



National Conference
NFPRHA 2015

Adding Primary Care to a Family Planning Setting

April 27, 2015

#NFPRHA1

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Primary Care: The PP Heartland Story

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April 27, 2015

Theatrics of Primary Care

- Is it needed?
- Are you ready?
- What are the challenges?
- How should you proceed?



A Long Goodbye: PPHeartland

Act One

Assessing

Planning

And

Implementing



Act two

**Snags,
Snafus,
and
Shape Shifting**



Act three

We laughed.

We cried.

**We said
goodbye.**



A New Adventure: PPHeartland

Subtitle: Learning from One's Mistakes

Act One

**Assessing
Planning
And
Implementing**



Act Two

A

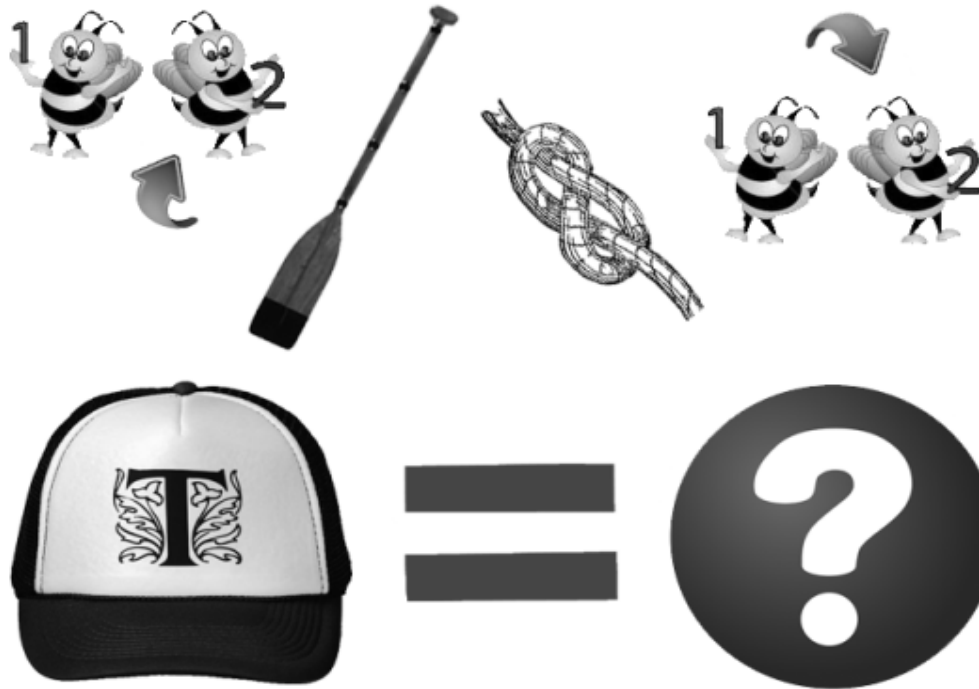
winding

path



Act Three





Thank you!

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ADDING PRIMARY CARE TO BELFAST FAMILY PLANNING

Evelyn Kieltyka • Sr. VP of Program Services • Maine Family Planning

SINCE ADDING PRIMARY CARE TO BELFAST

Compared to a baseline year, in the first year of the primary care service, Belfast increased:

- orders for labs and other testing by 30%.
 - prescriptions for contraception by 15%.
 - all other prescriptions by 134%.
 - referrals for mammograms by 160%.
 - all other referrals increased by 243%.
- 

BUSINESS IS INCREASING

Compared to the baseline year, in the first year of primary care service, Belfast saw:

- 17% increase in overall visits
- 14% increase in unique patients

Compared to the first 6 months primary care was available, the second 6 month period saw a:

- 45% increase in appointments with primary care




ASSESSING READINESS: PATIENT SURVEY

Determine if there is a need for primary care

- What primary care practices do patients currently have access to?
- How many family planning patients do not have primary care?

Pre-implementation survey by Maine Family Planning (MFP) of 496 patients showed:


- 62% went to other health care providers for services MFP does not provide
 - 84% would choose MFP to meet their primary care health needs, if offered.
- 

IMPLEMENTATION: WHAT TO CHARGE?

Because of regulations preventing price-fixing:

- the research to determine an appropriate sliding fee scale and price list for primary care services required extensive resourcefulness.

