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Health Reasearch Brief

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Lessons learned from *The Right Time* show how to advance reproductive health during COVID-19 and beyond

Although the COVID-19 pandemic has disrupted reproductive health systems across the world, it offers researchers, practitioners, policymakers, and communities the opportunity to identify innovative strategies that promote access to contraception (Faccio et al. 2021). This brief presents lessons learned from *The Right Time*, a multipronged reproductive health initiative in Missouri that supports policy, service delivery, and people-centered innovation. Drawing on 47 interviews conducted in summer 2021 with clinic staff, patients, and community partners, the brief discusses the changes COVID-19 brought to the reproductive health landscape in Missouri and how *The Right Time* adjusted its strategy to ensure access to comprehensive contraceptive care. It also provides insight into how continuing the reproductive health strategies developed by *The Right Time* during the pandemic—particularly at the levels of policy, health and social service delivery, and community—can expand contraceptive access and advance people's autonomy in making decisions about their reproductive health throughout the pandemic and beyond.

In the United States, the COVID-19 pandemic widened existing disparities in access to reproductive care among people of color, people with limited incomes, and populations marginalized for their gender or sexual orientation (Lindberg et al. 2020; Diamond-Smith et al. 2021) (Exhibit 1). Even before the pandemic, these communities faced greater barriers to accessing any contraception, let alone their contraception of choice. Furthermore, lack of access has contributed to higher rates of preventable unwanted pregnancies that increase the risk of poor perinatal and child health outcomes in these communities (Guttmacher Institute 2019).

Exhibit 1. The COVID-19 pandemic has taken a toll on people's reproductive health

1 in 3 women encountered delays or cancellations of sexual and reproductive health care due to the pandemic.

Black, Hispanic, and queer women, as well as women with limited resources, experienced more delays or cancellations for sexual and reproductive health care.

Over half of women reported barriers to accessing sexual and reproductive health care during the pandemic.

Barriers included lack of support persons, clinic closures, fear of COVID-19, and household burden.

22% of women reported not using their preferred contraceptive method due to the pandemic.

People of color, who lost their job, or experienced food insecurity used their preferred method even less.

1 in 4 women worry more about being able to afford or obtain contraception because of the pandemic.

Hispanic women, queer women, and women with limited resources reported increased worries.

Sources: Lindberg et al. 2020; Diamond-Smith et al. 2021.

Note: Data sources use the term "women" to describe people assigned female at birth. The authors of this brief recognize that not all people identify within a binary gender and that the term women does not represent everyone who needs sexual and reproductive health care services. As a result, this brief uses the term people throughout unless the data source or citation uses the word women.

The initiatives that began before and endured during the pandemic offer insight into strategies to reverse decreasing trends in contraceptive access and how to continue advancing systemic changes that lie at the roots of inequities in contraceptive access and perinatal and child health outcomes. *The Right Time* (TRT) initiative, implemented in Missouri a year before the pandemic and in operation during the pandemic, made significant changes and adjustments to meet its goal of ensuring comprehensive contraceptive access to all people, regardless of their circumstances. Here, the brief discusses the challenges and opportunities faced by TRT during the pandemic, the strategy shifts that occurred to meet the moment, and the implications for reproductive health in the future.

