Sustainability Solutions

How Title X Programs and FQHCs Can Work Together

LIFE AFTER 40

PROJECT CASE STUDY

National Family Planning & Reproductive Health Association

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Executive Summary

Background & Methods

Changes in the health care environment are motivating many publicly funded family planning providers to shift their organizational structure and/or operations to remain viable. As the number of people obtaining health insurance increases, more people will seek primary care services that include family planning and sexual health services, and/or a one-stop-shopping model of care, rather than stand-alone specialty providers, like family planning health centers. Engaging with federally qualified health centers (FQHCs) can lead to a more sustainable business model while maintaining a mission to provide high-quality health services to low-income and underinsured individuals and families.

For this case study, the National Family Planning & Reproductive Health Association's (NFPRHA) *Life After 40: The Family Planning Network and the ACA* project team identified three Title X-funded organizations that each use different approaches to engage with FQHCs, and interviewed key personnel from each agency. At Finger Lakes Community Health (FLCH) in upstate New York, a Title X-funded agency ***merged*** with a section 330-funded community and migrant health center.[1] The Westside Family Health Center (WFHC) in California gradually ***transitioned*** from a Title X-funded agency to an FQHC. The Family Planning Association of Maine (FPAM) is a Title X grantee that ***subcontracts*** with FQHCs to provide Title X services. Interviews focused on answering key questions including:

- How do organizations make the decision to engage with an FQHC?
- How are relationships initiated?
- What motivates FQHCs to partner with Title X providers?
- What does the implementation process look like with different organizational models involving Title X and FQHCs?

This two-part case study was designed to focus on two separate components of establishing an FQHC strategy: Part 1 explores the decision-making process, and Part 2 examines the implementation process for each model. Each part describes the different FQHC strategies, contains analyses of the organizations' experiences, and identifies common themes across all three models. A companion workbook was also developed to present resources and tools that were gathered during these site visits, created by NFPRHA, or adapted from other agencies.

Part 1: The Decision to Engage with a Federally Qualified Health Center

The Merger

Before the merger, Yates Family Planning (YFP) operated four Title X-funded health centers in upstate New York. Finger Lakes Migrant Health Care Project (FLMH), a section 330-funded community and migrant health center, operated three FQHCs in an overlapping service delivery area. In 2009, the organizations merged and began operating as Finger Lakes Community Health (FLCH) in 2010. The executive director and the board of YFP had been considering merging with a larger, more stable organization as part of a strategic plan to improve financial stability for several years when the executive director of FLMH proposed the merger. The executive director of FLMH was interested in the merger because she was looking to expand FLMH's service region without negatively impacting YFP health centers. A variety of factors made the merger feasible, including motivated leadership, an existing relationship between the organizations, a shared mission, and the fact that the merger resolved preexisting problems for both organizations.

The Transition

Westside Family Health Center (WFHC) was founded as a women's health center in 1974 and has received Title X funding for more than 35 years. To respond to changing patient needs and remain viable, WFHC gradually added services like prenatal care, pediatrics, adolescent health, and finally family practice over the course of 20 years to eventually become an FQHC in 2007. There was a domino effect of decision points where each decision to expand services led to another opportunity to expand services even further. This gradual process felt natural, and each step was obvious to the staff who were interviewed. Each phase of organizational change was accompanied by multiple operational adjustments that brought WFHC closer to the capability to provide the comprehensive services that define an FQHC.

The Subcontract

The Family Planning Association of Maine (FPAM) is the only Title X grantee in Maine and provides family planning services in 47 health centers across the state. FPAM operates 18 direct service health centers, six school-based health centers, and subcontracts Title X services to other agencies including Planned Parenthood and four FQHCs, which operate 19 health centers in rural areas of Maine. In 2000, FPAM was searching for a sustainable solution to a marked decline in patients and visits when the Office of Population Affairs (OPA) announced the availability of supplemental funds for Title X grantees to expand service areas and patient access to family planning services. FPAM decided to engage with FQHCs that operate health centers in rural communities and proposed a subrecipient relationship to expand its service region and enhance existing health services for patients in need. FPAM used a ZIP code analysis to reveal gaps in rural service delivery and determine which FQHC-operated health centers would not compete with FPAM–operated sites. The elements that motivated and supported the subcontract agreements were sustainability, the desire to expand existing services, established relationships, thoughtful discussions regarding implementation, and overcoming political adversity.

Common Themes in Decision Making

- **Choosing an Engagement Strategy** - Common motivating factors to engage with FQHCs included the need to sustain family planning services, the drive to address patient needs, and external support for organizational changes (e.g., the availability of new funding). Across all three models, leadership, implementation planning, and strategies for when and how to engage staff were identified as being critical to the decision-making process.
- **Making the Case to Partner** - When Title X organizations approached FQHCs to work with them, several components of a partnership were appealing to the FQHCs: enhancing family planning and reproductive health services to improve patient care, the availability of technical assistance for program implementation staff, the opportunity to expand service areas, a shared mission to serve at-risk populations, and strong preexisting relationships among organizations and/or staff.
- **Challenges** - Participating agencies encountered challenges and barriers to the decision-making process that provide insight for organizations that are considering similar options. An example is the need to develop strategies to preemptively address concerns from potential partner organizations and internal stakeholders, including the board of directors and staff.

Part 2: Implementation of Engagement Strategies with FQHCs

The Merger

To implement the merger, it was important to consider legal and regulatory concerns, and necessary physical site changes prior to making programmatic changes. In addition, all YFP staff members were brought over in the merger and FLCH immediately had to address issues of employment structure (e.g., benefits and earned time off, and staffing roles and responsibilities). The decision to merge happened quickly and there was little time to plan for implementation. Many organizational and operational changes were made to integrate Title X services into the primary care setting, and operations staff were given complete autonomy to use a trial-and-error approach to integrate the programs. Changes were made to data reporting and billing practices, including adapting the EHR system and combining section 330 and Title X fee scales. Patient services changed due to new scheduling practices, the way supplies and medications were dispensed, and enhanced confidentiality procedures. As day-to-day operations shifted, the agency culture shifted, too. It was the dedicated staff from each organization working together that made it possible to integrate Title X services and culture into an FQHC environment.

The Transition

With each phase of its expansion, WFHC gradually created an infrastructure and a set of primary care services that allowed it to ultimately obtain an FQHC designation. The first step to obtain full FQHC status was an application and approval for FQHC look-alike status. When the health center applied for look-alike status in 2004, WFHC had already made many of the adjustments necessary to comply with look-alike and section 330 regulations including adding prenatal care, pediatrics, and family practice. The biggest adjustment to comply with the requirement was not related to service delivery, but rather to achieving and maintaining a board composition of at least 51% consumers. In 2007, WFHC received section 330 funding under the New Access Points grant.

WFHC's ability to maintain Title X funding and keep up with reporting and documentation requirements through all of the agency's changes has been largely due the fact that the agency uses Title X funds solely for administrative costs, and not to subsidize care. This is possible because California has a number of public programs that provide low-income residents with access to family planning services. Still, to ensure integration of Title X services, it has

been necessary to make adjustments to billing and reporting procedures including adaptations to the sliding fee scale, the EHR system, and to patient scheduling practices.

To address agency culture shifts through the many phases of change, WFHC provides a wide variety of communications and support for its staff. Efforts to involve staff in the implementation process made them feel valued, that their opinions were important, and motivated staff to implement the necessary operational changes.

The Subcontract

FPAM, the Title X grantee in Maine, uses subcontract agreements to partner with FQHCs. It maintains such agreements with four FQHCs, including HealthReach and KVHC. HealthReach initially implemented Title X services into three health centers in 2000 as a pilot program, and has since integrated Title X into all 11 health center locations. KVHC integrated Title X services into all three of its health centers in 2012. Organizational and operational changes were necessary to integrate the Title X program such as assessing the patient experience including confidentiality practices, how supplies and medications were dispensed, and implementing new documentation and reporting practices that involved adapting the EHR systems.

HealthReach and KVHC emphasized the importance of having support from the FPAM project director to launch the Title X program. A "Family Planning 101" training and technical support with additional funding to incorporate Title X data elements into the FQHCs' EHR systems were highly valued. The FPAM project director also provides ongoing support to completely integrate Title X into FQHC operations in the form of trainings, attending FQHC site meetings, sharing resources, and assisting with monitoring and other quality improvement activities to assure compliance with section 330 and Title X regulations.

Common Themes in Implementation

- **Careful Research** - When implementing organizational changes associated with an FQHC strategy, all three models were concerned with how the insurance marketplace impacts service delivery, the need to identify necessary organizational changes, and adaptations to EHR systems to include Title X/section 330 data elements. It was also essential to review state and federal regulations and any applicable legal issues associated with the implementation.
- **Potential Challenges & Barriers** - All three organizational models experienced challenges with documenting Title X services, integrating fee scales and billing practices, and tensions associated with agency culture change. The case study discusses how each agency addressed these challenges and provides guidance for organizations interested in engaging FQHCs in a similar way.
- **Recommendations for the Implementation Process** - Essential components to successfully integrate Title X/section 330 services into a new organizational model were identified. Recommendations include:
    - Assess and strengthen management capacity;
    - Make a detailed and realistic implementation plan;
    - Identify champions who will lead operational changes and address cultural shifts;
    - Ensure electronic health records meet reporting needs;
    - Plan for ongoing support and communication; and
    - Develop marketing strategies.

Conclusion

The operational adjustments that were made to restructure all three organizational models resulted in positive outcomes. Each agency strengthened its internal capacity; expanded patient access to Title X and primary care services which resulted in increased patient volume; and diversified revenue streams for a more stable, mission-driven business model.

Introduction

Many publicly funded family planning providers are shifting operations, or changing the way they deliver services to create a more mission-driven business. This shift is designed to maintain the Title X mission while addressing the business requirements needed to survive. As changes in the health care environment make it more challenging to maintain freestanding family planning health centers, Title X organizations are investigating options to engage with federally qualified health centers (FQHCs) in an effort to be included in integrated delivery systems and remain viable.

The National Family Planning & Reproductive Health Association's (NFPRHA) *Life After 40: The Family Planning Network and the ACA* project aims to assist its members implement this type of strategic change. This case study examines three NFPRHA member organizations that have developed sustainability plans involving FQHCs, and details experiences and lessons learned from the participating organizations. The companion workbook presents resources and tools that were gathered during these site visits, developed by NFPRHA, or adapted from other agencies, to assist administrators in their decision-making and implementation processes when considering how to engage with FQHCs as part of an organizational strategic plan.

Background

In 2011 and 2012, there was a decrease in the total number of Title X patients served nationally, and this trend likely persisted in 2013.[2,3] Between fiscal year (FY) 2010 - FY 2013, the Title X family planning program experienced $39.2 million in funding reductions - with $14.9 million of the cut just from sequestration – a total of 12.3%.[4] As a result of funding reductions, the total number of Title X users shrunk from 5.22 million users to 4.76 million during this time period, with no indication that patients went elsewhere for care. Moreover, between 2011 and 2012, there was a decrease of 193 service sites, from 4,382 to 4,189.[5] The decrease in patient numbers can be partially attributed to the change in national Pap smear guidelines, which recommended less frequent screening, and the increased use of long-acting reversible contraceptive (LARC) methods, which reduced the need for frequent contraceptive management visits.[6]

Publicly funded family planning providers are accustomed to adapting their business models in response to changing regulations, national standards and priorities, new guidelines, and now to the diversity of health plan coverage within insurance marketplaces and the Medicaid expansion. As many Title X grantees and subrecipients launch electronic health record (EHR) systems, navigate increased insurance billing, and engage with Accountable Care Organizations (ACO) and primary care providers, it is important to plan for how these shifts impact the organization. For many Title X providers, a key to sustainability is to engage with FQHCs which have the resources, infrastructure, and political appeal that family planning organizations may need, but lack the breadth of family planning and sexual health services and expertise that Title X providers possess.

Title X & Federally Qualified Health Centers

While both the Title X and FQHC programs are housed in the US Department of Health and Human Services, Title X of the Public Health Service Act is administered by the Office of Family Planning within the Office of Population Affairs (OPA), and FQHCs, which are funded by section 330 of the Public Health Service Act, are administered by the Health Resources and Services Administration (HRSA).[7] The Title X and FQHC programs share similar missions, quality standards, target populations, and some operational imperatives (e.g., use of a sliding fee scale for low-income patients). Both FQHCs and Title X-funded providers are considered essential community providers under the Affordable Care Act (ACA), and are required to serve low-income individuals with culturally and linguistically appropriate care, and to provide referrals for services that are outside the scope of care provided onsite. Both are required to conduct routine quality assurance activities to ensure adherence to program standards and guidelines.

Despite these similarities, there are several important differences in the programs:

- **Scope of Service -** FQHCs must provide primary care including voluntary family planning and all "enabling services" either directly or

by referral, whereas the sole focus of Title X is family planning and sexual health care. FQHCs are required to provide family planning services, but the breadth of services and supplies are determined by individual health centers and community need. In contrast, Title X's family planning requirements are comprehensive and detailed, including a broad range of contraceptive methods and services.

- **Sliding Fee Scale -** Although both programs require use of a sliding fee scale, the structure and nuances of how the fee scale is used differ. Title X prohibits charging patients who report a family income below 100% of the federal poverty level, but the section 330 fee scale permits minimal charges for patients below 200% of the federal poverty level. In addition, the Title X fee scale can be used for patients earning below 250% of the federal poverty line, whereas the FQHC fee scale caps at 200%.
- **Confidentiality -** As with any health care provider, FQHCs and Title X providers are required to protect patient confidentiality in accordance to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Due to the sensitive nature of Title X services, the program has additional, more stringent protections. In particular, the federal Title X guidelines assure confidentiality for teens, which overrides any state statutes that may undermine adolescents' rights to confidential sexual and reproductive health services. Furthermore, a minor's eligibility for discounted confidential services must be based on the minor's income. In addition, while Title X requires that patients responsible for paying a fee for their services must be given bills directly, it does not require an explanation of benefits (EOBs) for services rendered. As a result, many entities use Title X funds to cover services for patients who have insurance, but request confidential family planning services.
- **Data Requirements and Reporting -** Title X requires patient, service, and visit data be reported via the Family Planning Annual Report (FPAR). FQHCs collect data through the Uniform Data System (UDS), which requires reporting of patient demographics, services provided, staffing, clinical indicators, utilization rates, costs and revenues on an annual basis.
- **Provider Type -** In addition to mid-level providers and highly trained support staff, FQHCs must also employ physicians who are appropriately licensed, credentialed, and privileged. In comparison, the vast majority of care provided at Title X health centers is by nurse practitioners, physician assistants, medical assistants, and trained family planning counseling staff except for the grantee agency's medical director who oversees the Title X project and must be a physician.
- **Governance -** FQHCs are required to maintain a board of directors that is comprised of at least 51% consumers and provides full oversight of the health system's operations.[8] While Title X requires consumer participation on an Information and Education Committee, there is no requirement indicating a percentage of board makeup.

Strong partnerships between these community health providers play a critical role in the health and well being of their patients. Several studies have shown how these federal programs, Title X and FQHCs, naturally fit as partners, and that collaboration improves the overall quality of patient care.[9,10,11] Building on these findings, this case study focuses on the decision-making process that is involved in choosing an engagement strategy with FQHCs, and the specific implementation steps that are required to operationalize the strategy.

Methods

NFPRHA's *Life After 40* project team designed this case study to provide its members with information and tools to use effective strategies for FQHC engagement thus improving the quality of patient care and overall sustainability of the organization.

A preliminary list of 45 organizations that engage with FQHCs was generated from NFPRHA member surveys, staff knowledge, and consultant input. The list was narrowed to 14 organizations based on criteria like regional location, organization type, and duration and type of FQHC engagement strategy. Phone interviews were successfully completed with nine organizations, which informed the final selection of three Title X-funded organizations that have used different approaches to engage with FQHCs.

At Finger Lakes Community Health (FLCH) in upstate New York, a Title X-funded agency, Yates Family Planning, ***merged*** with a section 330-funded community and migrant health center. The Westside Family Health Center (WFHC) in California gradually ***transitioned*** from a Title X-funded agency to an FQHC with Title X funding. The Family Planning Association of Maine (FPAM) is a Title X grantee that ***subcontracts*** with FQHCs to provide Title X services.

Each participant site provided basic organizational information through a written survey. Key staff were interviewed at each organization from the administrative and direct service levels, and staff from two of four FQHCs that have a subcontract relationship with FPAM were also interviewed. Interviews

focused on answering several key questions including:

1. What motivates organizations to decide to engage with an FQHC?
2. How do organizations make the decision to approach an FQHC?
3. How are relationships initiated?
4. What does the implementation process look like with different organizational models involving Title X and FQHCs?

The case study narrative and companion workbook were developed using information and tools gleaned from these interviews. The case study narrative details the decision-making process that was used in each model of engagement and the implementation process used to operationalize the strategy that had been chosen. As with prior case studies, the companion workbook serves as an operational guide to planning and implementing organizational changes. It contains tools, resources, and information that participating organizations contributed and that NFPRHA developed or adapted from outside agencies.

How to Use This Document and the Companion Workbook

This case study was designed to focus on two separate components of establishing an FQHC strategy: Part 1 explores the decision-making process, and Part 2 examines the implementation process. The two sections can be read independently or as a contiguous document. In each part, three different strategies for working with FQHCs are described and analyzed. The **Common Themes** section at the end of each part provides analysis across all three strategies while the **Takeaways** section and **Conclusion** highlight recommendations.

