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Strengthening the Safety Net: Pathways for Collaboration Between Community Health Centers and Family Planning Programs

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The surge in demand for health care likely to be created by the implementation of the Affordable Care Act will have enormous ramifications for safety-net providers, such as community health centers (CHCs) and family planning centers. Meeting that demand, as well as the needs of the millions of Americans who will continue to be uninsured, will require safety-net providers to be creative, nimble and open to change. Strategic alliances between CHCs and family planning centers, building on their shared mission and different but complementary strengths, could redound to the benefit of both provider systems and the communities they serve.

Community health centers represent the single largest primary care system in the United States. Authorized under section 330 of the Public Health Service Act, CHCs are organized around four basic principles: location in medically underserved areas, governance by a board dominated by patients, provision of care to individuals regardless of their ability to pay and provision of comprehensive primary and preventive health care, including family planning, either directly or through arrangements with other agencies. In 2010, some 1,100 CHCs provided primary care to approximately 20 million patients in more than 8,100 locations nationwide.[1] In addition, nearly 1.1 million patients received some contraceptive services at CHCs that year. The Affordable Care Act makes a major investment in expanding CHC capacity in anticipation of a surge in demand as the law is implemented.

In 2006, more than 7 million women received publicly funded contraceptive services at 8,200 sites nationwide.[2] Of these sites, 4,300 received some funding through the Title X program; these sites served 4.7 million contraceptive clients. The Title X program essentially sets the standard for the provision of publicly supported family planning services in the United States and is the organizing force behind the national effort. Program guidelines require that clients at sites funded through the program be offered a package of contraceptive services and closely related preventive care, including a pelvic exam, Pap test to screen for cervical cancer, physical exam, blood pressure check and breast exam; women at high risk for sexually transmitted infections are expected to be tested and to receive appropriate counseling, treatment and medical referral.[3] Although family planning centers that are funded through Title X and those that are not are largely similar, Title X–funded sites generally offer a somewhat broader range of contraceptive methods and are faster to incorporate new methods into their service set.[4]

A Shared Mission

Both the national family planning effort and CHCs have their roots in the Johnson administration's signature War on Poverty. CHCs grew out of a pilot program launched in 1965 by the Office of Economic Opportunity, which made the first-ever federal family planning grants in that same year. Stemming from their shared roots in efforts to combat poverty and its health effects, both CHCs and family planning centers continue to focus on serving low- and moderate-income individuals who are often disenfranchised from the health care system by virtue of their income, insurance status, age, immigration status or place of residence.

Overwhelmingly, both programs serve low-income individuals. Seventy percent of clients served at Title X–funded centers in 2009 had incomes below the federal poverty line ($18,530 for a family of three in 2011),[5] and 90 percent had incomes below 200% of poverty.[6] Figures for CHCs are virtually identical: In 2010, 72% of patients were poor, and 93% had incomes below 200% of poverty.[1] Many of the clients served in either type of site are uninsured or covered by Medicaid.

Both programs serve large numbers of women of childbearing age. Nearly all women served at Title X–funded sites are in this age-group.[6] Women comprise 59% of CHC patients, nearly half (47%) of whom are of childbearing age.[1] Twenty-three percent of CHC patients and 64% of women receiving care at Title X–funded centers are aged 18–29, the age-group most at risk of unintended pregnancy.[7]

Their locations and missions mean that CHCs and family planning centers typically serve as patients' entry point into the health care system. Six in 10 women who obtain care at a family planning center describe it as their usual source of medical care.[8] In fact, in many cases, a family planning center may be their exclusive source of care: According to one study conducted at Planned Parenthood sites in Los Angeles, 29% of adults and 19% of teens said it was their only source of medical care.[9] Similarly, four in five CHC patients consider it their usual source of care.[1]

Complementary Strengths

Although family planning centers and CHCs serve similar populations and provide an overlapping package of care, they have different but complementary strengths. Patients who use CHCs as their family planning provider can receive a full array of primary health care at one site, allowing for services to be holistic and medical records to be fully integrated. An integrated approach also makes "one-stop shopping" possible, giving patients the convenience of being able to obtain all their care at one place, possibly even in one visit. And it offers the possibility of a medical home, not only for the patient, but for the entire family as well.

Yet, some of the very features of comprehensive care that might be clear advantages for some women may be impediments for others. Especially for adolescents and young adults who desire full confidentiality, using a CHC for their family planning services—where they might be seen by relatives, friends or neighbors—can pose a problem. Additionally, for some women, having the same provider who is caring for and known to other family members may be an impediment.