About *The Right Time*

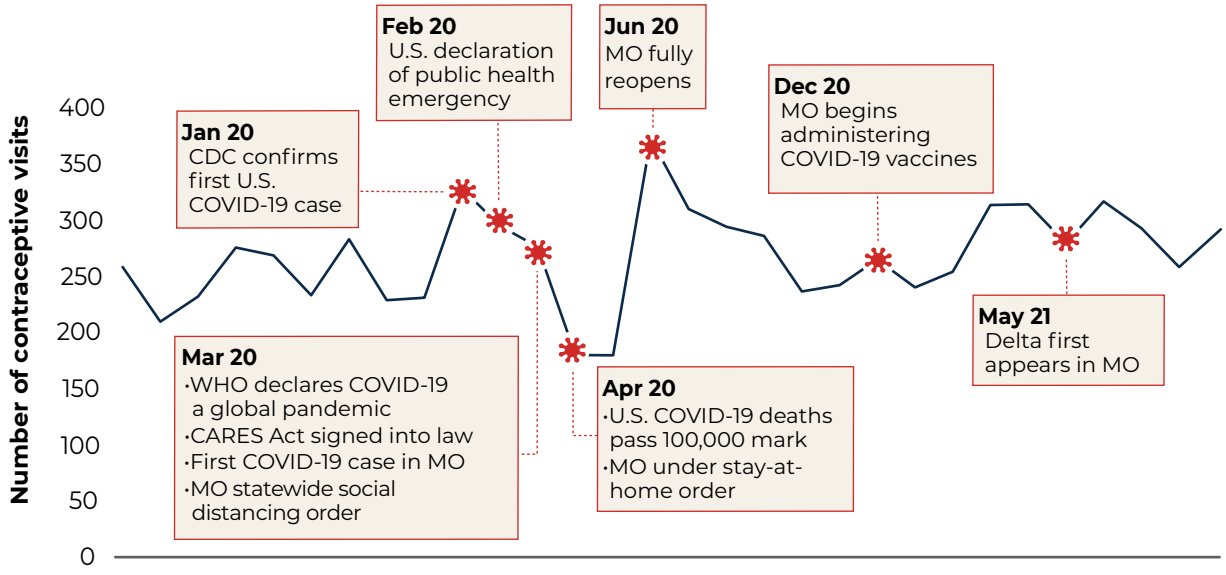
The Right Time initiative is funded by Missouri Foundation for Health and supported by the Missouri Family Health Council, Power to Decide, and Mathematica. Launched in 2019, *The Right Time* operates in 12 health centers in the St. Louis metropolitan area and Northeast, Central, Southwest, and Southeast Missouri. This initiative helps people take control of their own health by increasing access to and use of contraception through clinical supply, community awareness, and environmental supports. Central to *The Right Time* is a strong commitment to equity and ensuring that all people, regardless of circumstance or characteristic, can access high quality, nonjudgmental, and affordable contraceptive care services. By increasing people's ability to choose whether, when, and under what circumstances to become pregnant, the initiative hopes to create healthier families, improve maternal and neonatal health, and increase health equity. ◢

Challenges to and opportunities in contraceptive access in Missouri during the pandemic

From 2018 to 2021, the number of women living in contraceptive deserts decreased from 396,800 to 375,800 across Missouri.[1] Yet despite gains in contraceptive access made before the pandemic, as more health centers offered the full range of contraceptive methods, the amount of people making appointments for contraception decreased at TRT's 12 participating health centers. This downturn in contraception visits began with the federal declaration of a public health emergency in February 2020, continued with Missouri's statewide social distancing order in March 2020 and stay-at-home order in April 2020, and was compounded by health care facility and workforce shortages, as efforts shifted away from primary care and into COVID-19 response. Correspondingly, the average contraceptive visits per TRT health center declined from a pre-pandemic high of 327 in January 2020 to a low of 179 in April 2020 (Exhibit 2) (AJMC Staff 2021). With Missouri's reopening in June 2020, contraceptive visits rebounded to an average of 372 contraceptive visits per TRT health center. Since then, along with various surges in outbreak of the virus, health centers have sustained this increased contraceptive demand by providing alternate care delivery and outreach models such as virtual visits and events, drive-through services, birth control apps, and extended contraceptive supply.

[1] Power to Decide (n.d.) defines contraceptive deserts as "counties where the number of health centers offering the full range of methods is not enough to meet the needs of the county's number of women eligible for publicly funded contraception, defined as at least one health center for every 1,000 women in need of publicly funded contraception."

Exhibit 2. Reduced demand for contraception because of the COVID-19 public health emergency



Sources: Schneider 2021; AJMC Staff 2021; *The Right Time* health center encounter data, April 2019 to September 2021.

Notes: Data includes 6 health centers from April 2019 to July 2020, 9 health centers from July to September 2020, 10 health centers from October to December 2020, 11 health centers in January 2021, 10 health centers from February to July 2021, 12 health centers in August 2021, and 11 health centers in September 2021.

CARES Act = Coronavirus Aid, Relief, and Economic Security Act; CDC = Centers for Disease Control and Prevention; MO = Missouri; WHO = World Health Organization.

Several factors influenced the declines and rebounds in contraceptive visits during the pandemic. These challenges and opportunities occurred at many levels, including policy and systems, social and community, health care center, and individual. Here, the brief provides illustrative examples of these challenges and opportunities, and (Exhibit 3) presents a more comprehensive list.