The companion workbook is referenced throughout the case study narrative by section and subsection so readers can easily find additional information and tools that pertain to key topics. For example, the Implementation Checklist is in workbook Section 3: Implementation, Subsection a. Integrated Operations and is referenced in the narrative this way: (**W3a**). The workbook is designed to be referenced quickly and independently from the narrative, with tools and templates that can be easily adapted for an organization's specific needs. In addition to operational tools, the workbook contains supplemental information that may be useful in developing and implementing organizational changes.

Part 1: The Decision to Engage with a Federally Qualified Health Center

The Merger: Finger Lakes Community Health

The following section details how Yates Family Planning decided to merge with Finger Lakes Migrant Health Care Project, Inc., to become an FQHC doing business as[12] Finger Lakes Community Health.

Brief History

Before the merger, Yates Family Planning (YFP) operated four Title X-funded health centers in Geneva, Penn Yan, Bath, and at Keuka College in upstate New York. The agency's mission was dedicated to the provision of family planning services and all clinicians and staff were trained in Title X data collection and reporting using paper charts and encounter forms. In addition to billing the New York State Department of Health (a Title X grantee) for Title X services rendered, the agency billed Medicaid and four private third-party payers for services.

Before the merger, Finger Lakes Migrant Health Care Project (FLMH), operated three FQHCs in Port Byron, Sodus, and Geneva, and operated a Mobile Migrant Program. FLMH was a section 330-funded community and migrant center providing primary and dental care to mostly undocumented migrant farm workers in upstate New York.

In late 2009, YFP merged with FLMH, and began operating as Finger Lakes Community Health, Inc. (FLCH) in early 2010. Title X family planning services are incorporated into primary care visits in all health centers. FLCH now operates 10 health centers in the Finger Lakes region of upstate New York, three of which are certified as Level 3 patient-centered medical homes. FLCH is an FQHC, which receives Title X funding, and serves over 17,300 patients each year through more than 66,400 visits for primary care, family planning, mental health, case management, and/or dental care. Of these, about 2,750 are Title X patients who make approximately 3,000 visits annually.

Deciding to Merge

For YFP the decision to merge was rooted in the need for financial stability. YFP had recently opened a new health center in Geneva when New York State did a Medicaid reimbursement adjustment. The combination of these events was the beginning of the organization's financial struggles. Then-Executive Director Marty Blumenstock negotiated with the state to bill for services monthly rather than quarterly to ease cash flow pressures, and initiated third-party billing with four insurers to diversify funding streams. With these financial pressures, and the pending changes associated with health reform, it was clear that these efforts would be insufficient to keep YFP operating.

YFP considered options to merge, or operate under an umbrella organization. First, Blumenstock appealed to Soldiers and Sailors, the Geneva Hospital, to discuss a possible partnership, but the hospital was unresponsive. In two years and two rounds of strategic planning, Blumenstock and the board also discussed the possibility of providing primary care. The health center in Bath already had primary care on its state operating certificate because the county health department had asked YFP to provide physicals in response to high rates charged by a local hospital for the service. However, at the time, the board wanted the agency to maintain its identity as a family planning organization and rejected expanding services to include primary care.

At the same time, FLMH was exploring options to expand operations into Penn Yan to see more patients. YFP had a health center in Penn Yan, and was participating in the FLMH Migrant Voucher Program to provide family planning services to FLMH patients. However, this arrangement was not cost effective for FLMH because it had to send its own staff to Penn Yan as YFP did not have the bilingual staffing to meet the patient needs. This meant that FLMH was paying YFP to deliver services, but had to use FLMH staff to do it. In addition, there was no other safety-net provider of primary health care in the area, so many patients were traveling from Penn Yan to the FLMH Geneva health center for services, a long and often hazardous route, especially in the winter. Opening a health center in Penn Yan would expand patient access to primary health services and would be more cost effective for FLMH.

Initially, Mary Zelazny, executive director at FLMH, approached the hospital in Penn Yan to explore the option of opening a dental care center, but the hospital urged her to wait. In 2009, almost two years later, Zelazny approached the hospital again and was encouraged to open a comprehensive health center. Concerned about the impact that opening a health center in Penn Yan would have on YFP, Zelazny proposed a merger of FLMH and YFP to her board of directors. In that meeting, the board recommended that Zelazny speak directly with the board of YFP.

In a private meeting with the YFP Board of Directors, Zelazny proposed merging the organizations, pointing out their similar missions to serve at-risk populations and that YFP would have increased financial stability. The YFP Board was interested, so Zelazny met with Blumenstock to discuss the idea further.

Zelazny and Blumenstock had known each other for years from working together on the Yates Health Planning Committee and through the FLMH voucher program, so it was easy to make the case for a stronger collaborative relationship. Zelazny was aware of the concern about YFP's ability to manage the impending changes in health care delivery systems with limited financial resources. Initially, they discussed the possibility of merging physical health center sites to reduce administrative and overhead costs, but that solution would not have provided the long-term financial stability that YFP needed. When Zelazny proposed a full organizational merger, Blumenstock felt it was "a great match" because of the agency's similar missions. In addition, Blumenstock was planning to retire and wanted to leave YFP in a stable financial position.

Blumenstock proposed the merger to the YFP Board of Directors, which was slightly hesitant because they did not want to lose the agency's identity as a family planning provider. Nonetheless, it made financial sense, so the two boards of directors met together to discuss the opportunity. After the joint meeting, each board formally approved the merger in September 2009. Several YFP Board members resigned as a result of the merger, and others continued on the FLCH Board and contributed to the 51% consumer representation requirement of FQHCs.

Implementation steps were not discussed as part of the decision-making process, but rather after the decision had been made. The executive directors informed the staff of the merger after it was approved by both boards. Staff was brought into the process when it became necessary to make decisions about the operational changes that were needed to complete the merger. (Part 2 provides details on these decisions and the implementation process).

After board approval, Blumenstock engaged her contacts at the state who were very supportive of the merger. New York State had been encouraging the collaboration between FLMH and YFP and was in favor of a more formal arrangement. Blumenstock met with the Department of Health's technical and finance staff who agreed to assist with the merger process. As the grantee for both organizations, the New York State Department of Health had to approve the transfer of YFP's Title X grant to FLCH. In addition, the Department of Health had the authority to end YFP's non-profit operating status and transfer the operations of its four health center locations to FLCH's operating certificate. Despite initial support and commitment, it took approximately two and a half years for the official merger to be completed through the state (**W1a**).

Reflections

Several factors were critical to making the decision to merge YFP and FLMH: the leadership from each organization was motivated to merge; the organizations had an existing relationship and a complementary mission; and the merger solved a problem for each organization.

Motivated Leadership

The decision process to merge was swift because the executive directors were motivated to merge, and were able to convince both boards of directors that it was mutually beneficial. YFP was struggling financially and its board had been considering merger as part of a sustainability strategy for two years. When FLMH proposed the merger, the YFP Board had already done substantial work to make such a significant decision. In addition, Blumenstock's desire to seek an avenue to stabilize YFP's finances before retirement accelerated the decision to merge.

Zelazny had waited more than two years for an endorsement from the hospital to open a health center in Penn Yan and was ready to move forward but did not want to negatively impact YFP. In addition, merging would remedy the financially inefficient migrant voucher services that were provided at YFP Penn Yan health center through the Migrant Voucher Program and improve direct services to patients.

An Existing Relationship

The executive directors' well-formed relationship played an important role in the decision to merge. The foundation of trust between the executive directors, and a basic understanding of the operations of each organization, contributed to the ease and fast pace of the decision.

Shared Mission

A critical element in the decision to merge was the organizations' shared mission to provide health care to underserved populations. It might have been difficult to decide to merge two organizations that did not adhere to the same vision.

Solution to a Problem

Prior to the merger, each organization had a problem, and this strategy solved both problems to create a sustainable model. YFP did not have the financial stability nor the infrastructure to adapt

> "We serve the same clientele with the same philosophies… we are sisters in that respect."
>
> – Marty Blumenstock, Former Executive Director, YFP

to the changing health care environment. Merging with a larger, more stable organization with resources and more diverse funding streams enabled the YFP Title X program to continue serving patients in the Finger Lakes. In turn, FLMH was able to expand their service locations, and gain access to YFP's existing patient base, many of whom were in need of primary care and dental services.

The Transition: Westside Family Health Center

Westside Family Health Center (WFHC), a Title X-funded women's health center, added services over 20 years and eventually became an FQHC.

Brief History

WFHC was founded as Westside Women's Health Center in Santa Monica, California in 1974 by a group of nurse practitioners and community activists. The group based the center's mission on *Our Bodies, Ourselves*, the groundbreaking book that inspired a movement to involve women in their health decisions at the physical, social, and political level. Title X funding has been a key funding source for more than thirty-five years. In 1990, the health center added prenatal care to its services to meet patient demand, and in 1992 a pediatric program was established in response to the high rate of uninsured children in the community. An adolescent health services program was added in 1996; although the program was developed in reaction to the increasingly high teen pregnancy rates in Los Angeles County, it expanded on Title X service requirements and provides comprehensive services to teens. In 1999 the health center launched a family practice program, serving patients with a wide variety of medical needs.

Westside Women's Health Center changed its name to Westside Family Health Center in 2001 to better reflect its new identity as a Title X-funded health center with new services for a broader population. With support from Los Angeles County, WFHC became an FQHC look-alike in 2004, and in August 2007 became an FQHC under HRSA's Health Center New Access Points[13] funding that supports the expansion of comprehensive, culturally competent, quality primary health care services in underserved areas.

Today, WFHC maintains section 330 and Title X funding and serves more than 9,500 patients from 248 ZIP codes through almost 31,000 visits each year. The health center provides family planning services, primary, prenatal, and pediatric care through a parent site in Santa Monica, two satellite sites, and a mobile medical unit serving seven locations, most of which are local high schools and mental health centers. In 2013, the health center secured a health insurance outreach and enrollment grant through HRSA to support patients in obtaining and maintaining insurance coverage. WFHC recently became certified as a Level 1 patient-centered medical home, and implemented eClinicalWorks, an electronic health records system, in August 2013. WHFC has plans to add dental and mental health services onsite in the coming years.

Deciding to Become an FQHC

The decision to apply for a section 330 grant to become an FQHC was described as the natural next step in the evolution of service delivery at WFHC. There was a domino effect of decision points where each decision to expand services led to another opportunity to expand services even further. This gradual process felt so natural, and each step so obvious to the staff who were interviewed, that it was difficult to identify key decision points. Each phase of changes brought WFHC closer to the capability to provide the comprehensive services that define an FQHC.

Debra Farmer was hired as president/CEO in February 1999 just after the board of directors had voted to merge with Venice Family Clinic (VFC) in the hopes of improving the agency's financial stability. Unhappy with the merger decision, the staff conducted a review of VFC, its patient population and operations, and reported back to the board that WHFC's existing patients could not be seen at VFC because of its status as a free clinic, which limited the capacity to see patients who lived in certain ZIP codes or whose income were above 100% of the federal poverty level. The board took up the vote again and rejected the merger.

With the merger rejected, WFHC still needed to execute changes to continue to operate. Farmer created new administrative positions to strengthen the health center's infrastructure and capacity for organizational change and implemented quarterly surveys to obtain patient feedback. Data from these surveys, along with patient visit data, indicated that patients were in need of more primary care services, so WFHC began hiring family practitioners rather than women's health clinicians. In addition, 97 clinic hours were added to the schedule to expand accessibility of services and to further strengthen a previously informal organizational structure. (Part 2 provides details on the changes that were implemented).

Moving forward with strategic organizational changes, WFHC applied for family practice funds made available through Los Angeles County from a public-private partnership initiative started by the Clinton administration. The health center received a $150,000 grant that was split evenly between the health center and another health care provider, the Center for Healthy Aging.

Eventually WFHC took over the entire family practice grant from the Center for Healthy Aging, which triggered a shift in the health center's patient profile. Older patients with different expectations and medical needs were seeking services as WFHC, which reinforced the health center's shifting scope of services towards providing adult and family primary care.

As the patient population became more diverse, the number of patients seeking a multitude of services increased, and WFHC saw the need to diversify funding streams and position itself to be eligible for the growing managed care market in California. In 2007, WFHC joined an independent practice association (IPA) for community health centers, Healthcare LA, which manages third-party contracts, including negotiating reimbursement rates and credentialing, and assigns new patients to the health center. (Part 2 provides details on WFHC billing practices).

In 2004, Los Angeles County approached WFHC and urged the health center to become a strategic partner to improve access to health care in the region. The county provided funds to hire a consulting team to complete the FQHC look-alike application. Later that year, WFHC was granted look-alike status by HRSA which required the health center to meet all of the same requirements as a section 330-funded agency. Although look-alike status does not include direct funds, benefits like enhanced Medicaid reimbursement rates made the transition worthwhile.

In 2006, WFHC's strategic planning consultant recommended that the health center apply for a section 330 New Access Point grant because funds for an urban setting would not be available under this grant in the future. The benefits of section 330 status included federal financial support, eligibility for coverage under the Federal Tort Claims Act, as well as making the agency eligible for other funding available to FQHCs. Since WFHC had already made the necessary operational changes to comply with section 330 regulations, meeting those specific requirements were not a concern. However, Farmer was reluctant to invest staff time and resources needed to complete the extensive FQHC application process.

The board of directors and a strategic planning consultant convinced Farmer to invest in writing the application because the benefits of becoming an FQHC would exceed the initial $30,000 investment to prepare the proposal. The window between the funding announcement and application deadline was 45 days. A consultant was hired to help with the application process, but staff time was still needed to obtain detailed health center information. During the 45 days spent preparing the application, it is estimated that the director of development spent 100% of her time, the director of clinical services spent about 90% of her time, and Farmer spent approximately 80% of her time working on the application that was submitted in December 2006. Initially, WFHC was not funded despite scoring a 98% with no deficiencies. WFHC was given no explanation, but the decision was likely due to the prioritization of funding other organizations. However, in August of 2007, Farmer was notified that funds were available after the initial disbursement and WFHC had received section 330 funding as a New Access Point based on its 2006 application.

While the initial application process took a significant amount of time and resources, the reapplication process was much simpler and the information contained in WFHC's section 330 applications has been useful when writing other proposals and reports (e.g., the HRSA application for outreach and enrollment services).

Reflections

A combination of factors positioned WFHC to become a look-alike, and then an FQHC including the availability of New Access Point funding and financial support from Los Angeles County, the agency's mission to respond to patient need, and the gradual implementation of changes to the service delivery model, including integrating primary care.

Availability of Funding

The decision to become an FQHC look-alike was largely motivated by the financial support from Los Angeles County to hire a consultant team to complete the look-alike application. WFHC was one of only two community health care providers on the west side of Los Angeles County serving low-income and underserved populations, which led the county to provide the necessary assistance to complete the health center's look-alike application. Without this initial support from Los Angeles County, WFHC likely would not have had the capacity to apply for look-alike status.

Similarly, the availability of New Access Point funds was an important motivating factor in the decision to become an FQHC. There was significant pressure to submit a proposal in 2006 because it was unclear whether these funds would be available for urban areas again.

Meeting Patient Needs Through Gradual Organizational Change

All staff who participated in case study interviews indicated that becoming a look-alike and then a full FQHC felt like natural steps in the evolution of the agency and were obvious decisions to best meet the needs of patients. In order to serve patients, it was critical to maintain the agency's mission while striving to operate as a business and maximize resources and revenue to remain viable.

WFHC used results from the 300 to 500 patient surveys that were completed each quarter to inform operational changes that could be made to better serve patients and expand the patient base (**W2b**). Patient feedback indicating a need for enhanced, comprehensive services, which was reflected in patient visit data, made it easy for the board of directors and Farmer to decide to proceed with the look-alike and then the section 330 application.

In addition, many services and operations that are required of FQHCs, such as prenatal and primary care, had already been implemented gradually, in multiple phases over the years. Similarly, since look-alikes are required to adhere to the same guidelines as FQHCs, WFHC had already implemented the changes necessary to be a full FQHC such as having a board that was comprised of 51% consumers. As a result, the decision to write a section 330 grant proposal was based more on the internal resources needed to complete the application and the additional funds the grant would provide rather than on the feasibility of implementing changes required to be compliant with section 330 regulations.

The Subcontract: Family Planning Association of Maine

This section focuses on the history and key factors involved in initiating and establishing Title X service subcontracts between the Family Planning Association of Maine (FPAM) and two of their four FQHCs subrecipients – HealthReach Community Health Centers (HealthReach) and Katahdin Valley Health Center (KVHC).

Brief History

Founded in 1971, FPAM is the only Title X grantee in Maine. FPAM provides Title X family planning services in 47 health centers across the state. FPAM operates 18 direct service health centers, six school-based health centers, and subcontracts Title X services to other agencies including Planned Parenthood and four FQHCs, which operate 19 health centers in rural areas of Maine. Almost 25,000 patients are seen through over 30,000 visits across all health centers. Of these, approximately 6,000 are Title X patients, and 5,200 are adolescents.[14]

HealthReach maintains a Title X subcontract with FPAM and operates 11 health centers that serve over 80 communities in central and western Maine. Almost 30,000 patients are seen each year, 10% of whom are adolescents, through over 99,800 visits. Approximately 2,400 of these patients receive Title X services.

KVHC implemented a Title X subcontract with FPAM in 2010, and serves approximately 10,000 patients through 30,000 visits annually at four health centers in rural Maine. Approximately 450 patients received Title X services in 2013.