Consider also that at Belfast, from Year 1 to Year 2, there was :

- significant decrease in the proportion of patients who were at the lowest step of the family planning sliding fee scale (from 44% to 38%).
 - significant increase in the proportion of Belfast patients who held private insurance (from 32% to 38%).
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IMPLEMENTATION: INSURANCE AND SELF-PAY

Family Planning billing systems need to be adjusted to be able to process and adjust rates for primary care visits

- Work closely with your EMR system to make these adjustments early.
- Consider how billing will be split between family planning and primary care.

Plan sufficient time to gain insurance credentials

- Takes 3-6 months for credentialing from each insurer
- Each insurer has different requirements




IMPLEMENTATION: PLANNING FOR REIMBURSEMENT

Conduct a review of payor mix of current family planning patients.

- A high volume of self-pay patients may require the practice to seek funding to subsidize care.

Consider the implications for different types of reimbursement methods

- The percentage of patients who use 3rd party insurance has increased at Belfast
 - The Belfast clinic obtained status as a rural health clinic, which improves MaineCare reimbursement rates.
 - It may be possible to increase reimbursement from third party insurers with NCQA classification of “patient centered medical home.”
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IMPLEMENTATION: FACILITY & INFRASTRUCTURE

Current facility

- Can the facility accommodate increased patient volume?
- Can the facility accommodate the additional equipment needed?

Many infrastructure requirements are necessary for insurance credentialing too

- Additional pharmacy space
- Belfast needed an EKG machine, Automated External Defibrillator, Phlebotomy chair and ability to provide age-appropriate vaccines


IMPLEMENTATION: ADDITIONAL STAFFING

Secure staff who are experienced and qualified in primary care

- Competitive market for qualified NP
- MFP hired a firm to help with process

Conduct assessment of current staff capabilities in regard to primary care

Provide continuous training

- How to conduct a comprehensive health history
 - How to follow up on referrals
 - Use of new equipment
- 

STAFFING CONT.

Responsibilities will change

- Front desk now asked to do more
- Scheduling procedures were affected due to the length of primary care visits


More staff will be needed

- Since primary care was added to Belfast, staff have doubled



IMPLEMENTATION: ATTRACTING NEW PATIENTS

Marketing primary care

- Plan for some confusion among clients
 - Clients do not recognize what “Primary Care” actually means
 - All family planning clients offered/handed a flyer about primary care services
 - ACA Navigator came to clinic to assist patients in signing up for ACA Marketplace
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IMPLEMENTATION: ATTRACTING NEW PATIENTS


Many have not had care in years and come in with chronic conditions

- Require lots of extra time to screen and treat

Teens

- Can use the family planning clinic without parental consent, but cannot use primary care without parental consent

Misconceptions

- Many think that primary care will be free like family planning services
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ASSESSMENT: YOUR DATA


Evaluate your own data to inform decisions on who to target, who you are reaching, what services to add

- Clients came in with various mental illnesses which led to a behavioral health office

Comparing year 1 to year 2 we have learned that Belfast clients are now:

- Significantly older
- Include more males
- Less likely to be single

Early adopters of Primary Care were:

- More likely to have private insurance
 - Were older on average
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ASSESSMENT: OTHER RESOURCES

MGMA

- <http://www.mgma.com/practice-resources/healthcare-management>

AHRQ

- http://pcmh.ahrq.gov/sites/default/files/attachments/Developing_and_Running_a_Primary_Care_Practice_Facilitation_Program.pdf

NCQA

- <http://store.ncqa.org/index.php/recognition/patient-centered-medical-home-pcmh.html>

Adding Primary Care to a Family Planning Setting

Cathy Bright

AVP of Services

Planned Parenthood of Mar Monte

Planned Parenthood Mar Monte (PPMM)

- California Planned Parenthood Affiliate
- Community Safety Net Clinics (Non-FQHC)
- 32 Health Centers in 16 counties in California and 1 in Nevada
- 67% are 20-34 years old
- 17% under 19 years of age
- 16% over the age of 35

FY 2014

- 245,840 patients served;
- 461,849 patient visits/encounters;
- 6% of the total patient visits were prenatal, adult or pediatric primary care visits/encounters.

FY 2014

- 68% live below 100% of the FPL
- 85% live at or below 200% of the FPL
- 23% are insured by MediCal (Medicaid)
- 59% are covered by California's Family PACT program, which provides contraceptives for those living up to 200% of FPL and who don't have ACA insurance.

