New Approaches in a Shifting Health Care Environment:
Case Studies from CA's Title X Family Planning Network
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California Family Health Council (CFHC) champions and promotes quality sexual and reproductive health care for all. For over 40 years, CFHC has been funded by the Office of Population Affairs to administer the Title X federal family planning program in the state of California.

California has the largest Title X system in the country. CFHC distributes Title X funding to more than 60 health care organizations that collectively provide family planning and related services to nearly 1,000,000 women, men and teens each year at 340 health centers in 38 of California's 58 counties.

In addition to the size and impact of CFHC's Title X network, it is also uniquely diverse. Members include federally qualified health centers, city and county health departments, Planned Parenthood affiliates and stand-alone family planning/women's health centers, school-based clinics, hospitals and universities.

Since the passage of the Affordable Care Act in 2010, members of CFHC's Title X provider network have had to adapt to a shifting health care environment, including the move of millions of Californians into new health coverage options.

As a result of this changing landscape, Title X providers across the state are developing and implementing new approaches to increase patient access to quality care and support their long-term sustainability.

This report highlights case studies of new approaches in 6 key areas:
NEW APPROACH

PPPSW and two FQHCs, FHCSD and NCHS, entered into a strategic partnership to strengthen their referral relationships and ensure patient access to a full continuum of coordinated sexual and reproductive health care services. PPPSW and FHCSD developed referral systems for pre-natal care (at FHCSD) and post-partum family planning services (at PPPSW.) NCHS and PPPSW also established an integrated women’s health maintenance system for cervical and breast cancer screenings and follow-up care. The system facilitates an exchange of lab data by a common lab provider, supports preventive and follow-up care and reduces unnecessary lab work and duplication of services in the region.

KEY RESULTS

This new approach helped PPPSW, NCHS and FHCSD to:

- Strengthen referral relationships to support expanded care coordination and patient access to a continuum of quality sexual and reproductive health care
- Improve electronic scheduling systems to monitor appropriate patient follow-up
- Develop effective care management transitions to better respond to preferences and needs of shared patients

NEXT STEPS

- Develop and utilize patient data to support health maintenance and enhanced care coordination
- Expand partnerships to include additional sites
- Establish channels for ongoing communication and partnership planning

This partnership resulted in a significant improvement in our ability to provide coordinated sexual and reproductive health care to our patients and helped us maintain more accurate health records.

- Director of Women’s Health Services Operations, NCHS
NEW APPROACH

To better serve the comprehensive health needs of their patients, DHS has worked to fully integrate family planning services into its OB/GYN/Women’s Health and Pediatric clinics and Patient Centered Medical Homes. A significant new approach that supports this integration of vital health services is incorporating an assessment of a patient’s reproductive life plan (RLP) into visits for all female patients of reproductive age. When DHS prepared to implement its Electronic Health Record (EHR) system, they designed a specific EHR template to assess the patient’s RLP. The question “Do you (or your partner) want to get pregnant in the next year?” was included in the template. The template also prompts the provider to ask the patient about her current birth control method if the patient has had unprotected sex within the past month. Providers were also trained to ask appropriate follow-up questions including: “What’s most important to you in a method?” “How important is privacy?” and “How important is ease of use?” To support successful implementation in diverse DHS settings, a training and companion video were developed and made available for nursing and other staff to download at any time through DHS’s Learning Net. Training participants can also earn Continuing Education Units.

KEY RESULTS

This new approach helped DHS to:

- Enhance patient care and experience
- Train over 200 staff in RLP counseling
- Ensure female patients of reproductive age receive appropriate care based on their RLP

NEXT STEPS

- Coordinate a centralized concerted effort by dedicated staff to change the culture of how to provide contraception education and services
- Build relationships from the top down within the large organization to mobilize staff training
- Ensure a patient-centered approach by making the conversation about the desires of the patient for having or not having children
- Build a report in EHR to obtain quantitative information to assess the number of women of childbearing age asked the RLP questions, as well as any related outcomes

Integrating family planning has been a win-win for our patients and care teams across our system.