To expand coverage in underserved areas and to increase patient numbers, FPAM decided to subcontract Title X services to FQHCs in rural communities in the early 2000s. HealthReach and DFD Russell were the first two FQHC organizations FPAM identified as their best potential partners. The outreach to both organizations was successful and the FQHCs opted to implement the Title X program incrementally throughout their health center networks. Over the following 11 years, FPAM established subcontracts with KVHC and Islands Community Medical Services as Title X subrecipients, and the last three FQHC service sites integrated the Title X program in 2012. (Part 2 provides detail on how the Title X program was integrated into the FQHC model).

Deciding to Subcontract Title X Services to FQHCs

In 2002, OPA announced the availability of supplemental funding for existing Title X grantees to expand their service areas to reach more patients in need of family planning services. FPAM considered using these funds to expand health center hours or clinician time, but the existing health centers were at capacity already and did not reach patients in more remote communities. In addition, FPAM-operated health centers had seen a decrease in the number of patients seeking services in previous years, which may have been the result of revised pap smear guidelines, or an increase in the use of LARC methods, so there was no guarantee that increasing hours or clinician availability would draw in new patients.

FPAM had already conducted a ZIP code analysis to determine where patients were coming from to receive services. The analysis indicated that more than 90% of patients lived within a 15-mile radius of FPAM-operated health centers, and the other 10% were coming from within 30 miles. This analysis revealed that there were gaps in the rural service delivery system.

FPAM decided to use the supplemental Title X funding to create a more sustainable business model by increasing patient volume and expanding the service region. It sought to do this by partnering with FQHCs in rural regions where Title X family planning services were not currently provided. Creating one-year Title X subcontracts was more cost effective than building new health centers and enabled FPAM to increase the number of reportable Title X patients and visits by accessing the established FQHC patient base (**W1a**). In return, the FQHCs improved the quality of their family planning and sexual health services. The availability of the supplemental OPA funds made the initial contracts possible because FPAM did not have to forfeit a portion of its base Title X grant to pay the FQHCs for subcontracted services.

To determine possible candidates for a Title X subcontract, FPAM looked at which FQHC-operated health centers that were located 15 to 30 miles away from FPAM-operated health centers. This proximity to FPAM's health centers allowed for staff collaboration between the FQHCs and FPAM, while reducing the potential for competition.

In addition to location, it was essential that the partner organizations supported a full range of sexual and reproductive health services and be willing, able, and committed to adhering to Title X guidelines. Although FQHCs' required services include family planning, the Title X guidelines require more comprehensive care. Some of the FQHCs that FPAM approached expressed resistance to providing confidential services to all patients or non-directive counseling and referrals. As these are fundamental principles of Title X, these organizations were determined not to be a good fit.

Pre-existing relationships between FPAM personnel and staff at prospective FQHCs was another important factor in identifying potential Title X subrecipients. Both FPAM's Senior Vice President of Program Services Evelyn Kieltyka, and Project Director Kini-Ana Tinkham, had previously worked with two separate FQHCs, one of which was HealthReach, in clinical capacities. These long-standing relationships were the reason FPAM chose to reach out to these organizations before other potential candidates.

The executive directors in both FQHCs responded positively. As part of the initial "pitch" of the Title X subcontract, FPAM made it clear that the FQHC's administrative team, clinicians, and staff could depend on the project director to provide the direct support needed to integrate the Title X program. That both Kieltyka and Tinkham were highly regarded former employees, and clinicians by training, which lent them credibility when discussing how services could be integrated into the FQHC environment. Rather than solely discussing the program from an administrative perspective, they discussed details of how Title X services could be integrated into the FQHC and the type of support FPAM would provide. This promise of support from a trusted ally was an important motivating factor for the FQHCs; staff from HealthReach indicated that it was essential to "make it easy" to implement the Title X program and to provide staff with the training and resources they needed to implement the changes.

> "As a safety net provider, [Title X] is an essential service."
>
> – Doug Kinsbury, Chief Information Officer, KVHC

Tinkham used information from the federal Uniform Data System (UDS) when approaching FQHCs with a subcontract proposal. She presented an estimate of existing FQHC patients who could benefit from enhanced family planning services and/or additional supplies. This emphasized the way in which Title X funds were considered "free money" because FQHCs were already required to provide family planning services. The availability of Title X funds enabled the FQHCs to augment existing health services as well as expand service offerings and improve quality of care.

As FPAM developed the Title X subcontract program and worked with the FQHCs to expand Title X services into more health centers, FPAM's collaboration with FQHCs gained credibility. Having contracts in place with two large FQHCs in the state was helpful when FPAM approached other FQHCs. For example, while there were no prior existing relationships when FPAM approached Islands Community Medical Services in 2003, FPAM's established subcontract program and previous experience working with FQHCs was a platform to initiate a conversation regarding a comparable arrangement. Similarly, KVHC was encouraged by the Primary Care Association (PCA) to collaborate with FPAM, which was an active member in the organization and had established a favorable reputation by then for working in the primary care setting.

In 2010, KVHC signed a subcontract agreement with FPAM. As mentioned previously, some FQHCs, particularly those in politically conservative areas, were not considered a good fit to work with FPAM because of the misconception that Title X includes abortion services, or that providing family planning to adolescents would "increase promiscuity." This was the case at KVHC for several years, but patience and persistence proved to be the key to this partnership. A contractual relationship with FPAM was not feasible until there was sufficient turnover of the KVHC Board of Directors - adding new members who were in favor of expanding family planning services. This change in board composition, coupled with a highly motivated chief operations officer, enabled KVHC to take on a Title X subcontract with FPAM.

KVHC was enthusiastic about expanding family planning and sexual health services that were currently offered, especially the ability to offer contraception onsite. The pharmacy who had previously provided access to 340B pricing was no longer willing to continue the partnership and FPAM provided an alternative, reliable avenue to secure these discounts and bulk orders with other pharmacies.

Reflections

The elements that motivated and supported the subcontract agreement between FPAM and the two FQHCs that participated in the case study were sustainability, the desire to expand existing services, building on established relationships, thorough discussion of implementation, and the patience to overcome political adversity.

Sustainability

There were several key factors that made subcontracting Title X services a logical choice for FPAM in order to improve sustainability. Through the subcontract, FPAM gained access to a new, established patient base without investing in new health center locations. The demographic analysis revealed FQHC locations filled a gap in the service delivery network and would not compete with FPAM-operated sites. In addition, the availability of additional OPA funds for Title X expansion and existing relationships with well-established FQHCs in underserved areas supported the subcontract strategy.

Expanding Reproductive Health Services

Key factors that motivated FQHCs to subcontract Title X services included: additional funds to expand existing services; improving care and providing additional/onsite contraceptive supplies and medications; and acquiring support for staff and clinicians including technical assistance to adapt the EHR.

Established Relationships

FPAM staff having a personal relationship was a very important step with two of the participating FQHCs. The long-standing relationship that existed between former employees who currently worked for FPAM was a critical success factor in initiating conversation with FQHCs and in FPAM's ability to negotiate a contract that would benefit both agencies. Having contracts in place with two FQHC organizations was helpful in reaching out to other FQHCs where a relationship was not established.

Discussion of Implementation Prior to Making Changes

Successful negotiations addressed how to operationalize the integration of Title X prior to signing a subcontract agreement (**W2b & W3a**). When FPAM approached FQHCs to propose a potential subrecipient relationship, details of how the program would be implemented were discussed in-depth to determine the feasibility and sustainability of the program within the FQHC setting. The project director provided education on the Title X program itself, how it could be integrated into the FQHC model, and how she would support clinicians and staff.

Overcoming Political Adversity

The political environment is an important consideration when assessing potential opportunities for collaboration. An unfavorable environment can present a challenge to partnership because of the stigma associated with family planning and sexual health services, whereas in a favorable environment, organizations may be more open to collaboration to improve services, access, and service delivery. However, as shown with FPAM's partnership with KVHC, leadership changes within an organization can make previously unfavorable partnerships feasible.

Common Themes in Decision Making

This section identifies common themes related to the decision-making processes in the three participating Title X agencies, considerations in developing operational strategies to work with FQHCs, ways for Title X organizations to make the case to work with FQHCs, and challenges or barriers to expect in the decision-making process.

Choosing an Engagement Strategy

Motivating Factors

Three main factors motivated the participating agencies to develop operational strategies involving FQHCs: sustainability, patient needs, and the health care environment.

1. Need to Sustain Family Planning Services

The three participating agencies shifted operations in different ways to develop mission-driven business models for long-term sustainability of their Title X programs. In the case of the merger, YFP was struggling financially and chose to merge with a larger, more stable organization with the infrastructure and the necessary resources (e.g., EHR system) to effectively adapt to the changing health care environment. WFHC was experiencing financial distress and considered a merger, but with staff pressure and a new president/CEO, the agency opted to adapt its service model gradually and add services over time while maintaining the organization's core mission to provide women's health services, including family planning. FPAM responded to a decrease in patient volume and the desire to expand the service area through integrating Title X services into a network of FQHC sites with an established base of patients in need of services. The broadening of service area and operations into a primary care setting enabled FPAM to increase patient volume and gain valuable experience incorporating Title X into other health services.

2. Addressing Patient Needs

An organization ceases to be viable if it no longer meets the needs of the populations it aims to serve. As more patients obtain insurance, many may decide to access services through primary care providers rather than at standalone family planning health centers, making it necessary for some organizations to expand services or service areas to meet patient needs. This may entail providing additional services improving the overall quality of care, and/or expanding access to family planning services and supplies in remote areas to underserved populations through subcontracting with other organizations.

3. Support for Change

In all three of the participating agencies, external factors supported the organizational changes that were made. As an example, the New York State Department of Health, the Title X grantee for YFP, was in favor of collaboration between FLMH and YFP, and the merger was viewed as an improvement to an existing partnership. In the case of WFHC, Los Angeles County was the motivating force behind the agency's FQHC look-alike application by proposing the initial idea and funding the application process. FPAM was under pressure to use new funds to expand patient access, which motivated the decision to approach FQHCs in rural areas that had patients in need of family planning services.

Generally speaking, a political environment that favors the provision of services can drive FQHCs and Title X organizations together and encourage collaboration, while an anti-choice environment can be a barrier because of the unfortunate misconception that Title X is synonymous with abortion services. As seen in Maine, FQHCs may decline to work with a Title X provider system for that reason.

Common Influences

Examining three different operational strategies involving FQHCs revealed some common factors to consider (**W2a**). Leadership vision and style were important factors in developing a sustainability strategy. In addition, key implementation considerations contributed to the decision-making process. In other words, early discussions on how organizations would need to adapt can help determine the feasibility and sustainability of a strategy.

1. Leadership

Individual leaders' analyses of the future of their organizations, and of family planning in their areas, motivated them to take action. How leaders make strategic decisions, inspire the workforce to implement changes, and even their personal motivations, impacted how the organizations chose to adapt. In the case of FLCH, the decision to merge was made by the leadership of both organizations, and did not involve staff of the organizations until after the decision was made. Staff were given complete autonomy to operationalize

the merger but did not have enough time to plan or provide training to ensure complete integration until a family planning program coordinator was named to oversee the program. In the case of WFHC, the president/CEO placed a high value on communication and training as the service model evolved, replacing staff as necessary when they resigned, which permitted the organization to adapt slowly to the changing needs of the community. The leadership at FPAM recognized the trend of decreasing patient numbers and quickly identified strategies to address this concern.

2. Implementation Planning

Through interviews with the participating organizations, it became clear that identifying roles and responsibilities to implement the proposed strategy during the decision-making process helps prepare staff for change and makes the implementation process smoother (**W3a**). In the case of FLCH, the speed of the decision to merge precluded thorough implementation planning, which meant staff roles and operational processes were addressed amidst many other changes. This was stressful for staff who felt unprepared and helped lead to an underreporting of Title X data. As FPAM's FQHC subcontract program grew over the years, it recognized the importance of discussing the implementation process during initial negotiations with FQHCs. As Title X services were gradually added throughout an FQHC partner's network, FPAM staff continued to emphasize operational tactics by meeting with individual health center staff to set clear expectations and explain the type of technical assistance FPAM could provide. This pragmatic approach ensured that the FQHCs understood the implementation process, the work involved, and the support they could receive to integrate the Title X program. These open discussions enabled the FQHCs to agree to a subcontract prepared for the changes ahead.

3. Staff Engagement

As part of the decision-making process, executives determined when and how to bring staff into the process (**W3c**). Involving key staff to provide operational input and help develop strategies for implementation during the decision-making process best prepared staff for changes and helped temper issues around agency culture change early in the process. Staff members who were ultimately responsible for operationalizing changes had a valuable perspective on the details and logistics associated with changes and their anticipated outcomes.

Making the Case to Partner

The federal government has directed billions of dollars to FQHCs since the passage of the 2010 health reform law and through the 2009 American Recovery and Reinvestment Act (ARRA), effectively designating them as the safety net providers of choice. These health centers often have greater infrastructure and resources than Title X organizations. On the other hand, Title X organizations have counseling expertise that FQHCs often lack.

What Motivates FQHCs to Partner?

A combination of benefits to partnering with a Title X agency were presented to FQHCs in initial conversations about collaboration strategies (**W2b**).

1. Enhanced Services that Improve Patient Care

As FQHCs strive to provide high quality essential services, meet Healthcare Effectiveness Data and Information Set (HEDIS) measures,[15] and section 330 performance indicators, it can be extremely valuable to engage with other "experts" in the health care field. FQHCs with Title X programs are more likely to have a comprehensive set of services, including outreach, education, counseling and onsite contraception.[16] Furthermore, Title X counseling guidelines promote highly effective counseling techniques when addressing sensitive issues, especially with males and adolescents. While provision of family planning services is a section 330 requirement, FQHCs often do not provide the range of reproductive and sexual health services, in-depth counseling, or supplies offered through Title X.

Because FQHCs provide some family planning services, Title X funds may be viewed as "free money" to enhance existing services. FPAM promoted the enhancement of established family planning services in partnership discussions with FQHCs, and this was also a factor for the Executive Director of FLMH in considering the merger with YFP.

In addition, some patients highly value confidential services. In all three states where case study participants operate, there are public payment sources for adolescents, including state Medicaid, which do not have the strong confidentiality protections fundamental to Title X. Title X continues to set the standard for patient confidentiality in family planning and provides critical funding for patients in need of confidential family planning and sexual health services.

2. Support for Staff

Interviews with clinicians and operations staff at each participating organization indicated that direct service personnel were enthusiastic about the opportunity to receive training, materials, and resources to improve patient care. The FLCH staff was dedicated and resourceful when it came to implementing operational changes, but indicated that more training and resources would have been helpful in the initial phases of the merger. WFHC staff was in favor of expanding services, but ample training, staff engagement, and consistent communication were fundamental to the success of the numerous transitions. In the case of FPAM, subcontracted FQHC health centers were especially interested in the availability of support and resources for clinicians regarding counseling and clinical protocols to improve the family planning program and expand service options for patients.

3. Expansion

Engaging with Title X providers creates opportunities for FQHCs to expand their patient base and/or their service area. As seen at FLCH, the FQHC added primary care and dental services into three existing YFP health centers that were well established in their communities and had a patient base in need of primary health services. Subsequently, the FQHC saved on the costs of opening new health centers and generating a patient base. In the case of FPAM, potential FQHC partners were provided with an estimate of how current health center patients would benefit from Title X services using the FQHCs' Uniform Data System (UDS) data. This approach illustrated that patients in need of Title X services were already seeking health care, and that subcontracting for Title X funds would enable the FQHCs to improve its family planning service delivery.

4. Shared Mission

Title X and FQHCs have a shared mission to provide high-quality, culturally competent services to uninsured and low-income populations; this commonality was a motivating factor for all three participants. FLCH, WFHC, and FPAM each found that the common principle of patient care and overlap of target populations allowed for a smoother transition to integrate the programs.

5. Strong Relationships

Natural partnerships often become established when organizations share a mission, population base, philosophical values, and/or when champions from both organizations recognize the value added by sharing information and resources. Once established, enhancing an existing partnership can be appealing simply because it is easier to trust a known entity, as seen in the case of FLCH and FPAM. In other cases, clinicians or staff from each organization might rely on each other for support and can serve as champions for a stronger collaboration strategy.

Potential Challenges & Barriers

Participating agencies encountered challenges and barriers to the decision-making process that provide lessons for organizations that are considering similar options.

Concerns from Potential Partners

The ability to anticipate potential concerns is an important skill among successful negotiators. While it is difficult to account for every possible situation, being prepared for common issues can ease hesitation and facilitate timely negotiations. Researching a potential partner through publicly available data and engaging personal networks can help identify conceivable obstacles. Two examples of concerns presented by FQHCs and how they were addressed follow.

- In politically conservative areas, the stigma associated with abortion services often extends to all family planning services and the Title X program. This inaccurate perspective can mean that FQHCs may be reluctant to associate with Title X organizations. To address misconceptions of the Title X program, education was provided early in the process about what services Title X offers and does not offer. These discussions helped to establish common ground with FQHCs by highlighting the similar missions, target populations, and quality assurance imperatives that the organizations shared. In addition, local teen pregnancy and STD rates were used to exemplify community need for Title X services.
- FQHCs are pursuing many initiatives including patient-centered medical home certification, meaningful use for EHR, and integrating behavioral health. Therefore, some FQHC staff expressed concerns about implementing an additional program that requires extensive documentation, especially when they already provide family planning services. Providing data indicating that established health center patients will benefit from the Title X services and a detailed, supportive plan to integrate the program proved to be an effective approach.

