to report time pressures. By contrast, financial resources were identified as barriers by 64% of sites not connected with Title X participation, compared to 35% reporting financial barriers at sites associated with Title X participation. Discomfort discussing the topic seemed, strangely, to be slightly higher among Title X-participating respondents.

Figure 14. Barriers to Routine Chlamydia Screening Among Largest Health Center Sites, By Title X Funding



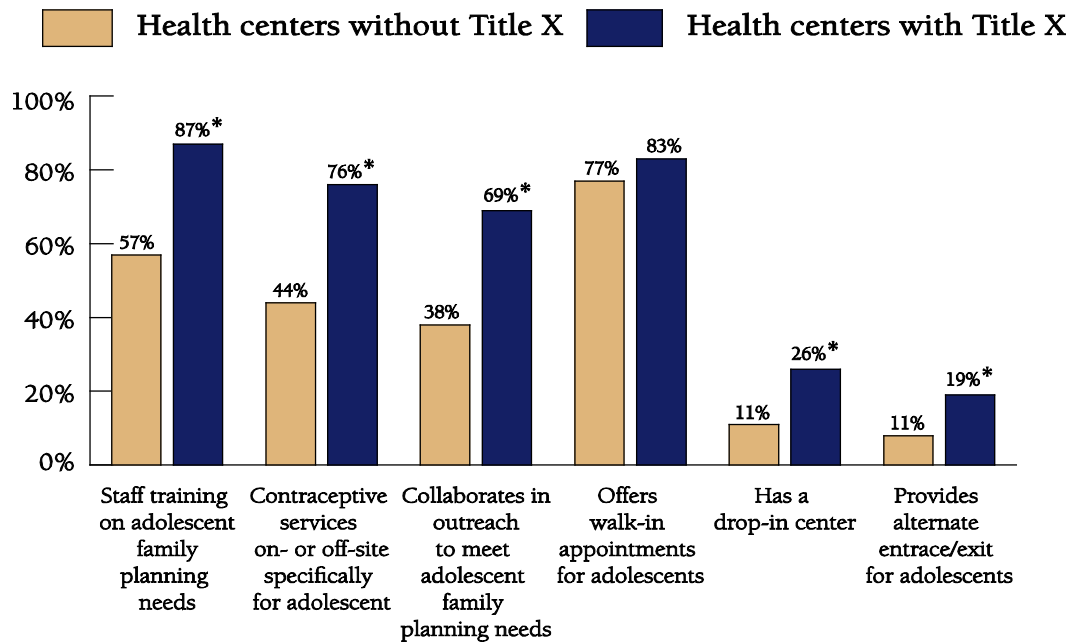
* Differences between Title X and non-Title X health centers are statistically significant at $p < .05$.

Adolescent Services and Practices

Health centers with adolescent-focused practices, as measured by specialized training, on-site services tailored to adolescents, and collaboration with other entities in outreach efforts, are more likely to participate in Title X. Eighty-seven percent of respondents receiving Title X reported that their largest sites employ staff with special training in adolescent treatment compared to only 57% of respondents without Title X funding. More Title X-funded respondents (76%) report that their largest sites collaborate in adolescent outreach activities compared to 44% among the largest sites reported by non-Title X recipients. A significantly higher proportion of Title X participating health centers offer adolescent-tailored programs at their largest sites compared to those that do not receive Title X (69% vs. 38%). Drop-in centers and alternate exits are also more common at largest sites of Title X recipient health centers.

Largest site practices associated with health centers receiving Title X funding were significantly more likely to maintain separate contact information for communications with adolescents regarding family planning services. However, a high proportion of health centers, both with and without Title X funding, reported that they take specific action to protect the privacy of medical records for adolescents (92% and 86%, respectively). Open-ended responses as part of the survey suggested that the most common forms of accommodation are provision of separate doors, hours, facilities, clinics, and practitioners. The use of separate billing and claims procedures also were reported, but not consistently.

Figure 15. Adolescent Health Services and Supports Among Largest Health Center Sites, By Title X Funding



* Differences between Title X and non-Title X health centers are statistically significant at $p < .05$.

The Relationship of State Policy Climate to Health Centers’ Family Planning Service Delivery

Using the policy climate measures described in the methodology, we sought to model how the policy climate is associated with health center family planning services. In models incorporating both Medicaid eligibility levels and other family planning state policies, we found that the presence of a Medicaid family planning expansion initiative alone is not a good predictor of the comprehensiveness of health center family planning services. At the same time, we also found that the overall supportive climate for family planning specifically as reflected in state laws governing access to care, coupled with broader Medicaid eligibility more generally, was jointly associated with more comprehensive family planning care. Our findings indicate that state financing and coverage policies may not necessarily be independently related to the availability of comprehensive family planning services.