Challenges. During the pandemic, availability of services declined at more than half of TRT health centers as they began COVID-19 testing, vaccination, or contact tracing. This shift in priorities toward COVID-19 response delayed non-essential care and reduced preventive care appointments, including those related to reproductive health or contraception.

In addition, fewer people sought reproductive health services at the start of the pandemic because of concerns about exposure to COVID-19. These changes related to COVID-19 worsened Missourians' already limited access to contraception. For example, even before the pandemic, uninsured people had limited sexual and reproductive health options because providers who performed or shared resources about abortions (such as Planned Parenthood) were prohibited from participating in Missouri's Medicaid family planning program (Missouri Department of Health & Senior Services n.d.)[2]

[2] Among reproductive-age people in Missouri, 22 to 38 percent need publicly funded reproductive health services (Missouri Family Health Council, Inc 2020).

In addition, a lack of access to reliable internet in rural Missouri—where a third of the population lives—limited access to telehealth services before the pandemic, and during the pandemic, worsened existing health disparities between urban and rural Missourians (Missouri Office of Rural Health n.d.).

Opportunities. The challenges to contraceptive care access led to opportunities that advanced equity in some policies and systems, reimagined contraceptive outreach and provision of care, and increased individual engagement in care. For example, because COVID-19 led some people to lose their jobs, health centers held food distribution and other social support events. This integration of health care with social service delivery served as a venue for increased outreach and uptake of contraception and created an environment that promoted family health and well-being. In addition, to promote continued contraceptive use during the pandemic, health centers employed alternate care delivery strategies, such as curbside contraception pick-up and mailing, drive-through Depo-Provera clinics, and technologies for mail-order contraception. Health centers can continue these practices after the COVID-19 pandemic recedes to reduce barriers to contraception.

Although these other methods of outreach and care delivery did much to promote contraceptive access, telehealth represented the most pivotal and far-reaching change to contraceptive care delivery, helping more people with structural barriers—such as those living in contraceptive deserts—access reproductive health care. Virtual modes of care delivery also allowed health centers to increase their overall patient numbers because fewer patients had to add on travel time for appointments. Uptake of long-acting reversible contraception also grew; spaced-out appointments intended to limit patient contact had an unintended benefit of allowing health care providers more time in-between appointments to accommodate same-day insertions. Another unintended benefit was the confidential nature of telehealth visits, which reduced barriers to contraceptive care for younger populations.

A survey commissioned by Power to Decide (2020)

showed that only a third of respondents could explain what telehealth is, and only a quarter knew how to find a telehealth provider, despite two-thirds agreeing that telehealth is an acceptable way to receive birth control. To increase awareness and uptake of telehealth, *The Right Time*'s media campaigns shared guidance on how to make telehealth appointments and what to expect during a telehealth visit. ◢

Exhibit 3. Factors influencing access to contraception during COVID-19 in Missouri