Internal Concerns from Stakeholders

As the Title X organizations decided to make changes in agency structure and/or service delivery, it was important to get stakeholder support. Both FLCH and WHFC had to obtain board approval before changes to the business model could be made; FPAM's board approved the management's policy of subcontracting with FQHCs but it was not involved with the selection of subrecipients. The process to get stakeholder buy-in is similar to making the case to potential partners: the need for change and benefits must be clearly defined. The use of data from financial reports, patient surveys, and environmental scans strengthened the proposals for FLCH and WFHC (**W2a** & **W2b**). Data can also help when individual board members want to see the organization move in a direction that is not a good match for the organization. For example, the majority of the WFHC Board strongly wanted the health center to merge with Venice Family Clinic. However, when it was revealed that merger would negatively affect patients, the board rejected the merger, and all but two board members resigned. The newly-formed board was able to pursue strategies in line with WFHC's mission.

The ability to preemptively address challenges can help facilitate stakeholder approval. Conducting preliminary, confidential conversations with trusted board or staff members is one strategy to assess how a proposal may be received. However, in some cases, turnover can be the most effective way to bring about change. WFHC used the voluntary departure of board members and staff as an opportunity to bring on personnel who fit the new organizational model. Furthermore, extensive staff training, patient survey data, and ongoing communications can ease tensions and get volunteers and staff on board with a new strategy.

Addressing concerns about agency culture change may involve a more extensive reevaluation of an agency's identity and internal values. Culture change can be effectively addressed through ongoing communication from leadership and empowering staff to be involved in decisions and operational changes when appropriate. While allowing the staff to drive the decision-making process is an uncommon leadership strategy, at the very least, keeping staff informed of changes, and the need to make the changes, can make staff feel involved and motivated to participate in the implementation process.

Takeaways

- Look for a motivated leader among potential merger partners to support the decision-making processes.
- Know your service area and market, including the presence or absence of other providers for underserved populations (**W2a**).
- Consider these elements in choosing which FQHCs to approach: utilizing current patient information, including demographic analyses to identify underserved areas; shared values; existing partnerships or relationships; the presence of other reproductive health providers in the region; and the political environment (**W2a**).
- Develop talking points to use when engaging with FQHCs that include: expanded funds for reproductive health services; addition or expansion of onsite contraception provision and more contraceptive options; enhancement of services to meet patient needs; and providing technical support for staff and clinicians to implement a Title X program (**W2b**).
- Address how to integrate the Title X program early in the decision-making process, including the type of support to be provided during the implementation phase and on an ongoing basis.
- Involve key operations staff as early as possible to gain perspective on the potential operational implications of the chosen FQHC engagement strategy and to ease tensions associated with agency culture change (**W3c**).

Part 2: Implementation of Engagement Strategies with FQHCs

The Merger: Finger Lakes Community Health

This section examines the complex, multi-stage process to implement the merger of Yates Family Planning with Finger Lakes Migrant Health Care Project, Inc. to operate as Finger Lakes Community Health.

Brief History

As detailed in Part 1, Finger Lakes Migrant Health Care Project (FLMH) and Yates Family Planning (YFP) merged to form Finger Lakes Community Health, Inc. (FLCH). The new, merged organization is an FQHC that operates 10 health centers, three of which are certified as a Level 3 patient-centered medical home, and serves over 17,300 patients each year through more than 66,400 visits for primary care, Title X family planning services, mental health, case management, and/or dental care. Nurse practitioners and physicians provide medical services while nurses, health educators, case managers, medical assistants and front desk staff provide intake, counseling, education, labs, and routine STD/HIV testing.

Across all health centers, approximately 2,750 Title X patients are reported making approximately 3,000 visits annually. Nine of the 10 health centers integrate family planning services into primary care visits, and long acting reversible contraceptives (LARC) are offered at all but two health centers.

Prior to the merger, YFP operated four Title X-funded health centers solely devoted to family planning and sexual health care. Women's health nurse practitioners provided clinical care and support staff provided counseling, education, testing, and outreach.

FLMH was an FQHC offering primary and dental care. Because of the Migrant Health program, FLMH was accustomed to providing intensive counseling and education, and bilingual staff were essential in the provision of culturally competent services to the predominantly Spanish-speaking migrant populations. Many patients were seen on location at their migrant camps rather than at a health center. With this model serving a specialized population, approximately 90% of patients were uninsured because of their undocumented status, and no one under 19 years old was charged for services.

Implementing the Merger

To implement the merger, FLCH had to physically integrate the two agencies, address legal issues associated with the merger, and implement organizational and operational changes necessary to complete the merger. (Part 1 provides more detailed information on how the organizations made the decision to merge).

Physical Changes

The physical merging of health center sites happened very quickly.

- September 2009: the boards of directors of YFP and FLMH approved the merger.
- November 2009: FLMH received emergency approval from the New York State Department of Health to take over YFP operations, including billing and payroll, and the staff was informed of the decision to merge.
- Early 2010: the new organization began to legally operate as Finger Lakes Community Health.
- March 2010: former YFP Geneva patients were being seen at the FLCH Geneva health center.
- April 2010: YFP Geneva health center closed.

As seen in this timeline, each entity had a health center located in Geneva. As a part of the merger, it was decided that services would be consolidated and provided at the FLMH location. There was anecdotal evidence that the move may have negatively impacted access for some patients, particularly teens. However, the FLMH facility was larger with more capacity to accommodate staff from both agencies, with room for growth.

Legal & Regulatory Considerations

Immediately after the boards voted to merge, Marty Blumenstock, the YFP executive director, engaged her contacts at the state who were very supportive. She worked with state technical and finance personnel who agreed to assist with the merger.

In contrast to the physical merger, the formal state approval processes were so cumbersome that the official organizational merger was not completed until nearly two and a half years after FLMH took over operations of YFP. New York State has a number of requirements to approve changes in service delivery organizations including licensure requirements. A Certificate of Need (CON) process is required by state law; health care facilities must apply for a CON for modifications including service

changes, ownership, and construction-related issues. Other requirements at the local level include facility inspections and other health and safety requirements.

Organizational & Operational Changes

Organizational changes to employment structure and staffing were necessary to accommodate staff from both agencies and to implement the necessary operational changes to complete the merger. Prior to the merger, Mary Zelazny and Marty Blumenstock, executive directors from FLMH and YFP respectively, kept a running list of what needed to be done to make the merger happen (**W2a & W3a**). Health center operations were adjusted to ensure that both Title X and section 330 grant requirements were being met and patient care standards were maintained. The executive teams at each health center were given the responsibility of operationalizing the merger, but since the physical merging of health centers happened so quickly there was little time to plan implementation. This meant that many operational decisions were made "on the fly," including decisions on staff training, data reporting, and billing processes. These changes had an impact on patients and agency culture.

1. Employment Structure

As part of the merger agreement, most of YFP's staff, including clinicians, were brought over into FLMH, which soon began operating as FLCH. This meant many changes for YFP staff related to compensation, benefits, and their roles in the new organization.

YFP employed 13 staff members at the time of the merger, and it was relatively easy to bring them to the 100-person FLMH system. There was an initial shifting of roles to avoid duplication of effort and to fit the operational model of an FQHC (e.g., "patient services representatives" became "receptionists" or "front end operations managers") and most staff were accommodated. There were staff resignations, which is to be expected in any merger; two YFP nurse practitioners left the agency to pursue other ventures.

Initially after the merger, there were two medical directors, one women's health clinician from YFP, and an internal medicine doctor from FLMH. The medical director from YFP left the agency to pursue private practice; this change in credentials of the agency's medical director negatively impacted reimbursement rates for family planning services. In the four years since the merger, FLCH has had three different medical directors, all with a primary care background.

Salary and benefit changes for YFP staff included different health insurance through FLCH, an adjusted pay scale, and changes in fringe benefits. FLCH had to find a way to compensate for YFP staff's earned time off and sick time, and how to switch the retirement program from a 403B matching program to a 401K. Some staff members had been working with YFP for more than 20 years, so staff were grandfathered into FLCH in terms of their time worked in the organization, which meant they were able to accrue earned time off at the rate of long-term staff. In addition, FLCH opted to financially compensate YFP employees for accumulated paid time off and start the accrual process fresh in the 2010 calendar year.

2. Staffing Changes: Roles and Responsibilities

One of the biggest shifts for FLCH clinicians was that they were expected to provide all available services (with the exception of dental). Originally, Title X-funded services were going to be housed in a family planning department within FLCH. However, once the health centers merged, Zelazny decided to integrate Title X services rather than establish family planning departments with women's health clinicians at each health center. She felt strongly that integrating Title X would enhance the reproductive health services already being provided, and there were not enough trained women's health clinicians on staff to provide specialized Title X family planning services at each health center. As a result, all YFP clinicians were expected to provide primary care, and FLMH clinicians were expected to enhance the provision of family planning services and documentation to adhere to Title X regulations. This new model of service provision contributed to the culture shift following the merger.

Another important staffing shift was when Blumenstock, who had been acting in a consultant role since the merger took place, retired in September of 2010. After she retired, there was no one designated to exclusively oversee the Title X program. The responsibilities of the position were split between program management and billing, but the limited time allotted for Title X coordination presented a challenge for staff and resulted in a slow decline in the number of Title X patients being reported.

In addition, FLCH had three different medical directors in the four years following the merger, and none of them supported or promoted the Title X program. Given the shortage of clinicians who are willing to work in an FQHC in upstate New York, Zelazny has been reluctant to compel medical directors to ensure complete integration of the Title X program. This meant that providers did not receive enough support and guidance to ensure that they understood the importance of providing family planning services in accordance with Title X regulations, completed the necessary documentation to bill for those services, and counted the patients and visits for the Family Planning Annual Report (FPAR).

In February 2012, a former YFP employee was named family planning program coordinator. This shift in infrastructure to expand internal capacity to manage the Title X program meant the program coordinator could devote more time to quality assurance initiatives including developing data system improvements and increasing clinicians' ability to capture the data elements required by Title X.

3. Data Reporting & Billing

It is challenging to merge Title X and section 330 data reporting and billing processes, in part because of the extensive documentation and unique reporting elements required by Title X and the differences in fee scale requirements. Changes needed to be made within the EHR system, including how it handled lab results and the sliding fee scale, and to billing practices to assure adherence to program guidelines and regulations.

Electronic Health Records

In 2010, soon after the merger, FLCH launched a new EHR system, eClinicalWorks (eCW). Implementation of the EHR was planned before the merger was discussed, so staff from YFP did not have the opportunity to provide input to ensure the system had the capacity to capture Title X data requirements and bill for services. Prior to the merger, FLMH was using a practice management system, and YFP was using the Ahlers system for reporting.[17] Since there was not sufficient time to adapt the new EHR system between the merger and launching the new system, Title X data continued to be captured using paper encounter forms and entering data into the Ahlers system after the EHR was in place. This was problematic because many clinicians were resistant to completing paperwork in addition to entering data into eCW.

In 2011, FLCH adapted the progress notes in eCW to include Title X data components, which still involved a lot of effort to check the progress notes for accuracy. In 2012, eCW was adapted again to have a separate section for Title X data, but some of the questions are duplicative and clinicians still struggle with completing all of the documentation required by Title X.

Labs

After implementing eCW, FLCH switched to Quest Diagnostics for their laboratory needs because Quest had the ability to send, receive, and report lab results through an electronic interface with eCW. Historically, YFP contracted with Quest, and FLCH was able to secure the same low rates for lab services that YFP had prior to the merger.

Fee Scale

Initially staff used the Title X fee scale for patients who qualified for and received services through the Title X program; and some existing FLMH patients benefitted from a fee scale broader than that used by the FQHC. For example, some FLCH patients who previously had to pay for services were able to receive family planning services at no additional cost. Anecdotally, staff noticed a better show rate among these patients. However, this was a challenging adjustment for FLMH staff who were not comfortable determining what designates a Title X visit or patient. Additionally, the EHR did not allow for more than one fee scale, which made data entry and billing for Title X services extremely confusing.

After months of planning, FLCH launched a single fee scale that combines primary care, dental, and Title X services in May 2013. To develop this fee scale, the family planning coordinator met with the billing manager on a monthly, then on a weekly basis. Initial staff training was conducted through individual in-person meetings, then through half-day group trainings. Providers were trained next and the fee scale was launched in May 2013.[18] A combined fee scale that met both Title X and section 330 requirements had to slide all the way to $0 and had to provide discounts to patients up to 250% of the federal poverty level at incremental levels (**W3b**). In addition to developing the fee scale, FLCH had to determine when it was appropriate to use the family planning sliding fee scale. The adopted protocol established that anyone who received family planning services qualified for a discount on the sliding fee scale regardless of other services provided.

Billing

Integrating the programs also meant changes in billing practices and reimbursement strategies. To assist the staff in determining which patients qualified for Title X services and how to bill for services, the two operations managers from each original agency created flow charts for the staff to use (**W3a & W3b**).

The organizations also had to address differences in insurance contracts and billing. While FLMH had been billing insurance for years, YFP had contracts in place with their insurance plans that allowed billing of modifier codes, billing for lab draws, and higher reimbursement rates for family planning visits. After the merger, YFP was billing under the medical director of FLMH and then FLCH, who was an internal medicine doctor. Suddenly, some family planning services were not being reimbursed at the same rates, or at all, because the agency was billing under a different medical director with different credentials. Attempts to renegotiate these contracts have not yet been made.

4. Patient Experience

The changes that had the largest impact on patients were appointment scheduling, the availability of supplies and medications, and confidentiality.

Scheduling

The primary change for patients associated with the merger was that they gained access to an expanded set of services. New services also meant a new way of scheduling patient visits and reorganizing the visit flow. The duration of appointment times were decreased; established patients were scheduled for 20 minutes instead of 30, and new patients would have 40 minutes instead of 45. During each visit patients are screened for both primary care and family planning needs. Registered nurses and non-clinical staff conduct intake with patients, provide counseling, education, STD and pregnancy testing, rather than the clinician doing all parts of the visit. Birth control and emergency contraception visits need to be accommodated the same day rather than scheduling them for the next appointment, which might be up to two weeks away.

With these efforts to streamline visit flow, clinician time was also adjusted. This meant that when patients requested specific family planning clinical staff, the particular clinician was not always available. This was especially problematic when the clinician who was available was not completely comfortable with providing and documenting health services in accordance with Title X guidelines.

In Geneva, the YFP health center closed and all staff members from YFP were brought into the new FLCH health center across town, so patients had to adjust to the new location, and new staff. Patients were notified of the merger and the change in location by phone.

Supplies & Medications
In addition to reorganizing visit procedures, it took about one month to smooth out how medications were to be distributed, including dispensing emergency contraception (EC). Prior to the merger, YFP dispensed medications, condoms, and birth control supplies at the front desk as prescribed by a clinician. After the merger, the FLCH policy was that no supplies or medications, including EC, were to be dispensed at the front desk, but rather as part of a clinician visit. New policies and protocols were developed, and now contraceptive refills or medication pick-ups are scheduled with a clinician who can approve the order. A nurse then facilitates the order by preparing the prescription label and packaging it. When a patient arrives for pick-up, the front desk staff notifies a nurse, who brings out the prescription for the patient.

Dispensing EC was more complicated because the FLCH medical director would not approve dispensing it over the counter. Instead, all patients who needed EC had a visit with a clinician, which often meant walk-in patients had to wait until a clinician was available for a visit. FLCH "acute" appointment timeslots are provided each day specifically for walk-in patients who need to see a clinician. If a clinician is not available, a nurse will contact a clinician at another FLCH health center who can review the patient's chart, approve the order for EC, and complete the necessary documentation in the EHR so the EC can be dispensed.

Confidentiality
In most of YFP former health centers, like Penn Yan, primary care services were added, and there is now a shared waiting room for family planning patients and patients seeking primary care services. Initially some YFP staff were concerned that family planning patients, particularly teens, would lose anonymity because more patients with different needs would be in the waiting room and there was a higher likelihood of a patient encountering someone familiar. Other staff believed that there was increased anonymity with the FQHC model because patients could be seeking any type of service, not just family planning. While anecdotal evidence on patients' perception regarding confidentiality in the waiting room is mixed, no formal data has been collected.

In addition, the way eCW is set up for FLCH, Title X patients are not separated out, which could compromise confidentiality. To prevent this, staff print out the entire record and black out anything related to family planning when someone besides the patient (i.e. parents or a partner) requests medical records. Insurance billing is also a challenge for this reason. To ensure that an explanation of benefits (EOB) is not sent home if the primary policy holder is not the patient, staff can request a "good cause waiver" from New York Health Options[19] that is good for one year, and allows the state's family planning waiver to be billed for family planning services. As a result, the private insurer is not billed and no EOB is sent.

Agency Culture Change

As is the case with most organizational changes, the merger caused significant culture change as services were integrated and operational differences were addressed. The culture had to change in day-to-day operations and how Title X services were integrated into existing programs. The agency supported the staff to make these changes and to adjust to a new agency culture.

Day-to-Day Operations

The executive director was confident in her operations personnel and granted complete control of how service delivery and day-to-day operations were integrated. While this meant staff was provided with little guidance as to how to integrate the programs, the operations teams were given total autonomy. As a result, how services were provided and integrated varied depending on clinician skills and patient needs.

Both organizations had dedicated and committed staff, but naturally there were disagreements over "how we do it" as new operational systems were put into place and staff was trained on existing protocols. For example, some staff were uncomfortable providing EC to teens or making condoms available in the waiting rooms. YFP staff were instrumental in training FLMH staff on language, process and attitudes, and helping them adapt to distributing EC and condoms to family planning patients.