Generally, CHCs are viewed as a place to obtain a broad package of care; given the politicization of family planning issues, some may want to retain this position. In contrast, family planning centers tend to be known specifically for the range of contraceptive services they provide and may have expertise that is particularly salient for some women. They may have specific proficiency in counseling around sexual and reproductive health issues. In addition, family planning centers may offer a somewhat wider choice of contraceptive methods than do providers that offer contraception along with a broader package of care; research to date shows that these centers may be more likely to offer IUDs and newer contraceptive methods, such as the patch and the ring, and more likely to dispense methods on site, rather than give women a prescription that must be filled elsewhere.[10,11]

Policy Environment Promotes Collaboration

Potential partnerships between CHCs and family planning centers would be facilitated by long-standing federal policy. Section 330 specifically encourages CHCs to collaborate with other providers in their communities.[12] In addition, the Health Resources and Services Administration, the agency that administers the CHC program, has repeatedly reiterated the importance of collaboration. For example, guidance issued on the large CHC expansion under health reform indicates that expansion plans should describe "how the health center will collaborate with…other [safety-net] providers in furnishing coordinated care to the underserved population in the service area."[13] Most recently, a funding announcement

for new health center sites identifies evidence of collaboration as a criterion that will be used by the agency in evaluating applications; applicants not including collaborative efforts are expected to justify their absence.[14] In short, collaboration has become an essential and expected component of a strong CHC program.

Title X similarly emphasizes collaboration. Program regulations require projects to make referrals to other health care facilities when necessary and coordinate with other local service providers.[15] Program guidelines elaborate on this requirement.[3] In addition, program priorities issued by the Office of Population Affairs, the agency that administers Title X, specify "partnering with other community-based health and social services providers."[16]

Moreover, because CHCs and Title X–funded family planning programs have compatible missions, some issues that might otherwise impede collaboration do not come into play. First and foremost, both programs require that individuals not be denied care because of an inability to pay.[3,17] Both programs utilize a sliding fee scale designed to put services within reach of low-income individuals (with minor differences in how the sliding fee scale is structured and applied).* Similarly, both programs grant eligibility for the federal 340B program, which provides discounts on the costs of procuring prescription drugs.

Potential Collaboration Models

Numerous options for collaboration are available to CHCs and family planning centers. These options fall on a continuum, from two independent organizations coordinating around referrals and information exchange at one end to a full corporate merger (whereby the CHC effectively would subsume the family planning center) at the other. A middle-ground approach would involve the CHC leasing capacity from a still-independent family planning center—a strategy that could improve continuity of care while maintaining the independent status of the family planning center.

Of course, CHCs and family planning centers can and do make informal referrals already. But the scenarios described below illustrate possibilities that may also require more structured legal relationships to address matters of corporate structure and assure full compliance with federal laws governing conditions of participation in both programs and protecting against fraud and abuse.

Cross referral. A CHC and a family planning center, although remaining fully independent, would establish a referral arrangement enabling individuals to obtain primary care through the CHC and family planning services through the family planning center. Both agencies would agree to serve referred individuals on a preferred or expedited basis, and each would remain fully responsible for the care it provides. But the arrangement could ensure that that there is "no wrong door" for patients—patients who enter through either "door" could easily receive robust referrals to the other for needed care.

Many women seeking contraceptive services from a family planning center come to their family planning visit with needs beyond the scope of services family planning centers provide. They may need treatment for conditions as diverse as bronchitis and eye infections, or they may have issues related to dental health, mental health or substance abuse. Under this scenario, the family planning center would refer the patient to the CHC for services the family planning center does not provide. Similarly, CHC patients who need a family planning service available only through the family planning clinic, or who want to obtain care from a separate family planning provider, would easily be referred to that site.

Additionally, the family planning center would assist clients, when needed, in navigating the insurance eligibility and enrollment process, to connect them with the coverage for which they are eligible. Because this patient navigation would

*For patients with incomes below 100% of poverty, Title X services must be provided free of charge, while CHCs may charge a nominal fee, as long as it does not create a barrier to care. The sliding fee scale for CHCs extends to 200% of poverty, while the Title X sliding fee scale extends to 250%. Reconciling these differences takes thought and careful planning, but it can, and has, been done successfully. Most notably, a CHC may use revenue aside from its funding through the section 330 program (such as other federal grants, or state, local or private funds) to support the cost of care provided to individuals at or below 100% of poverty or to those between 201 and 250%.

involve individuals who are patients of both programs, the two agencies would set up an electronic information exchange for these shared patients that, with the patient's permission, would facilitate receipt of additional care. Doing so would allow a client needing follow-up care to leave the site not just with a name and a phone number of a referral provider, but with an actual appointment for follow-up care and with her medical information having been transmitted to that provider; it would also enable the family planning center to arrange for that follow-up care to be expedited when necessary. This sort of electronic information exchange would also give the family planning center access to information on the follow-up care received, so that its records will be complete when the client returns for additional family planning services at a later date.

