

# The Future of the Infertility Prevention Project

Policy Implications and Recommendations in  
Light of Passage of the Patient Protection  
and Affordable Care Act

## FULL REPORT

Submitted:  
November 15, 2011



JSI Research & Training Institute, Inc.  
*Promoting and Improving Health*

1725 Blake Street, Suite 400 Denver, Colorado 80202



To Whom It May Concern,

JSI Research and Training Institute, Inc. /Denver (JSI/Denver), the former administrator of the Region VIII Infertility Prevention Project (IPP), is pleased to share the following report, *The Future of the Infertility Prevention Project: Policy Implications and Recommendations in Light of the Patient Protection and Affordable Care Act*.

The primary focus of the *Futures* project was to design, implement, and follow an objective process documenting IPP structure, strengths, challenges, and opportunities within the context of a reformed health care environment as of November 2011. This report includes suggestions as to the role of IPP moving forward, in the context of overall infertility prevention activities. The recommendations presented in this report are based on an analysis and synthesis of many diverse data sources. In partnership with the Centers for Disease Control and Prevention (CDC), Division of STD Prevention, findings and recommendations have been further clarified over the past year.

This report is not intended to be all-inclusive, but to serve as a starting point for the advancement of infertility prevention activities within a changing health care environment. Since November 2011, when this report was originally prepared, IPP has changed substantially. The activities formerly conducted under the auspice of the IPP infrastructure are now broadly addressed within the national network of STD-Related Reproductive Health, Prevention, Training, and Technical Assistance Centers (STDRHPTTACs). In addition, changes in the interpretation of the Affordable Care Act have occurred since the creation of this report that may affect some of the conclusions presented.

The information contained in this report is an initial set of findings and recommendations intended to aid in planning efforts surrounding the advancement of infertility prevention activities. Its purpose is to serve as a resource to help leaders evaluate and modify their organization's business practices to meet requirements under the Affordable Care Act and be better positioned to adapt to changing roles and public health needs. The findings and recommendations contained within this report may be presented to and shared with key stakeholders and constituents. Other materials, such as factsheets, whitepapers, technical briefs, or case studies may also be developed using the findings and recommendations presented in this report.

JSI would like to thank the former IPP Regional Coordinating Agencies for their assistance throughout the *Futures* project, from developing the project's framework to collecting and analyzing data. We also thank all involved parties for providing input into the assessment process and participating in various aspects of the data collection for the assessment. JSI hopes that this report is helpful in guiding the future direction of the infertility prevention in a changing health care environment.

**JSI Authors**

Yvonne Hamby  
Graham Smith  
Christine Barron  
Andee Krasner  
Karen Schneider  
Steve Meersman

**JSI Editors**

Christine Barron  
Alissa Marchant  
Mary McCrimmon  
Julie Ray

**Consultant Contributor**

Ellen Teig

**About JSI Research & Training Institute, Inc.**

JSI Research & Training Institute, Inc., (JSI) is a health care research and consulting organization dedicated to improving the health of individuals and communities. JSI prides itself on its ability to provide assistance that is tailored and responsive to the specific needs of our clients, ranging from small local organizations to large federal and international agencies. Our focus on program evaluation, clinical care, prevention, training, and management consulting has allowed us to apply practical, technically sound, and innovative solutions to the challenges facing health care agencies, community-based organizations, and policy makers, in both the public and private sectors.

For this particular project, JSI brought to bear its history, experience, and resources that have been developed through its STI/HIV and reproductive health projects for local and state communities.

**Acknowledgements**

This assessment and report was made possible through the cooperative agreement from the Centers for Disease Control and Prevention (CDC), Division of STD Prevention (DSTDP) and the Office of Population Affairs/Office of Family Planning, Cooperative Agreement Number 6 FPTPA080012-29-02. The authors would like to thank Steven Shapiro, Charlotte Kent, Kevin O'Connor, Raul Romaguera, and Catherine Satterwhite at CDC for their support throughout the assessment; Elizabeth Torrone and LaZetta Grier of the DSTDP, CDC for providing current data for the report; and all the IPP coordinators and IPP infrastructure staff for conducting key informant interviews with their regional advisory committees. We would also like to thank the many representatives of key stakeholder groups across the country that participated in interviews and completed surveys. Finally, we would like to thank the IPP coordinators and project advisory committee members who guided this project.

**National Infertility Prevention Coordinating Agencies**

PHS Region I-JSI Research & Training Institute, Inc./Boston	PHS Region VI-Cardea Services/Austin
PHS Region II-Cicatelli Associates, Inc./New York	PHS Region VII-Development Systems, Inc./Kansas City
PHS Region III-Family Planning Council/Philadelphia	PHS Region VIII JSI Research & Training Institute, Inc./Denver
PHS Region IV-Cicatelli Associates, Inc./Atlanta	PHS Region IX-Cardea Services/Oakland
PHS Region V-Health Care Education & Training/Indianapolis	PHS Region X-Cardea Services/Seattle



## Future of IPP Assessment National Advisory Committee

Clare Coleman  
*President and Chief Executive Officer*  
*National Family Planning and Reproductive Health Association*

William Smith  
*Executive Director*  
*National Coalition of STD Directors*

Peter Kyriacopoulos  
*Senior Director of Public Policy*  
*Association of Public Health Laboratories*

Katie Heyer  
*Program Associate-HIV/STD*  
*National Association of City and County Health Officials*

Susan K. Maloney  
*Managing Senior Fellow & Senior Program Officer*  
*Partnership for Prevention/National Chlamydia Coalition*

Naomi Seiler  
*Associate Research Professor*  
*Department of Health Policy, School of Public Health and Health Services*  
*George Washington University*

*When citing information from the Future of IPP report, please use the following format:*

JSI Research & Training Institute, Inc./Denver, *The Future of Infertility Prevention Project Health Impact Assessment: Policy Implications and Recommendations in Light of Passage of the Patient Protection and Affordable Care Act*, July 25, 2012. This assessment and report was made possible through the cooperative agreement from the Centers for Disease Control and Prevention, Division of STD Prevention (DSTDP), and Cooperative Agreement Number 6 FPTPA080012-29-02.



## ACRONYM LIST

ACO	Accountable care organization
AHRQ	Agency for Healthcare Research and Quality
AwDC	Adults without dependent children
BPHC	Bureau of Primary Health Care
CBP	Client-based prevention
CER	Comparative effectiveness research
CHC	Community health center
DHAP	Division of HIV/AIDS Prevention
DSTD	Division of STD Prevention
EHR	Electronic health record
EMR	Electronic medical record
ESI	Employer-sponsored insurance
FMAP	Federal Medical Assistance Percentage
FPL	Federal Poverty Level
FQHC	Federally-qualified health center
HHS	Department of Health and Human Services
GPRA	Government Performance and Results Act
HCR	Health care reform
HE/RR	Health education and risk reduction
HIAP	Health Insurance Assistance Program
HIE	Health Insurance Exchange
HIPAA	Health Insurance Portability and Accountability Act
HIT	Health information technology
HPSA	Health Professional Shortage Area
HRIB	Health Reform Implementation Board
HRIP	High risk insurance pool
HRSA	Health Resources and Service Administration
ILI	Individual-level intervention
IPP	Infertility Prevention Project
MIS	Management information system
MUP	Medically Underserved Population
NCHHSTP	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
NHM&E	National HIV Monitoring and Evaluation
OPA	Office of Population Affairs
PCMH	Patient-centered medical home
PMPM	Per-member per-month
PPACA	Patient Protection and Affordable Care Act
REC	Regional Extension Center
RHIO	Regional health information organization
USPSTF	U.S. Preventive Services Task Force

*See Appendix A for a listing of key topics and short descriptions pertinent to the intersection of health care reform and the IPP. Note: These descriptions are not intended to be exhaustive.*



## TABLE OF CONTENTS

## Full Report

<b>INTRODUCTION.....</b>	<b>1</b>
Background	
National Health Care Reform	
Key Provisions	
<b>METHODOLOGY.....</b>	<b>4</b>
Overview	
IPP Project Area Profiles	
Key Informant Interviews	
Surveys	
Quantitative Research	
Survey Data Management and Analysis	
Qualitative Research	
Key Informant Interviews	
KII Data Management and Analysis	
Methodological Considerations (Limitations)	
<b>ASSESSMENT RESULTS.....</b>	<b>14</b>
Prevention.....	<b>14</b>
Background	
Issues Pertaining to FP, STI Clinics and FQHCs	
Challenges	
Moving Forward under Health Care Reform	
Opportunities to Leverage the Strengths of the IPP	
Expedited Partner Therapy Implementation	
Challenges	
Opportunities to Leverage the Strengths of the IPP	
Conclusion	
Recommendations	
Recommendation 1	
Recommendation 2	
Insurance Coverage.....	<b>25</b>
Background	
Third-Party Billing Capacity Development	
Challenges	
Opportunities to Leverage the Strengths of the IPP	
Confidentiality Concerns for Adolescents	
Challenges	
Moving Forward under Health Care Reform	
Opportunities to Leverage the Strengths of the IPP	
Conclusion	

**Recommendations**

- Recommendation 3
- Recommendation 4
- Recommendation 5
- Recommendation 6

**Health Information Technology.....35****Background****Electronic Disease Surveillance System Improvement**

- Challenges
- Moving Forward under Health Care Reform

**Geographic Information Systems Mapping**

- Moving Forward under Health Care Reform
- Opportunities to Leverage the Strengths of the IPP

**Conclusion****Recommendations**

- Recommendation 7
- Recommendation 8

**Innovation and Quality Improvement.....43****Background****Innovative Partnerships and Collaborative Opportunities**

- Moving Forward under Health Care Reform
- Challenges
- Opportunities to Leverage the Strengths of the IPP

**Social Media/Marketing**

- Challenges
- Opportunities to Leverage the Strengths of the IPP

**Conclusion****Recommendations**

- Recommendation 9
- Recommendation 10
- Recommendation 11

**Minority Health and Health Equity.....54****Background****Minority Health and Health Equity**

- Challenges
- Moving Forward under Health Care Reform

**Conclusion****Recommendations**

- Recommendation 12
- Recommendation 13

**Workforce.....61****Background****The Role of Public Health Nurses**

- Challenges
- Opportunities to Leverage the Strengths of the IPP



**School-Based Health Centers**

- Moving Forward under Health Care Reform
- Challenges
- Opportunities to Leverage the Strengths of the IPP

**Conclusion**

**Recommendations**

- Recommendation 14
- Recommendation 15

**KEY FINDINGS AND CONCLUSIONS.....66**

**Key Findings.....66**

- Prevention
- Insurance Coverage
- Health Information Technology
- Innovation and Quality Improvement
- Minority Health and Health Equity
- Health Care Workforce

**Strengths of the IPP**

- Successes if IPP Sexual and Reproductive Health Service Delivery Partners
- Successes of IPP Infrastructure/Coordinating Agencies

**Additional Findings**

**Conclusion.....69**

**REFERENCES ..... 71**





## INTRODUCTION

Impending health care reform presents an opportunity for the Infertility Prevention Project (IPP) to work on multiple levels (federal, state, and local), within and across sectors (public, private, and community-based) to advance strategic priorities for preventing and controlling chlamydia and gonorrhea. However, as key regulatory uncertainties remain, it is difficult to fully delineate the impact of health care reform on the IPP, particularly for STI prevention.

As a result of these uncertainties, The Centers for Disease Control and Prevention, Division of Sexually Transmitted Disease (STD) Prevention (CDC/DSTD) issued a request for proposal to the ten IPP coordinating agencies outlining ideas, processes, and outcomes envisioned as a result of health reform and addressing the role of the IPP in a reformed healthcare enrollment. In October 2010, JSI Research & Training Institute, Inc./Denver (JSI) was contracted to conduct a multi-level health impact assessment (HIA) methodology, which included a comprehensive plan with strategies on how to maximize opportunities and address or mitigate negative impacts of health care reform on the IPP. The HIA model addressed these questions via a four-pronged approach, with each step supporting, informing, and overlapping:

- \* Evaluating effectiveness
- \* Describing change
- \* Capitalizing on new opportunities
- \* Informing and coordinating collaborative efforts

The purpose of the assessment was to provide insight and direction to key areas of interest to the DSTDP, IPP coordinating agencies, and IPP service delivery partners:

1. Describe anticipated changes in the delivery of IPP services, data collection, and reporting.
2. Provide a comprehensive analysis of the Patient Protection and Affordable Care Act's impact on the IPP, including how the IPP should realign priorities to cover service area gaps and reach communities with greatest need.
3. Provide direction as to how the IPP can assume a broader leadership role to assure screening, treatment, and partner services for at-risk women and men.
4. Re-purpose the IPP to meet the needs of the changing health care environment, assuming the authorizing language remains constant.

The outcome of this impact assessment included a plan of action to address policy and programmatic implications through short-term strategic responses.

### Background

Sexually transmitted infections (STIs) remain among the most challenging public health problems facing the United States. Chlamydia and gonorrhea are the most frequently reported nationally notifiable diseases in the country, and STIs account for the greatest health disparities between racial/ethnic populations among all infectious diseases. There is also a heavy burden of chlamydia and gonorrhea among adolescents and young adults. "Untreated, chlamydia and gonorrhea increase a woman's risk for pelvic inflammatory disease (PID) and infertility."<sup>5</sup> Furthermore, most STIs are associated with an increased risk of acquiring and transmitting human immunodeficiency virus (HIV). In addition to the physical and psychological consequences of STIs, these diseases exact a tremendous economic toll. Direct medical costs associated with STIs in the United States are estimated to be as much as \$14.7 billion annually.<sup>6</sup> These substantial physical, emotional, and fiscal costs are unnecessary because STIs are preventable, and early detection and treatment through routine screening can prevent costly and severe complications.<sup>7</sup>

The CDC, in collaboration with the Office of Population Affairs (OPA), Office of Family Planning (OPA, OFP) of the Department of Health and Human Services (HHS), has supported the Infertility Prevention Project (IPP) in all ten U.S. HHS regions since 1995. The national IPP funds: 1) chlamydia and gonorrhea screening and treatment services for low-income, sexually-active women attending family planning, STI, and other women's health care clinics; and 2) the regional IPP infrastructures/coordinating agencies. From its start in 1988 as a demonstration project in HHS Region X, the IPP has expanded to include all ten federal HHS regions.<sup>8</sup>

The IPP is authorized under Section 318(a)(b)(c) of the Public Health Service Act (PHSA) [42 U.S.C. Section 247c(a) (b) (c)], as amended. Regulations governing the implementation of this legislation are covered under 42 CFR Part 51b, Subparts A and D. Funding was first made available through the 1992 congressional appropriation (see Appendix D for authorizing legislation).



The two primary areas of focus authorized through the appropriation and the PHSA are:

- \* Preventable cases of infertility arising as a result of sexually transmitted diseases
- \* Authorized activities targeting any STI causing infertility in women if not treated

The purpose of the service delivery funding is to enhance the prevention of STI-related infertility by supporting and improving the ability of public health departments to implement activities and promote interventions that prevent STI acquisition.<sup>9</sup> This is accomplished through the collaborative efforts of sexually transmitted disease (STI), family planning (FP), and laboratory services providers throughout the national IPP. The project works to promote innovative, high-quality, and cost-effective approaches in the prevention of STI-related infertility, especially in adolescent girls and young adult women. Prevention approaches are designed to link surveillance, clinical, laboratory, behavioral, and epidemiologic activities to prevent transmission of STIs that result in PID, infertility, and ectopic pregnancy.<sup>10</sup>

The purpose of IPP is to facilitate and encourage chlamydia and gonorrhea screening and treatment among young, low-income women to prevent the development of infertility related to STIs. IPP works directly to address the most vulnerable populations (uninsured and underinsured females) as part of a larger public health effort to ensure that all at-risk females, particularly those aged <25, have access to screening and treatment services. During calendar year 2010, more than 1.6 million chlamydia tests among young women (N=1,674,229) were reported through IPP, in addition to over 1.5 million gonorrhea tests (N=1,551,786). Almost half a million chlamydia tests among young men (N=446,173) were reported, as well as 427,941 gonorrhea tests. These reported tests among young men and women aged 15-24 years were administered in a diverse group of facilities that range from Family Planning Title X clinics, STI clinics, community health centers, juvenile detention centers, and prenatal clinics.<sup>11</sup>

Funding for regional IPP infrastructures/coordinating agencies is provided through an inter-agency agreement with the DHHS, OPA, OFP and their Title X Regional Family Planning Training Center grantees. The purpose of funding is to provide centralized project management and coordination of all regional IPP activities. Infrastructure partners are responsible for assuring project area and regional collaboration among STI prevention programs, family planning programs, IHS partners, laboratories, prevention training centers, and other relevant partners.<sup>12</sup>

Within each region, representatives of state STI programs, state family planning and women's health programs, and the state public health laboratories meet several times a year as regional advisory committees (RAC) to formulate a common approach to the prevention of chlamydia and gonorrhea infections and their sequelae. The key components of the regional infertility prevention programs are:

1. **Clinical** (screening, treatment, partner management)
2. **Training and Education** (of clinicians and laboratorians)
3. **Laboratory** (tests, bulk purchasing, performance, turn-around-time, quality assurance)
4. **Data Collection and Reporting** (local, state, and regional data collection, management, and analysis).

The RAC acts in an advisory capacity in the implementation of the goals and objectives of the CDC National IPP on the regional and project area levels. RAC meetings are structured to enhance project area efforts in realizing national, regional, and local IPP goals and objectives in the prevention of STI-related infertility. It is the ultimate goal of the regional process to inform, support, and enhance STI-related practices across many disciplines and settings through the promotion and exploration of evidence and science-based programming.<sup>13</sup> The IPP infrastructure staff provides technical assistance to individual project areas and is primarily responsible for:

- \* Coordination and promotion of cooperation and innovation among the project areas
- \* Quality assurance and maintenance of a regional prevalence monitoring system
- \* Data analysis and reporting activities
- \* Promotion of project activities
- \* Promotion for best practice cost-effective screening and treatment activities<sup>14</sup>

### National Health Care Reform

In May 2010, President Barack Obama signed into law the Patient Protection and Affordable Care Act (PPACA). This historic legislation calls upon health care professionals to capitalize on new opportunities to resolve the growing challenges facing the United States health care infrastructure—and the citizens who rely upon it—through innovation and collaboration. Implementation of the PPACA—health care reform (HCR)—will have immense consequences for clients, clinics, and related facilities and programming. As such, it is imperative to the viability and future operations of the IPP to develop a broad-based, realistic, and practical understanding of the implications inherent in several of the PPACA's provisions, not only for STI prevention services, but for the larger health care



system in which these services exist. The new federal health care law will expand coverage to tens of millions of uninsured Americans, resulting in coverage for approximately 95 percent of the legal population.<sup>15</sup>

### **Key Provisions**

Sexual and reproductive health services will be included in basic benefit packages. The PPACA requires health plans to cover designated women's preventive services without cost sharing for the member, specifically including:

- \* Chlamydia screening for younger women and other women at higher risk
- \* Gonorrhea screening for all women at higher risk
- \* Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs

Services that must be covered under the preventive services umbrella include:

1. A- and B-rated services recommended by the U.S. Preventive Services Task Force (USPSTF), such as:
  - \* Sexually transmitted infection (STI) prevention counseling for adults and adolescents at higher risk
  - \* Chlamydia screening for: a) non-pregnant, sexually-active women under age 25; b) pregnant women under age 25; and c) older women at increased risk
  - \* Gonorrhea screening for all women at higher risk, including those who are pregnant
  - \* Syphilis screening for all pregnant women and those at increased risk.
2. STI prevention counseling for adults at higher risk.
3. Expanded Medicaid coverage for all Americans below 133 percent of the federal poverty level.
4. Health insurance exchanges created for individuals and small employers to pool risk and purchase insurance.
5. Medicaid enrollees, including newly eligible childless adults, will receive adequate health coverage, including key sexual and reproductive health coverage.<sup>16</sup>

The health impact assessment (HIA) was intended to help key stakeholders better understand if and how key programming related to the prevention of chlamydia and gonorrhea can remain viable and pertinent as the nation moves forward under federal health care reform. Specifically, JSI explored the interface between the IPP service delivery and

infrastructure, and the PPACA. The Future of the IPP report is designed to provide insight and direction to key areas of interest relating to the IPP, including the role of the IPP infrastructure; improving and leveraging partnerships; defining the IPP's role in communicating best practices in screening and treatment of chlamydia and gonorrhea; addressing service area gaps through key concepts, such as the medical home service delivery model; and describing anticipated changes in data collection and reporting practices as private and public health systems institute electronic health records (EHRs). This work was part of ongoing efforts to strengthen local, state, and regional responses to STI and reproductive health challenges within the context of health care reform and the impact of the recent economic recession on the STI, family planning, and public health laboratory partners.

In order to ensure that the assessment fully accounted for the unique attributes and geographic diversity of the IPP partners, JSI worked collaboratively with all regional coordinating agencies in all aspects of initiative planning, implementation, and evaluation. Building on regional activities and partnerships, it employed the HIA model as the primary means of facilitating initiative activities. This model was timely because: a) it mirrored the IPP structure and strengths; b) it was a flexible, multidisciplinary approach that used data to identify the health implications of proposed policies and programs, and helped advance decisions to support healthier communities; c) it addressed significant and ongoing reductions in public health infrastructure and workforce; and d) it highlighted health care reform's emphasis on modernizing the public health system, leveraging community resources and partnerships, and developing concepts related to establishing a quality-improvement approach to public health.

The report is divided into four sections: Introduction, Methodology, Assessment Results, and Key Findings/Conclusions. The methodology section describes the process whereby JSI gathered the information needed to support the development of the recommendations. The assessment results section describes the information gleaned from the internal and external research conducted by JSI. Recommendations and rationale reflect JSI's findings, which incorporate the input of the regional IPP coordinating agencies and the National Advisory Committee. The key findings/conclusion section of the report summarizes the focus of the recommendations. Appendices provide supporting documentation where referenced and are a separate PDF file.



## METHODOLOGY

JSI's methodology was centered on the concept that while the optimal approach to fortifying the IPP would draw from best practices around the nation, the way to apply those models to the service delivery partners would come from the field of service delivery (state family planning and STI programs, public health laboratories, and local clinics). In order to conceptualize a sustainable model for the IPP system of care and infrastructure coordinating agencies, JSI utilized the following methodology.

### Overview

In order to provide a context in which to understand the overall assessment findings and recommendations, JSI conducted an initial environmental scan. Through this scan, JSI identified six key areas that will most likely have a significant impact on both the provision of chlamydia and gonorrhea screening/treatment services as well as the role of the IPP infrastructure in a reformed health care environment:

1. Prevention
2. Insurance coverage
3. Health information technology
4. Innovation and quality improvement
5. Minority health and health equity
6. The health care workforce

Within those domains, the assessment utilized a mixed primary data collection methodology consisting of: i) IPP project area profiles; ii) key informant interviews; and iii) surveys.

i. IPP project area profiles: These profiles (see Appendix C) helped identify several focus areas within the six overarching domains, determine successful attributes of the current structure of IPP, and challenges that impacted their viability. Project area profiles also served to gain local-level, service delivery, and infrastructural context, and to identify specific regional areas of focus within the above six overarching domains:

- \* Issues pertaining to family planning (FP) clinics, STI clinics, and federally-qualified health centers (FQHCs)
- \* Third-party billing capacity development within public health laboratories, family planning clinics, and STI clinics
- \* Minority health/health equity
- \* Confidentiality concerns and coverage for adolescents
- \* Expedited partner therapy (EPT) implementation and private practice

collaboration

- \* The role of public health nurses
- \* Innovative partnerships/collaborative opportunities
- \* Social media/marketing
- \* Electronic disease surveillance system improvement
- \* School-based health centers (SBHCs)
- \* Geographic information systems (GIS) mapping

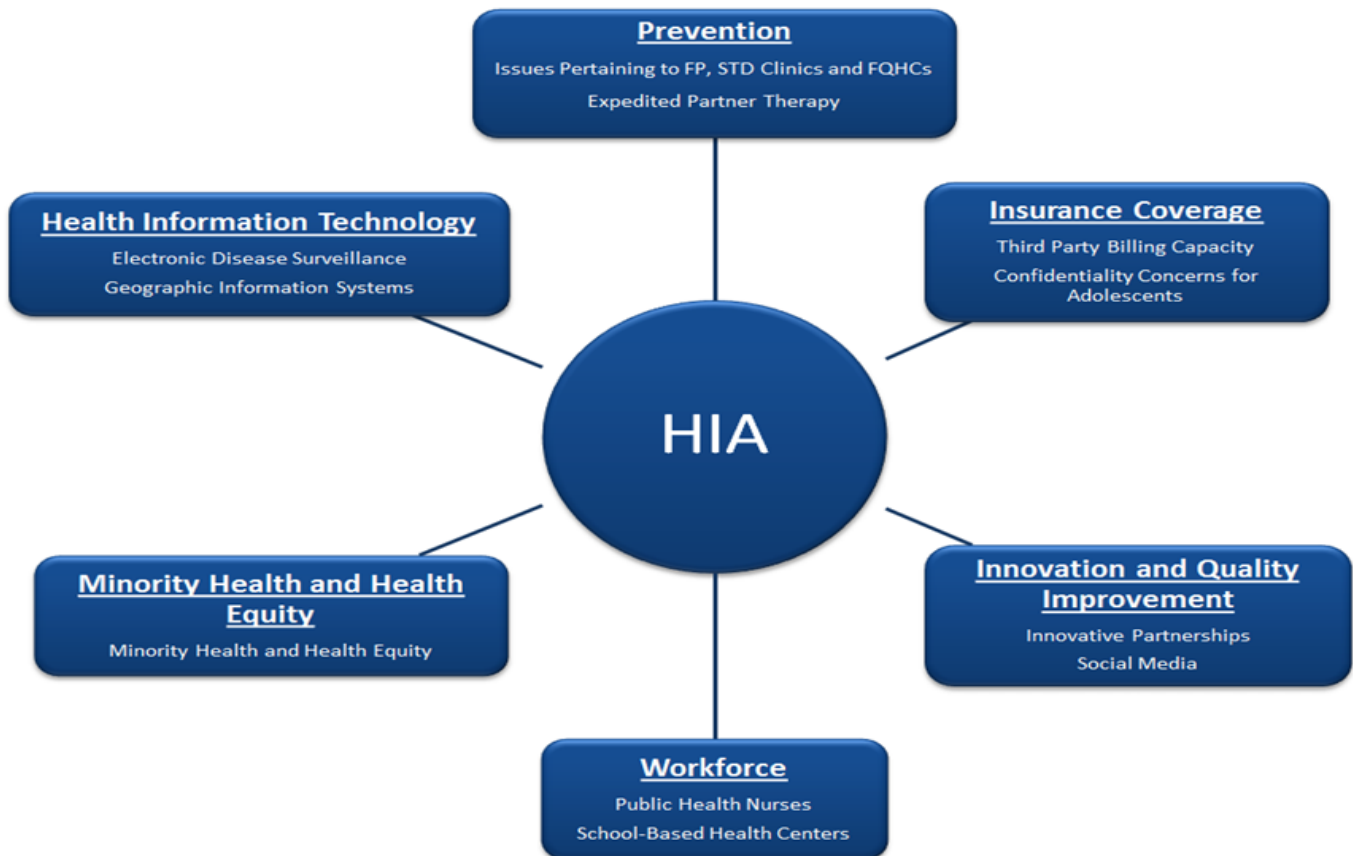
ii. Key informant interviews (KII): These were conducted at the regional and national levels, and served to better understand the strengths and challenges associated with the infrastructural elements (regional areas of focus) that could assist in the development of best practices to address regionally specific gaps or weaknesses as identified quantitatively with the surveys in Section iii.

iii. Surveys with state FP and STI programs; public health laboratories; and IPP FP and STI clinics: The surveys served to highlight regionally specific strengths, weaknesses, and gaps as they pertain to the national IPP Infrastructure in areas such as third-party billing capacity, partnership development, or the utilization of public health nurses. Generally the surveys were open for data collection from August – September 2011.

JSI used the IPP regional profiles to identify several issues within the six key areas that specific regions are in a unique position to address and analyze with primary data collection efforts. Each region was asked to utilize local resources to describe specific issues pertaining to both the current structure of the IPP, potential future challenges arising from a shifting healthcare landscape, and recommendations for moving forward. These resources described successes, challenges, and best practices from each assigned focus area. Each domain had multiple sub-areas of focus; some were explored as a national focus and others at a regional level. Based on information gathered through the project area profiles and the state PPACA profiles, JSI assigned specific areas of focus to the regions that addressed strengths, challenges, and best practices related to that particular area. See Table 2 on page 10-11, which outlines the regional interview assignments for each of the eleven focus areas listed under the IPP project area profiles section.



Regional areas of focus fit within the evaluation's overarching framework according to the following graphic:



Based upon these research components, JSI developed recommendations pertaining to the future of role of the IPP and the larger system of care addressing infertility prevention. Although JSI implemented quantitative and qualitative methods alike to identify relevant information, the majority of the research was qualitative. These methods are described in detail in the following pages.





## Quantitative Research

JSI developed a list of background data and sources that might inform the project and provide relevant quantitative data. A list of quantitative data reviewed is included in Appendix E. In addition, JSI reviewed other pertinent reports referenced in Appendix E to provide a context for the data obtained for the IPP. The quantitative research enabled JSI to formulate its recommendations to reflect the particular socio-demographics and health status of the core IPP service base. Additionally, JSI conducted surveys with state FP and STI programs; public health laboratories; and IPP STI and FP clinics. The surveys highlight regionally specific strengths, weaknesses, and gaps as they pertain to the national IPP infrastructure; for example, third-party billing capacity or partnerships with SBHCs (Appendix F).

Generally, the surveys were open for data collection from August to September 2011.

- \* Clinic Capacity Survey (Clinic): 9/6/2011 - 10/12/2011
- \* FP and STI State Partners Survey (State): 8/29/2011 - 11/4/2011
- \* Laboratory Partners Survey (Lab): 8/29/2011 - 10/11/2011

A total of 955 surveys were completed. The response rate for each survey tool follows:

- \* Clinic Capacity Survey: 17% (RR=754/4523)
- \* FP and STI State Partners Survey: 104%\* (RR=155/148)
- \* Laboratory Partners Survey: 72% (RR=46/64)

See Table 1 below, which outlines the number of responses to each survey tool per state.