In addition, since all YFP staff members were brought over in the merger, the physical health center space became more crowded at each location. While this physical closeness enabled the staff to work together and use each other for support, the tight quarters contributed to the tension associated with working out operational differences and agency culture change.

Integrating Title X Services

YFP staff and clinicians needed to adapt to providing primary care, and FLMH staff needed to understand what makes a Title X family planning visit and learn Title X "language." For instance, when someone calls for "a check up" s/he might be asking for STD testing rather than an annual physical. Several clinicians, including the medical director, were resistant to accommodating the rigorous documentation and reporting requirements

for Title X into primary care visits. As a result, staff would often make appointments for patients who specifically had family planning and sexual health needs with the former YFP staff. This practice meant that Title X services were not fully integrated into operations, creating a separation within the organization of Title X services and primary care.

The changes in appointment scheduling created a culture shift, too. YFP staff and clinicians were used to spending 45 minutes with new patients, but section 330 clinic efficiency standards call for shorter visit times to streamline patient flow. This can be difficult when adhering to Title X's extensive counseling and documentation requirements, so staff had to adjust their expectations as well as their visit flow. To help staff adjust to this change, onsite training for front desk staff was expanded from one day of learning and observing, to one full month of support and training. In particular, a shadowing component was added to the curriculum to allow new staff to experience what happens during each step of a patient's visit.

Support for Staff

Having champions of the programs is an essential element to making changes within an organization. To support the staff through operational changes and the associated culture shift, operations managers from both original agencies maintained a "get it done" attitude and were accessible to provide ongoing support. One of the key operations staff from YFP made herself available in person and on the phone throughout the implementation process to answer questions, most of which were related to the Title X program. One staff member reported that it was extremely important to have this "help line" she could call any time of day to have her questions answered.

Outcomes

While this merger between a Title X-funded agency and an FQHC achieved financial sustainability for the Title X program and the FQHC, there are still operational adjustments needed to fully integrate both program standards and regulations.

Financial Sustainability

YFP made the transition to a financially viable organizational model by combining operations with a larger and more stable organization. Title X services continue to be available in all of the same communities, and to even more patients.

Expanded Services

Patients from FLMH and YFP have access to additional services under one roof, offered in more health centers from their established providers. FLCH expanded operations to provide culturally competent services with bilingual and multicultural staff in more communities, and migrant farm workers have access to Title X family planning services onsite at their migrant camps.

Documentation & Reporting

Despite these positive outcomes, the number of Title X patients reported receiving services in the Finger Lakes region has decreased since the merger. A slight decrease in patients is always expected when major change occurs in an agency, such as relocating a health center or merging with anther organization. However, rather than an actual decline in the number of patients who are receiving Title X services, this reported decrease is a result of underreporting, as many clinicians are still resistant to completing the documentation required by Title X. In addition, since eCW has not been configured to ease entering Title X data components, a significant amount of time must be spent completing the appropriate progress notes and entering FPAR data manually.

Reflections

Important lessons can be learned from the YFP and FLMH merger experience. The merger of two organizations is often difficult and typically takes time for all involved to fully acclimate to a new environment. FLCH has made great strides to integrate the programs over the last few years and lessons learned through the experience offer insight on challenges and how a tenacious and committed staff is an invaluable asset.

Oversight

Merging two organizations is challenging and the requirements of the Title X and section 330 programs add complexity. The biggest challenge FLCH faced is that the amount of work to coordinate the Title X program within the agency was underestimated. Improvements have been made since a designated family planning (Title X) program coordinator was named and given ample time to manage the program, however, some clinicians are still resistant to Title X documentation. Consequently, patient numbers, services, and visits continue to be underreported. Developing an EHR template for Title X services to streamline documentation and support clinicians' ability to manage visit time is a top priority for the family planning program coordinator.

Preparation

Because the executive directors were highly motivated and New York State was supportive, the decision to merge and subsequent administrative merger were quick. This meant that decisions about operational components such as the different fee scales, third-party billing for services, medication disbursement, EHR documentation, lab services, and appointment scheduling were decided upon and implemented after the physical merger, which was stressful for staff and patients, and resulted in initial underreporting and loss of third-party revenue.

Training

There were few opportunities for formal training to ensure the two staffs understood each organization's protocols and grant requirements prior to the physical merger. This meant that Title X requirements and regulations were often being explained to FLMH staff as a patient was on the phone or in person. FLMH staff who were interviewed expressed that this type of individual, ongoing support, including access to a

YFP staff member, was essential to their ability to offer Title X services to patients after the merger. For example, when staff reported a need for clarification on what makes a Title X family planning visit, two decision-making flow charts were developed to assist with determining if a patient qualifies for Title X services and billing (**W3a & W3b**). Additional upfront training on the nuances of the Title X "language" and billing and reporting requirements would have been helpful. At the same time, the women's health clinicians who worked at YFP did not have as much experience offering primary care services and would have benefitted from additional training as part of the merger.

Staff Involvement

Again, there was little time for staff to prepare for the pending culture change of the organization and to plan for operationalizing the merger. Staff members were informed several months prior that the merger would take place, but the timeline was dependent on approval from the New York State Department of Health. Once temporary emergency approval was granted, there was an all-day staff meeting held in November 2009 to bring the staffs of both agencies together. Another all staff meeting was held during the following summer and staff reported that these were extremely valuable meetings. Staff who were interviewed indicated that more trainings and meetings that included all staff members would have been welcome by the staff teams. Additional meetings would have improved staff understanding of the Title X program, ensured their commitment to integrating the program, and provided needed support to adjust to the inevitable culture shift.

Despite the articulated desire for earlier involvement in the merger process, the staff demonstrated a strong commitment to navigating the organizational changes to ensure patients' needs were met. Over time, day-to-day operations were streamlined and improved due to a staff willingness to communicate, adjust, and work together to achieve common goals. The flexibility and autonomy given to staff to operationalize the integration created an environment where solutions could be quickly identified and implemented as needed.

Patient Awareness & Access

There was little marketing to promote the merger and, in some cases, the relocation of YFP health centers. This was likely a function of how quickly the merger took place and an attempt to be sensitive to the potential negative reaction of some community members about family planning services being brought into the FQHC.

Some staff were concerned that patients were not aware the merger happened, that new services were available and, that some health centers had moved. All patients were called on the phone, some brochures were updated, ads that were sent out did not always highlight family planning services, and there was one press release announcing the merger in October of 2009.

Despite these targeted efforts, most patients were not aware of the expanded set of services until they came in, and it is possible some patients did not return as a result of the relocation or the presence of new providers. In particular, there was concern that fewer teen patients would access services at the Geneva health center because it was farther from the high school than the YFP health center had been. As part of continued quality assurance efforts, FLCH's family planning program coordinator is developing a patient survey that is specific to the family planning program to evaluate patient satisfaction regarding available services and service delivery.

The Transition: Westside Family Health Center

This section details how Westside Family Health Center (WFHC) evolved from a small Title X-funded women's health center into an FQHC by gradually adding services in response to patient need.

Brief History

WFHC is an FQHC with reproductive health services provided through a Reproductive Health Department and incorporated into Family Practice, Prenatal, and Pediatric Departments. WFHC is based out of one health center in Santa Monica, California, and has two satellite sites and a mobile medical unit that provides clinical services and educational workshops at seven locations, most of which are local high schools and mental health centers. The organization serves more than 9,500 patients from 248 ZIP codes through almost 31,000 visits each year. Of these, 5,600 are Title X patients. All forms of birth control are offered including long-acting reversible contraceptives (LARC).

Implementing Look-alike and FQHC Requirements

Most of the changes that are necessary to transform a Title X health center into an FQHC (e.g., primary care services and board membership composition), were made over many years in response to community needs. This created an infrastructure that allowed WFHC to ultimately obtain an FQHC designation. (Part 1 provides details on the decision to become a look-alike and then an FQHC).

Organizational & Operational Changes

While the health center has not moved locations, physical expansion of the site has been necessary to accommodate additional staff and new services. No legal issues were encountered as the health center expanded services, and all appropriate changes were made when Westside Women's Health Center legally changed its name to Westside Family Health Center in 2001.

The following details how WFHC changed in each phase of expansion, how Title X services are integrated, data reporting and billing practices, and the patient's experience.

1. Expansion

To get a complete understanding of how this Title X-funded agency made the transition to become an FQHC, it is important to examine the service changes that were made prior to the decision to apply for section 330 funding. Since the health center's service delivery model has changed gradually over 35 years, some institutional memory has been lost, but there is still much to learn from how changes were implemented when the health center added prenatal care, pediatrics, and family practice; became an FQHC look-alike; and ultimately a New Access Point FQHC.

Prenatal Care

In 1990, WFHC began offering prenatal services in response to patient demand. To implement the prenatal program, WFHC employed women's health nurse practitioners, who provided prenatal care. These clinicians would see patients until the end of their pregnancy at which point they would be referred to a doctor who maintained a working relationship with the health center. This small program evolved when the midwifery program at University of California, Los Angeles (UCLA) contracted with WFHC to be a training site. All of the nurse midwifery students were required to do a rotation at the health center under the supervision of a licensed nurse midwife professor. The students were paid through a grant from UCLA. This was a mutually beneficial relationship because patients were happy to be able to give birth with the same team they had been seeing throughout their pregnancy and, since the nurse midwives were training through UCLA, all patients gave birth at UCLA Medical Center. When UCLA lost this grant, WFHC offered to pay the nurse midwifery students to continue the relationship. Now, WFHC contracts with Eisner Pediatric and Family Center nurse midwives to provide prenatal care at WFHC.

Pediatrics

In 1992, WFHC hired a pediatrician and a pediatric nurse practitioner who were able to see patients eight to 12 hours each week. In the early 2000s, WFHC saw a 15% decrease in pediatric patients as patients took their children to area providers due to a shift in Medi-Cal from fee-for-service to a managed care reimbursement model. When WFHC contracted with a new community health center-specific Independent Practice Association (IPA), Healthcare LA, in 2007, the number of pediatric patients coming to WFHC stabilized, and even increased by as much as 28% one year. This increase is partially attributable to the need for vaccinations.

As pediatric patient numbers and needs have increased over time, it has been necessary to expand the program to 32 hours per week. In addition to the pediatric nurse practitioner who took on more hours, the WFHC medical director and a family nurse practitioner also see pediatric patients.

Adolescent Health

In 1996, WFHC launched an adolescent reproductive health program in response to the high teen pregnancy rates in Los Angeles County. Recent college graduates were hired and trained as outreach & education workers and community health workers, and they ran a teen clinic twice a week with a family planning nurse practitioner. Now adolescent health is integrated into health center operations and WFHC operates a mobile unit where services are provided onsite at seven local high schools.

Since all California residents under 18 qualify for the state's Medicaid family planning program, Family PACT[20] (Family Planning, Access, Care, and Treatment), all services are covered by this state program and private insurers are not billed. This means there are no confidentiality concerns regarding EOBs or parents otherwise being informed by a third party of services rendered.

Family Practice

The effort to provide primary care came after the WFHC Board of Directors considered and rejected a merger with Venice Family Clinic in 1998. (Part 1 provides information on the decision not to merge with VFC).

In 1999, WFHC received $75,000 from Los Angeles County for adult medicine that was available as part of the public-private partnership initiative started by the Clinton administration. The grant was intended to serve low-income and uninsured populations. That same year, WFHC hired a new president/CEO, Debra Farmer, who began building the agency's administrative capacity through hiring a director of finance, a director of clinical services, and a clinic manager. Prior to filling these positions, the agency's infrastructure was much more informal, and could not keep pace with the rapid expansion of services and programs. These new administrative positions and personnel were critical to the stability and continued growth of the organization.

In 2000, WFHC launched the Family Practice Program and hired its first full time physician to oversee the program. WFHC now receives almost $350,000 annually for adult and family medicine through Healthy Way LA.[21]

Look-alike and New Access Point Section 330 Funding

In 2004, Los Angeles County approached WFHC and urged the health center to become a strategic partner to provide safety net health services in the region.

The county provided funds for a consulting team to complete the FQHC look-alike application, and later that year, WFHC was granted look-alike status. One year later in 2006, WFHC applied for a section 330 grant and was funded as a New Access Point in 2007.

WFHC had already made many of the operational adjustments that are required to transform from a Title X-focused agency to a primary care look-alike such as the addition of primary care services, which began with a shift toward hiring family practice clinicians when women's health practitioners left the health center. Now, physicians and family nurse practitioners provide clinical services, and all support staff, including outreach workers, are cross-trained in clinic operations to ensure smooth site operations and consistency for patients.

The biggest adjustment for WFHC was complying with the FQHC requirement to maintain a board membership composition of at least 51% consumers. This transition was difficult because it was challenging to recruit patients with the set of skills required to fulfill board member expectations. However, over the years WFHC has found that while patients on the board may lack financial, policy, and administrative experience, their ability to "speak the patient language," literally and figuratively, has been invaluable. For example, WFHC has a native Spanish-speaking board member for the first time. While participation was initially limited, this board member has become more active and offers a vital perspective. To help new board members succeed, WFHC staff and clinicians work to prepare patients before board meetings to increase their capacity to participate in a meaningful.

To support the agency's transformation to an FQHC, WFHC hired a consultant to develop a board training and revise the board of directors' guidelines to ensure compliance with section 330 regulations. Board members are required to complete a self-assessment each year to confirm they understand their roles and the regulations to which they must adhere to uphold agency standards and comply with regulations (**W2b**).

2. Title X Services

WFHC's ability to maintain Title X funding, and keep up with reporting and documentation requirements, through all of the agency's changes has been largely due to how the agency uses these funds, and supplements program activities with other sources of funding.

WFHC uses the majority of its Title X funds to support clinicians who provide family planning and sexual health services. WFHC does not use Title X to support a large proportion of patient visits and services because California has multiple programs that subsidize health services. Medi-Cal, the state Medicaid program, covers low-income residents, 17 years old and under, and undocumented residents. Healthy Way LA provides the same type of coverage for Los Angeles County, and many patients qualify for Family PACT. When possible, it is more cost-effective to use other payment sources to cover visit costs because WFHC receives approximately $24 per visit when the Title X sliding fee scale is used, but the actual cost per visit is closer to $160. With these other sources to pay for patient visits and services, the Title X sliding fee scale is for patients who do not qualify for or refuse to participate in the state public assistance programs, and are therefore dependent on Title X to cover the cost of services. For this reason, Title X continues to be an essential safety net for low-income and uninsured populations.

WFHC purchases all contraceptives as well as some medications and vaccines through the 340B program. Some medications are procured through various pharmaceutical companies' Patient Pharmaceutical Assistance Programs (PPAP). Patients who are eligible for the PPAP receive assistance signing up, and are eligible for free medications which are dispensed through WFHC. All other medications are purchased through a vendor with appropriate pharmacy labeling for individual dispensing. Occasionally bulk drugs are purchased but require repackaging for individual dispensing, which adds to the cost.

Despite the fact that multiple sources of funding are available to subsidize services and supplies that have historically been paid for with Title X dollars, WFHC must still adhere to program guidelines. With its foundation in sexual and reproductive health, the health center continues to prioritize the Title X program, so new work plans were recently created to ensure adherence to both Title X and section 330 requirements.

3. Data Reporting & Billing

Advances in electronic systems and information technology over the past 10 years have improved data reporting and billing systems capabilities. WFHC has adapted by implementing an EHR system, using a unified section 330 and Title X fee scale (**W3b**), and adapting billing and reporting practices to ensure compliance with state, section 330, and Title X regulations, as well as ensuring reimbursement for services.

Electronic Health Records

As billing and reporting became more complex, WFHC implemented an electronic practice management system in 2000. With this system, the health center began cross-training all staff and implemented a centralized registration process to streamline patient scheduling and improve clinic efficiency.

In August 2013, WFHC implemented eClinicalWorks (eCW), an EHR system with advanced billing and reporting capabilities. The philosophy driving the implementation of this system was that it was not an IT project but an agency-wide effort to improve clinical services and patient care. Use of a team-based approach and outside expertise made the transition smoother than expected. Clinicians developed the electronic templates to include essential clinical components and the required documentation for Title X and the section 330 grant. The California

Family Health Council, California's Title X grantee, provided critical support to design the necessary background mapping in eCW to extract FPAR data and use the sliding fee scale to ensure adherence to both Title X and section 330 regulations.

Even with this new EHR system in place, clinicians report that it still takes approximately 10 minutes to complete the documentation for a visit and ensure that all reporting requirements have been met.

Fee Scale & Billing
For many years, WFHC used straightforward fee-for-service billing and the Title X fee scale without the need to contract with private insurers. The vast majority of WFHC patients are eligible for California's Family PACT, which covers a set of public health subsidy programs and services. Therefore, the health center could simply bill the appropriate state program or use the Title X sliding fee scale (**W3b**).

After implementing the Family Practice Program in 1999, WFHC's patient population became more diverse and WFHC needed to diversify funding streams and sought to position itself to be eligible for the growing managed care market in California. In 2007, Healthcare LA built a specialty care network on the Westside of Los Angeles enabling WFHC to contract with Medicaid Managed Care for a capitated rate. The rate was set at $47 per visit, which when combined with the capitated payments was reconciled annually to a Prospective Payment System (PPS) rate of $119 per visit. This is a much higher reimbursement rate than the average $24 per visit collected when using the combined section 330/Title X sliding fee scale. The capitated rate increased recently following a rate-setting review.

