Region I IPP June Meeting
June 4, 2012

Family Planning Subcommittee Meeting

Participants
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Positioning for the Future – new partnerships, changes, FQHCs, etc.

A. Planned Parenthood of Northern New England (ME, NH, VT)
    a. Changed our practice management system and have rolled out to 20 health centers across the three states
    b. EHR (NexGen) – now we receive notification of abnormal results
    c. We are rolling out EHR health center by health center instead of all at once
    d. The charge passing really helps with billing and reimbursement
    e. We partnered with the State of VT, and are expanding insurance access to individuals 200% of the poverty line.
    f. We incorporated a limited family practice – the end goal will to be a medical home. We are providing training on this through our electronic system at all of the health centers. We will be adding on services that will allow them to qualify as a limited medical home (ie.g. management of diabetes, cholesterol).
    g. The goal is to become a medical home as there are many women and teens that only get medical care at family planning sites.
    h. We are using online protocol not associated with PP, to help make up for the fact that this is not the area of expertise of our providers.
    i. We are working to expand scope of male services. In such that we are adhering more closely to the Planned Parenthood federation protocol as written.
    j. Planned Parenthood cannot use a standard EHR system and so must have a tailored system.
B. Discussion on Transition out of Sexual/Reproductive Health Specialty
    a. If you are a family nurse practitioner, there is other certification you need to get. Evelyn will send link to a document on this transition to the group.
    b. Also issues come up surrounding who is your medical director, and what can they supervise.
    c. Outside of reproductive health services minors require parental consent.
    d. This depends on state law and 'mature minor' statute.

e. There is a divide between the way private practice practices vs. public health practices. They are very different. Because of community practice, we need to protect our agencies.
f. Understanding the laws of the state where you practice and creating some sort of standardization for protocol is important.
g. HPV vaccine needs parental consent .
h. There is a fee scale for Non Title X services. How do you provide both FP and non FP services in the same visit?
i. We had to bill for different types of services in the past, and often times asked people to come back for a second visit.
j. We lose patients to OBs during pregnancy and in MA to primary care as well.
k. At PPSNE, we have partnerships with OBs and often they send patients back after. When they go to CHCs they don't come back because they are in the health center system and there is no incentive to send patients back. In Connecticut right now there is too long of a wait and so many patients do come back after not getting in to CHCs.
l. In NH they are trying to decrease ER use and there are collaborations between CHCs, ER, and Prenatal Services. They have patient navigators in Northern NH to follow up with individual ER patients. They do have difficulty recruiting physicians, but have a great model. Rural areas may be a better example of collaboration going forward.
m. In Connecticut they have a rotation (3 month) for Nurse Practitioners out of school at CHCs. The positions are unpaid but this gives them experience that they need so they are able to utilize this.
n. Trends to meet the new environment are: 1.) Practices merging together or creating agreements or 2.) Expansion of practices.

C. Family Planning Association of Maine
a. We are looking at one of our sites for a way to work on integration of primary care. We have one center where we have an Adult Nurse Practitioner and we have another provider with a lot of experience in Primary Care. The Nurse Practitioner is receiving additional training. We are trying to see how receptive patients are and if we can recruit more patients. This is not an area where there is lack of Primary Care services – all of ME is saturated with primary care. We are going to try to layer in these services. We are trying to go for a niche. We are looking to do 'comprehensive women's health'.
b. In ME, Nurse Practitioners can admit, but everyone in ME signs off to the hospitalist.
c. Call has been a big contentious issue. We have two physicians who take call, but we are also working with a primary care practice that is excited about what we are doing. We got lucky that they want work with us and so now we have four people to share the call. It's a credibility thing for us, to start looking for key messages to patients in order to get them to come to us.
d. Branding is important.
e. We are looking to continue working in reproductive age range.
f. It's a sophisticated thing creating these partnerships, as well as community dependent. It is very case specific and you need to create MOUs, etc. This is a job for upper management.
g. We are going live with six centers in June for an Athena Health EHR. We did all online training with Athena Health. People had to complete modules, and do user training. It is web based so we don't need server / storage capacity. Athena Health also does our billing (that's how the company started).
h. We went live with the practice management piece in September, so all clinics have already started using this at the front desk, etc. We can do scheduling; there are time stamps on visits. It has been great for quality management.

i. They (Athena Health) take 8% of billing.
j. They also do prompt coding.
k. We are writing policies around records security and confidentiality. This is necessary with staff logging in offsite, etc.(others are working on this in the Region and having a provider dedicated laptop may help with security).

