Child TRENDS

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How Family Planning Providers Are Addressing Clients' Reproductive Health Needs During COVID-19

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During the COVID-19 pandemic, family planning clinics across the United States have faced challenges in their efforts to effectively serve clients. The pandemic has restricted the ability of clinics to offer in-person reproductive health care and has forced staff to develop new policies and procedures to continue providing services.

Disruptions to the provision of reproductive health care are of particular concern to federally funded Title X clinics because they primarily serve low-income and uninsured individuals—populations that have historically experienced high rates of unintended pregnancy. Additionally, prior to the pandemic, a large percentage of people were in need of publicly funded family planning services; this number has likely increased due to high rates of unemployment among low-income workers during the pandemic. As such, Title X clinics have prioritized the development of strategies to maintain access to and continuity of family planning services during the pandemic.

From July 2020 to January 2021, Child Trends conducted interviews with representatives from more than 30 current and former Title X clinics to better understand their experiences providing family planning services during the pandemic. This brief describes clinics' experiences and the adaptations and strategies they adopted to provide family planning services while ensuring the safety of staff and clients, as well as the practices they would like to continue to implement beyond the pandemic.

Key Findings

- The COVID-19 pandemic has forced family planning clinics to adapt their service delivery to protect the safety of staff and clients. Clinics have made an effort to continue to meet client needs.
- To ensure that clients can receive their selected contraceptive method in a timely manner, clinics have reserved limited in-person appointments for clients wanting insertion or removal of long-acting reversable contraceptives, incorporated new approaches to administering contraceptive injections, and offered flexible distribution of other contraceptive methods.
- Clinics have invested in telehealth infrastructure and have incorporated technology to streamline in-person services.
- To conduct in-person appointments safely, clinics have reduced or eliminated waiting rooms, relocated services outside, and reorganized client flow inside clinics.
- Providers are enthusiastic about continuing the use of telehealth services, digital infrastructure, and creative approaches for distributing prescriptions beyond the pandemic.

- Despite providers' enthusiasm for maintaining telehealth services long-term, some expressed concerns about its feasibility due to government regulations and insurance company policies. These were major barriers to integrating telehealth prior to the pandemic.

Study Background

This brief is part of a larger research project, which began prior to the pandemic, that describes trends in publicly funded family planning services. When the United States began shutting down in response to COVID-19 in March 2020, the research team amended the provider interview protocol to collect information about the impact of the pandemic on clinics. The additional questions asked about adaptions clinics have made in response to COVID-19, how well these changes have been meeting clients' needs, challenges associated with modifying service delivery and responding to the pandemic, and intentions to maintain new practices long-term. Data were collected from staff at 33 current and former Title X clinics during hour-long, semi-structured interviews. The interviewers wrote summaries within 48 hours of conducting the interviews. Interview recordings were transcribed. Interview summaries, transcriptions, and discussions among the interviewing team were used to develop themes highlighted in this brief.

The appendix table presents data on the clinics where staff were interviewed. Twenty-nine of the clinics were current recipients of Title X funding and four were former recipients. We interviewed staff from at least one clinic (and up to five) in each of the ten U.S. Department of Health and Human Services (HHS) regions. Clinic types included health departments (n=12), federally qualified health centers (n=11), hospital clinics (n=2), and other clinic types (n=8). Two thirds of the clinics were in urban or suburban areas (n=22), and one third were in rural areas (n=11). Thirty-nine percent of interviewees reported that at least 20 percent of their site's family planning clients are Black, and 45 percent reported that at least 20 percent of their family planning clients are Hispanic. Interviewees also reported whether their clinic has a significant portion of clients from specific underserved populations; they most frequently reported serving clients with mental health (n=10) or substance use (n=9) challenges, people experiencing or at risk of experiencing homelessness (n=9), those experiencing intimate partner violence (n=8), and people with limited English proficiency (n=7).

Findings

Responding to the COVID-19 pandemic

Family planning clinics, along with the rest of the U.S. population, have experienced significant changes and challenges as a result of the COVID-19 pandemic. Starting in March 2020, when states began to issue stay-at-home orders, family planning clinics were obligated to provide services while following evolving safety guidelines. As of May 2021, federal guidelines published by the Centers for Disease Control and Prevention outline continuing restrictions on operating capacity for health providers.

As a result of the length and unstable nature of the pandemic, Title X providers who participated in interviews noted that they had made ongoing changes rather than a single set of adaptations. Federal and state guidance on how clinics should navigate COVID-19 has also rapidly evolved. Providers expressed that the uncertainty and how quickly the situation was changing have been some of the biggest challenges in responding to the pandemic:

> **Every day there was a new fire to put out**. Every day you...kind of felt like you were reassessing. Everything was just happening so quickly..."