Contractual collaboration. More extensive collaboration would involve the CHC essentially leasing capacity from the family planning center to provide family planning and patient navigation services to CHC patients. This model could improve access to services and continuity of care without jeopardizing the independent status of the family planning center; both the family planning provider and the CHC would remain independent organizations with their own corporate structures.

Under this scenario, a CHC would contract with a family planning center to deliver services to CHC patients on its behalf. Because the CHC would be paying the family planning center for the care, the CHC would maintain responsibility for the services and monitor their provision. To the extent the family planning center provides care to CHC patients, the services would be considered services of a federally qualified health center for purposes of payment under Medicaid or the Children's Health Insurance Program. Because shared patients would be considered CHC patients, billing and collection of revenues for services rendered would be done by the CHC in accordance with its policies, necessitating that the two providers reconcile their differing fee scales.

Such an arrangement would give CHC patients a greater complement of family planning services, as well as access to practitioners with specialized family planning expertise—either or both of which may not have been previously available at the CHC—while helping to meet the needs of those who prefer to obtain their family planning services from a separate provider. It would also ensure that CHC patients seen at the family planning site would be able to receive all necessary follow-up care, along with non–family planning services (e.g., acute care, dental care and other preventive care) through the CHC. To promote seamless patient care, the two agencies would establish an electronic information exchange that would facilitate the transmission of medical information for shared patients, as well as referrals between the two.

Outside the purview of the agreement with the CHC, the family planning center would continue to operate as it traditionally had done. For example, clients who are not CHC clients would continue to be served by the family planning center solely on its own behalf. Any services that are not included in the agreement, potentially such as sterilization, would be provided independently by the family planning center.

Such an arrangement would also allow for clinicians from the family planning center to deliver services at CHC sites. In such a case, however, the family planning provider would not be distinguished from other CHC staff and would be subject to its policies and procedures when providing care.

Corporate merger. Under the most far-reaching scenario, a family planning center and a CHC would develop a comprehensive affiliation agreement under which the family planning center would be merged into and become an actual part of the CHC. This would allow family planning services to be offered along with the broader array of CHC services, under the same organizational umbrella, although services could be offered in separate locations. However, because this approach would merge the family planning center into the CHC, the family planning program would give up its autonomy, separate identity and status as an independent organization.

Win-Win for Providers and Clients

Collaboration offers important benefits for these two critical safety-net provider systems, as well as for women. Strategic partnerships with family planning centers offer CHCs a new way to reach patients they have not already reached. At the same time, collaboration would allow family planning providers to leverage their role as a gateway to the health care system to play a unique role in the comprehensive health care safety net emerging with the implementation of health care reform.[18]

But most importantly, collaboration offers myriad benefits to women. Those new to the health care system entering through the family planning gateway could both receive the family planning services they are seeking and be connected to the coverage for which they are eligible. Both they and existing family planning clients could gain access to the full set of services available through a comprehensive system of care. And those already served by CHCs could gain a new option for meeting their sexual and reproductive health needs while retaining all the benefits of being part of a broader system. Because of the clear benefits for all involved, providers should explore the various collaboration options carefully and determine the best path forward.

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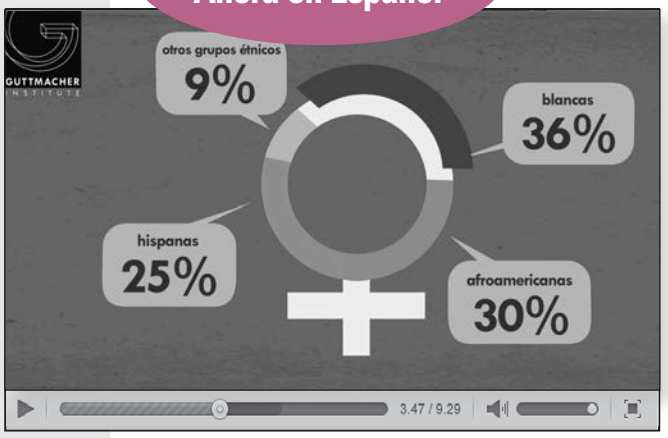

Myths and facts presented out of context are all too common in the U.S. abortion debate. Misinformation extends to even the most basic questions: Who are the women who obtain abortions? Why do they decide to end a pregnancy? What are their life circumstances?

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