Overall, however, the state policy environment in which health centers operate *is* an important factor that is associated with their ability to prescribe and deliver the full range of contraceptive and family planning services in their communities. While this finding reflects point-in-time conditions, it does suggest that more generous Medicaid eligibility standards, coupled with more generous funding levels and a climate more supportive of family planning programs, combine to create the conditions under which health centers can develop more robust programs and provide a more comprehensive range of family planning services.

Qualitative Results: Exploring Health Centers' Ability to Provide Comprehensive Family Planning Services

Barriers Reported by Survey Respondents

Approximately 250 respondents answered the open-ended portion of the survey, which permitted them to describe barriers to their ability to offer more comprehensive services. Some 57% of respondents (with no differences in the percentage of respondents based on the receipt of Title X), indicated that they encounter barriers to the provision of family planning services. Barriers identified spanned funding issues, restraints on access to services, staffing challenges, reaching adolescents, political and cultural hurdles to providing care, outreach activities, confidentiality concerns, and providing care to specific population groups.

Financial challenges were the most frequently reported barrier health centers face in meeting the family planning and reproductive health needs of patients. The second most frequently reported barrier was access to specific family planning services. Access issues include a respondent's inability to provide a requested contraceptive method or specific services because of the cost of offering the service or the lack of a community referral site. Staffing emerged as the third most frequently reported barrier. The types of staffing problems reported included the absence of staff, staff who were not sufficiently trained in culturally appropriate care, staff turnover and recruitment difficulties, and the lack of staff with expertise in family planning and reproductive health care.

Many health centers reported barriers specific to adolescent care, including an inability to provide specific services in school-based health centers, access difficulties because of the location of care, strict parental consent laws, school systems opposed to allowing sex education, and difficulties in maintaining the confidentiality of services.

Many health centers also reported barriers to providing family planning care as a result of community political environment. Political factors included provider refusal to provide services or fill prescriptions, conservative social values and religious objection to family planning and abortion, opposition toward Title X funding, protestors and violence outside of abortion clinics, and state laws or regulations.

Health centers also reported other barriers including lack of patient transportation, low patient literacy and compliance, funding requirements, a low level of community knowledge regarding available services, challenges coordinating with other providers, and underlying patient health issues.

In-Depth Case Studies

Our survey results were supplemented by case studies that provide deeper insight into the factors that advance or impede the provision of family planning services at health centers. What became clear was the extent to which human and financial resources – attracting and retaining staff and being able to afford in the types of investments that enable comprehensive services – play a role in health centers' family planning programs. These resource-based considerations may intensify when coupled with uncertainties created by the policy environments in which

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health centers operate. The survey results show that health centers strive to make a basic set of family planning services available at all practice locations, but that building this capacity presents a challenge.

The health centers visited during the site review employed advanced practice nurses (e.g., certified nurse midwives, family nurse practitioners) and other mid-level practitioners as part of their practice teams. Far fewer had OB/GYNs. Advanced practice nurses and other mid-level practitioners provided the majority of reproductive health and family planning services, while physicians attend more complex patients. Limitations on resources have meant that health centers have had to be more efficient in their use of staff, with mid-level practitioners working at the top of their scope of licensure. In some cases, however, particularly in smaller health centers, the expectation is that staff OB/GYNs will furnish a full range of reproductive health services, from family planning through maternity care, while mid-level providers remain responsible for other forms of primary health care. This level of pressure on the physician member of the team may constrain the availability of preventive services because of high demands for maternity care and other services that only a physician can provide.

Staffing variations can be considerable from health center to health center and within health center sites. They appear to be predominantly a reflection of funding, the ability to recruit and retain certain types of health professionals such as OB/GYNs (in many communities health center family practice physicians have obstetrical privileges because of the extreme difficulty in recruiting OB/GYNs), and specialized nursing and counseling staff. It is important to note that in some health centers, family practice physicians are expected to provide family planning services unless a gynecological problem is present. A major challenge in this model of care is finding time to adequately train clinical staff in the specialty aspects of family planning and to keep them up-to-date about new techniques and procedures.