During the pandemic, many Title X family planning clinics stopped seeing clients in-person, others offered significantly fewer in-person appointments, and a few completely stopped delivering services. Despite the ongoing challenges, many clinics have worked to ensure the availability of family planning care. For example, to minimize the number of staff and clients physically in the clinic and to accommodate social distancing requirements, some clinics have implemented a rotation schedule where staff alternate between being at the clinic and providing services from home via telehealth. During this time, providers have focused their reduced capacity on essential family planning services, as summed up by one respondent who said, "So, when [the pandemic] first hit, we basically canceled any screening services. We wanted to make sure that all of our clients got their birth control…we just put anything off that we could put off."

Providers we spoke with discussed several key strategies that their clinics have used to prioritize family planning care, described in detail below.

Adaptations to deliver contraceptive methods

Most clinics adapted their procedures to ensure that clients could keep using their contraceptive method while taking into consideration their safety and comfort. Providers described three types of adaptations:

Reserving limited in-person appointments for clients wanting insertion or removal of long-acting reversable contraceptives (LARC)

To avoid gaps in contraceptive use, many providers have prioritized scheduling in-person appointments for clients that want LARC insertion or removal. Because of limited in-person appointments, some clinics have maintained waiting lists for LARC insertion or removal appointments and other in-person procedures. For clinics that do not offer in-person appointments or do not have LARC waiting lists, clients are given the option to use a bridge method like an oral contraceptive or Depo-Provera. For example, one provider noted that their clinic prioritized finding appointments for clients who both wanted a LARC and did not currently have a contraceptive method:

> **If they didn't have any method at all, those were the patients that we were very concerned about**, and we tried very fast and hard to get them in as soon as we were able to see patients in person...We did, however, try to prescribe them a bridge method while we were waiting to be able to see them for any long-term procedure that they wanted."

Incorporating new approaches for administering contraceptive injections

Many clinics changed the way that Depo-Provera is administered by extending the timeframe for delivering the shot from 12 weeks to 15 weeks, switching from the intramuscular version of the shot to the subcutaneous version so that clients could self-administer at home, and incorporating curbside services for injections. Extending the timeframe of Depo-Provera and switching to subcutaneous injection of Depo are both research-based practices that were developed prior to the pandemic but became more prevalent out of necessity during the pandemic.

Being flexible in their distribution of other contraceptive methods

Providers reported expanding the ways they distribute contraceptives, based on client needs, noting that "a lot of our patients are kind of in fear of coming into a doctor's office." Prior to the pandemic, a few clinics had begun mailing contraceptives and other prescriptions to clients' homes, sending prescriptions to local pharmacies, and offering curbside pick-up. Since the pandemic, many additional clinics have implemented these initiatives. One respondent explained, "So say you came for a pill refill…we will go deliver those out to the vehicle just to prevent people coming into our waiting room." Clinics have also been flexible in redirecting clients to pick up contraceptives in more convenient locations. One respondent said, "We've been able to work with the providers to get some things to the pharmacy like emergency contraception…[we can] have it sent to the pharmacy. And that goes for other birth control methods as well like pills and the patch." Finally, since the pandemic, clinics have also followed guidelines developed by the Reproductive Health National Training Center and have extended the time between annual exams (previously required for renewing prescriptions for contraception) and distributed additional months' supply of contraceptives to clients.

Adaptations to develop and improve virtual services

In response to the COVID-19 pandemic, several clinics have prioritized building or expanding digital infrastructures for service provision. In this brief, we define telehealth as appointments that are done via phone or video with a clinician and other services provided via a digital infrastructure, such as ordering prescriptions or laboratory testing. Providers reported adapting their services in two ways:

Using technology to streamline in-person services

Clinics have incorporated technology to ensure that in-person services are provided safely. For example, several clinics have used online portals for clients to complete intake forms before arriving to the clinic to reduce the time spent inside the clinic. Clinics have also implemented text messaging systems. A staff member noted that clients really like being able to text the clinic with questions for their provider. One respondent explained that although these changes were made with client safety in mind, they have also improved efficiency*:* "So spending less direct contact with clients…but I feel like it's also allowed [providers] to accommodate more clients because it sort of streamlines [the clinic's] flow."

Investing in a telehealth infrastructure

Clinic staff have leveraged existing and new telehealth platforms to provide contraceptive counseling, prescribe contraceptive methods, order laboratory testing, and conduct other non-urgent family planning appointments via a phone and/or video call. Before the pandemic, some clinics were not able to offer telehealth services due to restrictions imposed by federal and state policies, but many of these restrictions

were lifted in response to the pandemic. Other clinics were previously unable to develop a telehealth infrastructure due to limited funds or time. The pandemic provided the impetus for clinics to invest in telehealth infrastructure to continue delivering services.