*\*Some agencies that completed the FP and STI State Partners Survey were not considered state-level IPP partners, resulting in a completion rate above 100%.*

**Table 1: Number of Responses to Each Survey Tool per State**

Volume of Survey Responses by State				
State Name	State Abbreviation	Clinic	State	Laboratory
Alaska	AK	5	2	1
Alabama	AL	36	10	1
Arkansas	AR	37	1	NR <sup>^</sup>
Arizona	AZ	5	2	1
California	CA	1	4	1
Colorado	CO	29	2	1
Connecticut	CT	13	1	1
Delaware	DE	1	1	1
Florida	FL	NR	NR	1
Georgia	GA	34	2	NR
Hawaii	HI	3	2	1
Iowa	IA	25	3	2
Idaho	ID	2	10	1
Illinois	IL	22	2	1
Indiana	IN	16	2	1

<sup>^</sup> NR=No response



Table 1: Number of Responses to Each Survey Tool per State

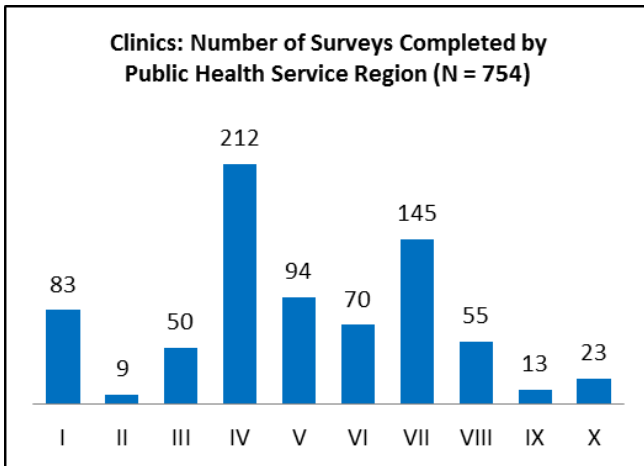
Volume of Survey Responses by State				
State Name	State Abbreviation	Clinic	State	Laboratory
Kansas	KS	4	2	NR
Kentucky	KY	62	2	1
Louisiana	LA	16	33	1
Massachusetts	MA	29	5	1
Maryland	MD	22	1	2
Maine	ME	18	1	1
Michigan	MI	23	2	1
Minnesota	MN	2	NR	NR
Missouri	MO	25	3	1
Mississippi	MS	1	NR	NR
Montana	MT	17	2	1
North Carolina	NC	51	1	1
North Dakota	ND	5	2	1
Nebraska	NE	91	1	1
New Hampshire	NH	10	1	1
New Jersey	NJ	2	7	1
New Mexico	NM	9	1	NR
Nevada	NV	4	1	2
New York	NY	1	2	NR
Ohio	OH	11	2	NR
Oklahoma	OK	NR	1	1
Oregon	OR	2	2	1
Pennsylvania	PA	7	5	NR
Rhode Island	RI	2	2	1
South Carolina	SC	8	1	1
South Dakota	SD	4	2	NR
Tennessee	TN	16	3	1
Texas	TX	9	NR	1
Utah	UT	NR	5	1
Virginia	VA	13	2	NR
Vermont	VT	11	2	1
Washington	WA	14	2	4
Wisconsin	WI	19	1	1
West Virginia	WV	7	1	2
Wyoming	WY	4	11	1
Puerto Rico	PR	5	1	NR
US Virgin Islands	USVI	1	1	NR
<b>Total</b>		<b>754</b>	<b>155</b>	<b>46</b>

^ NR=No response

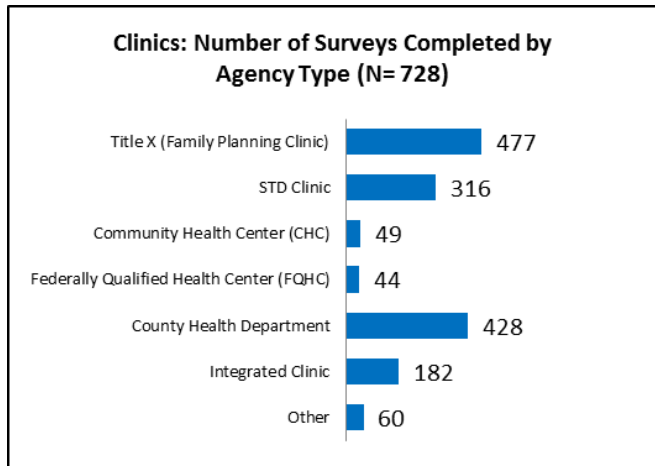


Pertinent regional distribution and agency information are included below in Graphs 1 through 6.

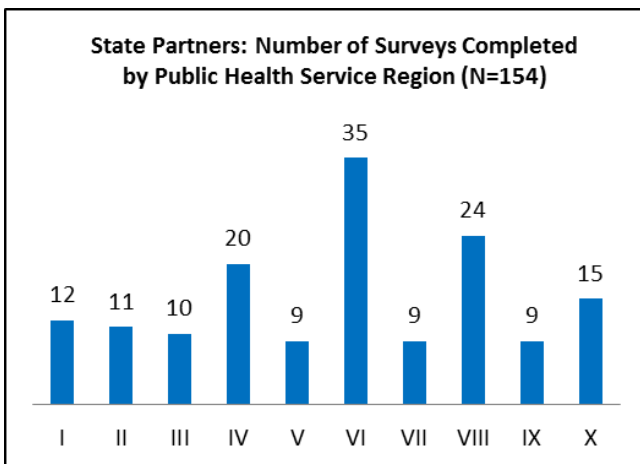
**Graph 1: Number of Clinic Capacity Surveys Completed by Public Health Service Region**



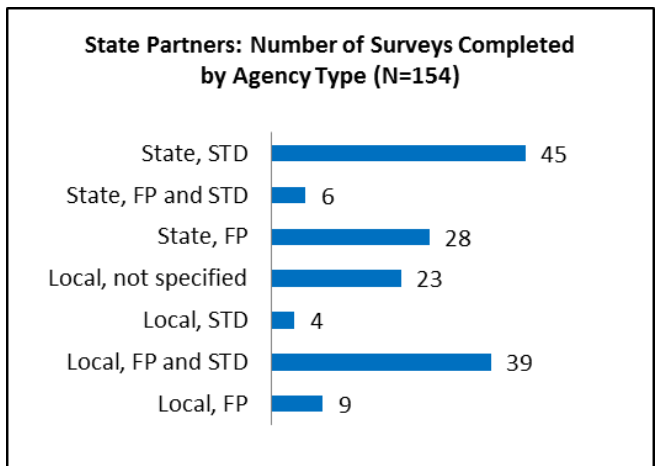
**Graph 2: My Agency is a (please mark ALL that apply):**



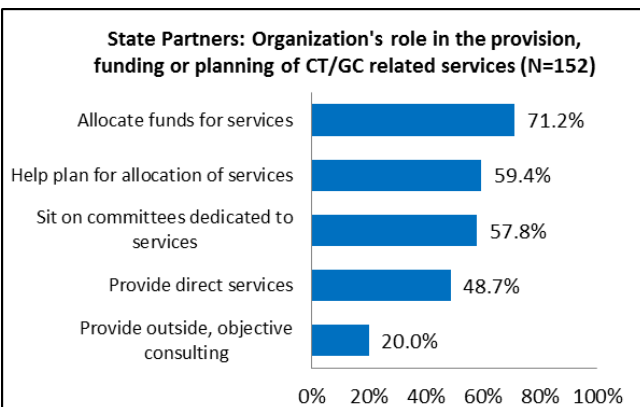
**Graph 3: Number of State Partner Surveys Completed by Public Health Service Region**



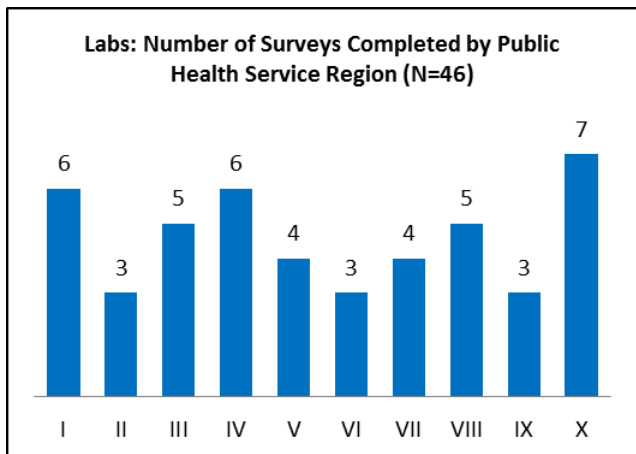
**Graph 4: My Agency is a (please mark ALL that apply):**



**Graph 5: Please indicate your organization's role in the provision, funding, or planning of chlamydia/gonorrhea related services. (Please comment in reference to STI-related services if you are unable to do so specifically in reference to chlamydia and gonorrhea).**



**Graph 6: Number of Laboratory Partner Surveys Completed by Public Health Service Region**



The vast majority of respondents to the Laboratory Partners Survey (39 of 46 respondents) indicated they represented a state public health laboratory. Graph 6 shows the regional breakdown of laboratory respondents.





### **Survey Data Management and Analysis**

A total of 758 clinics completed the clinic capacity survey. One-hundred and fifty-five agencies completed the FP and STI state partners' survey, and 46 agencies completed the laboratory partners survey. If respondents didn't complete the state and program or clinic type fields, surveys were dropped. This resulted in the following final survey counts: 754 for clinic; 155 for program; and 46 for laboratory. Weights were created for national percentages to account for differences in response rates by state and allowed all states to be equally represented in the results. For example, of the 15 agencies completing the FP and STI state partners survey, 32 respondents were from Louisiana (21%), 11 were from Wyoming (7%), and two were from New York (1%). Differences in number of respondents by state was also true for the Laboratory Partners Survey (e.g., four of the 46 respondents were from Washington, two were from West Virginia, and one was from California) and the Clinic Capacity Survey (e.g., 91 of the 754 respondents were from Nebraska, 62 were from Kentucky, and 1 respondent was from New York). Without weighting the data, respondents from states with a large number of respondents—thus accounting for a large proportion of the survey's final sample—would potentially dominate the results. To adjust for these differences in response, weights were calculated to ensure that all states with respondents carried equal weight in the analysis. All analyses were conducted in SAS version 9.2. Generally, *weighted percentages* and *unweighted sample sizes* are reported. Unweighted sample sizes (N) provide information on the actual number of respondents to a given question.

Those survey questions that had “I don't know” as a response option were categorized as “I don't know” only if a respondent checked a box labeled with that response. In most cases, respondents could check multiple responses including “I don't know.”

### **Qualitative Research**

The methods proposed for this project were primarily qualitative and consisted of regional IPP stakeholders and national content expert key informant interviews (KIIs). The KIIs better understand the strengths and challenges associated with the 11 infrastructural elements listed in Table 2, leading to the development of best practices that could be utilized to either fill or address regionally specific gaps or weaknesses as identified quantitatively with the survey tools. KIIs are an important aspect of qualitative data collection when the outcome is intended to generate recommendations for programs or services to address a particular health issue.

### **Key Informant Interviews**

JSI used the IPP regional profiles to identify several issues within the six key areas that specific regions are in a unique position to address and analyze with primary data collection efforts. Each region was asked to utilize local resources to describe specific issues pertaining to both the current structure of the IPP, potential future challenges arising from a shifting healthcare landscape, and recommendations for moving forward. These resources described successes, challenges, and best practices from each assigned focus area. Each domain had multiple sub-areas of focus; some were explored as a national focus and others at a regional level. Based on information gathered through the project area profiles and the state PPACA profiles, JSI assigned specific areas of focus to the regions that addressed strengths, challenges, and best practices related to that particular area. See Table 2, below, which outlines the regional interview assignments for each of the eleven focus areas listed on page 4.



**Table 2: Regional Interview Assignments for Each Regional Focus Area**

PPACA Domain	Regional Areas of Focus (as outlined in Regional Guidance Sheet)	Regions Conducting Recommended Area of Focus for Analysis
<b>Insurance Coverage Subdomains:</b> 1. Medicaid Expansion (Coverage for low income populations) 2. Medicaid Family Planning Waivers and State Plan Amendments 3. Extension of Dependent Coverage 4. Essential Health Benefits Requirements 5. Coverage Issues and Challenges for Adolescents	1. Issues pertaining to Family Planning clinics (FP), STI clinics, and Federally-Qualified Health Centers (FQHCs)  2. Third-Party Billing Capacity Development within Public Health Laboratories, Family Planning Clinics, and STI Clinics  3. Confidentiality Concerns and Coverage for Adolescents	Due to the degree of importance of these issues, all regions were asked to focus on these questions.  Due to the degree of importance of these issues, all regions were asked to focus on these questions.  • Region 1 • Region 2 • Region 3 • Region 9
<b>Health Information Technology Subdomains:</b> 1. The role of HIE, HIO, and RHIOs 2. Service Delivery and Surveillance System Improvement 3. Electronic Health Records	1. Electronic Disease Surveillance System Improvement  2. Targeting High-Risk Areas Through GIS Mapping Software	• Region 2 • Region 5 • Region 8 • Region 10  • Region 1 • Region 4
<b>Innovation and Quality Improvement Subdomains:</b> 1. Patient Center Medical Homes 2. Accountable Care Organizations 3. Service Integration and Coordination	1. Use of New Media (social media/marketing and online learning ops)  2. Innovative Partnerships/Collaborative Opportunities	• Region 5 • Region 7 • Region 8  Due to the degree of importance of these issues, all regions were asked to focus on these questions.
<b>Minority Health/ Health Disparities Subdomains:</b> 1. Improving Women's Health 2. Data Collection Improvement 3. Issues Pertaining to Special Populations	1. Minority Health/Health Disparities	• Region 3 • Region 4 --Outreach and targeted screening for African-American communities • Region 8 --Outreach and targeted screening for American Indian communities • Region 9 • Region 10--Outreach and targeted screening for American Indian communities
<b>Workforce Subdomains:</b> 1. Spending for FQHCs 2. Innovative Nursing Programs 3. The Role of Federal Organizations	1. The Role of Public Health Nurses  2. School-Based Health Centers	• Region 3 • Region 4 • Region 8 • Region 10  • Region 1 • Region 3 • Region 5 • Region 9



PPACA Domain	Regional Areas of Focus (as outlined in Regional Guidance Sheet)	Regions Conducting Recommended Area of Focus for Analysis
<b>Prevention Subdomains:</b> 1. Coverage of Preventive Health Services 2. Improving Access 3. The Role of Federal Organizations	1. Expedited Partner Therapy (EPT) Implementation and Private Practice Collaboration	<ul style="list-style-type: none"> <li>• Region 1</li> <li>• Region 2</li> <li>• Region 3</li> <li>• Region 5</li> <li>• Region 7</li> <li>• Region 9</li> <li>• Region 10</li> </ul>

The state PPACA implementation profiles provided information on PPACA-related issues implemented over the past year at a state and regional level. JSI reviewed key initiatives that were implemented in each state over the past year since the PPACA was passed. These initiatives were presented based on their relevance to either key issues identified from the PPACA due to their potential impact on IPP.

The KIIs were conducted at regional and national levels. The potential interview included health care providers, payers, advocates, legislative and agency staff, researchers, outreach and enrollment workers, and representatives of other key stakeholder groups important to IPP or its core partners. JSI proposed a three-tiered approach for data collection in relation to the key informant interviews:

**Tier 1** was required of all regions and primarily included core IPP stakeholders, as defined below:

- \* Regional advisory committee representatives
- \* Regional or state advocacy groups and/or professional groups
- \* Other key partners of the IPP program, such as city/county public health labs, private labs, or SBHCs, CHCs, or IHS facilities
- \* Clinics participating in IPP—STI and FP Clinics

**Tier 2** was not required, but the regional coordinators were encouraged to consider reaching out to the groups within this tier, which primarily included regional offices and state health departments, as listed below:

- \* Regional Offices
  - Office of the Director
  - Office of Public Health and Science (OPHS)
  - Regional Health Administrator
  - Regional Family Planning Consultant
  - Regional Women's Health Coordinator
- \* State Health Departments
  - Maternal & child health programs
  - HIV prevention programs
  - Ryan White programs

**Tier 3** was required at the national level only (JSI Denver's responsibility) and included the following groups:

- \* Centers for Medicare and Medicaid Services-Office of Regional Health Administrator
- \* Division of Medicaid and Children's Health Operations
- \* Federal Oversight of State Medicaid Programs and Children's Health Insurance Programs (CHIP)
- \* Regional primary care associations
- \* Regional or state health information exchanges
- \* Regional or state offices of rural health
- \* State insurance exchanges
- \* State accountable care organizations
- \* Payers

In addition to the Region VIII-specific KIIs, JSI conducted KIIs with stakeholders listed under Tiers 2 and 3; and at the national level, JSI attempted to schedule KIIs with key stakeholders for the IPP and its partners, including the National Coalition of STD Directors, National Family Planning and Reproductive Health Association, Association of Public Health Labs, National Chlamydia Coalition, National Coalition of County and City Health Officials, Office of Population Affairs, Centers for Disease Control (Division of STD Prevention and Division of Reproductive Health).

JSI developed a discussion tool for the regional KIIs to gather information on the strengths and challenges related to the eleven areas of focus (Appendix G). JSI worked closely with the regional IPP coordinating agencies to develop a list of individuals and groups to be included in the national key stakeholder interviews. Regional KIIs were conducted between 6/1/2011 and 8/31/2011.

The potential sampling or interview frame for the regional interviews was 165 key informants; JSI and the other regional IPP coordination agencies conducted 130 KIIs representing FP and STI state partners, local health departments, and laboratory



programs from all ten DHHS public health regions. This represents 79% interview rate.

Additionally, JSI conducted 27 national KIIs. The sampling frame developed for Tier 2 and 3 key informants included 60 public health, policy, and technology professionals with expertise in: adolescent health; policy analysis; social health; school-based health care; family planning and STI policy; health workforce; minority health; and HIT. The national KIIs represented the following entities:

- \* National Coalition of STD Directors
- \* DHHS, Office of Adolescent Health
- \* American Social Health Association
- \* National Assembly on School-Based Health Care
- \* Regional VIII Family Planning Consultant
- \* National Association of City and County Health Officers
- \* Colorado Rural Health Center
- \* DHHS Office of Minority Health
- \* National Black Women's Health Imperative
- \* Urban Indian Health Institute
- \* Guttmacher Institute
- \* National Family Planning and Reproductive Health Association
- \* National Women's Law Center
- \* George Washington University
- \* National Chlamydia Coalition
- \* DHHS Health Resources and Services Administration
- \* American College Health Association
- \* Association of Public Health Laboratories
- \* DHHS Office of Family Planning, Office of Population Affairs
- \* National Chlamydia Laboratory Coordinator
- \* Society of Adolescent Medicine
- \* Planned Parenthood Federation of America
- \* DHHS Centers for Disease Control and Prevention, DSTDP

The national KIIs were conducted from 9/1/2011 – 10/15/2011 and represented a 45% response rate. All interviews were guided with discussion tools to gather information from key informants regarding the strengths and challenges related to the eleven areas of focus (see Appendix G).

Each interviewee received a copy of the key informant interview consent form prior to all interviews for the Region VIII and national KIIs. After clarifying questions and assuring that each interviewee understood the assessment's purpose, both interviewee and interviewer signed a consent form. Interviews were conducted by phone, except

in the few cases where a face-to-face interview was requested. Most interviews were conducted by two staff: one to lead the interview process and a second to take notes. The interviews were also recorded.

JSI conducted one-on-one calls with each coordinating agencies to review the specific areas of focus that the region would be addressing; review the pertinent discussion guides; provide guidance on how to conduct the KIIs; and the format for data submission (see the notes template Appendix H). No financial incentives were provided to key informants for their participation in this assessment. If the coordinating agency utilized the consent form for their regional KIIs, they were responsible for tracking the completion of consent forms and interviews for their regional interviews.

### ***KII Data Management and Analysis***

Key informant interviews were documented in typed notes taken during interviews. A summary of findings was developed in order to eliminate the possibility that specific responses to be linked to specific individuals. The summary was developed from each of the regional data submissions using the notes template. A total of 63 transcripts representing all of the 130 regional interviews were initially summarized into regional focus area summaries, summarized below as number of transcripts submitted by each region. Each region submitted one transcript for each regional focus area they addressed, as outlined in Table 2 on page 10.

Region	Number of Transcripts Submitted
I	7
II	6
III	7
IV	6
V	7
VI	4
VII	5
VIII	7
IX	7
X	7

The transcripts from each of the 27 national KIIs were summarized and added to the regional data. Reference to personally identifying information was deleted when audio tapes were transcribed. The assessment team used an iterative analysis process whereby they moved back and forth through the data in order to find, compare, and verify the patterns, concepts, categories, properties, and dimensions of the themes.



Although review of the transcripts or call notes was ongoing throughout data collection, the main process of analysis was carried out when data collection was completed. A 'framework' technique developed by the National Centre for Social Research was used. The first four steps of this technique were employed primarily to order and manage the data:

1. Familiarizing
2. Identifying a thematic framework and developing a coding structure
3. Indexing
4. Charting (rearranging the data according to the thematic content) and then arranging each theme or content area by strengths, challenges, healthcare reform, and recommendations.

Codes are descriptive words or category names which identify a segment of text from key informant interviews. The codes were themes derived from the topic guide, points of interest for the IPP stakeholders, and other important thoughts identified from the initial readings of the transcripts/notes. The 90 transcripts were then coded (63 regional interview transcripts and 27 national KII transcripts). The team reviewed the coded transcripts to reduce bias among the three team members analyzing the data. Finally, the transcripts were analyzed according to themes.

The following strategies were employed to enhance the validity of the primary qualitative data collection:

- \* The literature review and secondary data review was used to dis/confirm key informant interview findings
- \* Inconsistencies among the primary data collected were triangulated with the findings with other data sources
- \* Findings were dis/confirmed by soliciting reactions from the assessment team to the drawn conclusions

### ***Methodological Considerations (Limitations)***

There are some limitations to consider with this study. With respect to the clinical capacity survey, there was a low response rate and due to a dissemination issue, there are no responses from the state of California.

Overall, it is difficult to quantify KII's responses gathered from their interviews because of the uncertainty of the impact of the policy implementation and the inability to sort their answers into categories that could have comparable meaning over time and across varied groups.

Furthermore, KII data cannot be generalized to other populations or groups of providers. Additionally, there may be bias in the participants' responses due to the following issues:

- \* Social pressure, particularly with the sensitivity of this topic.
- \* KII participants were asked to reflect on the impact of a policy that had not yet been fully implemented and holds many more uncertainties about how or if it will be.
- \* The passive recruitment strategy may have impacted representation of KII participants.

These potential limitations may have had some impact on the participants' selection to participate in the surveys and KIIs and responses to questions.

However, the participants' responses were not inconsistent with findings in the literature, which further supports the minimal impact of these limitations on the results.





## ASSESSMENT RESULTS

The findings and recommendations in this section are organized initially by the six healthcare reform related areas and then presented by the regional focus areas related to the health reform areas, as shown in assessment framework on page 5. All results are drawn from the following data sources: secondary data review, key informant interviews, and surveys, as well as the results from the national research. These are summarized below.

### Prevention



### Background

#### ***Disease Trends and Associated Costs***

There are approximately 19 million new STI infections each year in the United States, and almost half of them are among young people ages 15 to 24;<sup>17</sup> and the cost of STIs to the health care system is estimated to be as much as \$16 billion annually.<sup>18</sup> Since many cases of STIs either go undiagnosed or some, such as human papillomavirus or genital herpes are never reported to the CDC, the cases of chlamydia, gonorrhea, and syphilis represent only a small fraction of the actual health care burden of STIs in the United States.<sup>19</sup>

STI screening is critically important to women's health. Chlamydia and gonorrhea are the two most commonly reported STIs. Left untreated, these conditions can lead to pelvic inflammatory disease (PID) and infertility. The U.S. Preventive Services Task Force (USPSTF) recommends universal chlamydia screening for all sexually active women younger than 25 years (including adolescents) and gonorrhea screening for sexually active women at increased risk for infection.<sup>20</sup> According to the 2010 U.S. Census, roughly 13.6 percent (or 21,308,500 individuals) of all females are between the ages of 15 and 24.<sup>21</sup>

During 2008–2009, the rate of reported chlamydial infections in women increased from 579.4 to 592.2 reported cases per 100,000 females. According to the IPP Prevalence Monitoring Database, in 2009 the median state-specific chlamydia test positivity among women age 15–24 years who were screened during visits to selected



family planning clinics in all 50 states, the District of Columbia, Puerto Rico, and the Virgin Islands was 7.5 percent (range: 3.5 percent to 15.5 percent). Chlamydia positivity was slightly higher among a subset of prenatal clinics in 18 states, Puerto Rico, and the Virgin Islands at 7.7 percent (with a range of 3.6 percent to 20.4 percent). Reported chlamydia rates exceeded reported gonorrhea rates among women in all states.<sup>22</sup>

During 2008–2009, the reported rate of gonorrhea in women decreased from 118.5 to 105.5 cases per 100,000 females. According to the IPP Prevalence Monitoring Database, in 2009 the median state-specific gonorrhea test positivity among women age 15–24 years who were screened during visits to selected family planning clinics in 46 states, the District of Columbia, Puerto Rico, and the Virgin Islands was 1.0 percent (range: 0.0 percent to 3.4 percent). Gonorrhea positivity was slightly higher among a subset of prenatal clinics in 18 states, Puerto Rico, and the Virgin Islands, at 1.2 percent (with a range of 0.0 percent to 5.5 percent).<sup>23</sup>

Since almost 80–90 percent of chlamydial infections and 50 percent of gonococcal infections in women are asymptomatic,<sup>24,25</sup> these infections are detected primarily through screening programs. Data on the natural history of chlamydial infection have limitations, but the available data indicate that 10%–15% of untreated chlamydial infections result in diagnosed clinical PID.<sup>26,27</sup> Once clinical PID occurs, as many as 10%–15% of cases might lead to tubal factor infertility.<sup>28</sup> A large proportion of the ectopic pregnancies that occur every year are due to the consequences of PID.<sup>29</sup>

Accurate estimates of PID and tubal factor infertility resulting from chlamydial and gonococcal infections are difficult to obtain, in part because definitive diagnoses of these conditions can be complex.<sup>30</sup> In 2009, approximately 100,000 women 15–44 years old had an initial visit to a physicians' office for PID.<sup>31</sup> During that same year, the estimated cost associated with treatment for PID was \$4,800 per case.<sup>32</sup>

Since the symptoms associated with PID are vague, this results in 85 percent of women to delay seeking medical care, which increases the risk for infertility and ectopic pregnancy.<sup>33</sup> A randomized controlled trial of chlamydia screening in a managed care setting implied that screening programs can reduce the incidence of PID by as much as 60 percent.<sup>34</sup>

In 2010, an analysis of the impact of local public health operations funding was conducted in Michigan. It was estimated that if 40 percent of the

chlamydia and gonorrhea cases identified and treated in Michigan during 2008–2009 had gone undetected and progressed to PID, there would be a savings of at least \$2.50 for each dollar allocated for chlamydia and gonorrhea screening.<sup>31</sup>

### **Barriers to Care**

National key informant interviews lent insight as to the varied and multifaceted barriers associated with accessing reproductive and sexual health care services. To this end, key informant interviewees often first spoke of the stigma associated with accessing these services. The stigma is felt by both the clients and health care providers who are not comfortable talking with patients about sex. Many interviewees also spoke of the national discomfort with sex and sexuality. There continues to be a need to normalize reproductive and sexual health services for both men and women, as well as to train providers how to talk about sex, contraception, and STIs with their patients.

---

***“It’s a  
completely  
foreign concept  
to go in for  
preventative  
care.”***

---

Most interviewees agreed that having no health insurance coverage—whether a person is uninsured or underinsured—is currently a barrier for many individuals in need of reproductive and sexual health care. Interviewees also noted that insurance companies do not prioritize reproductive and sexual health care services, especially those related to prevention. Linked to the insurance barrier is the fact that even when clients do have insurance, they may lack the financial means to pay for the covered services, tests, and treatment. This problem is exacerbated for individuals who lack comprehensive insurance coverage.

Another barrier that was highlighted by a number of national interviewees is the fact that funding for public health departments, Title X Family Planning programs, and STI programs has been significantly reduced in the past few years. A number of clinics have been forced to close or reduce services. The clinics that remain open are often understaffed and overwhelmed by clients, who cannot obtain appointments for the preventive services they need when they need them. This becomes more difficult when the hours of the clinic are cut back and when clients must travel further in order to receive services.

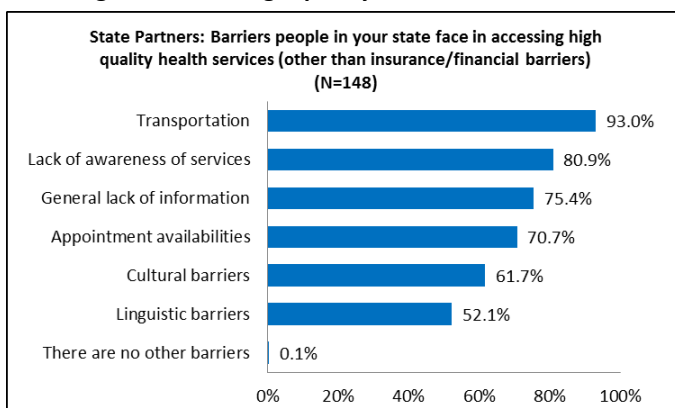


Some interviewees noted that in addition to not being able to access the services, clients are not receiving the education they need in order to prevent STIs. For example, clients may not know that they need to be tested for STIs, or they may assume that they are being tested during their annual exam (when in fact they are not). Additionally, some clients may be fearful of actually knowing their status, or may be in denial about the risks associated with sex and STIs.

Interviewees felt that some populations have additional barriers to overcome when seeking reproductive and sexual health services. Most frequently, adolescents, men, racial and ethnic minorities, and undocumented individuals were mentioned as having a more difficult time accessing services. Some interviewees also felt that specific services were more difficult to access for everyone. There was much talk about how the administration of expedited partner therapy (EPT) varied by community in those states where it is allowed. Interviewees felt that often providers do not know how to implement EPT in their clinics, or they are concerned about the legal ramifications of providing treatment to partners. It was also mentioned that access to pharmaceuticals is an issue for some clients, especially clients living in small towns or rural or frontier areas where either there is not a pharmacy close by, or the pharmacy in their community will not provide the appropriate pharmaceuticals (for example, birth control for teens).

Survey findings substantiate many of the concerns raised by key informant interviewees pertaining to client-level barriers in accessing care. Specifically, IPP state partners were asked to identify the most common barriers that individuals face in accessing health services. As seen in Graph 7 below, 93 percent of the 148 respondents who provided an

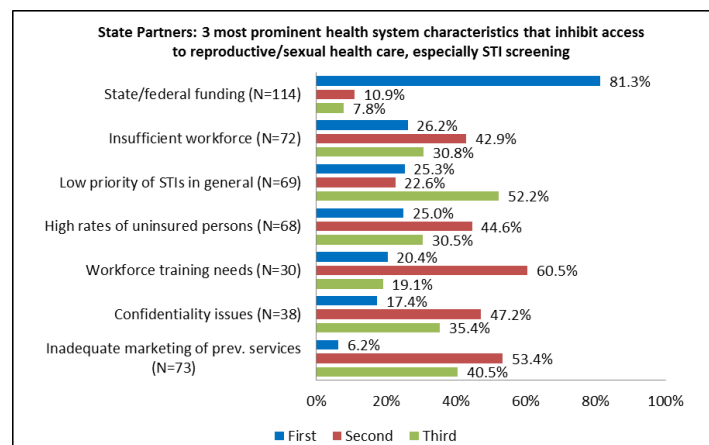
**Graph 7: Other than insurance or financial issues, what barriers do people in your state face in terms of being able to get access to high quality health services?**



answer to this question indicated that transportation was a barrier in their state. A lack of awareness of services and a lack of information were also commonly cited. Fewer individuals, however, indicated that linguistic or cultural barriers were faced.

State partners were also asked to indicate the three most-pervasive health system characteristics that inhibit access to reproductive and sexual health care. As can be seen from Graph 8 below, the most-commonly cited primary barrier was (a lack of) state/federal funding. In fact, of the 114 respondents who indicated state/federal funding as one of the three most prominent barriers, 81.3 percent indicated this as the primary barrier. Inadequate marketing for preventive services was the second-most commonly cited barrier, indicated by 73 respondents. Only 38 respondents, however, indicated that confidentiality issues were among the three most prominent barriers.

**Graph 8: In your opinion, and with respect to your state, what are the three most prominent health system characteristics that inhibit access to reproductive/sexual health care, especially to STI screening? (Please mark ALL that apply)**



When asked to describe how the PPACA will impact reproductive and sexual health services, many national interviewees cited the acceptance of the Institute of Medicine (IOM) recommendations to include a number of preventive health services for women at no cost. Interviewees hope that including these services will allow women increased access to the birth control and STI services they need. Some interviewees also felt that expansion of Medicaid eligibility will be a benefit, especially for childless adults and men who previously were not able to receive Medicaid. Some interviewees also felt that the PPACA will help the system move toward a more comprehensive approach to providing care, and that STI screening and treatment coverage will become more consistent across insurance plans. Some





interviewees wondered about how prepared the health care system is to handle an influx of clients who have not been accessing the system due to lack of insurance. Other interviewees felt that while the payer mix will change, the number of individuals accessing the system will remain the same.