Community influence and health centers' perceptions of their communities

Communities – and health centers' perceptions of their communities – matter in terms of how family planning services are structured and the range of services offered. Health centers are designed to reflect their communities; through their community board governance over staffing and policies, health centers bring a distinctive “community standard” to their practices and operations, not in terms of the technical quality of the services furnished but in the choices made about the range and depth of care offered. Health center operations rest on objective needs assessments and periodically updated planning. But health centers also have accountability built into their operations through community board governance and extensive interaction with patients. Inevitably, this effort to square the results of objective planning with the multiple demands of medically underserved communities, and to do so with limited resources, may lead some health centers to put less emphasis on a broad and robust family planning program.

Health centers' community relationships play a special role in the case of health centers that are long-time members of their communities. Staff at one such health center indicated that the demand for family planning is affected by the fact that many patients may not seek family planning services because they know the staff. Adolescent patients may feel uncomfortable in these situations, staff report, because their parents receive their care at the center and they have concerns about privacy and confidentiality.

Staff in numerous study sites reported that community attitudes were an issue because family planning was not well accepted; religious, cultural, and health literacy barriers were

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viewed as important. These responses shed additional light on why our survey results show significant variation in the depth and scope of health centers' family planning services, particularly with respect to the use of counselors, the degree of outreach to hard-to-serve populations such as adolescents, active measures to preserve confidentiality, and the range of procedures available. Concerns over community beliefs also may inhibit efforts to aggressively secure additional funding to create more robust programs. Community concerns also may affect decisions to stock and make readily available inexpensive oral contraceptives as well as emergency contraception, the provision of which may be strictly a matter of purchasing and stocking and do not require advanced trained on-site personnel to furnish or administer.

The Importance of Title X Funding

The presence of Title X funding can be understood as both an indicator of health center willingness to grow robust programs as well as a factor in creating such programs. Title X participation is not compulsory; health centers must desire to obtain grant funding, must pursue it, and must go through the additional responsibilities associated with compliance. Title X funding also offers evidence of the ways in which additional resources and focus can achieve, in terms of the scope and depth of on-site family planning procedures, the presence of counselors, the presence of special outreach programs, and on-site treatment for certain STIs. The importance of additional targeted funding was evident in all of our interviews, because of the stress under which health centers operate and their obligation to offer primary health care across the age spectrum. The challenges of meeting community need clearly are lessened for any particular population or service when additional resources, such as Title X funding, can be secured. Health centers may be particularly eager to pursue these resources when they sense both community need and desire for care as a result of the absence of alternatives, such as an independent Title X grantee. To illustrate this point, one interviewee at a health center in Texas noted that its Medicaid-financed women's health program⁸⁷ "works in tandem with [the state's Title X-funded program, which] serves as a safety net in a sense [for] anything not covered under the women's health program." Health centers with a commitment to family planning may be particularly interested in pursuing Title X funding to help offset the cost of family planning services to uninsured patients.

Some health centers have been unwilling to seek Title X funding because of the more stringent requirements applicable under the program or have been unsuccessful because they could not meet program standards. Other health centers have developed successful working relationships with Title X service sites, which may be public health clinics or independent nonprofit clinics. Where these relationships exist, respondents indicated that they have been longstanding and successful. In particular, health centers that either had sought and failed to obtain Title X funding or decided not to pursue funding noted that the counseling and outreach obligations under Title X proved to be particularly challenging. In a few cases, these additional burdens, when added to the other practice stressors, led health centers to give up their Title X awards.

⁸⁷ Our interviews were conducted prior to Texas' decision to end its Medicaid family planning program.

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Availability of Medicaid

As our analysis of policy factors that influence the comprehensiveness of care suggests, health centers are aware of the difference Medicaid makes. Staff interviewed noted the barriers faced by their uninsured patients, particularly in the case of referral services and services that required a higher copay on health centers' sliding fee schedules. Adolescents without insurance independent of their parents and who either would not or could not disclose treatment to their parents reportedly faced barriers to contraceptive access because they could not afford oral contraceptives that were not dispensed on-site, but instead had to be filled through a separate pharmacy prescription requiring payment.

Even where Medicaid is present, other factors appeared to leave patients effectively disinsured for essential treatment. For example, Medicaid beneficiaries enrolled in managed care plans would not be able to fill their STI treatment prescriptions at a health center pharmacy that is out-of-network, thereby increasing the likelihood of delayed access to care. A similar out-of-network concern was raised by respondents in the context of laboratory tests that a health center is not authorized to process because its laboratory services are considered out-of-network.

Similarly, health centers may not be able to fill STI treatment prescriptions on-site; this can be true even for patients covered by Medicaid in cases in which the health center believes that their state Medicaid program excludes coverage of a treatment or requires that prescriptions be filled in specific locations. Another notable area of concern for health centers and other safety-net providers is the cost of lab tests that need to be processed externally and whose costs become unaffordable to many uninsured patients.