After securing look-alike status, WFHC dedicated one staff person to working with the IPA around credentialing and billing. Today, WFHC still does not contract with private insurers because of the complexities of the billing processes, and because the vast majority of health center patients either qualify for one of the many public assistance plans, including Title X and section 330, or pay full fee. Prior to becoming an FQHC, 96% of WFHC patients were uninsured, and now approximately 86% are uninsured. Projections indicate that 55% to 60% of uninsured patients will become eligible for Medi-Cal in the coming years.

WFHC uses the Title X fee scale for all patients receiving family planning services at separate family planning appointments. While family planning is incorporated into FQHC operations, patients are scheduled for separate visits to meet their family planning needs. The sliding fee scale is always used to charge Title X patients who wish to pick up supplies or medications if a visit is not necessary.

Reporting
When WFHC became an FQHC, it was required to complete Uniform Data System (UDS) reports for HRSA. Due to a difference in use of terminology and definitions, there was a learning curve as to the intricacies of data collection. For example, during the first year of funding, WFHC mistakenly counted clinical visits, lab visits, and counseling visits as medical encounters rather than just clinician visits. As a result, the health center's patient and visit numbers were inflated. WFHC adjusted its work plan for the following year to more accurately indicate lower projected numbers of patients and visits. Despite this initial over-reporting of patients and visits, WFHC has since secured a 5-year section 330 grant.

4. Patient Experience

WFHC made operational adjustments to scheduling, confidentiality, and quality improvement to ensure adherence to both Title X and section 330 regulations:

Scheduling
Patients often come to WFHC with multiple medical needs and, because of payer regulations, different appointments need to be scheduled for patients who need to pick up birth control supplies or other specific family planning and sexual health services. When not all medical needs can be addressed in a single visit, each patient is assigned to one provider to manage his/her care and respond to the patient's needs. To address FQHC efficiency guidelines, WFHC shortened visit times and added clinic hours to expand access to services. These changes have contributed to a shift in agency culture that patients have had to adapt to, which is discussed in detail below.

Confidentiality
With Title X services integrated into an FQHC setting rather than being provided in a standalone facility, confidentiality, especially for teens, became an issue. There is a perception that teens will feel uncomfortable in the waiting room of a multi-service health center because there is a possibility that they will encounter someone who would tell their parents they were at the health center. This is not as big a concern at a teen clinic, or a dedicated family planning health center. Historically, WFHC held a teen clinic twice each week, but teen services are now offered throughout the day. In addition, WFHC operates a mobile medical unit, paid for with ARRA funds that services seven area high schools and two other service providers in the county. WFHC is one of two health centers that provide family planning and sexual health services in the school systems; all other providers have a primary care focus. The mobile unit offer teens another option to obtain services if they are concerned with being seen at the health center location.

Quality Improvement
Most operational changes have an impact on patients so quality improvement (QI) efforts are in place to ensure a high level of patient satisfaction and adherence to both Title X and section 330 regulations.

WFHC formed a Quality Improvement Committee made up of the chief operations officer, the medical director, the director of community outreach & education, the director of clinical services, nurse practitioners, physician assistants, and community health workers from each department. This committee uses a "Plan, Do, Study, Act" (PDSA) model for implementing changes, which involves testing new

ideas before full implementation. This method of initiating changes helps staff understand their role and participate in implementation (**W3a**).

WFHC is shifting the agency's QI focus from chart reviews to data and performance measures. Data from QI efforts are often used when discussing changes with clinicians and staff so they are aware of the trends in patient data, financial changes, etc., and can understand why changes need to be made.

Agency Culture Change

While WFHC maintains its founding purpose to provide services in the context of the women's health movement, the culture of the agency has evolved along with the many organizational changes. Redefining agency culture is often one of the most difficult things to address when organizations make dramatic changes. The changes at WFHC affected patients and staff, and the agency employed strategies to help these constituent groups adapt to the shifting agency culture.

Patients

The culture has shifted for patients as the agency transitioned from a women's health-centered model to a multi-service FQHC with a primary care focus. For example, some patients who were used to the health center predominantly serving women and girls were not comfortable seeing men in the waiting room, and there were complaints when the agency launched the Family Practice Program. Staff explained the benefits of having more services under one roof, and most patients' expectations adjusted.

After becoming a look-alike, patients needed to adjust to shorter visit times; a change that was not met with enthusiasm. However, with longer clinic hours each day and weekend availability, patients have more options when making appointments. To help patients understand all of the changes, WFHC developed a Patient Handbook to explain patients' rights and responsibilities along with what the health center offers.

> "Without change there is no movement."
>
> – Shirley Ho, Women's Health Nurse Practitioner, WHFC

Overall, since WFHC became an FQHC, patients report being happier because there are more services available to them under one roof, and in a familiar place that they know and trust. WFHC still strives to be patient-centered and uses positive, fun in-reach to communicate to patients and inform them of changes. For example, for weeks prior to launching the new EHR system, WFHC advertised the "Big Bang" through newsletters, posters, and flyers, so patients were well prepared when it happened.

Staff

As the service delivery model shifted over the years, WFHC did not reorganize the staffing structure by firing employees, but instead took the opportunity to fill positions with staff and clinicians with different skills and training whenever employees left the agency. Employees who chose to leave the agency because they were uncomfortable with the changes were replaced by staff/clinicians with skills that were a better fit for the new service model.

In becoming an FQHC, the staff needed to adapt to offering new services, longer clinic hours, including working on some weekends and holidays, and a more diverse patient population. To help staff adjust to agency culture change, the executive and administrative teams at WFHC used many forms of communication, including regular e-blasts and newsletters, paired with internal support and training opportunities.

- Daily team huddles where staff meet briefly to discuss a patient's needs and attempt to minimize the number of appointments s/he needs.
- Monthly clinician meetings at which the chief operating officer and medical director meet regularly with all clinicians. This has been essential in on-boarding new providers, and ensuring that providers are a part of operational decisions and implementation processes (e.g., EHR, patient-centered medical home model).
- All new staff and clinicians spend a minimum of one full week shadowing and being observed. In addition, the director of community outreach and education conducts a full-day training with family planning and sexual health-focused content with all new staff.
- The California Family Health Council, the Title X grantee, offers trainings that staff attend. WFHC's medical assistants and community health workers go through the Community Health Course, which provides education and counseling training.
- WFHC uses "Relias/Elevate" online trainings. All staff are required to attend a minimum of one online training each month.
- Each year, staff complete an individual self-assessment as part of their annual job assessment.
- The executive director meets individually with each staff member outside of their annual assessment.

In addition to training and individual support, WFHC recognizes and rewards staff. All senior staff have blank note cards and they handwrite impromptu notes to staff to acknowledge a job well done. If patient and/or visit goals are met, staff is rewarded with access to prime parking spaces and money is given out for the staff member of the month, quarter, and year. Staff members are also recognized on birthdays and anniversaries of dates of hire.

Outcomes

Becoming an FQHC has had positive outcomes for the agency's sustainability in a changing health care environment, including new funding opportunities and a more diverse patient mix.

New Funding Opportunities

At an administrative level, there is an enhanced sense of pride and credibility that comes with FQHC status. This designation brings new opportunities to diversify funding streams and raise money for the health center. WFHC is now better positioned to apply for other funding (e.g. the HRSA Outreach and Enrollment grant) or other resources that may only be available to FQHCs. Additionally, FQHC status affords WFHC increased reimbursement rates through the IPA and Medi-Cal.

FQHC status is also appealing to private funders, which is important because private funds are needed to help cover agency costs. Despite becoming an FQHC, and using a multitude of grant funds to pay for services, WFHC raises over $1 million each year in private funds needed to support operations.

As an FQHC, the health center is covered under the Federal Tort Claims Act (FTCA), which provides enhanced insurance coverage for the health center. WFHC decided to get wrap-around coverage in addition to the basic coverage under FTCA, to ensure the agency is well-protected.

Patient Mix

With a wider array of services WFHC brings in a more diverse set of patients who are in need of a variety of different services. This creates a stable platform for WFHC to operate in the environment created by the ACA that champions medical homes and comprehensive service provision rather than specialty care.

The health center still serves many women and girls and more than 58% of patients seen at the health center qualify for Title X services, which represents a slight decrease in the number of Title X patients in recent years. Similarly, while the vast majority of WFHC patients are uninsured, this proportion dropped from 96% to 86% since the agency became an FQHC. This is an indicator that the health center is seeing a more diverse set of patients, and perhaps the services are more appealing to those with insurance.

Reflections

There are key events and factors that contributed to WFHC's successful transition to an FQHC and integration of the Title X program.

Sustainability

The decision to add services to an existing reproductive health program was an effort to respond to patient needs and also served to diversify funding streams to sustain the WFHC patient-centered business model. Complete integration of the Title X program into this FQHC model was possible because of the availability of other funding sources for Title X patients and services. Family planning services for the majority of WFHC patients are covered by one of California's strong safety-net programs, which affords WFHC the flexibility to use Title X funds to build staff capacity and infrastructure.

That the services were added on gradually over the years, and were not accompanied by major restructuring of existing staff, contributed to the feeling that these organizational changes were natural next steps in the evolution of the agency. In addition, integrating new services in response to patient need created a stable supply and demand system for services in the community and put WFHC in an excellent position to apply for look-alike status and then become a full FQHC.

Billing

The IPA provided invaluable support to WFHC in the form of contract negotiations, credentialing, rate setting, and a simplified billing structure for Medi-Cal and other public subsidy programs. As WFHC assesses the changing mix of payers in the community, it will likely become necessary to establish contracts with private insurers, and the IPA will again provide support with contracting and billing.

The complexities of billing multiple sources for patient services involved balancing payer regulations with section 330 regulations stipulating a one-purpose visit. This often meant that WFHC patients need to make additional appointments for services rather than having all of their needs taken care of during one visit.

Staff Engagement

Executive staff made strategic decisions as to how and when to engage other staff regarding changes to operations (**W3c**). While executives ultimately made decisions, staff at all levels were often encouraged to offer input in planning stages and post-implementation. Using a PDSA model to test and assess smaller changes prior to complete implementation is one way staff were involved in operational changes (**W3a**). Being a part of the planning process allowed staff to gain an understanding of why changes were needed and how they would be individually impacted prior to fully implementing the changes. WFHC staff reported feeling that their opinions were valued, which helped ease the transition with operational changes and expectations.

The Subcontract: Family Planning Association of Maine

The Family Planning Association of Maine (FPAM) supported the implementation of a Title X program through subcontracts with four FQHCs. Two of the FQHCs, HealthReach Community Health Centers (HealthReach) and Katahdin Valley Health Center (KVHC), were interviewed as a part of this case study.

Brief History

FPAM was founded in 1971 and is the only Title X grantee in Maine. FPAM funds Title X family planning services in 47 health centers across the state including direct service sites operated by FPAM, school-based health centers, and four FQHCs, which operate 19 health centers in rural areas of the state.

The first two FQHC subcontracts were initiated in 2000 with HealthReach and DFD Russell. Initially the Title X program was integrated into only several health centers at a time, and gradually the FQHCs expanded their Title X programs to all of their health centers. FPAM later contracted with Islands Community Medical Center's Vinalhaven health center in 2003 and then with KVHC in 2010. This incremental approach to adding subcontracted health centers allowed FPAM to develop a standardized approach to implementation that could easily be tailored to the needs of the particular organization and individual health centers.

In 2013, almost 25,000 patients were seen through more than 38,500 visits across all health centers. Of these, approximately 6,000 are Title X patients, and 5,200 are adolescents. (Part 1 provides details on how these contracts were put in place).

Implementing Subcontracted Title X Services

FPAM immediately identified the project director, a champion of the Title X program, to work closely with the FQHCs to develop individualized implementation plans to integrate the Title X program into their health centers. No FPAM-operated health centers were physically integrated with an FQHC health center, rather FPAM's Title X program was integrated into the primary care settings, which required no physical or legal changes. Over the course of 12 years, as the Title X subcontract program grew, the FPAM project director developed systems and approaches to assist with the organizational and operational changes necessary to integrate Title X into an FQHC setting.

Organizational & Operational Changes

The following section details how FPAM supported FQHCs to implement a variety of changes to integrate a Title X program into an FQHC model. Specifically discussed are how Title X services are provided, the support FPAM provides to FQHC staff, and how data and billing requirements are managed.

1. Title X Service Provision

As part of the initial one-year agreement, FQHCs are required to sign both an administrative contract and a clinical contract (**W1a**). In this agreement, a family planning coordinator (FPC) must be identified who serves as FPAM's contact and is responsible for overseeing the integration of Title X into the health centers. In addition to an FPC, KVHC opted to establish an implementation team consisting of the chief operations officer, chief financial officer, clinical coordinator, quality manager, and an IT expert. The designation of an FPC is fundamental to the success of the integration. The roles and expectations of the FPC are clearly outlined in the contract, which sets the standards for accountability.

The subcontracting relationship with FPAM helps the FQHCs to enhance family planning services by improving the patient experience, access to supplies and medications, and confidentiality protocols.

Patient Experience

The integration of Title X services has enhanced the reproductive health services that were being offered at the FQHCs. Staff from KVHC anecdotally report that patient satisfaction has increased since Title X services were integrated in 2010.

Patients now receive more services in one visit. More contraceptives are available onsite at KVHC and are given out during a visit, while counseling and education efforts have focused on engaging males and teens in their health decisions.

All patients are asked more detailed questions about their sexual and reproductive health, and FQHCs report an increased sensitivity to the family planning and sexual health needs of males as a result of integrating Title X. The FPAM project director provided extensive education and training on new counseling techniques to engage males and, as a result, questions regarding sexual and reproductive health are incorporated into every male visit. The male provider at KVHC has embraced the Title X integration effort and incorporated new counseling and education language. He has been instrumental in improving services to males and the number of male patients receiving Title X services increased from 65 in 2012 to 97 in 2013.

Supplies & Medications

Prior to contracting with FPAM, the FQHCs had different methods for dispensing medications and contraceptives. In some health centers, no contraceptives were dispensed and patients were given a prescription to fill at a pharmacy. In other health centers, some types of contraceptives were dispensed. Working with FPAM to facilitate 340B contracts with area pharmacies provided access to a wider variety of methods.

In the case of KVHC, the ability to provide access to a wide variety of

contraceptive options was a big and well-received change. The pharmacy that KVHC worked with in the past to provide 340B pricing was no longer willing to continue with the partnership. The subcontract with FPAM was an avenue for KVHC to work with other pharmacies who would provide 340B pricing so the health center could offer more contraceptives onsite. This was a welcome opportunity for patients and clinicians, who were happy to offer patients with more effective birth control options.

HealthReach already offered contraceptives onsite; contraception is now dispensed and discussed in other health visits as appropriate and during separate contraceptive management visits. In addition, accessing 340B pricing through FPAM stimulated operational changes regarding how the health center purchased supplies. Prior to using the 340B program, items were purchased in large bulk quantities through their central office, which often lead to medications and contraceptives expiring before they could be dispensed. Now supplies are ordered through the 340B program in smaller bulk quantities at the health center level rather than purchasing in larger quantities previously needed to receive discounts.

FPAM has been able to coordinate and offer trainings on LARC methods to the FQHCs, but it has been challenging for clinicians to get enough practice to offer the methods with confidence.

Confidentiality

In some health centers providing confidential services to teens was met with resistance. The FPAM project director discussed the value of counseling patients on parental involvement while assuring confidentiality as needed. She also educated FQHC staff on additional reasons patients may want confidential services, like intimate partner violence or young adults continuing to use their parents' insurance.

In addition to new counseling practices, new systems had to be put in place within the EHR system to ensure confidentiality from insurers that send home an EOB. To address this situation, the FQHCs created a separate record for patients who need confidential services by adding "Confidential" in front of a patient's first name (**W3a**). This means that some patients have two charts. For example, a patient has a regular chart for "Sally Smith" and all confidential services provided are in the "Confidential Sally Smith" chart. The record is locked so insurers are never billed. Instead, services in confidential charts are paid for using the Title X sliding fee scale so EOBs are never sent out. The participating FQHCs have very few confidential records, and the ones they do keep are mostly for teens.

2. Support for Staff

FPAM is committed to being heavily involved in the implementation, integration, and oversight of subcontracted Title X programs to help them develop the infrastructure and internal capacity to provide Title X services. The project director works intensively with each organization and tailors support to its specific needs through provision of education, information, tools, and resources to ensure that staff understand the Title X program and that regulations, including documentation and reporting, are adhered to within the FQHC setting.

FPAM provides FQHC with a "Family Planning 101" session, ongoing support via tools and resources, and support for quality improvement efforts.

Family Planning 101

Once an agreement is put in place, the FPAM project director arranges an educational workshop to review essential elements of the Title X program including information on Title X services, such as clinical visits, counseling, supplies, and referrals for prenatal care, abortion, or adoption services; how medications are dispensed and paid for depending on the payer source; reporting and documentation requirements; and determining what qualifies as a family planning patient and visit (e.g., if a patient is 14 to 44 years old and is asked even one family planning question) (**W3c**).

As part of this training, the project director places high value on hearing what the participants have to say, particularly around their concerns with providing sensitive services to teens and access to abortion services. In this way she is able to clarify misinformation (e.g., Title X does not provide funding for abortion) and help the FQHC integrate the program in a way that will make the staff most comfortable.

