The Future of the Infertility Prevention Project

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

EXECUTIVE SUMMARY

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Executive Summary

The Future of the IPP: Policy Implications and Recommendations in Light of Passage of the PPACA

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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 the history, experience, and resources that have been developed through its STI/HIV and reproductive health projects for local and state communities.

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National Infertility Prevention Coordinating Agencies
PHS Region I-JSI Research & Training Institute, Inc./Boston
PHS Region II-Cicatelli Associates, Inc./New York
PHS Region III-Family Planning Council/Philadelphia
PHS Region IV-Cicatelli Associates, Inc./Atlanta
PHS Region V-Health Care Education & Training/Indianapolis
PHS Region IV-Cardea Services/Austin
PHS Region VII-Development Systems, Inc./Kansas City
PHS Region VIII-JSI Research & Training Institute, Inc./Denver
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### ACRONYM LIST

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>ACO</td>
<td>Accountable care organization</td>
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<tr>
<td>AHRQ</td>
<td>Agency for Healthcare Research and Quality</td>
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<td>AwDC</td>
<td>Adults without dependent children</td>
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<td>BPHC</td>
<td>Bureau of Primary Health Care</td>
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<td>Centers for Disease Control and Prevention</td>
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<td>CBP</td>
<td>Client-based prevention</td>
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<td>CER</td>
<td>Comparative effectiveness research</td>
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<td>CHC</td>
<td>Community health center</td>
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<td>Division of HIV/AIDS Prevention</td>
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<td>EMR</td>
<td>Electronic medical record</td>
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<td>ESI</td>
<td>Employer-sponsored insurance</td>
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<td>Federal Medical Assistance Percentage</td>
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<td>Federal Poverty Level</td>
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<td>Family planning training center</td>
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<td>GPRA</td>
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<td>Health education and risk reduction</td>
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<td>Health Professional Shortage Area</td>
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<td>HRIB</td>
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<td>High risk insurance pool</td>
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<td>HRSA</td>
<td>Health Resources and Service Administration</td>
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<td>ILI</td>
<td>Individual-level intervention</td>
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<td>Infertility Prevention Project</td>
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<tr>
<td>MIS</td>
<td>Management information system</td>
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<td>MUP</td>
<td>Medically Underserved Population</td>
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<td>National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention</td>
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<td>USPSTF</td>
<td>U.S. Preventive Services Task Force</td>
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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.
# The Future of the IPP: Policy Implications and Recommendations in Light of Passage of the PPACA

## Executive Summary

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See Full Report
The Centers for Disease Control and Prevention, Division of Sexually Transmitted Disease Prevention (CDC/DSTDP), in collaboration with the Office of Population Affairs, 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 and STI clinics; and 2) ten regional infrastructure/coordinating agencies. From its start in 1988 as a demonstration project in HHS Region X, IPP has expanded to include all ten federal HHS regions.

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 sexually transmitted infections (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) for gonorrhea. Almost half a million chlamydia tests among young men (N=446,173) were reported, as well as gonorrhea tests (N=427,941). These reported tests among young men and women aged 15-24 years were administered in a diverse group of facilities that range from Title X Family Planning clinics, STI clinics, community health centers, juvenile detention centers, and prenatal clinics.1

In order to expand infertility prevention activities through the early detection and treatment of chlamydia and gonorrhea, and meet the needs of at-risk populations, the regional infrastructure/coordinating agencies take a systematic approach to the continued implementation of the national IPP and their respective regional program structures. The coordinating agencies, working with CDC and their regional advisory committees (RACs), strive to be innovative in delivering high-quality, low-cost services to the largest number of people. As each regional committee and coordinating agency work toward strengthening local, state, and regional responses to STI and reproductive health challenges, they are committed to:

- Internal and external partnerships and collaborations
- Adopting a multi-sectoral approach to address the social and cultural factors that increase individual and community vulnerability
- Capacity-building to create or enhance sustainability

The IPP promotes best practices in screening and treatment for chlamydia and gonorrhea among females and their partners in both the public and private sectors. Since 2005, the coordinating agencies have implemented two measures of effectiveness ² in order to help target chlamydia and gonorrhea screening activities to assure that resources are used in the most cost-effective way and that adequate screening coverage is occurring for the highest risk populations of women. Additionally, the IPP has provided a convenient realm for testing and identifying innovative ways to improve and expand chlamydia and gonorrhea testing and treatment services to those most in need (See Appendix B for a listing of manuscripts—published, in press, or under review—that use national, regional, or state IPP data, and conference abstracts based on work across the Regional IPP).

Impending health care reform presents an opportunity for the 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.

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1 Estimate of chlamydia screening coverage among sexually-active women attending family planning clinics, stratified by standard age groups; and the proportion of chlamydia screening tests performed, in...
As a result of these uncertainties, CDC/DSTDP 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, 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.
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Methodology

In order to focus the assessment, the JSI project team developed a multi-faceted impact analysis process that was guided by three main principles: 1) involve all stakeholders in the process, from planning to analysis; 2) identify impact based on quantitative and qualitative data; and 3) use multiple sources for gathering information.