The interviewees clearly expressed that there will be continued need for safety-net services. Even with the implementation of HCR, individuals will fluctuate between types of coverage, or may choose not to use their insurance for reproductive and sexual health services (for confidentiality reasons). Millions of individuals, particularly the undocumented population, will remain uninsured and will need safety-net services. Some interviewees noted that safety-net clinics provide accessible and confidential preventive services at times of urgent need. One interviewee said that the only way preventive services will function appropriately is if they can be accessed immediately when people need them most.

Interviewees predicted that stigma related to sexual health services will continue, especially in small towns, and rural and frontier areas. Safety-net services have shown that they are the most adept at providing these services to vulnerable populations or specific groups of people. Interviewees also noted that many clients prefer not to access reproductive and sexual health care services in a primary care setting. These clients prefer to receive care from experts who are trained to ask the right questions in a nonjudgmental manner and who provide the highest quality care possible.

Interviewees repeatedly expressed concern that there will not be sufficient funding for safety-net clinics and public health prevention efforts in the future. As a result, many safety-net clinics will significantly reduce services or be forced to close, leaving a severe need for public health promotion and prevention messages.

### Issues Pertaining to FP, STI Clinics, and FQHCs Challenges

Regional KIIs echoed many of the challenges expressed by national KIIs, including the effects of budget cuts on state and local agencies, the stigmatization of STIs by clients and providers, and the ability of the health care infrastructure to manage a potential influx of new clients as individuals gain access to new forms of coverage. Among the primary factors affecting programmatic sustainability, however, are economic pressures. General concerns surrounded funding and budget cuts on the state and local level, continued or elevated unemployment among the client base and an increased demand for IPP services as a result. Increased demand for screening services, in fact, were noted across three regions and were attributed to individuals losing health coverage.

Of additional concern was that family planning services in particular might be cut so that local health departments can focus on “essential services.” This pertained to both IPP funding as well as Title X funding. It was generally expressed that a decrease in services could lead to an increase in chlamydia and

gonorrhea incidence.

Multiple interviewees also noted seeing reductions in staffing due to the economic recession and recent funding cuts. In fact, of the 10 reporting regions, staffing issues were mentioned in six. Concerns included being forced to reduce staff, inability to fill vacancies, high staff turnover, and losing qualified personnel to the private sector where more competitive salaries

might be found. Similarly, with fewer resources, several project areas noted concerns that services would be curtailed, which would result in an increase in disease incidence. In fact, one project area noted that the IPP was the only available source of funding for chlamydia and gonorrhea screenings. In this case, should IPP funding discontinue, this project area noted a major concern in providing services to vulnerable populations.

---

***“The loss of STI-specific clinics is worrisome because it’s a place for confidential services for patients that need them... It’s naïve to say coverage means more access.”***

---



In addition, some regions have noted STI clinics either closing or reducing hours due to funding shortages or reimbursement delays from the state. In Massachusetts, closings have been a result of the state's 2006 health care reform. It was noted that such closings have negatively impacted screening services by decreasing points of access to care. A number of regions noted fiscal concerns about receiving adequate reimbursement for services, particularly from Medicaid. Two concerns were raised with respect to this issue; first, reimbursement rates appear low in general and cuts, while manageable, may subsist should economic conditions continue to deteriorate; second, because of a shifting client base, one interviewee questioned whether or not Medicaid would be able to pay for all the screenings currently provided by the IPP.

Specific political pressures were also noted in three regions. Interviewees cited instances of state officials blocking family planning funds to Planned Parenthood clinics. In fact, one interviewee noted that health department officials had prevented grant applications for federal funds, feeling that the private sector was more suited to handle the program or issue. Such political concerns were so apparent for one interviewee that the sustainability of the IPP was questioned solely on these grounds.

### ***Moving Forward under Health Care Reform***

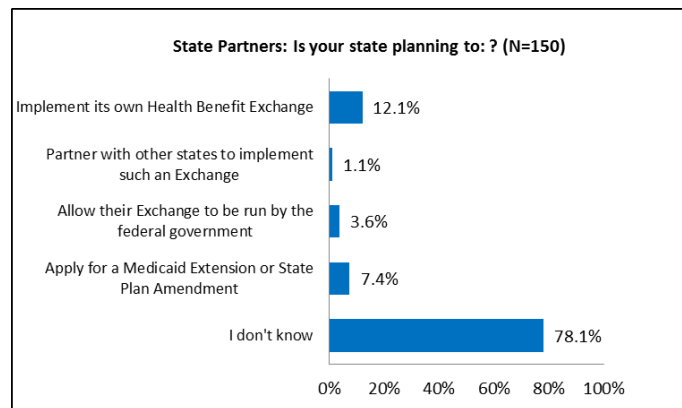
Challenges pertaining to health care reform in particular were also noted, primary: a) uncertainty associated with reform; b) general complexity associated with the legislation; and c) stalled

***“The biggest barrier is that there are not many clear messages coming from the federal or state level, and therefore it is difficult to prepare.”***

implementation efforts in some regions. These three specific barriers resulted in additional challenges to strategic planning for reform, identifying future challenges, preparing local agencies, and properly and efficiently training

staff. In fact, seven regions noted that it was difficult to predict what will happen under reform, how the legislation will affect local-level agencies, and what the specific impact will be on family planning clinics, STI clinics, and public health laboratories. Uncertainty in Congress in particular was noted, and one interviewee stated that the definition of reform is “not absolute,” despite the fact that the PPACA has been signed into law.

**Graph 9: Is your state planning to:**



To that end, state partners were asked to indicate whether their individual state was planning to either: a) implement its own health benefit exchange; b) partner with other states to implement an exchange; c) allow their exchange to be run by the federal government; or d) apply for a Medicaid Extension or State Plan Amendment. Of the 150 respondents who provided a response to this question, almost 80 percent did not know, as shown in Graph 9, above.

Uncertainty about when and where funding cuts would be made, and one interviewee expressed concern that IPP funding could be absorbed by Medicaid in an attempt to cover costs of newly-insured individuals. Another interviewee noted concern that future funding would be directed to providers who offer a broader range of care, while yet another anticipated that grants for direct service provision would likely dissolve as more individuals become insured. One interviewee stated that funding cuts will “be upon people sooner than they realize.”

Lack of HCR implementation at the state level was noted by five regions, with many interviewees stating that there was little or no noticeable planning for the implementation of HCR or for the client transition from uninsured to insured. Several states, it was noted, were doing little or nothing to convert, and a lack of leadership or guidance at the local level led to additional strategic planning barriers. In addition, varying levels of belief in and recognition of HCR and its inevitable impact were noted.

Another prominent challenge associated with HCR is related to the shifting client base that will likely access services through either primary or private providers as a result of being newly insured. It was widely acknowledged that testing services would be more accessible to individuals with insurance, and



some interviewees questioned whether or not the IPP—or the safety net in general—would be necessary if HCR is implemented as intended. One interviewee also noted that regardless of whether or not the safety net will actually be necessary post reform, the perception in Congress is that public health will no longer be necessary if “everyone has insurance.”

Opinions varied about the degree or direction of a potential shift in the IPP client base. While some interviewees stated that it was inevitable that the IPP client base would decrease as opportunities to access care become available in the primary care or private sector, others stated that increased access to Medicaid or parental insurance coverage would actually increase the IPP client base. One interviewee predicted that the IPP client base could increase in rural areas in particular, where competition among providers would be less of a concern. However, this opinion was countered by an interviewee who felt as though rural clinics, with an already low clinic volume, would no longer have a reason to stay open. Despite such varied opinions the majority of interviewees acknowledge that the client base for the IPP and the safety-net system in general will likely decrease for a number of reasons:

- a) clients will have more opportunities to transition to either private or primary care and will no longer choose to obtain services at public health departments
- b) individuals will migrate into medical homes
- c) new competition is emerging, such as out-of-state private companies with 24-hour emergency centers offering comprehensive care

Because of such transitions, a number of concerns were expressed about the quality of sexual and reproductive health care at private and primary care facilities in particular. It was felt among five regions that primary care providers either do not talk about family planning or STI issues or are uncomfortable doing so; are inadequately trained to provide family planning services, ask sexual health questions, provide STI screening or treatment, or serve adolescents; may not be attuned to CDC guidelines and treatment protocols; may not be prepared to provide such services (i.e., may not have the screening capacity or necessary medications in stock); may not be as quick to adopt new recommendations such as EPT; may not conduct asymptomatic screenings; and may not prioritize sexual and reproductive health.

It was also expressed that private providers in particular do not invest in prevention education, and may not be interested in attracting or serving the vulnerable populations that the IPP currently targets

due to low reimbursement rates or reduced compensation for services.

### ***Opportunities to Leverage the Strengths of the IPP***

Interviewees largely agreed that there will be a post-health care reform role for the IPP and the safety net, primary to continue to provide high-quality confidential services. It was noted that the IPP has built a structure in which funded agencies are specialists and experts in the field. Interviewees frequently noted that Title X providers are leaders in sexual and reproductive health, and that Clinics participating in IPP are trusted by their clients and known as agencies where individuals can receive care “without being chastised” and without worrying about potential breaches of confidentiality.

It was also suggested that IPP-funded agencies take a larger role in consumer education and outreach. Interviewees noted the importance of improving marketing efforts in order to increase IPP service utilization, as well as the

necessity of educating individuals on the importance of STI screening. One interviewee noted that it was likely that local budgets will cut consumer health education, leaving a large gap that could be filled with IPP funding. As another stated, “health education is a big component of what IPP can do.”

Similarly, some interviewees stated that IPP-funded agencies could serve as a bridge to new forms of access. Educating individuals that they are now eligible to apply for and enroll in health insurance, and helping individuals navigate insurance exchanges or Medicaid applications, were mentioned as important functions for IPP funded agencies, because in many cases they are the only provider a client sees in a given year.

It was also noted that the infrastructural arm of the IPP could enhance provider education efforts in both the public and private sector, particularly surrounding health care reform and reducing the uncertainty associated with the legislation. As one interviewee stated, “Identifying expertise in another state or at the federal level and bringing it to us as a

---

***“The public health workforce will need to assume a consultant role and become experts on how to advise FQHCs how to screen for STDs and how to provide FP services.”***

---



group of states is important because states are floundering.” Additional suggestions for the infrastructure included:

- \* Normalizing the STI and HCR discussion
- \* Providing resources necessary to develop skill sets in expansion areas (such as primary care settings) for STI service provision

Providing quality assurance support across both public and private sectors pertaining to: a) asking sexual health questions; b) new advancements or CDC recommendations such as EPT; and c) advancing the use of new testing technology

***“IPP is a great way to standardize a best practice.”***

The IPP’s role in provider education could be greatly facilitated by its noted strengths in the fields of communication and coordination, as well as dissemination of best practices and guidance. It

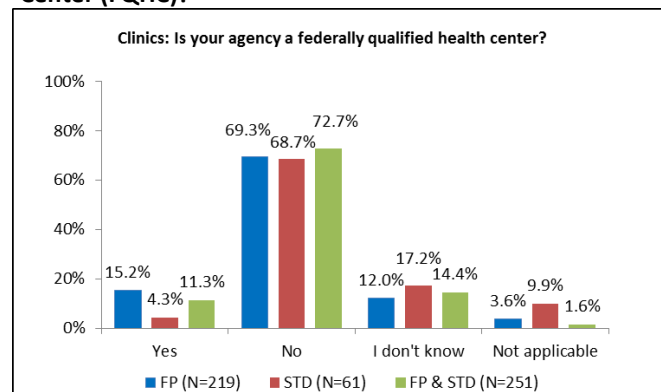
was noted, for example, that the IPP infrastructure provides: a) opportunities to collaborate between family planning and STI clinics; b) opportunities to coordinate and observe trends across states; and c) a connection to the federal level that facilitates understanding of policy and change. It was also noted that the IPP has been critical in infertility prevention and is an excellent forum in which to standardize and disseminate a best practice. The IPP itself was referred to repeatedly as a “go to” source for up-to-date information.

In order for IPP-funded agencies to remain viable, sustainable structures, additional recommendations were made for how to adapt to a new health care environment. Primary among such suggestions included expanding services, client bases, and partnerships. The need for service expansion was expressed in interviews across five regions. Interviewees stated that economic or political pressures might cause some programs to stop the provision of direct services, and would need to adapt to assume consultant or educational roles for both providers and clients. Where possible, others felt that increasing the range of services within specific agencies may make such practices more competitive for business as well as more attractive to potential partners, such as medical homes. Specific examples included expanding capacity to be able to care for complications such as diabetes, obesity, and high blood pressure.

National key informant interviewees echoed this perspective, stating that the scope of services at FP and STI clinics may need to expand in the future to

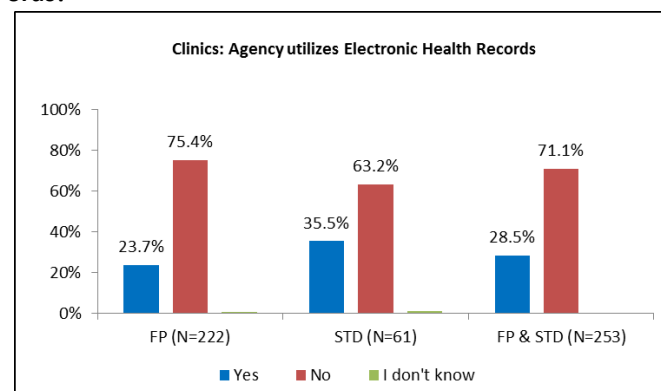
include more primary care services. There was talk of FP clinics in some communities transitioning into the role of an FQHC. To this end, regional interviewees also noted that IPP partner clinics should become FQHCs if possible. There are two primary reasons why establishing FQHC status would be beneficial: 1) PPACA legislation designates significant funding to FQHCs under Section 5601 (see Appendix A); and 2) in order for a health plan to be qualified under a health benefits exchange, it must include “essential community providers,” a term that includes FQHCs, within its provider network.<sup>36</sup> Regional interviewees pointed out, however, that IPP partner clinics will face challenges attaining FQHC status because many do not provide primary care services. In fact, according to survey findings, only a small portion of IPP partner clinics are credentialed FQHCs. See Graph 10, below.

**Graph 10: Is your agency a Federally Qualified Health Center (FQHC)?**



Additionally, clinics may need to become more competitive in the marketplace in order to maintain their current client base and to attract new clients. This will require clinics to provide high-quality care in a more efficient manner and to utilize EHR technology. While survey findings indicate that very few IPP clinic partners currently utilize EHRs, many have plans to develop this capacity in the future. See Graphs 11, below and 12 on the next page.

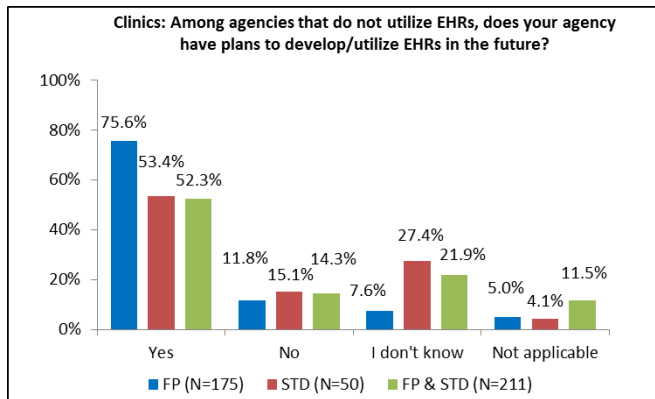
**Graph 11: Does your agency utilize electronic health records?**







**Graph 12: (If your agency does not utilize electronic health records) does your agency have plans to develop or utilize electronic health records in the future?**



In addition to service expansion, some key informant interviewees expressed an interest in expanding the IPP client base to include more males. As one interviewee stated, “Even though women suffer the long-term effects, to make any sort of dent in the disease burden men need to be tested and educated.” It was also noted that women may not disclose every sex partner. This has particular consequences for partner notification services. Even in the event that an agency has an effective partner notification or EPT program in place, these systems can fail if a woman does not disclose a sex partner. Interviewees also noted that USPSTF Grade A and B recommended services (see Appendix A for more detail) apply mostly to women, and that men will not have the same access to free routine screenings as women under health care reform. One interviewee went on to mention that the Health Effectiveness Data and Information Set (HEDIS) report card does not incorporate male screening coverage. This interviewee also noted the importance of both screening and educating men in efforts to reduce STI-related disease burden.

The importance of partnership expansion was noted in interviews across three regions. Interviewees stated that it is critical to develop processes to understand change and challenges, as well as to determine potential partners and how to collaborate with them. Some interviewees felt that it was increasingly important to engage outside agencies about the benefits that a partnership with the IPP can provide. For example, it was suggested that family planning providers can offer cost-effective care and become part of broader networks in order to reduce provider burden resulting from a potential client influx. It was also noted that IPP-funded agencies could serve as experts or specialists in reproductive care and that it may become necessary to move to a contract model in order to incorporate

SBHCs, FQHCs, and universities if STI clinics lose direct-service capacity.

De-stigmatizing STIs and establishing solid advocacy arguments were also recommended. It was noted that a primary barrier to both making testing more accessible and making funding “palatable” to political officials is the characterization of STIs as “deserved” or “dirty.” In this vein, some interviewees suggested developing advocacy arguments about the medical links to infertility, in particular. Other interviewees felt that regardless of health care reform, public health advocacy arguments must be developed, because the private sector may not be as attuned or interested in developing population-based programming and may be more interested in treating individual patients.

Finally, increasing efficiency on both the local and federal levels was noted as particularly important considering funding cuts and continued economic pressures. One interviewee noted attempts to operate more efficiently and build capacity, especially as it pertains to third-party billing. To this end, it was noted that streamlining programmatic processes from the federal or state level would help reduce administrative burdens on the local level. For example, one interviewee stated that his/her agency works in several states. In some of those states, the IPP covers chlamydia but not gonorrhea. In others, both tests are covered by the IPP. This has caused operational challenges to providing and tracking free tests. Another interviewee stated that standardizing the IPP would help smaller organizations with less infrastructure participate if the administrative burden could somehow be reduced.

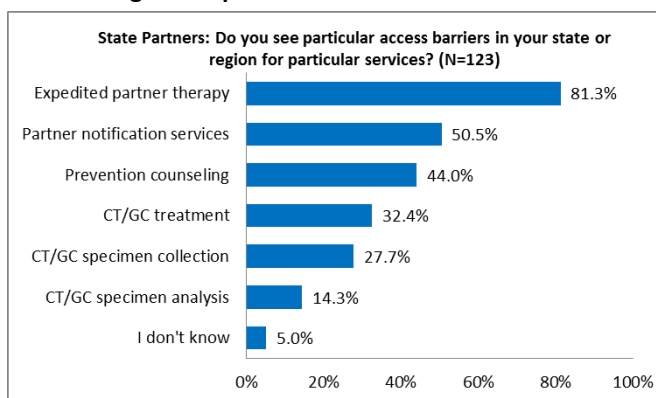


## Expedited Partner Therapy Implementation Challenges

A number of specific challenges to successfully implementing expedited partner therapy (EPT) were detailed across regional KIIs. Legislative and political challenges may be the most pressing and were noted in interviews across four regions. These challenges included lack of government support to pass legislation legalizing EPT, as well as the inability to use 340B drugs in EPT programs, making it too expensive to dispense medication. Insurance-related barriers were noted in interviews across three regions and pertained to both an inability to be reimbursed for EPT-related service and medication expenditures as well as limitations associated with dispensing medications to an individual's partner who may be uninsured. Other interviewees noted that even in project areas in which EPT is legal, implementation at the clinic level may not be occurring as expected. Incentivizing clinics to conduct EPT was another challenge, as one interviewee stated, "We get judged by the number of clients that come in the door. We don't get any points for doing (EPT)." Additional concerns included having available funding to purchase and distribute prepackaged medications to public health providers, as well as monitoring the utilization or uptake of EPT through the health care service sector, both public and private. As another interviewee stated, "it would be very, very challenging to identify how much of it (EPT) is occurring in the private sector and to what extent."

These challenges may contribute to why the vast majority of respondents to the state partners survey indicated that barriers to EPT access persist. See Graph 13, below.

**Graph 13: Do you see particular access barriers in your state or region for particular services?**



Opinions varied as to how HCR would impact local-level EPT implementation. One interviewee, for example, stated that EPT could be more challenging under HCR due to potential funding cuts to the public health sector. Other interviewees felt as

though HCR had the potential to enhance EPT by increasing the likelihood that client's partners will be covered by insurance. Still others simply stated that they did not know what the impact of HCR would be on EPT.

Given the general uncertainty associated with EPT under HCR and the overarching challenges associated with implementing EPT at the local level, several interviewees noted the ongoing need for awareness campaigns, guidelines, and distribution of official recommendations. One interviewee noted the need to "convince providers that a client is not fully treated unless her partner is also treated." Another interviewee noted the importance of working within the private sector because most chlamydia infections are diagnosed by private providers.

## Opportunities to Leverage the Strengths of the IPP

Challenges and the uncertainty associated with HCR notwithstanding, a number of interviewees pointed to some key facilitators of successful EPT implementation, foremost being the provision of proper guidance through training and awareness campaigns. To this end, interviewees noted posting materials on health department websites, conducting webinars, developing protocols and guidance documents, conducting presentations, and publishing articles in conjunction with key partners. In addition, interviewees noted several key partners to successfully implementing EPT, among them pharmacists, the state medical society, and public health boards. Interviewees also noted the importance of conducting pilot projects to demonstrate success, buying pre-packaged medication packets for easy distribution, and enabling health care providers to indicate through HEDIS measures whether or not they were providing EPT to partners.

Understanding local-level implementation of EPT was another critical facilitator. Several interviewees suggested conducting surveys in order to identify areas in which EPT was not being implemented and target outreach accordingly. Interviewees noted that these surveys were instrumental in identifying training needs across private and public sectors. In addition, one interviewee noted that utilizing a comprehensive approach to addressing sexual health with a community focus, rather than utilizing a singular focus on EPT itself, was particularly helpful in gaining provider support for the program.

Meanwhile, advocacy arguments for EPT continue to be developed. For example, on October 1, 2010, NCSD sent a letter to Dr. Tracy Wolff, Medical Officer



with USPSTF, requesting that the USPSTF consider the evidence on EPT as part of the next re-review of gonorrhea and chlamydia screening recommendations. The USPSTF is an independent panel of experts that makes evidence-based recommendations regarding the provision of clinical preventive services, which include screening, counseling, and preventive medications associated with primary care.

### Conclusion

Both national and regional key informant interviewees expressed consensus that: 1) vulnerable populations will continue to exist after HCR has been implemented; and 2) there will a continued need for safety-net services.

Interviewees stated that after HCR implementation, vulnerable populations will continue to include adolescents and teens in need of confidential services; women victimized by domestic violence; individuals with fluctuating insurance; politically controversial populations; homeless clients with mental illnesses; individuals with lower socioeconomic status; individuals who have major medical for catastrophic coverage only; individuals who refuse or forget to enroll in an insurance plan; young adults (commonly referred to as the “young immortals”); and undocumented individuals ineligible for any form of health insurance coverage.

The continued need for safety-net services was said to result from insurance fluctuations, appointment waiting periods, paperwork, complexity of enrollment, ongoing confidentiality concerns, and remaining cost of services. One interviewee summarized these concerns, stating that “coverage does not equal access.” It was also commonly expressed that with new forms of coverage, there will be an influx of new clients seeking services, the demand of whom may strain the private sector.

### Recommendations

**Recommendation 1:** Maintain the scope and volume of funding for direct service through diverse funding sources and provision of the IPP through 2013. Re-evaluate funding appropriations one year after full implementation of the PPACA to determine the extent of remaining need pertaining to: a) women and men between the ages of 15 and 24; b) Hispanic populations with limited English proficiency; c) any client needing confidential services; d) undocumented individuals; and e) formerly incarcerated individuals.

**Rationale:** This recommendation is made in light of the general consensus that unmet need and vulnerable populations will persist even under full implementation of HCR, and that the current health care workforce will struggle to meet the potentially growing demand of a newly-insured population base. The national interviewees were very clear that safety net services will continue to be needed in the future due to individuals fluctuating between types of coverage, choosing not to use their insurance for reproductive and sexual health services, and being uninsured. The majority of interviewees emphasized that there will still be millions of people uninsured—and that they will need safety-net services. This is especially true for the undocumented population. Some interviewees mentioned that there will always be a need for easy-to-access, confidential preventive services. One interviewee said that the only way preventive services work is if they can be accessed by people when they need them. Safety-net clinics provide easy access to preventive services when people need them most.

The national interviewees noted that the PPACA may make health insurance coverage a reality for some vulnerable populations that previously did not have health insurance. But the majority of the key informants felt that communities that have traditionally been underserved, such as racial and ethnic minorities, the formerly incarcerated, undocumented individuals, adolescents, and men, will continue to face challenges when accessing reproductive and sexual health care services.

The two groups identified most consistently as needing safety-net services were undocumented and formerly incarcerated individuals. National interviewees acknowledged that the PPACA excludes the undocumented population from participating in the expanded Medicaid services or insurance exchanges. The interviewees stated that this will be a large population of people who will remain uninsured post-PPACA. Also, some respondents noted PPACA may make access issues worse for undocumented immigrants because there are



restrictions about when they can start participating in health insurance exchanges. Moreover, some key informants felt that there are currently health insurance coverage transition problems for the formerly incarcerated population and that this issue will not be resolved by the PPACA. Specifically, there is confusion about the availability of Medicaid coverage for the incarcerated population during and after incarceration.

**Recommendation 2:** The design of the infrastructural arm of the IPP as 10 distinct coordinating agencies should be maintained through December 31, 2013. Between now and then, the CDC should work with key stakeholders, including the regional IPP coordinating agencies, to determine their role in building local-level capacity to effectively respond to changes and needs resulting from implementation of the PPACA, such as targeting resources to those most in need and assisting the state STI programs to transition from a service delivery focus to a policy, management, and systems focus.

**Rationale:** As noted by national interviewees, there will be a number of unintended consequences of the PPACA, some that can be predicted now and others that cannot. Some noted that it would be important to leverage IPP infrastructure strengths and successes in communication, coordination, and dissemination of best practices to guide sexual and reproductive health partners through the reformed health care landscape.

Because the high degree of uncertainty in the field and ongoing resource constraints have resulted in an inability to conduct strategic planning at the local level, it is imperative to help STI program directors and staff understand not only the elements of transformation but *why* change is crucial to the survival of the STI program. The current IPP coordinating agencies are in a strong position to provide technical assistance related to change management. Change management requires a culture and skill shift at all levels of an organization, from front-line employees to directors. As the funder and federal oversight program, CDC is in the best position to provide the 'maps' for each group so they can make this shift. The critical steps in initiating change management are:

1. Create awareness and desire for change
2. Build knowledge and ability to manage change
3. Assess effectiveness of directors, managers, and employees in managing change
4. Reinforce and reward change competency

A key element of this shift is to develop a workable strategic and/or business plan that comprehensively addresses all aspects of the program's culture, practices, and processes. These practices and processes include:

- \* Implementation of billing and reimbursement systems
- \* Mining various data sources to monitor trends
- \* Developing advocacy/policy and partner outreach plans



## Insurance Coverage

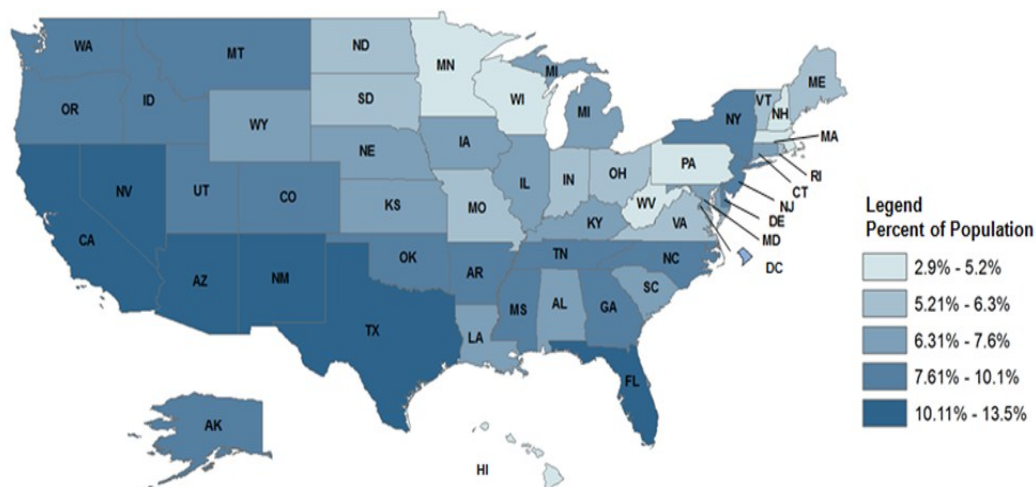


## Background

### ***Access to Health Insurance Under Reform***

The PPACA will expand insurance coverage by about 30 million people when it is fully enacted in 2014. According to some estimates, however, 19 million non-elderly individuals are projected to remain uninsured after full implementation of the PPACA (projected simulations were made as though the PPACA were fully implemented in 2011). Figure 1, below, provides a graphic representation of projections made by the Urban Institute on a state-by-state basis.

**Figure 1: Projected Percentage of Nonelderly Population to Remain Uninsured, Assuming Full Implementation of the PPACA in 2011<sup>37</sup>**



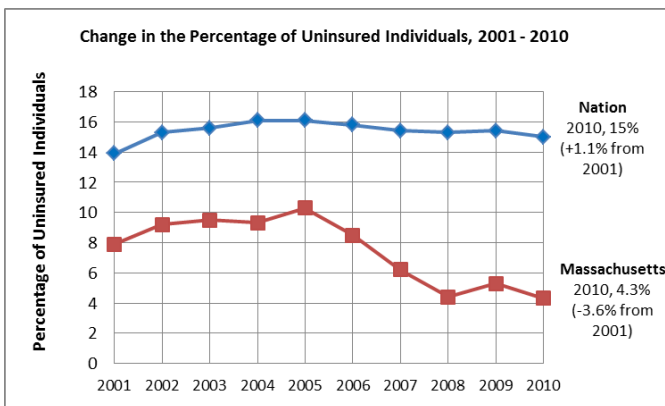


Although the number of uninsured people will be cut in half, this still falls short of universal coverage. Safety-net providers and programs will still face the challenge of providing services for a full range of individuals still in need. Knowing more about who will remain uninsured after full implementation of the PPACA will assist safety-net providers, organizations, support systems, and policy makers to determine ongoing needs for those who remain uninsured to provide access and meet the needs of these populations.<sup>38</sup>

Massachusetts enacted health care reform in 2006, which resulted in a sharp decline in the percentage of uninsured individuals throughout the state. However, 4.3 percent of the population remained uninsured as of 2010<sup>39</sup> (see Graph 14 below). A study completed in 2008 by the Robert Wood Johnson Foundation found that this population was more likely to be: male, young, and single; racial/ethnic minorities and non-citizens; unable to speak English well or very well; and living in a household in which there was no adult able to speak English well or very well. Compared with insured respondents, uninsured adults also reported substantially lower levels of educational achievement; more unemployment; lower family income; and greater financial stress. The report also found that one in three of the remaining uninsured adults in Massachusetts in 2008 were non-citizens.<sup>40</sup>

The process of implementing health care reform has highlighted the needs of vulnerable populations.

**Graph 14: Massachusetts Health Insurance Coverage Over Time, 2001-2010<sup>41</sup>**



According to the Commonwealth Fund, nearly one of three (29 percent) working-age women (19-64 years old)—or an estimated 27 million—went without health insurance for at least some part of the year in 2010.<sup>42</sup> Of the 27 million women who were uninsured at some point during 2010, half (49 percent) were in families with at least one full-time worker, and two of five (18 percent) were in families with part-time workers. One-third (33 percent) of

uninsured women were in families in which no one had a job. Additionally, the Commonwealth Fund found that the following groups would remain uninsured and vulnerable to the need for health care:

- \* Young, Hispanic, and women with low and moderate income. This particular group highlights the need for culturally competent health care to meet the diverse client needs of those likely to remain uninsured after reform.
- \* Those with incomes below 133 percent of the federal poverty level (\$29,327 for a family of four). In fact, almost half (51 percent) were uninsured during 2010.

Finally, the report found that women are more likely than men to be insured through a spouse or partner's employer.