Ongoing Support

The FPAM project director estimates that between 40% and 50% of her time is currently spent supporting FQHCs with Title X programming and conducting quality assurance activities (e.g., analysis on patient and visit data, chart audits, and shadowing staff and clinicians). The FQHCs need the most support on documenting Title X visits, integrating Title X requirements into their EHR systems, and counseling practices and language for teens and males.

After the "Family Planning 101" session, the project director provides between two and four hours of technical assistance initially, and then about one full day over the course of the first year

"You've got to be respectful of people doing primary care… and integrating into their system."

– Kini-Ana Tinkham, Project Director, FPAM

of implementation. She spends time with key people at each health center site including the FPC and clinicians to determine what type of support they need. She observes front desk operations and patient flow through the health center to identify how Title X services can be integrated, and attends at least two full staff meetings each year. This appraoch builds individual relationships with FQHC staff, which has proven beneficial in improving adherence to program requirements.

In addition to the FPAM project director providing support, three to four clinicians who work in FPAM-operated health centers agreed to participate in a preceptor training course and work directly with clinicians from the FQHCs. FPAM clinicians visited FQHC health centers to shadow clinicians to build the relationship and provide support, and the FQHC clinicians often contact FPAM clinicians with questions. These relationships have been a valuable support system to sustaining Title X within FQHCs.

Tools & Resources

In addition to in-person support, FPAM developed a binder with tools and resources for the FQHCs to use during initial implementation of a Title X program and on an ongoing basis. These tools include (**W3c**):

- A list of diagnosis codes that are used in Title X family planning visits (**W3b**);
- Detailed instructions on using the federal Region 1 data system for FPAR reporting;
- The definition of a family planning patient, visit, and encounter;
- Information on options counseling and abortion referrals; and
- Data from the Maine Youth Risk Behavior Survey.

This binder is updated and distributed annually, and was recently made electronic for easier distribution and access.

The project director also uses listserves and e-blasts to send out pertinent information throughout the year, such as relevant CDC Morbidity and Mortality Weekly Reports, updates to national standards of care, and training and conference opportunities. As FQHCs are unlikely to receive these types of educational materials from other sources, this is another opportunity for FPAM to be a content expert for FQHCs.

Quality Improvement

FQHCs are required to conduct extensive quality assurance activities to monitor adherence to section 330 guidelines and progress toward performance measures. With support from FPAM, quality assurance measures specific to the Title X program are integrated into these ongoing program monitoring activities including routine data analysis and regular meetings specific to Title X integration. The FPAM project director is often invited to staff meetings to provide support and education, as well as answer questions.

The FPC at each FQHC holds a monthly meeting with staff to discuss Title X integration, answer questions, provide education and support as needed, and review data for quality improvement purposes. The FQHC's FPC reviews the monthly data analysis, including patient data and the diagnosis codes that were entered in each visit, to determine if the appropriate documentation was completed to make the patient and the visit reportable for Title X (**W3c**). The analysis includes reviewing where information was entered incorrectly or omitted. Spreadsheets with these data are compiled to show which clinician was responsible for the visit, so s/he can go back into the EHR system and complete the appropriate documentation and understand how to improve in the future. Discussing data this way in monthly meetings created a friendly sense of competition among clinicians and contributes to increased compliance. The FPCs also audit charts and meet privately with clinicians and staff to go through documentation and answer questions.

FPAM requires regular reporting from subcontracted health centers that include progress reports and evaluation on their work plan (**W1a**). Originally, FPAM required quarterly reports, but now reporting is semi-annual.

The FPAM project director conducts annual site reviews at each FQHC using the official OPA Title X review tool. She observes clinicians, follows patients through visits, and conducts chart reviews. While she is onsite, the project director takes the opportunity to meet with staff and provide any necessary updates, information, or education as needed.

3. Data Reporting & Billing

The biggest challenge FPAM and the FQHCs faced in implementing a Title X program was integrating the reporting and documentation requirements into the FQHCs' various EHR systems. About 80% of subcontracted FQHC health centers have integrated data systems to report FPAR data, and some are still using paper or online submission into the Region 1 centralized data system that houses FPAR data for all of the region's Title X grantees.[22]

FPAM supported FQHCs to adapt their EHR systems, their fee scale, and billing practices to incorporate Title X documentation and reporting requirements.

Electronic Health Records

The two participating FQHCs were using different electronic platforms when the organizations took on a Title X subcontract through FPAM. Adapting these systems to incorporate Title X data elements was an intensive process that involved IT experts from each FQHC and FPAM, the FPAM project director, and two Region 1 JSI-contracted technical staff. Once it became clear how much effort was needed to expand existing EHR capabilities to accommodate Title X requirements, FPAM provided the FQHCs with a $5,000 stipend to offset the personnel and technology costs associated

with configuring EHR systems to accommodate the Title X program.

The FPAM project director spent between 60 and 80 hours on conference calls with FQHC technical staff and Region 1 JSI technical staff to support the development of the EHR systems to accommodate Title X requirements and to develop a "data strip" through the agency's EHR system. This allows FPAR data to be extracted and directly entered into the Region 1 data system. Conference calls were conducted every two weeks for about six months. Both FQHCs that participated in this case study have a dedicated, in-house IT staff member who was instrumental in creating custom templates for the clinicians to complete for Title X visits (**W3b**).

Originally, HealthReach was using paper encounter forms and extracting Title X data from each visit one by one to report to FPAM. In October 2010, the health center implemented NextGen and linked the Title X reporting requirements to the health center's patient-centered medical home documentation requirements. There was a 20% to 70% increase in the use of Title X templates. This system was designed and tailored with pop-ups that appear with the top four diagnosis codes that are entered for a visit, including Title X codes. These pop-ups serve as reminders to use a template for essential information (**W3b**). If a Title X diagnosis code is not entered as one of the first four codes, then no pop-up appears. If the clinician then forgets to complete the Title X template, the visit is flagged as incomplete on the monthly patient/visit report and the information is entered by hand into the EHR before it gets reported to FPAM.

When KVHC agreed to subcontract for Title X services, the health center had a very cumbersome, rigid EHR system from CompuGroup Medical. Initially, it took one week of testing and trial and error with test patients to develop Title X templates in the system. The health center also used a separate "1-2-1 Tracks" data system to build and use custom reports and pull out data.

In November 2013, KVHC launched Athenahealth, a much more flexible EHR. Athenahealth has worked with other Title X-funded organizations, including FPAM, and was able to provide guidance to the IT team at KVHC and it took less than one day to create the necessary templates for Title X reporting. This system allows for "triggers" to be built in that flash if required information is left blank (e.g., pre- and post-visit contraceptive method). This system is much easier to use than the former EHR. Rough projections indicated the health center will report between two and three times as many Title X visits than ever before in the first month after launch. If Title X data is missing, it still needs to be entered into the record by hand, and staff estimated that this process can take approximately two hours each month.

Fee Scale & Billing

The sliding fee scale is another significant challenge when incorporating a Title X program into any health care setting. FPAM provides FQHCs with the fee scale that FPAM-operated health centers use along with recommendations on how it can be integrated into FQHC health centers (**W3b**). In an effort to streamline processes and integrate Title X family planning into a primary care setting, FPAM's subcontracted FQHCs' use the section 330 fee scale when any component of the visit is related to primary care. If the visit is strictly family planning (e.g., a pregnancy test or contraceptive management), the Title X fee scale is used so those visits can be slid to $0 and can be discounted up to 250% of the federal poverty level. All contraceptive supplies are paid for on the Title X fee scale.

The managed care market in the state of Maine is growing; between 58% and 71% of patients seen at FPAM, KVHC, or HealthReach health centers receive state Medicaid reimbursement or are privately insured. This means that the Title X sliding fee scale is not used as frequently for visits as it might be in other regions with a higher number of uninsured patients.

Agency Culture Change

The ongoing support from FPAM and from each health center's FPC has been critical in addressing culture change at the FQHCs. Some staff were resistant to the additional documentation required for Title X because "it's two more clicks." The clinical coordinator at HealthReach explained that they needed to document to get the funds, and the quality manager at KVHC emphasized, "Pay for performance is here!" To help clinicians and staff adjust, both the FPCs and FPAM's project director worked to streamline the documentation process in the EHR systems, and promoted the importance of Title X services and supplies to patients.

Originally, some FPAM-operated health center staff were uncomfortable with Title X funds being directed to what appeared to be a competitor agency, but the senior vice president of program services visited the health centers and used the ZIP code analysis to explain that the health centers were far enough away not to attract each other's patients.

There are regions of the state where family planning services are opposed for political reasons, and FQHCs in these regions have chosen not to take on a Title X subcontract either because key personnel were opposed to Title X services, or because the community would not respond positively to the change. In the case of KVHC, the board of directors was not initially in favor of providing Title X services, until there was enough turnover on the board. This provoked a culture shift within the agency and, coupled with an enthusiastic chief operations officer, enabled the FQHC to take on a Title X subcontract. At the time, KVHC did not have a medical director, and the current medical director is not supportive of birth control due to his religious beliefs, but does not hinder Title X integration into the health center.

Outcomes

Over the years, FPAM has worked to further develop a mission-driven business by expanding access to Title X services, improving the FQHC program as a result of federal program reviews, and incorporating Title X services into a primary care setting.

Increase in Access to Title X Services

Integrating FPAM's Title X program into an FQHC setting expanded patient access to Title X services throughout rural Maine. The effort was more cost-effective than opening a new health center, and made more sense than expanding access at existing health centers that were at capacity but seeing a decline in patients. FQHCs provided a base of patients who were in need of, but did not previously have access to, Title X-funded services.

Title X Federal Review

In 2009, the first FQHC-subcontracted Title X program was reviewed by OPA. The reviewers were unfamiliar with the FQHC-subcontract model, which was not widely used or accepted at the time. While the family planning policy was well received, reviewers found it difficult to navigate the EHR because templates were not smoothly incorporated and the electronic consent forms were difficult to review.

In 2012, OPA representatives reviewed HealthReach. The fee scale was viewed as problematic because it did not have enough gradual steps, and because of how it was used. With help from FPAM and the Region 1 program consultant, the Title X fee scale was revised to have more gradual steps, and a process was put in place to always use the Title X fee scale for contraceptives and family planning-only visits. If any component of the visit is primary care, FQHCs use the section 330 fee scale.

No one questioned the quality of care provided at the FQHCs, but FPAM was cited for not providing enough oversight regarding the quality of the programs. In addition, reviewers recommended FQHCs take more initiative monitoring themselves. In response, FPAM has developed a team for financial and clinical oversight of FQHC program operations, which provides more intense oversight to the FQHCs and promotes internal management of the program.

Primary Care Pilot

FPAM's work integrating Title X services into primary care settings established a solid foundation of operational knowledge that has enabled FPAM to pilot its own primary care health center. In 2012, FPAM began laying the groundwork at its Belfast health center to integrate primary care into an existing Title X services model. The health center layout was conducive to primary care and the staff were enthusiastic about including an experienced women's health care nurse practitioner. In addition, Maine has a law called the Advanced Practice Act, allowing nurse practitioners to manage patient care without the oversight of a physician, so FPAM hired a family nurse practitioner to work alongside the women's health care nurse practitioner. Belfast is in a medically underserved area, so depending on the success of this pilot, FPAM may seek a look-alike or FQHC designation.

Reflections

Key factors essential to successful integration of a Title X program into an FQHC model include identifying champions of the programs, establishing clear expectations, piloting the subcontract model, and ensuring accurate documentation.

Champions

Dedicated champions can make all the difference to the success of a new program. The FPAM project director initiated and supported integration of FQHC subcontracts, and it was her enthusiasm, expertise, and support that built excellent working relationships with key personnel at the FQHCs. These relationships proved invaluable when clinicians needed support or resources, and when FPAM needed quality improvements. Rather than putting all of the onus on the FQHCs to implement the Title X program, the FPAM project director strove to make integration easy by providing education, training, materials, and tools, and being accessible for meetings and site visits when necessary.

Ongoing Support

Ongoing support to operationalize a Title X program within a primary care setting was critical to getting and keeping staff on board and ensuring that Title X standards and requirements are always a priority. Support included regular meetings to discuss integration of Title X services, providing relevant data analysis to indicate accuracy of documentation (**W3c**), providing training as needed, and sharing of resources. FPAM initiated a shadowing component so FQHC clinicians could visit one of the FPAM-operated health centers to experience how Title X services were provided.

One of the most important ways FPAM provided ongoing support was by permitting the project director to be readily accessible to FQHC partners. Once the FQHC program grew to four subcontracted entities, she estimated that almost half of her workload involved providing support to them. This dedicated time and responsibility was critical in ensuring complete integration of Title X services into the FQHC setting.

Establishing Clear Expectations

In the decision-making process and throughout the implementation process, the FPAM project director was forthcoming and honest about the work involved in integrating a Title X program. Some of the specificity is due to the fact that the relationship is contractual and requires details that assure the FQHC as subrecipient will adhere to Title X program requirements (**W1a**). Because of this, expectations were made clear from the beginning and FQHC staff

were prepared not only for the steps required to integrate Title X services, but also for the type of support they would receive from FPAM. For example, FPAM requires each FQHC to name a family planning coordinator who is responsible for reporting and oversight of the program, and serves as FPAM's contact. This expectation ensures an FQHC staff member is designated and can be held accountable to make the Title X program a high priority.

Piloting the Model

FPAM and HealthReach initially agreed to integrate Title X services into only three of the FQHC's health centers, which served as pilot programs for the subcontract. This allowed the FPAM project director and the FQHC to refine the implementation process and support needed to successfully integrate a Title X program into an FQHC. As a result of these pilot programs, FPAM was able to respond to the FQHC health centers' needs by developing a "Family Planning 101" workshop with an accompanying family planning binder (**W3c**), and a method for supporting FQHCs to adapt their EHR systems. This established an implementation strategy that served as model to further expand FPAM's FQHC-subcontract program.

Documentation

Without an easy, reliable system for Title X documentation, adherence to program guidelines and accurate reporting cannot be ensured. FPAM's technical and financial support in adapting the FQHCs' existing EHR systems to integrate Title X data components was essential to establishing appropriate documentation and reporting practices. In addition, using visit data to track and show where documentation was lacking was an effective practice to improve Title X documentation practices among staff and clinicians (**W3c**).

Common Themes in Implementation

While the details of implementing different engagement strategies with FQHCs can vary widely depending on the organizations involved and the chosen service delivery model, there were commonalities among the experiences of the participating agencies. Differences between the studied models included the degree of change needed, which was largely dependent on the type of engagement strategy. Among the participating agencies there were common required operational changes that were accomplished, overarching lessons learned regarding implementation, and challenges and barriers along the way.

Careful Research

Several common considerations and topics for research regarding the implementation of organizational changes associated with an FQHC strategy were noted among the case study participants. It was essential to review state and federal regulations and any applicable legal issues associated with the implementation. In addition, participants considered how the insurance marketplace would impact service delivery, the need to identify necessary organizational changes, and adaptations to EHR systems to include Title X/section 330 data elements.

State and Federal Regulations

Prior to implementing a new organizational model, it is important to research individual local, state, and federal regulations or requirements (**W2a**). These may include licensing, certifications, Medicaid and other reimbursement policies, and individual federal grant requirements. For example, when YFP and FLMH merged it was necessary to obtain emergency approval from the state so that FLMH could take over operations of YFP. In contrast, the state did not need to be notified when FPAM signed new subcontracts with FQHCs, but OPA had to be notified as these new contracts impact Title X service provision in the state.

Legal Issues

Formal agreements and contracts were developed with the help of legal counsel and were closely examined by attorneys prior to signing (**W1a**). In the case of a merger or name change, state and federal authorities must be notified and it may also be necessary to alert local organizations including ACO members, and complete any necessary documentation.

Insurance Marketplace

It is important to understand the ways in which insured patients access and pay for care, and the impact these trends have on service delivery, in order to establish a reimbursement strategy for any new organizational model. At WFHC, when state Medicaid switched from a fee-for-service model to a managed care model, former WFHC patients sought care at other health centers that were contracting with their respective plan. In response, WFHC contracted with an IPA, which enabled the health center to become an eligible provider under Medicaid managed care plans.

Payer mix also impacted the way Title X funds were used in each organization. As an example, a high proportion of FPAM's patients are privately insured or have state Medicaid, which means that fewer patients rely on the Title X sliding fee scale to pay for services. In this situation, where many patients have insurance to pay for services, Title X funds can be directed to subsidize staff salaries, trainings, supplies, and lab fees.

Organizational Changes

All case study participants found the following operational adjustments critical to consider and plan for when exploring or executing organizational change:

- Confidentiality practices;
- Contracts with insurance plans and vendors (e.g., laboratory);
- Health center hours and locations;
- Health information technology capabilities and data reporting mechanisms;
- Personnel policies (e.g., pay scale, benefits such as retirement plans, earned leave/paid time off);
- Sliding fee scale;
- Staffing structure and staff roles; and
- Visit flow and visit components.

Electronic Health Records

The capacity of EHR systems to integrate Title X requirements and reduce the burden of additional documentation and reporting was an important factor in successful integration of a Title X program into a primary care setting. In fact, this was so critical to the success of Title X integration, questions regarding EHR systems should be asked of any potential partner. FLCH tested different approaches to gradually adapt its EHR to include Title X documentation.

FPAM's project director established clear expectations about the EHR system requirements for Title X documentation prior to initiating subcontract agreements. She then spent considerable time with each FQHC health center providing technical assistance to integrate Title X data elements into their EHRs. Each system required different adaptations to make Title X integration achievable for staff and clinicians. In response to the FQHCs' needs, FPAM directed additional technical support and funds to their subrecipients to offset the costs associated with adapting its EHR systems.