- Family Planning Clinical Programs Manager
case study | Women’s Community Clinic

Since 1999, Women’s Community Clinic (WCC) in San Francisco, has used an innovative volunteer-based business model to provide affordable and accessible health care services to Bay Area women and girls. WCC has more than 150 active volunteers and serves 4,000 women annually with over 6,000 clinical appointments. WCC operates innovative programs to meet the health needs of the community they serve, including a volunteer health worker program, a health careers training program with a focus on African American women from the Western Addition community in San Francisco, and outreach and support for homeless women.

NEW APPROACH

WCC added primary care to their scope of service provision in 2014. Integrating family planning and primary care has required WCC to develop and implement several new systems and operationalize a Care Team staffing model that includes Medical Assistants and Registered Nurses (RNs). WCC created a training program for their Medical Assistants to ensure that they are able to leverage their scope and training to perform vaccinations, injections and provide mental health and domestic violence screening. WCC also made changes and enhancements to improve their primary care workflows as a result of participating in the Coleman Rapid Dramatic Practice Improvement™ program. These workflow changes included enhancing team communication processes, pre-visit planning and chart scrubbing, and moving vitals into the exam rooms. WCC staff also started collecting appropriate intake information prior to the patient visit and conducting more effective client reminder calls to better prepare clients for their visit. WCC has integrated primary care measures into their overall quality improvement infrastructure and improvement teams.

KEY RESULTS

This new approach helped WCC to:

- Integrate primary care services into family planning care to enhance health care delivery and long-term sustainability
- Leverage Medical Assistants to provide appropriate screenings and vaccinations
- Reduce overall cycle time, decrease “third next available” appointments, and increase patient volume

NEXT STEPS

- Allocate staff time and resources to ensure changes continue to be effective and patients have access to high quality, integrated care
- Continue to refine and institutionalize changes implemented
- Integrate more comprehensive mental health services to be a more fully inclusive medical home

"WCC is now able to provide better, more well-rounded care."

- WCC Provider
NEW APPROACH

The Nevada County Public Health Department embarked on a campaign to enhance their delivery of quality contraceptive care and increase patient access to and utilization of the most effective forms of birth control. As part of this quality improvement campaign, protocols and systems were developed and implemented to ensure that every female patient of reproductive age was asked when and if they would like to become pregnant, as part of their Reproductive Life Plan (RLP) assessment. If pregnancy was not desired within the coming year, providers and other staff were trained to ensure that patient-centered contraceptive counseling techniques were utilized and that medically accurate information about the most effective options for birth were presented. To support effective implementation of the campaign, staff time was dedicated to participate in continuing education offerings provided by the American College of Obstetrics/Gynecology's LARC Project and CFHC's Learning Exchange. Staff also used teaching strategies to debunk myths and misconceptions about long-acting reversible contraceptives (LARCs) and address questions about side effects to reduce discontinuation rates.

KEY RESULTS

This new approach helped the Nevada County Public Health Department to:

- Better integrate RLP assessments into patient visits with females of reproductive age
- Improve staff capacity to provide quality family planning services and patient centered contraceptive counseling
- Increase patient utilization of the most effective methods of birth control

NEXT STEPS

- Continue to invest time and resources into staff training and patient education
- Increase budget for LARC devices by $30,000
- Work with the billing department to track LARC insertions and reimbursement and provide quarterly statistics to fiscal staff

"The numbers speak for themselves – over a three year period, we more than tripled the number of family planning patients using the most effective methods." - Nurse Practitioner
Imperial Beach Community Clinic (IBCC), is a federally qualified health center that provides integrated comprehensive primary care, behavioral health services, family planning services and clinical case management to a culturally diverse patient population in San Diego County. IBCC operates two Patient Centered Medical Home sites in the southwest region of the county and serves nearly 11,000 patients annually.