Additionally, for some the proportion that health care costs, either insurance premiums or medical bills, took of their household income was quite substantial. For example, a third (33 percent) of working-age women—an estimated 26 million—spent 10 percent or more of their income on premiums and out-of-pocket costs in 2010, up from 25 percent in 2001.<sup>43</sup> In 2010, 57 percent of women with incomes below 100 percent of poverty (\$22,050 for a family of four) and 64 percent of those earning from 100-to-199 percent of poverty (\$44,100 for a family of four) reported medical bill or debt problems, up from 45 percent in 2005.<sup>44</sup> As a result of these financial hardships, 48 percent of working-age women—an estimated 45 million people—reported that because of cost they did not fill a prescription; skipped a recommended test, treatment, or follow-up; had a medical problem for which they did not visit the doctor; or did not see a specialist when needed.<sup>45</sup>

### **Insurance Expansion**

According to data released in a 2011 report of the National Center for Health Statistics at the CDC, the PPACA has already increased the number of young adults who have health insurance, a population particularly important to safety net providers who offer a range of family planning and support services. Data from the National Health Interview Survey (NHIS) shows that in the first quarter of 2011, the percentage of adults between the ages of 19 and 25 with health insurance increased by 3.5 percentage points, representing approximately 1 million additional young adults with insurance coverage compared to a year ago. The PPACA allows most children to remain on their parents' health insurance plans until age 26. No other age group experienced a gain in coverage, and experts agree that the PPACA made a difference.<sup>46</sup>



However, confidentiality remains a significant concern for adolescents and young adults. Mandated parental notification laws would likely increase risky or unsafe sexual behavior and, in turn, the incidence of adolescent pregnancy and sexually transmitted diseases.<sup>47</sup>

In addition, each state is charged with the task of establishing an “American Health Benefit Exchange” by 2014 within which legal U.S. citizens will have the ability to purchase health insurance from competing issuers. It is estimated that approximately 43.8 million persons will enroll in either this or a Small Business Health Options Program (SHOP),<sup>48</sup> which is akin to a health benefit exchange designed for the small group market. States have a multitude of options for administration of such exchanges, but control will be assumed by the federal government should a state fail to establish the proper infrastructure by 2014. Any health insurance plan bought or sold within an exchange will have to abide by new regulations designed to protect consumer rights while providing benchmark benefits.<sup>49,50</sup>

Also important, the 2010 health reform legislation gives states new authority to expand Medicaid eligibility for family planning services to women and men who are otherwise ineligible for the program.<sup>51</sup> Over the past 15 years, 22 states have received federal approval to extend Medicaid coverage for family planning services to residents solely on the basis of income under a “waiver.” A provision in the law provides for a streamlined process for a state seeking to expand Medicaid eligibility for family planning, and it also expands coverage of a larger population than currently included in any existing waiver program.<sup>52</sup> Twenty-eight states do not currently have an income-based family planning expansion. In January of 2011, The Guttmacher Institute conducted an analysis to determine the potential impact of expanding the Medicaid eligibility for family planning services, and found the following impacts could be realized through the “waiver” provision of the PPACA<sup>53</sup>:

- \* Nineteen states without an expansion could each serve at least 10,000 individuals, see a reduction of at least 1,500 unintended pregnancies, and save at minimum \$2.3 million in state funds in a single year by expanding Medicaid eligibility under the new legislation.
- \* Nine of these 19 states could each serve at least 50,000 individuals, reduce the number of unintended pregnancies by at least 7,500, and save at least \$17.4 million in state funds in a single year.

- \* Among the 22 states that already have a family planning expansion in place because of the older waiver process, 11 could each serve at least 10,000 individuals, see a reduction of at least 1,300 unintended pregnancies, and save at least \$1.7 million in state funds in a single year, in addition to what their expansions already achieve.<sup>54</sup>

Most key informant interviewees were hopeful that increased access to health insurance coverage will result in more individuals accessing reproductive and sexual health services, although very few interviewees felt this was the likely outcome. With an estimated 2.5 million women with Medicaid coverage obtaining care services at a publicly-funded family planning clinic, and three quarters of such women considering those clinics to be their usual source of care,<sup>55</sup> the context in which the clinics participating in the IPP provides services cannot be ignored. While the number of individuals with insurance will increase, there is no guarantee that services will be easy to access or that individuals will feel comfortable utilizing their health insurance for reproductive and sexual health services. Some interviewees were concerned that adolescents and young adults (covered under a parent's policy) who were previously utilizing publicly-funded services would be less likely to use insurance to access services due to confidentiality concerns. Additionally, interviewees reported that although clients may have new insurance opportunities, they may not be familiar or comfortable with utilizing services at private clinics.



### Third-Party Billing Capacity Development

With the advent of health care reform, both national and regional key informant interviewees agreed that FP and STI clinics will need to operate differently in the future. There was almost universal agreement that as the number of individuals with insurance increases, one of the primary challenges for FP and

---

*“...billing is a critical step for all IPP partners toward achieving financial stability.”*

---

STI clinics will be engaging in third-party billing for services. Clinics will no longer be able to provide only “free” or “donation-only” services.

Interviewees recognized that setting up the

internal and external systems for billing is a time consuming and energy intensive process; however, establishing these systems will be necessary in order for the clinics to survive. Interviewees talked at length about supporting the workforce of FP and STI clinics as they transition to an environment that includes contracting with insurance companies and engaging in third-party billing.

### Challenges

While the benefits of developing third-party billing capacity were largely undisputed by regional interviewees, their perspectives on the challenges of doing so varied substantially. Legal barriers to third-party billing implementation are typically related to politics and statutory language. Elected officials may believe states should not run private enterprises, and state regulations in some project areas mandate certain tests to be free, which may become an outdated concept post reform. For those states with legislative policies that prohibit their ability to implement third-party billing, this challenge primarily impacts public health laboratories, categorical STI clinics, and FP title X clinics housed in city/county health departments.

The more consistently identified challenges to third-party billing capacity development included the following:

- \* Lack of uniformity in billing processes across clinics in a program area
- \* Limits in experience and comfort developing memoranda of agreements with insurers
- \* Costly changes related to IT infrastructure

Other general challenges noted in primary data collection included:

1. **Capacity.** It was noted that greater capacity-building challenges would be experienced by STI clinics and public health laboratories, which may lack key infrastructural components as a result of historically not billing for services.
2. **Resource and infrastructure constraints.** Lack of funding, staff, or a sizeable client base present additional challenges. Several interviewees noted that staff shortages due to budget cuts greatly reduce clinical capacity to devote resources to third-party billing. In addition, the cost per transaction required to bill a single visit or service could be too high to be cost-effective in low-volume facilities.
3. **Monitoring development.** This barrier was noted in two regional interviews. Lacking a system to monitor either success or failure creates challenges associated with determining the extent to which individual facilities are billing and where to target resources accordingly.
4. **Public health mindset.** Some interviewees cannot compete with the private sector and avoid taking their business. In addition, some believe that the mission of public facilities is to serve uninsured individuals or vulnerable populations regardless of insurance status.
5. **Incentives.** Revenue generated by agencies may go into a local or state general fund, to no benefit to a specific laboratory or STI program. In addition, some interviewees did not see the need to bill third parties because their current client base is largely uninsured, and billing third parties would not add value to the clinic or its clients.
6. **Contract development.** Interviewees noted challenges associated with managing multiple managed care organizations with which agencies may have to contract, ensuring reasonable reimbursement rates, being able to bill for services provided by nurses, and the complexity associated with managing a high volume of contractual agreements.
7. **Confidentiality.** This was noted as a barrier to even considering billing third parties. As one interviewee noted, “we are liked for confidentiality, if we do bill insurance we can’t control their reporting and explanation of benefits, which will make it more difficult to provide confidential testing.”
8. **Systems interface.** Lack of system interface capacity was a concern particularly for public health laboratories. Extracting information from





outside agencies or providing test results across systems that cannot interface is a challenge and could make providers hesitant to utilize or enter into agreements with state public health laboratories.

9. **Efficiency and proper coding.** Without appropriate procedures in place or qualified staff, billing inefficiently could increase staff time or delay reimbursements.

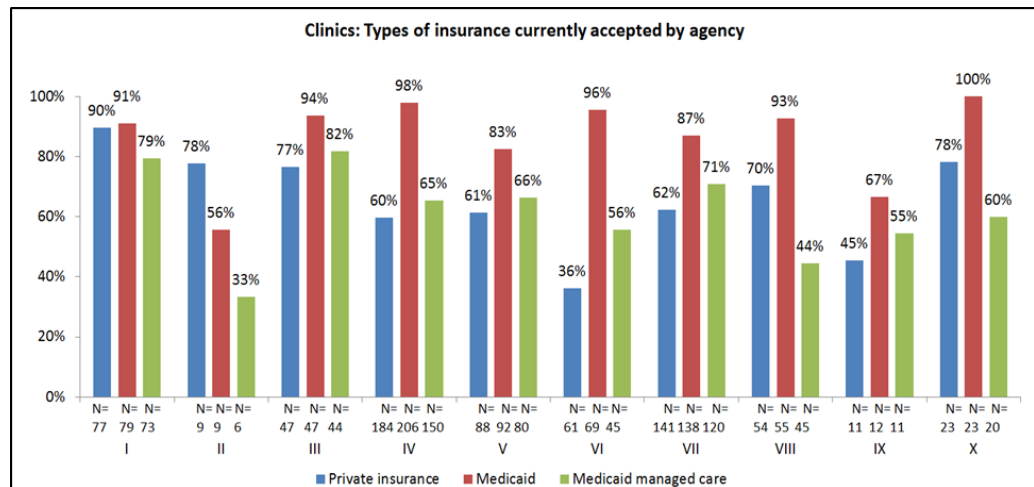
10. **Price breaks.** Currently, some family planning and STI clinics receive price breaks for laboratory testing, which would no longer be available if the clinic began to bill third parties.

In addition, public health laboratories may face some unique challenges associated with collecting the necessary billing information from the clients themselves. To that end, inability to interface Laboratory Information Management Systems (LIMS) in order to retrieve or send data with either providers or health departments is an inhibitive and costly barrier.

### **Opportunities to Leverage the Strengths of the IPP**

With regard to the barriers and capacity-building needs, regional interviewees mentioned a number of strengths that could be leveraged in order to help build third-party billing capacity, the foremost being experience. Regional interviewees noted that while many IPP-funded agencies currently bill third parties, capacity varies on both the state and county levels. Family planning agencies were noted to have more experience with billing, and it was suggested that FP agencies might help other FP or STI clinics develop capacity. Planned Parenthood facilities in particular were noted to be more advanced than either traditional FP facilities or STI clinics, and have developed skills in billing and coding procedures along with successfully contracting with insurance companies and other health care providers, which could be leveraged.

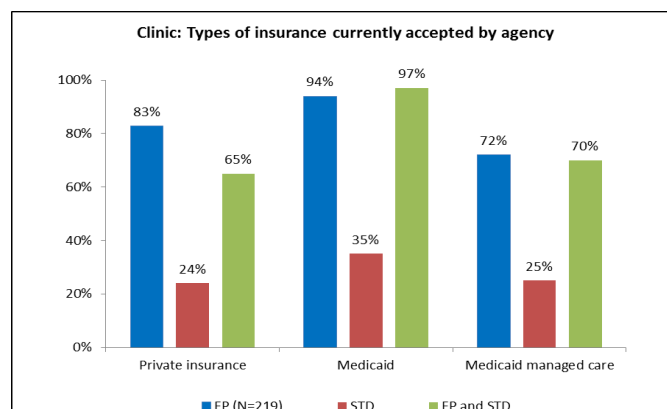
**Graph 15: Does your agency currently accept the following types of insurance?\***



\* Please note: Regional percentages presented in this graph are unweighted and represent the true frequency with which clinics reported billing capacity.

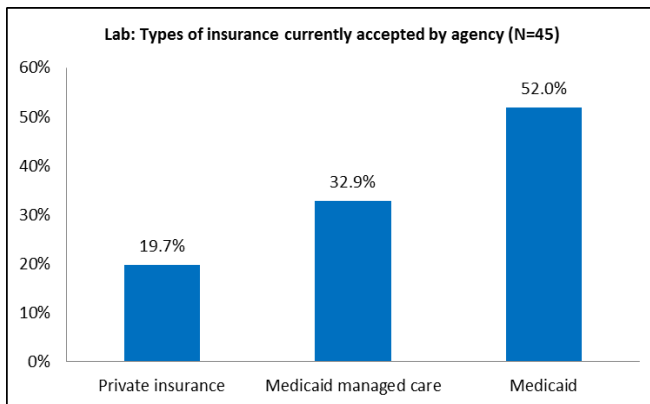
To better understand clinical capacity to bill third-party insurance carriers at the local level, clinics were asked to indicate whether they accepted either: a) private insurance: b) Medicaid; or c) Medicaid managed care. As Graph 15 shows, individual clinics were more likely to accept Medicaid than they were to accept private insurance, with the exception of Region II, an anomaly likely explained by a low respondent frequency. In addition, survey findings confirm regional interviewee perspectives that FP clinics are more likely to have third-party billing capacities than are either STI clinics or public health laboratories, as can be seen from Graphs 16, below and 17 on the next page

**Graph 16: Does your agency currently accept the following types of insurance?**





**Graph 17: Does your lab currently bill the following types of insurance for chlamydia and gonorrhea related**



Some regional interviewees also noted that third-party billing capacities have allowed their agencies to both increase and diversify their funding stream. One interviewee, in fact, offered to make available reports showing the amount of revenue generated from third-party billing. In addition, outsourcing billing practices was mentioned as a way to develop capacity in cases in which resources may be scarce. From the laboratory perspective, for example, turning billing back over to the clinics could be a cost saving strategy. For smaller agencies with less or no infrastructural capacity, it was suggested to connect to a larger entity such as an FQHC with the appropriate knowledge/resources could bill for them. In fact, one project area noted attempts to increase their partnerships with several FQHCs for exactly that purpose. Another project area noted attempts to identify an outside contractor to conduct all billings.

Considering these capacities and the benefits of third party billing, several implementation and training efforts were noted across the regional interviews. Implementation efforts involved participating in billing advisory groups to standardize billing services and pricing; meeting with health plans and engaging in discussions as to how to better coordinate the provision of public health care in the reformed environment; and passing legislation ensuring that insurance plans recognize “public health” as a provider. Training efforts have involved workshops, IPP advisory committee meeting presentations, webinars, maintaining listservs to communicate with providers, and technical staff trainings. Some interviewees noted using local experts to develop content for trainings on a variety of common billing issues.

Agencies that had developed these capacities or partnerships mentioned common facilitators to successful billing practices, including:

- \* Ability to directly communicate with and train clinic staff
- \* Development of systematic procedures and trainings
- \* Technical assistance and training on billing and coding
- \* Guidelines and model procedures
- \* Development or purchase of off-the-shelf software
- \* Standardized coding and billing, procedures and the development of efficient coding practices
- \* Staff participation in trainings
- \* Implementation of EHRs
- \* Resources, such as experienced staff and funding
- \* Hiring practices: for example, it was noted that sites “should hire people who know how to do third-party billing.” One interviewee noted that the director of finance at his/her agency had a private-sector background, and that this type of experience was necessary to develop capacity and leadership in this area.

Regional interviewees also identified a number of potential roles for the IPP under health care reform that could help partner clinics take advantage of their experience. These included the development of training materials and the identification and dissemination of best practices. Suggestions for training opportunities included hosting workshops, creating presentations and providing opportunities to capitalize on the expertise of billing experts. It was also suggested that the IPP infrastructure could provide information about other agencies’ best practices. In this sense, the IPP could identify states that could demonstrate the benefits of billing in order to facilitate the translation of such efforts into other states. Other suggestions included the development of standardized guidelines and protocols, as well as devoting specific funding to capacity-building efforts for billing and workforce development.

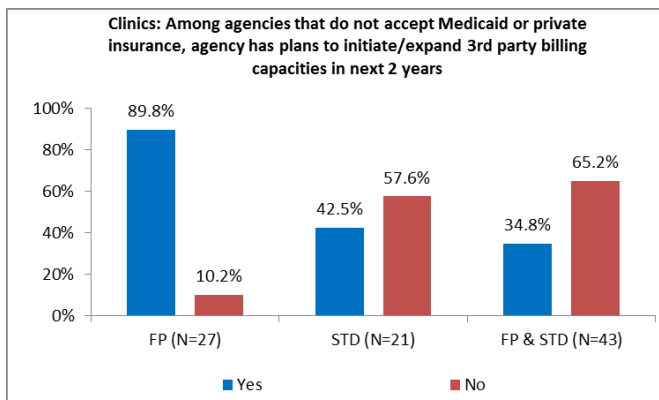
In contrast, two interviewees felt that the IPP is not suited to provide third-party billing assistance, stating that billing may be outside the scope of the IPP, which is generally more involved with surveillance and screening. One interviewee felt that the IPP could only contribute if the program could actually arrange funding for third-party billing initiatives and another stated that it was simply difficult to determine the IPP’s role moving forward. In light of “bureaucratic resistance to change,” however, one interviewee felt that there was a particular need for advocates to continue to encourage providers to both screen and provide



sexual and reproductive health services despite either HCR or third-party billing capacity. This person also stated, that, however, “It will be disastrous for jurisdictions that won’t or can’t develop systems for billing.”

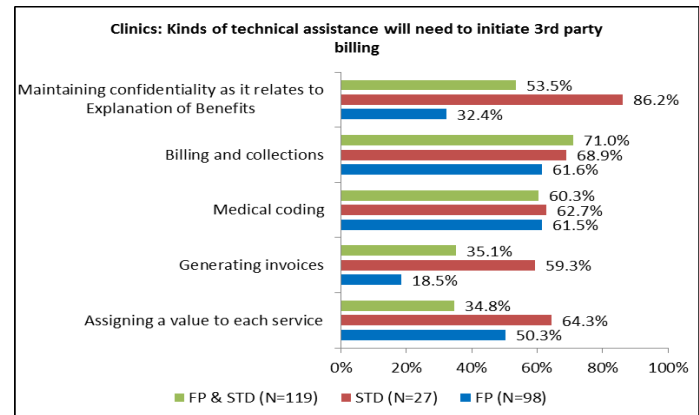
Accordingly, survey analysis demonstrates that among the 138 respondents representing clinics that do not have third-party billing capacity, approximately half have plans to initiate or expand that capacity within the next two years, a rate which varies depending upon clinic type. As shown in Graph 18 below, individuals representing family planning clinics alone were much more likely to respond that their clinic had plans to initiate third-party billing capacity within the next two years.

**Graph 18: If your agency does not accept Medicaid or private insurance, does your agency have plans to initiate or expand 3rd party billing capacities in the next 2 years?**



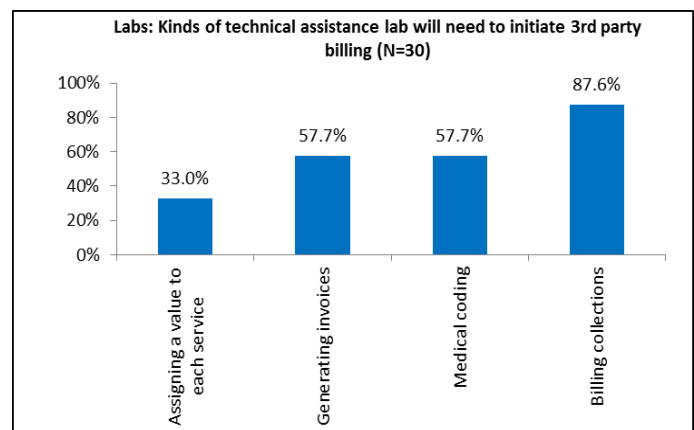
Survey findings also provide insight on the local clinics’ and laboratories’ specific technical assistance needs to initiate or expand billing capacities. As seen in Graph 19, among the 119 respondents representing FP and STI clinics who answered this specific question, the most commonly-cited technical assistance need was about billing and collections. This was also the case among respondents representing FP clinics alone. Among respondents representing STI clinics alone, however, confidentiality concerns pertaining to explanations of benefits were the most commonly-cited technical assistance need.

**Graph 19: What kinds of technical assistance does your agency need in order to initiate or expand 3rd party billing?**



Laboratory partners were also asked to indicate the types of technical assistance they would need in order to initiate third-party billing, and, as can be seen in Graph 20 below, technical assistance for billing and collections were again the most commonly cited.

**Graph 20: What kinds of technical assistance do you feel your lab will need in order to initiate 3rd party billing?**





### Confidentiality Concerns and Coverage for Adolescents

Confidentiality issues are particularly acute for the IPP client base seeking sensitive reproductive health services. Fear of disclosure may result in a client forgoing the use of insurance coverage to pay for services, while explanation of benefits (EOB) forms that result in parental notification create serious impediments to adolescents seeking services. While adolescents and young adults comprise a significant proportion of the individuals most strongly affected by confidentiality concerns, non-Medicaid insured individuals with personal reasons for requesting confidentiality, such as undocumented populations, immigrants, victims of domestic violence, MSM and other stigmatized populations, can be strongly affected as well.

#### Challenges

Nevertheless, IPP-funded agencies face a number of challenges related to EOBs that contribute to clients' reluctance in utilizing their private insurance for reproductive health services. While confidentiality

---

***“As long as concerns about EOBs exist for adolescents, they will be discouraged from accessing care.”***

---

agreements with private providers similar to those secured with Medicaid have been advanced, there are currently no established agreements in place, and private insurers routinely mail EOBs to their clients. In particular, interviewees expressed frustration over their inability to bill private insurances as a result of statutes and regulatory roadblocks

that require the insurance to send clients an EOB. One interviewee estimated that as many as half of their clinic's current IPP clients are insured but do not utilize their insurance when accessing FP and STI services because of confidentiality concerns. Another interviewee stated that fears of billing errors on the clinics' part prevented them from billing any STI test performed, regardless of insurance type.

#### Moving Forward under Health Care Reform

Almost all interviewees worried that patient confidentiality concerns will persist upon full implementation of health care reform. As the number of individuals eligible to be covered as dependents increases, challenges faced by private providers in meeting the demand for confidential services noted above will be exacerbated accordingly. Expanding coverage will not alleviate the demand for confidential services that private

providers currently have limited capacity to offer, nor will it mitigate concerns regarding insurers that mail EOBs to clients. In particular, several interviewees felt that confidentiality issues will need to be addressed within the political arena before health care reform is implemented. Interviewees also expressed uneasiness that recent political conversations surrounding FP and STI services have had limited success in acknowledging facts relating to the importance of confidentiality in the service environment.

---

***“It is not a question of who is paying the bill... it's a question of an individual's privacy.”***

---

With the advent of health care reform, the IPP has the potential to play a significant role in addressing these challenges and facilitating the provision of confidential services. Interviewees stated that despite the increased number of individuals eligible to be covered under private insurance, there will be continued unmet need for people such as adolescents; non-Medicaid insured individuals with personal reasons for requesting confidentiality, undocumented populations, immigrants, victims of domestic violence, MSM, and other potentially stigmatized groups. Because some medical home models or CHCs may not be as experienced or skilled in providing confidential care, advocacy for the safety net and the continuation of IPP-funded agencies will be critical.

#### Opportunities to Leverage the Strengths of the IPP

Interviewees also expressed the hope that the IPP will serve as a facilitator for discussions on a national level, especially in the political arena. Interviewees felt that in particular, national support is needed in order for the IPP to implement a solution that prevents the mailing of EOBs unless requested by the client receiving services. Interviewees also viewed the IPP infrastructure as a significant body of subject matter expertise and specific experience in STI trends, treatment options, and disease epidemiology. Dissemination of trainings, guidelines, and best practices in both local and national spheres will be critical ways in which the IPP infrastructure can educate the increasing number of new partners who will provide reproductive health services under HCR.

IPP-funded agencies have historically been successful in creating an environment where teenagers and young adults feel comfortable that their confidentiality will be maintained. Interviewees





expressed that their agencies have been effective in leveraging grant funds, family planning benefit waivers, and Medicaid agreements in order to provide confidential services. In particular, Medicaid agreements exist in several locations that prevent EOBs from being sent to adolescents, alleviating clients' fears of disclosure.

### Conclusion

Both national and regional key informant interviewees agreed on a number of issues pertaining to insurance coverage under health care reform. First, interviewees agreed that the development of third-party billing capacity will be critical to the sustainability of IPP clinic partners. Second, interviewees agreed that with the importance of third-party billing, resources and technical assistance should be directed toward these efforts across both FP and STI clinics. Third, interviewees agreed that despite new health insurance access points, such as a health benefits exchange or an expanded Medicaid program, challenges will persist in individual ability to access or utilize affordable health care. Primary among such concerns may be the persistence of the potential to breach patient confidentiality resulting from explanations of benefits. These ongoing challenges necessitate the viability of safety-net services in a reformed health care landscape.

### Recommendations

**Recommendation 3:** Devote training and technical assistance resources to facilitate third-party billing capacity development, especially targeting STI and FP clinics and public health laboratories.

*Rationale:* The national interviewees agreed that Title X family planning and STI clinics will need to operate differently in the future. There was almost universal agreement that one of the primary changes for Title X family planning and STI clinics will be engaging in third-party billing for services. Clinics will no longer be able to provide “free” or “donation-only” services; they will have to offer billable services as well. It was recognized that setting up the internal and external systems for billing is a time consuming and energy intensive process, but establishing these systems will be absolutely necessary in order for the clinics to survive. Interviewees talked at length about supporting the workforce of Title X family planning and STI clinics as they transition into an environment that includes contracting with insurance companies and engaging in third-party billing.

Because of the general acknowledgement across key informants that an increasing volume of individuals will have access to health insurance coverage post-January 1, 2014, and the secondary data projecting the number of uninsured individuals in the United States to decrease by 50% or approximately 23 million with the full implementation of HCR, clinics and laboratories will have to have the capacity to bill third parties in an efficient and effective fashion. According to key informant interviewees, developing third-party billing capacity has increased and diversified revenue streams, resulting in increased sustainability.

**Recommendation 4:** CDC and the IPP should work at the state and national level to ensure that confidential sexual health services are available in the new health care environment.

*Rationale:* Stigma related to sexual health services will continue, especially in small towns and rural and frontier areas. Safety-net services have shown that they are best at providing these services to so-called vulnerable populations or specific groups of people. National interviewees noted that a lot of clients do not like accessing reproductive and sexual health care services in a primary care setting. They prefer to receive care from the experts who are trained to ask the right questions in a nonjudgmental manner and to provide the highest quality care possible. There is, also, widespread concern about access to confidential sexual health services for a variety of



populations, including adolescents and vulnerable populations.

It was frequently reported in the national interviews that adolescents will continue to have confidentiality issues when seeking reproductive and sexual health care services. Many interviewees felt that the PPACA actually made confidentiality issues more of a concern for adolescents and young adults given that they can be covered by a parent's policy until age 26. Some respondents were very concerned that adolescents will not seek care if they know that a parent will be receiving an explanation of benefits describing the types of services accessed by the teen.

In addition, while US Preventive Services Task Force (USPSTF) grade A and B recommendations do include expanding access to and coverage for preventive screening services, they do not specify sexual health services for men.

**Recommendation 5:** CDC and the IPP should consider opportunities to address the sexual health needs of males through data supported screening recommendations.

*Rationale:* Some respondents stated that while low-income men have a lot to gain with the expansion of Medicaid eligibility, reproductive and sexual health preventive services for men have not been as clearly defined as they have been for women.

**Recommendation 6:** CDC should continue to work at the federal level to change the definition of CT client treatment to include partner treatment regardless of the partner's insurance status.

*Rationale:* Some interviewees also felt that specific services were more difficult to access for everyone. There was much talk about how the administration EPT varied by community in those states where it is allowed. Interviewees felt that often providers do not know how to go about implementing EPT in their clinic or are concerned about the legal ramifications of providing treatment to partners. It was also mentioned that access to a pharmaceuticals is an issue for some clients, especially people living in small towns or rural or frontier areas where there may not be a pharmacy.

The use of EPT has been limited because providing medication to a partner depends on the partner's status as a covered beneficiary. Insurance-related barriers were noted in interviews across three regions and pertained to both an inability to be

reimbursed for EPT-related service and medication expenditures. Dispensing medications to uninsured partners through the 340B drug program is cost-prohibitive because the Health Resources and Services Administration's (HRSA) definition of a client is highly exclusive.





The Health Data Initiative (HDI) is a public-private collaboration that encourages the utilization of health data. The goal of the initiative is to develop applications to raise awareness of health and health system performance and engage community action to improve health.<sup>61</sup> The HDI hopes to see an expanding array of applications being built using data from the Department of Health and Human Services (HHS) and other data suppliers.

At the core of many HIT initiatives is the use of EHRs. The widespread use of EHRs in the United States is inevitable. They will improve caregivers' decisions and patient outcomes. Health care providers working within the publicly-funded family planning network sometimes serve as the only source of care for low-income, uninsured, and under-insured individuals. Providers often experience difficulties accessing patient records and complete histories because many individuals move on and off health insurance plans and in and out of different provider networks. EHRs would help to minimize these issues and provide quality and continuity of care.

The Health Information Technology for Economic and Clinical Health Act (HITECH)<sup>62</sup> provides incentive payments to Medicare and Medicaid clinicians and hospitals for privately and securely using EHRs to achieve specific improvements in care delivery. Currently, publicly-funded family planning systems face many barriers, such as appropriate staffing, material resources, and the HIT infrastructure to fully implement EHRs, that make them ineligible for these incentives.<sup>63</sup>

In a 2011 report prepared for the Agency for Healthcare Research and Quality (AHRQ), state and regional demonstration health information exchange (HIE) projects were reviewed. As presented in the report, the key lessons from the review highlighted the importance of detailed project planning and management; building community trust; policy and technical operations that are mutually informative and simultaneously developed; technological considerations and testing; demonstrating value; and long-term sustainability.<sup>64</sup>

### ***STI Surveillance***

There was consensus among national key informant interviewees that currently a limited amount of data related to reproductive and sexual health service delivery is being collected. Several interviewees speculated that the following variables are among those collected: risk history, type of test technology utilized, test results, and patient demographics. However, there was not agreement among the interviewees about which specific variables are

collected consistently.

Reasons that these variables may not be collected were thought to relate primarily to the stigma associated with asking and answering the questions in a health care setting. Many interviewees thought that it would be helpful if reproductive and sexual health data collection standards and requirements were established and shared with HIT vendors to insure that the systems meet the requirements.

National key informant interviewees also provided insight as to the potential benefits and concerns associated with HIEs. In order to make certain that STI-related variables are collected, reported, and utilized within these structures, interviewees recommended that the following individuals and organizations be part of the conversation: the CDC, surveillance experts, health insurance plans, funders, FP clinics, Planned Parenthood, STI clinics, public health departments, school-based health centers, justice system health clinics, private providers, laboratories, EHR vendors, and advocacy groups.

There was substantial discussion and concern expressed about confidentiality as it relates to HIT and HIEs. Interviewees were concerned about the unintended release and misuse of information confidential information, and would like a policy to protect individuals from this happening. Interviewees also highlighted the current conversations about not collecting reproductive and sexual health variables from specific groups of people, such as adolescents. There was a mixed reaction to this idea as some feared that incomplete data sets would result, and concern about how and who would decide which health variables are more confidential than others. Some HIEs have decided to have either opt-in or opt-out policies, to allow patients to decide whether they want their information to be shared between treating providers and public health departments. Under this policy, patients may opt out of sharing health data defined as "sensitive" or all health data. Unfortunately, this could result in underreporting of some health conditions, such as STIs, as patients may consider STI-related information more sensitive than other health information.

### ***Utilizing Local Data***

Interviewees repeatedly reported that data is not currently being utilized to its full potential at the local level. For some, it could be due to a lack of expertise in data analysis, but most interviewees believe it is likely due to limited capacity because of budget constraints at the state. Many states have skilled epidemiologists on staff, but because of state





budget issues, they are not able to commit substantial time to STI data use and planning. Clinic staff and local health departments need additional training so that they can use their own data in a meaningful manner.