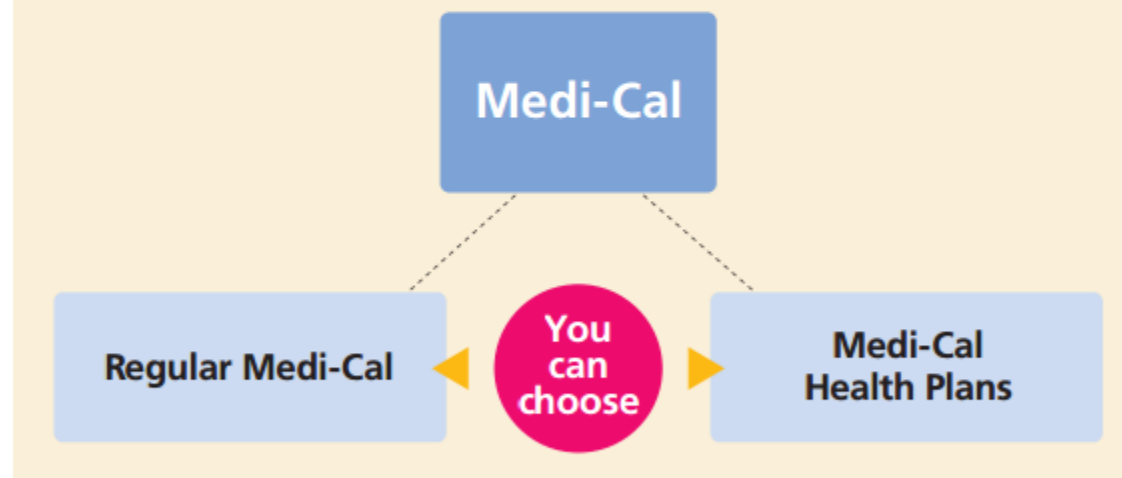
MediCal Managed Care

- In the late 1990's many counties in California began to offer managed care programs through the Medicaid system. Today, more than 60% of people covered by MediCal are enrolled in a managed care program.
- Many safety net community clinics made the decision to provide primary care services through these new managed care programs, including PP of Santa Clara County, who would eventually acquire multiple smaller affiliates to form PPMM.

**Many counties in California have 2 kinds of Medi-Cal.
The 2 kinds are**

1. Regular Medi-Cal.
2. Medi-Cal Health Plans.

Both kinds of Medi-Cal give you the same basic benefits.



You can choose which kind of Medi-Cal you want. With both kinds, you will get the same basic benefits and care. But the way that you get care may be different.

PPMM Health Centers with Integrated Primary Care

Currently PPMM has nine health centers and one community college offering integrated reproductive health and comprehensive primary care services.

These centers are located in 12 California counties with multiple MediCal Managed Care contracts.

MediCal Managed Care

- The premise, at the time, was PP could continue to see our same patients, providing continuity of care, and improving health outcomes and patient satisfaction.
- This did not turn out to be true; many patients, if not the majority, had chronic conditions, with multiple diagnoses, including mental health and substance issues.

Expanding Primary Care Under ACA

PPMM has added two new primary care centers in the last two calendar years and a third is scheduled to begin providing primary care services before the end of 2015. All are located in counties with capitated health plans and quality based incentives.

Benefits

- Improves patient care;
- Meets community need;
- Improves ability to negotiate for higher reimbursement rates, incentive payments, jurisdictional money, and PCMH designation;
- Improves recruitment and job satisfaction for mid-level Providers.

Challenges

- Complex patient care; high acuity medicine;
- Lower reimbursement rates that vary from county to county. What may be profitable in one county may not have the same outcome in another;
- Complexities of frequency and billing from plan to plan;
- Balancing Service Mix (18% - 20%);
- Staff training;
- PP name not synonymous with primary care;
- Physician recruitment.

Lessons Learned

As much as possible integrate primary care into daily reproductive health including:

- Integrated patient schedules;
- Cross trained line staff;
- Use intake and posting models for all service types modifying as needed;
- Use patient centered teams and delegate as many tasks to RN (if used) or MA's as possible, based on scope.

Lessons Learned

- Don't assume a "one size fits all" business model approach.
- Based on community need, it may be necessary to cap primary care services;
- The "right" EMR/EHR templates are critical to provider productivity;

Lessons Learned

- Duplication of effort/patient education;
- Pediatrics is a time intensive service;
- Maintaining consistent systems & processes;
- Under estimating billing/frequency complexities;



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Questions