Telehealth has allowed providers to reach clients they may not have otherwise been able to reach during the pandemic. One provider explained: "I feel like we're almost back to our volume pre-COVID…these [technological adaptations] are helping increase [the number of patients we see] and making sure we can still see patients that need to see us."

Providers noted that telehealth has helped address access barriers that clients faced before the pandemic related to transportation, scheduling (particularly for clients with children or inflexible work schedules), time, and financial barriers (e.g., the cost of taking off work or paying for transportation or childcare). Providers reported some unanticipated benefits of telehealth, including that some clients seem to feel more comfortable during phone call and online visits, perhaps due to a greater sense of anonymity.

Telehealth has also posed challenges to clinics and their clients. Some providers expressed missing the client contact during in-person visits, and that it can be hard for them to "draw conclusions" or make new diagnoses without being able to examine clients in-person. Telehealth has also made it more difficult for providers to communicate with clients, read their body language, and ultimately build relationships with them. Providers noted that accessing telehealth services and the lack of privacy during telehealth appointments have been major barriers for some clients, particularly adolescents, who may not feel comfortable speaking openly while at home. One respondent explained:

> "**We have young people that really like it because they don't have to come into the center,** but then we have a lot of young people that share rooms with their younger siblings, or their parents are home, so they didn't feel comfortable."

Some clients lack the technology needed to participate in telehealth, such as reliable internet access, cell phone data, and smart phone or computer access. These barriers are especially pronounced in some rural communities. One respondent from a rural clinic said:

> "**I know a lot of our clients do not want to do televideo or a Zoom follow up thing.** It uses their data, and out here we have a lot of clients that have like Straight Talk, which you buy your data on a month-to-month basis, and they don't want to waste it on something like that…So, if it's costly for them so they would much rather just have a phone call or come in."

Clinics have ensured that clients receive services by phone telehealth or in-person if they do not have access to video telehealth services.

Adaptations to in-person visits

Clinics have made adaptations to minimize the spread of COVID-19 while still providing in-person family planning services. Pandemic safety considerations mean that fewer people can be in each space at the same time, which complicates clinics' approaches for organizing waiting rooms and patient flow. Clinics have adapted their services by:

Reducing or eliminating waiting rooms

Most providers have either reduced the number of seats available in their waiting areas or eliminated seating completely. Since the pandemic, many clinics have kept their doors locked to control their building capacity, required clients call upon their arrival to the clinic, and asked clients to wait either in their vehicles or outside the clinic until their appointment time. Instead of using waiting rooms for the check-in process, some clinics call clients to check them in before their scheduled appointment time.

Relocating services to the outdoors

Numerous clinics have relocated select services outdoors or have expanded their physical space in creative ways to help ensure safety. For example, one clinic set up outdoor trailers, or "pods," to create more space. One staff member said, "They look a lot like the metal container-type things…currently [we] have two providers who are outside and seeing patients in those little pods." Additionally, some clinics have utilized outdoor spaces to start the check-in process, including completing medical forms via tablet, conducting COVID-19 screenings and temperature checks, and distributing masks and hand sanitizer.

Reorganizing client flow inside the clinics

Many providers described reorganizing client flow inside the clinic and minimizing clinic foot traffic to protect clients and staff. For instance, using different entrances for entry and exit has helped reorganize clinic traffic. Additionally, one clinic described that once clients are fully checked in, they "tr(y) to put [clients] in the exam rooms as soon as we can, on arrival and we have them stay in one exam room as much as we can through the whole visit."

Even though clinics have been implementing innovative adaptations, these solutions are sometimes imperfect, and clinics continue to face challenges with client flow. One clinic noted that they "have people who wait out in their cars and in chairs along the sidewalk. We have people in the waiting room. Sort of these layers of people waiting to come in and be seen."

Continuing adaptations post-COVID-19

Some COVID-related adaptations have helped providers address barriers in existing systems and approaches to deliver family planning services. Providers have reflected upon their current operations to assess whether they should maintain these adaptations long-term. For example, one staff member explained:

I think realizing that we have these barriers in place, whether it was, 'Oh, you need to come in every 12 months for your birth control prescription renewal,' or 'No, we can't. We're not able to prescribe you that without a face-to-face visit.' And **those things were kind of unquestioned barriers that we all just sort of accepted.** And then realizing how quickly they were able to bust through them, that's what we really need to do. I guess I just don't think you can go back on to that stuff."

Some providers noted they are likely to continue several COVID-specific adaptations after the pandemic ends. These include:

Telehealth services

Clinic staff are enthusiastic about maintaining telehealth indefinitely. One respondent said, "I think [telehealth] has totally shaped, or actually changed, the way that a lot of medical providers have thought about providing medical care." Staff believe that telehealth has helped make family planning services more accessible to clients by circumventing barriers to in-person visits, such as lack of time, transportation, and childcare.