National key informants noted the need to standardize the collection of data across all sites and to make sure that organizations not duplicate data collection and analysis efforts. There was much discussion about the variation between data collected and reported by public and private clinics and labs. The majority of interviewees felt that private clinics and labs do not report STI data as rigorously as their public counterparts. However, there was hope that HIT may make reporting easier for private facilities, which would in turn improve overall STI surveillance.

One interviewee pointed out that to ensure that STI surveillance improves with increased use of HIT, STI reporting must become a requirement in the next stages of meaningful use as defined by the Centers for Medicare and Medicaid Services (CMS) and the Office of the National Coordinator for Health IT (ONC). This would ensure that all facilities aiming to meet the meaningful use requirements would report STI-related variables. There was also some discussion of using HIEs to track, monitor, share, and understand STI data. Databases should flow through the HIEs so that pertinent data can be aggregated to create registries, which would support public health authorities in their efforts to prevent and control the spread of STIs.

## Electronic Disease Surveillance System Improvement

### Challenges

Regional interviewees indicated a number of challenges associated with the development of statewide electronic disease surveillance systems. Among the primary IPP-related challenges is the fact that such systems are generally not used for IPP-related prevalence monitoring because they typically do not capture negative test results. One project area noted the need for a separate database to be used for IPP prevalence monitoring. In addition, many interviewees noted that some statewide systems monitored information pertinent to all communicable diseases—with the exception of HIV. In fact, only one project area reported the ability for their statewide electronic database to interface directly with eHARS, a common surveillance system used to capture HIV-related variables.

Additional challenges associated with statewide surveillance systems included reduced flexibility as some systems lack the ability to do mass record updates; reduced speed and inability to generate reports with large records during work hours; data completeness, particularly for race and ethnicity data within Electronic Laboratory Reports (ELRs); collecting appropriate information from private providers and laboratories, especially pertaining to HEDIS data for chlamydia screening; funding to implement system updates; and connecting providers to the statewide system. This latter challenge was particularly notable as it requires time and funding to facilitate system interface capacities, which is in turn crucial to accurately identifying gaps in service provision or treatment.

Funding and infrastructural development challenges were cited in interviews across three regions, and pertained to local-level capacity to plan for and support infrastructure development and the adoption of EHRs. Project areas that had converted to electronic surveillance systems and EHRs noted both the complexity of such a transition as well as the high volume of funding, administrative support, staff time, and planning needed for such an effort. One project area in particular that had converted from STD\*MIS to Maven noted that the conversion “was an enormously complex, extremely expensive process that took several years, required close collaboration and cost millions of dollars.” This interviewee went on to state that it was unlikely that financially strapped project areas would be able to replicate such a transition.



Another commonly noted challenge had to do with data silos and the high cost of developing system interface capacity, even for relatively advanced agencies such as Planned Parenthood. This challenge has resulted in some project areas reporting an inability for FP and STI data to communicate with each other, which may mean incomplete data reports and reduced efficiency in direct service delivery efforts.

---

***“The flow of data between electronic disease surveillance systems is more important than the system itself.”***

---

The difficulty in obtaining complete demographic information, particularly race and ethnicity data, was another prominent theme, noted in interviews across five regions. This was attributed to a number of factors, including a low level of staff understanding of the importance of collecting this information, the stigma associated with recording race/ethnicity data, and a general lack of provider compliance, particularly among the private providers. Finally, interviewees across three regions reported the need to streamline provider reporting forms, noting that paper records and manually entering information into data surveillance systems are burdensome and time consuming. They suggested that having the ability to electronically report cases would ease such administrative burden.

### **Moving Forward under Health Care Reform**

Common strengths associated with statewide electronic data collection and surveillance systems included:

- \* **Improved data quality** by reducing data entry error through the use of electronic prompts and by reducing duplication through alerts designed to flag similar records.
- \* **Reduced burden** of data entry for case reports.
- \* **Improved ability to track repeat infections** and identify core groups.
- \* **Improved reporting timeliness and local-level access.** Local users can see real-time data as it is entered and can follow-up with clients faster, without a heavy reliance on the state health department for report generation and analysis.
- \* **Improved geographical analysis** at the city and neighborhood level.
- \* **Increased capacity to monitor treatment timeliness** for chlamydia and gonorrhea<sup>66</sup>.

In addition, many interviewees noted that HCR has the potential to increase data accuracy and timeliness, ease administrative burden, and help providers meet data reporting requirements through an increased focus on digitization and electronic data collection. For example, one interviewee noted that with electronic case reporting, providers can be ‘forced’ digitally to submit forms accurately and completely. In addition, with an increased focus on the development and utilization of electronic medical records, administrative burden can be greatly reduced. Substantial challenges remain, however, for low volume or financially struggling facilities to complete such a conversion.

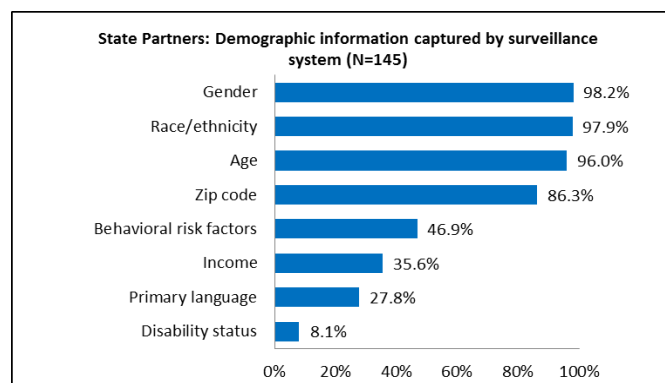
Interviewees were also asked to comment on: 1) new reporting requirements surrounding primary language and disability status; and 2) health information exchanges. Questions about new reporting requirements were developed in response to Section 4302(a) of the PPACA:

“...The Secretary shall ensure that, by not later than 2 years after the date of enactment of this title [March 23, 2012], any federally conducted or supported health care or public health program, activity or survey... collects and reports, to the extent practicable -

- a) Data on race, ethnicity, sex, primary language, and disability status for applicants, recipients, or participants;
- b) Data at the smallest geographic level such as state, local, or institutional levels if such data can be aggregated;...”

While the phrase “to the extent practicable” in the above legislation leaves room for interpretation, this specific provision could have important implications for surveillance reporting. As shown in Graphs 21, below and 22 on the next page, according to the state or laboratory partners’ survey findings, neither primary language nor disability status are variables routinely captured by disease surveillance systems.

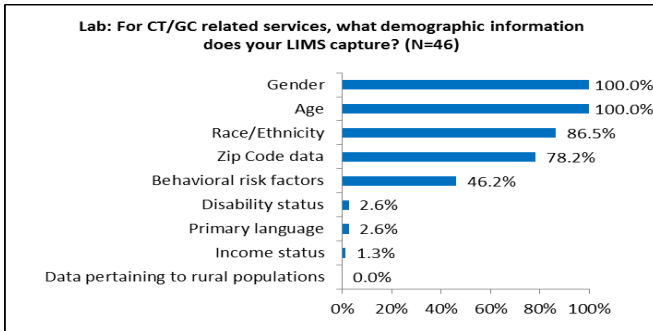
**Graph 21: For chlamydia and gonorrhea related services, what demographic information does your surveillance system capture? (Please mark ALL that apply.)**







**Graph 22: For chlamydia and gonorrhea related services, what demographic information does your LIMS capture? (Please mark ALL that apply.)**



Regional interviewees noted that while primary language and disability status for IPP participants are generally not currently-collected variables, it will be possible to develop this capacity with the proper direction. Lab requisition forms, for example, would have to be changed, providers would have to be incentivized, and additional variables would have to be included in electronic databases. Modifying data systems to include additional variables, however, would not address the problem that some agencies face in terms of collecting complete information from hospitals and clinicians to begin with, and one interviewee hoped that new provisions, such as Section 4302, will force or otherwise incentivize providers to report. For this reason, some interviewees felt that it was increasingly important to become involved in the development of and access to HIEs. It was noted, for example, that collection of key variables within HIEs would depend on how such exchanges are operated and monitored. If, for example, they depend largely on ELR reporting, one interviewee noted that the quality of race and ethnicity data could degrade. This interviewee also noted that access to key variables such as pregnancy status could be less available if future HIEs do not require such data elements to be collected. Another interviewee noted that a lack of involvement on the part of state STI personnel could be problematic if such personnel do not have input as to what variables should be included in HIEs.

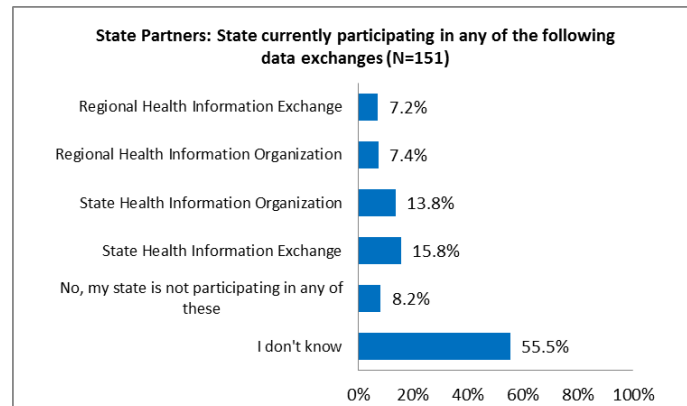
Considering the importance of HIEs and their potential to help public health decision-making, some interviewees recommended that the IPP should focus on accessing data from regional health information organizations (RHIOs) and even help to establish requirements that STI representatives have a voice as HIEs are formed and data elements/formats selected. One interviewee from a region that has made advancements in the development of RHIOs noted that while such structures were designed to assist in the coordination of care, public health had become the primary user of RHIOs in that

particular project area. This interviewee went on to state that “Local advocacy played a big part in getting public health ‘to the table’ and gaining access to these systems.”

To this end, IPP state partners were asked to indicate if their state was participating in any form of a data exchange.

While a number of respondents indicated that their state was participating in a health information exchange, the majority of respondents did not know if their state was participating in such structures. See Graph 23 below.

**Graph 23: Is your state currently participating in any of the following data exchanges?**



Other recommendations for the IPP under HCR included a continued role in quality assurance, and expanding efforts to include educational outreach to private providers to ensure that complete and accurate data is collected across sectors. Training and technical assistance for HIEs, electronic case reporting, and data reporting requirements in the PPACA were also suggested.

*“Local advocacy played a big part in getting public health ‘at the table’ and gaining access to these (health information exchange) systems.”*



### Geographic Information Systems Mapping

Geographic information systems (GIS) can expedite IPP surveillance and targeting. GIS combine mapping capabilities with additional database management and data analysis tools. As GIS software becomes increasingly available for widespread use, so has the availability of geographic information and the ability to identify spatial relationships that are beyond the scope of traditional tabular data analysis.

### Moving Forward under Health Care Reform

GIS has a number of strengths that IPP could leverage. Interviewees cited the ability to define neighborhood characteristics and map socio-demographic information such as income, race/ethnicity, education, and the locations of geographic features. GIS can also be used in surveillance and targeting to map client-level data and clinic data. This could include client and clinic density, utilization, cost, positivity, clinic incidence and prevalence, disease clusters, and the evolution of disease profiles in certain areas.

These mapping capabilities will provide the IPP with enhanced client, clinic, and disease management. Interviewees cited the ability to identify areas in need of testing, areas in need of testing based on extreme travel times, and areas with testing saturation. GIS allows for data overlay, which facilitates connections between morbidity, demographics, and other social determinants of health. Accordingly, interviewees mentioned that GIS would make it possible to identify disease clusters more swiftly and accurately. Because GIS software can also show disease evolution over time, it can serve as a valuable tool for creating predictive models. These mapping tools provide agencies with important information that can help the IPP determine where to target resources and enhance their screenings.

GIS also provides a method by which IPP-funded agencies can present information for outreach and educational purposes. Several interviewees stated that in their experience, spatial patterns are often more apparent when visually depicted, as opposed to when they are presented in tabular or graphical formats, allowing audiences to grasp information more quickly. One interviewee stated that their agency currently uses GIS to recruit new Clinics participating in IPP by identifying and presenting information to clinics in high morbidity areas. Another interviewee cited the powerful impact a GIS-developed map of morbidity rates had in advocacy efforts to develop a screening collaboration with their local school system.

### Opportunities to Leverage the Strengths of the IPP

While GIS presents many opportunities for the evolving IPP, a number of challenges may arise in its utilization. While the availability of spatial data has increased exponentially in recent years, not all data is uniformly available for all geographic areas. Data gaps can be exacerbated by incomplete reporting, particularly from FQHCs or private providers, or by data that has not been reported in a uniform manner. Most significantly, however, are the resources and workforce requirements needed to purchase and use GIS, which requires significant funds and training.

A number of interviewees felt that the IPP has the ability to enhance agencies' utilization of GIS software and to alleviate some of the challenges in obtaining funding and/or uniform data. Interviewees recommended the need for nationwide guidelines to standardize GIS data collection, storing, cleaning, and coding of data. Others suggested the creation of online channels through which IPP-funded agencies could share information, as the ability to download certain types of preprogrammed data (i.e., census data) would reduce cost and labor hours.

Interviewees also cited IPP's potential to provide resources, expertise, and trainings in interpreting GIS data and maps. In particular, interviewees were interested in GIS as a topic for a conference or online forum. Several interviewees also suggested the creation of a nationwide online GIS users group at the state or infrastructure level that could serve as a useful platform for discussion. These efforts have wide potential for enhancing IPP-funded agencies' technological capacity and fostering collaboration among partners.

### Conclusion

Both national and regional interviewees agreed that state-based participation in HIEs will be critical to ensuring that sexual and reproductive health-related variables are captured in new systems and utilized to improve programmatic efforts. Survey findings and regional interviews indicate that awareness needs to be raised about the scope and purpose of these structures, as well as the importance of state-level participation in their development.

National and regional interviewees also agreed that local-level training efforts must be made and maintained to ensure that sexual and reproductive health variables are consistently collected and efficiently utilized across both public and private sectors.



## Recommendations

**Recommendation 7:** Gradually (i.e. between July 1, 2012 and December 31, 2013) dissolve data collection and warehousing responsibilities of IPP coordinating agencies. During that time, the CDC should work with key stakeholders, including regional IPP coordinating agencies and state partners, to support state and local STI programs, FP programs, and public health laboratories in efforts to: a) develop and utilize electronic health records; and b) participate in the development of health information exchanges.

**Rationale:** The public health and health care systems are going through tremendous change at this point in history, and the STI, FP, and public health labs are struggling to keep up with the changes while improving the quality of data collected by a wider network of providers who are providing screening and treatment for chlamydia and gonorrhea. Going forward, state STI programs will face the challenge of transitioning from a regional chlamydia and gonorrhea prevalence monitoring system to a state system. Particular concerns noted by the regional KIs included that quality data collection efforts could be particularly challenging without public health laboratories, as the role of the state laboratory is critical in terms of monitoring disease prevalence and providing data to identify risk factors and changes in disease burden. However, regional IPP coordinating agencies are in a unique position to provide technical assistance to aid in this transition. The coordinating agencies are adept at: 1) identifying what data needs to be collected at the clinic and state level for prevalence monitoring; 2) developing protocols for merging, cleaning, and reporting data within the requirements of state and federal requirements, and; 3) using data for quality assurance and quality improvement (QA and QI) to improve targeted, cost-effective screening and compliance with treatment protocols.

There were national interviewees who believe that reproductive and sexual health variables are not being collected routinely. Reasons related primarily to the stigma associated with asking and answering sex- and reproduction-related questions in a health care setting. Many interviewees thought that it would be helpful if reproductive and sexual health data collection standards and requirements were established and shared with health information technology (HIT) vendors to ensure that the systems meet the requirements.

National key informants noted the need to standardize the collection of data across sites and to make sure that organizations not duplicate data collection and analysis efforts. There was much

discussion about the variation between data collected and reported by public and private clinics and labs. The majority of interviewees felt that private clinics and labs do not report STI data as rigorously as their public counterparts. However, there was hope that HIT may make reporting easier for private facilities, which would in turn improve overall STI surveillance.

Interviewees repeatedly reported that data is not currently being utilized to its full potential, likely due to lack of local-level data analysis expertise. Clinic staff and local health departments need additional training in order to use their own data in a meaningful manner.

Based on the issues and changes noted above, the IPP infrastructure should transition from data collection and warehousing. Instead, it could provide technical assistance to program areas and clinics on various data-related activities such as negotiation with HIT vendors, coordinate state and regional data exchanges to include IPP-related data variables, and mine various data sources and use data to tell their program's story.

The findings from the literature review and national key informant interviewees suggest that state and local IPP data be routinely shared with the HHS Health Data Initiative via the Community Health Data source, which includes 1,170 metrics of community health and health care performance. The Health Data Initiative is a major new public-private effort to help Americans understand health and health care performance in their communities, and to help spark and facilitate action to improve performance. The Health Data Initiative mirrors the core activity of the IPP, which is to utilize data to inform programmatic decision-making and improve services. The fundamental approach of the initiative is to catalyze the advent of a network of community health data suppliers (starting with HHS) and "data appliers" who utilize that data to create applications that: 1) raise awareness of community health performance; 2) increase pressure on decision makers to improve performance; 3) facilitate and inform action to improve performance.<sup>66</sup>

**Recommendation 8:** State and local health departments, in collaboration with CDC, should release a brief policy statement targeted to private and public health care providers, community health centers, FQHCs, primary care practices, FP clinics, STI clinics, and public and private laboratories to outline current and new reporting requirements and the importance of collecting information on race, ethnicity, sex, primary language, disability status,



and other social determinants of health from individuals receiving sexual and reproductive health services.

*Rationale:* This recommendation is made in light of Section 4302 of the PPACA, as well as survey findings indicating that specific PPACA variables, such as primary language and disability status, are not routinely collected. However, regional interviewees agreed that with the proper direction these variables could be included in electronic surveillance systems. In addition, regional interviewees agreed that training efforts should be in place to ensure the routine collection of race and ethnicity data in addition to other social determinants of health and STI surveillance data variables.

Many national key informants agreed that a limited amount of data related to reproductive and sexual health service delivery is currently being collected, although there was not agreement on which specific variables are being collected consistently. Several interviewees thought that the following variables are currently being collected: risk history, type of test technology utilized, test results, and patient demographics. When asked what reproductive and sexual health variables they would like to see collected in addition to those already being collected, interviewees listed the following: risk behavior, previous pregnancies, contraceptive use, STI history (counseling, results, and treatment), number of sex partners (lifetime and/or past six months), description of clients screened and not screened, description of clients tested, and specimen site/source.

Interviewees felt that in order to make certain that STI-related variables are being collected, reported, and utilized within HIE the following individuals and organizations need to be involved: the CDC, surveillance experts, health insurance plans, funders, Title X family planning clinics, Planned Parenthood, STI clinics, public health departments, school-based health centers, justice system health clinics, private providers, labs, electronic health record vendors, and advocacy groups.





A word cloud visualization of terms related to social media and reproductive health. The most prominent words are 'social', 'media', 'STD', 'sexual', 'partnerships', 'reproductive', 'health', 'care', 'healthcare', 'FQHCs', 'planning', 'information', 'need', 'population', 'target', 'community', 'challenges', 'HIV', 'important', 'individuals', 'agencies', 'programming', 'messages', 'developing', 'regions', 'confidentiality', 'training', 'family', 'time', 'sector', and 'social'.



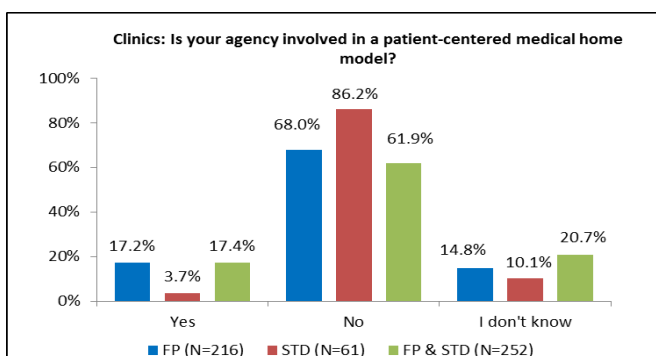
### ***Positioning Sexual and Reproductive Health in a Reformed Environment***

A number of national interviewees pointed out that currently, FP and STI clinics serve as critical entry points to the health care system for many patients. Interviewees speculated that even with the advent of health care reform, individuals who prefer to receive reproductive and sexual health services from FP and STI clinics will not be comfortable going to a primary care provider for these services. Other interviewees expressed doubts about the quality of sexual and reproductive health care services provided in primary care settings. Many of the national interviewees believe it is time for Title X family planning and STI clinics to form alliances with primary care providers and clinics in their community. These relationships will be of value in the post-PPACA world. Some interviewees noted that it takes a lot of time to create alliances with other health care providers and clinics.

National key informant interviewees were evenly divided between saying that FP and STI clinics are not integrated into PCMH models, and saying that it is possible that FP clinics could frame themselves as a medical home (or collaborate or co-locate with another clinic that is a medical home). Many interviewees responded by saying that STI clinics specifically did not fit into the PCMH, as having a separate clinic for STI services could potentially fragment care. One interviewee felt that it is best to treat an STI patient as a whole person with other primary care needs.

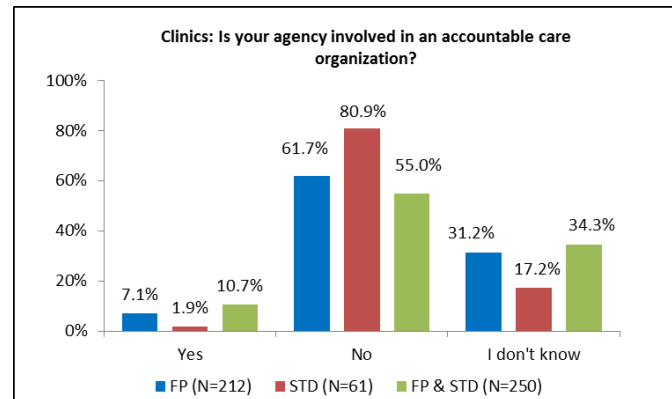
Very few interviewees commented on how FP and STI clinics fit into the ACOs. Some respondents said they are not yet aware of ACOs, and others said that ACOs are intended to focus on chronic disease prevention, not on issues such as STIs. Finally, it was pointed out by a number of interviewees that how STI and FP clinics fit into the PCMH and ACO models will vary by community. Survey findings substantiate these perspectives, as very few IPP clinic partners indicated that their clinics were

**Graph 24: ... is your agency involved in a Patient-Centered Medical Home model?**



involved in either PCMHs or ACOs. See Graphs 24 and 25.

**Graph 25: ... is your agency involved in an Accountable Care Organization?**



When asked to describe how access to reproductive and sexual health services will change if FQHCs are the primary providers of these services, interviewees frequently pointed out that all FQHCs are different, and how they providing reproductive and sexual health care will vary by community. Many interviewees were hopeful that FQHCs will embrace their new role as providers of reproductive and sexual health care services, but recognized that in reality, FQHCs may prefer to refer patients to other providers, such as FP and STI clinics. Some respondents also noted that FQHCs do not exist in every community, and that relying on them for reproductive and sexual health services may reduce access in certain areas of the country.

While a few interviewees stated that FQHCs were well equipped to offer reproductive and sexual health services, most interviewees expressed doubts. Many interviewees felt that quality of reproductive and sexual health services could be compromised, at least in the near term, if FQHC providers do not receive adequate training to provide these services. Training will take time, but interviewees pointed out that training provides the opportunity for FQHCs to work with FP and STI clinics. A lot of emphasis was placed upon FQHCs working with FP and STI clinics, especially in regard to referrals and to prevention, education, and outreach. It was also noted that there is a need to establish guidelines that all clinics follow when providing reproductive and sexual health services so that the quality of care is universal.





### Innovative Partnerships and Collaborative Opportunities

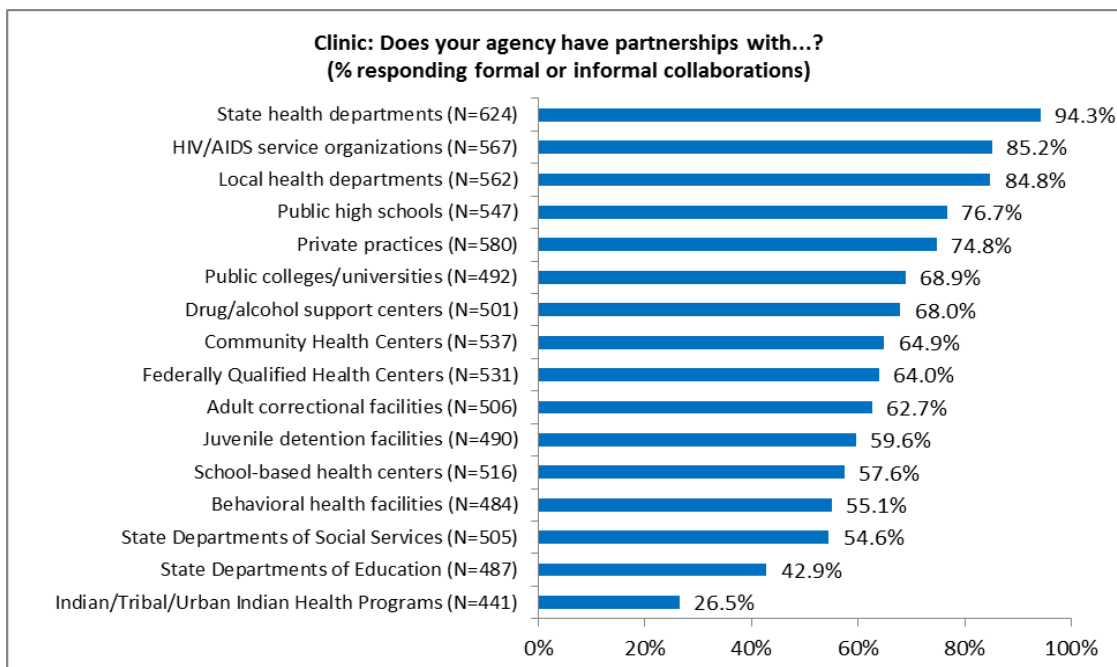
According to regional interviewees, current collaborative efforts among IPP partner agencies were diverse and varied, lending to a rich base of local and regional expertise. Commonly cited mutually beneficial partnerships included community-based organizations (CBOs), managed care organizations (MCOs), departments of education, detention facilities, youth facilities, and social service departments. Survey findings highlight specific IPP partnerships at the clinic level. As shown in Graph 26, a high percentage of agencies maintain partnerships with state and local health departments, HIV and AIDS service organizations, public high schools, and even private practices. Less frequent, however, were partnerships with FQHCs, SBHCs, behavioral health facilities, and correctional/detention facilities. Quantitative information about the extent to which partners have engaged in such partnerships on a regional basis can be found in Table 3 on the next page.

---

***“It is important to get out from behind your desk, have a conversation and engage partners around what benefits they can get from the partnership with IPP.”***

---

**Graph 26: Does your agency have ties/partnerships/collaborations with any of the following types of agencies? (Formally is defined as having a contract or memorandum of understanding (MOU) in place.)**



Please note: percentages presented at the national level, as in Graph 26, are weighted. Percentages at the regional level, as in Table 3, are unweighted.



**Table 3: Does your agency have ties/partnerships/collaborations with any of the following types of agencies? (Formally is defined as having a contract or memorandum of understanding (MOU) in place.)\***

	I		II		III		IV		V		VI		VII		VIII		IX		X	
	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N
Adult correctional facilities	68%	44	22%	9	62%	29	51%	127	59%	68	79%	53	54%	103	52%	42	45%	11	63%	19
Behavioral health facilities	65%	46	38%	8	70%	33	46%	123	48%	64	68%	50	55%	99	46%	39	33%	9	56%	18
Community health centers	81%	54	88%	8	63%	32	57%	142	62%	69	73%	52	69%	106	59%	44	30%	10	58%	19
Drug/alcohol support centers	87%	53	56%	9	71%	31	49%	122	61%	66	71%	49	58%	99	60%	42	73%	11	67%	18
Federally qualified health centers	61%	44	61%	8	61%	34	61%	144	61%	73	61%	53	61%	104	61%	41	61%	9	61%	20
HIV/AIDS service organizations	96%	57	89%	9	80%	35	77%	146	87%	75	94%	52	80%	113	83%	47	82%	11	75%	20
Indian/Tribal/Urban Indian health programs	25%	32	0%	8	4%	25	8%	111	18%	60	30%	43	21%	92	31%	39	36%	11	58%	19
Juvenile detention facilities	62%	39	50%	8	61%	31	35%	121	50%	68	57%	49	50%	98	36%	39	55%	11	68%	19
Local Health Departments	88%	50	75%	8	89%	36	85%	150	88%	76	93%	61	89%	109	84%	44	67%	9	83%	18
Private practices	88%	52	63%	8	74%	35	74%	157	83%	76	76%	58	79%	115	83%	48	36%	11	79%	19
Public colleges/universities	91%	45	63%	8	67%	30	59%	121	58%	64	71%	49	65%	103	57%	42	56%	9	60%	20
Public high schools	91%	53	78%	9	81%	37	69%	138	73%	73	75%	53	71%	107	83%	46	80%	10	75%	20
School-based health centers	78%	50	67%	9	74%	35	48%	125	49%	68	59%	54	44%	102	50%	42	36%	11	47%	19
State Departments of Education	50%	42	50%	8	52%	33	45%	122	33%	60	72%	54	44%	100	31%	39	40%	10	28%	18
State Departments of Social Services	61%	44	29%	7	71%	34	59%	128	52%	66	89%	53	62%	105	50%	38	40%	10	63%	19
State Health Departments	97%	59	89%	9	98%	40	90%	166	94%	82	100%	64	95%	122	98%	49	100%	10	100%	21

\*Here, percentages are unweighted and represent the raw percentage of respondents per region who indicated having either a formal or informal partnership. "N" represents the number of respondents who answered either "yes – formally"; "yes – informally" or "no" to a specific agency type within this question.



### ***Moving Forward under Health Care Reform***

Regional interviewees acknowledged a number of critical partnerships for the safety net and the IPP. The most prominent suggestions were with primary care facilities, private sector providers, and FQHCs/CHCs. Many regional interviewees recognized the importance of partnering with primary care providers as a key link to the sustainability of the safety net given the PPACA focus of providing comprehensive care and realizing efficiencies. As one interviewee stated, “The best way to ensure that we and our services are protected is to be a part of primary care.” Interviewees across seven regions acknowledged the importance of these partnerships. Private sector collaborations were noted as important in interviews across four regions, as it was commonly acknowledged that more individuals will be privately insured under health care reform and the client base is likely to shift toward private providers. Interviewees in seven regions noted the importance of partnerships with FQHCs/CHCs to facilitate referrals, target geographic locations that FQHCs may be unable to serve, and to ensure high-quality reproductive health services.

Partnerships with Medicaid providers, health plans, and managed care organizations were also noted by regional interviewees in five regions as particularly important. These partnerships address issues such as confidentiality concerns arising from explanations of benefits (EOB) and the need to reach out to client bases that are likely to access new forms of coverage such as Medicaid or private insurance. There was some discussion about funders potentially offering financial incentives for creating these relationships—or for FP and STI clinics to provide referrals to primary care providers.

Regional interviews in five regions noted that the importance of partnerships with schools and academic institutions because of their ability to reach youth and adolescents with key educational messages. Maintaining partnerships with correctional facilities and the Indian Health Service (IHS) were also noted as important because they target high-risk and highly transient populations respectively.

### ***Challenges***

Interviewees in four regions acknowledged that establishing these partnerships may be challenging for a number of reasons, primarily resource constraints. Finding the funding and staff time necessary to develop these partnerships and collaborative opportunities will be particularly challenging. In addition, some regional interviewees noted that these partnerships will not happen unless

individual facilities were mandated or at least under direct leadership to do so. In addition, clarifying responsibilities was another notable barrier, as was philosophical orientation, such as specific religious affiliations, lack of interest, or the belief that certain populations such as prisoners or undocumented immigrants do not deserve health care.