D. New Hampshire
   a. We are strengthening existing partnerships. In New Hampshire we tend to want to keep existing institutions.

E. South Eastern Massachusetts
   a. We are adding services.
   b. Starting to work with GYNs and help them to build a practice. We don't lose our clients.
   c. Looking for a new medical director. While also looking a different models, such as partnering with a hospital.
   d. We are working with the criminal system. Looking to do HIV work in the prisons, as much of this work got defunded. There are a lot of challenges working in the prisons. When they get out however they come to the site. We are working with commercial sex workers, addicts etc. They are very appreciative and this builds report.

F. Planned Parenthood Massachusetts
   a. We are trying to become more saavy with 3rd party billing. One area of focus is 3rd party pharmacy billing, this is a real challenge at the clinic level. At the front desk we don't have the information from the insurance company on what is covered.
   b. We are trying to prevent losing money on pills. Or have a pharmacy get the revenue.

G. Discussion on Pharmacies
   a. Being not able to bill at point of sale is an issue. Patients have expectations of getting what they need from Planned Parenthood. This brings up the issue of customer service.
   b. We are only using generics now. Patients hate switching pills, which is something we have to do.
   c. Massachusetts clinics have been approached by Walgreens to link up their systems. They (Walgreens) do service and handling and then split revenue with the clinic. You (the clinic) do the scripting and Walgreens will manage your inventory. They bill the insurance. They also purchase pills at a prime vendor rate. This has been done with CHCs in Boston with both Walgreens and CVS.
   d. This linking would give clients more access to pharmaceuticals than clinics can.
   e. You have to do this through a specific Walgreens. They can make adjustments for sliding-fee scale.
   f. This ability to link is national – and they are doing this because of the prime vendor price.
   g. Roberta will send a link to share with more information on this.
      You need to have 340B patients for this systems link.

H. Connecticut – Planned Parenthood Southern New England
   a. We have gotten a pharmacist and we've invested in a program for billing.
   b. They say the amount coming in will start to grow, but it has been small so far.
   c. There is the issue of paying a co-pay and then individuals get billed later on.
   d. There is a year to a year and a half to get the system worked out.
   e. One problem is that you can go elsewhere and get pills cheaper.
   f. We are setting up a 'pills by mail' program and piloting for both self-pay and insurance.
   g. We've been on EHR and use Vision. Because of Next Gen we can do HEDIS Measures and get meaningful use information very easily.
   h. EHR is a headache to implement, but the data you get is amazing.

i. People are sometimes overriding the code check manually. We sent out a memo that people have to use this.
j. Haven't measured changes yet – as we started it two years ago, and our last center is just getting converted. We do see less patients now.
k. We gave six months for people to get back to the same numbers. We gave a month of scheduling change as well.
l. We didn't lose providers, but it is difficult to get people transitioned.
m. Our ability to respond to audits is amazing because of it.

I. Web Security / Policies
   a. Make protocol around texting patient info on cell phones.
   b. Pagers are still needed.

J. On Call Payment
   a. There is the question of: What do you pay Nurse Practitioners for on call?
   b. For physicians it's part of the role.

K. National Health Service Corps
   a. Family Planning Qualification has opened up for the Corps.
   b. Planned Parenthood staff got rejected, but they are trying to follow back up and they think their application will go through the second time.
   c. You need to be in medically underserved area.

L. Work Force
   a. We get new grads by precepting them. They have at least two months working with someone before they work alone (PPSNE)

M. Rhode Island
   a. All family planning is in community health centers.
   b. The Department of Health is trying to reduce Title X burden on CHCs. .
   c. We have FTE posted for additional staff at the Department of Health.
   d. What is being done to streamline FQHCs documentation? (In NH they do site visits, modeled after federal review).
   e. Will have Trish Washburn pass on streamlining of policy to interested people. Perhaps (outside of IPP) New England should have a work group on this.