Most significant, according to respondents, were the barriers created by the high cost of IUD and sterilization services and the low payment rates available for these services under insurance plans. In the case of Medicaid, one would assume that cost would not be an issue because of the special FQHC payment rate that applies to both FQHC services (services of physicians, nurse practitioners, physician assistants, clinical psychologist and social work services, and ancillary services) as well as other ambulatory care furnished by the health center. But our interviews underscored the extent to which state Medicaid programs appear to exclude numerous types of ambulatory procedures from the FQHC payment formula, instead paying for these services on a per-procedure basis and at a deeply discounted rate.

This approach to Medicaid payment in turn has spillover effects on the entire health center operation. Whatever care is furnished to Medicaid patients must also be made available to privately insured and uninsured patients, for whom the revenue flow is even more deeply depressed, because of the complete lack of coverage in the case of uninsured patients or the presence of high deductibles and cost-sharing, along with numerous payment exclusions, in the case of privately insured patients. In other words, the absence of FQHC payment principles for all family planning services, coupled with the absence of *any* payment in the case of uninsured and under-insured patients, results in significant limitations on health centers' ability to offer a robust service.

For health centers with Title X, these limitations are not as substantial, since the family planning grant will often cover services that Medicaid does not. However, the issue of cost barriers frustrated all the study sites, even those that receive Title X funding. While Title X provided added flexibility, even that funding source had limits:

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“...Our providers feel more empowered to ask [what the patient wants].... We’ve been given more flexibility in how we administer that because of the Title X funds. “I think you should have the same flexibility as if you weren’t in the family planning program to . . . say (and this is my opinion) I need to discuss birth control, what are my options, versus I need Mirena [because it is the covered contraceptive].”

Adolescent services

All of the interviews underscored health centers’ concern about the need for special programs for adolescents, as well as the challenges in providing comprehensive and confidential care for adolescents. Some of this concern may be the result of health centers’ lack of clarity regarding state confidentiality policies, or the absence of policies related to separate billing for adolescent family planning services in order to maintain confidentiality. For some of the respondents, the initial financial intake, as well as the financial methods for accommodating teens’ preference not to use their parents’ insurance, pose significant obstacles to family planning and reproductive health services. Health centers also reported that teens may not realize that low-cost, confidential care is available through the health center.

Although the survey results suggested a fairly high level of involvement in school health, most of the case study sites did not provide any school-based clinical services or school-based sex education. The lack of partnership with local schools was seen as a lost opportunity by several case study sites. One study site did maintain school-based clinics but was prohibited from furnishing on-site contraceptives.

Referral arrangements and networks

Interviewees recognized the importance of well-established referral systems as critical to enhancing family planning access and reported both formal and informal referral relationships with family planning clinics, local hospitals, and other health care organizations. Referral services typically included vasectomies and female sterilizations, follow-up on irregular Pap smears, and pregnancy care. Some but not all referral arrangements included explicit agreements to make referrals available on a sliding fee basis. Interviewees considered referral arrangements a strategy for making services more accessible but also recognized the financial limitations of such arrangements because of the costs associated with underwriting referral care: “I think that there are some services that are a bit more expensive, and I think that there is room for us to perhaps strengthen that relationship with our partners . . . in terms of providing those services, not that we can’t, but I think in a financially more sustainable manner, because we’re taking the hit for it [the cost of the services], not shifting the cost to the patients.”

The survey results suggest that health center referral relationships with family planning clinics are slightly more likely to be outgoing than incoming, and our case studies help explain this finding. Health centers appear likely to recognize the need for a special type of family planning service and thus refer (such as confidential teen services or services that are furnished free of charge rather than on a discount). At the same time, interviewees noted that family planning clinics understood that the health center was an affordable source of referral treatment for non-reproductive primary health care.

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Diverse patient needs

All of the sites noted the provision of care for specific sub-populations, such as those who face language access barriers or who possess unique cultural and religious beliefs that pose challenges for providing reproductive health and family planning services. For example, one health center with growing Asian and African immigrant populations has dedicated some of its Title X funding and additional grant funds to family planning outreach tailored to these specific populations. Another health center reported challenges arising from a changing patient population and was facing a dramatic increase in low-income, uninsured, Hispanic families with higher fertility rates. These demographic changes, according to the staff, necessitated more interpretation and case management services. In other cases, participants suggested that the lack of information and knowledge about family planning among immigrant groups created additional service challenges. In these cases, staff cited a critical need for additional resources.