Developing partnerships with private providers and FQHCs was noted by regional interviewees as particularly challenging for a number of unique reasons. First, not knowing the capacity of a potential partner to deliver STI screening and preventive services could inhibit an agency from developing an appropriate advocacy argument about how such a partnership would enhance services or efficiency. Second,

FQHC/private sector agencies may be more focused on primary care and less focused on STI prevention or service provision. Perspectives from FQHC representatives indicate that they may believe they are simply more suited or at least equally suited to provide sexual and reproductive health services. Third is the question of reciprocity. While FP and STI clinics may refer to FQHCs or private providers, there is no guarantee that such referrals will be reciprocated. Additional challenges include: obtaining complete demographic information from partner agencies, particularly in the private sector; administrative barriers because Title X regulations are very different from FQHC regulations on fee scales; how to know that the agency to which an FP/STI clinic refers is able to ensure confidentiality despite EOBs; how to forge partnerships at a level with the authority to implement or engage potential new partners; and how to frame the IPP in particular, as it may be difficult to develop advocacy arguments with agencies that may not have the same focus or target populations.

---

***“Safety-net providers are inadequately prepared to link with the existing primary care infrastructure because they are underserved, often lack knowledge of how commercial systems function, and do not have relationships with the existing infrastructure.”***

---



Regional interviewees noted several challenges pertaining to integration of STI and HIV programming. The strategic planning necessary to accomplish such integration can be a long and time-consuming process, even though HIV programming may not prioritize full STI screenings and may even overshadow STI programming. Even in cases where preventive efforts are integrated across STI and HIV-related programming, actual service provision might not be. Finally, it was further noted that more integration occurs at the local level than it does at the federal level.

### ***Opportunities to Leverage the Strengths of the IPP***

Regional key informant interviewees noted a number of specific benefits pertaining to partnerships with schools and HIV programs. Efforts to screen in dorm room settings, for example, yielded positivity rates as high as 13 percent. This success was attributed to developing programming to reach young adults where they were, as opposed to asking them to walk to the nearest health center.

---

***“For the first  
dorm screening,  
we saw 13%  
positivity.”***

---

Integration efforts with HIV programming were also noted to have a number of strengths, including the ability to share resources and increase efficiency by avoiding duplication or

targeting the same high-risk individuals across multiple programs; data improvement resulting from streamlined collection and reporting; the ability to bundle services into a single primary care visit for at-risk populations; and the ability to integrate messages into the community.

Common facilitators to relationship development were highlighted by regional interviewees, especially the ability to provide data to potential partners highlighting either the successes/strengths of a particular program or community need. Establishing a rapport with the target agency was also noted as a key facilitator of relationship development. It was noted that this could be accomplished either by knowing someone at the target agency or making an effort to meet with them personally. Finally, incentivizing a target agency was particularly important and might be accomplished through financial incentives, opportunities to increase targeting efforts, or opportunities to fill key gaps or provide missing services. Interviewees also noted the importance of developing an argument for why a particular target agency should enter into a partnership with the soliciting agency.

Given the challenges, potential benefits, and importance of partnership development, a number of recommendations were made and potential roles for the IPP identified. First, interviewees across three regions noted the importance of training private providers on the importance of routine STI screening. Second, training and capacity-building efforts among the public sector were proposed in the following areas:

- \* ***Developing processes to understand change:*** Facilitating local-level strategic planning for partnership development is critical when considering both time and resource constraints.
- \* ***Partnership facilitation:*** IPP partners will need training and technical assistance in order to overcome common and substantial challenges associated with developing partnerships with the private sector. Guidance, for example, is needed on how to create contracts with the private sector. How-to manuals and sample outreach letter templates were also suggested.
- \* ***Marketing and messaging:*** It was also noted that FP and STI clinics will need to market themselves to both insurance carriers and new partners. These clinics will need assistance, however, in developing advocacy messages about the strengths of IPP service delivery agencies. One key way to accomplish this could be training or technical assistance on how to utilize local-level data in order to establish grounds for programmatic success.



### Social Media/Marketing

In recent years, social media has become an increasingly important tool in the health care environment. Social media networks are bringing together patients, clinicians, researchers, and educators to engage patients in their health and aid in tackling emerging issues. Virtually limitless, social media encompasses a wide variety of communication tools, from videos to podcasts to blogs to text messages to website development to community forums.

In a prominent example of the power and potential of social media, the Mayo Clinic shared success stories and best practices with the health care community in an online webinar through ModernHealthcare. Strategic planning for the social media venture began with gathering best practices from other communities, and social media became a key component of how the clinic began reaching out to their community. The venture started as a weekly 90-second TV spot, as the clinic recognized that many local news agencies did not have the appropriate staff time to develop health care-related news stories. These 90-second spots lent themselves to podcasts, for which individuals could subscribe and have podcasts sent to them. When the clinic began putting the podcasts on iTunes, their listening audience jumped from 900 to 74,000. This initial success demonstrated the value of social media and its ability to communicate to a wide variety of audiences. From the initial podcasts, their social media venture expanded to include online videos, a Facebook presence, and an internal blog. This “[free online health community](#)” is a place where individuals can connect and discuss common issues through conversation threads, with topics ranging from infectious diseases to men’s health. Recognizing that word-of-mouth has been and will continue to be among the most powerful ways to both spread information and gain community trust, social media allowed the Mayo Clinic to “capture the power of the personal recommendation.”<sup>74</sup> For additional tools and resources, visit the [Mayo Clinic Center for Social Media](#).

Regional interviewees also acknowledged the advantages of utilizing social media networks, particularly for initiating campaigns and communicating at low cost. It was noted that pre-existing (and thriving) online social networks can provide valuable channels through which clinics can reach their client base, particularly youth and adolescents, without having to produce traditional communications materials. Social media can be also used as a method of encouraging individuals to enroll with a medical provider, or to increase awareness on the importance of data reporting in

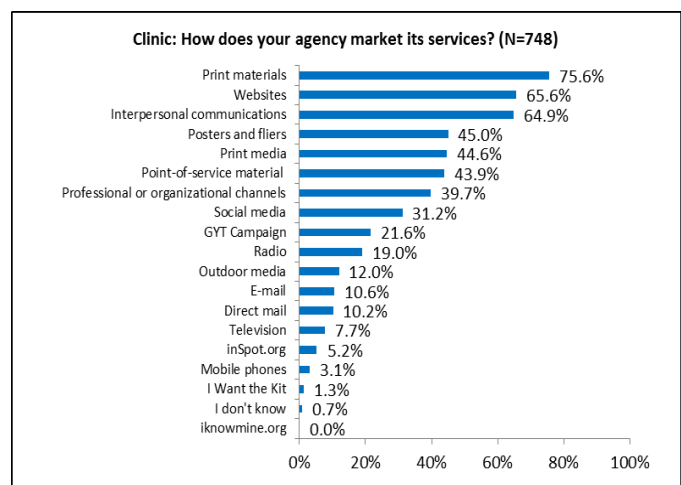
the community of private providers.

With the advent of health care reform and the proliferation of new information, new media will be critical in reaching adolescents and other vulnerable populations. New media will be needed more than ever to educate and motivate high-risk populations to take advantage of increased access points and new benefits under health care reform. Interviewees felt that outreach to private providers in particular will be important as health care reform is implemented, because they will need training and guidance on using screening criteria appropriately. One interviewee felt that in light of health care reform, social media marketing to clients should be redirected entirely to providers.

Social media will also be increasingly important due to a rapidly changing client base. IPP funded agencies will need to target and provide outreach, information, and services to an evolving community quickly and effectively. Interviewees thought that educational campaigns, which tend to be costly and time consuming, might be more cost-effective and efficient if run through social media campaigns.

Survey findings described the current utilization of social media at the clinic level. Responses shown in Graph 27 below show that survey participants rely heavily on both print materials and interpersonal communication. Fewer respondents, however, indicated utilizing forms of newer media, including social media ventures, and fewer still indicated participating in the CDC’s annual Get Yourself Tested campaign.

**Graph 27: How does your agency market its services? (Please mark ALL that apply)**





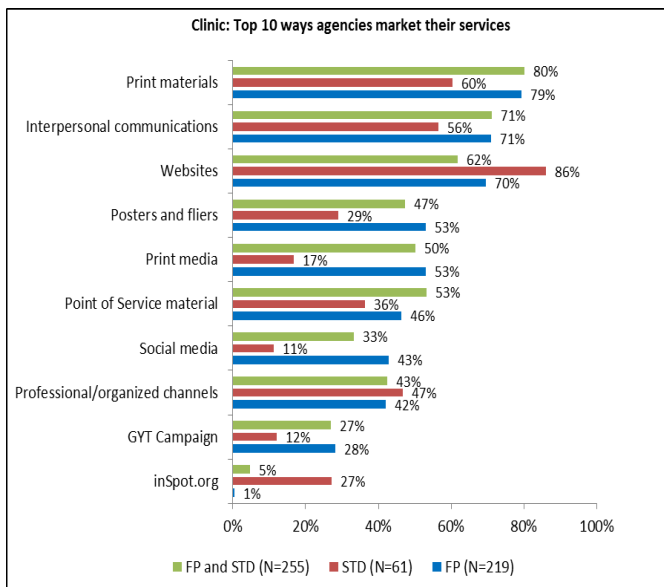


**Table 4: How does your agency market its services? (Please mark ALL that apply)**

	I		II		III		IV		V		VI		VII		VIII		IX		X	
	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N
Direct mail	20%	16	33%	3	4%	2	11%	24	11%	10	10%	7	8%	11	13%	7	8%	1	9%	2
E-mail	19%	15	44%	4	6%	3	6%	13	4%	4	7%	5	13%	18	15%	8	15%	2	9%	2
GYT Campaign	37%	30	11%	1	14%	7	10%	20	30%	28	7%	5	20%	28	26%	14	23%	3	35%	8
I don't know	1%	1	0%	0	0%	0	3%	7	1%	1	0%	0	4%	6	0%	0	0%	0	0%	0
I Want the Kit	0%	0	0%	0	12%	6	0%	0	3%	3	0%	0	1%	1	2%	1	0%	0	4%	1
iknowmine.org	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0
inSpot.org	0%	0	0%	0	2%	1	0%	0	12%	11	0%	0	1%	1	2%	1	8%	1	4%	1
Interpersonal communications	74%	60	56%	5	54%	27	58%	122	59%	55	58%	40	60%	86	69%	37	85%	11	70%	16
Mobile phones	6%	5	0%	0	4%	2	2%	4	2%	2	1%	1	3%	5	9%	5	0%	0	4%	1
Outdoor media	11%	9	33%	3	8%	4	20%	43	10%	9	3%	2	14%	20	20%	11	0%	0	22%	5
Point-of-service material	48%	39	33%	3	56%	28	42%	89	41%	39	35%	24	38%	54	57%	31	62%	8	57%	13
Posters and fliers	64%	52	56%	5	48%	24	46%	96	46%	43	48%	33	52%	74	67%	36	23%	3	65%	15
Print materials	86%	70	89%	8	72%	36	72%	152	78%	73	67%	46	70%	100	78%	42	69%	9	96%	22
Print media	51%	41	56%	5	32%	16	56%	117	41%	39	36%	25	52%	75	81%	44	46%	6	57%	13
Professional or organizational channels	42%	34	33%	3	36%	18	26%	54	37%	35	16%	11	29%	41	50%	27	62%	8	43%	10
Radio	30%	24	11%	1	16%	8	33%	70	24%	23	16%	11	29%	41	30%	16	15%	2	26%	6
Social media	68%	55	56%	5	36%	18	28%	58	29%	27	10%	7	49%	70	50%	27	8%	1	35%	8
Television	11%	9	0%	0	2%	1	16%	33	4%	4	10%	7	17%	24	19%	10	8%	1	9%	2
Websites	79%	64	89%	8	56%	28	59%	124	65%	61	36%	25	66%	95	70%	38	69%	9	87%	20
Total N	-	81	-	9	-	50	-	210	-	94	-	69	-	143	-	54	-	13	-	23

According to agency type, as shown in Graph 28 below, STI clinics reportedly utilize social media at a lower rate than do FP clinics.

**Graph 28: How does your agency market its services? (Please mark ALL that apply)**



### Challenges

Despite the acknowledged advantages of using social media, interviewees noted barriers to using social media as well. One of the most significant challenges faced by IPP-funded agencies in utilizing social media is the bias against social media in the workplace. Staff or clinicians often do not feel comfortable using social media because of its association as a recreational tool, and fears of being considered unproductive contribute significantly to staff reluctance. Interviewees also stated that it might be difficult for people to think beyond the traditional ways that public health information is spread. And some interviewees cited agency-wide firewalls that allow limited access to social media sites, which would make it difficult if not impossible for local and state health departments to initiate or access social media content.

Social stigma about reproductive health also creates barriers to using social media. Interviewees expressed discomfort in publicizing information about sexual health, particularly when it is linked to their personal accounts on social media sites.





On a larger scale, a number of interviewees found that conservative government bureaucracies and their administrations are often reluctant to use social media that has sexual content because of the fear of backlash from certain factions of the population. Some of the biggest challenges expressed stem from an inability to receive approval from higher ranks within the state government.

Financial restrictions can also limit an agency's ability to run a successful social media campaign. While the cost of a social media campaign is relatively low, many clinics lack expertise to use social media. Social media is transitory, and staff is required to keep messages up-to-date and relevant to the target population. It is difficult to ensure that clinicians and staff stay updated and current on the latest social media trends, and many clinics don't have staff available to maintain their social media connections over time.

Finally, confidentiality or perceived confidentiality issues were cited as barriers to using any kind of social media to reach out to individuals. Interviewees stated that a number of individuals, including clinicians, staff, and patients, are skeptical of technology and potential breaches of confidentiality.

### ***Opportunities to Leverage the Strengths of the IPP***

A number of interviewees suggested ways that the IPP could further the use of social media. Interviewees emphasized the importance of developing educational materials and best practices about the use of social media that other project areas could use. Interviewees asked for online webinars providing both basic and advanced information on how to develop, implement, and evaluate new media initiatives. Some recommended

---

***“It is important to understand your audience and utilize the media forms that they are interested in.”***

---

the aggregation of best practices through an online portal, while others recommended the dissemination of best practices collected through webinars and trainings.

Other interviewees shared their experiences and advice in implementing a social media campaign, some citing success stories from their local or statewide agencies. A

number of interviewees, for example, stated that their clinics have distributed incentives, information

on partner services, and facts about sexual health for partner services through social media. An STI director stated that many local agencies are using some form of social media to contact their client base for upcoming appointments or reminders to pick up medications. One interviewee cited a campaign in their region that prompted the state IPP to allocate additional tests and resulted in a 2-fold increase in screening.

Several interviewees emphasized the importance of understanding a campaign's audience. New media is likely to be demographically specific, so messages that appeal to certain populations may not work for others. These interviewees recommended conducting focus groups and market research to understand how the population is changing, use the mediums the target population is using, collect evidence to support assessments, and develop messages that will be appealing and effective.

Evaluations were also cited as essential for measuring the viability of new media campaigns. Interviewees recommended evaluating campaigns both through quantitative and qualitative means; some conducted surveys before and after the campaign, while others tracked printing and distribution of materials, web analytics, and feedback from providers. One interviewee emphasized the importance of adapting to the needs of the audience and population; if the audience does not respond, the social media campaign must change. Finally, interviewees stated that agencies need to develop a protocol or set of procedures for using social media in the workplace. Social media must be approved on a state or county level in order to alleviate employees' reluctance to utilize it in the workplace.

### **Conclusion**

National and regional key informant interviewees agree that partnering with both the private and primary care sectors are key to the survival of IPP clinic partners. Many agencies have developed this capacity, but others will struggle to find the resources and expertise to successfully partner with these sectors. Local-level trainings would help prepare IPP partners for key challenges associated with these efforts, such as managing contracts, developing local advocacy arguments and targeting specific agencies to partner with.

Social media is widely regarded as a cost-effective way to reach new populations, and should be encouraged and supported on both the state and local levels. Social media can be a highly effective way to communicate with and across the health care community and the public. There is tremendous



growth potential in this sector, as survey findings demonstrate a high reliance on print materials, especially in relation to social media ventures.

### Recommendations

**Recommendation 9:** Promote partnership development with both the private sector and primary care providers, including contract development, outreach, marketing, and messaging.

*Rationale:* There are many reasons why it is beneficial to develop new partnerships. Two that are relevant to the IPP include the fact that sexual and reproductive health programs are increasingly impacted by political and economic challenges and the looming shift of service delivery as a result of health care reform (HCR). However, even before these changes compelled the public health STI, FP, and lab partners to expand the core IPP partnership, the IPP core partners had started developing partnerships with primary care, school-based health centers, and correctional health.

Many of the national interviewees believe it is time for Title X family planning and STI clinics to form alliances with primary care providers and clinics in their community. These relationships will be of value in the post-PPACA world. Some interviewees noted that it takes a lot of time to create alliances with other health care providers and clinics. There was some discussion about funders potentially offering financial incentives for creating these relationships, or for Title X family planning and STI clinics to provide referrals to primary care providers.

Additionally, regional key informant interviewees widely acknowledged that the sustainability of the safety net is tied to its ability to develop relationships with the primary care sector. However, because the current safety net infrastructure lacks the resources and expertise to form successful partnerships, it will need technical assistance, training, and capacity-building.

While JSI believes that the partnership with family planning has and will continue to be an important collaboration with STI programs, we also believe that the new service delivery landscape, which will lose public health infrastructure as well as healthcare reform implementation, requires a new way of thinking about partnerships and collaborations. As a result, JSI suggests that IPP infrastructural funding for the coordinating agencies be separated from the OPA funding stream to the family planning training centers. This would give IPP maximum flexibility to make data-driven decisions about the best way to meet the populations most in need of services and

support. Historically, the funding mechanism for the IPP coordinating agencies from OPA served to encourage, support, and solidify the collaboration between the STI and FP programs within the regional partners. However, this collaboration has been stable for some time, and regional partners have evolved and expanded to better reflect the larger service delivery environment in which they are operating, including universities, school-based clinics, private practices, and FQHC.

**Recommendation 10:** Reproductive and sexual health providers, such as the Title X FP and state STI programs, should be involved in educating new partners—particularly in the private and primary care sectors—on sexual health care best practices and guidelines, such as promoting awareness of chlamydia and gonorrhea screening guidelines.

*Rationale:* The national interviewees repeatedly expressed concern that by focusing on providing STI services in a primary care setting, that there will be a loss of STI prevention, screening, and treatment expertise. There was much discussion about training primary care providers to be comfortable with asking the right health screening questions and talking with their clients about sexual health risks. Many interviewees noted that Title X family planning and STI clinics currently have the workforce to provide this type of training to primary care providers and medical students.

Regional key informant interviewees repeatedly expressed concern that new partners—particularly in the private and primary care sectors—may be less skilled in discussing sexual health issues with clients. As more people become insured, key informant interviewees acknowledged that these sectors will likely see new patients seeking these services, and IPP partners are uniquely positioned to provide sexual health expertise in order to ensure continuation of quality health care in a reformed health care environment.

Many of the national interviewees said that they are not sure if FQHC providers are comfortable with providing comprehensive reproductive and sexual health services. Many interviewees felt that the quality of reproductive and sexual health services could be compromised, at least in the near term, if FQHC providers do not receive adequate training to provide these services. Training will take time, and it was also noted that there is a need to establish guidelines that all clinics follow when providing reproductive and sexual health services to make the quality of care universal.



**Recommendation 11:** Facilitate local-level capacity-building pertaining to the utilization of data to develop advocacy arguments.

*Rationale:* Regional key informants acknowledge that: a) local data is critical to develop arguments for why outside agencies may want to partner with sexual and reproductive health agencies; and b) local-level agencies may lack the resources, expertise, or capacity to utilize data to this effect. See recommendations 6 and 7 for more information on how to provide data utilization support.

Furthermore, several of the national key informants discussed how databases should flow through the HIE so that pertinent data can be aggregated to create registries, which would support public health authorities' efforts to prevent and control the spread of STIs as well as create policy and advocacy support for the importance of sexual and reproductive health services.

There was a lot of discussion and concern expressed about confidentiality as it relates to HIT and HIE. Interviewees were concerned about the unintended release of information and the misuse of this information. Interviewees also highlighted the current conversations about not collecting reproductive and sexual health variables from specific groups of people, such as adolescents. Reactions to this idea included concerns about having incomplete data sets, and who would and how to decide that certain health variables are more confidential than others.

Some health information exchanges have decided to have either opt-in or opt-out policies, which allow patients to decide if they want their information to be shared between treating providers and public health departments. Patients may opt-out of sharing all health data or only that defined as "sensitive."

## Minority Health and Health Equity



## Background

The CDC estimates that there are approximately 19 million new sexually transmitted infections each year, which cost the U.S. health care system \$16.4 billion annually and cost individuals even more in terms of acute and long-term health consequences.<sup>75</sup> CDC surveillance data show much higher rates of reported STIs among some racial or ethnic minority groups than among whites.<sup>76</sup> Regardless of race or gender, data show that sexually-active adolescents and young adults are at increased risk for STIs when compared to older adults. A range of factors contributes to these disparities, including poverty, lack of access to quality health care, stigma, and an already high prevalence of STIs in communities of color that increases a sexually-active person's risk of infection. These factors can prevent in-need individuals from seeking STI prevention, screening, and treatment services.”<sup>77</sup>

Black individuals represented almost half of all reported chlamydia cases (48 percent) in 2009. The reported chlamydia rate among black populations is eight times higher than whites and three times higher than Hispanics (1,559.1 per 100,000 for blacks compared to 178.8 for whites and 504.2 for Hispanics).<sup>78</sup> Young black women aged 15-24 are most affected. In 2009, there was one chlamydia case reported for every 10 black women in that age group (10,629.7 per 100,000).<sup>79</sup> Young Hispanic women and men aged 20-24 have the highest reported chlamydia rates among Hispanics, which are twice as high as those among whites in the same age group (in the 20-24 age group: 3,679.7 per 100,000 Hispanic women compared to 1,727.8 for white women; 1,077.8 per 100,000 Hispanic men compared to 491.9 for white men).<sup>80</sup>

Black individuals, who represent 14 percent of the U.S. population, accounted for 71 percent of all gonorrhea cases in 2009.<sup>81</sup> The reported gonorrhea rate among black populations is 20 times higher than among white populations and almost 10 times higher than among Hispanic populations (556.4 per 100,000 for blacks compared to 27.2 for whites and 58.6 for Hispanics).<sup>82</sup> Young black women bear the heaviest burden of gonorrhea (rate among those aged 15-19: 2,613.8 per 100,000; rate among those aged 20-24: 2,548.7 per 100,000).<sup>83</sup> Young Hispanic women and men aged 20-24 have the highest reported gonorrhea rates among Hispanics, which are twice as high as those among whites in the same age group (in the 20-24 age group: 274.9 per 100,000 for Hispanic women compared to 186.4 for white women; 215.7 per 100,000 for Hispanic men compared to 80.8 for white men).<sup>84</sup>





Racial disparities exist in diagnosed cases of PID and are consistent with the marked racial disparities observed for chlamydia and gonorrhea. In particular, disease rates are two-to-three times higher among black women than among white women. However, because of the “subjective methods by which PID is diagnosed, data on racial and ethnic disparities should be interpreted with caution.”<sup>85</sup>

“While significant disparities related to diagnosed cases of sexually transmitted infections exist, less than half of people who should be screened receive recommended screening services. Undetected and untreated STIs can increase a person’s risk for HIV and cause other serious health consequences, such as PID and infertility. STI screening is important for the early detection of STIs and, when combined with treatment, is one of the most effective tools in protecting an individual’s health and preventing others from infection.”<sup>86</sup>

Certain populations experience significant barriers to the receipt of recommended screening and treatment for STIs, resulting in significant disparities. Services to low-income individuals are critically important. According to the Kaiser Family Foundation, of all the uninsured adults with incomes at or below 133 percent of the federal poverty level (FPL), 38 percent did not receive any medical care for a period of more than two years.<sup>87</sup> Members of this subgroup are younger than other uninsured adults in this income group and are less likely to be parents.<sup>88</sup>

Teens may also experience significant barriers to care. STIs among 15-to-19-year-olds continued to rise in 2009. The CDC estimates approximately half of the new STI cases that occur each year are acquired by individuals between 15-and-24-years-old, despite their representing only one-quarter of the sexually-active population.<sup>89</sup> The reasons for this disparity include, sexually-active youth are more likely than older individuals to engage in risky sexual behaviors, such as unprotected sex and having multiple sex partners, and to further exacerbate the impact of STIs on teens, youth also face barriers to reproductive health care services, related to availability, ability to pay, transportation, and confidentiality concerns.<sup>90</sup> However, researches at the Mailman School of Public Health found that minors are more likely to seek treatment for an STI if they don’t need to notify their parents, though many do voluntarily. Confidentiality laws will also affect whether they accurately disclose their health history and where they go for services.<sup>91</sup>

Residents of rural areas are nearly twice as likely as their suburban counterparts to lack health insurance, with 21 percent of rural Americans lacking health insurance compared to 12 percent of suburban Americans.<sup>92</sup> In addition to lacking health insurance, mental illness may be highly stigmatized, be under-diagnosed, and receive inadequate treatment for mental illness. The issues in how mental illness is managed in rural areas may contribute to behaviors such as drug use, early initiation of sexual activity, or unprotected sex with multiple partners, which put individuals at greater risk for STIs.<sup>93</sup> In addition to the stigma that rural residents experience with accessing services for mental illness, they also experience the same stigma related to sexual health services. The University of Indiana lists nine factors associated with challenges of providing STI/HIV prevention services in rural areas. These include:

- \* Lack of infrastructure to support MSM
- \* Rural to urban travel for sex
- \* Denial that HIV exists in rural areas
- \* Stigma toward HIV and those at risk
- \* Traditional values
- \* “Hidden” at-risk populations
- \* Isolation – social and geographic
- \* Limited access to healthcare resources
- \* Methamphetamine use<sup>94</sup>

Stigma, racism, and other forms of discrimination only serve to exacerbate the factors listed above in trying to serve those individual at-risk for STIs or HIV.<sup>95</sup>

There were an estimated 11.1 million unauthorized immigrants living in the United States in March 2009, a number that declined by about a million since 2007, according to Pew Hispanic Center estimates.<sup>96</sup> Six-in-10 Hispanic adults living in the United States who are not citizens or legal permanent residents lack health insurance. Four-in-10 non-citizen, non-legal permanent resident Hispanic adults state that their usual provider is a community clinic or health center.<sup>97</sup> Non-citizens are more likely than citizens to be uninsured; this is due to their limited access to employer-based health coverage and restrictions for public coverage, (47 percent vs. 15 percent).<sup>98</sup> The Kaiser Commission on Medicaid and the Uninsured found that in addition to their higher uninsured rates, non-citizens are much less likely than citizens to have a usual source of care, to have had any recent contact with a health professional, or to receive preventive or primary care.<sup>99</sup> Barriers not only exist in obtaining care, they exist at the clinic itself. Nearly half (48.6 percent) of all U.S. physicians in 2008 reported that difficulty communicating with patients because of language or





cultural barriers was at least a minor problem affecting their ability to provide quality care.<sup>100</sup>

### Local Targeting Efforts

With these issues in mind, regional interviewees were asked to comment on special populations who may either be subject to health disparities or will likely face remaining access barriers under health care reform. Interviewees were first asked to describe specific populations that their agency targeted for health disparity reduction initiatives. A number of project areas indicated a particular focus on African American and Latino youth, whom they consider most at-risk. Another project area indicated a region-wide effort to involve men in service provision. Other regions reported a focus on a variety of populations, including Native Americans, women, seasonal migrant workers, Hispanic populations, individuals who are in poverty or adolescents who cannot afford services, incarcerated populations, undocumented individuals, those in extreme poverty, and uninsured individuals or individuals who are unable or unwilling to use insurance at the time of service.

To this end, community outreach efforts included education, marketing and advertising; ensuring that outreach materials are culturally appropriate; using social media; testing in detention centers and women's incarceration facilities; opening new sites to ensure access for American Indians/Alaska Natives (AI/AN); and working with local health departments to provide access for high-school students. Some regions reported conducting workgroups on adolescent and sexual health; hosting annual conferences targeting local youth; providing training and education workshops; and collaborating with local migrant councils, FP clinics, chemical dependency clinics, and Urban Indian

clinics.

Survey findings indicate that IPP partner clinics provide services to a diverse client base, although the most prominent racial demographic served is white. As shown in Table 5 below, white populations comprise the most prominent demographic across all agency types, while African American populations comprise the second-most prominent demographic.

---

***“Racial and ethnic composition of a geographical area often does not paint an accurate picture of the existing health disparities...”***

---

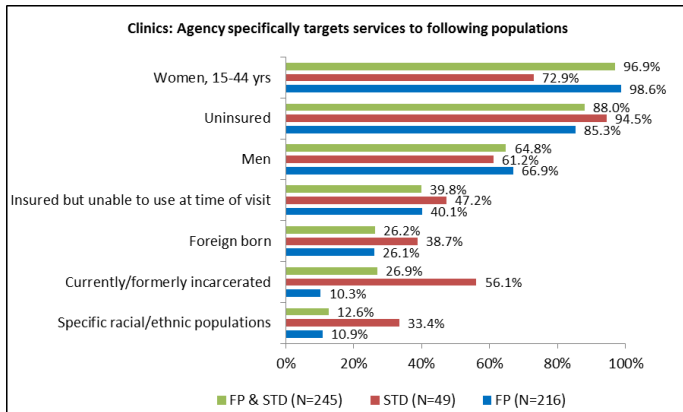
Clinics were also asked to describe whether or not they target services to specific populations. As can be seen in Graph 29 on the next page, among the 216 survey respondents representing FP clinics alone, almost 100 percent of respondents indicated that they target women between the ages of 15 and 44 years. Only 67 percent of such agencies, however, indicated that they target men, and only 10 percent indicated they target the formerly incarcerated. Of the 49 individuals representing STI clinics alone, however, only 73 percent indicated that they targeted women, while 56 percent indicated that they targeted incarcerated populations.

**Table 5. How would you describe your agency's client base? (Please indicate the three most prominent demographics that apply)**

Clinics: Three most prominent demographics that describe your agency's client base									
	FP			STI			FP & STI		
	First (N=220)	Second (N=206)	Third (N=187)	First (N=61)	Second (N=59)	Third (N=56)	First (N=249)	Second (N=699)	Third (N=211)
American Indian/Alaska Native	0.3%	11.5%	28.2%	0.0%	5.4%	16.3%	0.5%	13.4%	25.1%
Asian	0.0%	6.5%	23.3%	0.0%	0.6%	20.9%	0.6%	2.3%	12.8%
Some other race	2.9%	10.1%	23.2%	0.0%	8.2%	40.8%	4.3%	15.7%	33.7%
Two or more races	6.1%	7.5%	22.8%	2.1%	1.6%	22.0%	1.1%	6.1%	26.7%
Black/African-American	17.7%	64.5%	0.0%	31.2%	84.3%	0.0%	23.3%	62.0%	0.0%
White	70.9%	0.0%	0.0%	66.7%	0.0%	0.0%	70.3%	0.0%	0.0%
Native Hawaiian/Pacific Islander	2.1%	0.0%	2.6%	0.0%	0.0%	0.0%	0.0%	0.4%	1.6%

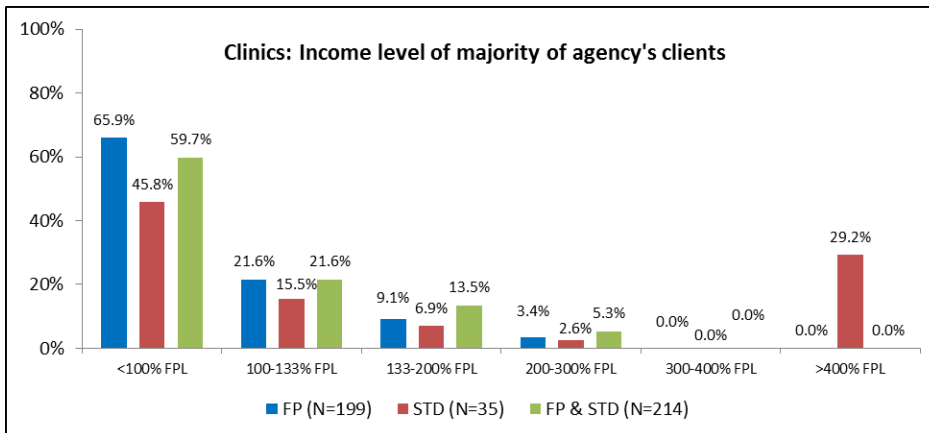


**Graph 29: Does your agency specifically target services to any of the following populations? (Please mark ALL that apply)**



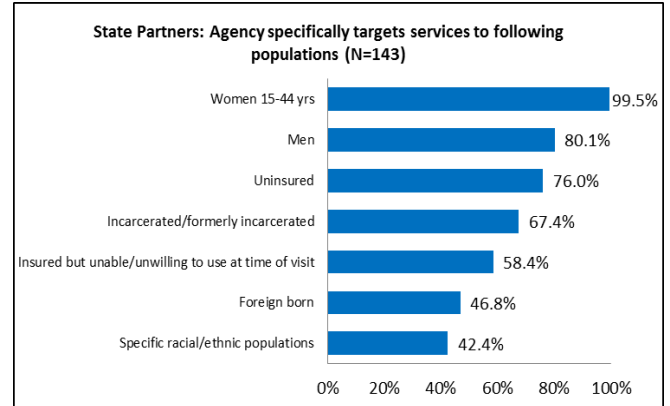
In addition, survey findings are very clear that IPP clinic partners serve a primarily low-income population. As seen in Graph 30 below, the largest income demographic served across both FP and STI clinics is comprised of individuals living below 100 percent of the FPL. IPP state partners were also

**Graph 30: How would you describe the income level of the majority of your clients?**



asked to describe whether or not they target services to specific populations. Among the 143 state agencies that responded to this question, almost all indicated that they do target services to women between the ages of 15-and-44 years (Graph 31). Less frequently targeted were foreign-born individuals, incarcerated populations, uninsured individuals, and men.