Potential Challenges & Barriers

There were common challenges that all three organizational models encountered including Title X documentation, integrating fee scales and billing, and agency culture change.

Title X Documentation

Title X providers were accustomed to the rigorous documentation requirements for reporting FPAR data and did not report much difficultly in adding section 330-required data elements. On the other hand, FQHC clinicians needed support and education to ensure accurate documentation of a Title X visit. Training involved a detailed overview of what type of encounter qualifies as a Title X patient and visit, a thorough description of the required data elements, and data collection and recording techniques (**W3a**). In the case of FPAM and WFHC, data is regularly reviewed with staff and clinicians to show which visit components were documented and which were omitted (**W3c**). This practice instilled a productive, informal competitiveness among the clinicians and proved extremely effective in improving data reporting performance.

Integrating Fee Scales & Billing Practices

Many providers in the publicly funded reproductive health care field are working to identify best practices to reconcile prioritizing patient care and maximizing revenue for a sustainable, mission-focused business model. OPA supports integrating the use of Title X fee scales into primary care settings as long as the guidelines for structuring the fee scale are upheld (e.g., slide down to $0 for patients with a family income below 100% of the federal poverty level). All three participating organizations were able to overcome the differences in federal regulatory structure between Title X and section 330 fee scales, and they now use a single fee scale with different approaches to charging patients (**W3b**).

Structuring the fee scale was the first step, followed by how and when to use it. Developments in the insurance landscape add another layer of complexity because of the different reimbursement rates from each payer and, in the case of a merger, different contracts. As seen in the FLCH merger, YFP had secured higher reimbursement rates for family planning services prior to merging, and after the merger those rates were no longer guaranteed. In addition, some public and many private insurance plans will only pay for one service at each visit, so organizations must determine how and whom to charge when a patient receives primary care services and family planning counseling in the same visit. One approach was to use the Title X fee scale for family planning-only visits (defined as a visit strictly for a pregnancy test or contraceptive management) and contraceptive supplies. In this model, if any type of family planning service is provided during a primary care visit, the section 330 fee scale applies. The visit is counted as a family planning visit, but the revenue collected is directed to the 330 program.

The need to bill insurance for part of a visit presented the biggest challenges (e.g., when a patient needs confidential family planning services and also has primary care needs). Providers address this need in different ways. For example, at HealthReach and KVHC a separate chart is created that is confidential, services are put on the Title X sliding fee scale, and the rest of the visit is billed to insurance (**W3a**).

Culture Change

Each participating agency experienced culture change as a new organizational structure or service delivery model was implemented. Transparency and regular communication from agency leadership early on in the decision-making and implementation processes helped staff adjust to cultural changes and effectively enact operational changes (**W3c**). It is to be expected that some staff and/or board members will chose to leave an organization during large-scale modifications. As with WFHC, this attrition can be seen as an opportunity to restructure staffing roles and/or promote a strategic plan.

Recommendations for the Implementation Process

Interviews with multiple personnel at Title X agencies and FQHCs provided a number of recommendations for organizational change involving FQHCs.

Assess & Strengthen Management Capacity

An assessment of both the initiating and potential partner organizations' internal capacity is fundamental to ensure that strong management and appropriate infrastructure are in place to implement needed organizational changes (**W2a**). In each case, the implementation plan identified a set of organizational changes that required strong management and oversight of implementation at all levels of the organization. For example, as WFHC began expanding services to include primary care, the executive director created new positions and hired staff with different expertise to help implement the new model of service delivery. Similarly, FPAM required FQHC subrecipients to identify a program coordinator which encourages the FQHCs to shift their internal infrastructure and priorities to sustain support for integrating Title X services.

Make an Implementation Plan

It is essential to develop a detailed work plan with objectives and activities that identify the staff members who are responsible for oversight and specific tasks (**W3a**). Involving staff to develop this plan garners support for the changes, and allows the people who are ultimately responsible for operationalizing the strategy to provide valuable input and shape a realistic and manageable plan. In addition, this type of plan sets clear expectations for the process and for the individuals involved.

As seen at FLCH, the operational staff were given autonomy to integrate the Title X family planning program into FQHC operations, but they had little time to plan for how the programs could be integrated. WFHC uses a "Plan, Do, Study, Act" (PDSA) model (**W3a**) for a multistep process that involves staff to plan, pilot an operational change, examine the impact, and then implement a change throughout the health center. The FPAM subcontract program has evolved over the years to have an established implementation program that is tailored to the specific FQHC health center needs. While it is the nature of a formal subcontract agreement, this type of expectation setting can be applied to other organizational models.

Identify Champions

Organizational champions are often the key to the success of a program or agency change. Once a decision is made regarding organizational change, it is essential to identify key operations staff who can serve as champions not only for the Title X program, but for the changes that are necessary to sustain the program. The champion must have the credibility and respect of other staff to effectively make the required decisions and operational changes. The newly-appointed family planning program coordinator at FLCH was successful in improving the integration of the Title X program because of her expertise from working at YFP, her in-depth knowledge of the Title X program, and her commitment to patient care.

Ensure Electronic Health Records Meet Reporting Needs

There are a wide variety of EHR systems on the market, and many health centers have implemented systems that have the capacity to document and export required program data elements. Adapting an EHR system to integrate additional data components (e.g., Title X/ section 330 data elements and clinic protocols) is an effort that can involve multiple staff, including clinicians, Title X project directors/managers, quality assurance staff and technical staff. In addition, training and ongoing support is essential to ensure accuracy of data reporting, sharing of new protocols and feedback for ongoing quality improvement adjustments and tracking of performance measures.

It is important to engage the EHR vendor to provide support and guidance on navigating system changes to accommodate new data elements for Title X documentation and reporting and clinic protocols. Ideally, a strategy for making these changes would be well underway before the new service delivery model is in place. This reduces the chance that patients or visits will be unaccounted for because the EHR system does not yet have the capability to capture the information or staff are not fully trained on the system.

Since there are many systems that can accommodate Title X requirements, it is useful to identify other agencies that can offer assistance to develop protocols and templates. One of the FQHCs in Maine chose to implement the same EHR system that FPAM uses, so FPAM technical and clinical staff were able to offer guidance on developing the system to incorporate the necessary components.

Plan for Ongoing Support and Communication

Once a new configuration for service delivery is in place, ongoing communication between the leadership and operations staff within an organization is critical to supporting the changes. A communication plan that is established as part of the implementation plan should outline when and how ongoing communications between agencies will occur and who is involved. This plan will help ease the tensions around agency culture change and improve the overall integration of programs and services.

Develop Marketing Strategies

A critical, and often overlooked, component to implementing major changes is designing and launching an appropriate marketing plan to alert patients and the community. Press releases announcing major changes, the release of new brochures, and distribution of flyers are essential components of a marketing plan (**W4a** and **W4b**). Many organizations do not develop strong marketing strategies because they do not have the resources, see the need, or are concerned about a political reaction. One of the FQHCs in Maine opted not to publicly advertise the provision of Title X services because its board of directors was concerned about the conservative community's response. Instead, the health center found more discreet methods to promote services. For example, the clinic coordinator contacted each school nurse individually to raise awareness of the availability of onsite contraception and confidential services.

WFHC offers an example of a successful marketing approach when it launched a new EHR system. Posters, newsletters, and e-blasts went out to patients in the weeks leading up to the "go live" date, calling it "The Big Bang." Health center staff were informing patients on the phone and in person of the change. On the day WFHC launched the EHR, a banner and balloons were hung in the waiting room announcing the big day. This was a fun approach to a major organizational change, and by giving patients fair warning about the new system, the launch was framed as something to celebrate rather than something to fear.

Takeaways

- Create working group teams comprised of key staff members, including clinicians (from both organizations, if applicable) to develop and monitor a work plan for implementation prior to initiating operational changes (**W3a**).
- Designate staff from both organizations to manage the Title X program, identifying who will monitor data and reporting, ensure adherence to requirements, and provide support to staff and clinicians.
- Develop a combined sliding fee scale with accompanying procedures for charging and billing that address patient needs while maximizing revenue for a sustainable business model (**W3b**).
- Invest time and resources into both initial and ongoing training, communication, and support for staff and clinicians on Title X services, documentation, billing, and reporting requirements (**W3c**).
- Address culture change through regular meetings and communication to empower staff and clinicians and keep them informed of changes. Promote a team approach to problem solving to encourage collaboration among staff.
- Develop working relationships with organizations prior to proposing a subrecipient service delivery model. Relationship building is essential and requires patience and sensitivity; it is important to "be there when they're ready for you," as Kini-Ana Tinkham, project director, FPAM, has said.
- Assess the capabilities of EHR systems to accommodate Title X reporting requirements prior to integrating services. It is important to prepare for initial implementation as well as ongoing assessments and system adjustments that will be needed. While this can be an arduous process, EHR is a critical component of sustainability.
- Ensure that the existing quality improvement process includes monitoring of implementation and identifying further improvements as necessary.
- Measure patient experience on a regular basis using formalized protocols. Data from these patient experience assessments can be used to inform strategic and operational changes.

Conclusion

These examples of engagement strategies between Title X providers and FQHCs provide insight into the decision-making and implementation processes necessary to integrate Title X and section 330 programs into one setting. While it is clear that there is no one correct model, it is also clear that positive outcomes can be achieved when Title X agencies and FQHCs collaborate to meet the needs of their communities.

Expanded Access to Health Care Services

Collaborating with an established health center broadens the services available in a community and enables patients who are already seeking health services to receive Title X or primary care services from the same provider they know and trust. These engagement strategies support the section 330 requirement to partner with community providers, and the Title X requirement to improve access to services to target populations. Engaging with FQHCs means that Title X organizations can expect to see an increase in patient numbers, and FQHCs can expect to see improvements in existing services and an increase in patient satisfaction.

Expanded Capacity

In all three models, the collaboration between Title X and FQHCs increased capacity to see patients. More patients accessed services, and organizations anecdotally reported improved quality of patient care as a result of training and expanded service offerings associated with the Title X program. FLCH added new service sites and new services were brought into existing health centers. WFHC gradually expanded access and grew to accommodate increases in patient demand. Clinicians at FPAM's subcontracted FQHCs received intense training on Title X counseling and education guidelines, and have improved skills to discuss family planning and sexual health with more patients. This expanded capacity is critical as more people obtain insurance coverage and seek medical services.

Increase in Patient Satisfaction

All organizations participating in the case study reported at least an anecdotal increase in patient satisfaction after the organizational changes were implemented to integrate Title X and section 330 programs. When community providers with similar missions, serving similar populations, collaborate to improve service delivery, it is likely that patients will be more satisfied with their care. Title X patients were excited to have access to a broader array of services, as seen in FLCH after the merger and at WFHC as services were added. In Maine, both FQHC participants anecdotally reported higher levels of patient satisfaction when the quality of reproductive health services improved, more patients were offered essential family planning services and more immediate access to supplies as a result of implementing the Title X program.

Diversification of Patient Populations

In all three models, the participating Title X organizations began to serve a more diverse patient population after implementing an organizational strategy with an FQHC. In the case of WFHC, new patients sought services as new programs were added (e.g., pediatrics and primary care). FPAM expanded Title X services to FQHCs in medically underserved rural areas that were already providing services to Title X target populations. The diversity of patient populations provides new opportunities for funding and may reduce financial vulnerability in a health care environment that favors a one-stop-shopping model of comprehensive care.

New Opportunities for Funding

With a comprehensive services model that includes primary care, there are more funding opportunities available related to health information technology, patient-centered medical homes, and patient navigator funds. As new money becomes available to primary care centers and FQHCs, some Title X organizations are left trying to piece together a program to apply for these funds that are not intended for them. It behooves organizations that are solely devoted to family planning and sexual health to reconstruct the service delivery model to have access to additional funds for improved patient care and sustainability, diversify services, or enact primary care partnerships. Similarly, if FQHCs are offered the opportunity to receive Title X funding, it may well be a mutually beneficial arrangement that increases funds for the FQHC and expands services for target populations.

Summary

To navigate changes associated with the ACA, publicly funded family planning providers are shifting their organizational model to meet patient needs. Developing relationships between Title X providers and FQHCs is a sound strategy for long-term sustainability that requires assessing and expanding agency capacity and possibly integrating new services. The experiences shared in this case study and tools provided in the companion workbook offer expertise from the field to support Title X organizations in making strategic decisions to shift service delivery models in response to the ever-changing health care environment and changing patient needs.

Endnotes

1. FQHCs are funded by section 330 of the Public Health Service Act. The terms section 330 and FQHCs can be used interchangeably.

2. Christina Fowler et al., *Family Planning Annual Report: 2011 National Summary*, rev. ed. (Research Triangle Park, NC. RTI International, October 2013), http://www.hhs.gov/opa/pdfs/fpar-2011-national-summary.pdf.

3. Christina Fowler et al., *Family Planning Annual Report: 2012 National Summary*, rev. ed. (Research Triangle Park, NC. RTI International, December 2013), http://www.hhs.gov/opa/pdfs/fpar-national-summary-2012.pdf.

4. Office of Population Affairs, *Title X Funding History* http://www.hhs.gov/opa/title-x-family-planning/title-x-policies/title-x-funding-history/.

5. Christina Fowler et al., *Family Planning Annual Report: 2012 National Summary*, rev. ed. (Research Triangle Park, NC. RTI International, December 2013), http://www.hhs.gov/opa/pdfs/fpar-national-summary-2012.pdf.

6. Ibid.

7. For a full description of FQHC program requirements, please see: HRSA, *Health Center Program Requirements*, October 2012, http://bphc.hrsa.gov/about/requirements/hcpreqs.pdf.

8. There are possible exceptions to the FQHC board requirements, particularly for publicly-operated entities. For more information please see: HRSA, *Policy Information Notice,* January, 2014, http://bphc.hrsa.gov/policiesregulations/policies/pin201401.pdf.

9. Susan Wood et al., *Health Centers and Family Planning: Results of a Nationwide Study*, (Washington, D.C.: George Washington University School of Public Health and Health Services and RCHN Community Health Foundation, 2013), http://sphhs.gwu.edu/departments/healthpolicy/publications/Health_Centers_and_Family_Planning.pdf.

10. Ann Loeffler et al., *Title X Family Planning Clinics and Federally Qualified Heath Centers: A Study of Collaboration*, (Denver: JSI Research and Training Institute, November 2012).

11. Rachel Benson Gold et al., *A Natural Fit: Collaborations Between Community Health Centers and Family Planning Clinics*, (Washington, D.C.: George Washington University School of Public Health and Health Services and RCHN Community Health Foundation, 2011), https://sphhs.gwu.edu/departments/healthpolicy/DHP_Publications/pub_uploads/dhpPublication_13AFEE26-5056-9D20-3D3479861216C7E4.pdf.

12. The phrase "doing business as" (DBA) is a legal term used in the United States and Canada, meaning that the name under which the business or operation is conducted and presented to the world differs from the legal name of the business.

13. New Access Points Grants fund *new* service delivery sites in underserved areas to provide comprehensive primary health care and access to mental and oral health services.

14. FPAM's total number of patients served includes all patients seen at FPAM-operated health centers and only patients receiving Title X services at subcontracted health centers.

15. HEDIS is a widely used set of performance measures that developed and updated annually by the National Committee for Quality Assurance to allow consumers to compare health plan performance.

16. Susan Wood et al., *Health Centers and Family Planning: Results of a Nationwide Study*, (Washington, D.C.: George Washington University School of Public Health and Health Services and RCHN Community Health Foundation, 2013), http://sphhs.gwu.edu/departments/healthpolicy/publications/Health_Centers_and_Family_Planning.pdf.

17. Ahlers & Associates operates the family planning data collection and reporting system for the state of New York.

18. The fee scale was modeled after the one developed and presented by Northwest Colorado VNA the 2012 NFPRHA National Conference.

19. New York Health Options is an enrollment center set up through the New York State Department of Health to assist individuals and providers with New York's public health insurance programs.

20. Family PACT is a permanent part of California's Medicaid program that pays for comprehensive family planning services for men and women with incomes under 200% of the federal poverty level, and all adolescents under 19 years old.

21. Healthy Way LA is a no-cost managed care program available to eligible low-income uninsured residents of Los Angeles County who are not eligible for Medi-Cal that assigns patients to a "medical home" and covers primary care and preventive services.

22. John Snow Institute (JSI) has a contract through OPA to develop this regional data system and provide the necessary technical support to ensure grantees and subrecipients are able to access and use the system for reporting and data analysis.

About NFPRHA

Founded in 1971 and located in Washington, DC, the National Family Planning & Reproductive Health Association (NFPRHA) is a 501(c)3 non-profit membership organization representing the broad spectrum of family planning administrators and providers who serve the nation's low-income, under-insured, and uninsured women and men.

As the only national membership organization in the United States dedicated to increasing family planning access, NFPRHA is committed to advocacy, education, and training for its members. NFPRHA works to help ensure access to voluntary, comprehensive, and culturally sensitive sexual and reproductive health care services and supplies, and to support reproductive freedom for all.

To that end, NFPRHA seeks to maximize the opportunities for protecting and expanding access to family planning services for vulnerable populations by advocating for programs and resources that enhance both the medical services provided through and infrastructure of the publicly funded safety net.

Furthermore, NFPRHA prepares its membership for changes in the health care economy by providing policy and operational analyses to help its members consider and execute strategies for adapting to evolving economic and policy climates, and by convening administrators and clinicians to share experiences and best practices that help enhance quality and service delivery.

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