Discussion and Recommendations

Discussion

The major role played by health centers in the lives of low-income, medically underserved women underscores the importance of further strengthening their ability to furnish comprehensive preventive family planning services. This study points to the factors that may help determine the extent to which health centers will be able to grow programs that are more fully responsive to women's health needs. Many of these factors are financial, since the evidence suggests that more generous Medicaid eligibility levels, coupled with targeted financing through Title X in order to support expanded staff and services, are effective in encouraging the growth of health center capacity. Expanded Medicaid eligibility under the Affordable Care Act, along with grant-based investment resources, furnish the revenue stream essential to the enhancement of service capabilities.

Other constraints, including the recruitment and retention of clinical and counseling staff, as well as supportive state policy environments, also play significant roles in determining the depth and range of health center programs. Still other factors, such as how state policies shape access to care among adolescents, including less restrictive parental consent laws and Medicaid policies that ensure privacy in the use of Medicaid coverage to secure access to family planning services, are also highly important. To a great degree, community attitudes toward family planning, as well as health centers' perceptions of community support for robust and accessible programs, also play important roles.

All health centers offer some level of family planning, and the great majority make what we term a "typical" package of family planning services available to their patients at numerous service sites. But the results of this study show that the availability of a typical range of family planning services is also influenced by access to staffing and to resources in the form of both grant-based investment funding, along with third party financing needed to sustain more robust services. These resources become especially important where the providers studied are part of the safety net and therefore have an obligation to serve uninsured patients in their communities. Previous studies of uninsured patient rates at health centers in the wake of the Massachusetts health reform plan show that these numbers not only will remain high but also will grow as a proportion of the total uninsured population, as other sources of uncompensated care shrink.

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These study results also reveal important gaps in care at health centers. Particularly notable is the lack of on-site, free oral contraceptives, as well as the absence of a broader range of on-site long-lasting contraceptive methods, along with a level and intensity of counseling needed to make family planning effective, and outreach to special populations.

Of special concern are Medicaid coverage and payment policies, which, as this study suggests, may permit payment for less than the full range of necessary diagnostic and treatment services needed in a comprehensive approach to family planning. Expanded eligibility for Medicaid is the critical first step. But equally important are payment policies that assure adequate levels of funding to maintain a full array of diagnostic and treatment services, along with exemptions from the otherwise applicable coverage restrictions that accompany modern insurance products. These coverage restrictions can include non-coverage for “out-of-network” diagnostic tests as well as coverage exclusions for prescribed drugs and devices obtained from an “out-of-network” provider. In light of the documented cost-effectiveness of family planning, these types of coverage and payment restrictions, which inevitably create access barriers among a low-income population, merit reconsideration.

Of importance as well is the avoidance by Qualified Health Plans sold in Health Insurance Marketplaces of coverage and payment policies that exclude safety net family planning providers and that exclude needed treatments and services on an “out-of-network” basis. In a world in which increasing emphasis is placed on health insurance payment methods that produce value, broader and more inclusive payment principles that are sensitive to patient care preferences and that encourage comprehensive programs by safety net providers of family planning services – both health centers and independent Title X clinics – would appear to be warranted. Such policies would encourage the most inclusive care possible, including access to all FDA-approved forms of contraception, on-site STI testing and treatment, extensive counseling in family planning methods and adherence, and patient management approaches that promote access to specialized services such as sterilization and vasectomies.

The Affordable Care Act contains four major advances that will both expand coverage for women and help strengthen community health centers’ preventive services programs, including family planning. The first advance is the Act’s Medicaid reforms, extending eligibility to an additional 17 million nonelderly persons by 2022. It is the nation’s poorest populations who remain at the core of the health center mission, and for this reason, the Medicaid reforms are anticipated to be particularly transformational for the future of the health centers program, allowing health centers to realize major improvements in the proportion of insured patients they serve. Furthermore, the Medicaid expansions are especially important for women; the Kaiser Family Foundation has estimated that the Medicaid expansion will cover as much as 55% of the nation’s 19 million uninsured women beginning in 2014.⁸⁸

The second major advance is establishment of subsidized coverage through Health Insurance Marketplaces. Women are likewise expected to gain significantly from the affordable

⁸⁸ Kaiser Family Foundation. Impact of Health Reform on Women’s Access to Coverage and Care <http://www.kff.org/womenshealth/upload/7987-02.pdf> (Accessed online January 1, 2013).