NEW APPROACH
IBCC developed and implemented an electronic user interface called the Automated Recall Tracker (A.R.T.). The A.R.T. organizes and presents information related to screening, referrals, and labs for sexual and reproductive health in a way that is easy to read and use. It has a set of 10 different screens with summaries and functions that allow clinic staff to efficiently track and coordinate care. The A.R.T. enables clinic providers to contact the specialists they refer their patients to, in order to request reports related to their treatment and diagnosis. The system saves staff time by allowing them to generate a list of lab reminder calls, rather than having to look at each individual chart. The A.R.T. is also leveraged to monitor inventory and prompt purchase orders when durable medical equipment is low in stock.

KEY RESULTS
This new approach helped IBCC to:

- Increase capacity to identify patients at higher risk for unintended pregnancy and sexually transmitted infections
- Improve care coordination for screening for breast and cervical cancer, sexually transmitted infections, HIV testing, and other patient referrals
- Improve ability to track and follow-up on lab and imaging results and other referrals
- Track durable medical equipment inventory to inform purchasing orders

NEXT STEPS
- Monitor the A.R.T.’s use and effectiveness and make modifications to adapt to issues that were not originally anticipated
- Assess workflow and data collection practices to identify areas for quality improvement
- Add new options to the A.R.T. system that will enable more efficient tracking capabilities while streamlining provider work flow

"A.R.T. has been a good tool for meeting needs we were formerly unable to accomplish with our EHR."

- Director of Care Coordination
The Center for Health and Prevention (The Center), a division of Community Action Partnership of San Luis Obispo, has a mission of fostering personal health and empowerment through access, advocacy and education. The Center provides direct sexual and reproductive health services in Arroyo Grande and San Luis Obispo and serves nearly 6,000 women, men and teens annually.

NEW APPROACH

The Center developed a patient portal and installed iPad stations in their lobby to access Bedsider.org and disseminate reminders to patients about their appointments and birth control use. Patients can log in to the portal to manage their appointments and submit requests for lab results, referrals, refills and enter demographic information to reduce wait times in the health center. In addition, patient portal display monitors are programmed to share information about other services that patients may be in need of, including resources for food and shelter, support for intimate and domestic partner violence survivors, and enrollment into health care coverage. The lobby iPads also have links to TeenSource.org, SLOdown.org and the website for Covered California, the state’s health insurance marketplace. The Center developed and implemented a concerted marketing effort to promote the patient portal. Strategies included running radio and television ads recorded in English and Spanish by teens and adults that volunteer with and work for the Center. Give-away items like lanyards, tote bags, flash drives, and pens were also distributed throughout The Center’s service region.

KEY RESULTS

This new approach helped The Center to:

- Enrich preventive care efforts, improve provider workflow, and improve care coordination
- Decrease no-show rates through the appointment reminder system
- Invest in marketing strategies that resulted in a large increase in new patients
- Present educational messages and share resources with patients waiting in the lobby

NEXT STEPS

- Develop a handout about the portal to give to patients at check-in to increase the number of patients that sign-up for the portal
- Continue to present best practices for leveraging patient portals and kiosks through peer-to-peer learning opportunities
- Seek and secure additional resources to expand patient portal marketing and efficacy to continue increasing patient volume

These new technologies have been a game-changer for us. They have provided a pathway to recruit new patients, enhance patient experience and share information with our community in new and exciting ways. - Clinic Director
NEW APPROACH

PPOSBC developed a new integrated automated kiosk system that collects and links patient intake data between service areas directly into PPOSBC’s electronic medical record system. The kiosk system leverages technology to help PPOSBC transition to a paperless environment. It is a flexible and highly configurable iPad application that interfaces directly with PPOSBC’s electronic health record system. PPOSBC’s goal was to achieve a more efficient, patient-focused service, while reducing check-in and overall wait times for family-planning and primary care patients. Kiosk implementation was also designed to increase patient portal activation to meet Meaningful Use Stage 2 requirements, and reduce failed patient contacts by phone and/or mail by enabling patients to self-edit their demographic information.