	Policy and systems	Social and community	Health care center	Individual
Challenges	▼ **Access to services** · Restrictions on providers participating in Extended Women's Health Services Program ▼ **Legislative engagement** · De-prioritization of policies not related to COVID-19 · Barriers to safely engaging in the legislative process (no virtual testimony)	△ **Structural barriers** · Lack of access to telehealth because of limited internet service in rural areas ▼ **Engagement opportunities** · Slowed down community outreach on contraception · Lack of in-person events to conduct outreach	▼ **SRH service capacity** · Shift of health centers to COVID-19 services · Temporary clinic closures · Reduction in walk-in appointments · Staff turnover and shortages	△ **Fearful attitudes** · Fear of COVID-19 exposure △ **Structural barriers** · Inability of support people to attend appointments · Lack of time to seek medical care because of increased child care or household responsibilities
	"Infections were running rampant through [the Capitol]. The regular session was halted multiple times." – ***TRT partner***	*"Because of COVID, we weren't allowed to make any distributions of marketing material because of risk of cross-contamination."* – ***Outreach coordinator at not-for-profit clinic***	*"At one point, I think 90% of our agency was diverted to COVID activities, and there were literally three of us doing family planning services."* – ***Health department clinician***	*"We had to have police officers and security because of people protesting and being angry over masks…We would have to either close our clinic and call people to not come in, or we have them come in a back door to protect their privacy."* – ***Health department billing staff***
Opportunities	△ **Access to services** · Waiver of mileage restrictions for APRN[a] · Flexibilities for administering and using telehealth through CMS[b] · Expansion of Medicaid[c] △ **Funding to support SRH** · Cares Act funding for MO HealthNet and SDOH · American Rescue Plan funding for Title X and Medicaid postpartum coverage	△ **Collaboration** · Strengthened community collaboration △ **Service integration** · Integration of contraceptive outreach into COVID-19 or SDOH-related events	△ **SRH service innovations** · Adapted workflows increased efficiency for in-person visits · Implementation of telehealth services · Innovations in contraceptive service delivery[d]	△ **Positive attitudes** · Feelings of confidentiality through telehealth platform △ **Accessibility** · Less travel and time for some because of virtual visits and curbside or mail-order pharmacy and lab tests
	"Missouri nurse practitioners have one of the strictest practice environments in the country." – ***State director of advocacy organization***	*"We had a food distribution event when COVID first came about. At that point, any vehicle that pulled up, we would talk to them about [TRT]. [We would ask] if you have relatives or you yourself [want birth control]."*– ***Billing staff at not-for-profit clinic***	*"I've delivered [birth control] pills in the parking lot or [at patient's] job sites. I've met people at health departments to give them shots. It's really just meeting them where they are…"*– ***Clinic administrator at not-for-profit clinic***	*"…a lot of young people actually enjoyed the telehealth…because younger kids hate to be seen doing certain things [such as getting birth control]…it offered a bit more confidentiality."* – ***Health department billing staff***

Source: Mathematica's analysis of relevant factors influencing access contraception during COVID-19 in Missouri.

[a] The Missouri Department of Health & Senior Services waived the restriction that APRNs had to practice within 75 miles of their collaborator.

[b] Regulatory waivers through CMS allowed health care providers from other states to provide virtual care, reduced administrative burden by allowing consistent billing across modalities, and allowed for voice-only telehealth services in areas with limited reliable internet service.

[c] Medicaid expansion will provide essential health coverage to more than 275,000 Missourians who were previously uninsured.

[d] Innovations include curbside contraception pickups and contraception mailings, drive-through Depo-Provera clinics, extended contraception supply, and technologies for mail-order sexually transmitted infection kits and urinary tract infection treatment.

APRN = advanced practice registered nurse; CARES = Coronavirus Aid, Relief, and Economic Security act; CMS = Centers for Medicare & Medicaid Services; SDOH = social determinants of health; SRH = sexual and reproductive health;TRT = *The Right Time* initiative.

Policies and strategies to take forward that improve contraceptive access and reproductive health

The innovations TRT implemented provide insight into strategies to increase access to contraceptive care and improve people's autonomy in deciding about their reproductive health even after the COVID-19 pandemic recedes. Some policies and practices during the pandemic allowed for systemic changes that could advance equity in contraceptive access, including reimbursing telehealth visits at the same rate as in-person visits, allowing greater flexibility in delivery of services through the advanced practice registered nurse waiver or voice-only telehealth, and integrating health and social services to deliver preventive care and increase use of services. The challenges to implementing these services among health centers, however, also highlight the other structural, organizational, and community-level changes needed to support these innovations. Here, we list two promising innovations supported by TRT during the pandemic that might require further consideration and support for implementation in other settings and continued use in Missouri.

Providing contraceptive care through telehealth. TRT demonstrated that the shift away from providing contraceptive care only in person has expanded access for many people; one of the largest medical groups in Missouri reported that more than 190,000 patients used its telehealth services in 2020 compared with just 4,000 patients in 2019, a 4,650 percent increase (Gerber 2021). Yet those without internet access and unfamiliar with the necessary technology remain excluded even though they are among those that might benefit the most. Furthermore, health center staff have highlighted that inconsistent practices in reimbursement for telehealth increases administrative burden, disincentivizes providers, and makes it difficult to communicate out-of-pocket costs to patients. Bundling contraceptive visits with other services—such as screening for sexually transmitted infections—also presents a barrier to telehealth provision. Fully leveraging the promise of virtual contraceptive services will require infrastructure improvements, mainly across areas without internet technology. It will also require standardized reimbursement policies and adaptations around ancillary services related to contraception.