The process was comprised of four phases intended to inform the strategic direction of the IPP: identify and define, convene, assess, and design. 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.

In order to carry out the impact assessment, the project team first conducted an extensive literature review to provide a context in which to understand the overall assessment findings and recommendations. The literature review also helped to identify six overarching domains likely to have a dramatic impact on the future of the IPP:

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.

Data Collection

i. IPP project area profiles: These profiles (see Appendix C) helped identify several focus areas within the six domains that pertained to the current structure of the IPP, potential future challenges arising due to the changing health care environment, and recommendations for how to move forward, as listed below:

- Issues pertaining to family planning (FP) clinics, STI clinics, and federally-qualified health centers (FQHCs)
- Third-party billing capacity development within public health laboratories
- 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 (KIIIs): These were conducted at the regional and national levels, and illuminated 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.

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 of the full report.
The KIIs were conducted at regional and national levels. The potential interviews 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
- IPP prevalence monitoring facilities—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 HHS 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
- Third party 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 were conducted between 9/1/2011 and 10/15/2011 and represented a 45% response rate.

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 for participation in the assessment.

**iii. Surveys with state FP and STI programs; public health laboratories; and IPP FP and STI clinics:** The surveys highlighted regionally-specific strengths, weaknesses, and gaps 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 to September 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)

*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 on page 6-7 of the full report outlines the number of responses to each survey tool per state.

**Data Management and Analysis**

**KII Data 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 pages 10-11 of the full report. Then the transcripts from each of the national 27 KIs were summarized and added to the regional data.

<table>
<thead>
<tr>
<th>Region</th>
<th>Number of Transcripts Submitted</th>
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<td>I</td>
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<td>II</td>
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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

**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 one 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.”
**Methodological Considerations (Limitations)**

There are some limitations to this assessment. 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. 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 has 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 KIIIs 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.

As noted in the acknowledgements, JSI worked collaboratively with the other Regional IPP coordinating agencies to carry out this assessment’s specific objectives and methodology.
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 of the full report. 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.

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.

“I wish that I had a crystal ball or manual that would tell me step-by-step how I am supposed to ensure my program is ready for HCR. With all this uncertainty it is hard to know where to start.”

Programs in 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 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.

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:
- There is 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
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of expertise.

* There is consensus that safety net 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 (finding a provider, may prove difficult in an environment that is expected to face severe workforce shortages. 2 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 (GIS) 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 a changing service delivery environment.
  - The need to expand communication and collaboration with other health care providers, such as primary care physicians and Federally Qualified Health Centers (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 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 electronic health records (EHRs), to report performance outcomes, enable quality

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**++ 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.”**
improvement, and for financial analysis and efficiency.

- EHR 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.
The following recommendations consider the diverse data sources analyzed and synthesized over the course of this project. Where appropriate, dates have been included to highlight the time-sensitive nature of suggested steps.

Prevention
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 individual 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 in 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 clear that safety net services will continue to be needed in the future due to a variety of factors including individuals fluctuating between types of coverage, choosing not to use their insurance for reproductive and sexual health services. 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. 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 expanded Medicaid services or insurance exchanges. The interviewees stated that there 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 infrastructure arm of the IPP as 10 distinct coordinating agencies should be maintained through December 31, 2013. Before 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

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, if they don’t already. Clinics will no longer be able to provide “free” or “donation-only” services; they will have no option but to bill 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 about supporting the workforce of Title X family planning and STI clinics as they transition into an environment that includes contracting with 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 need 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, 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 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 worse for adolescents and young adults who are 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 or young adult.

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 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 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 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 an inability to be reimbursed for EPT-related service and medication expenditure. 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.

Health Information Technology
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 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 KIIIs included 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 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 facilitates, 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 negotiation with HIT vendors, coordinate state and regional data exchanges to include IPP-related data variables, and mine various data sources to 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; and 3) facilitate and inform action to improve performance.

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. They should state 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 variables they would like to see collected in addition to those already being collected, interviewees listed the following: recent risk behavior, previous pregnancies, contraceptive use, STI history (counseling, results, and treatment), number of sex partners (lifetime and/or past six months).

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.

Innovation and Quality Improvement

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). 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 with 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 FQHCs.

**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, there will be a loss of STI prevention, screening, and treatment expertise. There was 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 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**

**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 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 could not use. 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.

Regional key informant interviewees suggested that safety net providers might act as bridges to new forms of insurance. 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.

**The Health Care Workforce**

**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 ensuing 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. 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.
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, to the more than 20 million people who are projected to gain insurance coverage under PPACA, and to 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 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 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 enter into referral networks 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 include:
  - 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
  - Provide evidence-based clinical services according to the most current 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 out of ten 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 Pap tests and STI tests and provide low-cost, high-quality services overall. Emphasizing these strengths as they approach partners, will improve IPP partners’ opportunities for collaboration.