KEY RESULTS

This new approach helped PPOSBC to:

- Transition to a paperless environment
- Leverage innovative technology to help clinical staff spend less time on administrative tasks and more time devoted to patient care
- Reduce patient check-in and wait time without compromising quality of care
- Increase patient satisfaction and decrease errors in collecting patient information

NEXT STEPS

- Include the use of structured data and history of present illness (HPI) questions in information collected at the kiosk level
- Transmit data to patient charts
- Make system enhancements to allow patients to make payments at the kiosk and update insurance information

“I feel like their customer service has improved tremendously and the waiting has been reduced. I used to wait 2 hours; now I’m in and out within an hour.”

- PPOSBC Patient Focus Group Participant
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case study | Santa Rosa Community Health Centers

Santa Rosa Community Health Centers (SRCHC) has been providing excellent, patient-centered, primary health care and health education to underserved people in Sonoma County since 1996. SRCHC provides comprehensive services including primary care, family planning, mental health, pediatrics, and transgender services. SRCHC is a Patient Centered Medical Home and sees over 41,000 people annually.

NEW APPROACH

SRCHC believes that securing coverage for their patients is critical to their long-term sustainability in a shifting health care landscape. As a result, SRCHC has invested in staff time and training to identify patients likely to be eligible for new coverage options and conduct in-reach to help them enroll. Staff that are trained Certified Enrollment Counselors (CECs) are provided lists of patients who state they are uninsured and who have upcoming appointments scheduled. This allows CECs to speak with patients before their appointments about signing up for health insurance. CECs are also provided lists of patients that are uninsured and who had had at least one appointment in the prior month. The CECs and patients discuss how health insurance could have assisted with the cost of their appointment(s) and any medication they were prescribed, and how they can enroll in coverage before their next visit to the health center.

KEY RESULTS

This new approach helped SRCHC to:

- Free up resources to provide care for patients not eligible for new coverage options or access services under other benefit programs
- Reduce visits that result in uncompensated care
- Help patients understand the value of coverage and assist them through the enrollment process

NEXT STEPS

- Establish better processes for screening patient lists with data from Electronic Health Records
- Make reminder calls to help ensure patients bring the necessary documents to their appointments
- Continue investing in more in-reach and outreach activities to support patients navigating enrollment options and systems

SRCHC CECs have made personal contact and provided follow-up in-person application assistance to over 3,000 patients and enrolled over 1,300 patients in health coverage.
case study | La Clínica de La Raza

La Clínica de La Raza (La Clínica) is a federally qualified health center with 31 clinics across Alameda, Contra Costa and Solano counties. La Clínica's comprehensive services include family medicine, pediatrics, women's health, and preventative medicine. La Clínica serves over 97,000 clients annually.

NEW APPROACH

La Clínica has developed outreach and enrollment strategies to increase awareness about the importance of having health insurance and resources available to support enrollment. La Clínica conducts in-reach with existing patients and regular outreach in strategic locations. La Clínica joined forces with local partners including local faith-based groups, housing agencies, schools, managed care plans, and Women, Infants, and Children (WIC) programs to get the word out about new pathways to coverage and care. To support and evaluate outreach efforts, La Clínica provided trainings and created tracking tools and a community calendar of events. In addition, La Clínica operates a dedicated outreach and enrollment phone number to direct callers to enrollment resources on a daily basis. La Clínica also participates in local collaboratives and consortias that provide resources and support for addressing enrollment challenges and improving services.

KEY RESULTS

This new approach helped La Clínica to:

- Increase outreach contacts
- Enroll over 1,000 individuals in coverage
- Make over 37,000 outreach and in-reach contacts with patients and community members about health insurance enrollment

NEXT STEPS

- Monitor and evaluate strategies to help patients and community members apply for and renew coverage
- Provide education to consumers on how to utilize coverage since many consumers are accessing health coverage for the first time and do not fully understand how to use it
- Leverage best practices from prior outreach and enrollment experience

Since July 2013, La Clínica has provided assistance to over 35,000 individuals and helped with over 7,000 applications and enrollments.
Planned Parenthood Mar Monte (PPMM) serves over 250,000 individuals annually across 29 California counties. With 32 health center locations and 11 community sites in the state, PPMM provides a wide range of sexual and reproductive health services including birth control, pregnancy testing and options counseling, STD testing and treatment, HIV testing, breast and cervical cancer screening, abortion, prenatal care, pediatrics and primary care.