Use of digital infrastructure

Clinics have invested a lot of time, effort, and money in developing and launching digital infrastructure. Providers anticipate that they will continue to use these new systems because they have proven to be convenient for both staff and clients. One provider explained, "I think a lot of the work that we've done to move various systems, electronic will continue…that was one of the very first things we did is to convert all of our forms to electronic. So, from consent for services to history forms, that's all electronic. And there's no way we're going to go back."

Use of creative approaches to distributing prescriptions

Providers expressed interest in continuing to use alternative approaches to distribute prescriptions, including curbside pick-up of birth control and supplies, mailing prescriptions to clients' homes, and providing Depo-Provera every 15 weeks instead of every 12. These strategies are convenient for clients, and clinics report that they reduce "no show" appointments. One provider explained, "as long as [pharmacy] continues [mailing prescriptions] for us, I think that that will continue."

Discussion

The COVID-19 pandemic has forced family planning clinics to adapt their service delivery to protect the safety of staff and clients. Title X providers have made ongoing changes to work within a constantly evolving environment and under previously unimaginable constraints. They have implemented strategies to continue delivering contraceptive methods, developed and improved their technology infrastructure, and streamlined in-person services. The findings presented in this research brief align with and extend other

research that has highlighted strategies that family planning clinics and other health providers have incorporated in response to COVID-19.

One key benefit of these adaptations is that they have removed some barriers to service utilization that existed before the pandemic. For example, providers have incorporated telehealth services, which addresses transportation barriers, scheduling challenges, time and financial barriers, and patient comfort and has allowed providers to reach clients that they otherwise may not have been able to reach. This can be particularly important for reducing the high unmet need for publicly funded family planning services. Also, alternative approaches to distributing contraceptives (e.g., curbside pick-up, mailing, extended Depo-Provera shot schedule) can increase the continuity of method use and thus potentially reduce the risk of unintended pregnancy associated with disruptions to method use.

Changes made in response to the pandemic may have important implications for the future of family planning service delivery. We found that Title X providers are enthusiastic about sustaining adaptations that have improved staff and client experiences, particularly the provision of telehealth, the creation of online portals and other digital infrastructure, and the flexible distribution of contraceptives. Some providers noted that these adaptations have benefitted many clients, particularly those who may not have the time or money to access in-person family planning services. However, other providers noted that the lack of privacy has been a barrier for some clients, particularly adolescents, and that some clients – particularly low-income clients and those in rural areas – may lack the necessary technology to access telehealth services. This tension highlights the importance of continuing to remove barriers to in-person care while maintaining the option for telehealth services.

Additionally, the ability to extend telehealth and contraceptive distribution services that have been implemented during the pandemic will depend on policy and regulations. For example, telehealth adaptations were made possible by state and federal entities loosening previous restrictions. Policymakers should assess whether updating policies and regulations to continue some of these approaches post-COVID-19 may be an effective way to increase access for the large number of people with unmet family planning needs.

About the Study

Through a grant from OPA, Child Trends is conducting a study to provide actionable recommendations to publicly funded family planning providers to better meet the health care needs of their clients—particularly the needs of underserved populations, such as Black, indigenous, and people of color (BIPOC), people with limited English proficiency, adolescents, and people living in rural areas. Child Trends is accomplishing this aim by conducting interviews with staff from publicly funded family planning providers that currently or recently received Title X funding, to explore innovative practices used to improve the accessibility of services.

Appendix

Table 1. Sample Characteristics

Funding Type	**#**	**%**
Non-Title X	0	0%
Title X (current)	29	88%
Title X (former)	4	12%
HHS Region		
Regions I	4	12%
Region II	3	9%
Region III	5	15%
Region IV	1	3%
Region V	4	12%
Region VI	3	9%
Region VII	3	9%
Region VIII	1	3%
Region IX	4	12%
Region X	5	15%
Clinic Type		
FQHC	11	33%
Health Department	12	36%
Hospital Clinic	2	6%
Other	8	24%
Proportion of Black or Hispanic family planning clients (categories not mutually exclusive)		
Clinics with 20% or more Black clients	13	39%
Clinics with 19% or less Black clients	20	61%
Clinics with 20% or more Hispanic clients	15	45%
Clinics with 19% or less Hispanic clients	18	55%
Service Location		
Rural	11	33%
Urban	22	67%
Clinics serving a substantial* proportion of select underserved populations		
People with limited English proficiency	7	21%
People experiencing or at risk of homelessness	9	27%
People in prison	1	3%
People experiencing IPV	8	24%
People who use substances	9	27%
People with mental health conditions	10	30%
Other underserved groups	3	9%

*Interviewees each determined what they considered to be a *substantial* proportion of clients. No numeric threshold was provided by interviewers.