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coverage in these Marketplaces; Kaiser estimates that 36% of all uninsured women will qualify for subsidized coverage through Qualified Health Plans.⁸⁹

The third major advance is the design of coverage itself, which emphasizes benefits of special importance to women's health. Women whose Medicaid entitlement rests on eligibility under Medicaid's traditional rules will continue to receive full coverage for family planning services and supplies, as well as other preventive services covered under state Medicaid plans. For newly eligible women, the Medicaid expansion means entitlement to "Alternative Benefit Plan" coverage, which include the full array of women's preventive benefits, including family planning education and counseling and all FDA-approved contraceptives, without cost-sharing.

The fourth and final advance is the major investment in health center growth that, when fully implemented, is expected to virtually double the number of patients served by health centers. Because the Act preserves both the special Medicaid FQHC payment rules and extends those rules to Qualified Health Plans sold in Health Insurance Marketplaces, the impact of this new market on health center operations will be considerable.

Our recommendations rest on this changing coverage landscape, as well as the findings from this study. They are consistent with the major areas of focus in health reform that are now so much in evidence: the heightened focus on improving the value and efficiency of health care; a focus on health investments that yield long-term cost containment; a focus on improving access to primary health care; and finally, an intensified focus on enhancing preventive health services for women.

Recommendations

Our recommendations fall into four major areas: policy guidance; practice re-design and quality improvement; value-based purchasing; and collaboration. In our view, these recommendations are highly complementary; they work best in tandem by providing the broad policy basis for performance improvement, a mechanism for testing, implementing, and communicating improvement efforts, and incentives for undertaking such efforts. We also discuss areas where further research is needed, in order to help guide the transformation process.

1. Develop Core Health Center Family Planning Guidance that Adapts to Health Center Practice Settings Emerging HHS Policy on Family Planning Practice

In 2013, the United States Department of Health and Human Services is expected to issue comprehensive family planning guidelines. These guidelines are expected to apply to the Title X family planning program while also setting clearer recommendations for other providers of family planning services beyond Title X grantees. The guidelines are expected to be comprehensive, addressing all aspects of family planning practice including the recommended components of primary reproductive health care, recommended practice approaches for hard-to-serve populations, contraceptive recommendations, recommendations related to education and

⁸⁹ *Id.*

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counseling, recommended standards for specialized procedures, and other matters. In the case of large and comprehensive providers of family planning services including health centers that operate very large programs, the recommendations might be appropriate in their entirety. For smaller health centers, for whom family planning services represent one element of a broader primary care practice, the recommendations might require adaptation.

The question of what should be expected of all health centers regardless of size, as well as what might be expected of the largest health centers, is key. Recommendations presumably would cover on-site practices (i.e., what is always expected to be available at one or more health center sites) as well as what types of written, formal referral arrangements would be appropriate, as opposed to informal referral practice. Articulating health center expectations, and tailoring those expectations to the variable conditions of health center practice, emerges from this study as a matter of great significance. What a health center of a certain size and staffing configuration should “typically” provide where preventive services related to women’s reproductive health are concerned, emerges as a major question of primary care access and quality. To be sure, local conditions may make uniform expectations difficult to achieve, but we believe that it is advisable to set initial expectations clearly.

For example, a central question that arose concerns on-site provision of oral contraceptives, the most commonly used form of birth control. Virtually all health centers prescribe oral contraceptives of course, but only about half dispense on-site; the remainder presumably write prescriptions that must be filled elsewhere. Certain financial considerations may cause health centers to limit their role to prescribing and not dispensing oral contraceptives; for example, as noted, women insured through Medicaid or private insurance may be covered for prescribed birth control oral medications only through network pharmacies. At the same time, the cost of standard oral contraceptives is so low that the consequences of not being able to provide immediate access to treatment may significantly outweigh the cost of providing on-site access. Furthermore, where the expectation is on-site access to certain prescriptions, such an expectation (coupled with expectations on the part of Medicaid agencies regarding the accessibility of family planning services) may add to health centers’ negotiating leverage in setting payment policies with managed care plans.

Another example where adaptation of broad HHS family planning policies to health center settings is concerned involves the use of long-acting reversible contraceptives (LARCs) that require insertion by specially trained clinical staff. LARCS, such as implants or IUDs, are highly effective contraceptive methods, and as such, making these technologies available to low-income and medically underserved women is vital. However, making them available takes financing, specially trained staff, and a clinically appropriate practice environment. A smaller health center may lack the start-up financing to recruit and train staff and acquire the higher cost supplies; at the same time, it may be located in or near a community in which a large clinical program offering comprehensive family planning services in fact is available to its patients, particularly as their insurance status improves. In such a situation, the answer to the problem of access may lie in the development and adoption of formally negotiated affiliation agreements under which, among other matters, referral protocols are established along with information exchange protocols that reflect all applicable privacy and confidentiality requirements. Using negotiated agreements in the case of more complex family planning services may make the most sense based on health center capacity, the availability of health professionals, patient preferences, and cost efficiencies.