NEW APPROACH

PPMM’s marketing strategies and resources have largely shifted toward reaching potential new patients online. With the help of a Search Engine Marketing (SEM) coach, PPMM dramatically improved their SEM by setting up and/or taking ownership of all Google+ listings for their health centers and applying for and receiving Google grants that provide $5,000 in free search advertising per month. PPMM optimized their SEM campaigns to drive down the cost-per-click and drive up the number of calls and appointments made. They also utilized “Ad Extensions” - a program offered by AdWords - to give ads more visibility and information. PPMM invested in enhanced YELP Listings to access their YELP pages, reviews, metrics and a YELP account representative. Yelp Listings allow PPMM to measure patient satisfaction and respond to patient feedback. In addition, PPMM developed new website landing pages specifically designed for use in ad campaigns with clear prompts that encourage site visitors to make an appointment.

KEY RESULTS

This new approach helped PPMM to:

- Increase website traffic (Yelp is now the top referral source to PPMM the website, driving 67% of their web referrals)
- Leverage free Google ads and ad-ons to maximize SEM activity impact
- Attract new patients through YELP listings that direct and connect potential patients to an online appointment system

NEXT STEPS

- Analyze and improve low-performing ads and redirect resources to those that are proving to be most effective
- Monitor search terms that trigger ads and identify words and phrases that could drive traffic to other service or brand sites
- Consistently evaluate the impact of paid digital marketing efforts
- Keep Yelp content up-to-date

“"Our comprehensive digital marketing strategy has dramatically increased the reach and engagement of our target audience, as well as our web and health center page activity."" - Director of Marketing
To make the vision of health care reform a reality in California and across the country, members of the state and nation’s Title X provider network must remain vital access points for the millions of low-income women, men and teens that rely on them for the care they need to protect their health and plan their families and their futures.

The case studies included in this report highlight just a few examples of how members of California’s diverse Title X network are developing and implementing new approaches to enhance service delivery and long-term sustainability in a shifting health care environment.

Although change comes with many challenges, providers throughout California’s Title X network are seizing the opportunities health care reform created to re-examine, redefine and redesign their business models.

To continue adapting to the evolving health care system today and in the future, Title X providers must be able to continue exploring new pathways for success and sustainability that:

- Build and enhance strategic partnerships that improve patient care coordination and maximize efficiency
- Integrate quality family planning (QFP) with other vital health services provided
- Support the delivery of QFP services
- Leverage technology to maximize efficiency and improve patient health outcomes
- Help patients navigate the enrollment process and understand how to use and keep their health coverage
- Increase awareness about Title X services among hard-to-reach populations

Ongoing changes to the health care delivery system are expected. Maintaining the status quo is no longer an option. Moving forward, resources must be made available to promote innovation throughout the Title X system and invested to ensure access to high value, quality care for those that remain in need of publicly supported family planning care.

Development and implementation of the new approaches featured in this report were supported by Title X funding and advance current Title X program priorities. They can serve as models to be replicated and adapted by Title X-funded health care organizations nationwide. For more information, contact info@cfhc.org.
about CFHC

CFHC champions and promotes quality sexual and reproductive health care for all. CFHC achieves its mission through an umbrella of services including advanced clinical research, provider training, patient education and consumer awareness, public policy and clinic support initiatives. As the administrator of California’s Title X federal family planning program—the nation’s largest Title X system—CFHC partners with a diverse Title X provider network that collectively serves nearly one million women, men and teens each year at over 340 health centers in 38 of California’s 58 counties.