**Graph 31: Does your agency specifically target services to any of the following populations? (Please mark ALL that apply)**



## Minority Health and Health Equity

### Challenges

Regional interviewees also pointed to a number of specific challenges in terms of local level capacity to appropriately target specific populations, primary among them being resources. One interviewee stated that developing better outreach methodologies to target specific communities would only be possible with additional funding and another stated that these types of projects have not been put in place due to funding shortages. Other interviewees noted that a lack of resources—including a lack of quality data from local agencies, a lack of staff time, human resources, or outside funding—has made it difficult to monitor and evaluate targeting efforts, which makes it hard to measure the volume of particular populations served.

Rural populations, it was noted, also pose unique outreach and access challenges. Rural populations face access barriers not associated with insurance coverage. One interviewee pointed out that, for example, rural residents are often “more conservative in their thinking” and therefore may have more stigmas associated with sexual health and be less likely to access services. It was also pointed out that rural residents are often underserved because of geographic isolation and transportation barriers. Interviewees differed, however, in their opinions as to how barriers particular to rural populations should be addressed at the state or federal level. One interviewee noted, for example, the need to “pay attention to rural America as well,” was concerned that the CDC does not see a need to focus resources on low-prevalence states. Another interviewee felt differently, stating that prevalence



studies should determine how resources are targeted and that low-prevalence, rural regions should not be the focus for screenings.

Another interviewee noted translation and interpretation challenges associated with providing culturally and linguistically appropriate care. This interviewee was particularly concerned that these types of services are not funded and third parties are not structured to reimburse for them, which forces agencies to absorb the often-substantial cost of these services.

Barriers pertaining to service provision for low-income individuals were also noted. Expanding services to low-income populations could be difficult because so few providers are willing to accept Medicaid patients because of low reimbursement rates. Because Medicaid will be a primary method of insurance coverage for low income individuals, they may struggle to find a provider. The “bifurcation of care” was also noted and one interviewee felt as though “Medical care/healthcare is delivered retroactively in poor communities and proactively in wealthier communities.” In addition, it was also noted that free tests provided through the IPP are critical to these low-income patients who may not be able to afford even small clinic fees not covered by insurance.

Substantial disparities were noted among AI/AN populations as well. One interviewee described NA/AN as “the primary minority population and the most underserved” in the project area. A number of barriers specific to this population were discussed, including:

- \* Mistrust of government-run institutions
- \* Strong stigmas associated with sexually transmitted infections
- \* Confidentiality concerns arising from strong social, communal, or familial ties
- \* Geographic distance from providers

It was noted that although AI/AN populations already have access to Indian Health Services, many remain uninsured on account of the aforementioned barriers. It was also noted that provider education directed at primary-care providers is extremely important, as these facilities are often the “sole source of trusted information for Native Americans.”

Finally, specific concerns about messaging to minority communities—particularly African American—were also noted. One interviewee stated that current messages targeted to African Americans

about the high prevalence of STIs in the community lead many to believe that acquiring an STI is inevitable. One possible way to address this would be to partner with local-level coalitions trusted by local communities to target messages in a culturally appropriate fashion.

With these issues in mind, there was again general consensus that “continued safety-net services will be needed in order to serve vulnerable populations.” It was also noted that, while health care reform will provide new tools such as insurance coverage, primary care service centralization, new opportunities to build coalitions, and HIT improvements, health care delivery “is a complicated function of access, provider availability, and the level of comfort between providers and clients.” As such, even with these new tools, barriers may persist. Specific examples of populations likely to experience ongoing need included:

- \* Individuals with language barriers
- \* Individuals in foster care
- \* Kids transitioning into adult care
- \* Homeless individuals
- \* Displaced youth
- \* Refugees and immigrants (especially the undocumented)
- \* People who are unemployed
- \* Victims of domestic violence
- \* Individuals with low levels of education

### ***Moving Forward under Health Care Reform***

National key informant interviewees noted that the PPACA may make health insurance coverage a reality for some vulnerable populations that previously did not have health insurance. But the majority of the key informants felt that communities that have traditionally been underserved, such as racial and ethnic minorities, the formerly incarcerated, undocumented individuals, adolescents, lesbian/gay/bisexual/transgendered/queer (LGBTQ), and men, will continue to face challenges when accessing reproductive and sexual health care services.

National interviewees also noted that they are not sure how PPACA intersects with the Indian Health Service, and believes that the major access issues faced by the AI/AN population will continue. One respondent noted it is unlikely that urban AI/AN will be comfortable with the medical home model because they are highly mobile and do not routinely seek care from just one clinic. Some key informants felt that there are current health insurance coverage transition problems for the formerly incarcerated population that will not be resolved by the PPACA. Specifically, there is confusion about the availability



of Medicaid coverage for the incarcerated population during and after incarceration.

National interviewees acknowledged that the PPACA excludes the undocumented population from participating in the expanded Medicaid services or insurance exchanges. The interviewees stated that this will be a large population of people who will remain uninsured post-PPACA. Also, some respondents noted PPACA may make access issues worse for undocumented immigrants because there are restrictions about when they can start participating in health insurance exchanges. Some informants reported that as a result of the PPACA and the cutting back of publicly-funded services, the LGBTQ population will lose services specific to their health care needs. Also, some respondents stated that while low-income men have a lot to gain with the expansion of Medicaid eligibility, reproductive and sexual health preventive services for men have not been as clearly defined as they have been for women.

When asked to name specific interventions or programs that have successfully reduced health disparities for the vulnerable populations, interviewees most frequently reported the following:

- \* Title X family planning program and clinics
- \* Medicaid Family Planning Waiver programs
- \* The Infertility Prevention Project
- \* School-based health centers
- \* Federally-qualified health centers
- \* Indian Health Services program efforts and clinics
- \* Community clinics that are co-located with emergency rooms
- \* STI screening in emergency rooms
- \* STI home-testing programs
- \* Increasing use of social media and information technology for educational purposes.

The interviewees felt that there will be a number of unintended consequences of the PPACA, including many that cannot be foreseen. Many interviewees were concerned that funding for safety-net services will be dramatically reduced or eliminated. While more people will have the ability to have health insurance coverage, the interviewees did not feel this would eliminate the need for safety-net services. There was a lot of concern about patients being able to understand the PPACA and how it applies to them, as well as the ability of individuals to utilize a system they previously have not been able to use.

### ***Opportunities to Leverage the Strengths of the IPP***

Regional interviewees had a number of potential recommendations for the IPP, one of which was to incorporate more males into the IPP core client base. This recommendation addresses the concern that USPSTF grade A and B recommendations to expand screening coverage at no cost to individuals with new insurance plans (i.e., those developed after passage of the PPACA) do not include men. Other recommendations included continued collaboration and integration efforts across HIV and STI programming in order to both increase efficiency and target high-risk communities. Offering chlamydia and gonorrhea tests at HIV sites, for example, was noted as highly valuable. In addition, it was felt that combining services rather than focusing solely on IPP services might a better way to serve the populations in need and that un-siloing programming would allow services to be provided in locations not previously accessible. As one interviewee stated, the “Current client base is defined by silos of current grant programs.”

---

***“There is some concern that not opening up screening criteria to include men is an issue of health equity.”***

---

Interviewees across three regions also noted the importance of continued efforts to target at-risk youth through schools. It was felt that high school clinics and centers are a prime location for targeting low-income young women. To that end, it was noted that educational materials should be developed and brought into high schools and universities in collaboration with school health nurses.

Finally, one interviewee noted the importance of delving deeper into data to better understand specific socioeconomic or geographic barriers for racial and ethnic minorities. This interviewee felt that simply defining populations according to racial or ethnic composition does not adequately define the specific concerns or challenges within a community. This interviewee went on to state that these terms needed to be defined better in order to develop effective advocacy arguments. Regional interviewees also commented on IPP’s potential role to promote health equity. Primarily, multiple interviewees expressed the sentiment that the IPP should remain viable “until we see a clear pathway.”





These interviewees reiterated the concern that certain populations will continue to fall through the cracks and that the IPP should continue to provide services to these populations, at least until the infrastructure is in place and can ensure that all individuals have access to high-quality STI and reproductive health services. As one interviewee stated that the IPP has “allowed the state to keep a lid on CT,” and expressed concern that minority populations would be increasingly vulnerable if the IPP dissolved.

Additionally, IPP must remain involved in maintain high-quality data collection in order to reduce STI prevalence and health-related disparities. Particular concerns were that quality data collection efforts would be particularly challenging without public health laboratories or IPP testing, as the role of the state laboratory is critical in terms of monitoring disease prevalence and providing data to identify risk factors and changes in disease burden. One interviewee noted that the IPP can help to preserve this role and ensure the availability of testing for “obscure or emerging illnesses and diseases,” which are not profitable in the private sector.

It was also noted that the IPP has an important role in the health care of immigrant populations, as the public health sector is particularly attuned to culturally competent and appropriate care. One interviewee noted that the IPP has historically played a key role in this and should maintain a focus on education and sensitivity to cultural differences.

In addition, another interviewee referenced outreach done through collaborations facilitated by the IPP between CHCs, STI programs, and public health laboratories in order to specifically target high-risk individuals. This interviewee expressed the concern that “without this collaboration, this targeting would be lost.” Acting as a facilitator in collaborative efforts across these programs to target high-risk individuals remains a critical role for the IPP.

### Conclusion

Reducing health disparities and achieving equity is fundamentally important to improving population health and reducing the burden of disease in disproportionately affected communities. Everyone, regardless of social and economic circumstances, should have the opportunity to attain his/her full health potential. Unfortunately for many people, disadvantaged conditions are pervasive during extended periods of time, and for some, membership in a disadvantage group lasts for generations. Reducing the barriers to effective prevention, screening, and treatment must be a

priority if greater equity in sexual and reproductive health care is to be achieved.

### Recommendations

**Recommendation 12:** Identify culturally appropriate tools and models for helping individuals enroll in new forms of health insurance. These tools should be adapted for STI and family planning programs, and must be available in both English and Spanish. Training for state and local STI and family planning program staff should also be provided for effective use of these tools at the local level.

*Rationale:* Overall, there was a lot of concern about patients’ ability to understand the PPACA and how it applies to them, as well as the ability of individuals to utilize a system they previously could not. This recommendation is based on specific findings in Massachusetts that showed that Hispanic individuals with limited English proficiency continued to struggle to access new forms of health insurance.<sup>101</sup> Regional key informant interviewees suggested that safety net providers might act as bridges to new forms of insurance. Identifying and adopting these tools could lead to substantial gains in access to coverage. This perspective was clearly supported by the number of interviewees who noted that Title X family planning and STI clinics are entry points into the health care system for many patients.

**Recommendation 13:** Encourage collaboration with local coalitions that are attuned to the specific needs of individual communities in order to target outreach messages in a culturally appropriate fashion.

*Rationale:* This recommendation takes into account findings that indicate that STI prevention outreach messages must be culturally appropriate if they are to be effective. It was noted in key informant interviews that local-level coalitions may be in a position to help develop specific outreach messages in a culturally-appropriate fashion.

Several of the national interviewees noted that the PPACA may make health insurance coverage a reality for some vulnerable populations that previously did not have health insurance. But the majority of the key informants felt that communities that have traditionally been underserved—racial and ethnic minorities, the formerly incarcerated, undocumented individuals, adolescents, and men—will continue to face challenges to accessing reproductive and sexual health care services.





## Workforce



## Background

Medicaid enrollment expansion under HCR is likely to greatly outpace growth in the number of primary care physicians (PCPs) willing to treat these new patients.<sup>102</sup> The Robert Wood Johnson Foundation study found an inverse relationship between the number of PCPs and the anticipated growth in Medicaid enrollment; Mid-Atlantic and the Northeast states report the largest number of PCPs per capita. states with the smallest number of PCPs per capita are concentrated largely in the South and Mountain West, and as noted previously, these regions are likely to see the largest percentage of increases in Medicaid enrollment in the years ahead and thus have a higher need for PCPs.<sup>103</sup> Many of these areas include rural areas with limited care and resources, leaving rural residents without adequate prevention, screening, and treatment.

A survey by the National Coalition of STD Directors found that 69 percent of STI programs experienced budget cuts in 2008, and that the number of categorical STI clinics in the United States declined by 10 percent over the last decade.<sup>104</sup> STI clinics diagnose roughly 25-50 percent of primary and secondary syphilis cases, 15-35 percent of gonorrhea cases, 10-35 percent of HIV cases, and 5-20 percent of chlamydia cases.<sup>105</sup> For bacterial STIs, these numbers are substantially higher than estimates based on patient reports, and suggest that STI clinics may be more important in the control of these infections, particularly syphilis and gonorrhea, than is generally thought. Policy makers must recognize that having access to medical care does not mean people will ask their primary doctor for an STI test. As Bill Smith, Executive Director of the National Coalition of STD Directors noted, "In Massachusetts, where budget cuts closed the state's publicly-funded STI clinics, there's been a dramatic uptick in reportable STIs despite the fact that the state has near-universal insurance coverage."<sup>106</sup> High-income countries other than the United States have had universal health insurance for decades, and many (e.g., the Netherlands, the United Kingdom, Australia) have elected to continue to support categorical STI clinics.<sup>107</sup>



---

***“There will be an extreme shortage of primary care physicians to provide a wide range of services. Therefore, it will be necessary to maximize the scope of practice for health care workers.”***

---

### **The Role of Public Health Nurses**

With expected workforce challenges under HCR, regional key informant interviewees were asked to comment on the role of public health nurses (PHNs) as well as the specific successes and

challenges associated with partnering with SBHCs. PHNs, it was noted, play a key role in dispensing medication, providing treatment services, acting as disease intervention specialists (DIS) when DIS are otherwise unavailable, and conducting patient and partner notification and field-delivered therapy. Standing orders under which PHNs are able to conduct chlamydia and gonorrhea screening services were particularly common.

### **Challenges**

A number of challenges, however, were also associated with the role of PHNs, primary among them being finding appropriate funding to provide salaries competitive with those in the private sector. Funding shortages in some areas have translated to staffing shortages. As a result, some project areas noted already utilizing PHNs to the full extent of their practice, with little room for growth. In addition, some interviewees felt as though PHNs are overburdened with paperwork and reporting requirements, which inhibit their availability to conduct additional services such as partner notification or community education.

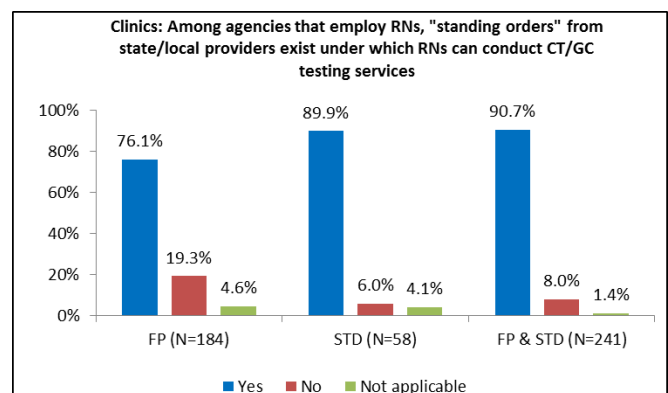
However, a number of interviewees noted that, considering the critical role of PHNs in the delivery of IPP-related services, combined with expected workforce shortages, it is important to identify areas in which the role of PHNs are limited and encourage programs to maximize the potential of nurses. Taking full advantage of innovative nursing provisions (see Appendix A) will be an important step at the local level given, as one interviewee stated, that “RNs are one of the most versatile work forces in public health.”

### **Opportunities to Leverage the Strengths of the IPP**

To this end, some interviewees noted that the IPP is needed to raise awareness and facilitate discussions about the potential benefits of expanding PHN capacity while taking full advantage of new opportunities in the PPACA to do so. For example, one interviewee noted that PHNs could contribute significantly to partner notification services throughout the country, and that IPP is a “vital vehicle for providing proper guidance” to see that this is accomplished. One interviewee went on to suggest that with a potentially expanded role of PHNs, in conjunction with anticipated workforce shortages, it would be useful to: “a) determine the license limit for various non-physician clinical staff; and b) create a network of those resources at the community/regional level.”

Interviewees noted the importance of partnering at the state level with boards of nursing in order to alleviate administrative barriers associated with using PHNs for services such as partner notification. Survey findings highlight the current scope of work of PHNs across IPP partners on a national scale. Within the clinic capacity survey, agencies were asked questions as to whether RNs are able to conduct specific services with respect to chlamydia and gonorrhea testing and partner notification services. Among the 757 completed surveys that responded to the question “Does your agency employ registered nurses (RNs)?” the vast majority (692 respondents) indicated “yes.” The 692 respondents representing agencies that do employ RNs were then asked to indicate whether or not standing orders existed from state or local providers (i.e., physician, D.O., nurse practitioner, or physician assistant) under which RNs are able to conduct chlamydia and gonorrhea testing services. As is demonstrated in Graph 32 below, the vast majority of respondents representing either FP or STI, or FP

**Graph 32: Do “standing orders” from state or local providers (i.e., a physician, D.O., nurse practitioner, or physician assistant) exist under which RNs are able to conduct chlamydia and gonorrhea testing services?**

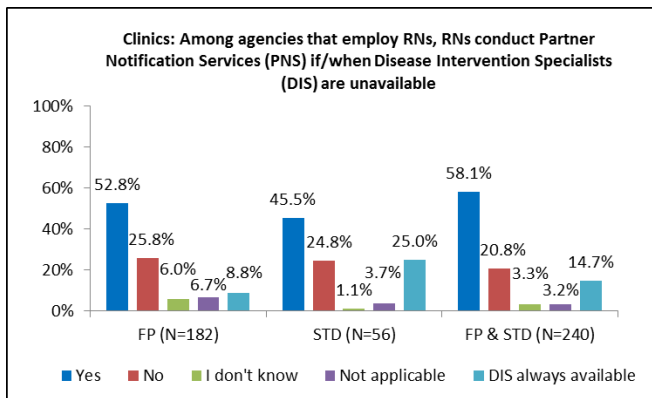




and STI clinics indicated that standing orders do exist under which RNs can conduct testing services. It should be noted, however, that among the 184 respondents representing FP clinics alone, almost 20 percent indicated that such orders do not exist.

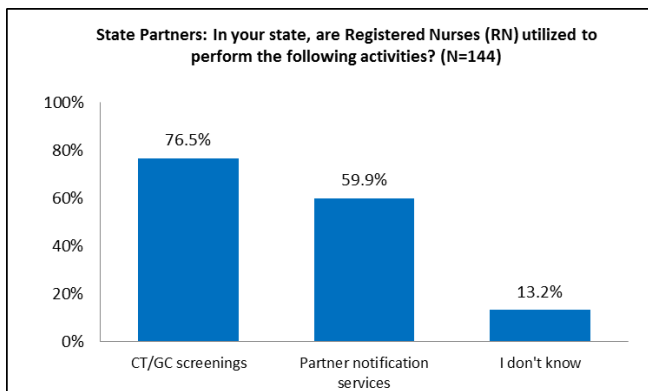
Less common was the extent to which RNs conduct partner-notification services. In fact, approximately 26 percent of respondents representing FP clinics alone, 25 percent of respondents representing STI clinics alone, and 21 percent of respondents representing FP and STI clinics indicated that RNs do not conduct partner-notification services if and when disease intervention specialists are unavailable. See Graph 33 below.

**Graph 33: Do RNs conduct partner notification services if/when disease intervention specialists (DIS) are unavailable?**



Findings from the state partner survey present similar results. According to Graph 34, below, individuals were more likely to indicate that RNs are utilized to perform chlamydia and gonorrhea screenings than they were to indicate that RNs are utilized to perform partner notification services.

**Graph 34: In your state, are registered nurses (RNs) utilized to perform the following activities? (please mark ALL that apply)**



### ***School-Based Health Centers***

Interviewees from five regions commented on the relationship with SBHCs as they pertain to the IPP and chlamydia and gonorrhea-related screening. Several specific strengths were associated with partnering with SBHCs, primary among them being increased access. It was noted that testing through SBHCs has expanded student access to onsite reproductive care, allowed greater access to screening and birth control, and contributed to thousands of students being tested each year. SBHCs have also provided opportunities to expand and increase access to sexual health education. In addition, SBHCs are considered a trusted and confidential source of information. It was noted, for example, that in some cases parents know and must accept that services provided within SBHC settings are confidential, and that SBHCs have a substantial focus on ensuring confidential access to services. Interviewees also commented on the ability of SBHCs to target at-risk youth who would otherwise not seek sexual health services.

A number of interviewees noted the importance of stakeholder collaboration, especially among departments of human services, departments of education and departments of health for implementing partnerships with SBHCs. One interviewee noted that his/her STI program had engaged in teleconference calls with SBHCs, departments of public health, STI programs, human services, and the local community nursing bureau in order to initiate programming. Accordingly, a high volume of SBHCs participated in the calls and discussed barriers to CT testing and potential ways to overcome them. A PowerPoint presentation to facilitate these discussions was developed and included the following:

- \* Sexual behavior data for adolescents
- \* CT prevalence and incidence data for adolescents
- \* Site-specific CT testing data
- \* Barriers to CT testing
- \* Questions and brainstorming to improve testing

The interviewee who provided this information offered to share the PowerPoint and methodologies with other IPP regions.

Messaging and data were other key facilitators to the expansion of chlamydia and gonorrhea screenings in SBHCs. One interviewee noted the success of establishing the link between health services and preventing teen pregnancy and infant mortality. Another interviewee had success in developing arguments appealing to academic institutions in particular, which included the negative consequences that STIs or unintended



pregnancy can have in academic performance. Data was also noted as a particularly powerful tool. One interviewee used local prevalence data to establish a precedence of need for services.

### **Challenges**

Of course, challenges persist and many interviewees commented on the potential barriers that could arise from school boards and parents. One challenge involved dispelling the myth that students will have more sex if they have access to reproductive health services. Another challenge involved gaining permission from the parents themselves. In addition, working with the bureaucracy of some public schools was noted as particularly challenging, as many interviewees cited conservative political viewpoints on the part of school boards or parents.

Scarcity of resources was another challenge in establishing SBHCs, and interviewees noted that some SBHCs have been forced to close for financial reasons. Staffing challenges were another notable concern, as were physical space constraints and lack of resources to conduct monitoring and evaluation to determine the effectiveness of these efforts.

Confidentiality was also a challenge for some interviewees, especially in light of HCR and expanded access to health insurance. A group of researchers with the University of Wisconsin-Milwaukee found adolescent girls are concerned about parental notification or parents finding out that they have accessed reproductive and sexual health services.<sup>108</sup> One interviewee noted that there were still no established agreements in place with private insurance companies to avoid sending EOBs to the homes of adolescent clients, even within SBHC settings. Yet interviewees were optimistic that if SBHCs can maximize third-party billing capacities, challenges associated with financial or resource constraints may be alleviated. Financial reimbursements could lead to increased revenue, support for infrastructure development, service expansion, solvency, and may even incentivize schools to operate SBHCs.

### **Opportunities to Leverage the Strengths of the IPP**

The role of the IPP in encouraging chlamydia and gonorrhea screening amongst SBHCs was noted as particularly important. One interviewee said that if IPP funding were decreased this type of screening would most likely decrease as well, as “frequent motivation and support from the IPP is needed to encourage SBHCs to screen.” Advocacy arguments developed in conjunction with the IPP could greatly promote the continuation of screening by highlighting the success and importance of sexual

and reproductive health services amongst SBHCs. In addition, one interviewee suggested that the IPP play a role in quality assurance for SBHCs in order to facilitate funding applications.

### **Conclusion**

Both national and regional interviewees acknowledged the challenges the primary care system may face as a result of increased numbers of newly insured individuals seeking services. Interviewees expressed concern as to whether clients will be able to get in to be screened and treated in a timely fashion, and additional concern was raised about scheduling issues and wait times for appointments. In addition, many interviewees questioned whether primary care providers would be able to provide STI education and prevention messages due to lack of comfort with the topic or to time constraints.

PHNs may be uniquely positioned to address changes or shortages in the workforce by providing coverage to assist populations adversely impacted by changing provider/patient demographics.<sup>109</sup> Nurses may be poised to help bridge the gap between coverage and access and to provide needed care to populations at risk of deleterious outcomes.<sup>110</sup> As the provider population ages and fewer young people are seeking training in the field, FP and STI clinics are having difficulty finding trained and qualified employees to meet the increasing patient population.<sup>111</sup> Education and training programs must be expanded and opportunities afforded by the PPACA used if a new generation of providers is to be accommodated.<sup>112</sup> Systems need to be put into place to encourage hiring, and provider incentives must be available for work in predetermined areas, including rural and other areas of increased need.<sup>113</sup>





## Recommendations

**Recommendation 14:** Promote local-level, field-based research and facilitate the dissemination of existing information on lessons learned about maximizing access to screening and treatment services and ensuring partner treatment. In addition, IPP coordinating agencies should have an ongoing role in providing data analysis and monitoring and evaluation technical assistance on the local level to quantify and market successful efforts.

*Rationale:* The IPP (infrastructure and service delivery settings ) can be a logical venue for field laboratory and program-based research. The implementation of small-scale demonstration projects can provide lessons learned or case studies valuable to the field. Local-level data demonstrating success in key fields such as the development of partnerships with school-based health centers (SBHCs), utilizing public health nurses to facilitate partner notification services, use of specific forms of social media, or private sector collaboration surrounding EPT can assist in the development of promotional outreach on behalf of IPP partner facilities. Local-level key informant interviews also highlighted capacity challenges pertaining to data analysis and monitoring and evaluation activities in particular.

**Recommendation 15:** Promote local-level awareness of opportunities to take advantage of innovative nursing provisions within the PPACA, such as Sections 5202 (Nursing Student Loan Program), 5308 (Advanced Nursing Education Grants), and 5309 (Nurse Education, Practice, and Retention Grants).

*Rationale:* This recommendation is made due to the concern noted from the national key informants about the primary care system being overwhelmed initially by the number of people seeking services as a result of increased numbers of insured individuals. Interviewees wondered whether clients will be able to get in to be screened and treated in a timely fashion. There was concern that scheduling issues and wait times would get worse before they got better. Also, there was some questioning about whether the primary care providers would be able to provide STI education and prevention messages due to lack of comfort with the topic or time constraints. One interviewee highlighted the increased need for patient advocates, who could ensure that clients receive the care and information they need.

Additionally, this recommendation addresses both national and regional interviewee perspectives on the critical role of PHNs in addressing future health care workforce shortages as described above.





## KEY FINDINGS AND CONCLUSION

### Key Findings

The key findings in this section are organized by the six healthcare reform related areas as shown in assessment framework on page 6. All results are drawn from the following data sources: secondary data review, key informant interviews, and surveys, as well as the results from the national research. The 90 transcripts were then coded (one transcript/notes for each KII from the regional focus area and one for each of the national KIIs).

Given the uncertainty surrounding implementation of the PPACA, a key challenge to the IPP partners is recognizing the need for change or transformation of their program model. However, many expressed appreciation that the CDC, through the Future of IPP assessment, is encouraging them to honestly assess the strengths and weaknesses of the IPP as a whole and as state and local partners.

The field (state STI and FP programs, public health laboratories, and clinics) do not identify themselves as IPP; rather, they see the IPP as one of many funding streams that they utilize to support screening and treatment for chlamydia and gonorrhea. In terms of the IPP as its own entity, it is the infrastructure/coordinating agencies and regional advisory committees that are seen as IPP, and within this rubric, the program is considered an agent and resource of best practices. Furthermore, the key role that the IPP infrastructures/coordinating agencies have played in highlighting best practices, for example related to developing strategies to best target limited resources for maximum impact, has allowed community clinics to reach the most vulnerable women (uninsured and underinsured females age <26 with >3% CT positivity) as part of a larger public health effort to help ensure that all at-risk females age <26 have access to screening and treatment services.

### Prevention

Both national and regional key informant interviewees expressed consensus pertaining to two key points: a) vulnerable populations will continue to exist after HCR has been implemented; and b) there will be a continued need for safety-net services.

Interviewees stated that after HCR implementation, vulnerable populations will continue to include adolescents and teens in need of confidential services, women victimized by domestic violence, individuals with fluctuating insurance, politically controversial populations, homeless clients with mental illnesses, individuals with lower socio-economic status, individuals with only major medical for catastrophic coverage, individuals who refuse or forget to enroll in an insurance plan, young adults commonly referred to as the “young immortals,” and undocumented individuals ineligible for any form of health insurance coverage.

The continued need for safety-net services was said to result from insurance fluctuations, appointment waiting periods, paperwork, complexity of enrollment, ongoing confidentiality concerns, and the remaining cost of services. One interviewee summarized these concerns, stating simply that “coverage does not equal access.” It was also commonly expressed that with new forms of coverage, there will be an influx of new clients seeking services, which may cause strain within the private sector to meet demand.

### Insurance Coverage

Both national and regional key informant interviewees agreed on a number of issues pertaining to insurance coverage under HCR. First, interviewees agreed that the development of third-party billing capacity will be critical to the sustainability of IPP clinic partners. Second, interviewees agreed that considering the importance of third-party billing, resources and technical assistance should be directed towards these efforts across both FP and STI clinics. Third, interviewees agreed that despite new health insurance access points, such as a health benefits exchange or an expanded Medicaid program, challenges will persist in individual ability to access or utilize affordable health care. Primary among such concerns may be the persistence of the potential to breach patient confidentiality resulting from explanations of benefits. These ongoing challenges necessitate the viability of safety-net services in a reformed health care landscape.



### Health Information Technology

Both national and regional interviewees agreed that state-based participation in HIEs will be critical to ensuring that sexual and reproductive health-related variables are captured in new systems and utilized to improve programmatic efforts. Survey findings and regional interviewees indicate that awareness needs to be raised as to the scope and purpose of these structures, as well as the importance of state-level participation in their development.

National and regional interviewees also agreed that local level training efforts must be made and maintained to ensure that sexual and reproductive health variables are consistently collected and efficiently utilized across both public and private sectors.