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However, before these types of practice modifications and contractual negotiations can take place, health centers need performance policies that clearly signal what is expected of them as a matter of either on-site practice or formal referral arrangement. Many may then need assistance and support in adopting practice re-design innovations or in negotiating such agreements. Which of the pending HHS recommended family planning services should be an on-site expectation of all health centers, and which should be covered by formal referral plans should be addressed, as well as identifying which types of services can continue to be handled via a more informal referral system.

In keeping with the enormous investment in family planning-related standard-setting already underway at HHS, we recommend that HRSA sponsor a family planning standards adaptation working group comprised of experts in family planning along with experts in health center clinical practice and program administration. Particularly important will be the adaptation of new HHS standards into health center practice. Such a workgroup would be ideally positioned to develop a more detailed set of translational guidance that takes a tiered approach to policy implementation, develops practice policies that are customized to health centers and that speak to the full range of health center practice considerations. This translational step in adapting emerging family practice guidelines to health center practice is critical to essentially closing the loop and assuring that the HHS guidelines are adapted to the world of health centers.

2. Establish a Family Planning Practice Re-Design and Quality Improvement Effort as Part of an Overall Primary Health Care Quality Initiative

Aligning well with any effort to adapt clinical practice guidelines to health center practice would be a more detailed practice re-design initiative that addresses all phases of family planning practice in health center settings. Essential to this undertaking is a well-balanced group consisting of persons knowledgeable about all phases of health center practice as well as experts in family planning and patient and consumer representatives who can jointly develop detailed practice guidance addressing all elements of a sound family planning practice in a health center context. Key issues that might be addressed include: 1) practices that promote comprehensive on-site services; 2) model referral agreements for more specialized care and interventions requiring staff with advanced training and knowledge; 3) guidance for counseling and advising hard-to-serve populations and methods for communicating with boards and communities; 4) the use of procedures that assure appropriate information exchange while adhering to all federal and state privacy and confidentiality standards; 5) payment practices that best incentivize practice modifications needed to strengthen family planning services, including payment for on-site services, education and counseling, patient outreach and support, and investments in staff training and education; and 6) the identification of performance metrics aimed at measuring health center progress in practice modification and the health results of such modification efforts.

The results of this type of practice re-design effort could be disseminated in a number of ways: through in-person trainings; training webinars; the use of written and multi-media communication ; and the establishment of performance improvement practice groups comprised of health centers across the country who come together to develop performance improvement plans for clinical practice and health care administration.

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3. Bring Value-Based Purchasing and “Health Home” Techniques to Family Planning

A hallmark of The Affordable Care Act is its emphasis on payment reform. The Centers for Medicare and Medicaid Innovation (CMMI) within CMS is charged with developing and testing new payment models that have the potential to improve the quality and efficiency of health care while holding down long-term costs. In light of the high value of comprehensive family planning access – indeed, so valuable that actuaries consider contraceptive services to be a zero-cost item for insurers – it makes sense to pursue a value-based purchasing strategy for family planning services. By “value-based” we mean a purchasing strategy that is designed to hold down overall prices while advancing quality. This approach to health care purchasing, which tests certain types of payment techniques such as payment bundling of episode-based treatments, should be readily adaptable to a family planning context. Services of critical importance to a payment bundle include counseling and educational services, a full array of on-site screening, diagnostic and treatment services, and on-site access to all FDA approved forms of contraception. This type of payment model also might override treatment limitations and exclusions in the case of providers that participate in a bundling demonstration and are effectively recognized by payers as qualified to serve as family planning health homes because they offer the full range of family planning services.

Testing new methods for bundling family planning payments and for introducing the episode-of-treatment concept into ongoing family planning delivery might be expected to produce two effects. The first would be to broaden the array of treatments available in health center and other family planning settings by explicitly incentivizing their provision, much as Title X grants currently act as a stimulus to quality improvement. The second effect would be more long term in nature. By strengthening family planning performance at health centers as well as in other safety net settings such as Title X clinics, payment reforms would allow payers and providers to test innovations that might carry over into other areas of primary health care practice, such as the ongoing management of other health needs.

4. Foster Health Center/Title X Family Planning Program Collaborations

Research suggests the importance of formal affiliation and referral arrangements. For years health centers and Title X family planning providers have worked alongside one another, both at the community level and as a matter of national policy. Both programs are joined through the Public Health Service Act. Both are administered by HHS, and they share mission, overall operational structures, and a great reliance on Medicaid payment policy. Both programs stand to be transformed by the Affordable Care Act’s insurance expansions, innovations in coverage design for family planning, and emphasis on payment reform. We believe that it is time for the two programs to seek greater collaborative alignment when possible.