"Being in a person-centered world where our services rely on people…we started offering telemedicine. Most of our population didn't want [telemedicine], didn't like it, and didn't have access to technology on their end."
– *Clinic administrator at a Federally Qualified Health Center*

"It's very difficult to do a very good comprehensive or productive visit over the phone or over the internet, and I think that many times we change to phones because of lack of good internet…"
– *Clinic administrator at a Federally Qualified Health Center*

"[Payers] wanted patients to get telehealth, and they had to figure out how to pay for it really quickly, and everybody did it a little differently. One payer wants a particular modifier, one payer wants a particular place of service, and then some payers said, 'we'll waive co-pays, we'll waive deductibles…' Everybody did it a little differently, and everybody had different timelines."
– *Billing staff at not-for-profit clinic*

Using alternative delivery models for pharmacy and lab tests. Curbside contraception and integration of sexual and reproductive health services with other social services reduced barriers to contraceptive uptake among TRT patients because people had a venue for safely obtaining contraception. These alternative delivery models required substantial operational changes to workflow and workforce, such as reserving time in the schedule for drive-through clinics and allowing patients to order birth control by mail. In some cases, changes to Medicaid reimbursement policies were also necessary to allow dispensing a year's supply of contraception at one time. Additional training and technical assistance related to telehealth on topics such as building rapport during virtual calls, submitting claims, and developing processes for late or missed appointments are necessary to make these innovations viable and sustained.

Regardless of the innovation, increasing use of any new services requires additional outreach to and communication with community members so they understand how to access these services and the benefits of doing so. Because of the increased awareness of health disparities resulting from the pandemic, future contraceptive outreach must acknowledge historical inequities and inherent biases in reproductive medicine, seeking to dismantle barriers to contraceptive demand. This might include hosting events in which the speakers are those most impacted by reproductive injustices or co-creating communications language with organizations run by women or trans people of color (NCJW n.d.)

"We have learned some really good lessons out of COVID. I think it forced us to look at providing services and supports a little bit differently. And I think it impacted the number of patients we've seen most definitely, but it also created opportunities to serve them differently."
– *TRT partner*

"We postponed our annual visits, but we never stopped providing services. We were always there for patients to get their shot, their pills. We mailed them. We tried to do whatever it took… patients do not want to come [to the clinic] because of COVID."
– *Clinic administrator at not-for-profit clinic*

"We started dispensing and ordering more pills to keep on hand. That way, we could dispense larger quantities of pills. Instead of giving three packs at a time, we're giving six to nine months, or a year's worth. It limited possible exposures and helped patients with transportation barriers."
– *Clinician at health department*

Conclusion

COVID-19 is not the first societal event that has led to contraceptive care transformation, and it won't be the last. One such event was the domestic gag rule from 2019 that placed restrictions on health centers receiving Title X funds, constricting reproductive autonomy for people who rely on these clinics for comprehensive family planning and preventive health services. Yet, just as health care providers, advocates, and patients adapted to the changing landscape then, we now too consider how innovations developed during the pandemic can carry forward to increase equitable access to reproductive health services. With Governor Michael Parson's declaring an end to the COVID-19 public health emergency in Missouri on December 31, 2021, applying the lessons learned from TRT might involve sharing testimony from safety-net providers on the importance of allowing advanced practice registered nurses to provide care across the state, or involve mobilizing community members to advocate for continued flexibilities with telehealth to reduce barriers to care. By mobilizing for change, researchers, practitioners, policymakers, and community members can advance the promising practices that emerged from TRT during the pandemic to improve reproductive health and contraceptive decision making for all Missourians, regardless of characteristics or circumstances.

Methods

This brief synthesizes information from interviews with 33 clinic staff at 11 health centers participating in *The Right Time*. This includes three Federally Qualified Health Centers, three health departments, two hospital-based clinics, and three not-for-profits. Seven of the 11 health centers are also Title X health centers. Health center staff interviews took place in June and July 2021 with clinicians, clinic administrators, outreach and education coordinators, front desk staff, and billing staff. This brief incorporates data from 10 interviews with community partners, *The Right Time* partners, bellwethers, policymakers, and Advisory Committee members as well as 4 interviews with *The Right Time* patients. These interviews took place from June to August 2021. Supplemental data include encounter-level data from 12 health centers participating in *The Right Time*, provider surveys fielded in June 2020, a policy scan, and a literature review. ◢

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For more about *The Right Time*, please visit https://therighttime.org/.

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