### Innovation and Quality Improvement

National and regional key informants agree that partnering with both the private and primary care sectors are key to the survival of IPP clinic partners. Many agencies have developed this capacity, but others will struggle to find the resources and expertise to successfully partner with these sectors. Local-level trainings would help prepare IPP partners for key challenges associated with these efforts, such as managing contracts, developing local advocacy arguments and targeting specific agencies with which to partner.

Social media is widely regarded as a cost-effective way to reach new populations, and should be encouraged and supported on both the state and local levels. Social media can be a highly effective tool to communicate with and across both the health care community and the public. There is substantial potential for growth in this sector, as survey findings demonstrate a high reliance on print materials, especially in relation to social media ventures.

### Minority Health and Health Equity

Reducing health disparities and achieving equity is fundamentally important to improving population health and reducing the burden of disease in disproportionately affected communities. Everyone, regardless of their social and economic circumstances, should have the opportunity to attain their full health potential. Unfortunately for many people, disadvantaged conditions are pervasive during extended periods of time, and for some, membership in a disadvantage group lasts for generations. Reducing the barriers to effective prevention, screening, and treatment must be a priority if greater equity in sexual and reproductive health care is to be achieved.

### The Health Care Workforce

Both national and regional interviewees acknowledged the challenges the primary care system may face as a result of increased numbers of newly insured individuals seeking services. Interviewees expressed concern as to whether clients will be able to get in to be screened and treated in a timely fashion, and additional concern was raised surrounding scheduling issues and wait times for appointments. In addition, many interviewees questioned whether primary care providers would be able to provide STI education and prevention messages due to lack of comfort with the topic or to time constraints.

### ***Strengths of the IPP***

IPP service delivery partners and the IPP infrastructure/coordinating agencies have notable strengths that can be leveraged throughout implementation of HCR.

### Successes of IPP Sexual and Reproductive Health Service Delivery Partners

Serving unmet need and vulnerable populations:

- \* IPP sexual and reproductive health partners are strategically placed in the community.
- \* IPP sexual and reproductive health partners already focus on addressing disparities and targeting vulnerable populations.

Experience providing high quality, confidential care:

- \* Expertise in client-based education and counseling.
- \* Staff have become specialists in sexual and reproductive health.
- \* Well-regarded facilities trusted for confidential service provision.

### Successes of IPP Infrastructure/Coordinating Agencies

Coordination and communication:

- \* Provide collaboration and coordination between FP and STI clinics and public health laboratory partners.
- \* Have helped service delivery partners observe trends and make improvements.
- \* IPP infrastructure/coordinating agencies also provide opportunities to exchange information.
- \* Identified repeatedly as a reference for best practices, tools and guidance.
- \* Provide key connection at the federal level to help local level prepare for change.
- \* Promote knowledge sharing and dissemination of best practices.

**Additional Findings:**

- \* A high degree of uncertainty in the field. This is due to two things: a lack of understanding of the PPACA and potential implications on a local level due to the complexity of the legislation; and a lack of state-level implementation and clear directives. These uncertainties about the implications of HCR have resulted in serious strategic planning challenges in the field.
- \* Acute financial challenges will be faced across the public health sector resulting from ongoing economic pressures and budget cuts, which have already resulted in staff shortages and loss of expertise.
- \* There is consensus that safety net<sup>+++</sup> services will continue to be needed in a post-reform environment, as noted by Figures 1 and 2 below, which present a snapshot of insurance coverage before and after health reform.

"Safety-net clinics have long played *the role of filling in the gaps in access to health care*" and there will be a continued need to fill for the safety net health reform for a few reasons. First, given that all projections estimate that 23 million people will persist to be without health insurance when the health reform law is fully implemented. Second, access to care and coverage are not synonymous. While nearly half of the coverage expansion is achieved by making more people eligible for Medicaid, as ECHO noted, it is well-documented that a sizeable minority of people who are eligible do not actually enroll. Even once coverage, whether it be Medicaid or private, is successfully obtained (Medicaid or private), utilization of the coverage through accessing healthcare services will depend on the ability to find a provider willing to see them. This last hurdle (of finding a provider, may prove difficult in an environment that is expected to face severe workforce shortages.<sup>114</sup> Below are the points that were identified by the regional KIIs:

- \* HCR has not adequately addressed patient confidentiality protections.
- \* Certain groups, such as adolescents, rural populations, racial/ethnic minorities, incarcerated individuals, and undocumented individuals, face additional barriers to enrolling in coverage and accessing services.
- \* Key informants often mentioned that private and primary care providers can lack skill, experience, and comfort in providing

confidential care to adolescents.

Safety-net providers, such as the IPP service delivery partners, should develop strategic plans for outreach, particularly to special populations. Given the substantial expansion of the Medicaid program to anyone 133% FPL or below, including childless adults, the FP and STI IPP partners could act as bridges to new access points within a reformed health care environment. Individuals attempting to enroll in a new plan or compare different plans, or who may be unaware of the opportunities available to them, may have questions that safety net providers are well suited to address. There are many larger HHS initiatives to incentivize and encourage community providers to provide information about the PPACA and facilitate enrollment in health care plan.

- \* IPP service delivery partners, STI clinics, and public health laboratories, in particular, will face substantial challenges in building third-party billing capacity.
- \* EPT implementation has faced legislative and regulatory barriers, provider resistance, and a lack of understanding about the importance of partner treatment in the prevention and control of chlamydia and gonorrhea.
- \* Geographic information systems mapping has been a valuable tool and facilitates connections between morbidity, demographics, and other social determinants of health, all of which assists in the focusing of outreach and intervention efficiency.
- \* IPP sexual and reproductive health partners can expect the following in a reformed environment:
  - The need to expand scope of services, model of care, and partnerships in order to distinguish themselves in a changing service delivery environment.
  - The need to expand communication and collaboration with other health care providers, such as primary care physicians and FQHCs. Some IPP partners may lack access to these organizations and will require expertise to market their services.
  - KIIs expect an influx of new clients to the health care system as individuals gain access to new forms of insurance. KIIs also agreed that the IPP client based may decrease as these clients become insured and seek sexual

<sup>+++</sup> For the purpose of this report, JSI used the Institute of Medicine (IOM) definition of the safety net. In 2000, the IOM defined the safety net as "Those providers that organize and deliver a significant level of health care and other health-related services to uninsured, Medicaid, and other vulnerable patients." Much of the discussion centers on which providers in a community are "safety net" providers, and which ones are not. The IOM also recognized the concept of 'core safety net providers': "These providers have two distinguishing characteristics: (1) by legal mandate or explicitly adopted mission they maintain an "open door," offering access to services to patients regardless of their ability to pay; and (2) a substantial share of their patient mix is uninsured, Medicaid, and other vulnerable patients."



and reproductive health services with new providers.

- Given the importance of documenting that services are consistent with evidence-based practices, there will be an increased need for robust data systems, such as EHRs, to report performance outcomes, enable quality improvement, and for financial analysis and efficiency.
  - Electronic health record systems to coordinate care, improve data management, document quality of care, and facilitate electronic billing will be a part of standard business practices. However, many IPP STI, FP, and laboratory partners lack the resources, IT infrastructure, and overall capacity necessary to implement EHR or interface electronically with other systems.
- Different health insurance plans will cover different services resulting in an array of coverage and more complex contracts than those that exist today.

## Conclusion

Reform is now a reality. It is time for IPP partners to determine how they will transform in order to continue to facilitate and encourage the delivery of infertility prevention services to at-risk populations, including those already insured, the more than 20 million people who are projected to gain insurance coverage under PPACA, and all those who remain uninsured. Agencies that can accomplish the following will be positioned to succeed in the era of health care reform:

- ⇒ Recognize the need to transform
- ⇒ Assess the strengths and weaknesses of the organization
- ⇒ Educate boards, managers, and staff on the need to transform
- ⇒ Strategically plan and implement transformation
- ⇒ Develop advocacy arguments utilizing local-level data
- ⇒ Develop efficient third-party billing capacity
- ⇒ Create partnerships with primary health entities
- ⇒ Assess changes and adjust as needed

Reform also means increased available funding for prevention services as Medicaid reimbursement expands and the door opens to third-party payer reimbursements. However, even before the passage of healthcare reform legislation, experts were predicting that sexual and reproductive health services providers would need to assess and adjust their business philosophies and practices to take advantage of the many opportunities that would follow reform. If programs and clinics are to capitalize on the opportunities created by parity and healthcare reform, they will need to develop competencies in the following functional areas:

- \* Develop a fiscal business approach to increase financial viability. Indicators of this competency include:
  - Capacity to bill all insurance and optimize third-party payment
  - Capacity to conduct cost analysis to understand their costs as they relate to service delivery and reimbursement rates
  - Capacity to develop successful partnerships and collaboration with appropriate agencies
  - Capacity to market to and retain new clients
  - Capacity to conduct outreach for and enroll clients in Medicaid



- \* Implement robust HIT systems that enhance quality and operations. Indicators of this competency includes:
  - Ability to take advantage of EHR incentives
  - Awareness of data collection needs and costs of making changes to data collection when entering into a HIE
  - Routine assessment of operations in order to identify and understand demand for services
  - Offer an appropriate and sustainable service mix
  - Use of a quality improvement system
  - Remain current about clinical services and guidelines

Change management requires a cultural and skill-shift at all levels of an organization (front-line employees, managers and directors). STI and family planning programs need TA to help them maintain sustainability post-HCR. Specifically, there is a continued need to address the following capacity-building needs:

- \* Provider education and training
- \* Reduce uncertainty about health care reform
- \* Contract negotiation and development
- \* Capacity-building assistance
- \* Provide guidelines and quality assurance standards across public and private health sectors
- \* Facilitate cooperation and collaboration—both within sectors in each state and across states—between FP, STI, and public health laboratory systems

Prevention is a key component of the PPACA and therefore a core component of the new health care landscape as reform is implemented. However, advocacy at the federal, state, and local levels must continue and will play a crucial role in:

- \* Ensuring meaningful input into future policies and regulations
- \* Educating individuals, families, and communities on new benefits and rights
- \* Continued inclusion of sexual and reproductive health services as an essential benefit

Due to the competition between primary care and prevention resources, tension between service delivery and public health prevention is growing. As such, it is important to attach advocacy arguments pertaining to reproductive and sexual health to the overall prevention argument. Reaching out to the Prevention Institute and Trust for America's Health to incorporate sexual and reproductive health into their messaging could enhance advocacy arguments on behalf of the public health prevention

community.

Some national interviewees felt that the PPACA will help the system move toward a more comprehensive approach to providing care and that STD screening and treatment coverage will be more consistent across insurance plans. Some interviewees wondered about how ready the health care system is to handle an influx of previously-uninsured clients. However, sexual and reproductive health programs that, for example, have partner notification services or provide confidential care for a sensitive service, provide substantial added value that primary care providers may not be as suited to address. Moving forward, the development of new partnerships with private sector providers, medical homes, and FQHCs, among others, will be challenging and critical to the sustainability of the IPP.

In spite of these challenges, the IPP is in a position to facilitate partnerships at the federal level as well as communicate best practices at the local level for several reasons. Sexual and reproductive health services are the initial point of entry into health care system for many women; six in 10 women who obtain care at a family planning clinic consider it their usual source of medical care. IPP partners delivering sexual and sexual and reproductive health services also have a high level of technical competence. These providers adhere to Title X and CDC screening and treatment guidelines, in order to screen appropriate groups for chlamydia and gonorrhea. They also provide appropriate follow-up to PAPs and STI tests; and provide low-cost, high-quality services overall. Including these messages as they approach partners, should improve IPP partners' opportunities for collaboration.<sup>115</sup>





## REFERENCES

## Full Report

- 1 Data Source: Regional Infertility Prevention Projects: All regional projects, in collaboration with state STD control and family planning programs, have reported chlamydia positivity data to CDC since 1997. In some of the HHS regions, federally-funded chlamydia screening supplements existing local- and state-funded testing programs.
- 2 ECHO: An Assessment of the Potential Impact of Health Reform on Free/Charitable Clinics. Retrieved from <http://www.wafreeclinics.org/admin/mod-cms/viewattachment.php?id=500>. Accessed on September 1, 2011.
- 3 Park, Todd. Chief Technology Officer, DHHS: Health Data Initiative Overview, presentation, Region VIII Culture of Data Conference, October 2011.
- 4 Service Delivery Models in the Affordable Care Act: What Title X Clinics Need to Know, Title X Grantee Meeting, August 2011, Loeffler, A. Region VIII FPTC Presentation.
- 5 Weinstock H, Berman S, Cates W, Jr. Sexually transmitted diseases among American youth: incidence and prevalence estimates, 2000. *Perspect Sex Reprod Health* 2004;36:6–10.
- 6 Chesson HW, Blandford JM, Gift TL, et al. The estimated direct medical cost of sexually transmitted diseases among American youth, 2000. *Perspect Sex Reprod Health*. 2004 Jan–Feb;36(1):11-9.
- 7 Department of Health and Human Services Centers for Disease Control and Prevention. (March 23, 2011). Infertility Prevention Project: Guidelines for Regional Infrastructure Support Project Narrative Request. CDC-OPA Inter-Agency Agreement.
- 8 Centers for Disease Control and Prevention (August 23, 2011). Infertility Prevention Project. Retrieved from: <http://www.cdc.gov/std/infertility/ipp.htm>. Accessed on October 1, 2011.
- 9 *ibid*
- 10 *ibid*
- 11 Data Source: Regional Infertility Prevention Projects: All regional projects, in collaboration with state STD control and family planning programs, have reported chlamydia positivity data to CDC since 1997. In some of the HHS regions, federally-funded chlamydia screening supplements existing local- and state-funded testing programs.
- 12 Department of Health and Human Services Centers for Disease Control and Prevention. (March 23, 2011). Infertility Prevention Project: Guidelines for Regional Infrastructure Support Project Narrative Request. CDC-OPA Inter-Agency Agreement.
- 13 JSI Research & Training Institute, Inc./Denver; Region VIII IPP Regional Plan: 2009-2011.
- 14 *ibid*
- 15 Buettgens, Matthew, Mark A. Hall. (March 2011). Who Will Be Uninsured After Health Insurance Reform? Robert Wood Johnson Foundation. Retrieved from: <http://www.urban.org/UploadedPDF/1001520-Uninsured-After-Health-Insurance-Reform.pdf>.
- 16 Department of Health and Human Services. Preventive Services Covered under the Affordable Care Act. Retrieved from: <http://www.healthcare.gov/news/factsheets/2010/07/preventive-services-list.html>. Accessed on October 31, 2011.
- 17 Weinstock H, Berman S, Cates W, Jr. Sexually transmitted diseases among American youth: incidence and prevalence estimates, 2000. *Perspect Sex Reprod Health* 2004;36:6–10.
- 18 U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. *Women's Health USA 2011*. Rockville, Maryland: U.S. Department of Health and Human Services, 2011. Retrieved from: <http://mchb.hrsa.gov/whusa11/hstat/hshi/pages/219sti.html>. Accessed October 31, 2011.
- 19 Chesson HW, Blandford JM, Gift TL, et al. The estimated direct medical cost of sexually transmitted diseases among American youth, 2000. *Perspect Sex Reprod Health*. 2004 Jan–Feb;36(1):11-9.
- 20 Meyers, D., Wolff, T., Gregory, K., et al. *USPSTF Recommendations for STI Screening*. Originally published in *Am Fam Physician* 2008;77:819-824. Retrieved from: <http://www.uspreventiveservicestaskforce.org/uspstf08/methods/stinfections.htm>. Accessed: October 1, 2011.
- 21 Howden, Lindsay M., Julie A. Meyer. U.S. Department of Commerce. (May 2011). Age and Sex Composition. 2010 Census Briefs. Retrieved from: <http://www.census.gov/prod/cen2010/briefs/c2010br-03.pdf>.
- 22 Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, Division of STD Prevention (November 22, 2010). Trends in Sexually Transmitted Diseases in the United States: 2009 National Data for Gonorrhea, Chlamydia and Syphilis CDC Factsheet. Retrieved from <http://www.cdc.gov/std/stats09/trends.htm>. Accessed October 1, 2011.



- 23 *ibid*
- 24 Hook EW III, Handsfield HH. Gonococcal infections in the adult. In: Holmes KK, Sparling PF, Stamm WE, Piot P, Wasserheit JN, Corey L, et al, editors. Sexually transmitted diseases. 4th ed. New York: McGraw-Hill; 2008. p. 627-45.
- 25 Johnson RE, Berman SM. Sexual transmission: *Chlamydia trachomatis*. In: Krämer A, Kretzschmar M, Krickeberg K, editors. Modern infectious disease epidemiology. New York: Springer; 2009. p. 357-80.
- 26 Haggerty C, Gottlieb S, Taylor B, et al. Risk of sequelae after *Chlamydia trachomatis* genital infection in women. J Infect Dis 2010;201(Suppl 2):S134--55.
- 27 Oakeshott P, Kerry S, Aghaizu A, et al. Randomised controlled trial of screening for *Chlamydia trachomatis* to prevent pelvic inflammatory disease: the POPI (prevention of pelvic infection) trial. BMJ 2010;340:c1642.
- 28 Haggerty C, Gottlieb S, Taylor B, et al. Risk of sequelae after *Chlamydia trachomatis* genital infection in women. J Infect Dis 2010;201(Suppl 2):S134--55.
- 29 Centers for Disease Control and Prevention. (September 28, 2011). Pelvic Inflammatory Disease (PID) CDC Fact Sheet. Retrieved from: <http://www.cdc.gov/std/pid/stdfact-pid.htm>. Accessed October 1, 2011.
- 30 Centers for Disease Control and Prevention. (November 22, 2010). STDs in Women and Infants. Retrieved from: <http://www.cdc.gov/std/stats09/womenandinf.htm#foot3>. Accessed October 1, 2011.
- 31 Centers for Disease Control and Prevention. (November 22, 2010). 2009 Sexually Transmitted Diseases Surveillance. Retrieved from: <http://www.cdc.gov/std/stats09/tables/43.htm>. Accessed October 1, 2011.
- 32 Public Sector Consultants Inc. (April 2010) Analysis of the Value of Local Public Health Operations Funding. Michigan Association for Local Public Health. Retrieved from: [http://www.muskegonhealth.net/publications/localhealthrpts/lpho\\_value.pdf](http://www.muskegonhealth.net/publications/localhealthrpts/lpho_value.pdf).
- 33 Hillis SD, Joesoef R, Marchbanks PA, Wasserheit JN, Cates W Jr, Westrom L. Delayed care of pelvic inflammatory disease as a risk factor for impaired fertility. Am J Obstet Gynecol. 1993;168:1503-9.
- 34 *ibid*
- 35 Public Sector Consultants Inc. (April 2010) Analysis of the Value of Local Public Health Operations Funding. Michigan Association for Local Public Health. Retrieved from: [http://www.muskegonhealth.net/publications/localhealthrpts/lpho\\_value.pdf](http://www.muskegonhealth.net/publications/localhealthrpts/lpho_value.pdf).
- 36 American Academy of Nursing. (September 2010). Implementing Health Care Reform: Issues for Nursing.
- 37 Buettgens, Matthew, Mark A. Hall. (March 2011). Who Will Be Uninsured After Health Insurance Reform? Robert Wood Johnson Foundation. Retrieved from: <http://www.urban.org/UploadedPDF/1001520-Uninsured-After-Health-Insurance-Reform.pdf>.
- 38 *ibid*
- 39 Long, Sharon K., Lokendra Phaders, and Victoria Lynch. (August 2010). Massachusetts Health Reform in 2008: Who are the Remaining Uninsured Adults? State Health Access Reform Evaluation, Robert Wood Johnson Foundation.
- 40 *Ibid*
- 41 Patel, Nita, Sejong Bae, and Karan P. Singh. 2010. "Association between Utilization of Preventive Services and Health Insurance Status: Findings from the 2008 Behavioral Risk Factor Surveillance System." Ethnicity and Disease. Vol. 20
- 42 Robertson, Ruth, Sara R. Collins. (May 2011). Realizing Health Reform's Potential: Women at Risk: Why Increasing Numbers of Women are Failing to get the Health Care they Need and How the Affordable Care Act will Help. Findings from the Commonwealth Fund Biennial Health Insurance Survey of 2010. *Commonwealth Fund*. 1502 (3)
- 43 *ibid*
- 44 *ibid*
- 45 *ibid*
- 46 U.S. Department of Health and Human Services. September 2011, "New Data: Affordable Care Act helps one million additional young adults get health insurance." News Release. Available at <http://www.hhs.gov/news/press/2011pres/09/20110921a.html>.
- 47 Jones, Rachel K. Alison Purcell, Susheela Singh, and Lawrence B. Finer. 2005. "Adolescents' Reports of Parental Knowledge of Adolescents' Use of Sexual Health Services and their Reactions to Mandated Parental Notification for Prescription Contraception." The Journal of the American Medical Association. 293: 340-348.
- 48 Buettgens, Matthew, Mark A. Hall. (March 2011). Who Will Be Uninsured After Health Insurance Reform? Robert Wood Johnson Foundation. Retrieved from: <http://www.urban.org/UploadedPDF/1001520-Uninsured-After-Health-Insurance-Reform.pdf>.
- 49 Johnson, Tracy and Rebecca Kellenberg. (2010). Health Insurance Exchanges: Viability and Influence on Private Markets. Health Management Associates.
- 50 Jost, Timothy Stoltzfus. "Health Insurance Exchanges and the Affordable Care Act: Eight Difficult Issues." The



Commonwealth Fund. September 2010.

- 51 Sonfield, Adam, Jennifer J. Frost, Rachel B. Gold. (January 2011). Estimating the Impact of Expanding Medicaid Eligibility for Family Planning Services: 2011 Update. Guttmacher Institute.
- 52 *ibid*
- 53 *ibid*
- 54 *ibid*
- 55 Kaiser Family Foundation: Focus on Health Reform. (December 2010). "Impact of Health Reform on Women's Access to Coverage and Care."
- 56 National Family Planning & Reproductive Health Association (Fall 2010). "Challenges and Opportunities for Family Planning Health Centers in Implementing Health Information Technology." A Policy Brief.
- 57 *ibid*
- 58 *ibid*
- 59 Image taken from: The Office of the National Coordinator for Health Information Technology. "Overview: Federal Health Information Technology Strategic Plan. 2011-2015." Available at <http://healthit.hhs.gov/portal/server.pt?open=512&mode=2&objID=3581&PageID=23952>.
- 60 *ibid*
- 61 Institute of Medicine of the National Academies. (July 2011). The Health Data Initiative. National Academy of Sciences. Retrieved from: <http://www.iom.edu/Activities/PublicHealth/HealthData.aspx>.
- 62 HITECH Programs & Advisory Committees. (February 17, 2009). HITECH Programs: Shaping the Future of Health IT. Retrieved from: <http://www.healthit.gov/policy-researchers-implementers/hitech-programs-advisory-committees>. Accessed on October 15, 2011.
- 63 National Family Planning & Reproductive Health Association (Fall 2010). "Challenges and Opportunities for Family Planning Health Centers in Implementing Health Information Technology." A Policy Brief.
- 64 Agency for Healthcare Research and Quality. (March 2011). Publication No. 11-0050-EF.
- 65 Romaguera, R., R. R. German, and D. N. Klauke. 2000. "Evaluating Public Health Surveillance." In *Principles and Practices of Public Health Surveillance*, ed. S. M. Teutsch and R. E. Churchill, 176–93. New York: Oxford University Press.
- 66 Park, Todd. Chief Technology Officer, DHHS: Health Data Initiative Overview, presentation, Region VIII Culture of Data Conference, October 2011.
- 67 Healthcare.gov. Report to Congress: National Strategy for Quality Improvement in Health Care. (March 2011). <http://www.healthcare.gov/law/resources/reports/quality03212011a.html>. Accessed on June 15, 2011.
- 68 U.S. Department of Health and Human Services Centers for Disease Control and Prevention. (2009). Program Collaboration and Services Integration: Enhancing the Prevention Control of HIV/AIDS, Viral Hepatitis, Sexually Transmitted Diseases, and Tuberculosis in the United States. An NCHHSTP White Paper. Retrieved from: [http://www.cdc.gov/nchhstp/programintegration/docs/207181-C\\_NCHHSTP\\_PCSI%20WhitePaper-508c.pdf](http://www.cdc.gov/nchhstp/programintegration/docs/207181-C_NCHHSTP_PCSI%20WhitePaper-508c.pdf).
- 69 *ibid*
- 70 Brantes, Francois, Alice G. Gosfield, Doug Emery, Amita Rastogi, Guy D'Andrea. Sustaining The Medical Home: How Prometheus Payment Can Revitalize Primary Care. Robert Wood Johnson Foundation. Retrieved from: <http://www.rwjf.org/files/research/prometheusmedicalhomes.pdf>.
- 71 Medpac. (June 2009). Report to the Congress: Improving Incentives in the Medicare Program. Retrieved from: [http://www.medpac.gov/chapters/Jun09\\_Ch02.pdf](http://www.medpac.gov/chapters/Jun09_Ch02.pdf).
- 72 Academy Health. (June 2009). Research Insights: Medical Homes and Accountable Care Organizations – If we Build It, Will they Come? Retrieved from <http://www.academyhealth.org/files/publications/RschInsightMedHomes.pdf>
- 73 U.S. Department of Health and Human Services Centers for Disease Control and Prevention. (2009). Program Collaboration and Services Integration: Enhancing the Prevention Control of HIV/AIDS, Viral Hepatitis, Sexually Transmitted Diseases, and Tuberculosis in the United States. An NCHHSTP White Paper. Retrieved from: [http://www.cdc.gov/nchhstp/programintegration/docs/207181-C\\_NCHHSTP\\_PCSI%20WhitePaper-508c.pdf](http://www.cdc.gov/nchhstp/programintegration/docs/207181-C_NCHHSTP_PCSI%20WhitePaper-508c.pdf).
- 74 Making the Business Case for Social Media in Healthcare. 2011. Produced by Mayo Clinic Center for Social Media in Collaboration with Modern Healthcare.
- 75 Centers for Disease Control and Prevention. (November 2010). Trends in Sexually Transmitted Diseases in the United States: 2009 National Data for Gonorrhea, Chlamydia and Syphilis. Retrieved from: <http://www.cdc.gov/std/stats09/trends2009.pdf>.
- 76 *ibid*
- 77 *ibid*



- 78 ibid
- 79 ibid
- 80 ibid
- 81 ibid
- 82 ibid
- 83 ibid
- 84 ibid
- 85 Centers for Disease Control and Prevention. (November 22, 2010). STDs in Women and Infants. Retrieved from: <http://www.cdc.gov/std/stats09/womenandinf.htm#pid>. Accessed October 1, 2011.
- 86 Centers for Disease Control and Prevention. (November 2010). Trends in Sexually Transmitted Diseases in the United States: 2009 National Data for Gonorrhea, Chlamydia and Syphilis. Retrieved from: <http://www.cdc.gov/std/stats09/trends2009.pdf>.
- 87 Kaiser Family Foundation. (December 2010). The Uninsured: A Primer Key Facts about Americans Without Health Insurance. Retrieved from: <http://www.kff.org/uninsured/upload/7451-06.pdf>. Accessed on September 30, 2011.
- 88 ibid
- 89 Centers for Disease Control and Prevention. (November 2010). Trends in Sexually Transmitted Diseases in the United States: 2009 National Data for Gonorrhea, Chlamydia and Syphilis. Retrieved from: <http://www.cdc.gov/std/stats09/trends2009.pdf>.
- 90 ibid
- 91 Chavkin, Wendy, Sara Rosenbaum, Judith Jones, Allan Rosenfield. Women's Health and Health Care Reform. Columbia University. Mailman School of Public Health. Retrieved from: <http://www.mailmanschool.org/facultypubs/womenshealthcarereform.pdf>
- 92 University of Indiana. Tearing Down Fences: HIV/STD Prevention in Rural America. Retrieved from: <http://www.indiana.edu/~aids/fences/Chapter%20One%20-%20Fences%20-%20New.html#HealthDisparitiesinRuralAmerica>.
- 93 ibid
- 94 ibid
- 95 ibid
- 96 Pew Hispanic Center. (2011). Unauthorized Immigrants in the U.S. Pew Research Center. Retrieved from: <http://pewhispanic.org/unauthorized-immigration/>.
- 97 ibid
- 98 The Kaiser Commission on Medicaid and the Uninsured. (March 2008). Medicaid and the Uninsured. Retrieved from: <http://www.kff.org/medicaid/upload/7761.pdf>.
- 99 ibid
- 100 Reschovsky JD, Boukus ER. (February 2010). Issue Brief 130: Modest and Uneven: Physician Efforts to Reduce Racial and Ethnic Disparities. Retrieved from: <http://www.hschange.com/CONTENT/1113/?PRINT=1>
- 101 Maxwell J, Cortes DE, Schneider KL, Graves A, Rosman B. (August 2011). Massachusetts' Health Care Reform Increased Access To Care For Hispanics, But Disparities Remain. Health Affairs. vol. 30 no. 8 1451-1460. Retrieved from: <http://content.healthaffairs.org/content/30/8/1451>
- 102 Cunningham, PJ. (March 2011). State Variation in Primary Care Physician Supply: Implications for Health Reform Medicaid Expansions. Center for Studying Health System Change. Robert Wood Johnson Foundation. Retrieved from: <http://www.rwjf.org/pr/product.jsp?id=72046>.
- 103 ibid
- 104 Golden, Matthew R., Peter R. Kerndt. (April 2010). Improving Clinical Operations: Can We and Should We Save Our STD Clinics? *Sexually Transmitted Diseases* 37(4) 264-265. Retrieved from: [http://publichealth.lacounty.gov/std/docs/golden\\_kerndt\\_2010.pdf](http://publichealth.lacounty.gov/std/docs/golden_kerndt_2010.pdf).
- 105 ibid
- 106 Krisberg, Kim. (August 2011). STD Programs Not Sexy Enough to Avoid Funding Cuts. Retrieved from: [http://scienceblogs.com/thepumphandle/2011/08/std\\_programs\\_not\\_sexy\\_enough\\_t.php?utm\\_source=networkbanner&utm\\_medium=link](http://scienceblogs.com/thepumphandle/2011/08/std_programs_not_sexy_enough_t.php?utm_source=networkbanner&utm_medium=link).
- 107 Golden, Matthew R., Peter R. Kerndt. (April 2010). Improving Clinical Operations: Can We and Should We Save Our STD Clinics? *Sexually Transmitted Diseases* 37(4) 264-265. Retrieved from: [http://publichealth.lacounty.gov/std/docs/golden\\_kerndt\\_2010.pdf](http://publichealth.lacounty.gov/std/docs/golden_kerndt_2010.pdf).
- 108 Reddy DM, Fleming R, Swain C. Effect of mandatory parental notification on adolescent girls' use of sexual health care services. JAMA. 2002;288(6):710-714. PubMed. Retrieved from: <http://www.ncbi.nlm.nih.gov/pubmed/12169074>.



- 109 Institute of Medicine. (2011). *The Future of Nursing: Leading Change, Advancing Health*. Washington,DC: The National Academies Press.
- 110 Ibid
- 111 Bharat S, Mahendra VS. ( 2007). Meeting the Sexual and Reproductive Health Needs of People Living with HIV: Challenges for Health Care Providers. *Reproductive Health Matters* 2007;15(29 Supplement):93–112. Retrieved from: <http://www.live.who.int/reproductivehealth/publications/rtis/providers.pdf>
- 112 U.S. Department of Health and Human Services. September 2011, Goal 5: Strengthen the Nation’s Health and Human Service Infrastructure and Workforce. HHS Strategic Plan. Available at <http://www.hhs.gov/secretary/about/goal5.html>
- 113 Ibid
- 114 ECHO: An Assessment of the Potential Impact of Health Reform on Free/Charitable Clinics. Retrieved from <http://www.wafreeclinics.org/admin/mod-cms/viewattachment.php?id=500>. Accessed on September 1, 2011.
- 115 Service Delivery Models in the Affordable Care Act: What Title X Clinics Need to Know, Title X Grantee Meeting, August 2011, Loeffler, A. Region VIII FPTC Presentation.







**JSI Research & Training Institute, Inc.**

*Promoting and Improving Health*