The findings in this report point to the significant number of health centers that also are Title X grantees. The findings also point to the enormously important role of Title X in strengthening health center performance through payment incentives coupled with explicit performance expectations. In many communities health centers effectively also play an integral role in the success of Title X because they make up its core provider community.

At the same time, the evidence in this study suggests that in most communities health centers and Title X grantees remain independent of one another. This choice to co-exist makes sense in many cases, since it represents a means of fostering more access points, more choice in

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providers, and as a means of separating out a one's general family practice provider from a provider of confidential family planning services.

Both models are flourishing as products of community choices, provider choices, and providers' perception of patient needs and preferences. Where health centers and Title X clinics exist as independent providers, it is also evident from our findings that the two providers typically maintain active referral arrangements, both formal and informal. These arrangements work in both directions; that is, patients who need family planning services beyond those offered at a health center, or who prefer to maintain a separate provider relationship for family planning purposes, may be referred to a Title X program. Conversely, patients of Title X clinics who need generalized primary health care typically would be referred to health centers for ongoing care and treatment.

It is evident that despite the informal relationships that have developed around the country, formalized policies have not fostered such relationships or promoted their formation. We believe that translating what has been an informal set of working relationships into a more formal menu of best practices, with supporting documents and examples of potential affiliation agreements, offers a means of further building on these collaborations. Collaboration efforts might focus on special populations, such as the joint development of programs for adolescents. They might also focus on referrals for specialized family planning services or joint relationship -- as part of a health center medical homes demonstration -- to develop effective family planning services for patients with serious physical or mental health conditions. A formal collaboration initiative also might focus on best practices in the area of patient information exchange to assure optimal data transfer for purposes of enhancing treatment quality, while guaranteeing HIPAA compliance as well as provider compliance with state privacy and confidentiality statutes. The two HHS agencies that oversee the programs might use the opportunity of the forthcoming family planning practice standards, as well as the Affordable Care Act's emphasis on both family planning access and the expanded use of health information technology, to launch a best practices initiative that guides health centers and Title X agencies in finding and establishing working collaboration models. This would include not only identifying the models, but also preparing model affiliation agreements that address issues ranging from joint program development, to information exchange, to joint practices aimed at the participation of high-need patients in medical homes demonstrations.

Recommendations for Further Research

The findings from this study point to much that can be done to further strengthen health center performance in the area of family planning. But, as is the case with all research, the results of this study point also point to important research opportunities.

1. *Study how do patients use health center family planning services and what are patient preferences.* One such opportunity is further research into the health care preferences of health center patients in the area of family planning. The large amount of family planning services furnished by health centers underscores their integral role in creating points of access for their patients. At the same time, no study ever has looked at why patients choose health centers for their family planning needs, what they value in such care arrangements or would like to see changed, or how they

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- perceive health centers as responding to their needs. Such research could be enormously helpful in efforts to tailor family planning policies to health center practice environments as well as initiatives aimed at practice re-design.
2. *Conduct an in-depth analysis of Medicaid FQHC payment policies and family planning.* Surprisingly little is known about how Medicaid agencies and Medicaid managed care organizations today account for certain costs associated with effective family planning programs, including payments for such activities as education and counseling, on-site dispensing of contraceptives, and payment for the adoption of new family planning technologies and their incorporation into health center practice. A more detailed examination of how health centers capture these costs as part of their FQHC payment-related cost reporting responsibilities, as well as how agency and managed care payment caps and limitations may affect the adoption of new technologies, would significantly strengthen the evidence base for payment reform.
 3. *Study the community environment for health center practice improvement in the area of family planning.* Another area of research is community perception of family planning and health center practice. In conducting this study we experienced significant resistance to discussion about family planning services and activities among a number of health centers. We were frequently told that were a health center to operate a more enriched family planning program, this would run counter to community preferences and furthermore, that even participation in research to better understand health center practices and choices may be problematic. We conclude that this issue needs to be examined in order to better understand the community environment in which health centers operate. Community is a powerful concept in the world of health centers; health centers grow organically from the communities that seek health center funding and that govern health centers once they are established. Popular support for family planning is high, even among people who identify themselves as religious. Thus, we believe that any effort to systematically improve health center family planning performance would build on a deeper understanding of both community perception of the provision of family planning services by health centers and the steps that might be taken to expand these vital services in all communities.